Bundle BCU Performance, Finance & Information Governance Committee 26 August 2025

1 PRELIMINARY MATTERS

1.1 13:00 - PF25.61 Welcome & Apologies - Verbal Update
Gareth Williams, Chair

1.2 13:02 - PF25.62 Declaration of Interest - Verbal Update
Gareth Williams, Chair

1.3 13:04 - PF25.63 Unconfirmed minutes of meeting held on 25 June 2025 - Paper Update
Gareth Williams, Chair
PF25.63 Unconfirmed minutes of meeting held on 25 June 2025 V2.0

1.4 13:09 - PF25.64 Matters Arising & Action Log - Paper Update
Gareth Williams, Chair
PF25.64 Matters Arising & Action Log V2.0

2 ITEMS FOR ASSURANCE

2.1 13:14 - PF25.65 Finance Report - Paper Update
Russell Caldicott, Executive Director of Finance
Include initial thoughts on budget Foundations for the Future
Include as an appendix the letter received on the submission of the IMTP
PF25.65 Finance Report Coversheet - Month 4
PF25.65 Finance Report

2.2 13:34 - PF25.66 Value and Sustainability - Paper Update
Russell Caldicott, Executive Director of Finance
PF25.66 Value and Sustainability
PF25.66 Value and Sustainability

2.3 13:54 - PF25.67 Integrated Performance Report - Paper Update
Stephen Powell, Director of Performance and Commissioning
PF25.67 Integrated Performance Report
PF25.67 Integrated Performance Report

2.4 14:14 - PF25.68 Progress against Planned Care Performance Targets - Presentation
Chief Executive

2.5 14:34 - PF25.69 Urgent and Emergency Care Programme Board
Tehmeena Ajmal, Chief Operating Officer
To include Annex on Health Board's response to MAG recommendations
PF25.69 Urgent and Emergency Care Programme Board

2.6 14:54 - PF25.70 Legal Services - Paper Update
Pam Wenger, Director of Corporate Governance
PF25.70 Legal Services

2.7 15:09 - PF25.71 Audit Wales - BCUHB Tackling the Planned Care Challenges - Paper Update
PF25.71 Audit Wales - BCUHB Tackling the Planned Care Challenges
PF25.71a Audit Wales - BCUHB Tackling the Planned Care Challenges Management Response - approved

3 ROUTINE REPORTING

3.1 15:19 - PF25.72 Board Assurance Framework - Paper Update
Pam Wenger, Director of Corporate Governance
PF25.72 Board Assurance Framework

3.2 15:29 - PF25.73 Corporate Governance Report - Paper Update
Pam Wenger, Director of Corporate Governance

PF25.73a Corporate Governance Repoort - Cycle of Business for the PFIG Committee 2025-26 V0.1

PF25.73b Corporate Governance Report - Committee Annual Report

PF25.73c Corporate Governance Report Committee Self Assessment Presentation 08.25

PF25.73 Corporate Governance Report - Cover

3.3 15:39 - PF25.74 Information Governance - Paper Update
Justine Parry, Assistant Director Of Compliance And Business Management
Information Governance Strategy
Information Governance Quarter 4 2024/25 Key Performance Indicators (KPI) Report.

PF25.74a Information Governance- Information Governance Strategy V10 PFIG

PF25.74b Information Governance- Q4 KPI 2024-25 Final V1 1

4 15:54 - FOR INFORMATION

4.1 PF25.75 Summary of Business to be Reported from Private - Paper Update
Pam Wenger, Director of Corporate Governance

PF25.75 Summary of Business to be Reported from Private

5 15:56 - CLOSING BUSINESS

5.1 PF25.76 Agree Items for Referral to Board / Other Committees - Verbal Update

5.2 PF25.77 Agree Items for Chairs Assurance Report - Verbal Update
Gareth Williams, Chair

5.3 PF25.78 Review of Meeting Effectiveness - Verbal Update
Gareth Williams, Chair

5.4 PF25.79 Date of Next Meeting - Verbal Update
Gareth Williams, Chair

5.5 PF25.80 Resolution to Exclude the Press and Public
Gareth Williams, Chair

Betsi Cadwaladr University Health Board (BCUHB)
UNCONFIRMED Minutes of the Performance, Finance and Information Governance Committee (PFIG)
held in PUBLIC on 25 June 2025
in the Boardroom, Carlton Court, St Asaph and via Teams

Committee Members Present	
Name	**Title**
Gareth Williams	Vice Chair (Chair of PFIG Committee)
Rhian Watcyn Jones	Independent Member
Prof Mike Larvin	Independent Member
Chris Lothian-Field	Independent Member
In Attendance	
Tehmeena Ajmal	Chief Operating Officer
Russell Caldicott	Executive Director of Finance
Dyfed Edwards	Chair
Nick Graham	Associate Direector of Workforce Optimisation
Dave Harries	Head of Internal Audit
Stuart Keen	Director of Environment and Estates
Justine Parry	Assistant Director of Compliance and Business Management
Carol Shillabeer	Chief Executive
Pam Wenger	Director of Corporate Governance
Apologies	
Jason Brannan	Deputy Director of People
Stephen Powell	Director of Performance and Commissioning
Dylan Roberts	Chief Digital and Information Officer
Committee Support	
Philippa Peake Jones	Head of Corporate Governance

PRELIMINARY MATTERS
PF25.52 Welcome and Apologies The Chair welcomed attendees to the meeting and noted apologies.
PF25.53 Declarations of Interest There were no Declarations of Interest.
PF25.54 Unconfirmed Minutes of the Meeting held on 6 May 2025 The minutes of the previous meeting were reviewed and agreed.

It was resolved that the Committee:

- **AGREED** that the minutes of the meeting held on 06.05.25 were a true and accurate record.

PF25.55 Matters Arising and Action Log

Matters arising included:

- An update on key barriers to improving performance
- An update on the use of Primary Care premises for minor procedures
- An update on Legal Services which was due to return to the meeting but will come to the next meeting noting that it had been shared with Audit Committee, via the Executive Committee whereby the team resources had been agreed

Action Log:

- The agenda item on the response to the Ministerial Advisory Group Report was deferred due to staff sickness and will return to the next Committee
- Russell Caldicott updated on the conversations ongoing in relation to Shared Services, noting that this would return once Alison Ramsey had confirmed a date for attending the Committee.

Action:

- Carol Shillabeer to share the key barriers information
- Share the value and sustainability work at the next Committee
- Have a substantive item on Legal Services at the next Committee

The Committee reviewed the action log and agreed to close the items suggested for close, also agreeing to combine action PF24/133.1 and PF24/107.1.

ITEMS FOR ASSURANCE

PF25.56 Finance Report

Russell Caldicott presented the Finance Report and highlighted the following sections:

- 2024/25 Financial Year-End Position:
  - The Auditor General was expected to sign off accounts with the same outturn as presented in the draft end of year position, i.e. a £7.6 million deficit
  - The Health Board had secured £74.6 million of conditional recurrent funding as recurrent funding: a further £82 million would be allocated again as a non-recurrent allocation

- 2025/26 Year-to-Date Financial Position:
  - Month 2 shows a £6 million deficit cumulatively
  - Driven by £4.5 million under-delivery of savings against £40 million target
  - Savings delivery to date:
    - £13 million “green” (secure)
    - £20 million “red” or opportunity stage

        - £10 million gap remains
- Cost Pressures:
    - Mental Health Services, Continuing Healthcare, and capacity-related overspends.
    - Operational overspend approx. £1.7 million (under 1% of total expenditure).
- National Insurance (NI) Funding Risk
    - Relatively modest shortfall in NI funding from the Welsh Government
- NHS Wales Context
    - £32–34 million risk remains across NHS Wales.
    - NHS Wales reporting £56 million overspend at Month 2: BCUHB accounted for £6 million of this compared to £12 million for Cardiff & Vale: and £17 million for Swansea Bay.

    - Four Health Boards had been asked to resubmit financial plans.
    - Underlying financial risk across NHS Wales: £240 million
- Capital Programme
    - 2025/26 capital allocation: £48 million
    - Focus on avoiding March-end spending spikes and early profiling
    - £14 million reprofile being developed to de-risk year-end pressures
    - Lessons from 2024/25: earlier goods received notice processing and supplier engagement
- Workforce and Pay Pressures
    - - Concerns about:
        - Increase in WTEs across IHCs which was not fully understood
        - Lack of clarity on workforce establishment and reconciliation
    - - Reconciliation report being prepared to distinguish:
        - Posts funded from £82 million non-recurrent allocation
        - Posts reinstated from reserves
        - Permanent establishment growth
- Value & Sustainability Programme
    - Programme underpins £40 million savings target.
    - Workstreams include:
        - Biosimilars and medicines optimisation
        - Workforce redesign and skill mix
        - Foundations for the Future
    - Emphasis on shift from technical measures to a focus on allocative efficiency and value-based healthcare.

In discussing the report, the Committee:

- Congratulated the finance team for their good work, especially for achieving the control total despite the financial challenges.
- There was recognition that the savings delivery was supported by accountancy adjustments, but the overall result was still positive.
- Non-Recurrent Funding: There was a clarification that the £11.5m received in January was a recurrent allocation and would continue to be part of the financial mix going forward along with the £74.6m.

- Alignment of Planning and Budget: There was a discussion about the difficulty of aligning planning with budget structures due to the current opaque budget structure and the dominant role of the Integrated Health Communities (IHCs).
- It was noted that future work would be needed to reshape how the budget is presented to make it easier to link to spending priorities: the importance of having a clear and transparent budget structure was emphasised as was Foundations for the Future as a key component of this development.
- Planned Care Funding: There was disappointment expressed about the inability to spend all the Planned Care funding provided by Welsh Government by year-end.
- The need to improve the procurement process to mobilise resources quickly was emphasised, alongside the importance of building in flexibility to enable extensions and variations to contracts.
- Savings and Performance: The savings target for the new year is challenging but should be deliverable.
- There was a discussion about the importance of starting early and maintaining momentum in delivering savings.
- Capital Expenditure: The small underspend in capital expenditure was noted, and there was a discussion about the need to avoid last-minute spending in the future.
- There was a recognition of the need for better utilisation of resources through a rigorous focus on productivity and the importance of aligning financial and operational performance: and that going forward increased resources would need to be directed towards the prevention agenda and to supporting early interventions in Primary and Community Care.

It was resolved that the Committee:

- **RECEIVED** and **SCRUTINSED** the Report.

PF25.57 Integrated Performance Report

Carol Shillabeer presented the report on behalf of Stephen Powell highlighting:

- Performance improvement is being embedded into the broader “Foundations for the Future” programme.
- A new integrated performance framework is under development, supported by Internal Audit, to support a more mature and systematic approach to performance management.
- The current report was acknowledged as showing a “picture” rather than telling a “story,” and efforts are underway to improve narrative and insight.
- Service reviews had recently taken place with the CEO Chairing them: these would now be held quarterly, with interim touchpoints to maintain momentum.
- Corporate Directorate Performance reviews were scheduled to commence, these are being held every six months.
- Recent engagements with the Welsh Government included Joint Executive Team (JET) meetings, Integrated Quality Performance Delivery sessions, and specific focus on areas such as cancer and urgent care
- In relation to People and Organisational Development PADR compliance was at 80%, indicating strong performance, there was a reduced turnover and agency spend and nursing vacancies had dropped significantly.

- In relation to Access and Planned Care, the number of over 104 week waits had increased again, which was worrying though not unexpected: there was an imbalance between follow up appointments (over 544,000) compared to first outpatient appointments (100,000) which needed to be addressed.
- Urgent and Emergency Care (UEC) showed small improvements but there was very significant work still to do.
- Cancer Pathways, there is a need to better balance resources between cancer and non-cancer urgent pathways and more detailed work is required to optimise cancer treatment pathways.
- The performance of CAMHS (Children and Adolescent Mental Health Services) against targes was improving (but still below targets) but there was a mixed picture with regard to Adult mental health services.

In discussing the report, the Committee made the following observations:

- That the overall message from the report was disappointing, with continued poor performance across almost all key targets which were within the Committee's remit
- However, progress had been made in terms of some key quality targets indicators (not the direct responsibility of the Committee) , e.g. complaints handling where the Health Board was the best in Wales; incident reporting, inquest response times, and clinical coding.
- Clinical leadership engagement and innovation are key to improvement with potential examples shared such as community physiotherapy days and extended radiology hours.
- Structural and Strategic Challenges were highlighted such as fragmented services and lack of unified models (e.g., ophthalmology) and that there was a need for standardised, scalable systems.
- Going forward there needed to be a shift focus from activity reporting to demonstrating impact and outcomes.
- In terms of the balance between follow-up appointments and new outpatient appointments, the Committee noted the very high number of follow-up appointments and noted that Workstream 5 had been launched to identify potential for much greater reliance on Patient Initiated Follow Up (PIFU) rather than routine appointments. A 10% reduction in follow-ups could yield capacity for a 50% increase in new outpatient appointments.
- The Committee noted that improvements in Urgent and Emergency Care which has been achieved during the winter had not been sustained. Concerns about winter preparedness and ambulance delays were highlighted with the normalisation of poor performance in terms of ambulance hand-overs being a cultural issue.
- With regards to next steps the Committee suggested:
    - Prioritise a small number of high-impact initiatives.
    - Move from persuasion to instruction where necessary.
    - Strengthen clinical ownership of performance improvement.
    - A Board development session to align on ambition and strategy.

Action

- Schedule a Board Development session to align ambition and strategy

It was resolved that the Committee:

- **RECEIVED** and **SCRUTINSED** the Integrated Performance Report.

PF25.58 – Integrated Medium Term Plan

Item withdrawn, as there was no formal response as yet from Welsh Government.

PF25.60 – Health Board's response to Ministerial Advisory Group (MAG) recommendations

Item postponed

PF25.61 – Estates Strategy

Stuart Keen gave a presentation on the development of an Estates Strategy highlighting:

- The agenda item was introduced as "Estates Rationalisation," but it was clarified that effective rationalisation requires a robust Estates Strategy. The current strategy (2023–2033) needs review and realignment with the Integrated Medium Term Plan (IMTP) and broader organisational goals.
- The Estates Strategy is intended to be an enabler, not a prescriptive list of projects. It will align with clinical strategies, workforce and digital strategies, capital planning, risk management, and decarbonisation goals. The strategy will also support business case development and partnership working with housing associations, local authorities, and third-sector organisations.
- The existing strategy was described as too generic and not sufficiently aligned with service delivery or strategic planning. There are significant data gaps in understanding current estate usage across Integrated Health Communities (IHCs). A common approach to data collection and analysis is being developed.
- The revised strategy will be robust, enabling, and aligned with the IMTP. It will provide a strategic plan for estate management and rationalisation, support decarbonisation and climate resilience, facilitate integrated service delivery, and enable better use of capital and revenue resources.
- The target is to present the updated strategy to PFIG and the Board by Quarter 4 (March 2026). Interim steps include data collection and analysis, establishing a Delivery Board, and drafting and refining the strategy document.

In discussing the presentation, the Committee:

- Welcomed the strategic shift and praised the direction of travel. The previous strategy was criticised for being disconnected from service needs.
- Observed that disposal of surplus property was highly desirable but must be strategic and not opportunistic.
- Questioned whether there were missed opportunities from Section 106 Agreements.

- Raised concerns about outdated assumptions regarding agile working and excessive paper storage.
- Emphasised the need for partnership working with Local Authorities, Universities, Registered Social Landlords and Third Sector Organisations.
- Noted the need to avoid duplication of infrastructure across public services.
- Supported moving away from bespoke, high-spec buildings and embracing modular, flexible, and adaptable environments. Lessons should be learned from the 21st Century Schools Programme and International models such as those in Australia and New Zealand.
- Noted that the Estates Strategy will be integrated with the 10-year strategic plan, the new Strategic Planning and Service Change Subcommittee of the Executive Team, and the Foundations for the Future programme.

Action

- Receive further updates at future meetings.

It was resolved that the Committee:

- **NOTED and SUPPORTED** the development of the revised strategy

PF25.62 – Corporate Services Financial Overview

Russell Caldicott presented the Corporate Services Financial Overview and highlighted:

- That there had been significant growth in Corporate expenditure over the past five years and that the report aimed to benchmark corporate spending, identify trends, and inform future strategic decisions regarding resource allocation and efficiency.
- Corporate spend had increased from 4.3% to 5.17% of the total budget with an absolute increase of £55 million (80%) in corporate costs over five years.
- The have been 500 additional Whole Time Equivalents (WTEs) added to corporate functions.
- There are benchmarking challenges due to inconsistent data across Health Boards
- There seemed to be justification for concerns about the sustainability and justification of Corporate growth.

In discussing the report, the Committee made the following observations:

- Concerns were raised over the scale of growth in corporate staffing and expenditure: there was evidence of significant ‘banding inflation’ as the cost of the establishment had increased by a significantly greater margin than could be accounted for by the increase in headcount and wage inflation.
- The average cost per WTE appeared very high: comparison with ONS data suggested that NHS corporate salaries were significantly above regional averages.
- There was a need for a strategic decision on the desired size and function of the corporate centre. It was noted that the organisation’s structure may be contributing to

inefficiencies and duplication and that there was a need for proper establishment controls and job evaluation processes.
- The Committee received confirmation that changes were underway to standardise job evaluation and control banding inflation and that benchmarking across Wales was being pursued to provide a clearer picture of efficiency.
- That the findings needed to be integrated into the Foundations for the Future and the Value and Sustainability programmes.
- The Committee acknowledged the importance of corporate functions but stressed the need for efficiency, transparency, and alignment with organisational priorities. The report was welcomed as a starting point for deeper analysis and strategic decision-making.

Action
- Further report on progress to the Committee with a refreshed position at the end of the calendar year

It was resolved that the Committee:
- **NOTED** the contents of the paper and further work to be undertaken within 'Foundations for Future' and the Value and Sustainability program (Workforce) in determining opportunity to deliver improvement and/or efficiencies

ROUTINE REPORTING

PF25.63 Corporate Risk Register

Pam Wenger presented the report highlighting:

- Due to the timing of the meeting, some of the entries were not fully populated and there were gaps in updates against some risk entries.
- The need to reprofile risks related to Planned Care and Urgent and Emergency Care (UEC), noting an upcoming Executive session to review risk tolerances and the effectiveness of mitigating actions.

  Russell Caldicott provided an update on the financial sustainability risk, suggesting that the risk score could be downgraded due to improved financial performance, including the confirmation of the £74.6 million and £82 million allocations.

In discussing the report, the Committee made the following observations:
- There were concerns about the UEC risk, questioning whether the likelihood score should be higher given the clear gap between Welsh Government expectations and the Health Board's IMTP commitments and that the risk may have already materialized into a performance issue.
- There was a discussion around the distinction between risks and issues, emphasising the need to clarify whether the risk is about failing to meet expectations or about actual harm to patients. They noted that some risks may have already crystallised into issues, and that the current scoring may not reflect this reality.
- Concern was raised about risk action management, noting that many actions were being extended without clear rationale.

- The concerns were acknowledged noting that stronger Executive oversight was required and that efforts were underway to align Board reporting and ensure that changes to risk scores or actions are properly justified and documented.
- The Committee, while noting the huge improvement in risk management over the last two years, agreed that the current approach to risk management needed further refinement, particularly in distinguishing between risks and issues, and in ensuring that mitigating actions are meaningful and timely.

Actions

- Executive session to review risk tolerances and action effectiveness.
- Reprofiling of UEC and Planned Care risks to reflect current performance realities.
- Clarification of risk verses issue definitions and appropriate categorisation
- Improved justification and documentation for changes to risk actions and scores to be included

It was resolved that the Committee:

- **RECEIVED** and **SCRUTINSED** the Report

FOR INFORMATION

PF25.64 Summary of Business to be Reported from Private

The Committee had previously considered the following matters in private session at the meeting held on 6 May 2025:

- Ty Glyder briefing - Community Dental Services
- Llandudno Othopeadic Hub
- Recommission of the Substance Misuse Detoxification Service
- Wheelchair Service and Repair
- Endoscopy insourcing extension
- PETCT tender approval

It was resolved that the Committee:

- **NOTED** the report

PF25.65 Cycle of Business and Committee Workplan

The Committee noted that work was ongoing to align the cycle of business with the IMTP. A request was made for colleagues to respond to the Committee Self Assessment to inform the Committee Annual Report.

CLOSING BUSINESS

PF25.66 Agree Items for referral to Board / Other Committees

Items for Referral to Other Committees

- People & Culture Committee: Corporate Centre Financial Overview.
- Planning, Population Health Partnerships Committee: Estate Strategy Presentation.

Messages for the Board

- Financial performance improving; savings delivery remains a key risk.
- Performance challenges persist, particularly in UEC; cultural and structural changes needed.
- Encouragement from progress on estate strategy and corporate services review.
- Risk Management processes under review to improve effectiveness.

PF25.67 Agree Items for Chair's Assurance Report

The above items would be included in the Chair's Assurance Report.

PF25/37 Review of meeting effectiveness

It was agreed due to timing for colleagues to share any feedback outside of the meeting.

PF25/38 Date of next meeting

26 August 2025

The Committee agreed to move this meeting to the afternoon.

Exclusion of 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."

Performance Finance & Information Governance Committee Action Log (Public)

Updated 20.08.25

Open Actions						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
1	PF25.57	25.06.25	**Integrated Performance Report** Schedule a Board Development session to align ambition and strategy	Pam Wenger	August 2025	Remain open Board Session in August is focused on strategy, work in progress on the re-development of the Performance Report.
2	PF25.63	25.06.25	**Corporate Risk Register** Executive session to review risk tolerances and action effectiveness.	Pam Wenger	October	Remain open Risk appetite session scheduled to take place with executives in Aug 25. Expect to close next PFIG meeting
3	PF25.63	25.06.25	Reprofile UEC and Planned Care risks to reflect current performance realities	Tehmeena Ajmal	October	Remain open Work is underway to re-profile the corporate risks and will be reflected in the next update of the Corporate Risk Register in October
4	PF25.63	25.06.25	Clarification of risk verses issue definitions and appropriate categorisation	Pam Wenger	October	Remain open

			to be included on the next Corporate Risk Register			This is covered in the Risk Management Framework – however, as the next report is not till October suggest this item remains open until then
5	PF25.55.1	25.06.25	**Matters Arising and Action Log** Carol Shillabeer to share the key barriers information	Carol Shillabeer	August 2025	Suggest close Circulated on 20 August 2025
6	PF25.55.2	25.06.25	**Matters Arising and Action Log** Share the value and sustainability work at the next Committee	Russell Caldicot	August 2025	Suggest close On agenda
7	PF25.55.3	25.06.25	**Matters Arising and Action Log** Have a substantive item on Legal Services at the next Committee	Pam Wenger	August 2025	Suggest close On agenda
8	PF25.61	25.06.25	**Estates Strategy** Receive further updates at future meetings.	Stuart Keene	February 2026	Suggest close Now captured on Cycle of business and will form part of routine reporting aligning to the Annual Plan
9	PF25.62	25.06.25	**Corporate Services Financial Overview** Further report on progress to the Committee with a refreshed position at the end of the calendar year	Russell Caldicot	August 2025	Suggest close Now captured on the Forward Work plan

10	PF25.63	25.06.25	Improved justification and documentation for changes to risk actions and scores to be included	Pam Wenger	October	Suggest close Any future changes to scores and dates to include rationale and provide level of assurance on report
11	PF25/135.4	23.12.24	**Integrated Performance Report** To share with Members a Neuro Diversity Team briefing which should include an overview of the current system highlighting possible improvements.	Carol Shillabeer	~~February 2025~~ Revised timescale April 2025	Suggest close **25.02.25** It was noted during the meeting that Carol is meeting with the Neurodiversity Team during the afternoon of 25.02.25 and an update would be provided at the next meeting. Update provided to Board on 31 July 2025
12	PF24/107.1	29.10.24	**PF24/107 Shared Service Partnership performance assurance report** Rebecca Nelson's attendance would be factored into the Committee workplan, along with areas of focus that would be agreed through the Committee Chair, Interim Executive Director of Finance and the Director of Corporate Governance	Pam Wenger	~~December 2024~~ Revised timescale End of June 2024	Suggest close This will be taken forward when the cycle of business is reviewed. PW and RC met with Alison Ramsey, Director of Finance in June 2025 Committee COB to be drafted following Board cycle of business approval.

						All Committee COB's are now drafted.
Closed Actions (as agreed at meeting on 25.06.25)						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
1	PF25/27.1	06.05.25	**Matters Arising and Action Log** Estates Strategy overview to return to the next PFIG Committee	Stuart Keene		Item on the agenda
2	PF25/27.2	06.05.25	**Matters Arising and Action Log** Share with IM's the MAG report and speech	Philippa Peake-Jones		Item shared in a weekly Corporate Governance update Link: Ministerial Advisory Group NHS Performance and Productivity | GOV.WALES
3	PF25/27.3	06.05.25	**Matters Arising and Action Log** Review action log and update and where possible ensure all items are covered in the Cycle of Business	Pam Wenger	June 25	Item on the agenda
4	PF25/26	06.05.25	**Unconfirmed Minutes of the Meeting held on 25 February 2025** Add item on the next agenda for response to the MAG and our response to it and enabling actions.	Stephen Powell	June 25	Item on the agenda

5	PF25/06.2	25.2.25	**Integrated Performance Report** Circulate a briefing note on admissions from Care Homes.	Stephen Powell	May 25	Included on the report – SP will clarify in the meeting
6	PF25/09.2	25.2.25	**Diabetes Service Performance Update** Gareth to raise the issue of GDPR nationally regarding the inability to access Primary Care data being raised as an issue.	Gareth Williams	May 25	Not formally raised this but it was brought up at MAG event.
7	PF24/41.3	30.4.24	**Performance Report** Provide focussed performance reports to PFIGC on Dermatology, Ophthalmology, Cancer, Theatre Utilisation and management of waiting lists, following Quality Round Table session with WG based on scheduling agreed with Director of Corporate Governance	Pam Wenger Sreeman Andole	~~June 2024~~ Revised timescale End of June 2024	The business cycle for all the Committees is being reviewed to align with the Annual Plan Delivery Plan as agreed by the Board in March 2024. **25.6.24** Committee requested to leave open until completed The Annual Delivery Plan will address all areas of Fragile Services and these will be monitored All Committee COB's are now drafted.

Teitl adroddiad: ***Report title:***	**2025-26 Month 4 (July) Finance Report**
Adrodd i: ***Report to:***	Performance, Finance and Information Governance Committee (PFIG)
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 26 August 2025
Crynodeb Gweithredol: ***Executive Summary:***	This report provides a briefing on the financial position of the Health Board as at the end of Month 4 (July 2025). In addition, the report includes an update on delivery of the approved Capital Programme and Savings delivery against target. <u>Finance Report</u> The Health Board is reporting a deficit of £11.4m as at 31st July 2025, which is largely driven by a shortfall in savings delivery, pressures associated with Escalated Beds, Healthcare Services provided by other NHS Bodies Contracts and a substantial increase in Mental Health Out of Area referrals. The Month 4 (July 2025) financial position of the Health Board is an in-month deficit of £3.6m, a deterioration of £2.0m from previous month, the increase largely driven by the shortfall in National Insurance contributions of £1.4m for the months of April to July 2025 (costs previously offset by anticipated allocations). The forecast is to deliver a balanced position in line with the plan submission and integrated medium-term plan (IMTP). However, progress is required at pace to convert current opportunities and further additional savings opportunities to green schemes. A significant component of being able to recover the year to date position centres upon delivery of savings targeted at commencement of the financial year. The Executives and IHC Directors have been informed via the Integrated Performance and Executive Delivery Group (IPEDG) of the requirements to fully identify the £40m savings requirements prior to the Month 5 MMR submission. Escalation meetings will be held with officers in regards to performance on savings delivery, Welsh Government further placing the Health Board under escalation for savings identification and delivery owing to the significant risk this presents in attainment of the financial plan. The risk to not attaining plan is the loss of the £82m allocation as we move into 2026/27 and beyond, conditions on retention of these funds centring upon attainment of the 2025/26 break-even plan key first duty of the Health Board. Focus will also need to continue on containing cost overruns and recovering the year-to-date deficit position, and a number of Grip and Control actions implemented in 2024/25 have continued into 2025/26. The below table summarises a revision to monthly forecast variance for 2025/26:

	2025/26													
	Actual				Forecast									
	April £m	May £m	June £m	July £m	August £m	Sept £m	Oct £m	Nov £m	Dec £m	Jan £m	Feb £m	Mar £m	Total Year to Date £m	Forecast Outturn Position £m
Total Monthly Surplus/ (Deficit)	(3.7)	(2.4)	(1.6)	(3.6)	(2.0)	(0.5)	0.0	2.3	2.5	2.9	3.0	3.2	(11.4)	0.0

Risks

Containment and reversal of cost overruns is now key, with the risk of attainment of the 2025/26 financial plan being assessed as circa £53.5m.

Savings

As referenced in the financial summary, the Health Board's financial plan requires a savings target of £40.0m to be delivered in 2025/26. The £40.0m target plan profiled on an equal twelfth's basis.

As at Month 4 (July 2025) the Health Board has identified £23.6m Green saving schemes, fortuitous Accountancy Gains of £1.9m giving a combined total of £25.5m, an increase of £8.0m from previous month. Recurring savings (those expected to continue into future accounting periods) total £18.2m with a full year effect of £24.3m, with an additional £7.3m identified as non-recurring (one off) savings.

Full year plan value of Red Schemes totals £2.7m and the full year plan value of further pipeline opportunities totals £9.9m. Savings delivered in Month 4 totalled £5.3m, of which £2.5m is recurring against a target of £3.3m.

It is important that identification and delivery of savings are progressed at pace, so as not to continue contributing to adverse performance in the early part of 2025/26 that will require recovery during the remaining months of the 2025/26 financial year (the period concluding on the 31st March 2026). The Executives and IHC Directors have been informed via the Integrated Performance and Executive Delivery Group (IPEDG) of the Welsh Government requirements to fully identify the £40m savings requirements and all schemes must meet the 'Green Schemes' criteria prior to the Month 5 MMR submission deadline.

Capital Programme

The approved Capital Resource Limit (CRL) for 2025/26 is £52.7m (including £0.2m IFRS16 Tranche 1) and is forecast to be spent in full. Year to Date expenditure is £5.1m.

The forecast outturn reflects the anticipated amendment of £3.9m which is contingency for the Orthopaedic Hub.

	The tender award for the Substance Misuse Building in Llandudno has been delayed which may impact on the anticipated cashflow. This has already been highlighted to Welsh Government.			
Argymhellion: ***Recommendations:***	The Board is asked to: • **Receive,** and scrutinise this report			
Arweinydd Gweithredol: ***Executive Lead:***	Russell Caldicott, Interim Executive Director of Finance.			
Awdur yr Adroddiad: ***Report Author:***	Michelle Jones, Head of Financial Reporting Daniel Eyre, Head of Capital Development			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☒ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	This paper aligns to the strategic goal of attaining financial balance and is linked to the well-being objective of targeting our resources to those with the greatest need as per the financial plan.			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	The financial plan and reporting, capital projects and discretionary programme assist the Health Board in meeting its' statutory and mandatory requirements.			
Yn unol â WP7 (sydd bellach yn cynnwys WP68), a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?	Naddo N Equality Impact (EqIA) and a socio-economic (SED) impact assessments not applicable.			

In accordance with WP7 (which now incorporates WP68) has an EqIA been identified as necessary and undertaken ?	The health board continues to assess the requirement for carrying out Equality Impact Assessments and Social-Economic impact assessments on a capital project by project basis.
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	BAF – Financial Stability From a capital perspective, the Health Board continues to experience occasions where tenders are exceeding budget estimates due to the volatility within the construction market and general inflationary pressures. The programme is monitored monthly to ensure that financial commitments align to available funding.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The Health Board is in receipt of £82m of non-recurrent funding from Welsh Government that requires attainment of the 2025/26 plan (a) delivery of financial balance £40m and (b) de-escalation from Special Measures £42m for these funds to be received recurrently (available for future financial years). If the plan is not attained then the funding of £82m will be at risk of clawback from Welsh Government and this places risk on the sustainability of existing service models.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Not applicable
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Not applicable
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	**Appendix A** **BAF risks** BAF SP14 – Estates & Capital *(There is a risk of failing to deliver and provide a safe and compliant built environment, equipment and digital landscape due to limitations in capital funding, adversely impacting on the Health Board's ability to implement safe and sustainable services through an appropriate refresh programme, could result in avoidable harm to patients, staff, public, reputational damage and litigation*.) **Link to Corporate Risk Register:** CRR24-06 Suitability and Safety of Sites CRR24-05 Delivery of the 25/26 Financial Plan
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)	Amherthnasol

Reason for submission of report to confidential board (where relevant)	Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations***	
Rhestr o Atodiadau: ***List of Appendices:*** A - 2025/26 Finance Report – July (Month 4)	

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

Finance Report – Health Board July - Month 4 2025/26

Russell Caldicott
Executive Director of Finance

Executive Summary

Objective		• To provide assurance on financial performance and delivery against Health Board financial plans and objectives; and give early warning on potential performance issues. To make recommendations for action to continuously improve the financial position of the organisation, focusing on specific issues where financial performance is showing deterioration or there are areas of concern.
Statutory Financial Duties	**Revenue**	• Year to Date is reporting a deficit of £11.4m. • In-month deficit of £3.6m, a deterioration of £2.0m from the previous month is largely a consequence of a shortfall in National Insurance funding • Year-to-date adverse performance driven by savings non-delivery, out of area mental health placement costs and additional capacity areas • Forecast position is to deliver a balanced position, which is in line with the financial plan for the year, noting the significant risks to delivery.
	Cash	• Closing Cash Balance as at 31st July 2025 was £6.1m, including £2.4m for Revenue and £3.7m for Capital projects. The Health Board is currently forecasting a closing cash balance for 2025-26 of £5.9m made up of £3.0m revenue cash and £2.9m capital cash.
	Savings	• The Health Board's financial plan has set a savings target of £40.0m to be delivered in 2025/26 profiled equally across the financial year. • Savings delivered in Month 4 totals £5.3m, £2.0m over the in month target of £3.3m. Year to Date Savings totals £9.5m, of which £5.0m is recurring. This includes Accountancy Gains of £1.9m, of which £1.7m were identified in month which contribute to the in month achievement. • Full year savings value of Green Schemes total £25.5m (including £22.4m Savings, £0.4m Income Generation, £0.7m Cost Avoidance and Accountancy Gains of £1.9m). Of these, £18.2m are recurring, with a full year effect of £24.3m, and £7.3m non-recurring. Additional red schemes and opportunities of £12.6m are under review.
	Capital	• Approved Capital Resource Limit (CRL) for 2025/26 is £52.7m.
	PSPP	• Quarter 1 PSPP for paying non-NHS invoices by number was 96.8% (Welsh Government target 95.0%). To be updated at Quarter 2.
Key Messages		➢ In-month position is reporting a deficit of £3.6m, a deterioration of £2.0m from the previous months position and year to date deficit is £11.4m, largely driven by the shortfall in National Insurance funding of £1.4m for the months of April to July 2025 (previously costs offset by anticipated allocations), pressures associated with Escalated Beds, Healthcare Services provided by other NHS Bodies Contracts and a substantial increase in Mental Health Out of Area referrals. ➢ The Executives and IHC Directors have been fully informed via the Integrated Performance and Executive Delivery Group (IPEDG) of the requirements to fully identify the £40m savings requirements prior to the Month 5 MMR submission. Escalation meetings will be held with officers with regards to performance on savings delivery, Welsh Government further placing the Health Board under escalation for savings identification and delivery owing to the significant risk this presents in attainment of the financial plan. ➢ The Health Board is also advised of significant risks relating to funding shortfalls, with total Quantifiable risks to the Health Board's financial position currently reported at £53.5m (See further detail in Slide 13). National Insurance funding confirmed on a non recurrent basis by WG is £18.7m which will present a shortfall of £4.2m (18.3% of costs), potential for increased contribution to the Welsh Risk Pool share and risk of Joint Commissioning Committee not being able to manage financial contractual performance.

Key Performance Indicators

Month 4 Position

In Month: £198.4m against plan of £194.9m

£3.6m adverse (£1.4m National Insurance impact in month)

Full Year: £772.2m against plan of £760.8m

£11.4m adverse

2025/26 Full Year Position

Forecast Balanced

There is significant risks associated with shortfalls in savings delivery and cost overruns from additional capacity and out of area mental health placements

YTD Divisional Variance

West IHC	£8.9m adverse
Central IHC	£11.3m adverse
East IHC	£14.1m adverse
Womens	£1.3m adverse
MH & LD	£6.9m adverse
Commissioning Contracts	£4.8m adverse
ICD Primary Care	£0.9m favourable
ICD Regional Services	£4.8m adverse
Support Functions	£1.8m adverse
Other Budgets	£41.7m favourable

Savings

In-month: £5.3m against target of £3.3m

£2.0m favourable

Full Year Savings Delivery

£23.6m against target of £40.0m

£16.4m adverse (Additional red schemes and opportunities of £12.6m are under review)

COVID-19 Impact

£3.3m YTD Cost

£13.0m COVID funding allocation from WG

Year to Date Income

£54.7m against budget of £53.6m

£1.1m favourable

Year to Date Pay

£383.3m against budget of £362.1m

£21.2m adverse

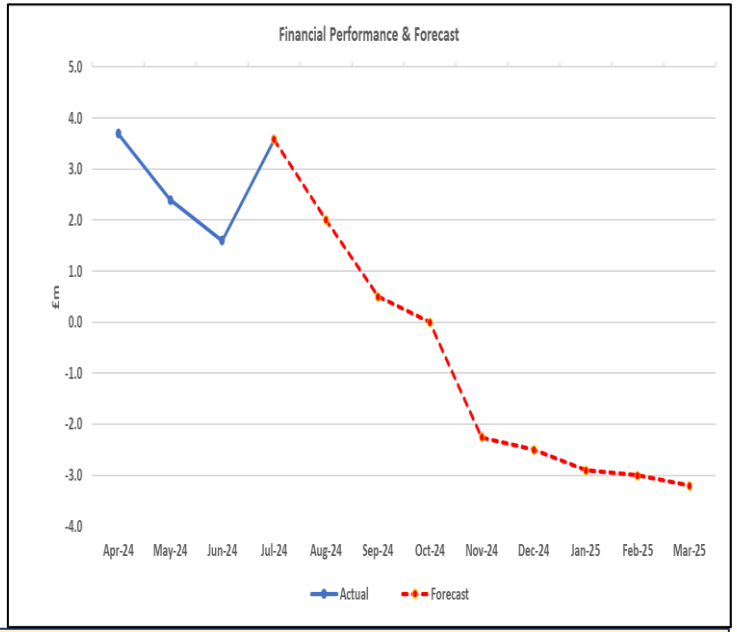
Year to Date Non-Pay

£443.6m against budget of £452.3m

£8.7m favourable

Revenue Position

	Actual				Forecast								2025/26 Cumulative against Plan				Full Year Forecast
	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	Budget	Actual	Variance	Variance	
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	%	£m
Revenue Resource Limit	(186.5)	(189.5)	(189.9)	(194.9)	(189.3)	(191.4)	(190.6)	(190.8)	(193.1)	(193.0)	(190.4)	(193.4)	(760.8)	(760.8)	**0.0**	0.00	(2,292.8)
Miscellaneous Income	(13.4)	(13.6)	(13.9)	(13.9)	(13.4)	(13.5)	(13.5)	(13.5)	(13.5)	(13.7)	(13.6)	(14.4)	(53.6)	(54.7)	**(1.1)**	2.2%	(163.9)
Health Board Pay Expenditure	94.9	96.4	96.0	96.1	94.8	95.2	95.3	95.3	95.4	95.7	95.4	95.4	362.1	383.3	**21.2**	5.9%	1,145.8
Non-Pay Expenditure	108.8	109.2	109.4	116.2	109.9	110.2	108.8	106.7	108.6	108.1	105.5	109.2	452.3	443.6	**(8.7)**	-1.9%	1,310.8
Total Deficit / (Surplus)	**3.7**	**2.4**	**1.6**	**3.6**	**2.0**	**0.5**	**0.0**	**(2.3)**	**(2.5)**	**(2.9)**	**(3.0)**	**(3.2)**	**0.0**	**11.4**	**11.4**		**0.0**



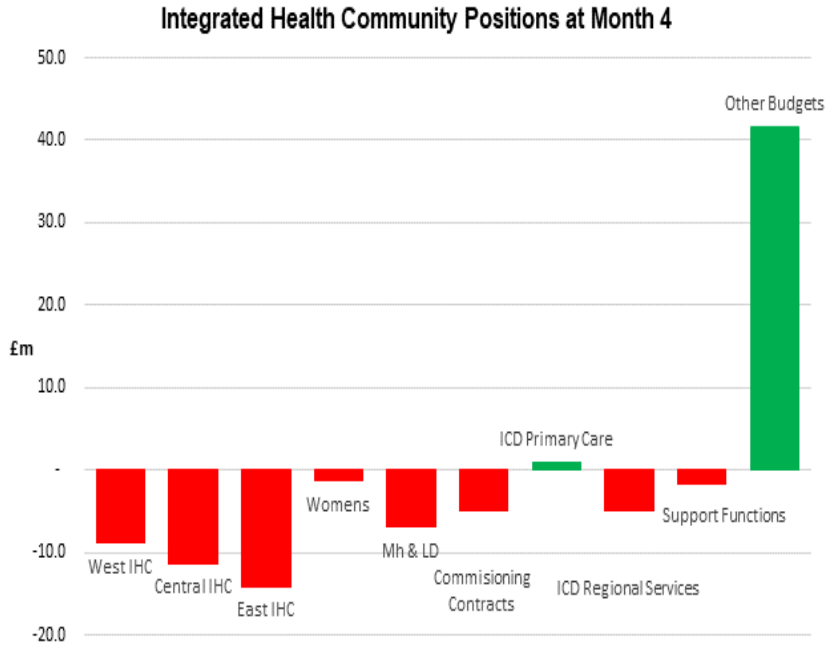
- The 2025/26 financial plan aligns with the strategic ambition of the Health Board in attaining the key financial duty to break-even. Expenditure commitments will need to be prioritised to enable the key financial duty and the performance ask to be attained. Achieving the control target in 2024/25 has resulted in the £74.6m conditionally recurrent funding received in 2023/24 and 2024/25 being allocated as recurrently in 2025/26 and the receipt of the £82.0m Improvement and Transformation funding allocation non-recurrently for 2025/26, with conditions associated with retention recurrently of the funds for 2026/27 and beyond being:
  - £40.0m Deficit Support Funding – Recurrent and non-conditional following submission and delivery of a financially balanced IMTP by the Health Board.
  - £42.0m Performance & Transformation Funding – Recurrent on de-escalation from Special Measures and Welsh Government having greater oversight and direction in use against Special Measures and Ministerial priorities.

- Focus will need to continue on containing cost overruns and recovering the year to date deficit position, and a number of Grip and Control actions implemented in 2024/25 have continued into 2025/26.

- The in-month position is reporting a deficit of £3.6m, a deterioration of £2.0m from previous months in-month position, and is £2.6m higher than the forecast deficit profiled for Month 4. Year to Date position is reporting a deficit of £11.4m, largely driven by the shortfall in National Insurance funding of £1.4m for the months of April to July 2025 (previously costs offset by anticipated allocations), pressures associated with Escalated Beds, Healthcare Services provided by other NHS Bodies Contracts and a substantial increase in Mental Health Out of Area referrals. This now representing over 30 patients at significant additional cost to the Health Board.

Divisional Positions

	In Month				Cumulative				Forecast Year End Variance against the Plan
	Budget	Actual	Variance to Plan	Variance to Plan	Budget	Actual	Variance to Plan	Variance to Plan	
	£m	£m	£m	%	£m	£m	£m	%	£m
WG RESOURCE ALLOCATION	(194.9)	(194.9)	0.0	0%	(760.8)	(760.8)	0.0	0%	0.0
WEST INTEGRATED HEALTH COMMUNITY									
Management	0.1	0.1	0.0		0.5	0.4	0.0		0.0
West Area	17.1	17.9	(0.8)		67.4	70.7	(3.3)		(9.1)
Ysbyty Gwynedd	11.0	12.6	(1.7)		44.0	49.1	(5.1)		(16.1)
Facilities	1.1	1.2	(0.1)		4.5	5.0	(0.4)		(1.1)
Total West	29.3	31.9	(2.6)	-9%	116.3	125.2	(8.9)	-8%	(26.2)
CENTRAL INTEGRATED HEALTH COMMUNITY									
Management	0.1	0.1	(0.0)		0.4	0.5	(0.1)		(0.2)
Central Area	23.3	23.7	(0.4)		89.2	91.7	(2.5)		(13.3)
Ysbyty Glan Clwyd	13.7	16.1	(2.4)		55.0	63.2	(8.2)		(23.8)
Facilities	1.3	1.5	(0.2)		5.3	5.9	(0.6)		(1.8)
Total Central	38.4	41.4	(3.0)	-8%	149.9	161.2	(11.3)	-8%	(39.0)
EAST INTEGRATED HEALTH COMMUNITY									
Management	0.1	0.1	0.0		0.4	0.4	0.0		0.0
East Area	24.8	26.5	(1.7)		97.8	105.1	(7.4)		(22.4)
Ysbyty Wrexham Maelor	11.8	13.4	(1.6)		47.0	53.0	(6.1)		(17.9)
Facilities	1.2	1.4	(0.2)		4.8	5.5	(0.7)		(2.0)
Total East	37.9	41.4	(3.5)	-9%	150.0	164.1	(14.1)	-9%	(42.2)
Total Midwifery and Women's Services	4.1	4.5	(0.4)	-11%	16.4	17.7	(1.3)	-8%	(4.0)
Total Mental Health and LDS	14.8	16.7	(1.9)	-13%	58.9	65.8	(6.9)	-12%	(16.9)
Total Commissioning Contracts	27.2	28.8	(1.6)	-6%	102.0	106.8	(4.8)	-5%	(12.7)
INTEGRATED CLINICAL DELIVERY PRIMARY CARE									
Covid Programmes	0.0	0.0	0.0		0.0	0.0	0.0		0.0
Dental North Wales	3.0	3.0	0.0		12.0	11.2	0.9		2.5
Community Dental Services	0.6	0.6	0.0		2.2	2.3	(0.1)		(0.3)
Other Primary Care	0.1	(0.1)	0.2		0.5	0.5	0.0		(0.4)
Total Integrated Clinical Delivery Primary Care	3.7	3.5	0.2	6%	14.8	13.9	0.9	6%	1.8
INTEGRATED CLINICAL DELIVERY REGIONAL SERVICES									
Provider Income	(1.9)	(1.9)	0.0		(7.6)	(7.9)	0.3		1.0
Diagnostic and Specialist Clinical Support	7.1	7.4	(0.3)		27.9	30.1	(2.2)		(8.2)
Cancer Services	5.6	6.4	(0.8)		22.4	25.4	(3.0)		(8.5)
Total Integrated Clinical Delivery	10.8	11.9	(1.1)	-10%	42.7	47.5	(4.8)	-11%	(15.7)
Total Service Support Functions	14.7	14.9	(0.2)	-1%	56.3	58.0	(1.8)	-3%	(5.1)
Total Other Budgets	13.9	3.4	10.5	75%	53.6	11.9	41.7	78%	160.1
Total Health Board Position	0.0	(3.6)	(3.6)		0.0	(11.4)	(11.4)		(0.0)



- In-month position is reporting a deficit of £3.6m, a deterioration of £2.0m from previous month. The forecast is to deliver a balanced outturn, which is in line with the financial plan for the year.
- Variable pay costs have increased in July by £0.5m from June driven by an increase of £0.4m in Locum and £0.3m in Agency, offset by a reduction of £0.2m in Bank.
- Further detail on Pay and Non-Pay spend is reported in Slide 6 and 11.

Expenditure – Pay & Non-Pay

Pay Costs	Actual				Forecast								Cumulative			Full Year Forecast
	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	Budget	Actual	Variance	
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Administrative & Clinical	13.2	13.3	13.3	13.3	13.7	13.8	13.8	13.8	13.8	13.9	13.8	13.8	54.1	53.0	1.1	165.5
Medical & Dental	22.3	22.7	22.2	23.1	21.1	21.2	21.2	21.3	21.3	21.3	21.3	21.3	80.5	90.3	(9.8)	255.5
Nursing & Midwifery Registered	28.8	29.1	29.2	28.9	29.3	29.4	29.4	29.5	29.5	29.6	29.5	29.5	109.3	116.0	(6.7)	354.1
Additional Clinical Services	14.2	14.7	14.6	14.4	14.5	14.6	14.6	14.6	14.6	14.6	14.6	14.6	53.0	58.0	(5.0)	175.3
Add Prof Scientific & Technical	3.9	3.9	3.9	3.9	3.7	3.7	3.7	3.7	3.7	3.7	3.7	3.7	16.6	15.7	0.9	44.8
Allied Health Professionals	6.4	6.3	6.4	6.5	6.3	6.3	6.3	6.3	6.3	6.3	6.3	6.3	24.3	25.6	(1.3)	76.0
Healthcare Scientists	1.7	1.7	1.7	1.7	1.6	1.6	1.6	1.6	1.6	1.6	1.6	1.6	6.8	6.9	(0.1)	19.0
Estates & Ancillary	4.3	4.4	4.5	4.3	4.5	4.5	4.5	4.5	4.6	4.6	4.6	4.6	17.1	17.5	(0.4)	54.7
Students	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.3	0.0	1.1
Health Board Total	**94.9**	**96.3**	**95.9**	**96.2**	**94.8**	**95.2**	**95.3**	**95.3**	**95.4**	**95.7**	**95.4**	**95.4**	**362.1**	**383.3**	**(21.2)**	**1,145.8**
Other Services (incl. Primary Care)	3.1	3.1	3.1	3.0	3.1	3.1	3.1	3.1	3.1	3.1	3.1	3.1	11.2	12.4	(1.2)	37.2
Total Pay	**98.0**	**99.4**	**99.0**	**99.2**	**97.9**	**98.3**	**98.4**	**98.4**	**98.5**	**98.8**	**98.5**	**98.5**	**373.3**	**395.7**	**(22.4)**	**1,183.0**

Non-Pay Costs as per Monitoring Return Table	Actual				Forecast								Cumulative			Full Year Forecast
	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	Budget	Actual	Variance	
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Primary Care Contractor	20.8	20.5	21.1	20.6	20.9	20.9	20.8	20.9	20.9	21.0	20.9	21.1	82.3	83.0	(0.7)	250.5
Primary Care – Drugs and Appliances	10.9	10.9	10.8	11.5	10.9	11.1	11.6	10.1	11.6	11.1	10.1	11.1	39.9	44.1	(4.2)	131.8
Provider Services – Non Pay	18.6	18.3	18.2	21.1	17.0	16.7	17.2	17.1	17.3	17.6	17.4	16.4	108.0	76.3	31.8	213.0
Secondary Care - Drugs	8.4	9.4	8.8	9.3	8.8	8.8	9.0	8.8	8.7	8.7	8.4	8.9	29.3	35.9	(6.6)	106.0
Healthcare Services Provided by Other NHS Bodies	32.2	31.9	31.1	33.5	30.9	30.8	30.8	30.7	30.7	30.7	30.7	30.8	122.7	128.7	(6.0)	374.8
Continuing Care and Funded Nursing Care	11.5	11.6	11.7	11.7	11.4	11.1	11.4	11.1	11.4	11.4	10.5	11.4	44.1	46.5	(2.4)	136.2
Other Private & Voluntary Sector	2.7	2.8	2.5	3.5	5.3	6.0	3.3	3.3	3.2	2.9	2.8	2.8	9.0	11.5	(2.5)	41.2
Joint Financing and Other	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.9	1.2	(0.3)	3.6
Losses, Special Payments and Irrecoverable Dets	0.2	0.4	0.2	0.6	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	1.0	1.5	(0.5)	4.4
Non-Pay Costs	**105.7**	**106.1**	**104.7**	**112.1**	**105.9**	**106.2**	**104.8**	**102.7**	**104.6**	**104.1**	**101.5**	**103.4**	**437.3**	**428.6**	**8.7**	**1,261.4**
AME/DEL Depreciation	3.2	3.2	4.7	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	6.1	15.1	15.1	0.0	49.4
Total Non-Pay	**108.8**	**109.2**	**109.4**	**116.2**	**109.9**	**110.2**	**108.8**	**106.7**	**108.6**	**108.1**	**105.5**	**109.2**	**452.3**	**443.6**	**8.7**	**1,310.8**

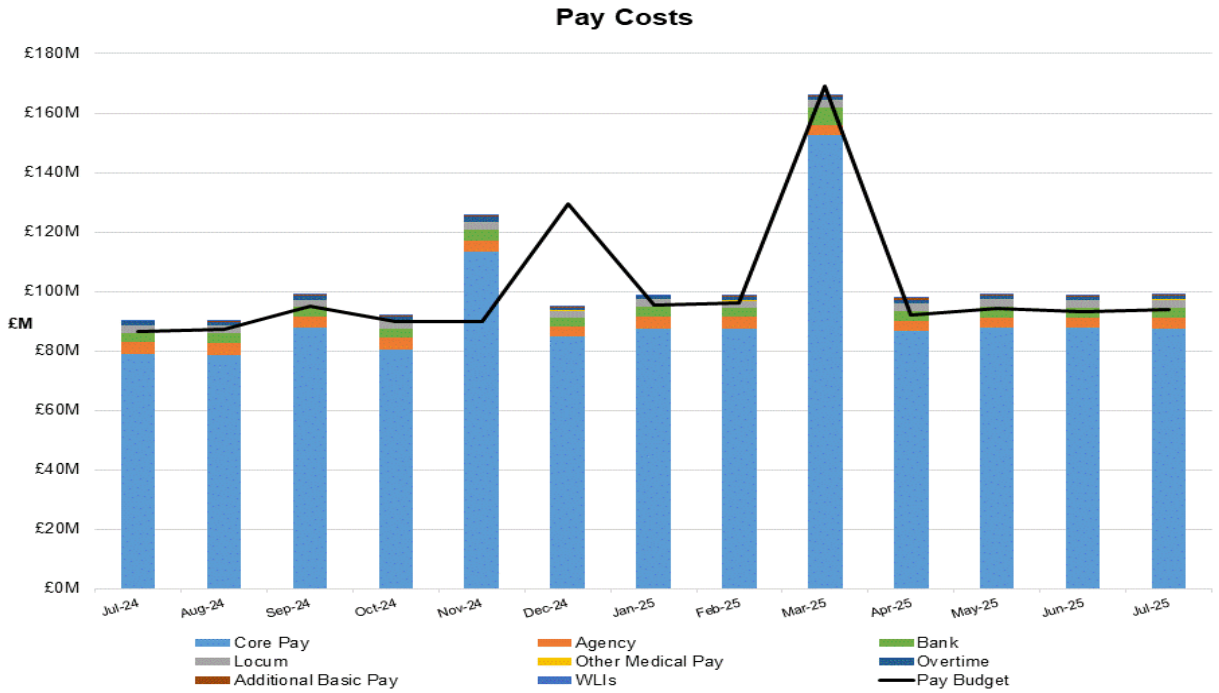
Health Board Pay:

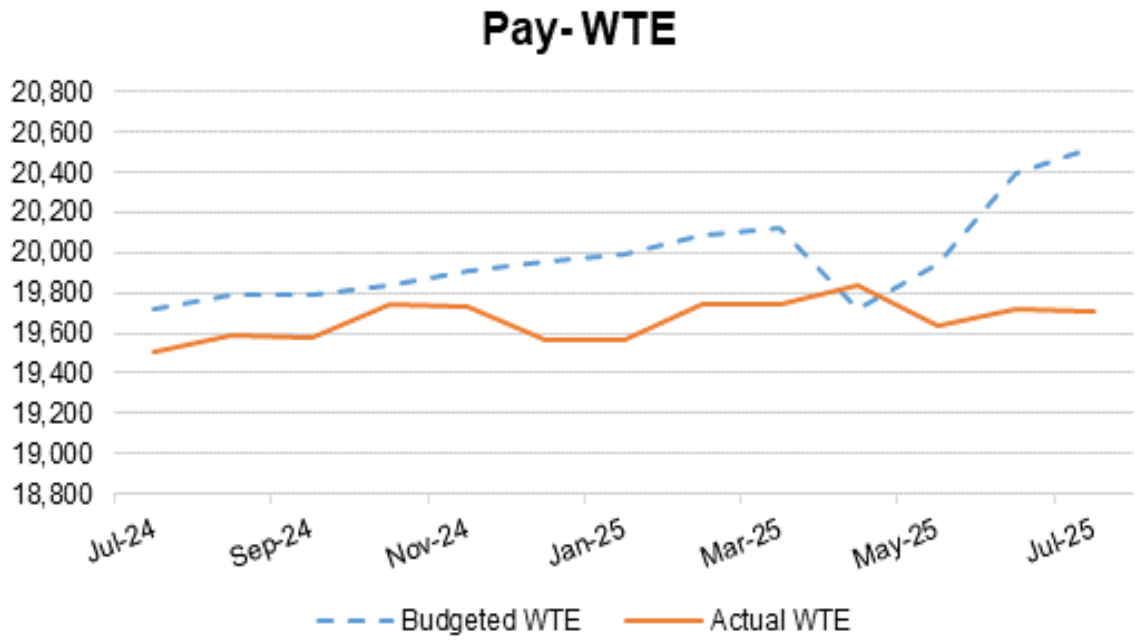
- Month 4 Provider Services Pay decreased by £0.3m (0.3%) from previous month.
- Overall variable pay costs have increased in July with an upward trend in agency and locum.
- Further detail on Variable Pay is reported in Slide 7 and Agency in Slide 9.
- Forecast pay costs exclude the 25/26 pay award cost which is assumed to be fully funded by WG.

Non-Pay Expenditure (excluding Depreciation):

- Total Non-Pay expenditure (excluding AME/DEL Depreciation) decreased by £7.4m from previous month.
- Further detail on Non-Pay expenditure movements is reported in Slide 11.

Expenditure – Pay





Variable Pay	2024/25		2025/26				
	M11	M12	M01	M02	M03	M04	Total
	£m	£m	£m	£m	£m	£m	£m
Agency	3.9	3.6	3.3	3.5	3.3	3.6	13.8
Overtime	1.1	1.3	1.1	1.1	1.2	1.2	4.6
Locum	2.4	2.5	2.6	2.7	2.4	2.8	10.5
WLIs	0.3	0.3	0.4	0.4	0.5	0.4	1.6
Bank	3.0	5.6	3.2	3.5	3.6	3.4	13.7
Other Non Core	0.1	0.1	0.1	0.0	0.1	0.1	0.2
Additional Hours	0.4	0.4	0.4	0.3	0.4	0.4	1.5
Total	**11.2**	**13.8**	**11.2**	**11.7**	**11.3**	**11.8**	46.0

- July budgeted WTE has increased which is largely driven by the removal of the negative CRES WTE – see next slide for additional detail.
- Variable Pay totals £11.8m for July, an increase of £0.5m from previous month driven by increases of £0.4m in Locum and £0.3m in Agency, partially offset by reductions in other areas.

Pay - WTE

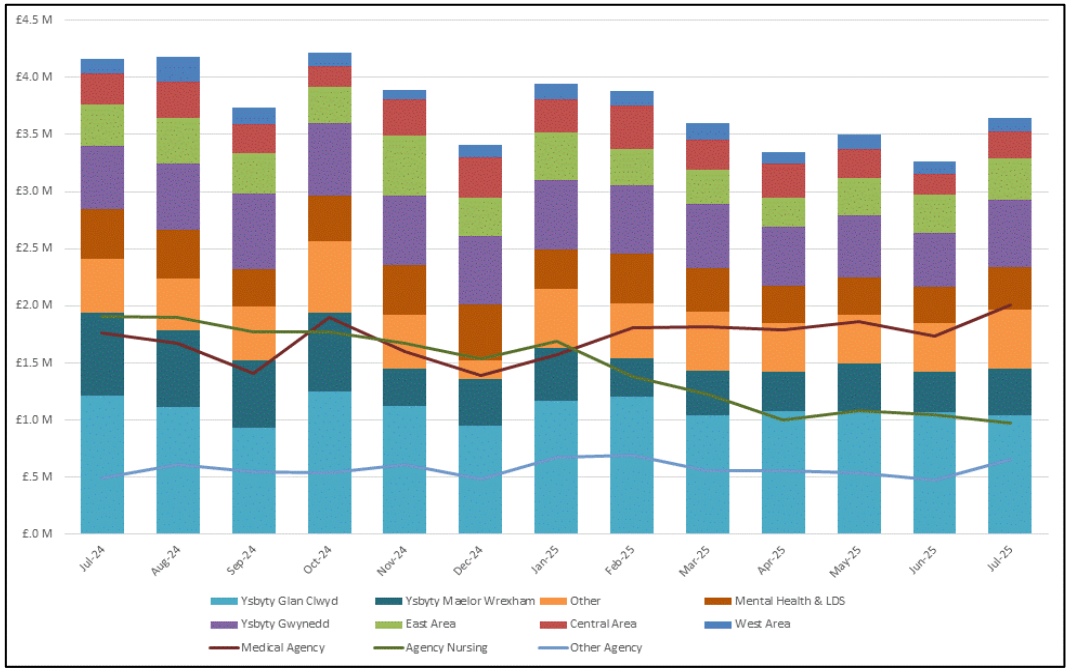
	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Movement M4 V M3
Budgeted WTE	20,086	20,122	19,719	19,941	20,400	20,522	122
Actual WTE	19,745	19,745	19,839	19,635	19,720	19,708	(12)

- Actual worked in July is 19,708, an decrease of 12 WTE since June.
- Budgeted WTE increased by 122 WTE in July from previous month, with the below providing further detail of the budgetary increases:-

BUDGETED WTE	Feb WTE	Mar WTE	Apr WTE	May WTE	Jun WTE	Jul WTE	Movement M4 v M3	Explanation of Key movements
West IHC	3,715	3,724	3,570	3,610	3,771	3,776	5	West Area -10 WTE Staff Turnover Factor/Negative budget removal, offset by West Facilities 13 WTE Removal of CRES,
Centre IHC	4,861	4,862	4,688	4,750	4,960	4,984	24	Central Area 10 WTE non recurrent A2A CAMHS funding and YGC 14WTE Removal of negative 24/25 WTE CRES.
East IHC	4,674	4,674	4,673	4,706	4,675	4,734	59	YWM – 57 WTE Removal of negative 24/25 WTE CRES
COVID Response	139	139	149	150	151	0	-151	151 WTE Mass Vaccination parent code moved to Public Health
Dental GDS	14	14	14	14	14	15	1	
Dental CDS	172	172	167	167	167	168	1	
Womens	697	693	687	693	694	694	0	
Diagnostics	980	980	982	1,008	1,010	1,014	4	
Cancer Services	417	417	416	416	423	423	0	
Mental Health & LDS	2,289	2,289	2,286	2,287	2,325	2,318	-7	Correction to North Wales Substance Misuse Area Planning Board funded posts
Other Primary Care	15	15	15	15	15	15	0	
Corporate	2,116	2,025	1,958	2,009	2,079	2,265	186	151 WTE WTE Mass vaccination parent code moved to Public Health, 7 WTE WPAS due to tncrease in DHCW income to fund staffing. 23 WTE WG funded project - Increase in DDaT and MHLD staffing working on project.
Med Ed/R&D	0	118	115	116	116	117	1	
TOTAL	**20,086**	**20,122**	**19,719**	**19,941**	**20,400**	**20,522**	**122**	

Pay Costs – Agency

	2025-26 Agency Spend £m												Full Year Expenditure £m
	Actual				Forecast								
	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	
West Area	0.1	01	0.1	0.1	0.1	0.1	.01	01	01	01	01	01	1.4
Central Area	0.3	0.3	0.2	0.2	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	3.2
East Area	0.3	0.3	0.3	0.4	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	4.1
Ysbyty Gwynedd	0.5	0.5	0.5	0.6	0.6	0.5	0.5	0.5	0.5	0.4	0.4	0.4	6.0
Ysbyty Glan Clwyd	1.1	1.1	1.1	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	12.4
Ysbyty Maelor Wrexham	0.3	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	4.4
Mental Health & LDS	0.3	0.3	0.3	0.4	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	4.1
Womens	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.1	0.1	0.1	2.0
Other inc pan BCU Cancer Services and Corporate	0.3	0.3	0.2	0.3	0.3	0.2	0.3	0.2	0.2	0.2	0.2	0.2	2.9
Total Agency	**3.3**	**3.5**	**3.3**	**3.6**	**3.5**	**3.4**	**3.4**	**3.3**	**3.3**	**3.2**	**3.2**	**3.2**	**40.4**



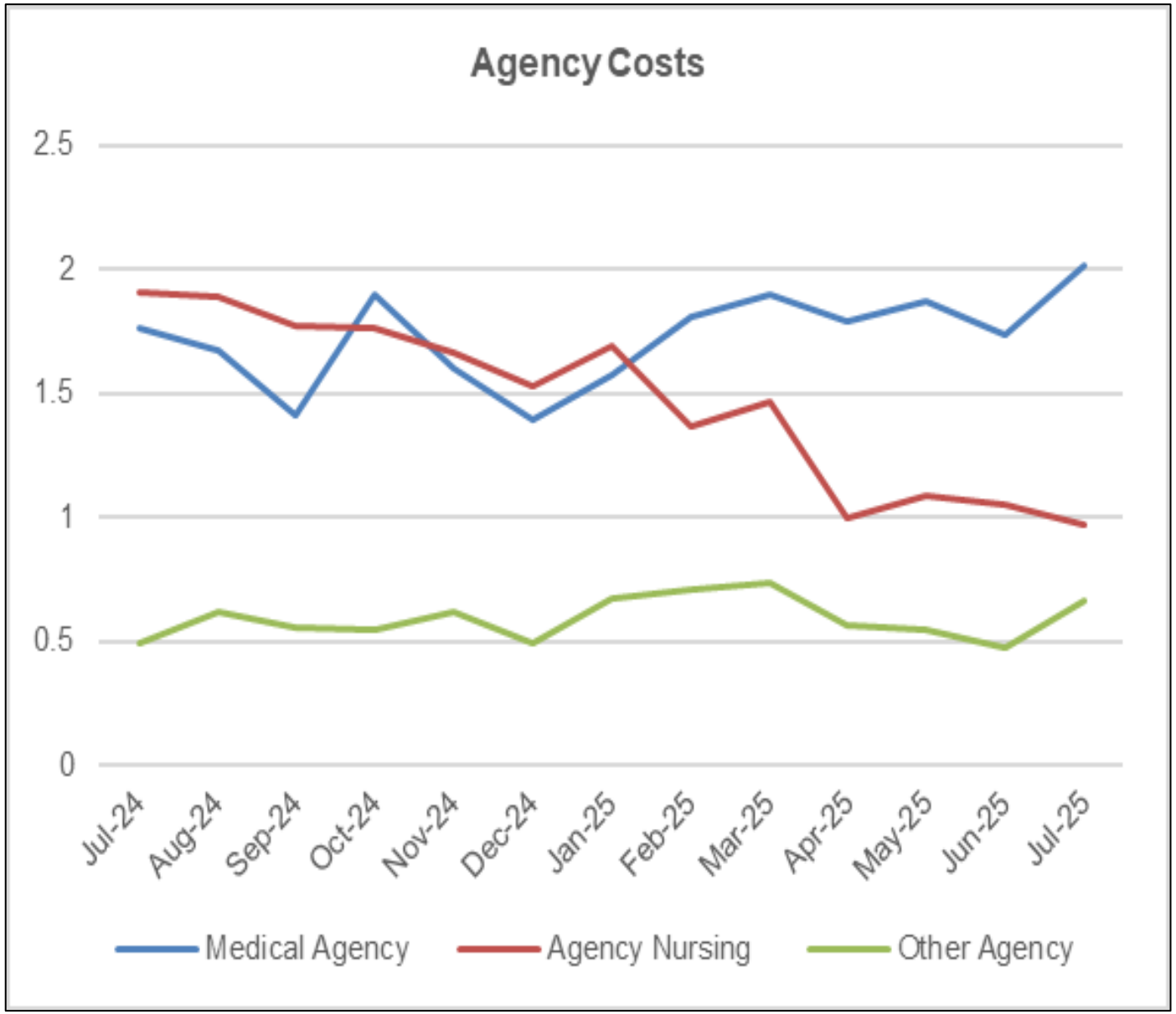
- Agency expenditure for July (Month 4) is £3.6m representing 3.7% of total pay, an increase of £0.4m compared to previous months spend. Monthly average spend in 2024/25 was £3.9m. 2025/26 Agency annual forecast outturn is £40.4m, a £1.4m increase compared to the £39.0m annual forecast outturn reported at Month 3.

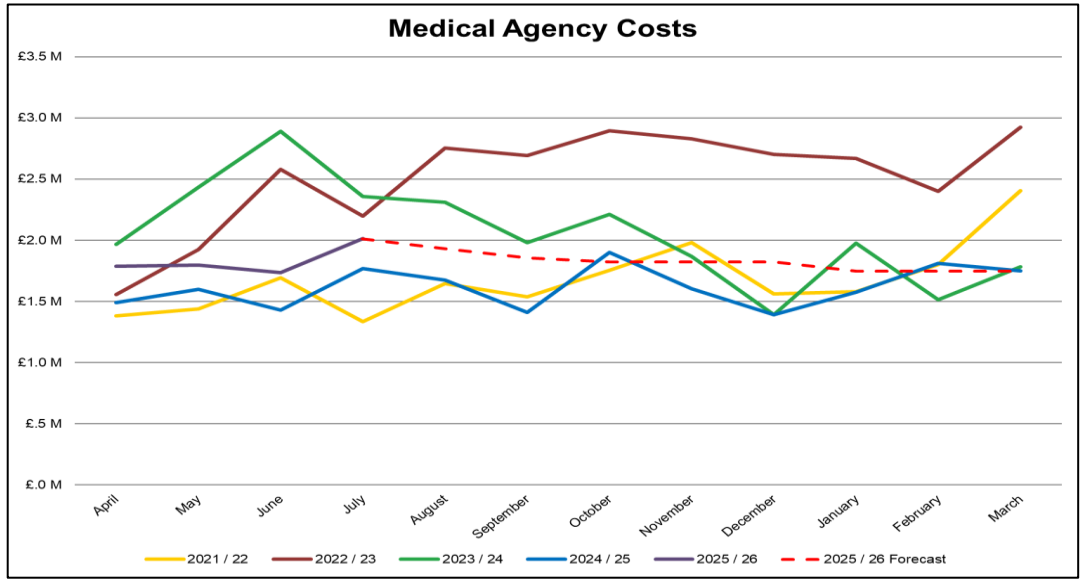
- Month 4 Medical Agency expenditure is £2.0m, an increase of £0.3m from previous month spend. The monthly average medical agency expenditure for 2024/25 was £1.6m. In-month Medical Agency spend is predominantly within Ysbyty Glan Clwyd (£0.6m), Ysbyty Gwynedd (£0.4m), Women's (£0.2m), Mental Health (£0.2m) and Ysbyty Maelor Wrexham (£0.2m), covering Medical vacancies and sickness.

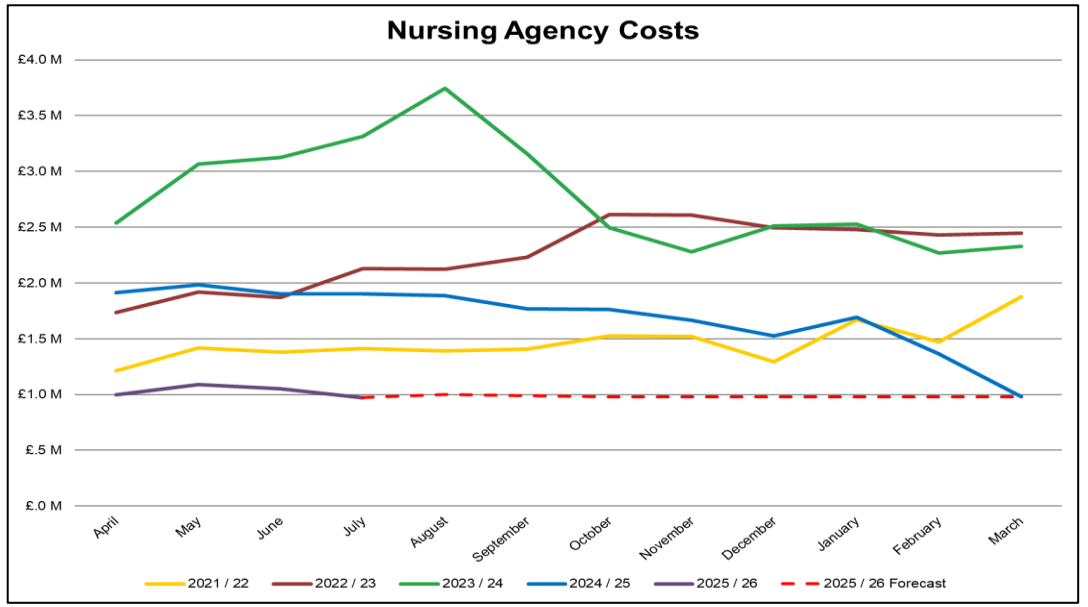
- Nurse agency costs totalled £1.0m for the month, the same as previous month spend. Month 4 Nurse Agency spend is £0.7m lower than the 2024/25 monthly average costs of £1.7m. The use of agency nurses is predominantly within Ysbyty Glan Clwyd (£0.4m), Ysbyty Maelor Wrexham (£0.2m), Ysbyty Gwynedd (£0.1m), Mental Health (£0.1m), and East Area (£0.1m). Agency Nurses have been used to staff escalated beds and cover ward vacancies to ensure the Nurse Staffing Act ward staffing levels are maintained. Other agency costs totalled £0.7m in Month 4, an increase of £0.2m from previous month spend. Other Agency costs mainly consist of Allied Health Professionals (£0.5m) with the remaining (£0.1)m being reported in Admin & Clerical.

- Work is ongoing to deliver the Cabinet Secretary workforce enabling action where the expectation is for non-clinical agency costs to reduce to Nil.

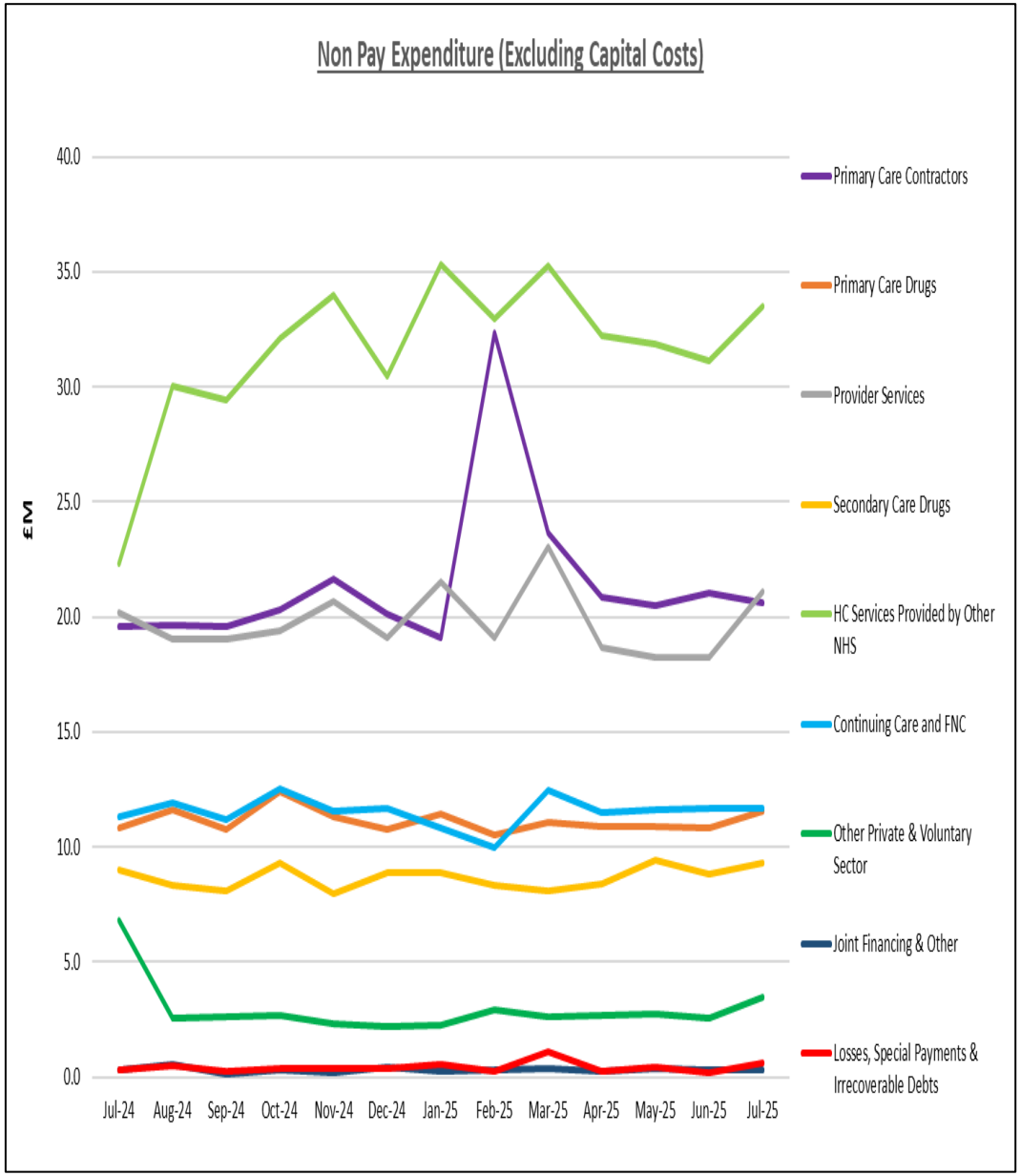
Pay Costs – Agency







Expenditure - Non Pay



- **Primary Care Contractor:** July expenditure is £0.4m (2.2%) less than previous month, of which £0.5m reduction is reported against General Medical Services (GMS) due to a £0.4m accountancy gain reported in-month.
- **Primary Care Drugs:** Expenditure is £0.7m higher than previous month. Despite Accountancy Gains of £0.6m being reported in Month 4 there has been a catch up of spend due to an under accrual relating to previous months and an increase in GP prescribed spend on weight loss drugs being £0.4m higher than reported within the same period in 2024/25.
- **Provider Services Non-Pay:** Expenditure increased by £2.9m, of which £1.1m is the year to date impact of the RIF Neurodevelopment waiting times funding, increase of £0.5m in Clinical Services & Supplies M&SE and implants due to increased theatre activity, £0.2m Establishment & Transport expenses, £0.3m Premises and Fixed Plan spend and £0.3m increase in External consultancy fees.
- **Secondary Care Drugs:** Expenditure increased by £0.5m (5.2%) from previous month, of which £0.1m is increase in Cancer Services and the remaining increase being reported across all Secondary Care sites in particular AMD.
- **Healthcare Services provided by Other NHS Bodies**: Expenditure is £2.4m (7.2%) higher than previous month, of which £2.7 is increase in JCC offset by a £0.3m reduction in English provider contracts.
- **Continuing Health Care (CHC) and Funded Nursing Care (FNC):** Expenditure is in line with previous month and £0.3m higher than forecast for the month due to an increase in additional CHC packages
- **Other Private & Voluntary Sector:** Spend increased by £0.9m (27.3%) from previous month, of which £0.3m is due to a significant increase in MHLD Out of Area placements due to a shortage of Medical staff and reduction in bed capacity due to the anti-ligature work and £0.7m increase in Planned Care activity.

Allocations

Description	£m
Allocations Received	**2,178.9**
Total Allocations Received	**2,1789.9**
Description	**£m**
Allocations Anticipated	
DEL Non Cash Depreciation	5.2
AME Non Cash Depreciation	3.7
Removal of Donated Assets / Government Grant Receipts	-0.8
Removal of IFRS-16 Leases (Revenue)	-4.4
Real Living Wage (Care Homes)	2.8
IM&T Refresh Programme	2.5
Six Goals	2.7
Pay award 24/25	68.6
Real Living Wage funding	4.2
Prevention and Early Years fund allocation 2025/26	1.2
RTT Waiting Times	5.0
Planned Care additional funding 2025-26 Phase 3 Outpatient support costs	0.6
All Ages Mental Health Digital Solution 25/26	2.2
EPMA 25/26	**3.2**
WRP top slice for 25/26 as per IMTP	-6.8
RIF MAS Dementia NR Funding 25/26	**0.7**
Cataract funding 2025/26	**6.3**
English CUF from 2.15 to 2.83 percent	**0.6**
RIF Dementia Action Plan	**2.2**
RIF Integration and Rebalancing Capital Fund (IRCF)	**0.5**
NWJCC English CUF 2.15 to 2.83 percent	**0.7**
Planned Care additional funding 2025-26 Phase 4 Diagnostics	**3.6**
RIF Neurodevelopment Waiting Times 2025-26	**2.8**
Wage Award WAST per pay Matrix JCC	**3.0**
Other	**3.5**
Total Allocations Anticipated	**113.8**

	£m
Total Allocations Received	**2,178.9**
Total Allocations Anticipated	**113.8**
Total Welsh Government Income	**2,292.8**

- The Health Board is funded in the main from the Welsh Government allocation via the Revenue Resource Limit (RRL). Total Revenue Resource Limit (RRL) for the year is 2,292.8m.
- Confirmed allocations to date are £2,178.9m. This includes £13.0m allocation for COVID-19, with £1.1m of COVID income profiled into July.
- Further anticipated allocations in year total £113.8m as detailed in the table.

Risks and Opportunities (not included in position)

- The below are risks and opportunities to the Health Board's financial position for 2025/26. Where it is clear of specific costs for both risks and opportunities, these are incorporated into the forecast position.

	Risks	£m	Level
1	Mitigation of Inflationary Cost Impact – Costs over funded levels	6.6	Medium
2	Mitigation of cost – Additional bed capacity & drug costs	8.0	Medium
3	Inability to mitigate ENIC funding shortfall	4.2	High
4	Under delivery against Savings Target (Gap of £14.5m ($40m less £25.5m), less 50% of (£12.6m Red Schemes and Pipeline Opportunities less MS VAT £0.562m).	8.5	Medium
5	Joint Commissioning Committee Performance - risk of JCC not managing the position	9.7	High
6	Dental Ring Fenced Allocation underspend potential clawback	2.5	Medium
7	Additional 25/26 WRP Risk Share Agreement (value above IMPT)	9.0	Medium
8	Workforce realignment	5.0	Medium
	Total Quantifiable Risks	**53.5**	

	Opportunities / Mitigations for the identified risks	£m	Level
1	In year VAT Opportunity (shown separate as requested by WG)	0.6	High
2	Opportunity to retain any slippage on ringfenced funding (No planned slippage to date)	TBC	High
3	Funding inflation on BCU English Contracts, difference between 15% and funded 2.28%	5.5	Medium
	Total Opportunities	**6.1**	

Balance Sheet

- The closing cash balance as at 31st July 2025 was £6.1m, which included £2.4m cash held for revenue expenditure and £3.7m for capital projects.
- The Health Board is currently forecasting a closing cash balance for 205-26 of £5.9m made up of £3.0m revenue cash and £2.9m capital cash.
- The cashflow forecast does not currently include the impact of the 2025-26 pay awards due to be made from August 2025 onwards, which will be added once the anticipated resource requirements have been included within the Resource Limits.

	Opening Balance Beginning of Apr-25	Closing Balance End of Jul-25	Forecast Closing Balance End of Mar-25
Non-Current Assets	£m	£m	£m
Property, plant and equipment	740.2	730.4	744.8
Intangible assets	0.8	0.7	0.8
Trade and other receivables	119.7	125.4	125.7
Non-Current Assets sub total	**860.7**	**856.4**	**871.3**
Current Assets			
Inventories	20.5	21.2	20.5
Trade and other receivables	128.7	158.0	163.5
Cahs and cash equivalents	5.9	6.1	5.9
Non-current assets classified as held for sale	0.6	0.6	0.0
Current Assets sub total	**155.6**	**185.8**	**189.9**
Total Assets	**1,016.3**	**1,042.3**	**1,061.2**
Current Liabilities			
Trade and other payables	232.3	236.7	224.4
Provisions	53.9	88.6	88.7
Current Liabilities sub total	**286.2**	**325.2**	**313.1**
NET ASSETS LESS CURRENT LIABILITIES	**730.1**	**717.0**	**748.1**
Non-Current Liabilities			
Trade and other payables	23.9	23.9	24.0
Provisions	120.9	126.6	126.9
Non-Current Liabilities sub total	**144.7**	**150.4**	**150.9**
TOTAL ASSETS EMPLOYED	**585.3**	**566.6**	**597.2**
FINANCED BY:			
Taxpayers' Equity			
General Fund	367.2	348.5	379.0
Revaluation Fund	218.2	218.2	218.2
Total Taxpayers' Equity	**585.4**	**566.6**	**597.2**

Capital

- The approved Capital Resource Limit (CRL) for 2025/26 is £52.7m (including £0.2m IFRS16 Tranche 1). Year to Date expenditure is £5.1m. The forecast outturn reflects the anticipated amendment of £3.9m which is contingency for the Orthopaedic Hub currently included in section 4 of the CRL. The tender award for the Substance Misuse Building in Llandudno has been delayed which may impact on the anticipated cashflow. This has already been highlighted to Welsh Government.

BUDGET 2024/25

1) Capital Resource Limit 2024/25	£m
WG Discretionary Capital	14.2
All Wales Scheme	38.3
Total CRL	52.5

Brief Overview / Update The purpose of this dashboard is to brief the committee on the delivery of the approved capital programme to enable appropriate monitoring and scrutiny. The report provides an update, by exception, on the status and progress of the major capital projects and the agreed capital programmes. The report also provides a summary on the progress of expenditure against the capital resources allocated to the Heath Board by the Welsh Government through the Capital Resource Limit (CRL).

CAPITAL PROGRAMME 2024/25	Initial Programme (£m)	Year to Date (£m)	Forecast Outturn (£m)	Current Over/Under Commitment (£m)	Comments
Divisions	3.4	0.6	2.9	0.4	Programmed planned works progressing supported by tenders/purchase orders.
Operational Estates	1.7	0.0	1.7	-	Programmed planned works progressing supported by tenders/purchase orders.
Medical Devices	3.5	0.0	3.5	-	Programmed planned works progressing supported by tenders/purchase orders.
Informatics	3.0	0.1	3.0	-	Programmed planned works progressing supported by tenders/purchase orders.
Mental Health	1.0	0.0	1.0	-	Programmed planned works progressing supported by tenders/purchase orders.
All Wales funding brokerage to be re-provided from discretionary	1.5	0.0	1.5	-	Brokerage managed within the programme.
WG Discretionary Capital	**14.2**	**0.8**	**13.8**	**0.4**	**Under Commitment**

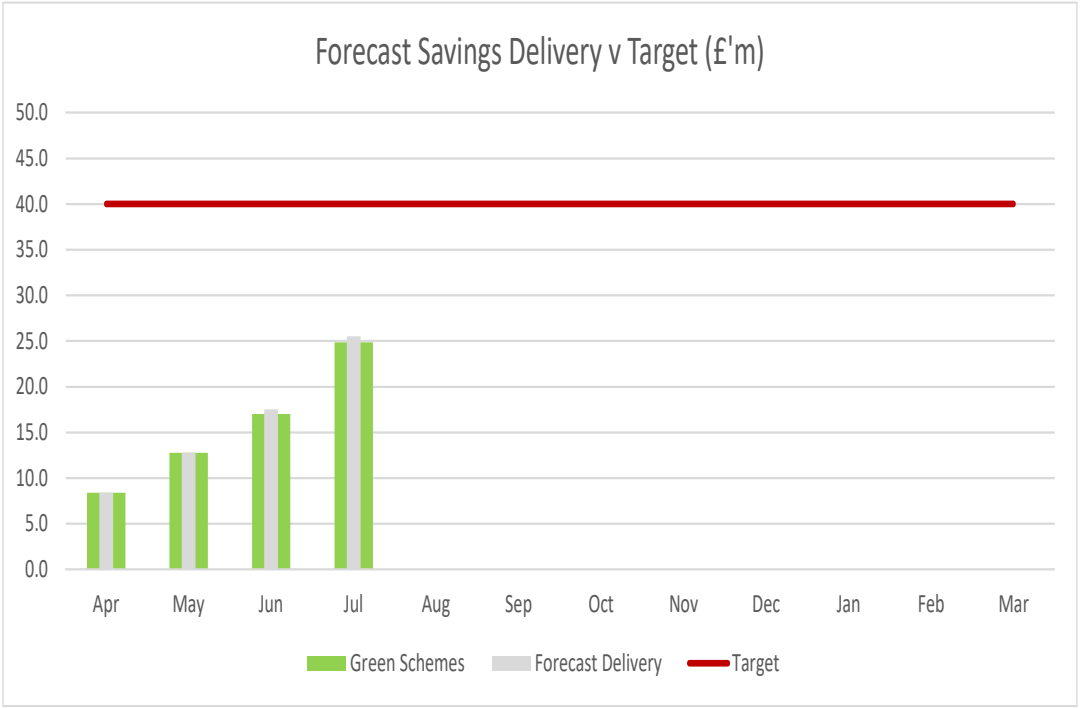
Capital

MAJOR CAPITAL SCHEMES (with in year spend)	Programme (£m)	Year to Date (£m)	Forecast Outturn (£m)	Current Over/Under Commitment (£m)	Comments
Substance Misuse Building, Llandudno	1.7	0.0	1.7	- 0.0	The forecast outturn reflect completion of the project in 2026/27. The contract tender award has been delayed and depending on the approval timeframe, there may be an impact on the in year cashflow. The issue has already been flagged with Welsh Government, however the impact will be formalised and reported as soon as final approval has been received.
Regional Orthopaedic Hub, Llandudno Hospital	11.7	3.5	15.9	- 4.1	**The project is progressing with completion forcasted by the end of the calendar year. The forecast outturn includes the contingency risk pot currently in section 4 in the CRL, profiled to be spent in year.**
Year End Funding – October 2024	0.5	0.0	0.5	-	Funding includes Digital Radiology Rooms and Endoscopy. All projects will complete in year.
Electrical Infrastructure upgrade - Ysbyty Glan Clwyd	2.9	0.0	2.9	-	**The project is programmed over the next 2 years. The contractor is due to start in September , with a completion date in 27/28.**
TEF - Fire	2.4	0.0	2.4	-	The TEF funding is across a number of projects. Business cases has been approved with allocations. All works will progress to achieve the CRL by year end.
TEF - Infrastructure	3.1	0.2	3.1	-	The TEF funding is across a number of projects. Business cases has been approved with allocations. All works will progress to achieve the CRL by year end.
TEF - Decarbonisation	0.2	0.0	0.2	-	The TEF funding is across a number of projects. Business cases has been approved with allocations. All works will progress to achieve the CRL by year end.
TEF - Mental Health	2.0	0.4	2.0	-	The TEF funding is across a number of projects. Business cases has been approved with allocations. All works will progress to achieve the CRL by year end.
TEF - Infection Prevention Control	0.8	0.0	0.8	-	The TEF funding is across a number of projects. Business cases has been approved with allocations. All works will progress to achieve the CRL by year end.
TEF - Decontamination	0.8	0.0	0.8	-	The TEF funding is across a number of projects. Business cases has been approved with allocations. All works will progress to achieve the CRL by year end.
IRCF - Conwy & Llandudno Junction Health & Social Care Centre	0.6	0.0	0.9	- 0.2	The project is currently being reviewed within the overall IRCF project prioritsation. There is an indication that the scheme is to be deferred to 27/28. Welsh Government has been made aware of the potential deferment.
IRCF - Caledfryn, Denbigh Health and Wellbeing Hub – acquisition costs and related fees	0.3	0.1	0.3	0.0	The current CRL reflects the design costs which is profiled to spent in year.
DPIF - All Ages Mental Health Digital Solution	0.6	0.0	0.6	-	The hardware will be procured in 2025/26.
Nuclear Medicine Consolidation at YGC	0.7	0.1	0.7	-	The current CRL reflects the fees to progess to FBC which is profiled to be spent in year.
Replacement Diagnostic and Treatment Equipment	9.8	0.0	9.8	-	The project is for two Linear Accelerators and a Spect CT, all of which are profiled to be delivered in this financial year.
Non-Radiology Ultrasound Replacement	0.3	0.0	0.3	-	**These medical devices will be procured in year.**
All Wales Capital	**38.3**	**4.3**	**42.6**	**-4.3**	**Over commitment**
Total Capital Funding Available	**52.5**	**5.1**	**56.4**	**-3.9**	

Savings Performance against Target

- The Health Board's financial plan has set a target of £40.0m to be delivered in 2025/26, profiled on an equal twelfth's basis.
- Savings identification, reporting and monitoring has been developed through a Value and Sustainability thematic model, with work progressing well to identify opportunities. A large number of these opportunities have been converted to deliverable savings, with Red and Pipeline schemes which still need further work to convert to Green schemes totalling £12.6m.
- Full year forecast value of Green Schemes totals £25.5m (including £22.4m Savings, £0.4m Income Generation, £0.7m Cost Avoidance and £1.9m Accountancy Gains). A forecast increase of £8.0m from month 3. Of these, £18.2m have been identified as recurring, with a full year effect of £24.3m, and £7.3m are non-recurring savings.
- In-month delivery includes Savings of £3.3m, £0m Income Generation, £0.2m Cost Avoidance and £1.7m of Accountancy Gains, against a £3.3m Target
- The combined year to date delivery is £9.5m, of which £5.0m is recurring, against a target of £13.3m.

Service Performance against Target	Annual				Year to Date		
	Target £m	Forecast Delivery £m	Delivery v Target (+ve = adverse) £m	FYE £m	Target £m	Delivery £m	Delivery v Target (+ve = adverse) £m
West Integrated Health Community	7.9	4.4	3.5	6.0	2.6	1.4	1.2
Central Integrated Health Community	10.0	5.0	5.0	5.3	3.3	1.2	2.1
East Integrated Health Community	10.0	4.8	5.2	5.2	3.3	1.8	1.5
MHLD	3.9	4.2	-0.3	5.4	1.3	1.2	0.1
Womens Services	1.2	0.1	1.1	0.1	0.4	0.0	0.4
Diagnostic and Specialist Clinical Support	1.8	0.8	1.0	0.4	0.6	0.4	0.2
Cancer Services	1.5	1.4	0.1	1.7	0.5	0.4	0.1
Community Dental Sevices	0.1	0.0	0.1	0.0	0.0	0.0	0.0
Corporate & Support Services	3.6	2.9	0.7	0.2	1.2	1.1	0.1
Saving Total	**40.0**	**23.6**	**16.4**	**24.3**	**13.3**	**7.6**	**5.7**
Accountancy Gains		1.9	-1.9			1.9	-1.9
Total		**25.5**	**14.5**	**24.3**	**13.3**	**9.5**	**3.8**



Savings Performance by Category

Savings - V&S Performance against Target (£'m)	Target £m	Forecast Delivery									Delivery v Target (+ve = adverse) £m
		V&S Board Categories									
Service / Area		Workforce £m	Medicines Management £m	Procurement & Non-pay £m	CHC £m	Pathway £m	Other - Commissioning £m	Other - Primary Care £m	Income £m	Total £m	
West Integrated Health Community	7.9	2.2	1.5	0.6	0.0	0.0	0.0	0.0	0.1	4.4	3.5
Central Integrated Health Community	10.0	0.6	1.6	0.5	1.8	0.0	0.5	0.1	0.0	5.0	5.0
East Integrated Health Community	10.0	1.9	1.5	0.9	0.5	0.0	0.0	0.0	0.0	4.8	5.2
MHLD	3.9	0.6		0.0	2.0		1.5			4.2	-0.3
Womens Services	1.2			0.1						0.1	1.1
Diagnostic and Specialist Clinical Support	1.8	0.1		0.6			0.0		0.1	0.8	1.0
Cancer Services	1.5	0.1	1.3	0.0						1.4	0.1
Community Dental Sevices	0.1	0.0		0.0						0.0	0.1
Corporate & Support Services	3.6	0.6	0.0	2.4	0.0	0.0	0.0	0.0	0.0	2.9	0.7
Total Cash Releasing Savings	**40.0**	**6.1**	**5.8**	**5.1**	**4.3**	**0.0**	**2.0**	**0.1**	**0.2**	**23.6**	**16.4**
Accountancy Gains		0.2	1.3	0.4						1.9	-1.9
Total		**6.3**	**7.1**	**5.5**	**4.3**	**0.0**	**2.0**	**0.1**	**0.2**	**25.5**	**14.5**

Recurring Performance against Target	Annual			Year to Date		
	Target £m	Forecast Delivery £m	Delivery v Target (+ve = adverse) £m	Target £m	Delivery £m	Delivery v Target (+ve = adverse) £m
R	40.0	18.2	21.8	13.3	5.0	8.3
NR	0.0	7.3	-7.3		4.5	-4.5
Total	**40.0**	**25.5**	**14.5**	**13.3**	**9.5**	**3.8**

Savings Variance

			Full Year			Year to Date		
Service	Scheme / Opportunity Title	Recurrent / Non Recurrent	Plan	Forecast	Variance Forecast vs Plan	Plan	Achieved	Variance Achieved vs Plan
Cancer	Biosimilar switching	R	36,024	3,002	-33,022	12,008	3,002	-9,006
Cancer	Biosimilar, switching from low cost effective to highly cost effective Part 2	R	19,842	17,996	-1,846	1,885	39	-1,846
Cancer	Enhanced Recruitment Controls Savings	NR	102,277	127,077	24,800	61,550	45,550	-16,000
Cancer	National agreed contracts for secondary care drugs	R	45,408	44,098	-1,310	15,136	28,194	13,058
Cancer	Outsourcing savings (homecare)	R	125,004	209,626	84,622	41,668	67,645	25,977
Cancer	Price decrease, National agreed contracts for secondary care drugs Part 2	R	87,216	73,685	-13,531	14,221	690	-13,531
Cancer	Release of Old Year Accrual Net Gains	NR	22,488	22,488	0	22,488	22,488	0
Cancer	Switch from brand to generic medicine, hospital contract	R	1,242,456	910,856	-331,600	311,356	248,705	-62,651
Corporate	Enhanced Recruitment Control Savings	NR	210,781	210,781	0	143,200	143,200	0
Corporate	Finance department training post vacancies 25-26 (N/R)	NR	48,159	48,159	0	28,578	28,578	0
Corporate	Non-renewal-Compellent Network Storage-YG	R	17,263	17,263	0	5,754	5,754	0
Corporate	Reversal of Linea accruals from 23/24	NR	133,400	133,400	0	133,400	133,400	0
Corporate	Review of senior staff establishment	R	55,033	55,033	0	18,344	18,344	0
Corporate	Senior posts Grade change	R	51,625	51,625	0	17,208	17,208	0
Corporate	Senior posts review/vacancies 25/26 (N/R)	NR	181,906	181,906	0	60,635	60,635	0
DSCS	Clinisy Contract	R	31,850	31,850	0	0	0	0
DSCS	EBME syringe pumps	NR	96,432	96,432	0	96,432	96,432	0
DSCS	Enhanced Recruitment Controls Savings	NR	48,408	59,994	11,586	21,372	25,234	3,862
DSCS	Mortuary Portacabins	R	25,328	25,328	0	8,443	8,443	0
DSCS	MSC KPI NR	NR	262,872	262,872	0	190,266	190,266	0
DSCS	Roche ABS Full Year Impact -Efficencies	R	151,584	151,584	0	50,528	50,528	0
DSCS	Scanassure Contract Price	R	36,330	36,330	0	12,109	12,109	0
DSCS	SGRT camera maintenance	NR	19,028	19,028	0	19,028	19,028	0
DSCS	Stem Cell Service	R	29,590	29,590	0	9,878	9,878	0
DSCS	Sunquest and Contract Management - Contract Maintenance agreements	NR	51,578	51,578	0	51,578	51,578	0
DSCS	Sunquest and Contract Management - Managed service contracts	NR	119,954	119,954	0	119,954	119,954	0
Estates	Enhanced Recruitment Control Savings	NR	15,203	15,203	0	10,135	10,135	0
MH&LDS	Enhanced Recruitment Control Savings	NR	89,221	89,221	0	67,963	67,963	0
MH&LDS	Reduction in nursing and HCSW Agency spend	R	198,448	198,448	-1	59,343	73,198	13,855
MH&LDS	Reduction in Out of Area Beds	R	1,605,771	1,502,570	-103,201	199,436	96,235	-103,201
MH&LDS	Reduction in Unfunded Posts within MHLD	R	226,356	226,356	0	75,452	75,452	0
MH&LDS	Right Care Programme	R	2,000,000	2,000,000	0	666,667	825,489	158,822
MH&LDS	Salary Sacrifice - Purchase of additional annual leave	NR	129,451	129,451	0	43,150	43,150	0
Midw & Womens	Non Pay Expenditure Grip & Control	R	100,000	100,000	-0	33,333	33,405	72
Primary Care	Corporate (pan-North Wales) - CHC Covid Provision	NR	120,326	120,326	0	120,326	120,326	0
Primary Care	Corporate (pan-North Wales) - FNC Supreme Court	NR	128,847	128,847	0	128,847	128,847	0
Primary Care	Enhanced Recruitment Control Savings	NR	34,496	34,496	0	34,496	34,496	0
Centre IHC	Acute Agency Accountancy Gain	NR	45,015	45,015	0	45,015	45,015	0
Centre IHC	Agency Booked Hours	NR	54,741	54,741	0	54,741	54,741	0
Centre IHC	Biosimilar, switching from low cost effective to highly cost effective Part 2	R	341,047	341,048	1	37,971	0	-37,971

Savings Variance

Service	Scheme / Opportunity Title	Recurrent / Non Recurrent	Full Year			Year to Date		
			Plan	Forecast	Variance Forecast vs Plan	Plan	Achieved	Variance Achieved vs Plan
Centre IHC	Blood glucose and ketone testing strips switch	R	35,000	30,438	-4,562	0	30,438	30,438
Centre IHC	Brands to generic Value & Sustainability basket	R	30,000	30,000	0	10,000	8,000	-2,000
Centre IHC	Cancellation of Nurse Agency Escalation Roster	R	353,666	353,666	0	0	0	0
Centre IHC	Cease contract to the British Red Cross	R	16,348	16,350	2	3,270	3,270	0
Centre IHC	Centre IHC - Continuing Health Care Schemes	R	1,760,000	1,759,998	-2	586,672	119,350	-467,322
Centre IHC	Closure of 4 X GP Beds - Holywell Community Hospital	NR	19,092	19,092	0	6,364	6,364	0
Centre IHC	Decision support software	R	349,992	349,992	0	116,664	264,277	147,613
Centre IHC	DOAC switch - edoxaban to rivaroxaban or apixaban	R	120,000	115,047	-4,953	1,000	52,802	51,802
Centre IHC	Dressings and Appliances	R	19,992	3,498	-16,494	6,664	3,498	-3,166
Centre IHC	Enhanced Recruitment Control Savings	NR	78,708	78,708	0	78,708	78,708	0
Centre IHC	GMS Accountnacy Gains	NR	166,337	166,337	0	166,337	166,337	0
Centre IHC	Holding of Telehealth Investment	NR	35,000	35,000	0	11,664	11,664	0
Centre IHC	ILD Service Non Recurrent Slippage 2025	NR	130,307	130,307	0	59,992	59,992	0
Centre IHC	LAC Income over-achievement - 2024-25	NR	24,000	24,000	0	24,000	24,000	0
Centre IHC	LAC Income over-achievement - 2025-26	NR	200,000	200,000	0	66,667	0	-66,667
Centre IHC	Low value Prescribing Value & Sustainability basket	R	2,400	2,400	0	800	640	-160
Centre IHC	Medicines optimisation work	R	450,000	212,320	-237,680	150,000	130,718	-19,282
Centre IHC	Non Recurrent Vacancy YGC	NR	82,680	82,680	0	0	0	0
Centre IHC	Novorapid to Trurapi insulin switch	R	7,000	7,000	0	1,400	973	-427
Centre IHC	Outsourcing savings (homecare)	R	107,004	70,629	-36,375	35,668	30,245	-5,423
Centre IHC	P&MM Accountancy Gains	NR	228,802	228,802	0	228,802	228,802	0
Centre IHC	Penrallt Rental Fee	NR	78,125	78,125	0	78,125	78,125	0
Centre IHC	Price decrease, National agreed contracts for secondary care drugs	R	40,068	15,784	-24,284	13,356	15,784	2,428
Centre IHC	Price decrease, National agreed contracts for secondary care drugs Part 2	R	10,203	13,641	3,438	1,843	1,980	137
Centre IHC	Repatriate drug spend back to external contract	R	300,000	356,831	56,831	100,000	118,944	18,944
Centre IHC	Residential Accommodation Central Rent Increase	R	11,296	11,296	0	0	0	0
Centre IHC	Review of intensity payments to all consultants in SACC	R	58,854	58,854	0	0	0	0
Centre IHC	Switch from brand to generic medicine, hospital contract (cardiology)	R	4,062	5,269	1,207	0	1,781	1,781
Centre IHC	Switch from brand to generic medicine, hospital contract (HIV)	R	14,064	4,332	-9,732	4,688	4,332	-356
Centre IHC	Switching from parent compound to biosimilar	R	57,027	4,772	-52,255	0	4,772	4,772
Centre IHC	Temporary Vacancies	NR	93,233	93,233	0	31,081	31,081	0
Centre IHC	Temporary Vacancies Clinical admin	NR	16,492	16,492	0	10,996	10,996	0
Centre IHC	Temporary Vacancies Clinical other Comissioning	NR	66,506	66,506	0	24,940	24,940	0
Centre IHC	Temporary Vacancies Community Services	NR	15,180	15,180	0	5,062	5,062	0
Centre IHC	Temporary Vacancies Non clinical admin	NR	111,917	111,917	0	42,522	42,522	0
East IHC	Agency Reduction - Community Services	R	300,000	300,000	0	100,000	100,000	0
East IHC	Biosimilar, switching from low cost effective to highly cost effective Part 2	R	114,126	114,126	0	0	6,471	6,471
East IHC	Blood glucose and ketone testing strips switch	R	30,000	33,872	3,872	6,000	9,872	3,872
East IHC	Decision support software	R	350,000	335,137	-14,863	116,664	101,801	-14,863
East IHC	Dietetic feeds reviews	R	30,000	26,667	-3,333	3,333	0	-3,333

Savings Variance

			Full Year			Year to Date		
Service	Scheme / Opportunity Title	Recurrent / Non Recurrent	Plan	Forecast	Variance Forecast vs Plan	Plan	Achieved	Variance Achieved vs Plan
East IHC	Discontination of Theatre Cataract packs in Opthalmology	R	12,740	12,740	0	2,548	2,548	0
East IHC	DOAC switch - edoxaban to rivaroxaban or apixaban	R	225,000	255,076	30,076	25,000	55,076	30,076
East IHC	Dressings and Appliances	R	50,000	37,502	-12,498	16,664	4,166	-12,498
East IHC	East IHC - CHC Cost Containment Schemes	R	531,000	531,000	0	173,000	173,000	0
East IHC	Enhanced Recruitment Control Savings	NR	111,180	111,180	0	99,938	99,938	0
East IHC	GMS Accountnacy Gains	NR	123,379	123,379	0	123,379	123,379	0
East IHC	Increased income - Dining room - Catering WMH	R	7,440	7,440	0	1,500	1,500	0
East IHC	Medicines optimisation work	R	540,000	528,741	-11,259	180,000	172,942	-7,058
East IHC	Nurse Agency Reduction	R	516,000	761,173	245,173	172,000	337,173	165,173
East IHC	Optimising treatment choice in patient pathway	R	5,700	1,425	-4,275	1,900	1,425	-475
East IHC	Outsourcing savings (homecare)	R	109,992	27,498	-82,494	36,664	27,498	-9,166
East IHC	P&MM Accountancy Gains	NR	322,149	322,149	0	322,149	322,149	0
East IHC	Price decrease, National agreed contracts for secondary care drugs	R	30,744	7,686	-23,058	10,248	7,686	-2,562
East IHC	Price decrease, National agreed contracts for secondary care drugs Part 2	R	27,430	32,505	4,715	5,846	5,667	-179
East IHC	Purchase of equipment through charity bid - Fluobeam	R	31,296	31,296	0	10,432	10,432	0
East IHC	Purchase of equipment through charity bid - YAG Laser	R	100,656	100,656	0	33,552	33,552	0
East IHC	Red Cross ED Wellbeing & Safe Home	R	125,127	125,127	0	25,026	25,026	0
East IHC	Reduced costs within catering Services East	R	77,661	77,661	0	6,224	6,224	0
East IHC	Reduced costs within Correspondence Hub	R	4,063	4,063	0	812	812	0
East IHC	Reduced costs within Correspondence Hub	NR	9,350	9,350	0	1,870	1,870	0
East IHC	Reduced costs within Domestic Services East	R	23,403	23,403	0	6,036	6,036	0
East IHC	Reduced staff contracted hours resulting in reduced pay costs	R	30,688	30,688	0	6,112	6,112	0
East IHC	Reduced staff contracted hours resulting in reduced pay costs	NR	32,160	32,160	0	6,432	6,432	0
East IHC	Reduction in medical gases costs	R	100,000	114,641	14,641	33,333	47,974	14,641
East IHC	Reduction in pay costs in Facilities East	NR	234,322	248,322	14,000	190,951	204,951	14,000
East IHC	Reduction in spend on Admin & Clerical Agency	R	15,000	15,000	0	5,000	5,000	0
East IHC	Reduction in spend on Nursing Agency - Surgery	R	120,000	244,519	124,519	40,000	84,519	44,519
East IHC	Rent increase in Residential accommodation East	R	12,539	12,539	0	0	0	0
East IHC	Settling of ITU Grievance session payment to Intensivists	R	111,700	111,700	0	37,233	37,233	0
East IHC	Switch from brand to generic medicine, hospital contract (cardiology & renal)	R	5,730	600	-5,130	800	600	-200
East IHC	Switch from brand to generic medicine, hospital contract (HIV)	R	7,200	1,968	-5,232	2,400	1,968	-432
East IHC	Switching from parent compound to biosimilar	R	108,000	108,000	0	0	0	0
West IHC	Biosimilar, switching from low cost effective to highly cost effective Part 2	R	34,549	32,238	-2,312	3,751	3,236	-516
West IHC	Blood glucose and ketone testing strips switch	R	35,000	43,576	8,576	0	22,410	22,410
West IHC	Brands to generic Value & Sustainability basket	R	19,992	16,660	-3,332	6,664	3,332	-3,332
West IHC	British Red Cross (BRC) - ED Wellbeing and Home Safe Service	R	89,892	94,355	4,464	19,295	25,347	6,053
West IHC	Decision support software	R	210,000	642,786	432,786	70,000	214,262	144,262
West IHC	DOAC switch - edoxaban to rivaroxaban or apixaban	R	120,000	34,575	-85,425	1,000	17,864	16,864
West IHC	Dressings and Appliances	R	19,992	16,660	-3,332	6,664	3,332	-3,332
West IHC	Enhanced Recruitment Control Savings	NR	31,957	31,957	0	31,957	31,957	0

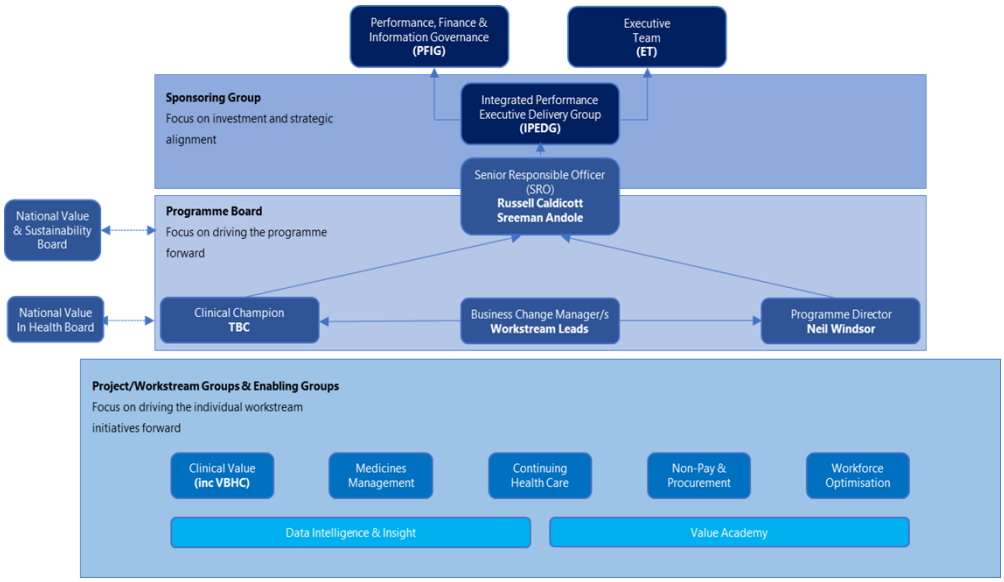
Savings Variance

			Full Year			Year to Date		
Service	Scheme / Opportunity Title	Recurrent / Non Recurrent	Plan	Forecast	Variance Forecast vs Plan	Plan	Achieved	Variance Achieved vs Plan
West IHC	Enteral Feed - consumables	R	20,000	20,000	0	6,667	6,667	0
West IHC	Enteral Feed - consumables	NR	10,000	10,000	0	3,333	3,333	0
West IHC	Facilities West: Rent Increase - Residential Accommodation	R	12,656	13,724	1,068	0	1,068	1,068
West IHC	Facilities West: In house provision of Catering Laundry at Ysbyty Gwynedd	R	17,867	17,867	0	0	0	0
West IHC	Facilities West: Night Service Ceasation - Cessation of Catering night service - PAY	R	36,020	36,020	0	3,299	3,299	0
West IHC	Facilities West: Retail outlet within main reception of Ysbyty Gwynedd.	R	59,500	58,880	-620	14,000	13,380	-620
West IHC	GMS Accountnacy Gains	NR	132,728	132,728	0	132,728	132,728	0
West IHC	Low value Prescribing Value & Sustainability basket	R	2,400	2,000	-400	800	400	-400
West IHC	Medicines optimisation work	R	399,996	341,564	-58,432	133,332	180,802	47,470
West IHC	Novorapid to Trurapi insulin switch	R	7,000	1,707	-5,293	1,400	569	-831
West IHC	Optimisation of treatment pathway for iron deficiency anaemia	R	4,050	3,240	-810	810	0	-810
West IHC	Outsourcing savings (homecare)	R	50,004	91,263	41,259	16,668	21,229	4,561
West IHC	P&MM Accountancy Gains	NR	101,102	101,102	0	101,102	101,102	0
West IHC	Pharmacy Aseptics Unit Sterile Wipes (Ysbyty Gwynedd)	R	22,386	20,521	-1,866	7,462	5,597	-1,866
West IHC	Price decrease, National agreed contracts for secondary care drugs - Renal	R	14,784	9,629	-5,155	4,928	9,629	4,701
West IHC	Price decrease, National agreed contracts for secondary care drugs Part 2	R	9,370	14,058	4,688	1,874	1,575	-299
West IHC	Procurement savings (rheumatology)	R	19,020	12,680	-6,340	6,340	0	-6,340
West IHC	Reduction in bank and agency locum - Children's	R	246,580	213,746	-32,834	82,193	49,359	-32,834
West IHC	Reduction in footwear costs	R	18,900	19,239	339	2,100	2,439	339
West IHC	Release of Medical Locum Accrual	NR	88,000	88,000	0	88,000	88,000	0
West IHC	Removal of lease for ACCTS Modular Office	R	89,981	89,981	0	29,994	29,994	0
West IHC	Review of Consultant intensity banding - Children's	R	14,289	14,289	0	0	0	0
West IHC	Service Relocation - Estates rationalisation - Parc Menai	R	67,285	67,285	0	21,545	21,545	0
West IHC	Switch from brand to generic medicine, hospital contract (cardiology)	R	1,830	262	-1,568	0	262	262
West IHC	Switch from brand to generic medicine, hospital contract (HIV)	R	14,412	9,608	-4,804	4,804	0	-4,804
West IHC	Switching from parent compound to biosimilar - AMD	R	186,654	186,654	0	0	0	0
West IHC	West Area review - GRIP AND CONTROL	R	724,337	724,337	0	241,446	241,446	0
West IHC	YG - EC - Minimise the Cost of Medical Agency	R	27,019	27,019	0	0	0	0
West IHC	YG - EC - Minimise the Cost of Nurse Agency	R	238,679	331,245	92,566	30,000	148,596	118,596
West IHC	YG - Medicine - Minimise the Cost of Medical Agency	R	25,432	25,432	0	0	0	0
West IHC	YG - Medicine - Minimise the Cost of Nurse Agency	R	183,774	184,478	704	48,000	704	-47,296
West IHC	YG - SACC - Minimise the Cost of Medical Agency	R	332,138	207,758	-124,380	52,000	58,474	6,474
West IHC	YG - SACC - Minimise the Cost of Nurse Agency	R	219,774	416,984	197,210	60,000	160,256	100,256
West IHC	Ysbyty Gwynedd, Accomodation - Annual (RPI based)	R	21,512	21,512	0	0	0	0
Subtotal			**22,000,747**	**22,034,357**	**33,251**	**7,948,381**	**8,210,956**	**262,575**
Procurement			2,843,293	3,477,172	633,879	885,542	1,312,602	427,060
Total			**24,844,039**	**25,511,529**	**667,130**	**8,833,923**	**9,523,557**	**689,635**

Teitl adroddiad: ***Report title:***	**2025-26 Month 4 (July) Value & Sustainability Report**
Adrodd i: ***Report to:***	Performance, Finance and Information Governance Committee (PFIG)
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 26 August 2025
Crynodeb Gweithredol: ***Executive Summary:***	This report provides a briefing on the Value & Sustainability Programme (which is one of four designated Major Change Programmes), as at the end of M4 (July 2025). The report includes background information on the programme structure and delivery priorities, a summary position on our savings plan, split by each Value & Sustainability workstream and delivery against target. <u>Programme Structure</u> A formal programme structure has been created, adopting the national Value & Sustainability framework, establishing five workstreams to oversee delivery. 1. Medicines Management 2. CHC 3. Workforce 4. Procurement & Non-Pay 5. Clinical Value (Variation) Following this, both the Integrated Performance Executive Delivery Group (IPEDG) and Executive Team (ET) approved a recommendation from the Programme Director to integrate Value Based Health Care (VBHC), into this single, unified approach. This was further supported by the National Value & Sustainability Board in June 2025, who approved the development of a new sixth workstream 'Value Based Health Care', mirroring our local programme **Fig 1 – Programme Structure** 

The Value & Sustainability programme has been designated a Major Change Programme (MCP) for 2025/26, which provides a further level of governance and oversight, as per fig 2 below.

Fig 2 – Governance Arrangements



The programme's primary delivery objectives (as per the Annual Plan 25-26) are:

- **2E.1** - Design and deliver a refreshed value and sustainability programme for 2025/26, which has clear outcomes based on broader measures of value, to deliver qualitative, performance and financial improvement.
- **2E.2** - Focus on Clinical Value to take advantage of nationally identified opportunities to expedite reductions in waste, harm and unwarranted variation.
- **2E.3** - Build on work to embed value principles into the wider organisational frameworks; planning, commissioning, multi-professional workforce modelling, performance, leadership and quality.
- **2E.4** - Design a value training programme as part of the journey towards a Value Academy for North Wales and a longer-term commitment to building knowledge and capacity in delivering value-led improvement.

<u>Savings Delivery</u>

As referenced in the financial report, the Health Board's financial plan requires a savings target of £40.0m to be delivered in 2025/26. The £40.0m target plan profiled on an equal twelfth's basis.

As at Month 4 (July 2025) the Health Board has identified £23.6m Green saving schemes, fortuitous Accountancy Gains of £1.9m giving a combined total of £25.5m, an increase of £8.0m from previous month. Recurring savings (those expected to continue into future accounting periods) total £18.2m with a full year effect of £24.3m, with an additional £7.3m identified as non-recurring (one off) savings.

	Full year plan value of Red Schemes totals £2.7m and the full year plan value of further pipeline opportunities totals £9.9m. Savings delivered in Month 4 totalled £5.3m, of which £2.5m is recurring against a target of £3.3m. It is important that identification and delivery of savings are progressed at pace, so as not to continue contributing to adverse performance in the early part of 2025/26 that will require recovery during the remaining months of the 2025/26 financial year (the period concluding on the 31st March 2026). The Executives and IHC Directors have been informed via the Integrated Performance and Executive Delivery Group (IPEDG) of the Welsh Government requirements to fully identify the £40m savings requirements and all schemes must meet the 'Green Schemes' criteria prior to the Month 5 MMR submission deadline. As plans progress within both the Planned Care and Urgent Emergency Care Major Change Programmes, additional opportunities identified through the adoption of best practice, including improvements in productivity & efficiency and reductions in waste need to be quantified and any financial opportunities built into the Clinical Value workstream, as a further contribution to the savings target. This will begin the transition to an improvement/transformation-led savings programme. In addition, any financial benefits from the funded Value Based Health Care schemes (or any other independent schemes within the Health Board) also require quantification and inclusion in the new 'Value Based Health Care' workstream. <u>Wider Benefits</u> In order to maintain and enhance clinical engagement, the progarmme has begun to expand its focus from exclusively financial improvement, to a wider set of value metrics, encompassing additional measures of patient outcomes, patient/staff experience, productivity, efficiency, green agenda, social value etc. A new and more holistic framework is currently under development, in conjunction with the Planned Care Major Change Programme and will be used as the blueprint to design and oversee all future value programmes.		
Argymhellion: ***Recommendations:***	The Board is asked to: • **Receive,** and scrutinise this report		
Arweinydd Gweithredol: ***Executive Lead:***	Russell Caldicott, Interim Executive Director of Finance.		
Awdur yr Adroddiad: ***Report Author:***	Neil Windsor, Programme Director – Value & Sustainability		
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision*	Am sicrwydd *For Assurance* ☒

		☐		
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☒ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	This paper aligns to the strategic goal of attaining financial balance and is linked to the well-being objective of targeting our resources to those with the greatest need as per the financial plan.
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	The Value & Sustainability Programme assists the Health Board in meeting its' statutory and mandatory requirements.
Yn unol â WP7 (sydd bellach yn cynnwys WP68), a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 (which now incorporates WP68) has an EqIA been identified as necessary and undertaken ?***	Naddo N Equality Impact (EqIA) and a socio-economic (SED) impact assessments not applicable. For each individual scheme within the overall programme, impact assessments should be undertaken and approved prior to submission.
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)***	BAF24-03 Not Achieving Long Term Financial Sustainability – currently a £1.8m variance between plan and savings target and a £14.5m variance between green 'RAG' schemes and target
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	As per our Financial Plan, the Health Board is in receipt of £82m of non-recurrent funding from Welsh Government that requires attainment of the 2025/26 plan (a) delivery of financial balance £40m and (b) de-escalation from Special Measures £42m for these funds to be received recurrently (available for future financial years). If the plan is not attained then the funding of £82m will be at risk of clawback from Welsh Government

	and this places risk on the sustainability of existing service models.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Not applicable
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Not applicable
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	**Appendix A** **BAF risks** BAF24-03 Not Achieving Long Term Financial Sustainability BAF24-06 Not Delivering the Required Improvements to Transform Care and Enhance Outcomes **Link to Corporate Risk Register:** CRR24-05 Delivery of the 25/26 Financial Plan
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Amherthnasol Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations***	
Rhestr o Atodiadau: ***List of Appendices:*** A - 2025/26 Value & Sustainability Programme Report – August (Month 5) v.1.2	

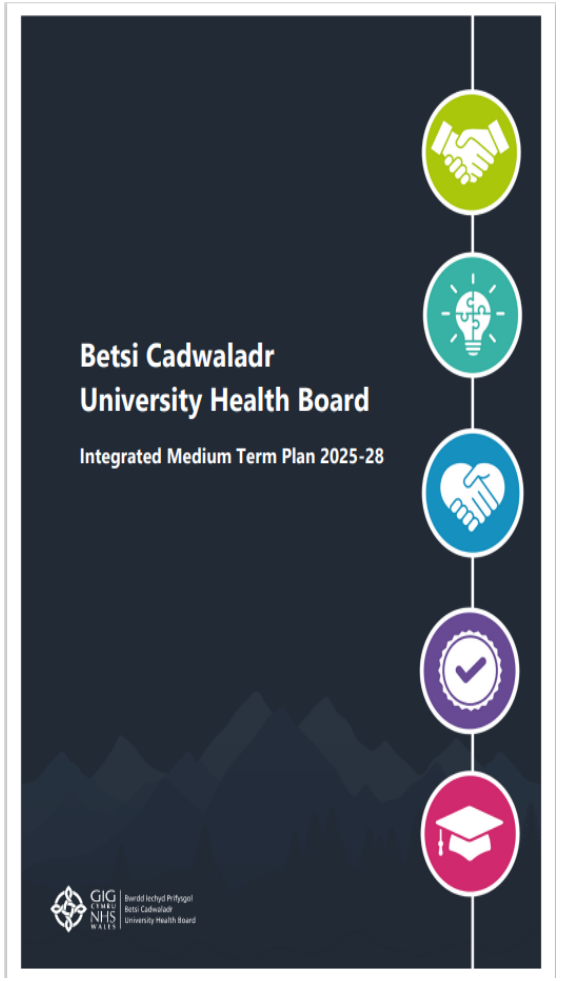
GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

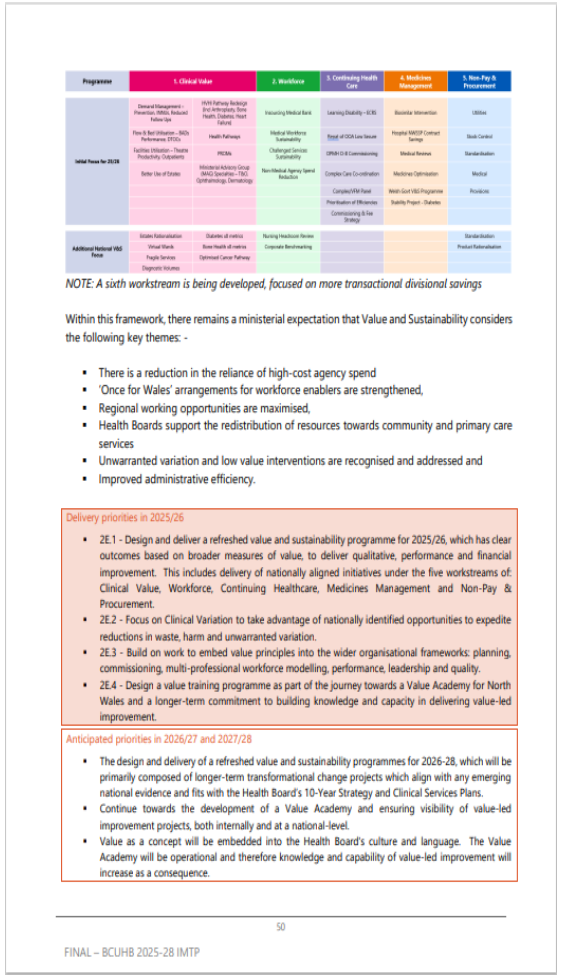
Value & Sustainability Programme Update – at M4

Neil Windsor
Programme Director - Value & Sustainability

Value & Sustainability Programme – An Integrated Value Approach

Value-Based Healthcare (VBHC) and Value & Sustainability (V&S) merged into one single, coherent approach, embedded into IMTP and fourth designated **M**ajor **C**hange **P**rogramme (MCP), built around the national V&S framework





Programme	1. Clinical Value		2. Workforce	3. Continuing Health Care	4. Medicines Management	5. Non-Pay & Procurement
Initial Focus for 25/26	Demand Management – Prevention, WIMA, Reduced Follow Ups	HVH Pathway Redesign (incl Arthroplasty, Bone Health, Diabetes, Heart Failure)	Insourcing Medical Bank	Learning Disability – ECRS	Biosimilar Intervention	Utilities
	Flow & Bed Utilisation – SWDs Performance, EPCCs	Health Pathways	Medical Workforce Sustainability	Repeal of CHCA Law Secure	Hospital MATERP Contract Savings	Stock Control
	Facilities Utilisation – Theatre Productivity, Outpatients	PROMs	Challenged Services Sustainability	DPNH CI-IE Commissioning	Medical Reviews	Standardisation
	Better Use of Estates	Ministerial Advisory Group (MAG) Specialties – TBC: Ophthalmology, Dermatology	Non-Medical Agency Spend Reduction	Complex Care Co-ordination	Medicines Optimisation	Medical
				Complex/VFM Panel	Welsh Govt VBQ Programme	Provisions
				Prioritisation of Efficiencies	Stability Project - Diabetes	
				Commissioning & Fee Strategy		
Additional National VBQ Focus	Estates Rationalisation	Diabetes s8 metrics	Nursing Healthcare Review			Standardisation
	Virtual Wards	Bone Health s8 metrics	Corporate Benchmarking			Product Rationalisation
	Fragile Services	Optimised Cancer Pathway				
	Diagnostic Volumes					

NOTE: A sixth workstream is being developed, focused on more transactional divisional savings

Within this framework, there remains a ministerial expectation that Value and Sustainability considers the following key themes: -

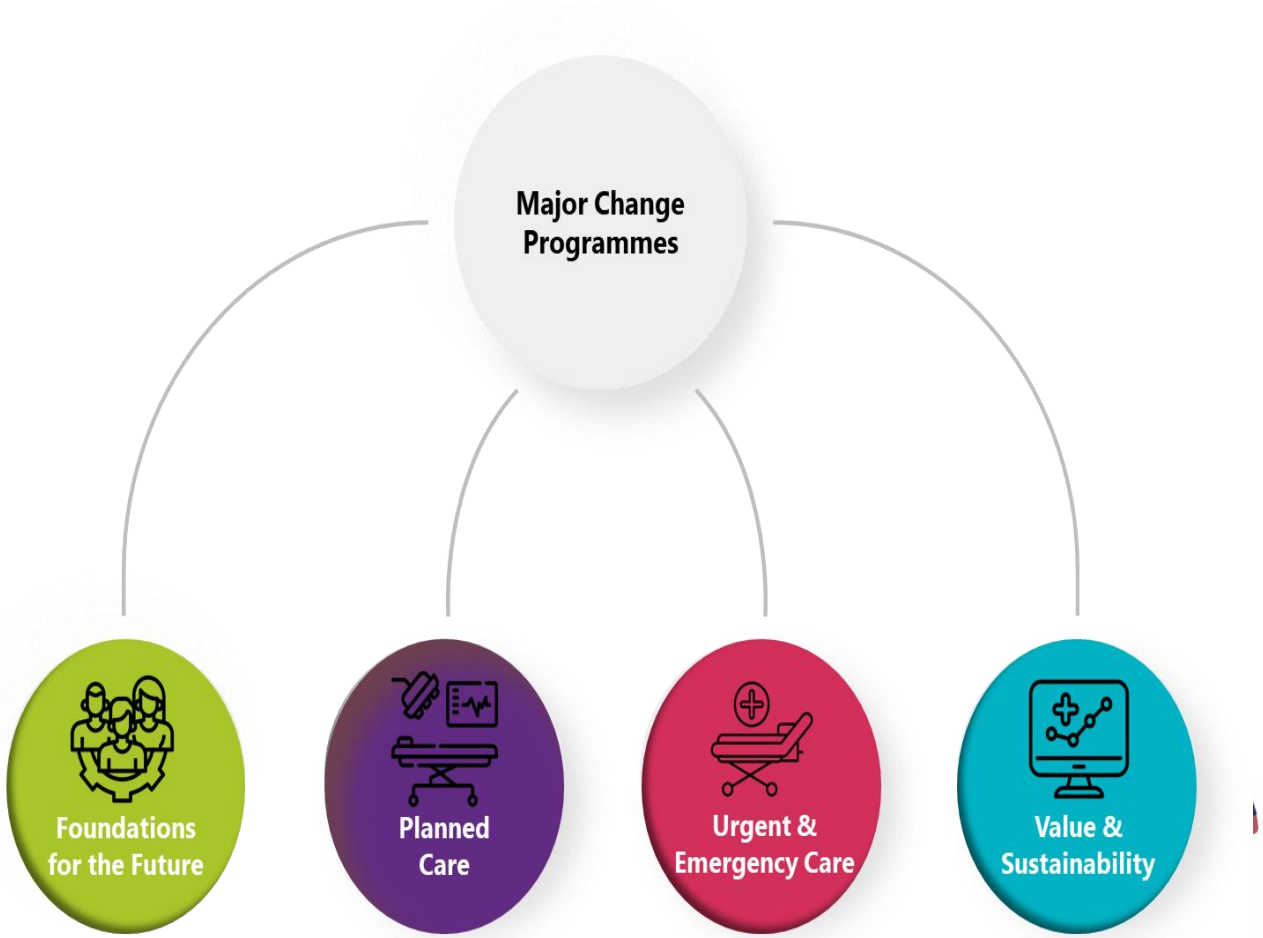
- There is a reduction in the reliance of high-cost agency spend
- 'Once for Wales' arrangements for workforce enablers are strengthened,
- Regional working opportunities are maximised,
- Health Boards support the redistribution of resources towards community and primary care services
- Unwarranted variation and low value interventions are recognised and addressed and
- Improved administrative efficiency.

Delivery priorities in 2025/26

- 2E.1 - Design and deliver a refreshed value and sustainability programme for 2025/26, which has clear outcomes based on broader measures of value, to deliver qualitative, performance and financial improvement. This includes delivery of nationally aligned initiatives under the five workstreams of: Clinical Value, Workforce, Continuing Healthcare, Medicines Management and Non-Pay & Procurement.
- 2E.2 - Focus on Clinical Variation to take advantage of nationally identified opportunities to expedite reductions in waste, harm and unwarranted variation.
- 2E.3 - Build on work to embed value principles into the wider organisational frameworks: planning, commissioning, multi-professional workforce modelling, performance, leadership and quality.
- 2E.4 - Design a value training programme as part of the journey towards a Value Academy for North Wales and a longer-term commitment to building knowledge and capacity in delivering value-led improvement.

Anticipated priorities in 2026/27 and 2027/28

- The design and delivery of a refreshed value and sustainability programmes for 2026-28, which will be primarily composed of longer-term transformational change projects which align with any emerging national evidence and fits with the Health Board's 10-Year Strategy and Clinical Services Plans.
- Continue towards the development of a Value Academy and ensuring visibility of value-led improvement projects, both internally and at a national-level.
- Value as a concept will be embedded into the Health Board's culture and language. The Value Academy will be operational and therefore knowledge and capability of value-led improvement will increase as a consequence.



Value & Sustainability Programme – Delivery Priorities 25/26

- **2E.1** - Design and deliver a refreshed value and sustainability programme for 2025/26, which has clear outcomes based on broader measures of value, to deliver qualitative, performance and financial improvement.

- **2E.2** - Focus on Clinical Value to take advantage of nationally identified opportunities to expedite reductions in waste, harm and unwarranted variation.

- **2E.3** - Build on work to embed value principles into the wider organisational frameworks; planning, commissioning, multi-professional workforce modelling, performance, leadership and quality.

- **2E.4** - Design a value training programme as part of the journey towards a Value Academy for North Wales and a longer-term commitment to building knowledge and capacity in delivering value-led improvement.

Value & Sustainability Programme – Overall Structure

Exec Lead	**Sreeman Andole**		**George Roberts**	**Angela Wood**	**Sreeman Andole**	**Russell Caldicott**	**TBC**
CFO/Senior Finance Lead	Adrian Butlin, Paula Jones, Nicola Hyde		Rebecca Hughes, Jemma Orlick	Paul Carter	Paul Carter, Dylan Pritchard	Rebecca Hughes, Michelle Jones, David Williams	TBC
Workstream Lead	TBC		Nick Graham	Jane Trowman	Lois LLoyd	Michelle Jones	TBC
Programme	**Clinical Variation**		**Workforce**	**Continuing Health Care**	**Medicines Management**	**Non-Pay & Procurement**	**Value-Based Health Care**
Key workstreams	Waiting List Management	Rationalise Ortho Implants	International Recruitment	High Cost Placement Reviews	Generic v Branded Drugs	Improved Contract Mgt	*HVHI – Hip Arthroplasty
	Referral Advice & Guidance		Nurse Staffing Levels	Consistent Pricing	Adoption of Biosimilars	Improved Mgt of Non-Pay	HVHI – Knee Arthroplasty
	Booking		Agency Reduction	Commissioned Care Planning	Low Value Prescribing		HVHI – Bone Health
	Pre-Op Effectiveness		Sickness Reduction				HVHI - Diabetes
	Follow-Ups						PROMs Platform
	UEC Flow/DToCs						Health Pathways
							** Locally Funded Schemes
Additional National V&S Focus 25/25	**'Fragile' Services – Phase 2**	**Fit for Purpose Admin Estate**	**Improved Job Planning & Rostering**			**Product Rationalisation & Standardisation**	**HVHI – Heart Failure**
			Standard Pay Rates for Additional Hours				

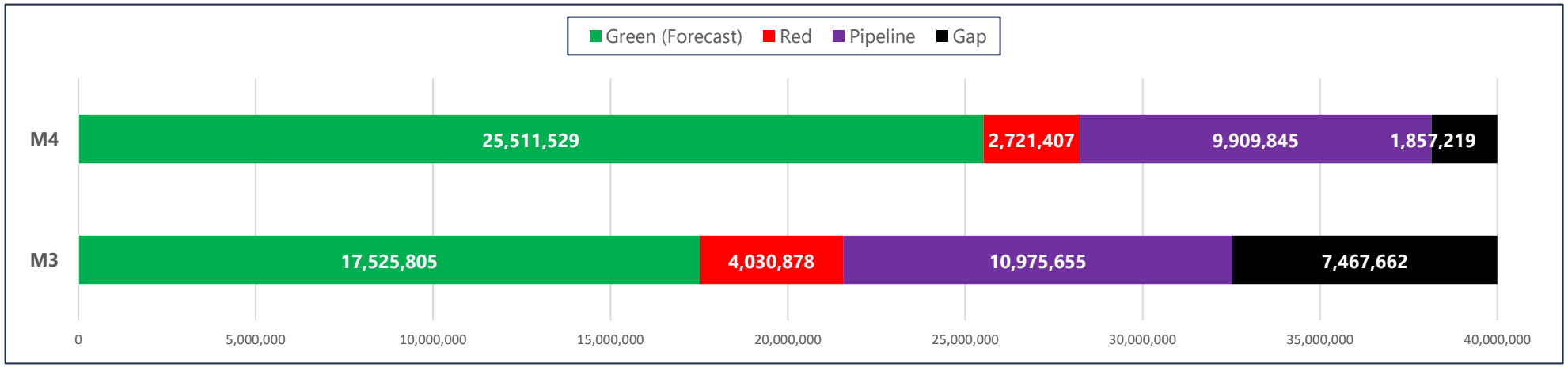
** HVHI = High Value, High Impact Pathway Interventions*
** *See slide 12 for details*

Value & Sustainability Programme – Summary Position (as per M4 Monitoring Return)

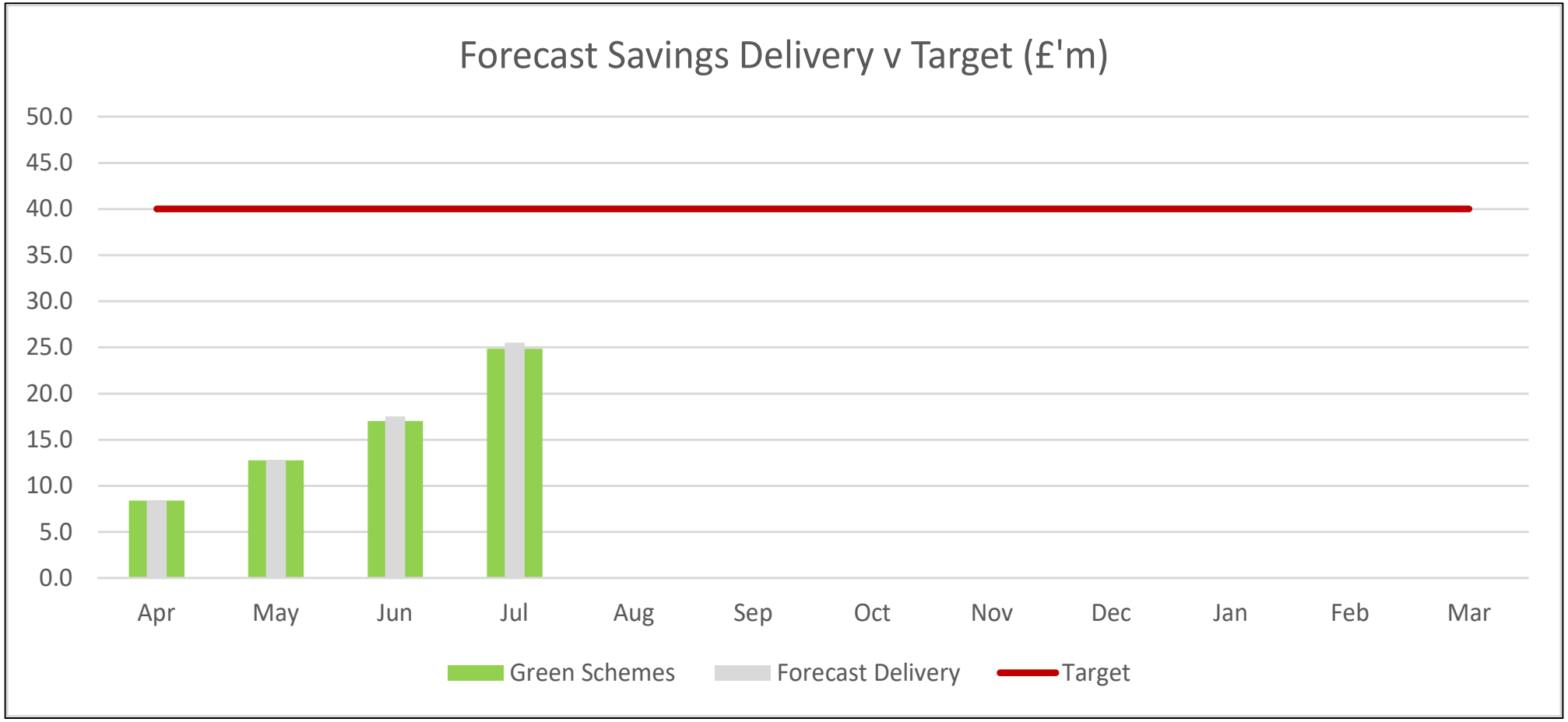
V&S Workstreams*	Green	Red	Pipeline	TOTAL
1. Medicines Management	7,115,896	29,997	1,942,382	9,088,275
2. CHC	4,290,998	2,024,801	975,000	7,290,799
3. Workforce	6,279,906	330,174	6,257,627	12,867,707
4. Procurement & Non-Pay	5,489,325	16,434	734,836	6,240,595
5. Clinical Value				
Other-Primary Care	128,233	320,000		448,233
Income	221,823			221,823
Other - Commissioning	1,985,347			1,985,347
Total	**25,511,529**	**2,721,407**	**9,909,845**	**38,142,781**
Target	**40,000,000**			**40,000,000**
Gap	**-14,488,471**			**-1,857,219**

Key	Definition
Pipeline	Total opportunity identified by Workstream Lead, as yet unvalidated (may include FYE)
Red RAG	Indicative values identified for individual schemes, but formal SSD's not submitted/validated
Green RAG	Savings opportunities fully profiled with submitted SSD's which have been validated

* An additional 6th Workstream (Value Based Health Care (VBHC) has been introduced to the Programme in-month, but as yet is not included in Monitoring Return categories



Value & Sustainability Programme – Green RAG Delivery (as per M4 Monitoring Return)



Green Schemes Plan	Green Schemes Actual/Forecast Delivery	Variance at M4
£24,844,399	£25,511,529	**£667,130**

Value & Sustainability Programme – 1. Medicines Management Workstream

National Priorities 24/25

1. Maximise biosimilar usage, including preferential use of lowest acquisition cost biosimilars (adalimumab, infliximab, etanercept, ranibizumab)
2. Switch to generic use of abiraterone, apixaban, lanreotide, lenalidomide, teriflunomide and sugammadex in secondary care
3. Stop prescribing medicines by brand in primary care where low cost generics are available
4. Preferential use of apixaban (or rivaroxaban) in primary care
5. Stop prescribing of medicines on low value list, including some over the counter medicines (restricted list)
6. Restrict prescribing of bath and shower emollients
7. Selection of lowest acquisition liothyronine preparations (5mcg and 10mcg)
8. Selection of dry eye preparations in accordance with local formularies
9. Maximise biosimilar use of Ustekinumab
10. Secondary care contract changes (generics and biosimilars)

Cabinet Secretary Enabling Actions

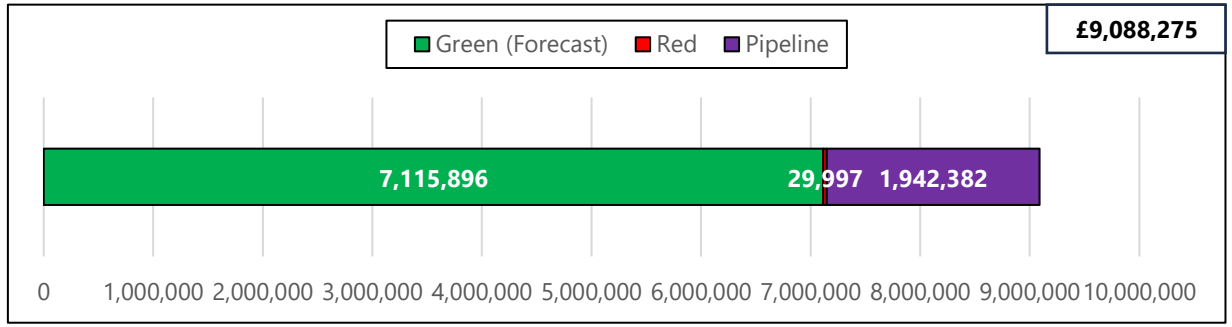
- Ensure full implementation of the high value medicines Value & Sustainability Board programme, which includes delivering opportunities against each of the four programme areas (maximise use of biosimilars, switch to generics, preferential use of medicines in primary care, restrict low value prescriptions)

Key Outcomes

- Increased savings relating to biosimilars
- Increased pace of adoption of biosimilars
- Improvements in prescribing of generic v branded drugs
- Reduction in low value prescribing

National Focus for 25/26

- Re-baseline existing schemes
- Maintain current performance
- Identify new schemes based on market entry/contract changes



RAG Rating	BCUHB Initiative	Value (£) at M4
Green	Administration and Management Efficiencies	768,527
Green	Digital driven efficiencies such as prescribing software usage	1,327,915
Green	Optimising medicine prescribing within clinical pathways	1,113,957
Green	Procurement efficiencies including maximising drugs rebates	1,190,641
Green	Product switching to cheaper alternatives and biosimilars	1,333,527
Green	Reduced non-necessary usage	57,660
Green	Other Medicines	1,323,670
TOTAL		**7,115,896**
Red	Optimising medicine prescribing within clinical pathways	29,997
TOTAL		**29,997**
25/26 Pipeline	Administration and Management Efficiencies	405,200
25/26 Pipeline	Procurement efficiencies including maximising drugs rebates	691,773
25/26 Pipeline	Product switching to cheaper alternatives and biosimilars	845,409
TOTAL		**1,942,382**

Value & Sustainability Programme – 2. Continuing Health Care (CHC) Workstream

National Priorities 25/26

1. An IT System (All-Wales)
2. Support for NHS nurse assessors and reviewers training and competency
3. A process to identify opportunities to ensure value through consistent pricing
4. A continuation of the High-Cost Placements Reviews
5. Further enhance the partnership between health and social care
6. Strategic Commissioned Care Planning.
7. Improving governance and oversight national and local CHC work.

Cabinet Secretary Enabling Actions

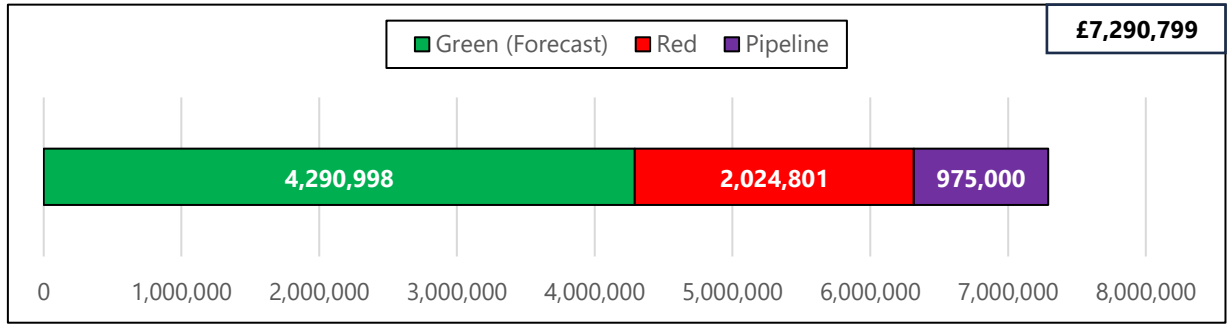
- Ensure implementation of Value & Sustainability Board recommendations which include continued actions to improve clinical and financial effectiveness associated with packages of care.

Key Deliverables

- Realise CHC quality and value improvements
- Create financial and process efficiencies
- To encourage sustainability in the sector
- To secure and enhance partnership involvement
- To secure and enhance relationships with the provider sector

Core Themes for 25/26

- Development of a more collaborative approach, formulated with the support the of NWJCC
- Development of new ways of commissioning for CHC
- Improving Patient outcomes and experience
- Standardization driving out avoidable variation supported by regional and national benchmarking



RAG Rating	BCUHB Initiative	Value (£) at M4
Green	Centre IHC - Continuing Health Care Schemes	
Green	East IHC - CHC Cost Containment Schemes	
Green	Right Care Programme	
TOTAL		**4,290,998**
Red	CCAPs	184,000
Red	Complex Care Co-ordination 1 - Existing	700,000
Red	Managing Backlog of Disputes	550,000
Red	West IHC - Continuing Health Care Schemes	590,801
TOTAL		**2,024,801**
25/26 Pipeline	Backlog of reviews	625,000
25/26 Pipeline	Commissioning & Fees Strategy (1,2,3)	0
25/26 Pipeline	Complex Care Co-ordination 1 - Extension	350,000
TOTAL		**975,000**

Value & Sustainability Programme – 3. Workforce

National Priorities 24/25

1. International Recruitment
2. Nurse Staffing Levels
3. Agency Reduction
4. Sickness Absence

Cabinet Secretary Enabling Actions

- Fully implement the actions outlined in the Variable Pay & Agency Control Framework Welsh Health Circular
- 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
- Ensure a reduction in agency spend on Healthcare support Worker, Admin & Clerical, and Estates & Ancillary staff to zero by 30th September 2025
- Ensure effective implementation of job planning policy, to include ensuring that > 90% of all Consultants have an agreed job plan in place at all times by 30th September 2025

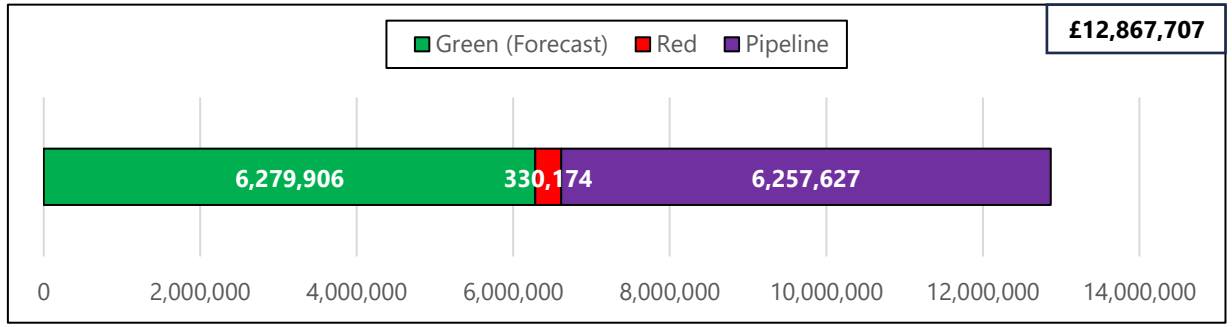
Key Deliverables

A material reduction in agency expenditure through a reduction in vacancies, supporting: -

- Enhanced quality and safety
- Improved patient experience
- Better value for money by avoiding the premium cost of agency staff
- Equity for the substantive workforce and those employed from the NHS bank

National Focus for 25/26

- Develop the scope for corporate benchmarking
- Understand trends for roles and functions where agency usage remains, to inform additional solutions
- Analyse the financial impact of a range of preferential national additional hours rates
- Enhanced rota management and rostering principles



RAG Rating	BCUHB Initiative	Value (£) at M4
Green	Administration and Management Efficiencies	166,733
Green	Enhanced Recruitment Controls	758,617
Green	Improved Agency Control Framework	1,192,916
Green	Optimised Workforce roles / models / teams / skill mix	518,741
Green	Recruitment activities that improve NHS workforce supply	1,747,175
Green	Other	1,047,474
Green	Other Agency	117,252
Green	Other Variable Pay	129,012
Green	Enhanced Rota Management and Rostering	601,988
TOTAL		**6,279,906**
Red	Improved Management of Non-Pay	330,174
TOTAL		**330,174**
25/26 Pipeline	Enhanced Recruitment Controls	730,000
25/26 Pipeline	Optimised Workforce roles / models / teams / skill mix	480,000
25/26 Pipeline	Other (incl HCA Headroom, V&S Workforce etc)	5,047,627
TOTAL		**6,257,627**

Value & Sustainability Programme – 4. Procurement & Non-Pay

National Priorities 24/25

- **Price & Volume –** Securing price, market share, best supply, common suppliers, commitment of volumes
- **Contracting Negotiations & Management** – Effective contract management of existing and new contracts, including PFI
- **Management of Service Contracts** – Exploring the art of the possible
- **Specific Areas of Opportunity** – Opportunity pipeline continuously updated, including opportunities around outsourcing exploration (Rad and Path), Maintenance Procurement & IT

Cabinet Secretary Priorities

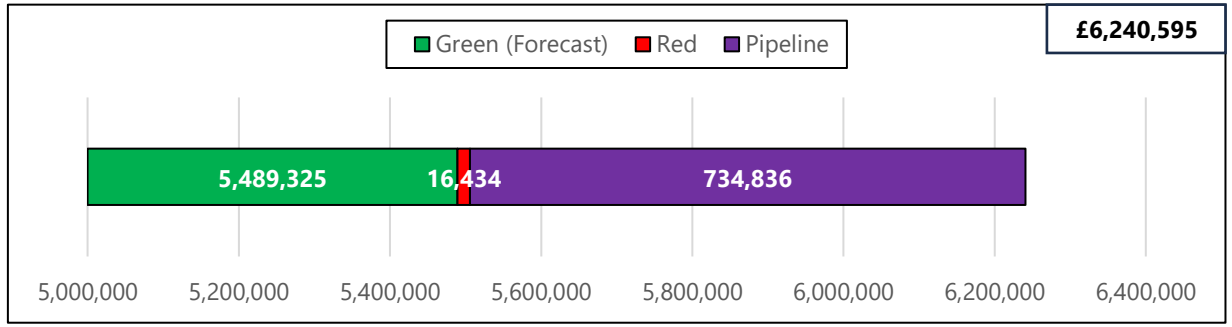
- Ensure implementation of Value & Sustainability Board recommendations, which included local implementation of clinically endorsed and mandated product choice to maximise market share and deliver best value

Key Deliverables

- Significant cash releasing savings over and above original targets
- Significant avoidance of inflationary pressures over and above reported cost pressures

Core Themes for 25/26

- Standardisation & Product Rationalisation



RAG Rating	BCUHB Initiative	Value (£) at M4
Green	Estate and Facilities - Efficiency Improvements	85,443
Green	Improved Contract Management - driving reduced prices and rebates.	3,911,027
Green	Improved Management of Non-Pay	745,292
Green	Other Procurement and Non-pay	671,842
Green	Product Rationalisation.	75,720
TOTAL		**5,489,325**
Red	Product Rationalisation	16,434
TOTAL		**16,434**
25/26 Pipeline	Other – Microsoft Licence, DDAT, Estates Schemes	734,836
TOTAL		**734,836**

Value & Sustainability Programme – Other

RAG Rating	BCUHB Initiative	Value (£) at M4
Green	Income	221,823
TOTAL		**221,823**

RAG Rating	BCUHB Initiative	Value (£) at M4
Green	Other Commissioning	1,985,347
TOTAL		**1,985,347**

RAG Rating	BCUHB Initiative	Value (£) at M4
Green	Other Primary Care	128,233
TOTAL		**128,233**

Red	Other Primary Care - Better Management of Primary Care Costs	320,000
TOTAL		**320,000**

Value & Sustainability Programme – 5. Clinical Value 'Shifting Towards a Wider Benefits Framework'

This workstream will highlight areas of waste and unwarranted variation and identify national/international best practice, which yield the best quality of care and value.

Delivered primarily via the following two Major Change Programmes (MCP's)

1. **Planned Care**
   - Waiting List Management
   - Referral Management
   - Booking
   - Pre-Op Effectiveness
   - Follow-Up

2. **Urgent and Emergency Care**

Early Draft of Planned Care 'Value' Framework

Benefit Category	Assumptions could be used for the benefit descriptions for the 'specific benefits' if linking in outputs and outcomes	Specific Benefit / Benefit Title Applied MEDIC: maintain, eliminate, decrease, increase, create	Workstream Alignment	Measurement Method	Example Metric
Quality & Safety Benefits	*Consistent validation ensures* accurate waiting lists and prioritisation. *Straight-to-test/treatment* reduces clinical risk from delays. *Standardised referral data* improves diagnostic accuracy. *National PIFU/SoS pathways* promote evidence-based follow-up. *Seen within optimal timeframes* enhances safety and outcomes.	Increased accuracty of prioritisation	WS1	Audit validation outcomes vs. clinical need; track escalation rates.	Validation accuracy (%)
		Decreased clinical risk	WS2 / WS6	Monitor incident reports related to delays or misrouting.	Incident reports
		Increased safer follow-up	WS5	Track PIFU compliance and adverse events in patients on these pathways.	PIFU compliance rate (%)
		Standardised care		Audit referral data completeness and adherence to templates.	Referral data completeness (%)
Productivity / Efficiency Benefits	*Optimised templates and theatre utilisation* increase throughput. *Administrative triage and direct listing* reduce bottlenecks. *Reduced DNA/CNA rates* improve slot utilisation. *Core capacity optimisation* enhances service delivery. *New-to-follow-up ratio alignment* reflects true demand.	Increased number of patients seen		Track number of patients seen per clinic/session.	Patients seen per clinic
		Increased faster triage		Measure average time from referral receipt to triage.	Average triage time
		Increased better use of slots	WS3 - Booking	DNA/CNA rate trends; % of rebooked slots.	DNA/CNA rate (%)
		Increased demand-led follow-ups		Monitor new-to-follow-up ratios and compare to benchmarks.	New-to-follow-up ratio
Environment Benefits	*Fewer unnecessary appointments and referrals* reduce travel and carbon footprint. *Daycase and minor ops* reduce resource-intensive inpatient stays. *Efficient use of clinical space and time* lowers energy and material waste.	Decreased travel		Estimate travel miles saved through fewer appointments.	Travel miles saved
		Decreased emissions		Use carbon calculators to estimate CO_2 reduction.	CO_2 reduction (tons)
		Increased efficient resource use		Track inpatient bed days saved; energy use per procedure.	Inpatient bed days saved
Social Value	*Empowered patients* contribute more actively to their communities. *Equitable access to care* supports social justice. *Improved health outcomes* reduce societal burden of illness. *Efficient systems* free up resources for broader community health initiatives.	Increased healthier communities		Population health indicators (e.g., smoking rates, diabetes control).	Population health indicators
		Increased equitable access		Compare waiting times and outcomes across geographic and demographic groups.	Waiting time equity

Value & Sustainability Programme – 6. Value Based Health Care

Funded Value Based Health Care Projects

- Lymphoedema & Cellulitis
- Prehabilitation Elective Cancer
- Value-Based Health Care (VBHC) Diabetes
- WAST Renal NEPTs 6-Day Service
- Endometriosis Gynaecology MAS
- PROMs Platform

Pathway Redesign

- Breast & Gynaecology Cancer
- Memory Assessment/Dementia
- Respiratory
- Orthopaedics
- Cardiology Heart Failure - Phase 1

Additional National Focus

- High Value, High Impact Pathways (HVHI)
- Hip, Knee, Bone Health, Diabetes and Heart Failure
- PROMs

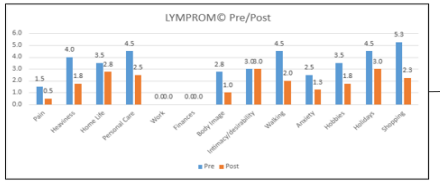
Lymphoedema & Cellulitis - NCIP & OGEP

Expansion of the National Cellulitis Improvement Programme (NCIP) into Primary Care/ Community through a two-month rolling programme of all people being admitted with cellulitis. Targeting the GP Clusters with cellulitis specific education, accelerating Consultant Connect referrals. The On the Ground Clinical Educator Programme (OGEP) working with patients and community nurses to provide education, raise confidence, and improve competence in compression therapy techniques and skin care strategies.

NCIP total invites to date	7020
LOS / Bed Days saved to date	455
Health Care Professionals attending education sessions	619
OGEP total patients seen (on caseload)	1060
Virtual triages reduces GHG emissions factor, saving (kgCo2e)	32,455.8

eqv. 507 people using a mobile phone for a year

Winners of the 2024 NHS Wales Awards (OGEP)



OGEP - Based on patients who have completed both pre and post PROMs. LYMPROM© has shown OGEP instigation and improvement in lymphoedema management affects the patient across all domains

Based on 853 patients having completed a 2-month review process. Savings calculation considering pre-intervention cost with post OGEP intervention costs (1st assessment & 2-month review).

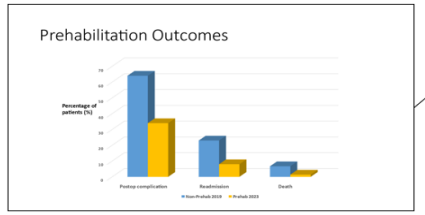
Based on 853 patients reviewed by OGEP	Pre	Post	Diff over 2 months	Diff over 6 months	% reduction
Staff costs	438,624	197,832	-240,792	-722,376	55
GP contacts (£134, £39, £16)	6,960	2,540	-4,420	-13,260	64
Emergency Department (£308)	6,160	5,544	-616	-1,848	10
Cellulitis Episodes* (£2000)	128,000	18,000	-110,000	-330,000	86
Antibiotics (£45)	2,880	405	-2,475	-7,425	86
Falls (£308)	14,476	7,700	-6,776	-20,328	47
Dressings	46,886	14,528	-32,358	-97,074	69
Compression	56,223	41,354	-14,869	-44,606	26
Totals	700,209	287,903	-412,306	-1,236,918	59
£ avoided per patient over 2/12	-972				

£972 savings per patient

Prehabilitation Elective Cancer

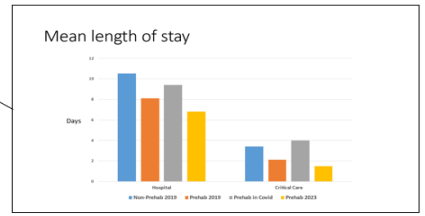
Specialist prehabilitation unit East IHC helping all major surgery patients to access a 4 - week programme of 3 sessions per week consisting of Physio, Psychology and wellbeing and Nutrition education sessions and support, making them better prepared and fully optimised prior to major surgery.

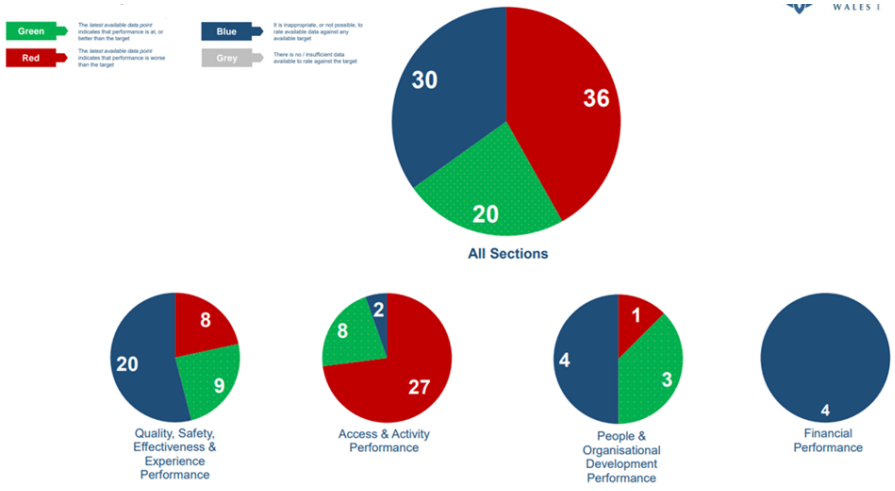
Specialist Prehab attendance to date	720
Adherence rate to course	90%
Reduces complications by up to	50%
Positive patient feedback 10/10	83%
Post-op keeping up healthier lifestyle	65%
Anxiety (GAD7) & Depression (PHQ9) scores decreased by	GAD7 37%, PHQ9 45%



Outcomes for post operative complications, readmission, and mortality are significantly positivity impacted following Prehab intervention

There is reduction in Length of Stay and Critical Care following Prehab intervention, and has also improved when comparing 2019 and 2023 Prehab interventions



Teitl adroddiad: ***Report title:***	Integrated Quality & Performance Report, Month 4 2025/2026
Adrodd i: ***Report to:***	Performance, Finance & Information Governance Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Wednesday, 27 August 2025
Crynodeb Gweithredol: ***Executive Summary:***	The Health Board endorsed the Integrated Performance Framework (IPF) 2023-2027 on the 28th September 2023. It is one of a three frameworks intended to drive the strategic objectives of the Health Board. The other frameworks being the new Integrated Planning Framework (IPlanF) and the Risk Management Framework (RMF). The three Frameworks support the Board Assurance Framework (BAF) and will align with the Quality Surveillance Strategy as it is developed. The purpose of Our Framework is to integrate key performance indicators (KPIs) from: - **1.** Key deliverables from the Annual Plan (IMTP) 2. NHS Wales Performance Framework (Quadruple Aims) 3. Key deliverables in response to WG, HIEW and other formal recommendations including Special Measures. There are 86 measures included in this report, 30 of which are locally defined or do not have a specified monthly target rate. Of the remaining measures, 20 (23%) are on target and 36 (42%) are off target. As indicated within the below graphic;  The Framework supports the delivery of better outcomes for our patients and our staff, and ensure that all stakeholders understand their roles, responsibilities, and accountabilities. The Framework supports performance improvement through articulation of key performance indicators and articulation of opportunities for improvement (utilising available industry benchmarks to assess performance) and builds

	on the commitment for all levels of the organisation to improve. Our Framework is firmly based on our values: - • Put patients first • Work together • Value and respect each other • Learn and innovate • Communicate open and honestly The Framework reflects the Health Board's current level of performance escalation with Welsh Government. The Framework implementation approach will be subject to review should escalation levels change. The Framework requires the production of an Integrated Quality & Performance Report (IQPR) and is presented at this committee (Appendix 1). The Performance & Commissioning Directorate has been working with our partners across the organisation, including the Executive and the Integrated Performance Executive Delivery Group (IPEDG) in developing our IQPR. The Committee should note the framework is continuing to be developed. Future reports will also outline the implementation and engagement arrangements for embedding the IPF and IQPR at various levels across the Health Board. These arrangements include putting in place formal and informal accountability review structures and escalation/ de-escalation mechanisms. The structure of our IQPR is based upon the Quadruple Aims as per the Welsh Government's healthier Wales paper, the NHS Wales Performance Framework 2025-26 and identifies where metrics fall within the Special Measures Framework for BCUHB or within the Ministerial Priorities. Performance is RAG rated against the targets set within the NHS Wales Performance Framework 2025-26, or as set by Welsh Government in the Special Measures Framework for BCUHB or outlined in the Ministerial Priorities. However, where appropriate, BCUHB's internal improvement trajectories as submitted and agreed by Welsh Government have also been included Key areas of escalation are identified within the 'Escalated Performance Measures' section at the beginning of the report, with the Executive identifying within a one-page summary and further detailed escalation reports key performance within the four quadrants of workforce, quality, performance and finance. Statistical Process Control (SPC) charts have been included where appropriate, with the cover report including reference to theatres utilisation, in future reporting these measures will be included (with improvement trajectories) within the main IQPR for members as reported local metrics.
Argymhellion: ***Recommendations:***	The Committee is asked to: Review the contents of the report and propose any actions arising from the report, or identify any additional assurance work or actions it would recommend Executive colleagues to undertake.
Arweinydd Gweithredol:	Stephen Powell, Director of Performance & Commissioning

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

In accordance with WP68, has an SEIA identified as necessary been undertaken?	Socio-economic Impact as it is reporting on actual performance.
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	There remains a number of risks to the delivery of care across the healthcare system due to the legacy impact the COVID-19 Pandemic had upon planned care delivery between 2020 and 2022. References to Corporate Risks have been made in the body of the report, where applicable. 24-04 Failure to Embed Learning 24-05 Financial Sustainability 24-10 Urgent and Emergency Care 24-11 Planned Care 24-12 Areas of Clinical Concern (encompasses ophthalmology and dermatology) 24-13 Timely Diagnostics
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The delivery of the performance indicators within our IQPR will directly/ indirectly impact upon the financial recovery plan of the Health Board.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	The delivery of the performance indicators within our IQPR will directly/ indirectly impact on our current and future workforce.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	This report has been reviewed by Executive Team. The full report has been reviewed by the Director of Performance & Commissioning
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	The Deputy Director of Performance continues to work with the Head of Risk Management in strengthening linkage from this report into the Corporate Risk Register and eventually Board Assurance Framework (BAF) once objectives have been set. References to Corporate Risks are included in the body of the report, where applicable. 24-04 Failure to Embed Learning 24-05 Financial Sustainability 24-10 Urgent and Emergency Care

	24-11 Planned Care 24-12 Areas of Clinical Concern (encompasses ophthalmology and dermatology) 24-13 Timely Diagnostics
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Amherthnasol Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations:*** Continued focus on any areas of under-performance where assurance is not of sufficient quality to believe performance is or will improve as described. The Integrated Quality & Performance Report will undergo further development into 2025-26 to reflect both the Health Board's strategic priorities and the NHS Wales Performance Framework 2025-26, as published in January 2025.	
Rhestr o Atodiadau: ***List of Appendices: 2*** *1: Summary of Report* *2: Integrated Performance Report in PDF*	

Appendix 1 **Summary of Report**

Committee: **Performance, Finance & Information Governance Committee**

Report title: **Summary of Integrated Quality & Performance Report (IQPR)**

Report Author: **Deputy Director of Performance & Commissioning**

1. Introduction

The Performance and Commissioning Directorate continues to develop and refine the performance report for the Health Board and its Committees, the key aim being to enable focus to be placed upon areas of high performance or those metrics requiring improvement, with the 'Integrated Quality & Performance Report' including a section summarising the areas requiring escalation for Board members, divided into the following four quadrants;

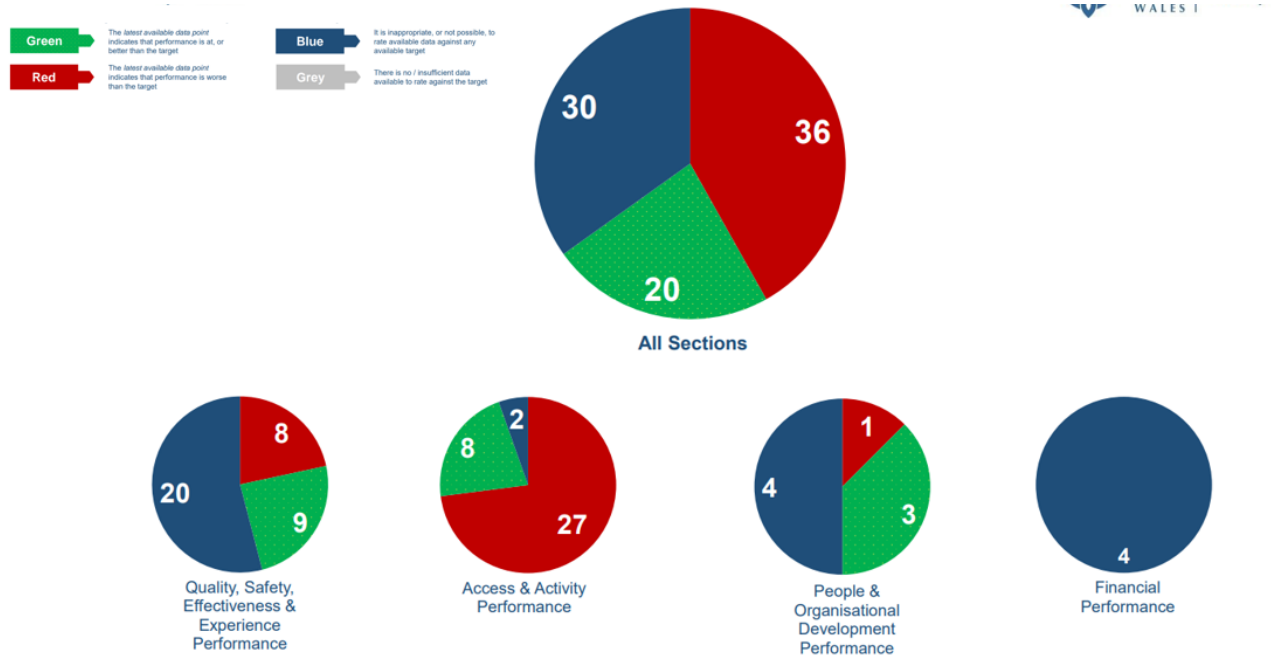
- Quality (Safety, Effectiveness & Experience) Performance
- Access & Activity Performance
- People & Organisational Development Performance
- Financial Performance

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

This report reflects performance against the NHS Wales Performance Framework for 2025-26. Furthermore, it includes several locally defined metrics within the Quality and People & Organisational Development domains.

For the remit of the Performance, Finance & Information Governance Committee, Quality, Safety, Effectiveness & Experience Performance, is not included in the report as this section falls within the remit of the Quality, Safety & Experience Committee (QSE).

2. Overall Summary



Of the measures from the NHS Wales Performance Framework included in the report, 19 are on target, 35 are off target. Although this is an improvement on the previously reported position, it remains clear that there continues to be significant risks to delivery on a number of key metrics for which the attached report at Appendix I, gives further detail within the relevant dashboards for each of the four quadrants, as articulated within the above graphic.

A prioritisation of the metrics off plan has been used to populate the escalation section of the IQPR (see Appendix I) to give greater focus to the metrics we are seeking to enhance in the short term. This summary report will indicate some key elements from our access and activity, our people and our finance as seen within the Health Board.

3. Key outputs from oversight of Performance

3.1 People & Organisational Development

The key areas highlighted centre upon:-

The monthly turnover rate of nursing and midwifery staff returned to 0.5% having been at a 0.9% in March but circa 03% - 0.4% in previous six months. As this measure is calculated as monthly rather than rolling the in-month increase can be attributed to retirements usually seen at the end of a financial year.

Sickness absence has increased to 6% in July. Stress and other mental health issues continue to be the main reason for sickness absence. The percentage rate of agency spend as a proportion of total pay bill at 3.7%, however work is underway to recover the position within Quarter 2.

3.2 Access & Activity Performance

(Corporate Risk 24-10 Urgent & Emergency Care)
(Corporate Risk 24-11 Planned Care)
(Corporate Risk 24-12 Areas of Clinical Concern)
(Corporate Risk 24-13 Timely Diagnostics)

This quadrant contains the greatest number of measures within the report, with the 37 measures within this section requiring oversight through PFIG. It is noted that based on latest information BCUHB is not achieving the target for 27 (73%) of these measures.

The Health Board has key areas of challenge, centred upon;

- Maintaining CAMHS and AMH performance
- Achievement of cancer standards and waiting times
- Planned Care waiting times and performance
- Ambulance handover times and performance
- Patient flow (emergency departments and delays to discharge)

3.2.1 Adult Mental Health Measures Performance

Performance against the assessment target improved and achieved the 80% with a performance of 81.8% in June 2025. The Health Board has continued to reduce waiting times for assessments and reduced long waiters. The Division has trajectories to achieve Part 1b target by the end of Quarter 1, however, have just missed out at 79.6%. As part of this focus is required on equity of service across the individual areas of North Wales with Denbighshire and Anglesey having been outlier areas during 2024/25.

During 2025/26 the expectation is that all measures will be compliant with national target by the end of Q2.

3.2.2 Children's & Adolescent Mental Health Services (CAMHS), and Neurodivergence

Performance against Part 1a of the Mental Health Measure was 98.5% compliance in June 2025 – above the target of 80%. Part 1b performance remains significantly below the 80% target at 50.3% but has been improving month-on-month since April 2025.

With latest performance of 14.0% against the 26 weeks target for children requiring assessment for neurodivergence, the performance continues to be significantly below target. This is recognised as a nationwide issue and work has started to develop and improve the service following participation in the Wales Rapid Design event along with partners.

Longest waits are down to 204 weeks with a plan to deliver zero patients waiting over 156 weeks by the end of quarter 4 of 2025/26. There were 6,462 patients waiting over 26 weeks in July, compared to 7,000 projected. A tender to commission outsourced capacity for assessments is being progressed.

3.2.3 Urgent & Emergency Care Performance

(Corporate Risk 24-10 Urgent and Emergency Care)

The performance for this element is focused 2025/26 Ministerial Priorities under the timely access of care priority area:

- Patients waiting greater than 1 hour for ambulance handover
- Patients waiting greater than 12 hours in the Emergency Department

There has been some improvement in performance with reductions seen in number of Delayed Transfers of Care, Ambulance handovers over 4 Hours and the number of patients waiting over 24 hours within our emergency departments. Focussing on process behind Double triaging, Rapid Access Triage (RATing) and re-visiting Consultant admitting rights to improve flow. Winter resilience planning commenced in line with self-assessment and gap analysis being completed to support improving length-of-stay (LoS) by September 2025.

3.2.3 Planned Care Performance

(Corporate Risk 24-11 Planned Care)
(Corporate Risk 24-12 Areas of Clinical Concern)
(Corporate Risk 24-13 Timely Diagnostics)

i. Single Cancer Pathway

The performance against the single cancer pathway (SCP) target remains fragile. In June 2025, cancer performance improved with BCUHB treating 54.9% (231 out of 421) of new cancer patients within 62 days of suspicion of cancer. Points to note are:

- Haematology met the 75% target
- Skin performance has improved but remains below target due to continued long waits for dermatology appointment
- Reduced performance in breast primarily due to the continued impact of the loss of clinic capacity in both screening and symptomatic services over the Easter period
- Delays to endoscopy continue to impact colorectal performance, leading to 14 breaches in month
- Over half of the urology breaches continue to be due to delays to prostate biopsy (29). However, national funding has been secured to train 2 staff in undertaking Local Anaesthetic Transperineal (LATP) prostate biopsies.

ii. Diagnostics

The number of patients waiting over 8 weeks for a diagnostic test increased further in in July with just over 15,000 patients experiencing waits of 8 weeks or more c7,000 more than the initial trajectory.

Additional funding £3.6M allocated to HB to support reaching expected position of zero waits of 8 weeks at end of March 2026

Revised trajectory in development, reflecting risks to delivery

Q2: Position expected to deteriorate in line with run rate whilst solutions implemented

- Radiology RISP implementation on 8th September limiting capacity for 1-2 weeks
- Internal monitoring to limit loss of capacity

Q3: Completion of procurement / Commencement of solutions

- Adoption of additional demand management measures
- Trajectory refinement in accordance with risks to delivery

Whilst everything possible is being done to prioritise cancer and urgent patients, the delays in diagnostics continue to impact upon delivery and treatment of cancer patients, in particular those requiring a diagnostic endoscopy.

iii. Therapies

In July 2025, 677 patients were waiting over 14 weeks for therapy. 57% (383) were waiting for Physiotherapy, whilst 41% (273) patients were awaiting dietetics intervention.

Physiotherapy: Proposal to continue to use additional locums until end of September and offer additional hours and weekend work (subject to uptake) to support reduction

Dietetics: Interim plan for 2 year fixed term post submitted for review to address current position whilst long term model is reviewed as part of the Gastroenterology Service Plan

iv. Referral to Treatment (RTT)

There was a small increase in the total volume of patients waiting over 52 weeks for a first outpatient appointment during July at 29,949. Insourcing of capacity for over 15,000 new outpatient appointments will enable significant reduction in the number of patients waiting over 52 weeks for a first appointment.

With additional solutions including improvements centring upon clinics adopting Treat-in-Turn methodology and targeting patients seen in clinic at Get It Right First Time (GIRFT) numbers, with greater oversight and the setting of booking rules to deliver improved productivity and further reduce the waiting time for a new outpatient appointment.

Whilst 208 weeks waits have been eradicated, one has occurred in July 2025. The patient will be seen in September however this means they will remain a breach in the end of August position too.

Patients waiting over 156 weeks and 104 weeks are the main focus through the 2025/26 and there has been a significant reduction in both cohorts. Whilst the number of patients waiting over 156 weeks, continues to fall, at 384, there has been a slight rise in the number of patients waiting 104 weeks at 5,477. As we progress through 2025/26, intense focus and support and substantial resources are being applied to further reduce the number of patients waiting more than 2 years and to clear the remaining 384 patients that have been waiting over 3 years.

The Chief Executive Officer with support from the Chief Operating Officer, Director of Finance and Director of Performance and Commissioning have taken charge of oversight of this area through weekly meetings and daily updates during this period and continued reduction is expected for patients waiting both within the 156 weeks and 104 weeks cohort as we move into 2025/26 with key areas of focus linked to

- Contracts have been mobilised for key specialties
- Review key specialties to understand case-mix risk (including Ophthalmology and Orthopaedics)
- Continued focus on treat in turn

- Review of Interventions Not Normally Undertaken (INNU)s

v. Follow Up Backlog over 100% of clinical review due date

The total number of patients that are overdue their clinical follow up date stands at 170,584 (25% of the North Wales population) Of these, the number of patients waiting beyond 100% of their due clinical follow up has, since October 2024, increased month on month and now stands at over 97,820 (approximately 15% of the North Wales population). The three specialties with the highest volume of patients waiting beyond 100% are Ophthalmology, Gastroenterology and Urology which combined account for c37% of the total. There is clearly a significant clinical risk within this cohort and Follow Up pathway is one of the key workstreams within Planned Care during 2025/26.

Efforts underway to reduce this backlog includes:

- Undertake a systematic approach to validating, data cleansing all Follow-up lists.
- Implement See on Symptoms (SoS) and Patient Initiated Follow-up (PIFU) on all priority specialties (linked to Optimisation Frameworks/GIRFT).
- Recalibrate capacity from follow-ups to new appointments in priority specialties, following assessment of opportunity.

The Follow up backlog includes ophthalmology patients prioritised as urgent (R1), and are over their clinical target date. Just over half of these patients are seen within 25% over their clinical target date, which may result in irreversible harm for those waiting beyond the clinical target date. Actions to reduce the potential for harm and reduce the backlog include:

- Focussed harm reviews within an integrated concerns management approach (including investigation, learning identification and application, feedback).
- Outsourcing of over 4,600 of the longest waiting cataract patients
- Direct listing for cataracts
- Commenced new glaucoma and medical retina pathways through primary care practices

3.2.5 Summary

Timely access to planned care and cancer pathways is a fundamental aspect of the Health Board commitment to improving services for the people of North Wales.

In 2025-26, focus will continue on meeting challenges through (a) enhanced utilisation of in-house capacity (b) validation of patients waiting for procedures (c) implementation of Treat-in-Turn methodology and (d) engagement with the commercial sector to offer short term solutions to capacity shortfalls.

The level of delayed pathways of care continued high emergency demand increased to compound system flow pressures, medical outliers driving continued use of agency

and adversely impacting upon capacity to service elective care, with potential impacts upon quality of care.

The Health Board key areas of challenge, centre upon: -

• Patient flow (emergency departments, and delays to discharge)

• Ambulance handover times and performance

• Delivery of planned care recovery including diagnostics

• Achievement of cancer standards

3.3 Financial Performance

(Corporate Risk 24-05 Financial Sustainability)

The 2025/26 financial plan aligns with the strategic ambition of the Health Board in attaining the key financial duty to break-even. Expenditure commitments will need to be prioritised to enable the key financial duty and the performance ask to be attained. Achieving the control target in 2024/25 has resulted in the £74.6m conditionally recurrent funding received in 2023/24 and 2024/25 being allocated as recurrently in 2025/26 and the receipt of the £82.0m Improvement and Transformation funding allocation non-recurrently for 2025/26, with conditions associated with retention recurrently of the funds for 2026/27 and beyond being:

- £40.0m Deficit Support Funding – Recurrent and non-conditional following submission and delivery of a financially balanced IMTP by the Health Board.
- £42.0m Performance & Transformation Funding – Recurrent on de-escalation from Special Measures and Welsh Government having greater oversight and direction in use against Special Measures and Ministerial priorities.

In-month position is reporting a deficit of £3.6m, a deterioration of £2.0m from the previous months position. Year to date position is a deficit of £11.4m, largely driven by the shortfall in National Insurance funding of £1.4m for the months of April to July 2025 (previously costs offset by anticipated allocations), pressures associated with Escalated Beds, Healthcare Services provided by other NHS Bodies Contracts and a substantial increase in Mental Health Out of Area referrals.

Savings

The Health Board's financial plan has set a savings target of £40.0m to be delivered in 2025/26, profiled on an equal twelfth's basis. There has been a significant step up in the Savings Plan reported at end of July (Month 4) with the Health Board having identified £23.6m Green saving schemes, fortuitous Accountancy Gains of £1.9m, giving a combined total of £25.5m, an increase of £8.0m from previous month. Of these savings, £18.2m is recurring with a full year effect of £24.3m and £7.3m identified as non-recurring savings.

Further work is required to convert £12.6m red and pipeline opportunities into Green Schemes.

Welsh Government has issued a deadline for the Health Board to identify the full £40m savings requirement and all schemes must meet the 'Green Schemes' criteria prior to the Month 5 Monitoring Return submission deadline.

4. Overall Summary

The Health Board continues to face significant challenges in attainment of the performance targeted within the national and local plans and escalation continues in these areas as a consequence. However, it is of note that in a number of areas performance continues to improve (based on historic delivery and in year comparison) and in some instances attains national targeted levels.

Throughout 2025-26, plans are being implemented to support delivery priorities to substantially improve elective wait times, outpatients (new & follow up) cancer and 8-week diagnostic performance.

Members are invited to review the detail contained within the performance report to assess areas of key challenge and improvement opportunity, debating delivery on a balanced scorecard.

5. Appendix

Appendix 1 – Integrated Quality & Performance Report – to 31.07.2025

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Integrated Performance Report

Reporting Period: to 31.07.2025

Presented to

Performance, Finance & Information Governance Committee

Wednesday, 27th August 2025

Produced on behalf of the **Performance, Finance & Information Governance Committee**
by the **Performance and Commissioning Directorate and Partners**

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Performance Escalations Report

Produced on behalf of the **Performance, Finance & Information Governance Committee**
by the **Performance and Commissioning Directorate and Partners**

Escalated Performance Measures at a Glance

KEY: ▲ **= Better** ▼ **= Worse** than previous reporting period

Quality (CRR 24-04 Failure to Embed Learning)

- ▼ New Never Events: **2** reported between May and June 2025 (Target 0)
- ▲ National Reportable Incidents (NRI): **1** overdue in July 2025 (Target 0)
- ▼ Learning From Events Reports (LFERs): **26** in July 2025 (Target 0)
- ▲ Clinical Coding Compliance: **74.6%** in May 2025 (above trajectory)

People & Organisational Development

- ▲ Personal Appraisal & Development Review (PADR): **81.8%** (Target 85%)
- ▼ Sickness & Absence: **6.0%** (Target Reduce)
- ▼ Agency Spend: **3.7%** (Target Reduce)
- ▼ Staff turnover less than 1 year service: **14%** (Target Reduce)

Access & Activity (CRR 24-10 Urgent and Emergency Care; CRR 24-11 Planned Care; CRR 24-12 Areas of Clinical Concern; CRR 24-13 Timely Diagnostics)

- ▲ CAMHS Part 1b: **50.3%**
- ▼ Neurodiversity: **14.0%**
- ▲ Adult Mental Health Part 1b: **79.6%**
- ▲ Adult Psychology: **75%**
- ▲ Ambulance Handover Delays 4 Hours: **422**
- ▼ ED 12 Hours: **3,848** (▲ 24 Hours **1,669**)
- ▲ Delayed Pathways of Care: **290**
- ▲ Single Cancer Pathway: **54.9%**
- ▼ Referral to Treatment: 104 weeks **5,477**; ▲ 156 weeks **384**; ▼ 208 weeks **1**
- ▼ Diagnostics over 8 weeks: **15,055**
- ▼ Follow up Backlog Over 100% due: **97,820**

Finance (CRR 24-05 Financial Sustainability)

Financial Position

- ▼ Year to date – Deficit versus Plan **-£11.4m**
- ▼ In month Variance to plan **-£3.6m**
- ▲ Full year outturn position - **Balanced Position** as per Plan

Savings Position

- ▼ Year to Date Savings Delivery including Accountancy Gains v target **-£3.8m**
- ▼ Forecast Savings Delivery including Accountancy Gains v Target **-£14.5m**

Capital Expenditure

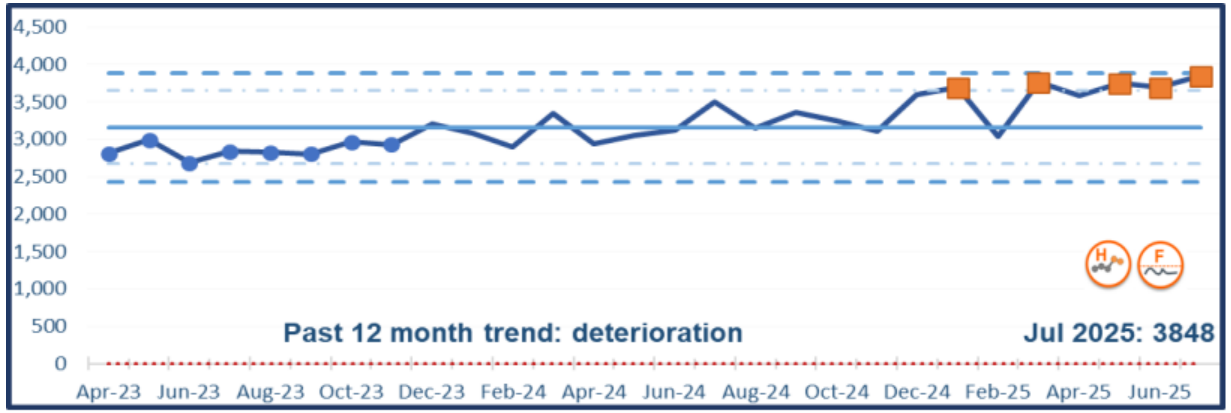
- ▲ Year to Date Plan is £10.4m. Spent £5.1m Underspend **£5.3m**.

Access & Activity: Escalated Performance Measures
Urgent & Emergency Care

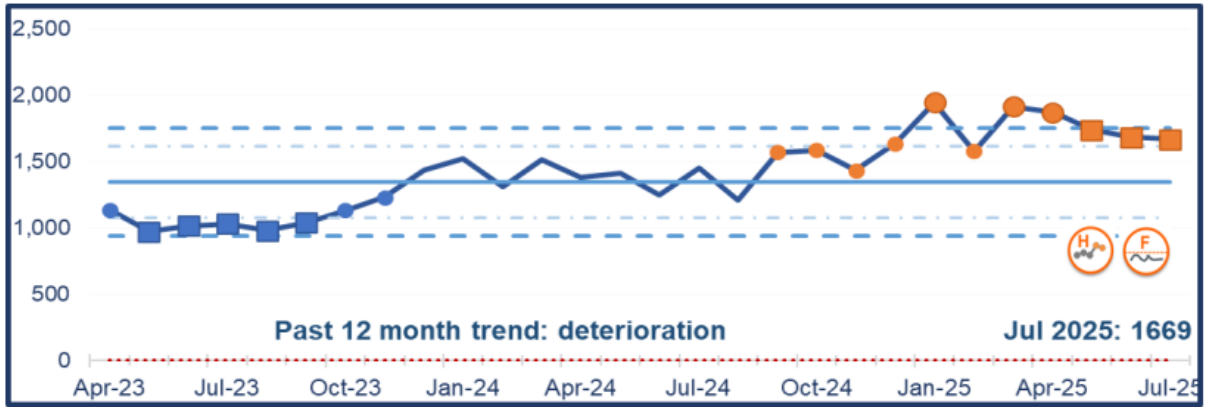
GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

There has been some improvement in performance with reductions seen in number of Delayed Transfers of Care, Ambulance handovers over 4 Hours and the number of patients waiting over 24 hours within our emergency departments. Focussing on process behind Double triaging, Rapid Access Triage (RATing) and re-visiting Consultant admitting rights to improve flow. Winter resilience planning commenced in line with self assessment and gap analysis being completed to support improving LoS by September 2025.

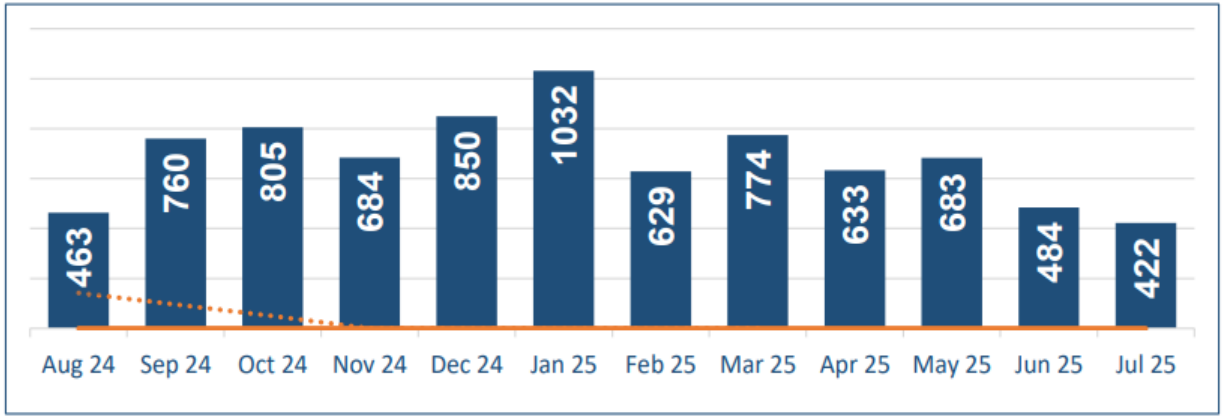
Number of 12 Hour Emergency Department Waits



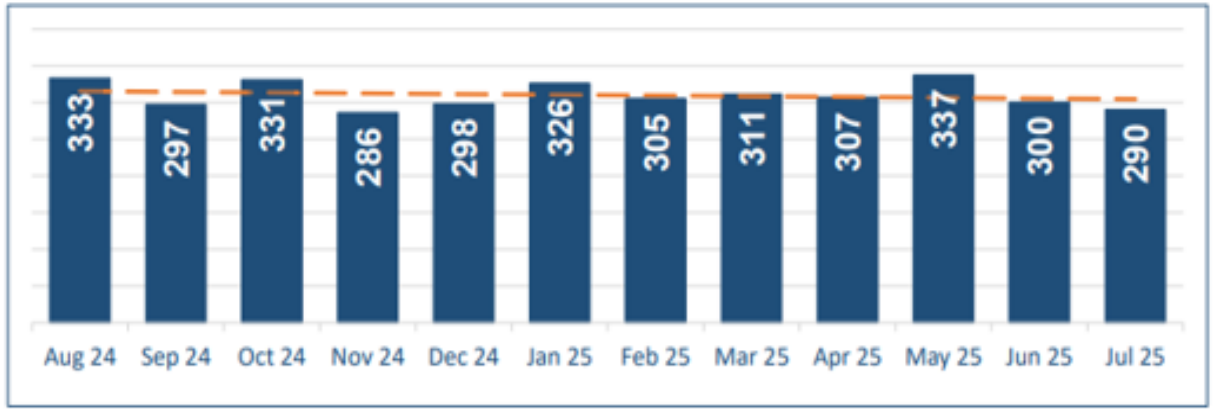
Number of 24+ Hour Emergency Department Waits



Number of 4+ Hour Ambulance Handover Breaches

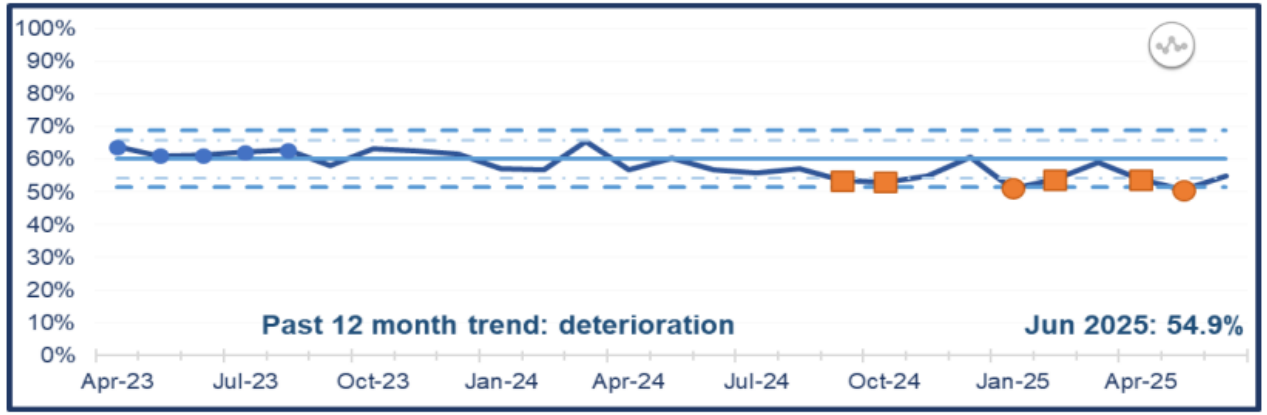


Number of Delayed Pathways of Care



Access & Activity: Escalated Performance Measures: Cancer

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



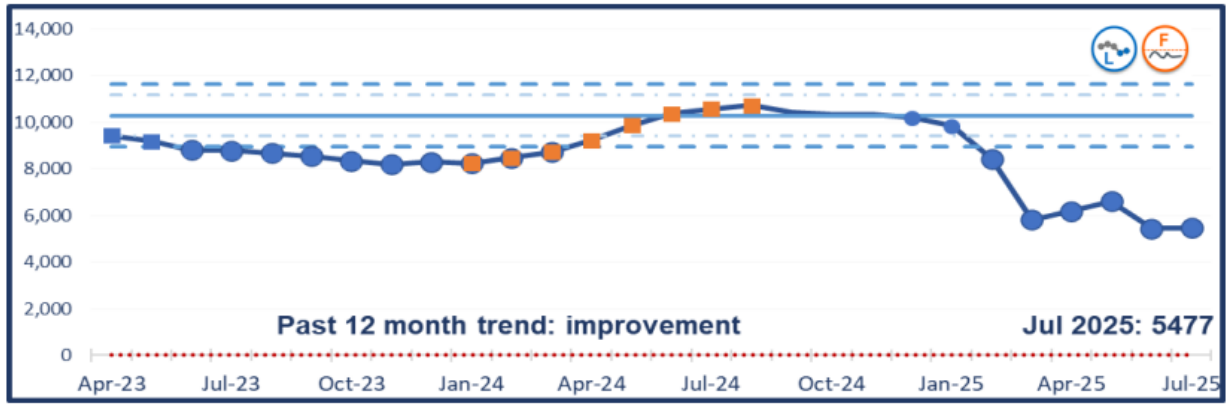
	BCUHB Total	West	Central	East
Haematology	76% (13/17) ↑	60% (3/5)	83% (5/6)	83% (5/6)
Skin	74% (70/95) ↑	65% (11/17)	71% (30/42)	81% (29/36)
Upper GI	64% (21/33) ↓	65% (11/17)	58% (7/12)	75% (3/4)
Breast	62% (26/42) ↓	63% (10/16)	56% (10/18)	75% (6/8)
Lung	60% (32/53) ↑	65% (13/20)	56% (10/18)	60% (9/15)
Gynaecology	44% (8/18) ↑	100% (1/1)	50% (5/10)	29% (2/7)
Colorectal	37% (17/46) ↓	50% (11/22)	15% (2/13)	36% (4/11)
Urology	36% (32/89) ↑	39% (12/31)	33% (10/30)	36% (10/28)
Head & Neck	17% (3/18) ↓	14% (1/7)	25% (2/8)	0% (0/3)
Total	55% (231/421) ↑	54% (74/137)	53% (86/162)	58% (71/122)

Colour coding: Above target ie 75% and above; 65-74%; below 65%; arrows reflect change from last month

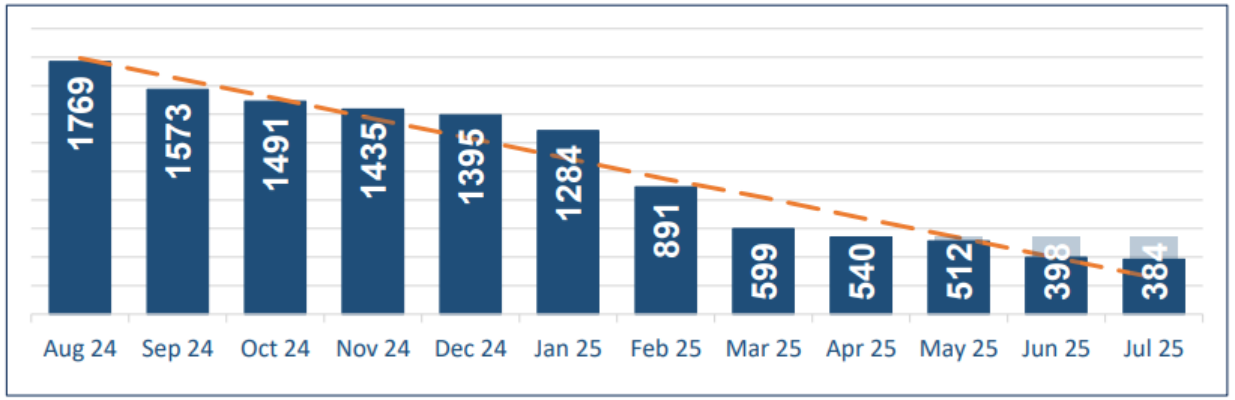
- In June 2025, cancer performance improved with BCUHB treating 54.9% (231 out of 421) of new cancer patients within target i.e. within 62 days of suspicion of cancer. Points to note are:
- Haematology met the 75% target
- Skin performance has improved but remains below target due to continued long waits for dermatology appointment
- Reduced performance in breast primarily due to the continued impact of the loss of clinic capacity in both screening and symptomatic services over the Easter period
- Delays to endoscopy continue to impact colorectal performance, leading to 14 breaches in month
- Over half of the urology breaches continue to be due to delays to prostate biopsy (29). However, national funding has been secured to train 2 staff in undertaking Local Anaesthetic Transperineal (LATP) prostate biopsies.

Access & Activity: Escalated Performance Measures

Number 104+ Weeks RTT



Number 156+ Weeks RTT



New appointments over 52 weeks
Insourcing of capacity for over 15,000 new outpatient appointments will enable significant reduction in the number of patients waiting over 52 weeks for a first appointment.

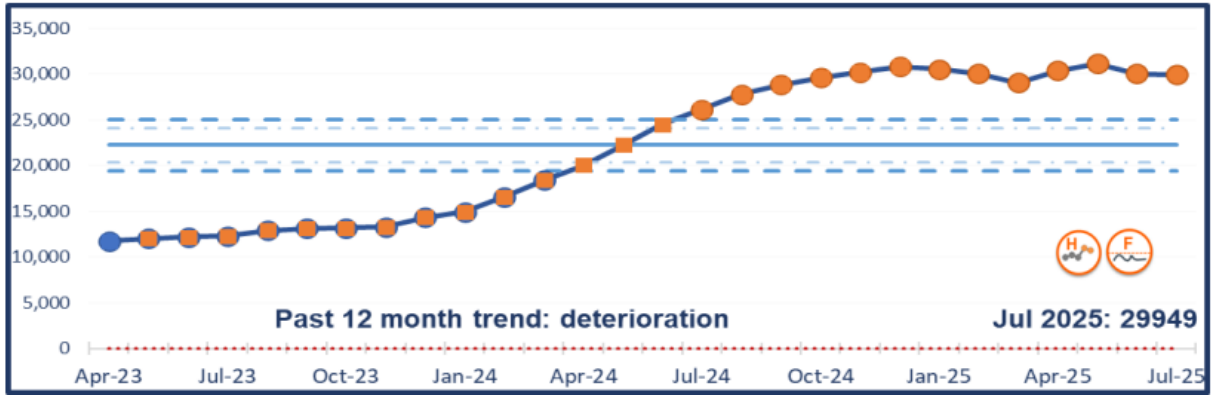
Referral to Treatment over 104 and 156 Weeks

- There was one orthopaedic breach of the 208 weeks in July. Patient booked into September so will show as a breach in August as well.
- Plans include element of enhancement for treat in turn, interventions not normally undertaken (INNU), screening and validation
- Outsourcing required to meet targeted Q2 delivery
- New Medica (Cataracts) ID Medical (Dermatology) Spire, Nuffield contracts in place and Wirral supportive of an LTA formation.
- Target is zero 104 weeks waits by 31.12.2025, some key specialities (Oral Surgery and Orthodontics examples) will require solutions to commence in Q2 for delivery to be assured (many of these also driving our 156 position).

Further Development:

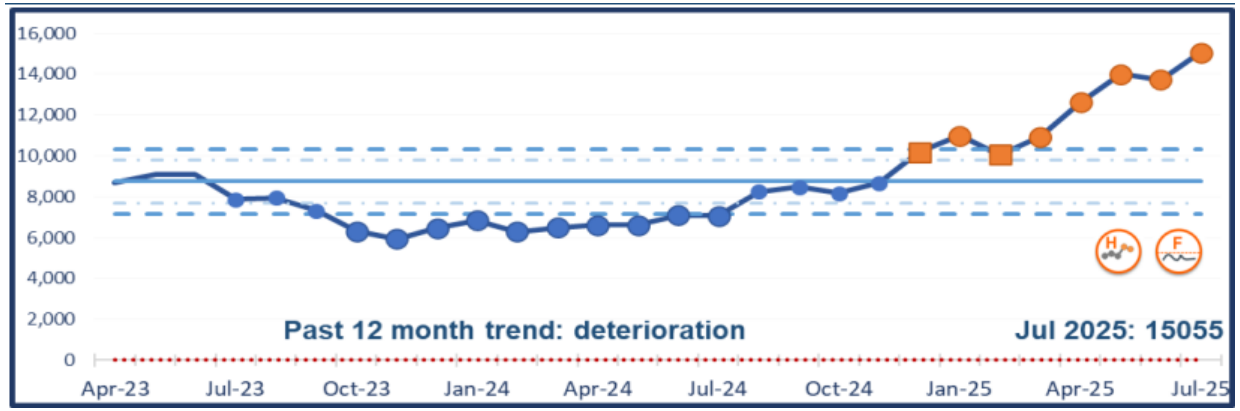
- Patient referral review (SOS & PIFU) with follow up reviewed and new appointments capacity maximised
- Utilisation – Theatres (start and finish times) & Outpatients (Booking to GIRFT standards)
- Cleansing of lists - Validation (clerical and clinical), INNU & Medically fit for Procedure

Number waiting over 52 weeks for a new appointment



Access & Activity: Escalated Performance Measures Diagnostics and Therapy Waits

Number Diagnostic Waits over 8 Weeks



- 15,056 patients waiting in excess of 8 weeks at end of July which is c7,000 adverse of initial target
- Adverse performance within Endoscopy and Radiology linked to increased demand and GP direct access
- Additional funding £3.6M allocated to HB to support reaching expected position of zero waits of 8 weeks at end of March 2026
- Revised trajectory in development, reflecting risks to delivery

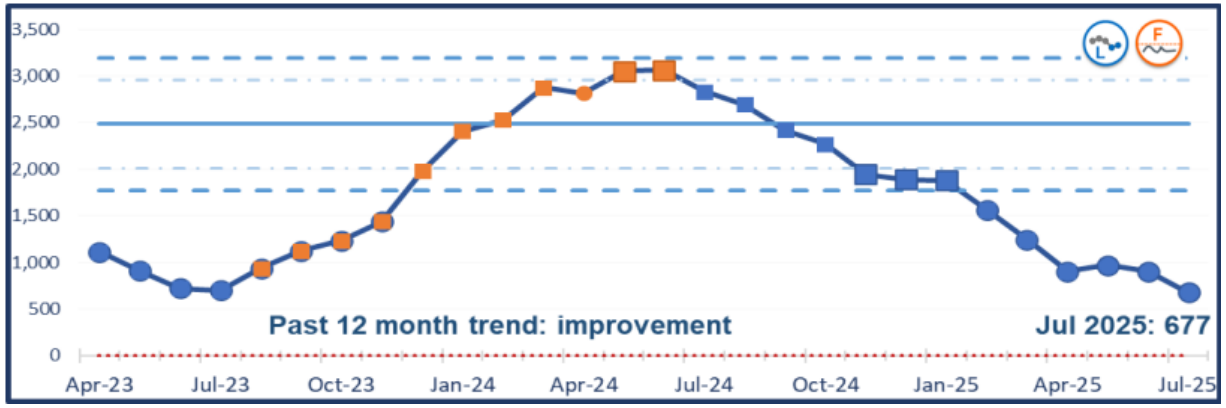
Q2

- Position expected to deteriorate in line with run rate whilst solutions implemented
- Radiology RISP implementation on 8th September limiting capacity 1-2 weeks
- Internal monitoring to limit loss of capacity

Q3:

- Completion of procurements / Commencement of solutions
- Adoption of additional demand management measures
- Trajectory refinement in accordance with risks to delivery

Number Therapy Waits over 14 Weeks



- 12 month trend improvement in number of patients waiting in excess of target
- Backlog predominantly within physiotherapy 273 patients (41%) and dietetics 383 patients (57%)

Dietetics – (East IHC) Interim plan for 2 year fixed term post submitted for review to address current position whilst long term model is reviewed as part of the Gastroenterology Service Plan

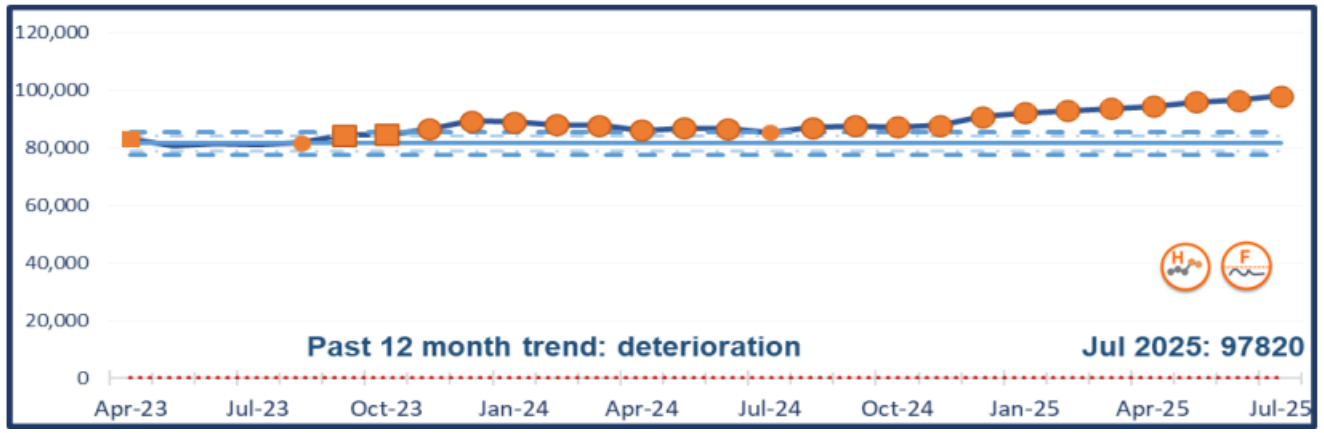
Physiotherapy (East IHC) Executive Director of Estates has met with East IHC service – availability of Plas Gororau will enable more accurate trajectory of recovery and offer economies of scale, reduced waste and better clinical cover for absence.

- Continuation of validation of waiting lists, group assessment days and remote activity

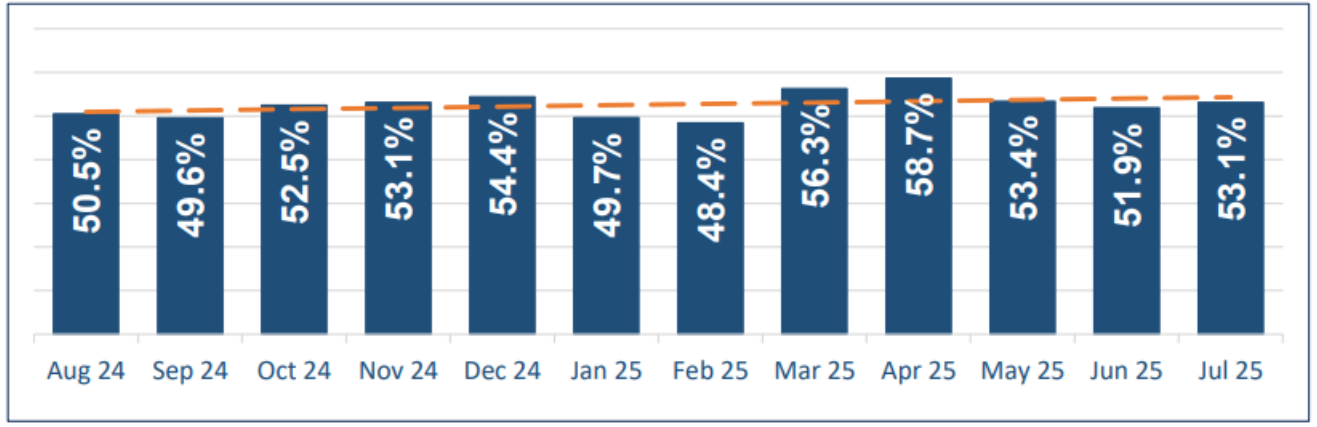
Physiotherapy (Central IHC) Proposal to continue to use additional locums until end of September and offer additional hours and weekend work (subject to uptake) to support reduction

Access & Activity: Escalated Performance Measures
Ophthalmology R1 and Follow-up Backlog

Follow-Up Backlog – Number over 100% of clinical due date



Ophthalmology R1 – % seen within 25% of clinical target date



The backlog of patients awaiting a follow up appointments over 100% passed their clinically due date continues to grow. Efforts underway to reduce this backlog includes:

- Undertake a systematic approach to validating, data cleansing all Follow-up lists.
- Implement See on Symptoms (SoS) and Patient Initiated Follow-up (PIFU) on all priority specialties (linked to Optimisation Frameworks/GIRFT).
- Recalibrate capacity from follow-ups to new appointments in priority specialties, following assessment of opportunity.

The Follow up backlog includes ophthalmology patients prioritised as urgent (R1), and are over their clinical target date. Just over half of these patients are seen within 25% over their clinical target date, which may result in irreversible harm for those waiting beyond the clinical target date. Actions to reduce the potential for harm and reduce the backlog include:

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- Outsourcing of over 4,600 of the longest waiting cataract patients
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- Commenced new glaucoma and medical retina pathways through primary care practices

Access & Activity: Escalated Performance Measures
Adult Mental Health

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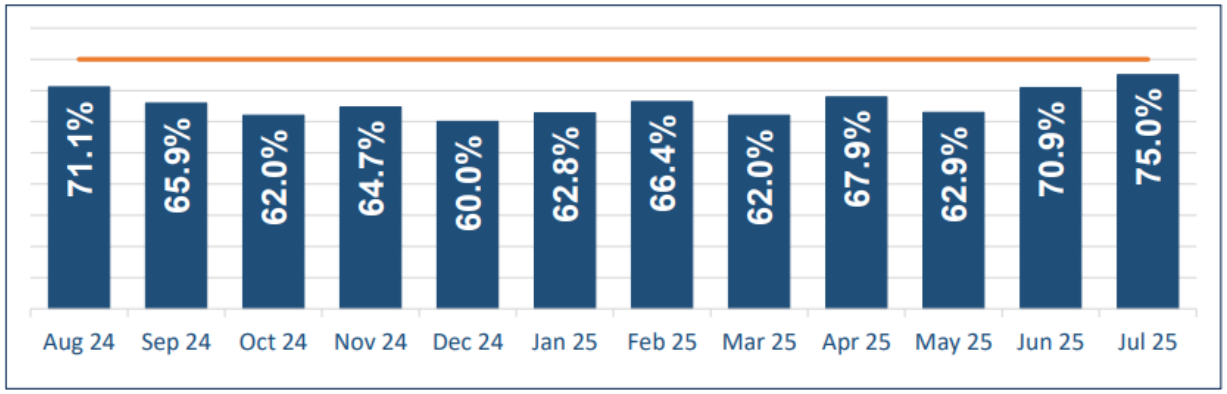
Percentage of patients waiting less than 26 weeks for adult psychological therapy

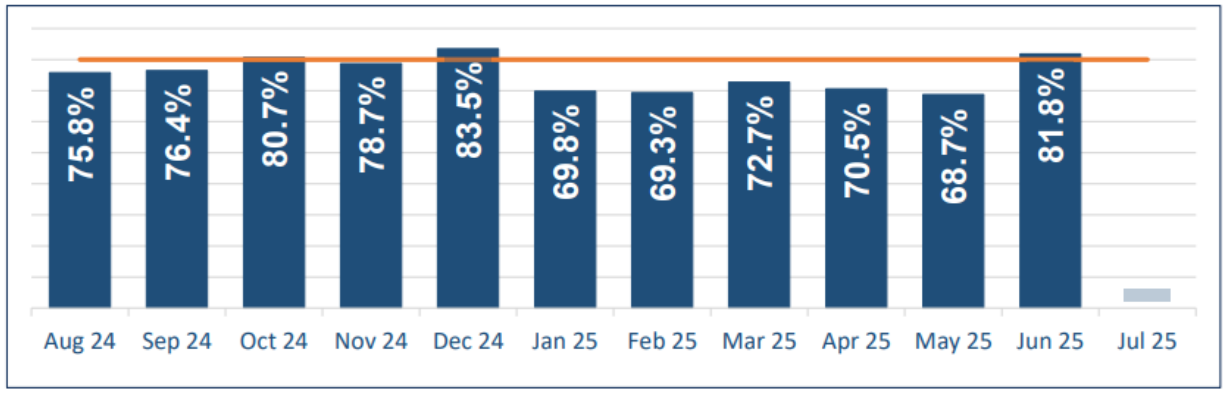


Psychological Therapies: Will see continued improvement into Quarter three as now appointed into several vacant posts across North Wales.

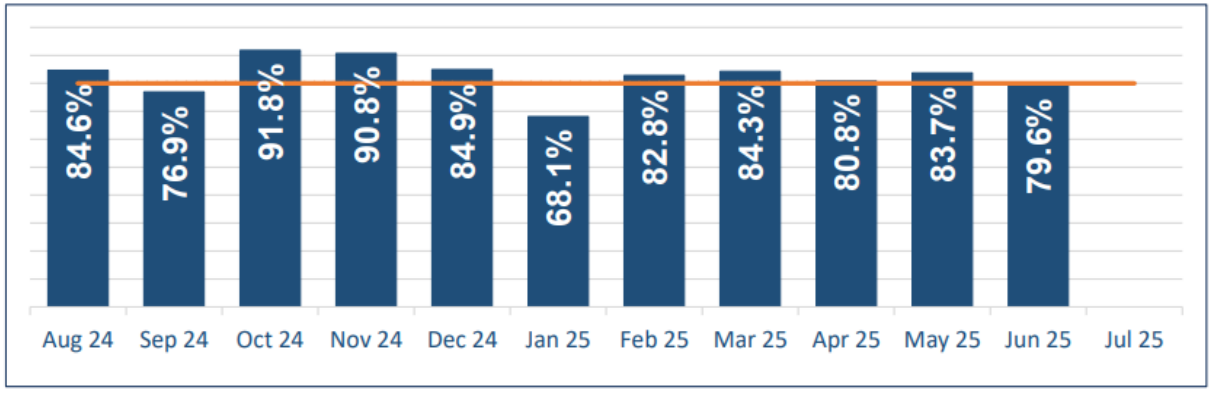
Part 1a: Compliant with predicted continued improvement. Focus remains on reducing the longest waits, from 396 in June down to 349 in July.

Part 1b: Just short of target rate but forecast is to achieve the target in July 2025 and continue above the 80% thereafter. For the first time since 2022/23, there are less patients waiting over 28 days than there are waiting less than 28 days.

Percentage of Local Primary Mental Health Support Service (LPMHSS) assessments undertaken within (up to and including) 28 days of the date of receipt of referral (for those aged 18 years and over)

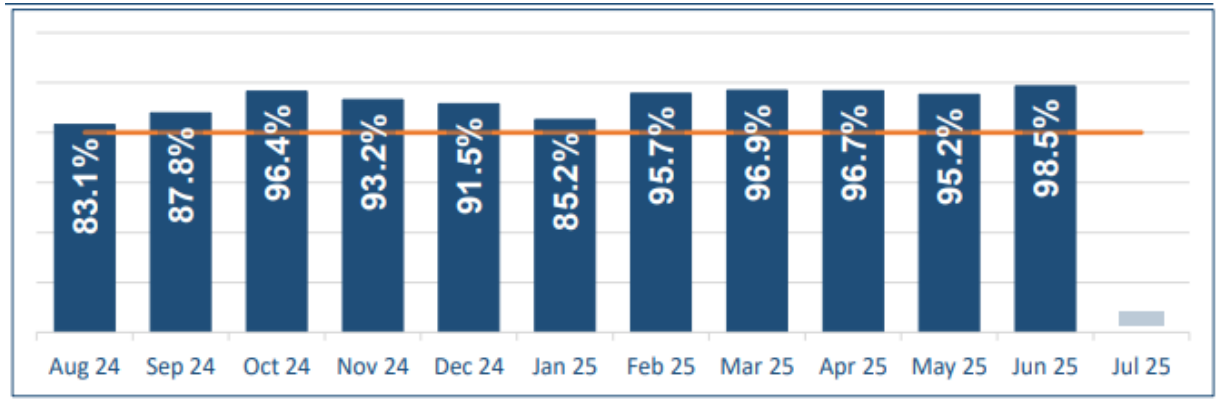


Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS (for those aged 18 years and over)



Access & Activity: Escalated Performance Measures CAMHS and Neurodevelopment

Percentage of Local Primary Mental Health Support Service (LPMHSS) assessments undertaken within (up to and including) 28 days of the date of receipt of referral (for those aged under 18 years)

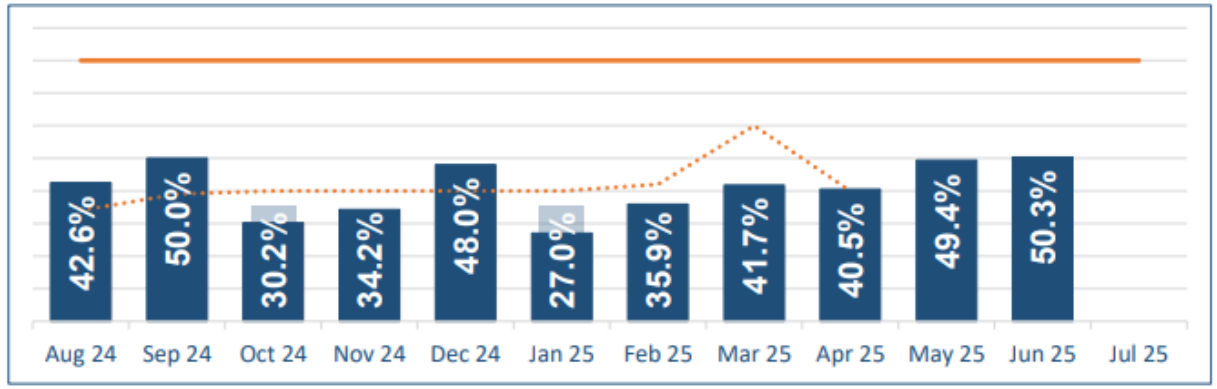


Neurodevelopment: Performance is starting to improve. Longest waits are down to 204 weeks with a plan to deliver zero patients waiting over 156 weeks by the end of quarter 4 of 2025/26. There were 6,462 patients waiting over 26 weeks in July, compared to 7,000 projected. A tender to commission outsourced capacity for assessments is being progressed.

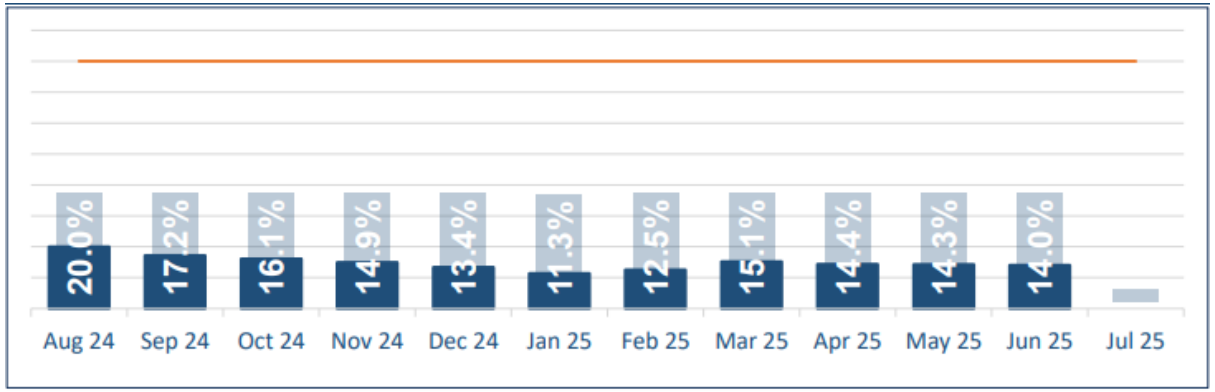
Part 1a: Continued and sustained performance above target rate.

Part 1b: Achieving sustained and continuous improvement in line with improvement trajectories.

Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS (for those aged under 18 years)

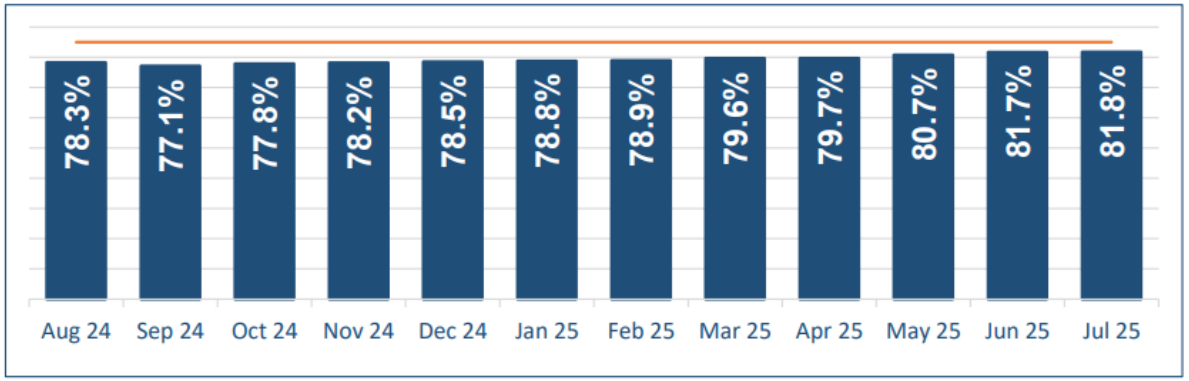


Percentage children and young people waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment



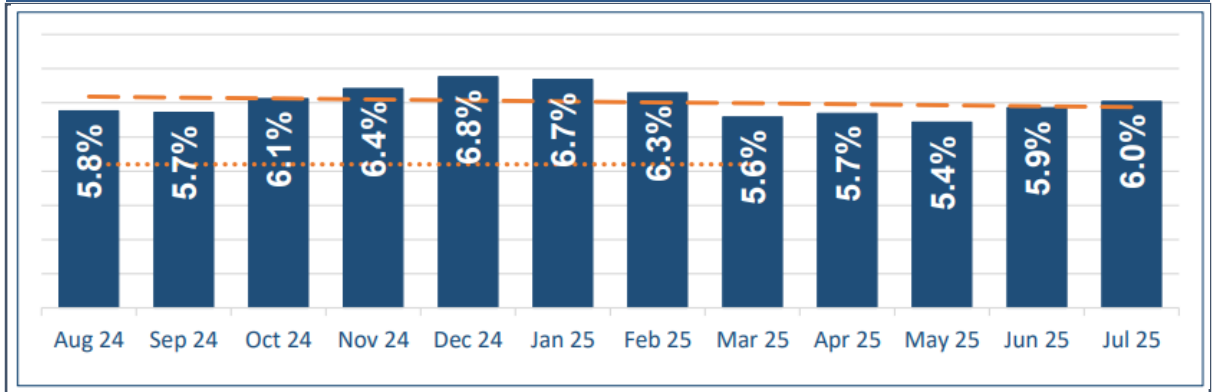
People & OD: Escalated Performance Measures

% of headcount who have had PADR in previous 12 months



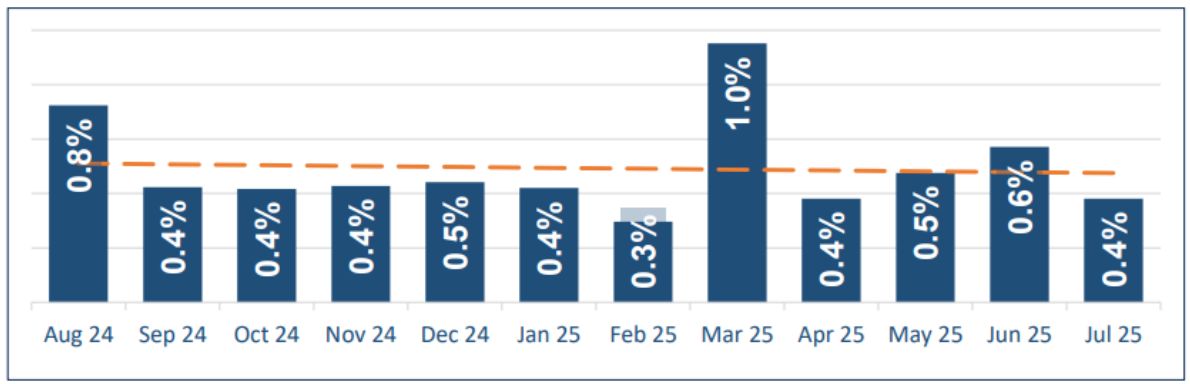
The PADR rate has been on an upward trend since September 2024 At 81.8%, just 3.2% off the 85% target, BCU has the second highest Appraisal Rate out of the 6 major Welsh Health Boards.

% of sickness absence rate of staff



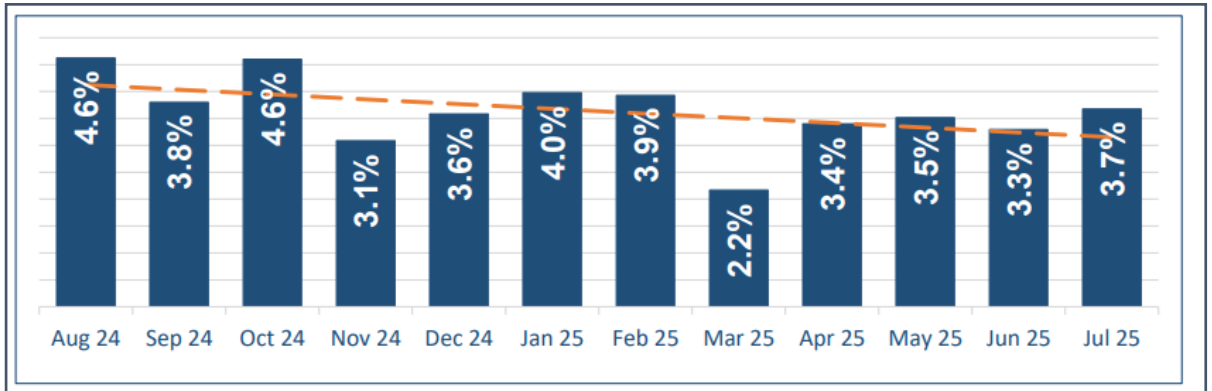
Whilst sickness rates remains higher than the same period in 2024, BCUHB maintains the lowest sickness rates out of the 6 major Welsh Health Boards..

Turnover rate for nurse and midwifery register staff leaving BCU HB



Despite a nurse vacancy rate of 475 Full Time Equivalent, turnover remains very low.

Agency Spend as % of pay bill



Whilst agency and locum spending rates has remained fairly static since April 2025, it is still lower than the same period of 2024.

Finance: Escalated Performance Measures

The 2025/26 financial plan aligns with the strategic ambition of the Health Board in attaining the key financial duty to break-even. Expenditure commitments will need to be prioritised to enable the key financial duty and the performance ask to be attained. Achieving the control target in 2024/25 has resulted in the £74.6m conditionally recurrent funding received in 2023/24 and 2024/25 being allocated as recurrently in 2025/26 and the receipt of the £82.0m Improvement and Transformation funding allocation non-recurrently for 2025/26, with conditions associated with retention recurrently of the funds for 2026/27 and beyond being:

- £40.0m Deficit Support Funding – Recurrent and non-conditional following submission and delivery of a financially balanced IMTP by the Health Board.
- £42.0m Performance & Transformation Funding – Recurrent on de-escalation from Special Measures and Welsh Government having greater oversight and direction in use against Special Measures and Ministerial priorities.

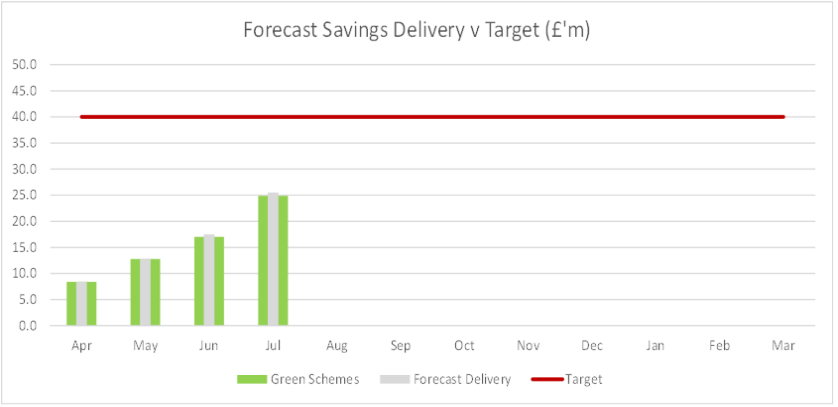
In-month position is reporting a deficit of £3.6m, a deterioration of £2.0m from the previous months position. Year to date position is a deficit of £11.4m, largely driven by the shortfall in National Insurance funding of £1.4m for the months of April to July 2025 (previously costs offset by anticipated allocations), pressures associated with Escalated Beds, Healthcare Services provided by other NHS Bodies Contracts and a substantial increase in Mental Health Out of Area referrals.

	Actual Position				2025/26 Forecast Position								
	Apr £m	May £m	Jun £m	Jul £m	Aug £m	Sep £m	Oct £m	Nov £m	Dec £m	Jan £m	Feb £m	Mar £m	Total £m
Surplus/ (deficit)	(3.7)	(2.4)	(1.6)	(3.6)	(2.0)	(0.5)	0.0	2.3	2.5	2.9	3.0	3.2	**0.0**

The Health Board's financial plan has set a savings target of £40.0m to be delivered in 2025/26, profiled on an equal twelfth's basis. There has been a significant step up in the Savings Plan reported at end of July (Month 4) with the Health Board having identified £23.6m Green saving schemes, fortuitous Accountancy Gains of £1.9m, giving a combined total of £25.5m, an increase of £8.0m from previous month. Of these savings, £18.2m is recurring with a full year effect of £24.3m and £7.3m identified as non-recurring savings.

Further work is required to convert £12.6m red and pipeline opportunities into Green Schemes.

WG has issued a deadline for the Health Board to identify the full £40m savings requirement and all schemes must meet the 'Green Schemes' criteria prior to the Month 5 Monitoring Return submission deadline.



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

Integrated Quality & Performance Report

Produced on behalf of the **Performance, Finance & Information Governance Committee**
by the **Performance and Commissioning Directorate and Partners**

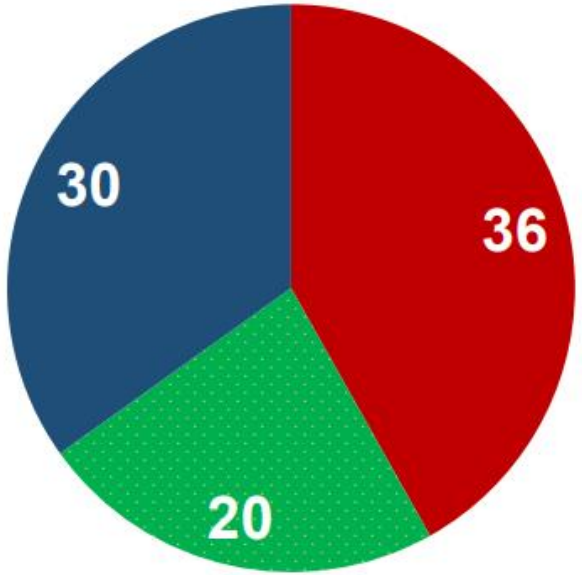
Summary of Performance

Green — The *latest available data point* indicates that performance is at, or better than the target

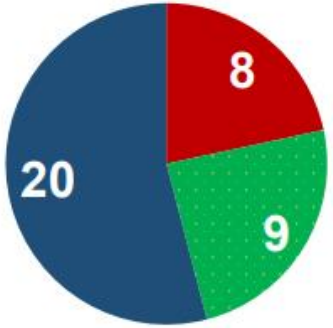
Red — The *latest available data point* indicates that performance is worse than the target

Blue — It is inappropriate, or not possible, to rate available data against any available target

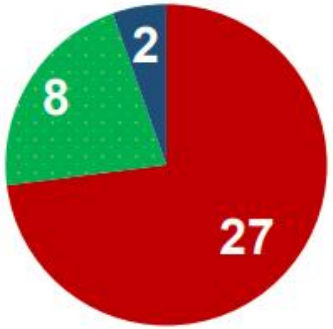
Grey — There is no / insufficient data available to rate against the target



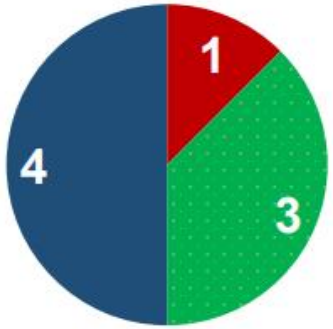
All Sections



Quality, Safety, Effectiveness & Experience Performance



Access & Activity Performance



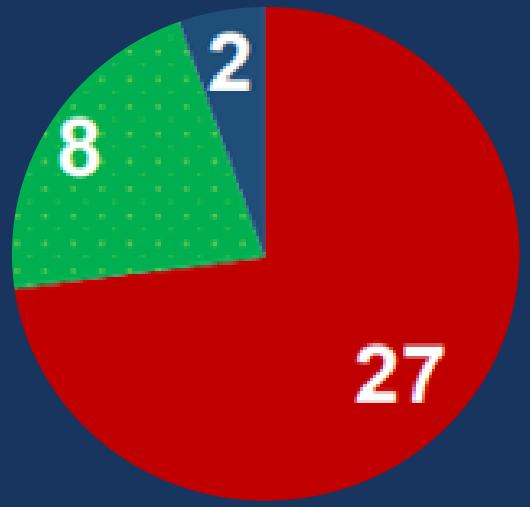
People & Organisational Development Performance

Financial Performance

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Section 1

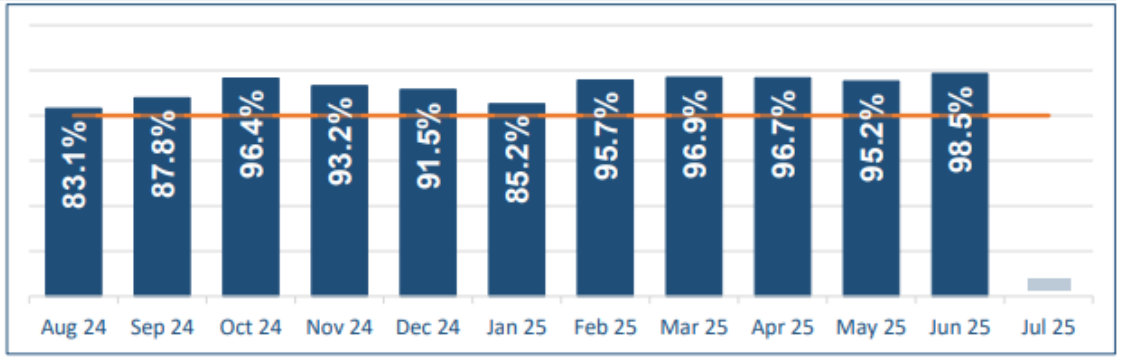
Access & Activity Performance

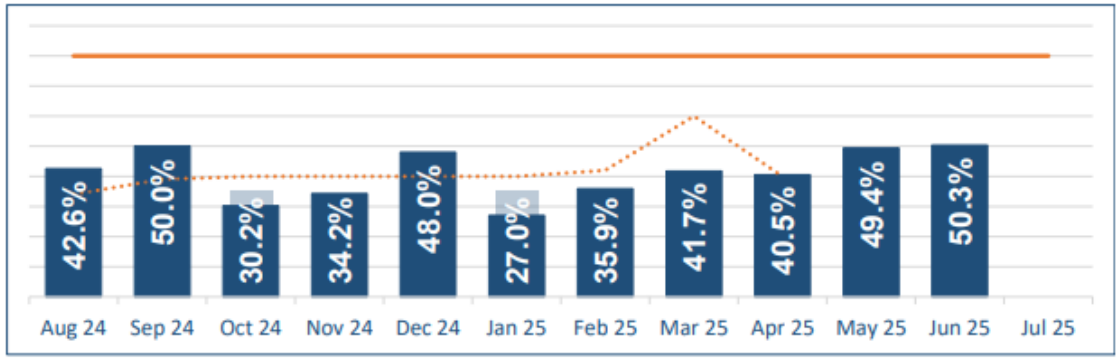


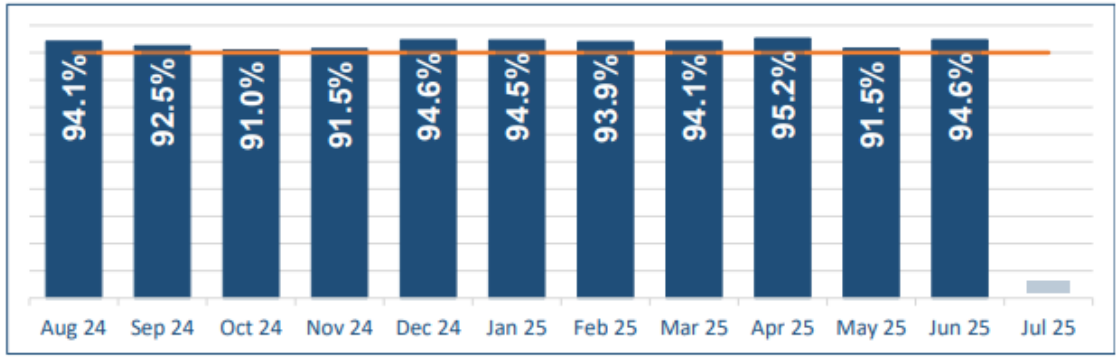
Produced on behalf of the **Performance, Finance & Information Governance Committee**
by the **Performance and Commissioning Directorate and Partners**

Access & Activity: Performance

Ref	Cmt	Measure	WG Target	Internal Target	BCU Position	Wales Rank
SM: DM16	PFIG	Percentage of Local Primary Mental Health Support Service (LPMHSS) assessments undertaken within (up to and including) 28 days of the date of receipt of referral (for those aged under 18 years)	80%	TBC	98.5%	4th of 7 (at Apr 25)
SM: DM15	PFIG	Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS (for those aged under 18 years)	80%	TBC	50.3%	6th of 7 (at Apr 25)
SM: DM16	QSE	Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan (for those age under 18 years)	90%	TBC	94.6%	5th of 7 (at Apr 25)

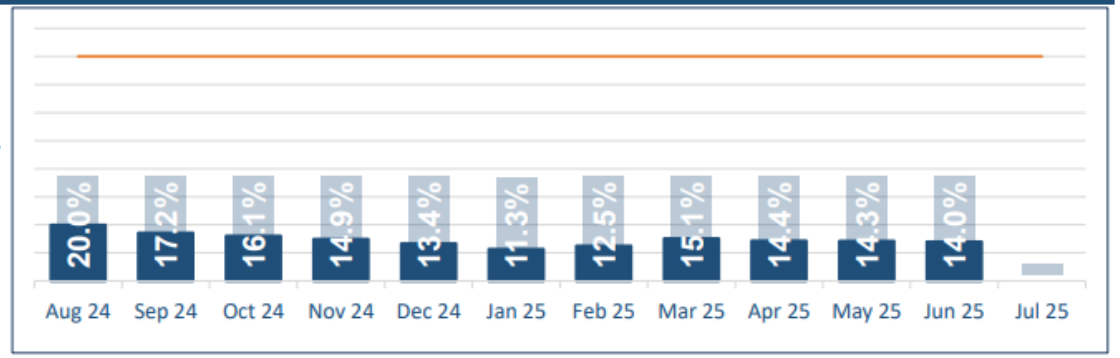


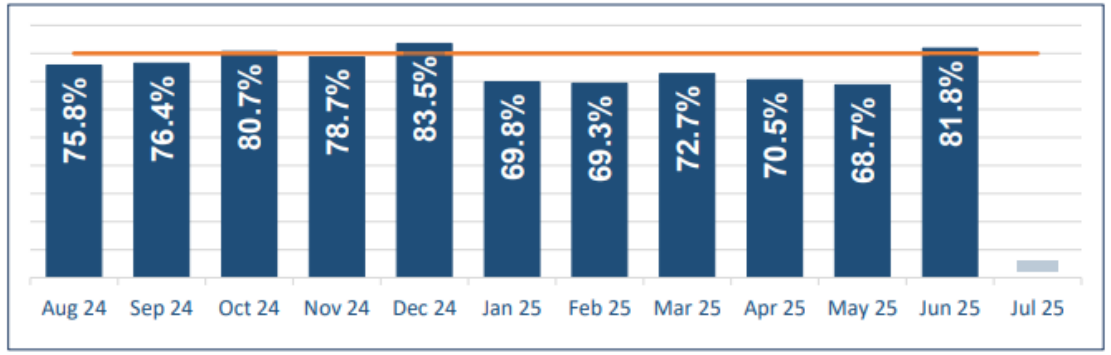


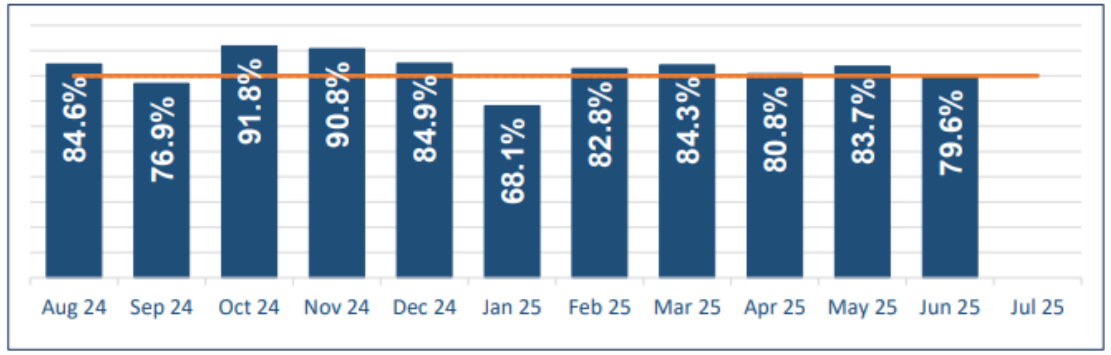


Access & Activity: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-11	PFIG	Percentage of children and young people waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment	80%	TBC	14.0%	6th of 7 (at Mar 25)
SM: DM11	PFIG	Percentage of Local Primary Mental Health Support Service (LPMHSS) assessments undertaken within (up to and including) 28 days of the date of receipt of referral (for those aged 18 years and over)	80%	TBC	81.8%	5th of 7 (at Apr 25)
SM: DM12	PFIG	Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS (for those aged 18 years and over)	80%	TBC	79.6%	7th of 7 (at Apr 25)

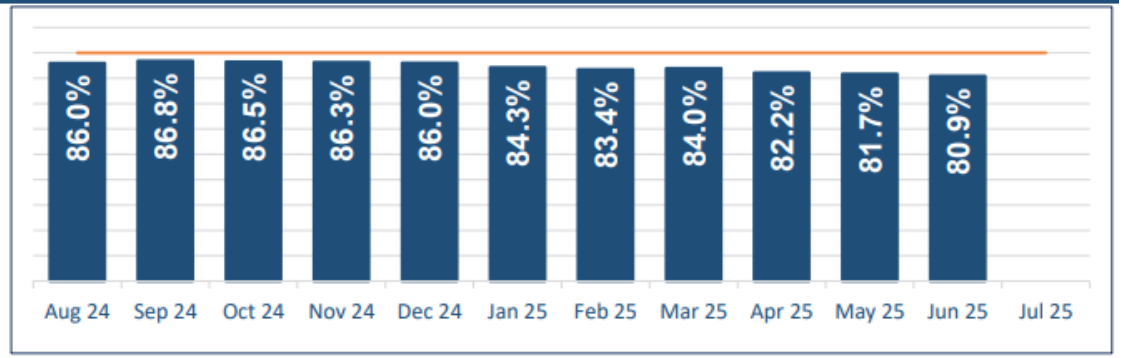


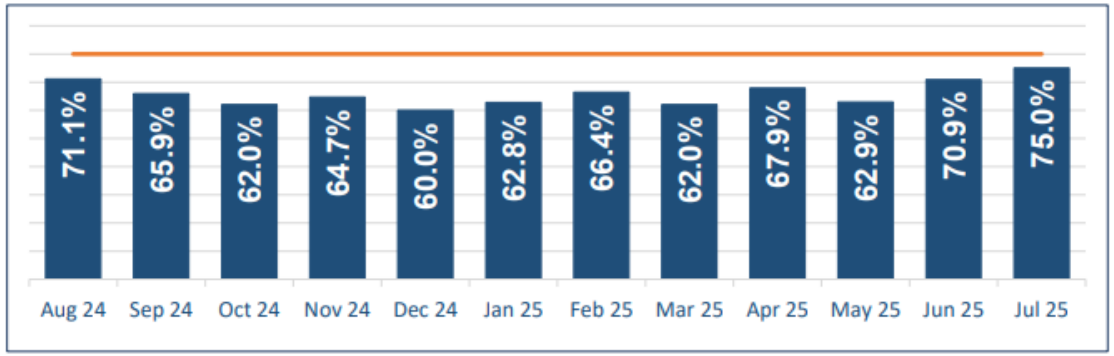


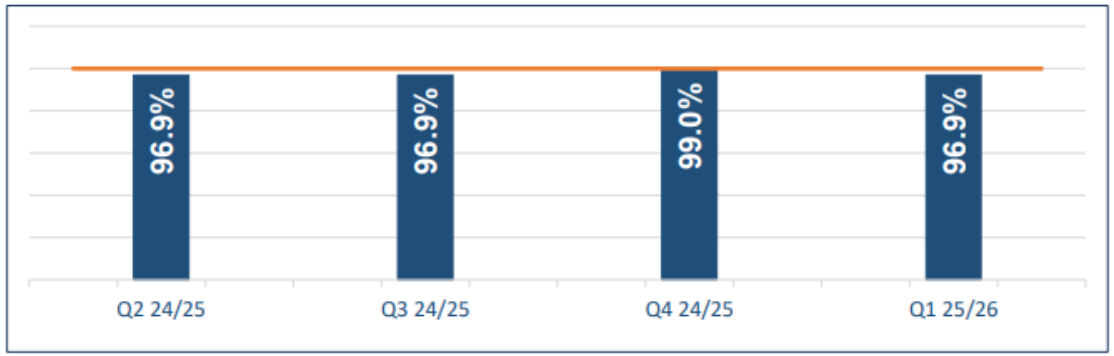


Access & Activity: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
SM: DM13	QSE	Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan (for those age 18 years and over)	90%	TBC	80.9%	5th of 7 (at Apr 25)
-	PFIG	Percentage of patients waiting less than 26 weeks to start a psychological therapy in specialist Adult Mental Health BCU Level	80%	TBC	75.0%	3rd of 7 (at Apr 25)
-	PFIG	Percentage of GP practices that have achieved all standards set out in the National Access Standards for In-hours	100%	TBC	96.9%	6th of 7 (at Mar 23)

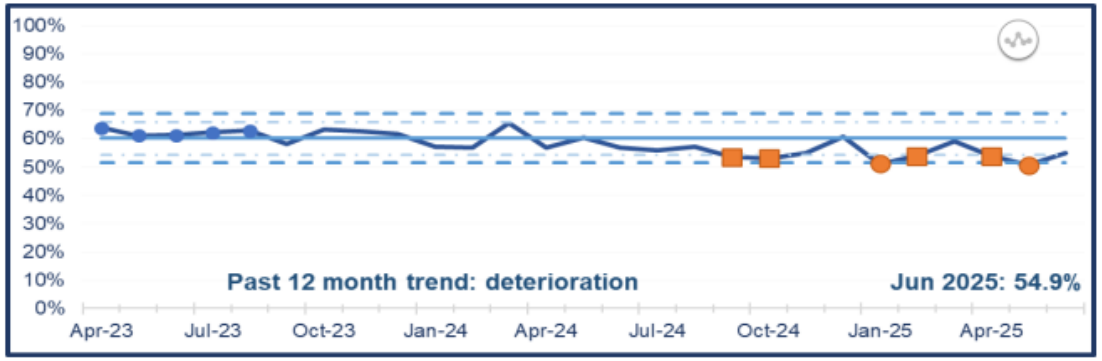


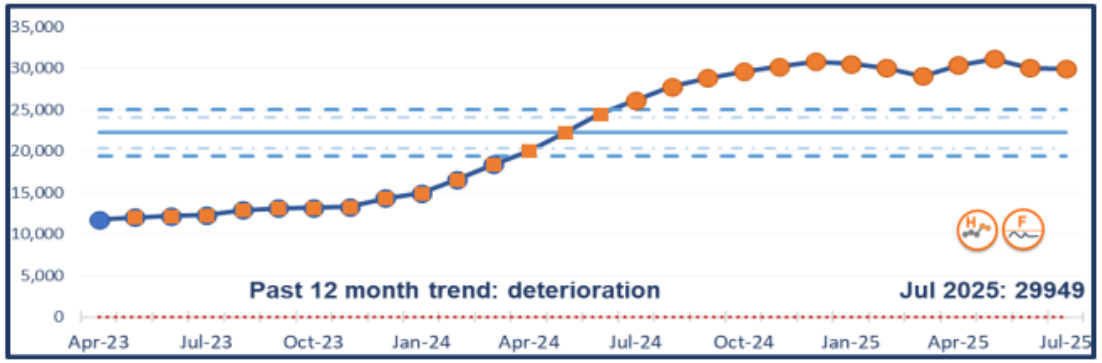


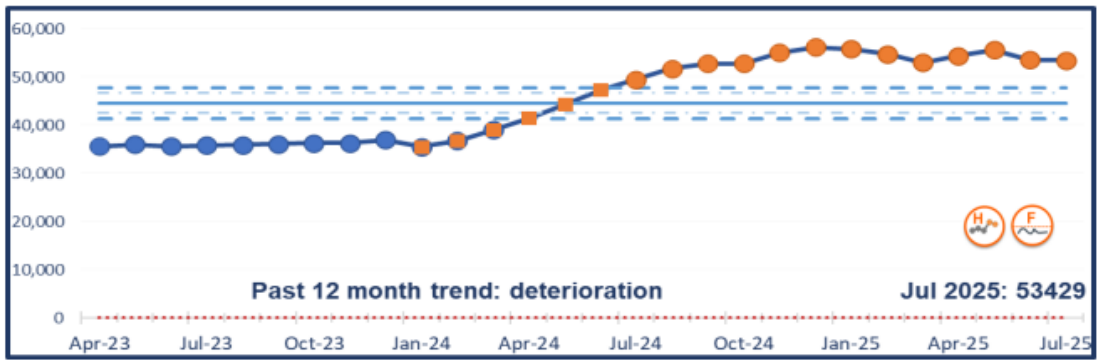


Access & Activity: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-11 SM: DM01	PFIG	Percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)	Increas-ing trend (to 80%)	TBC	54.9%	6th of 6 (at Apr 25)
CRR: 24-11	PFIG	Number of patients waiting over 52 weeks for a new outpatient appointment	0	TBC	29949	7th of 7 (at Apr 25)
CRR: 24-11 SM: DM02	PFIG	Number of patients waiting more than 52 weeks for referral to treatment	Decreas-ing trend (to 0 by Jun 25)	TBC	53429	7th of 7 (at Mar 25)

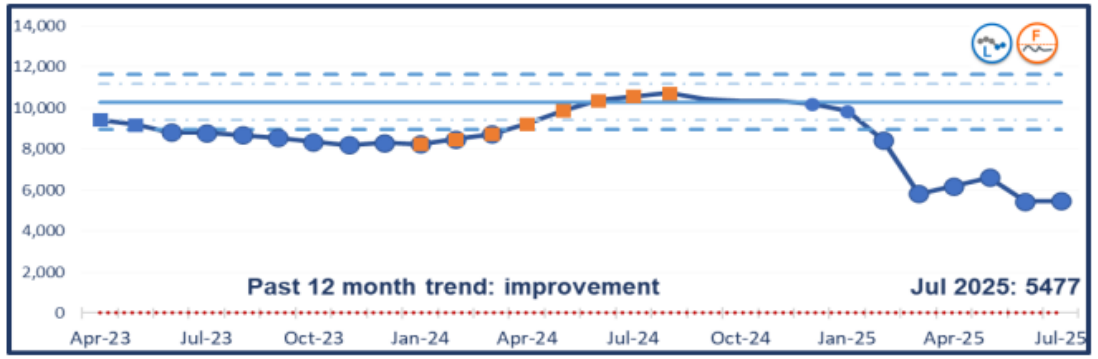


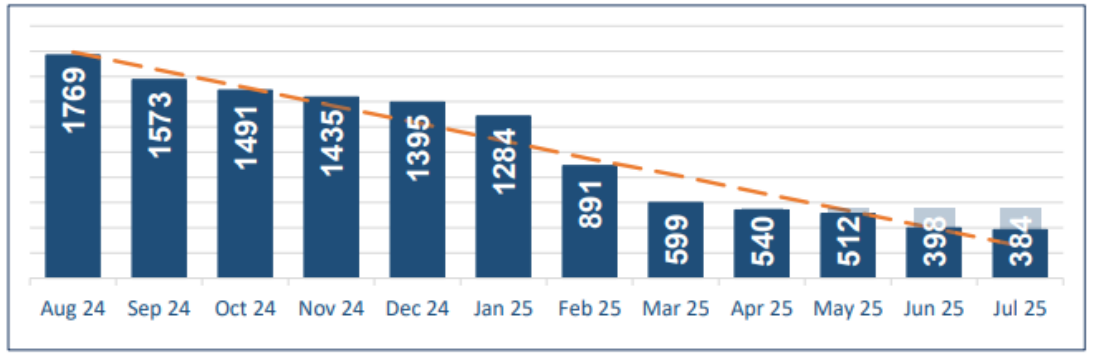


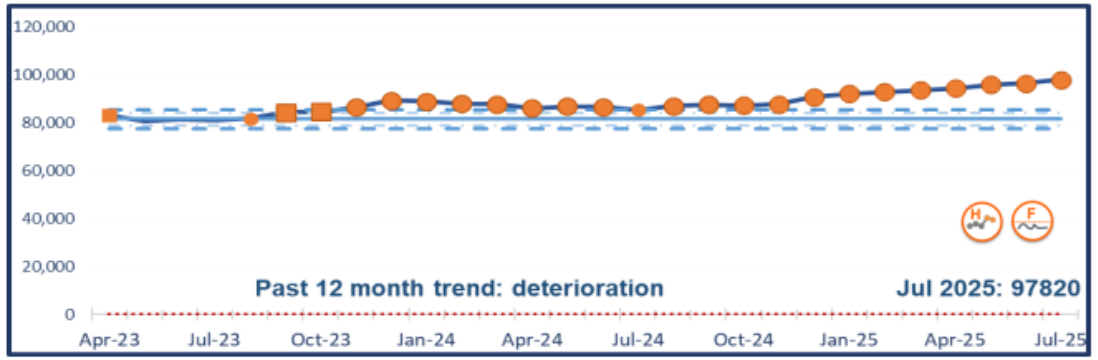


Access & Activity: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-11 SM: DM03	PFIG	Number of patients waiting more than 104 weeks for referral to treatment	0	TBC	5477	7th of 7 (at Apr 25)
CRR: 24-11	PFIG	Over 156 weeks all stages	N/A	TBC	384	
CRR: 24-11	PFIG	Number of patients waiting for a follow up outpatient appointment who are delayed by over 100%	Equivalent month decrease	TBC	97820	7th of 7 (at Apr 25)

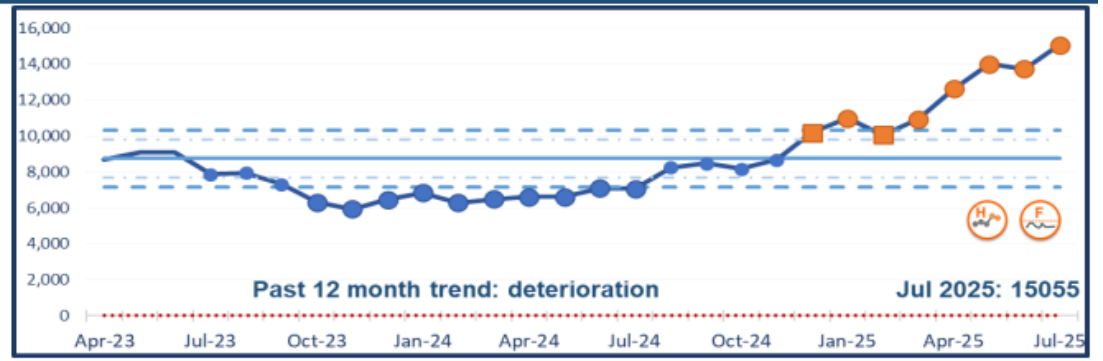


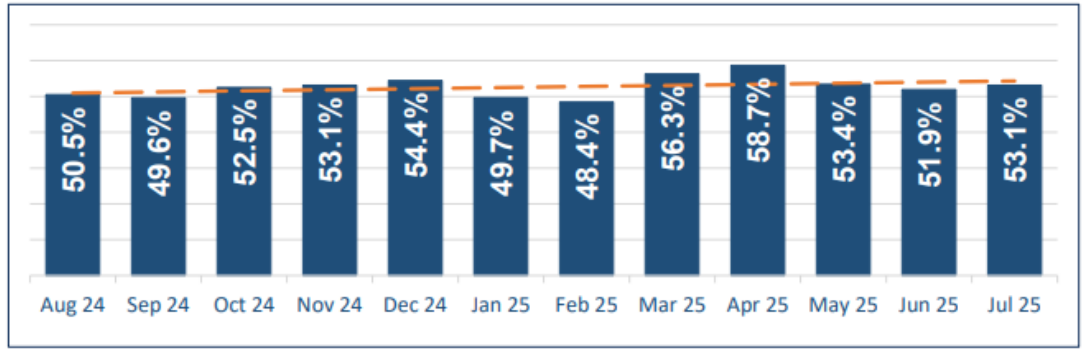




Access & Activity: Performance

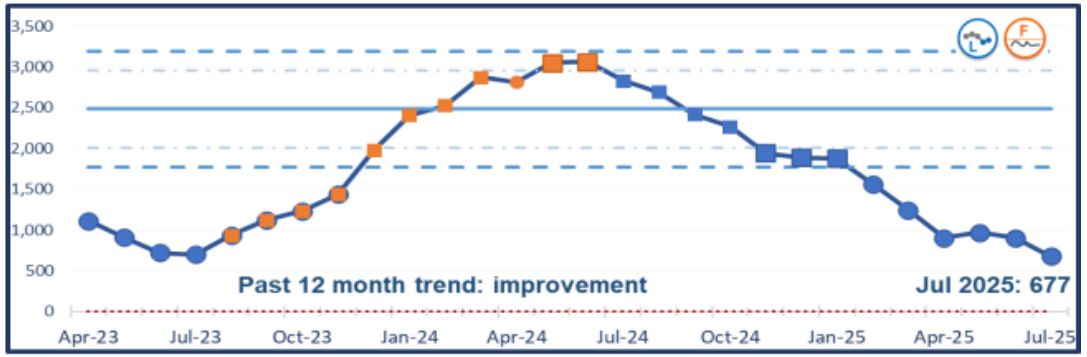
Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-13 SM: DM04	PFIG	Number of pathways waiting 8 weeks for specific diagnostic	0	TBC	15055	6th of 7 (at Apr 25)
CRR: 24-11 24-12	PFIG	Percentage of ophthalmology R1 appointments attended which were within their clinical target date or within 25% beyond their clinical target date	Increas-ing trend (to 95%)	TBC	53.1%	5th of 7 (at Apr 25)
CRR: 24-11	PFIG	Percentage of children (aged under 18 years) waiting 14 weeks or less for a specified Allied Health Professional (Includes: Art therapy; podiatry; dietetics; occupational therapy, physiotherapy and; speech and language therapy)	100%	TBC	99.2%	4th of 7 (at Apr 25)

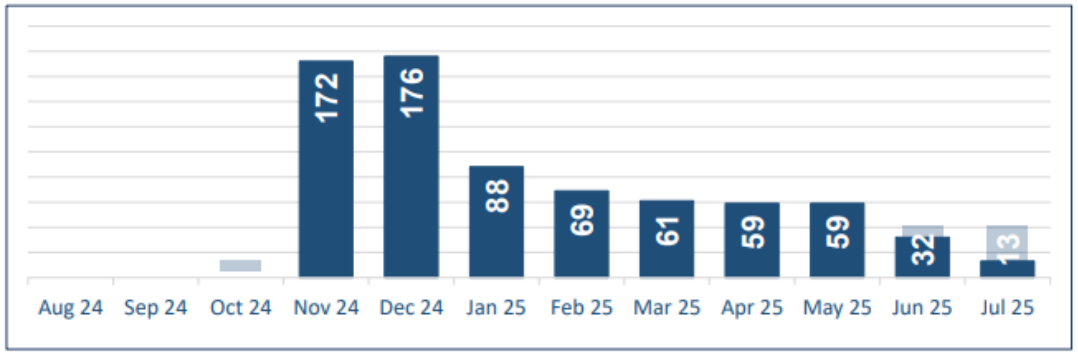


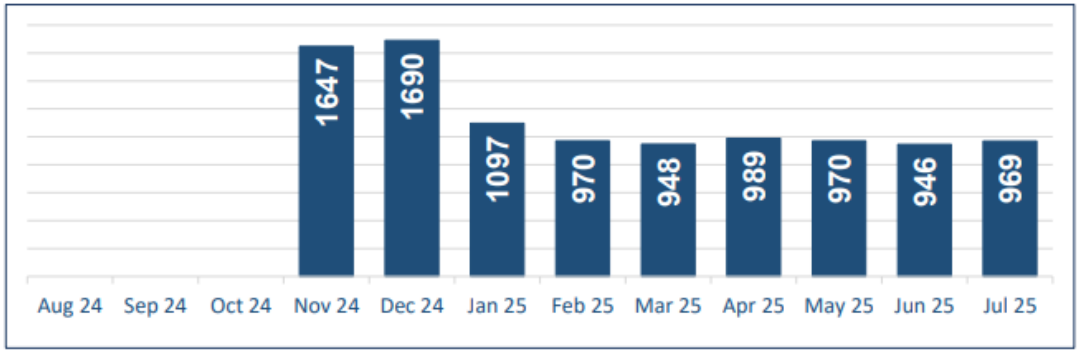


Access & Activity: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-11 SM: DM05	PFIG	Number of patients (all ages) waiting more than 14 weeks for a specified therapy (excluding audiology)	0	TBC	677	6th of 7 (at Apr 25)
-	PFIG	Number of adults waiting more than 14 weeks for all audiology pathways (to include new and existing pathways for hearing aids, tinnitus and balance)	Month on Month Reduction	TBC	13	
-	PFIG	Number of children waiting more than 6 weeks for all audiology pathways (to include new assessment and intervention pathways)	Month on Month Reduction	TBC	969	

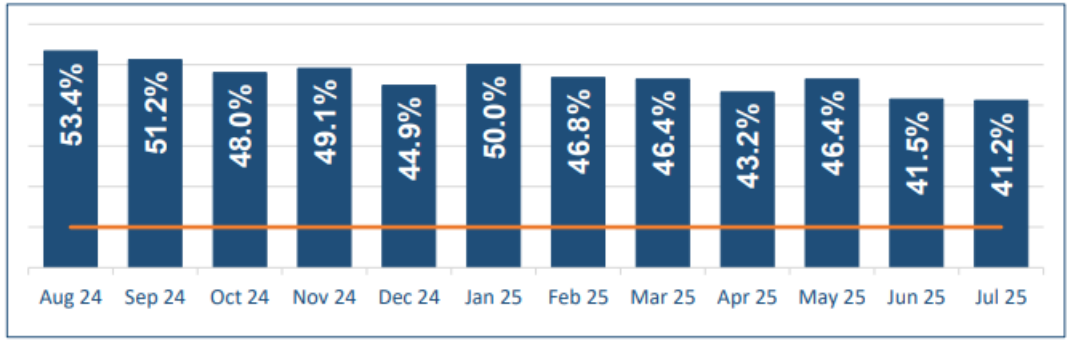


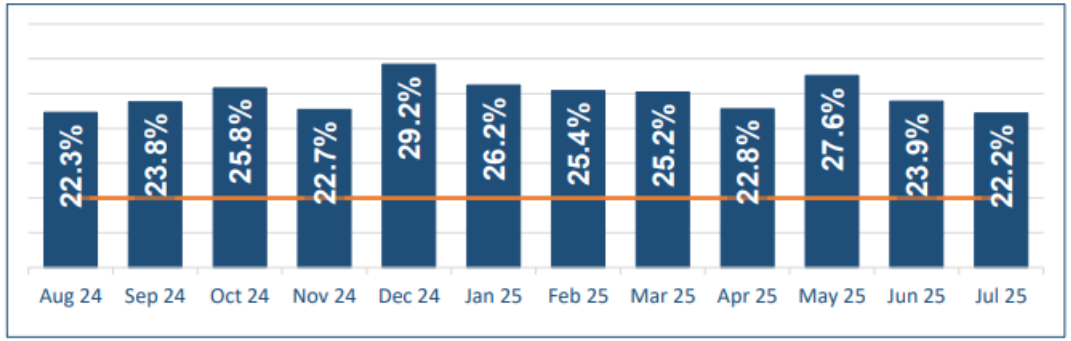




Access & Activity: Performance

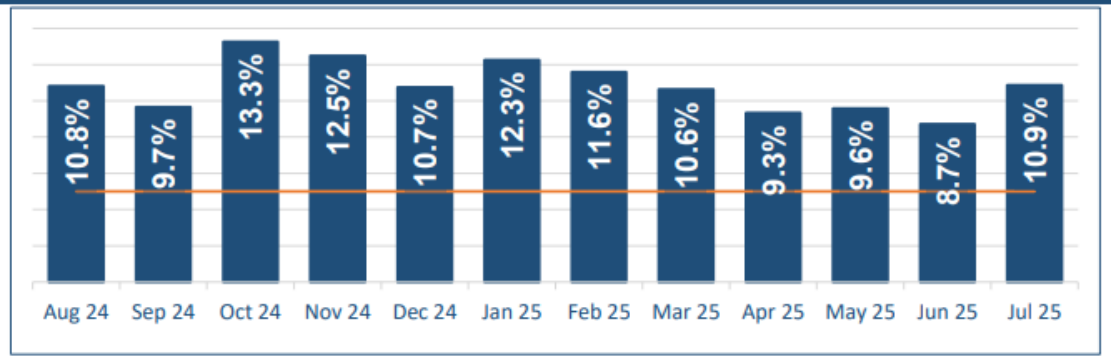
Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	PFIG	Number of cases per theatre session	2.5	TBC	2.1	
-	PFIG	Percentage of lists with a start time 15 minutes or more past the scheduled start time	<10%	TBC	41.2%	
-	PFIG	Percentage of lists with an end time of over 60 minutes before the scheduled finish time	<10%	TBC	22.2%	

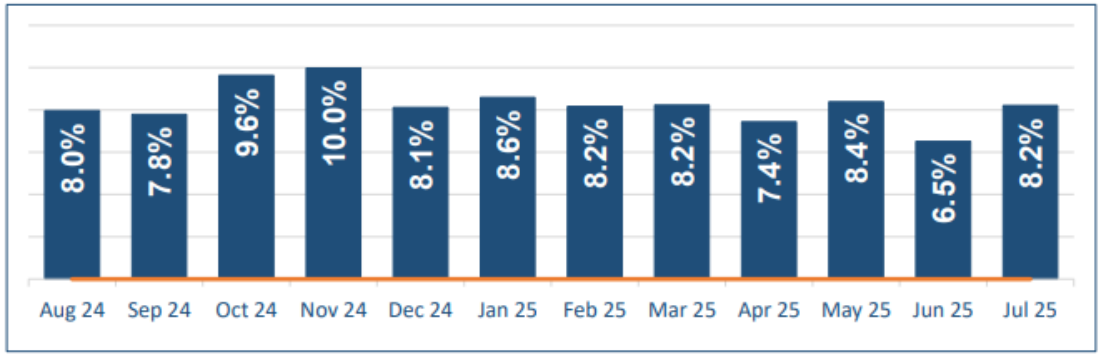


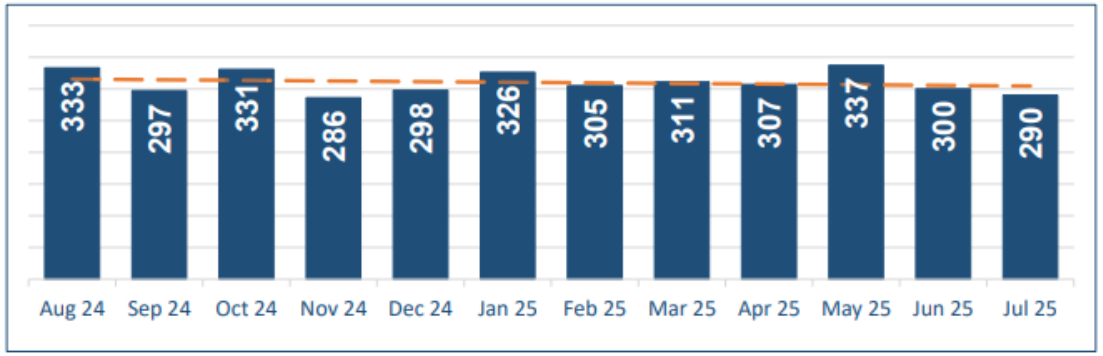


Access & Activity: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	PFIG	Percentage of scheduled operations cancelled either on the day or the day before the scheduled operation	<5%	TBC	10.9%	N/A
-	PFIG	Percentage of scheduled operations cancelled on the day of the scheduled operation	0.0%	TBC	8.2%	
-	PFIG	Number of Pathways of Care Delayed discharges	Decreas-ing trend	TBC	290	8st of 8 (at Apr 25)

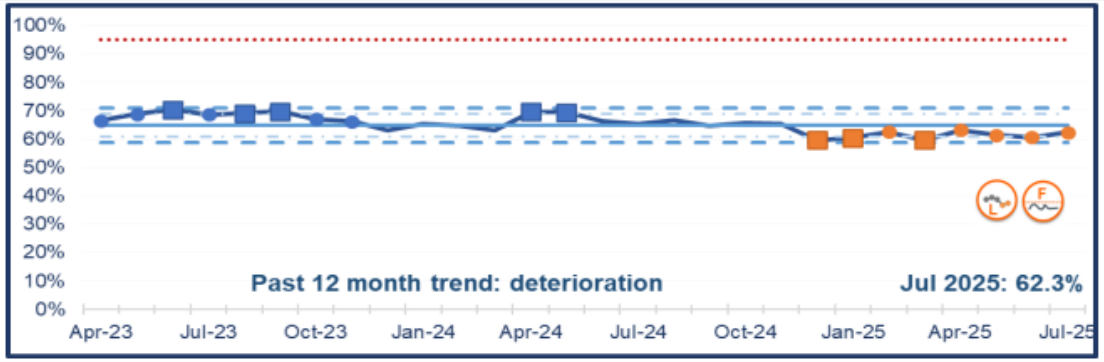


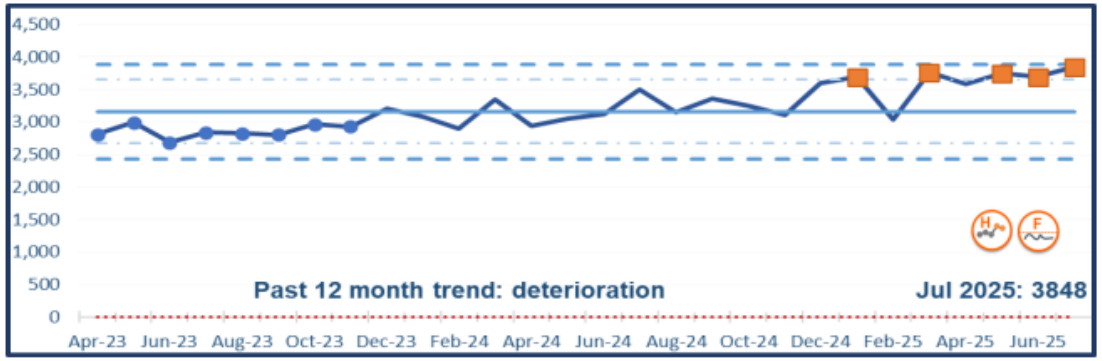


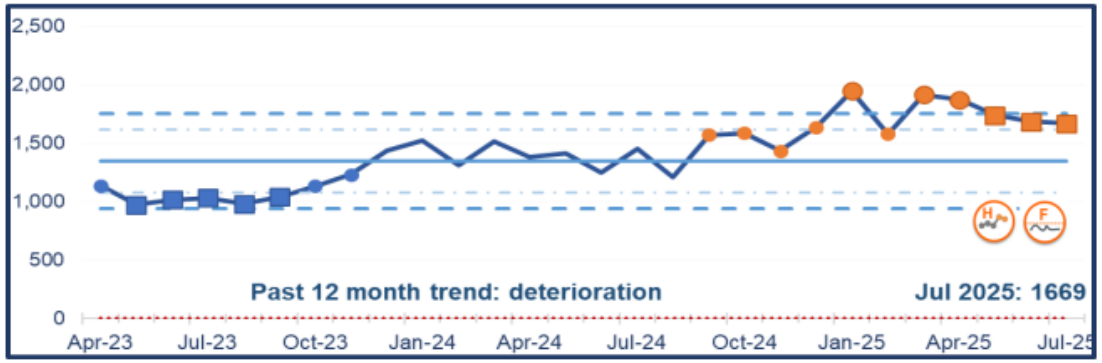


Access & Activity: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-10	PFIG	Percentage of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge	Equival-ent month increase (2025/26 to 2024/25) to 95%	TBC	62.3%	7th of 7 (at Apr 25)
CRR: 24-10 SM: DM08	PFIG	Number of patients who spend 12 hours or more in all hospital major and minor emergency care facilities from arrival until admission, transfer or discharge	Equival-ent month reduct-ion (2025/26 to 2024/25) to 0	TBC	3848	7th of 7 (at Apr 25)
-	N/A	Number of patients who spend 24 hours or more in all hospital major and minor emergency care facilities from arrival until admission, transfer, or discharge	N/A	TBC	1669	

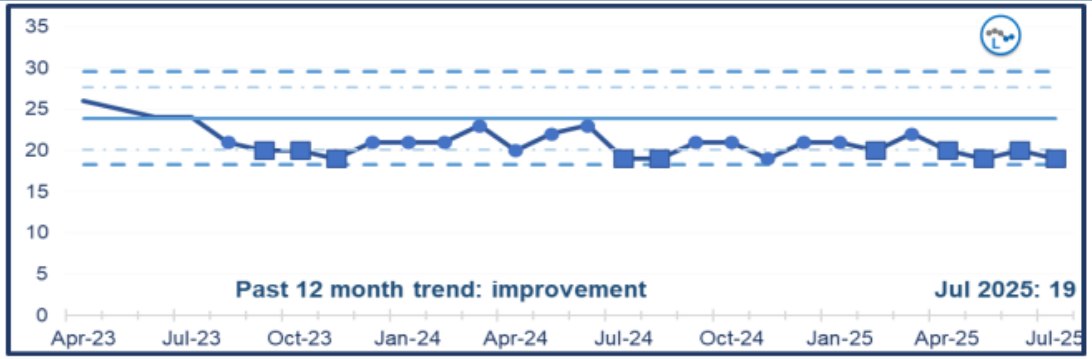


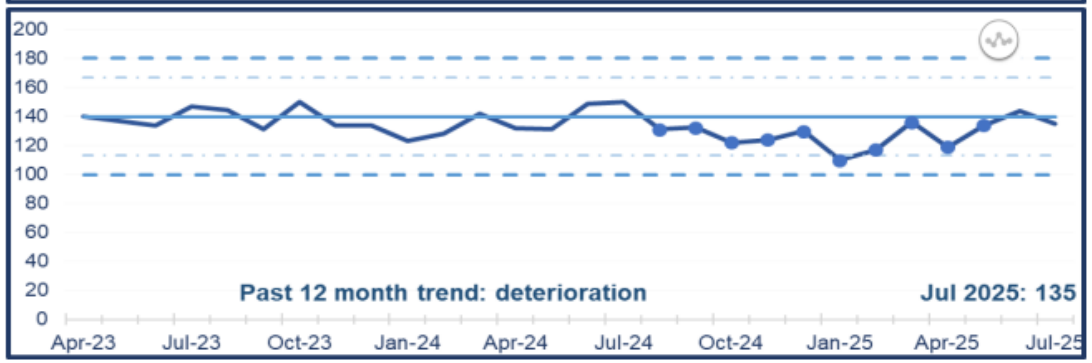


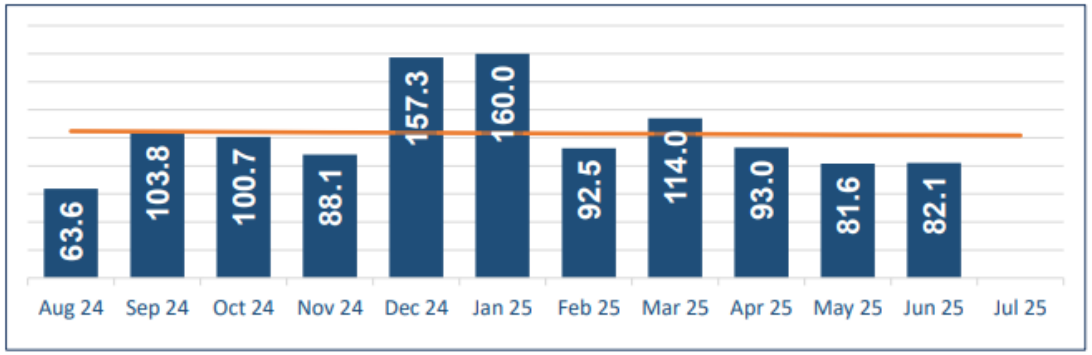


Access & Activity: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-10	PFIG	Median time from arrival at an emergency department to triage by a clinician	15 minutes or less	TBC	19.0	4th of 6 (at Apr 25)
CRR: 24-10 SM: DM07	PFIG	Median time from arrival at an emergency department to assessment by a clinical decision maker	60 minutes or less	TBC	135.0	6th of 6 (at Apr 25)
CRR: 24-10	PFIG	Median emergency response time to amber calls	Decreas-ing trend	TBC	82.1	2nd of 7 (at Apr 25)

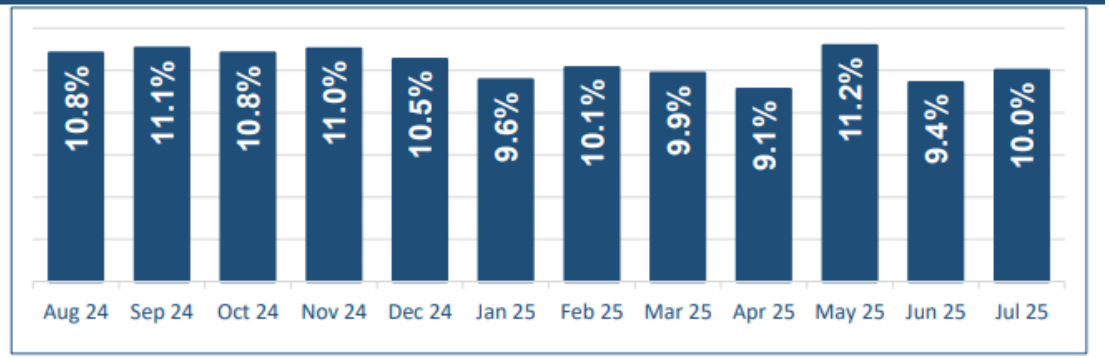


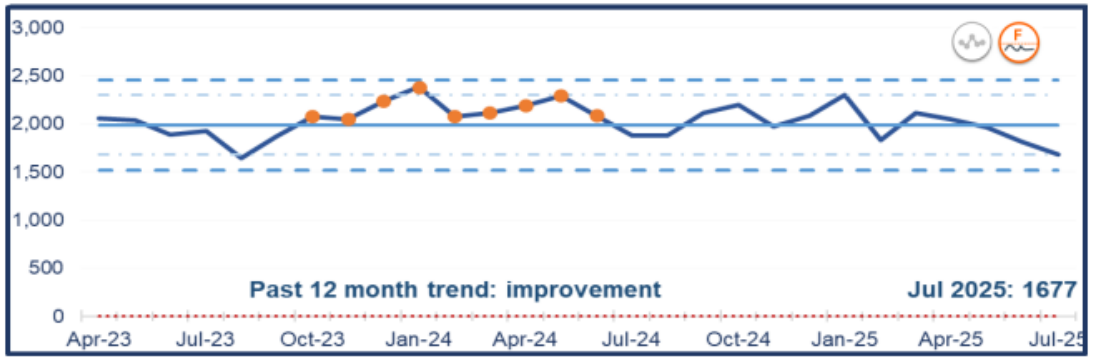


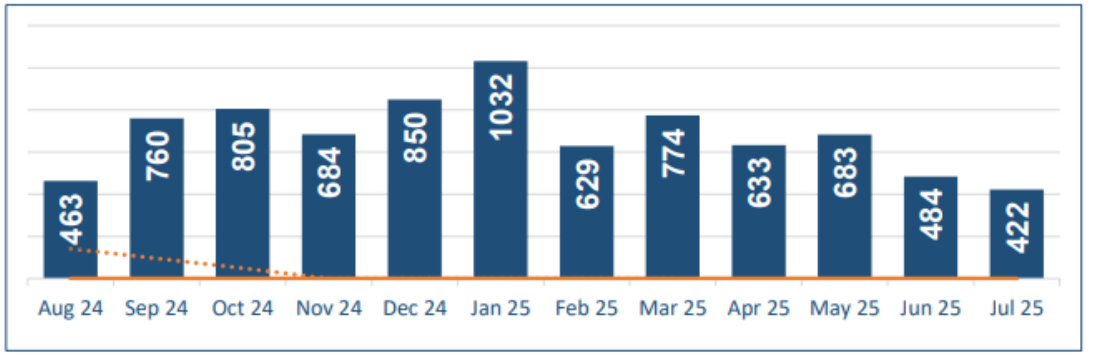


Access & Activity: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	PFIG	Percentage of ambulance handovers within 15 minutes	Equival-ent month increase (2025/26 to 2024/25) to 100%	TBC	10.0%	N/A
CRR: 24-10 SM: DM06	PFIG	Number of ambulance patient handovers over 1 hour	0	TBC	1677	6th of 6 (at Apr 25)
CRR: 24-10	PFIG	Number of ambulance patient handovers over 4 hour	0	TBC	422	

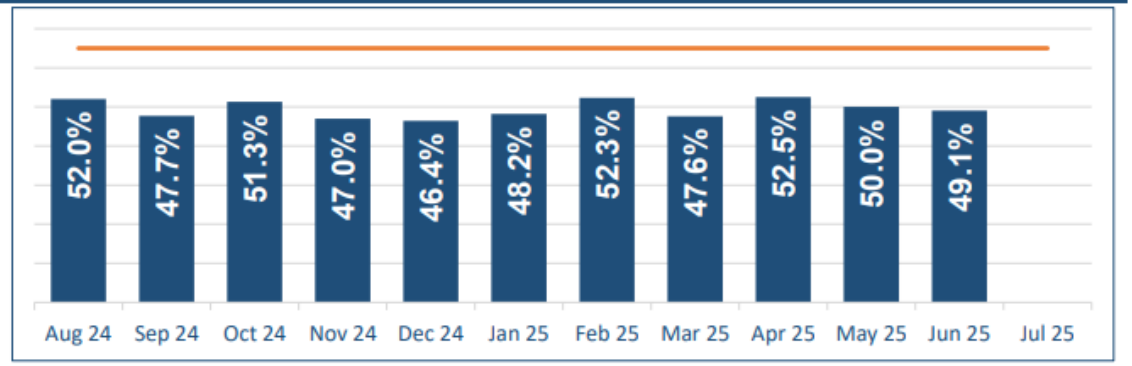






Access & Activity: Performance

Ref	Cmt	Measure	WG Target	Internal Target	BCU Position	Wales Rank
CRR: 24-10	PFIG	Percentage of emergency responses to red calls arriving within (up to and including) 8 minutes	65%	TBC	49.1%	2nd of 7 (at Apr 25)



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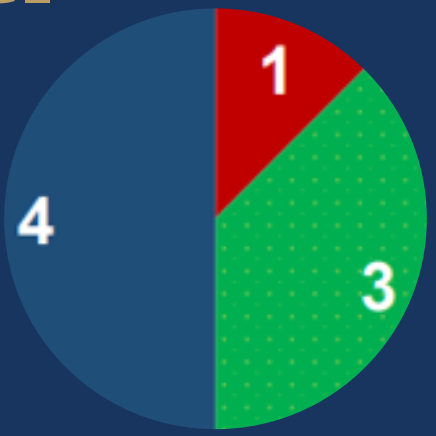
Section 2

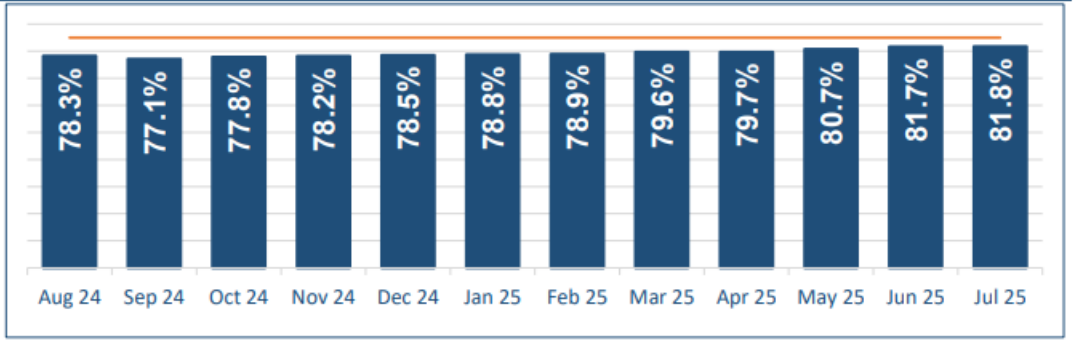
People & Organisational Development Performance

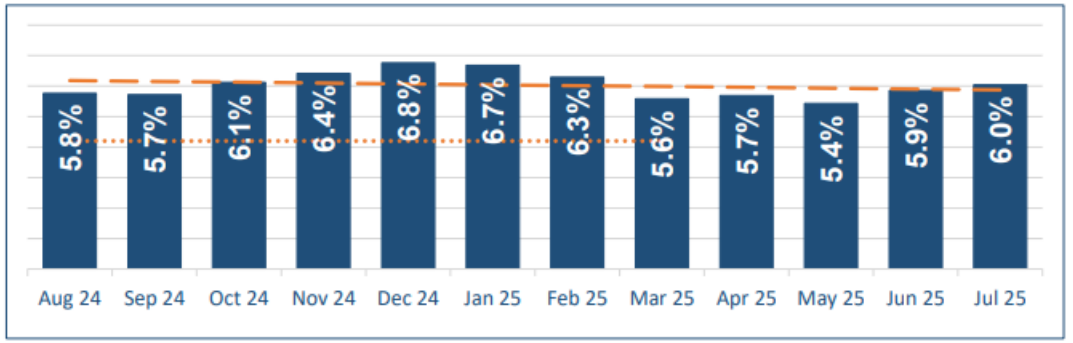


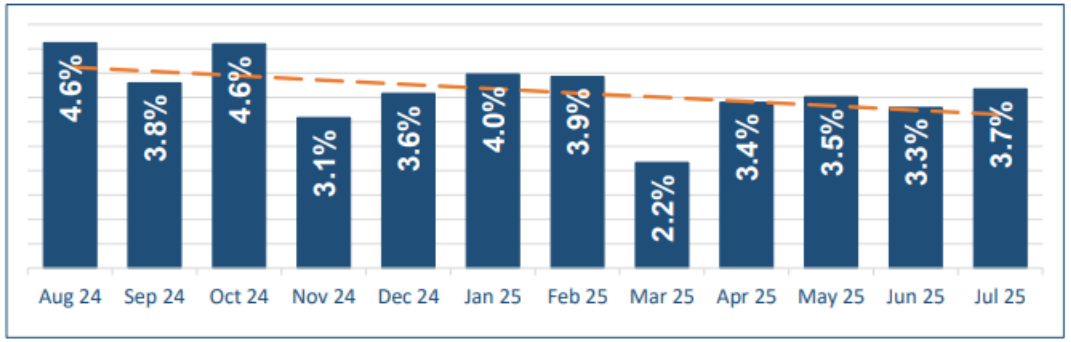
Produced on behalf of the **Performance, Finance & Information Governance Committee**
by the **Performance and Commissioning Directorate and Partners**

People: Performance

Ref	Cmt	Measure	WG Target	Internal Target	BCU Position	Wales Rank*
-	PFIG	Percentage of headcount by organisation who have had a Personal Appraisal and Development Review (PADR) in the previous 12months (excluding medical appraisal, and doctors and dentists in training)	85%	TBC	81.8%	7th of 13 (at Mar 25)
-	PFIG	Percentage of sickness absence rate of staff	Decreas-ing trend	TBC	6.0%	7th of 13 (at Mar 25)
CRR: 24-05	PFIG	Agency spend as a percentage of total pay bill	Decreas-ing trend	TBC	3.7%	9th of 12 (at Mar 25)

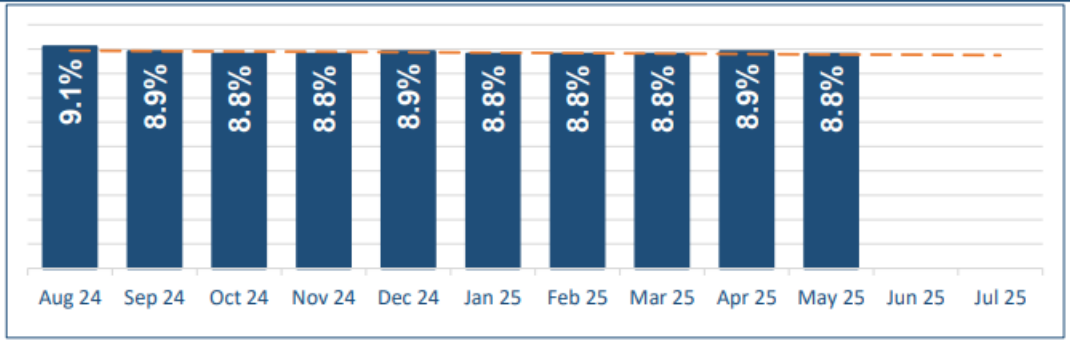


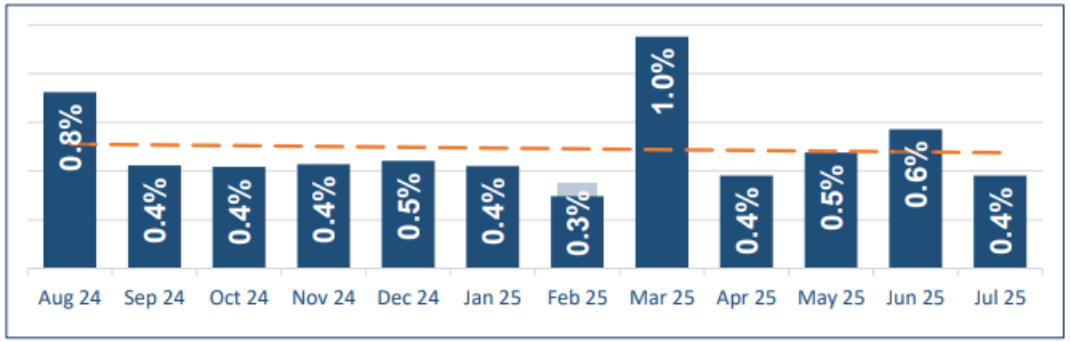


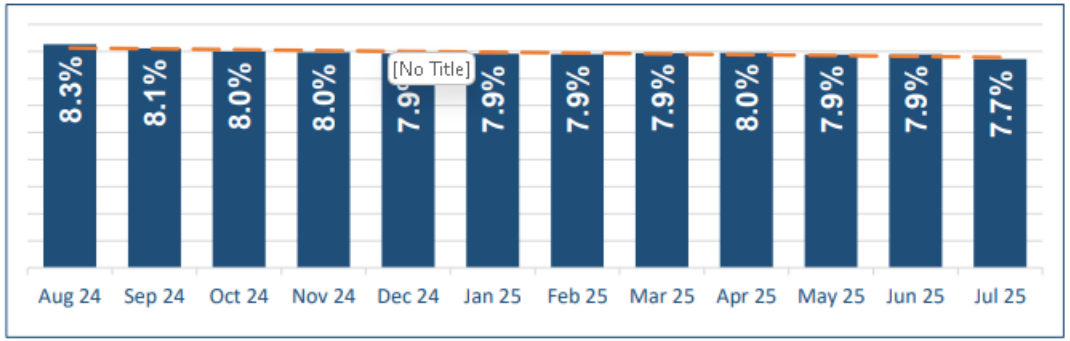


People: Performance

Ref	Cmt	Measure	WG Target	Internal Target	BCU Position	Wales Rank*
-	PFIG	Turnover rate for nurse and midwifery registered staff leaving NHS Wales (HEIW data)	Decreasing trend against 2019/20	TBC	8.8%	
-	PFIG	Turnover rate for nurse and midwifery registered staff leaving BCUHB (monthly, not 12 month rolling figure)	N/A	TBC	0.4%	
-	PFIG	12 month rolling turnover rate (External)	N/A	TBC	7.71%	

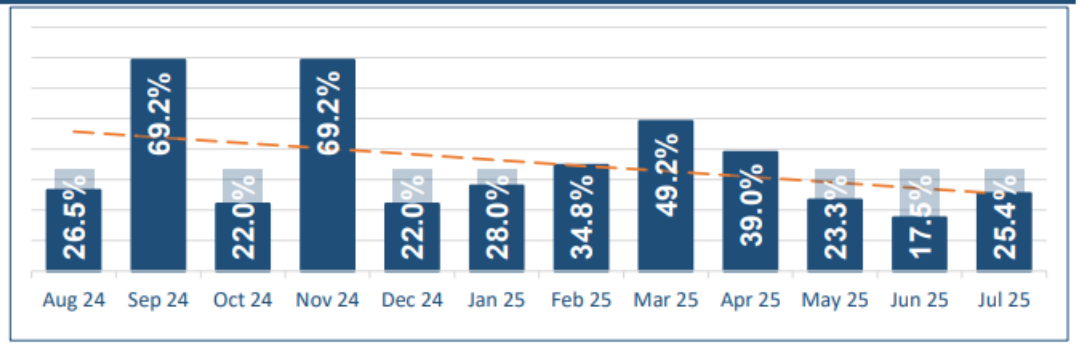


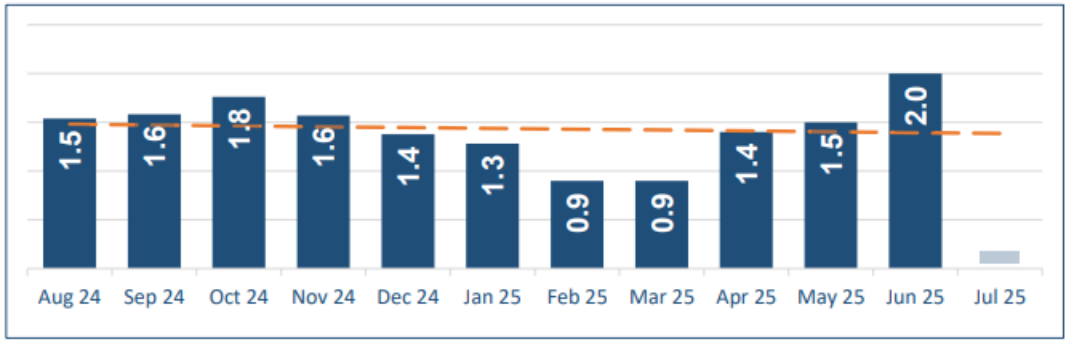




People: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	PFIG	Roster compliance	N/A	TBC	25.4%	
-	PFIG	Open disciplinary cases per 1000 staff	N/A	TBC	2.0	





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Section 3

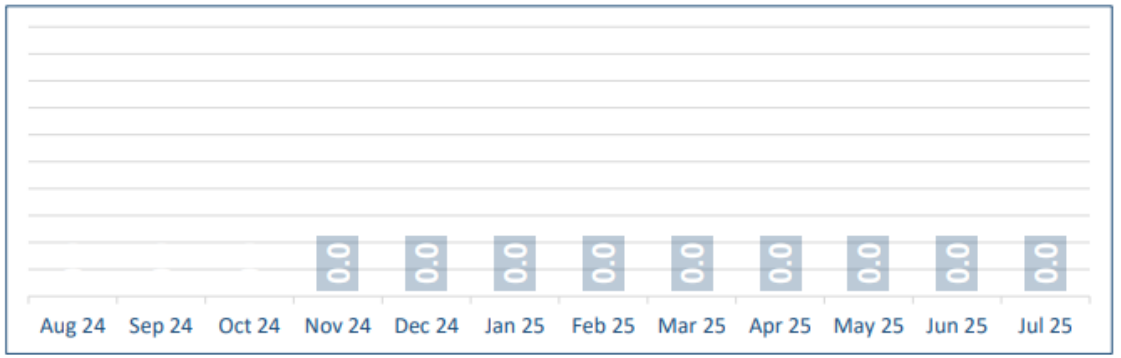
Financial Performance

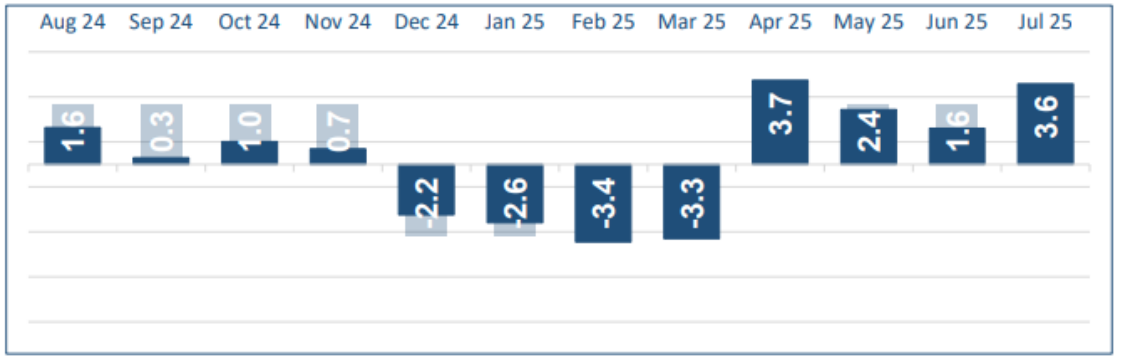
4

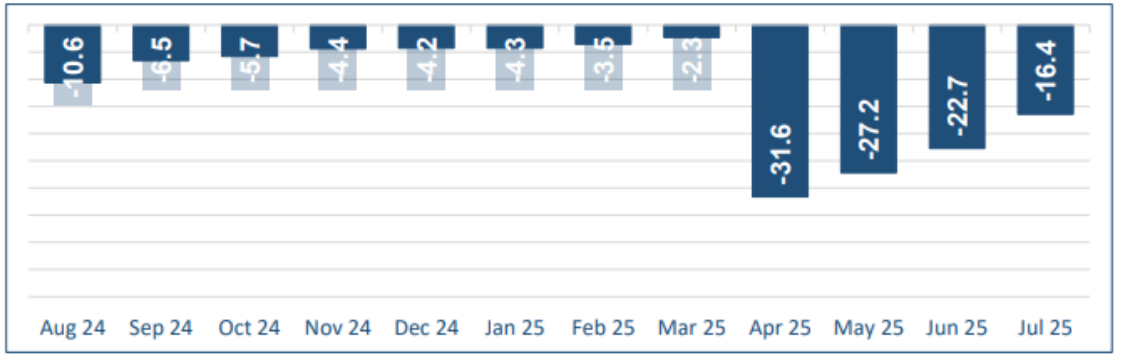
Produced on behalf of the **Performance, Finance & Information Governance Committee**
by the **Performance and Commissioning Directorate and Partners**

Finance: Performance

Ref	Cmt	Measure	WG Target	Internal Target	BCU Position	Wales Rank
CRR: 24-05	PFIG	Forecast outturn (£million)	N/A	TBC	0.0	
CRR: 24-05	PFIG	In month variance to plan (£million)	N/A	TBC	3.6	
CRR: 24-05	PFIG	Forecast savings delivery against target (£million)	N/A	TBC	-16.4	

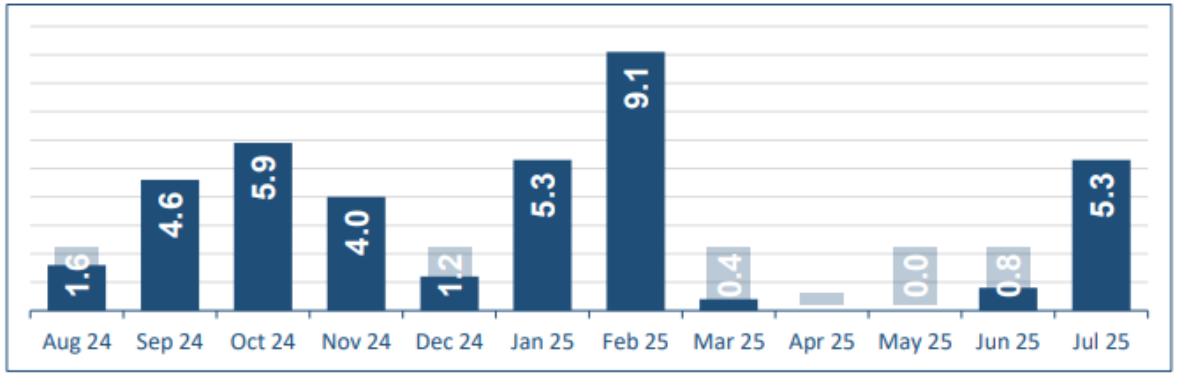






Finance: Performance

Ref	Cmt	Measure	WG Target	Internal Target	BCU Position	Wales Rank
CRR: 24-05	PFIG	In year capital expenditure against plan (£million)	N/A	TBC	5.3	



Finance: Performance

BCU Wide and Divisional Positions (Red = overspend against plan)	April £m	May £m	June £m	July £m	YTD £m
West IHC	(2.0)	(2.2)	(2.1)	(2.6)	(8.9)
Central IHC	(3.4)	(2.3)	(2.6)	(3.0)	(11.3)
East IHC	(3.4)	(3.5)	(3.8)	(3.5)	(14.1)
Womens	(0.3)	(0.3)	(0.3)	(0.4)	(1.3)
MH & LD	(1.6)	(1.5)	(1.8)	(1.9)	(6.9)
Commissioning Contracts	(1.2)	(2.2)	0.2	(1.6)	(4.8)
ICD Primary Care	0.2	0.4	0.1	0.2	0.9
ICD Regional Services	(0.8)	(1.6)	(1.3)	(1.1)	(4.8)
Support Functions & Other Budgets	8.9	10.8	9.9	10.4	39.9
BCU Wide	**(3.7)**	**(2.4)**	**(1.6)**	**(3.6)**	**(11.4)**

Service Performance against Target	Annual				Year to Date		
	Target £m	Forecast Delivery £m	Delivery v Target (+ve = adverse) £m	FYE £m	Target £m	Delivery £m	Delivery v Target (+ve = adverse) £m
West Integrated Health Community	7.9	4.4	3.5	6.0	2.6	1.4	1.2
Central Integrated Health Community	10.0	5.0	5.0	5.3	3.3	1.2	2.1
East Integrated Health Community	10.0	4.8	5.2	5.2	3.3	1.8	1.5
MHLD	3.9	4.2	-0.3	5.4	1.3	1.2	0.1
Womens Services	1.2	0.1	1.1	0.1	0.4	0.0	0.4
Diagnostic and Specialist Clinical Support	1.8	0.8	1.0	0.4	0.6	0.4	0.2
Cancer Services	1.5	1.4	0.1	1.7	0.5	0.4	0.1
Community Dental Sevices	0.1	0.0	0.1	0.0	0.0	0.0	0.0
Corporate & Support Services	3.6	2.9	0.7	0.2	1.2	1.1	0.1
Saving Total	**40.0**	**23.6**	**16.4**	**24.3**	**13.3**	**7.6**	**5.7**
Accountancy Gains		1.9	-1.9			1.9	-1.9
Total		**25.5**	**14.5**	**24.3**	**13.3**	**9.5**	**3.8**

Finance: Agency & Locum Spend

B - Agency / Locum (premium) Expenditure - Analysed by Type of Staff		1	2	3	4	5	6	7	8	9	10	11	12		
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	Forecast year-end position
REF	*TYPE*	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
1	Administrative, Clerical & Board Members	49	62	81	70	69	72	95	105	13	115	75	93	899	899
2	Medical & Dental	1,489	1,597	1,428	1,766	1,672	1,410	1,900	1,601	1,390	1,573	1,811	1,817	19,454	19,454
3	Nursing & Midwifery Registered	1,912	1,985	1,902	1,904	1,889	1,768	1,765	1,667	1,528	1,693	1,363	1,226	20,602	20,602
4	Prof Scientific & Technical	10	10	12	10	23	14	14	17	7	12	8	0	137	137
5	Additional Clinical Services	19	23	32	9	27	16	27	21	12	3	26	(3)	212	212
6	Allied Health Professionals	467	449	378	396	485	428	400	454	447	539	591	454	5,488	5,488
7	Healthcare Scientists	25	15	3	9	11	10	12	20	9	7	0	12	133	133
8	Estates & Ancillary	(1)	9	8	1	5	16	0	4	6	(2)	6	4	56	56
9	Students	0	0	0	0	0	0	0	0	0	0	0	0	0	0
10	TOTAL AGENCY/LOCUM (PREMIUM) EXPENDITURE	3,970	4,150	3,844	4,165	4,181	3,734	4,213	3,889	3,412	3,940	3,880	3,603	46,981	46,981
11	Agency/Locum (premium) % of pay	4.4%	4.6%	4.3%	4.6%	4.6%	3.8%	4.6%	3.1%	3.6%	4.0%	3.9%	2.2%	4.1%	4.1%

Finance: Performance Month 4 (July 2025)

The 2025/26 financial plan aligns with the strategic ambition of the Health Board in attaining the key financial duty to break-even. Expenditure commitments will need to be prioritised to enable the key financial duty and the performance ask to be attained. Achieving the control target in 2024/25 has resulted in the £74.6m conditionally recurrent funding received in 2023/24 and 2024/25 being allocated as recurrently in 2025/26 and the receipt of the £82.0m Improvement and Transformation funding allocation non-recurrently for 2025/26, with conditions associated with retention recurrently of the funds for 2026/27 and beyond being:

- £40.0m Deficit Support Funding – Recurrent and non-conditional following submission and delivery of a financially balanced IMTP by the Health Board.
- £42.0m Performance & Transformation Funding – Recurrent on de-escalation from Special Measures and Welsh Government having greater oversight and direction in use against Special Measures and Ministerial priorities.

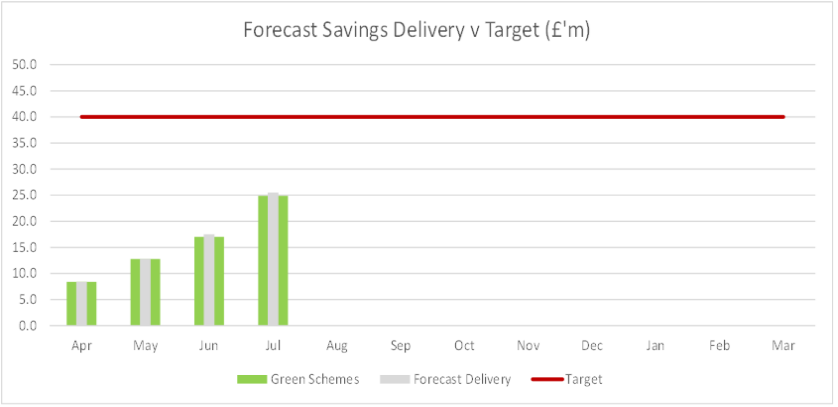
In-month position is reporting a deficit of £3.6m, a deterioration of £2.0m from the previous months position. Year to date position is a deficit of £11.4m, largely driven by the shortfall in National Insurance funding of £1.4m for the months of April to July 2025 (previously costs offset by anticipated allocations), pressures associated with Escalated Beds, Healthcare Services provided by other NHS Bodies Contracts and a substantial increase in Mental Health Out of Area referrals.

	Actual Position				2025/26 Forecast Position								
	Apr £m	May £m	Jun £m	Jul £m	Aug £m	Sep £m	Oct £m	Nov £m	Dec £m	Jan £m	Feb £m	Mar £m	Total £m
Surplus/ (deficit)	(3.7)	(2.4)	(1.6)	(3.6)	(2.0)	(0.5)	0.0	2.3	2.5	2.9	3.0	3.2	**0.0**

The Health Board's financial plan has set a savings target of £40.0m to be delivered in 2025/26, profiled on an equal twelfth's basis. There has been a significant step up in the Savings Plan reported at end of July (Month 4) with the Health Board having identified £23.6m Green saving schemes, fortuitous Accountancy Gains of £1.9m, giving a combined total of £25.5m, an increase of £8.0m from previous month. Of these savings, £18.2m is recurring with a full year effect of £24.3m and £7.3m identified as non-recurring savings.

Further work is required to convert £12.6m red and pipeline opportunities into Green Schemes.

WG has issued a deadline for the Health Board to identify the full £40m savings requirement and all schemes must meet the 'Green Schemes' criteria prior to the Month 5 Monitoring Return submission deadline.



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University Health Board

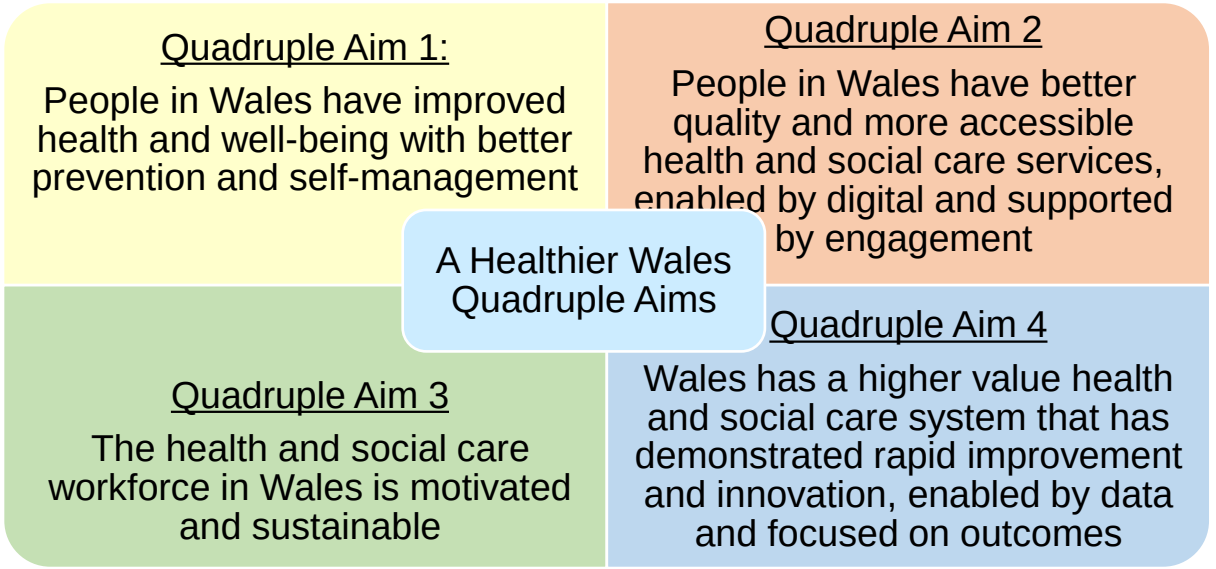
About the Integrated Quality & Performance Report

Produced on behalf of the **Performance, Finance & Information Governance Committee**
by the **Performance and Commissioning Directorate and Partners**

NHS Wales Performance Framework 2024-25

The performance measures in the NHS Wales Performance Framework for 2025-2026 reflect the National Programme areas as outlined in the NHS Wales Planning Framework 2024-2027. The 2025/26 revision now consists of 51 quantitative measures

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



Integrated Quality & Performance Report

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

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

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

About this report: Rating System

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

Green — The *latest available data point* indicates that performance is at, or better than the target

Red — The *latest available data point* indicates that performance is worse than the target

Blue — It is inappropriate, or not possible, to rate available data against any available target

Grey — There is no / insufficient data available to rate against the target

Exception

Referring to a deviation or departure from the normal or expected course of action, it signifies that a specific condition or event requires attention or further action to address the deviation and ensure corrective measures are taken

Escalation

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

Criteria of an exception

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

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

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

Criteria for escalation

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

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

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

About this report: Charts

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

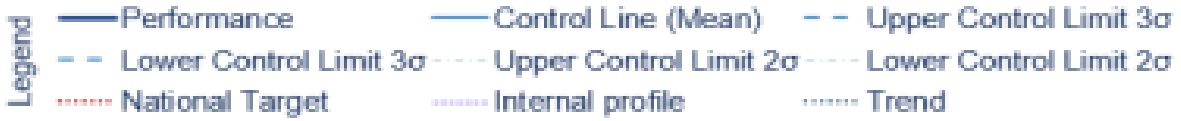
Variance

- Common cause variation present: there is no significant change or pattern
- Special cause variation present: changes or patterns appear to show improvement
- Special cause variation present: concerning changes or patterns present that require investigation / action.
- Special cause variation present: a upwards or downwards change or pattern is evident, which is neither positive or negative in nature.

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

- No assurance: we would expect to sometimes achieve, and sometimes miss the target
- Positive assurance: we would consistently expect to achieve the target
- No assurance: we would consistently expect to miss the target
- There is no profile or target, or insufficient data, thus assurance can not be ascertained

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



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

Introduction to Integrated Quality & Performance Report (IQPR)

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

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

The Integrated Performance Framework (IPF)

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

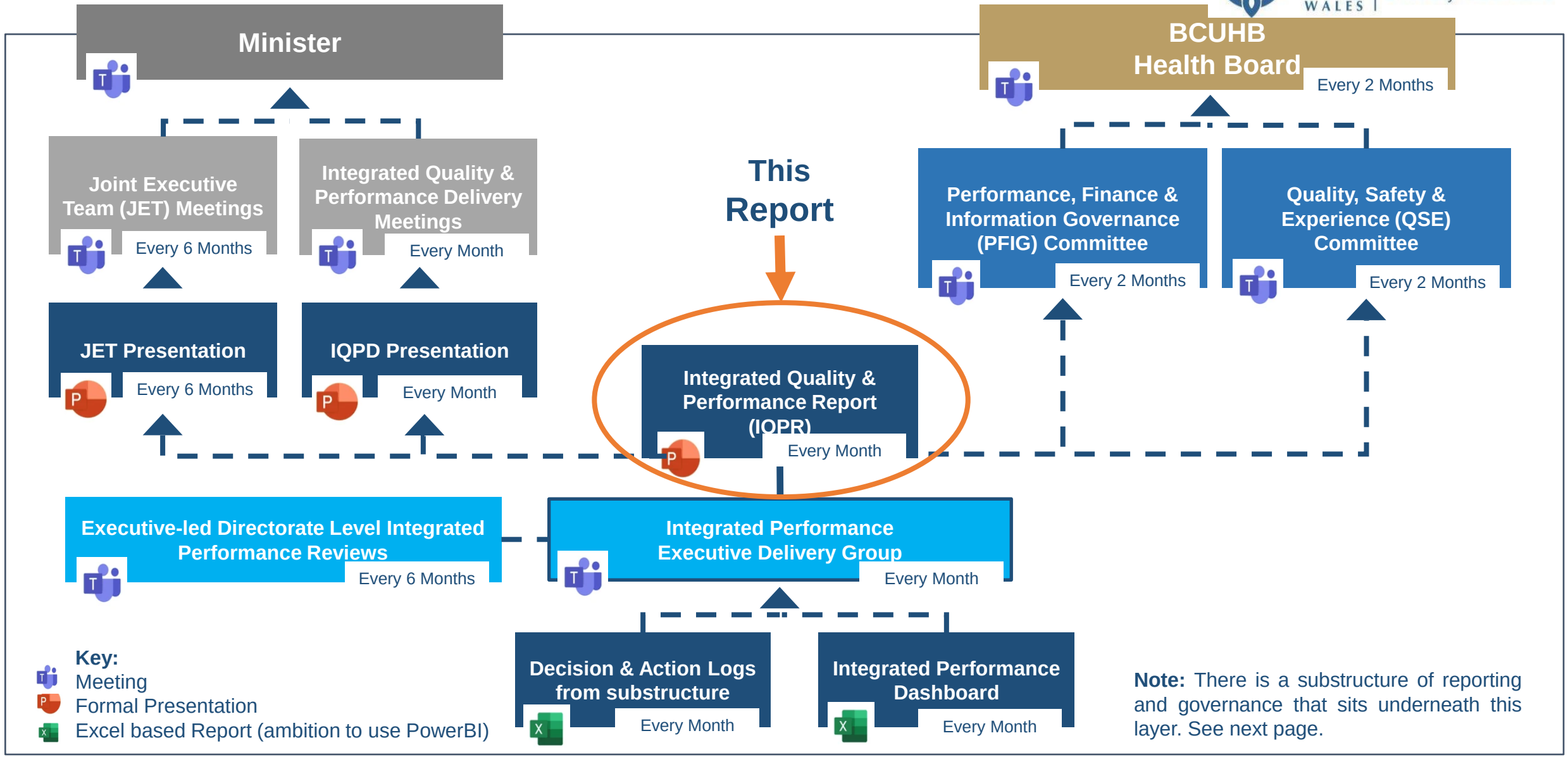
The Integrated Performance Framework sits within a "triumvirate" together with the Integrated Planning Framework and the Risk Management Framework (also ratified at Health Board on the 28th September 2023). This triumvirate of frameworks will encompass the planning, safe delivery and monitoring of the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

Where does the IQPR feature within the Performance Governance Structure

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

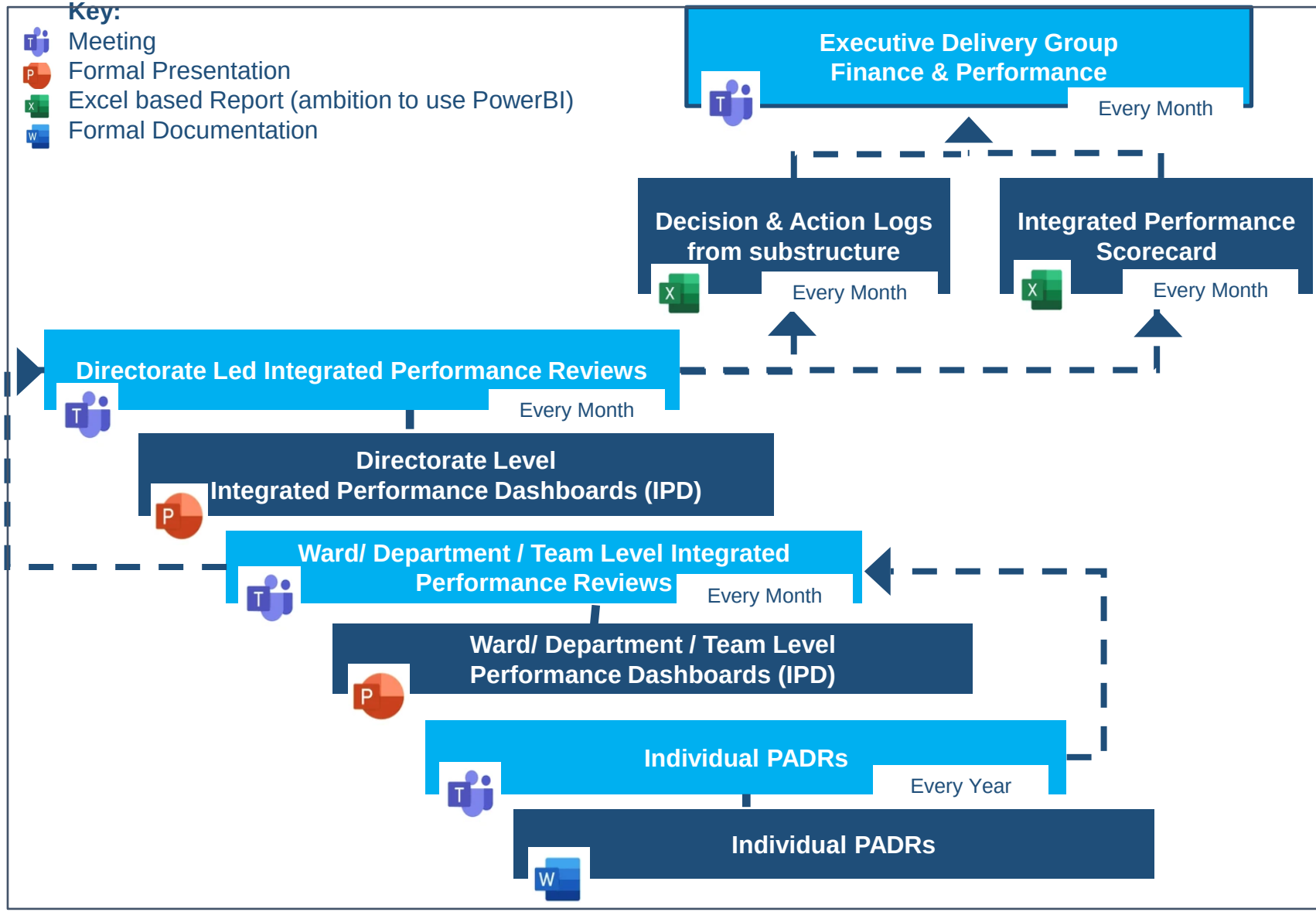
The IPR will be embedded as the 'single version of the truth' and used to report on performance to the Health Board, it's scrutinising committees namely Performance, Finance & Information Governance (PFIG) Committee and Quality, Safety & Experience (QSE) Committee and externally to Welsh Government.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

The Integrated Performance Reporting & Governance Superstructure



The Integrated Performance Reporting & Governance Substructure

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



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

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

Performance & Commissioning Directorate Outputs

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

Additional Information

Update on Actions from previous PFIG Meeting

Update on Actions from previous PFIG Meeting

Update on Actions from previous PFIG Meeting

Update on Actions from previous PFIG Meeting

Update on Actions from previous PFIG Meeting

Further Information

Our Integrated Quality & Performance Report
Betsi Cadwaladr University Health Board

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

Our website www.bcu.wales.nhs.uk

Stats Wales https://statswales.gov.wales/Catalogue/Health-and-Social-Care

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

follow @bcuhb

http://www.facebook.com/bcuhealthboard

Appendix

Abbreviations

Please see below a list of abbreviations commonly found within the report:	
A&E	Accident and Emergency
AB	Aneurin Bevan Health Board
ADHD	Attention Deficit Hyperactivity Disorder
ASD	Autistic Spectrum Disorder
BCU/BCUHB	Betsi Cadwaladr University Health Board
C&V	Cardiff and Vale University Health Board
Cmt	committee
CRR Ref	Corporate Risk Register Reference
CTM	Cwm Taf Morgannwg University Health Board
ENT	Ear, Nose, and Throat
GDS	General Dental Services
GP	General Practitioner
HDda	Hywel Dda University Health Board
HEIW	Health Education and Improvement Wales
IHC	Integrated Health Community
LPMHSS	Local Primary Mental Health Support Services
MH&LD	Mental Health and Learning Disabilities
MMR	Measles, Mumps and Rubella
NHS	National Health Service
NR	non-recurrent
PADR	Performance Appraisal and Development Review
PFIG	Performance, Finance, and Information Governance Committee
QSE	Quality, Safety, and Experience Committee
R	recurrent
SB	Swansea Bay University Health Board
WAST	Welsh Ambulance Services NHS Trust
WG	Welsh Government
YTD	year to date

Partners

This report has been produced on behalf of Our Performance, Finance & Information Governance Committee by the **Performance Directorate in** partnership with:

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

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

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

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

Teitl adroddiad: ***Report title:***	Urgent & Emergency Care (UEC) Programme Update
Adrodd i: ***Report to:***	Performance, Finance & Information Governance Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 26 August 2025
Crynodeb Gweithredol: ***Executive Summary:***	This report provides an update on the progress of the UEC major change programme for quarter 1 of 2025/26 financial year. The Committee should note that programme structure of the UEC Programme was restructured in November 2024 following the appointment of a Programme Director; The programme structure was reconfigured into four workstreams, in line with best practice across Wales, reporting through to the UEC Improvement Board with an integrated membership of Local Authority partners and supported by colleagues from the NHS Wales Performance & Improvement. 1. Support at the individual's front door 2. Hospital front door 3. Hospital flow 4. Discharge from hospital Workstream leads have been appointed to oversee the each workstream, maintain pace of delivery and ensure outcomes are delivered. Whilst a clinical lead remains in place across workstreams 3 & 4, discussions are ongoing to appoint an overarching clinical lead for the programme. The UEC Programme is developing robust governance arrangements following the substantive appointment of the Chief Operating Officer and this will be further strengthened by bringing together all the major change programmes into the Transformation and Strategic Planning Directorate with the sharing of a consistent programme approach and best practice. The Cabinet Secretary expectation for health boards in 2025/26 outlined within the national planning guidance in regard to UEC is. *'Improve timely access to care, reducing the length of wait in key areas of the urgent and emergency care stream through addressing variation'.* To support this expectation there are 5 enabling actions aligned to the national 6 Goals programme for UEC, these map across to the relevant workstreams outlined above. 1. Implementation of the community based falls response (Workstream 1) 2. Implementation of the remote clinical assessment services framework - Single Point of Access (SPOA) (Workstream 1) 3. Implementation of acute frailty model (AFS) at the front door (Workstream 2) 4. Implementation of the Welsh Health Circular - Ambulance Handover Guidance (Workstream 2) 5. Implement the Optimum Hospital Flow Framework (Workstream 3)

Associated with the enabling actions are key performance measures and trajectories. Progress against each trajectory is detailed within the report with evidence of supporting actions and plans for future developments.

The Quarter 1 performance against each KPI and trajectory is as noted below;

Key performance measure	Q1 Position	Trend
Implementation of the community based falls response		
Conveyance of L1 and L2 fallers to be reduced by 10% by end of December 2025 against a March 2025 baseline, with a further 25% reduction by the end of March 26.	meeting trajectory	improving position
Implementation of the remote clinical assessment services framework - Single Point of Access		
Reduce conveyance from care homes by ambulance to ED: no higher than 50% conveyance rate by end of December 2025, sustained until the end of March 2026	meeting trajectory	improving position
Implementation of acute frailty service (AFS) at the front door		
TBC following release of acute frailty framework. 85% of same day emergency care (SDEC) referrals discharged on same day	not meeting trajectory	static position
Implementation of the Welsh Health Circular - Ambulance Handover Guidance		
In line with the Ministerial Advisory Group report, Health Boards should ensure that no ambulance handover should exceed 45 minutes, with a focus on achieving the 15 minute handover target wherever possible.	not meeting trajectory	improving position
Implement the Optimum Hospital Flow Framework (OHFF)		
Discharges by midday: 33% by end of December 2025, sustained until end of March 2026	not meeting trajectory	improving position

The improvements made through the UEC programme support operational delivery and therefore are also directly related to the special measures de-escalation performance indicators summarised in the table below:

	<table><tr><th>Key performance measure</th><th>Q1 Position</th><th>Trend</th></tr><tr><td colspan="3">Ambulance Handover Delay</td></tr><tr><td>(superseded by measure 4 above)</td><td></td><td></td></tr><tr><td colspan="3">Time to clinician</td></tr><tr><td>Median time from arrival at an emergency department to assessment by a clinical decision maker should not exceed 60 minutes</td><td>not meeting trajectory</td><td>improving position</td></tr><tr><td colspan="3">12-hour breaches in Emergency Departments & Minor Injury Units</td></tr><tr><td>Continuous improvement towards no more than 10% of patients waiting over 12 hours at each individual site and across the health board</td><td>not meeting trajectory</td><td>improving position</td></tr><tr><td colspan="3">Pathway of Care Delays (PoCD)</td></tr><tr><td>Continuous reduction of 5% in pathways of care delays for 3 consecutive months and then maintained for 4 months</td><td>meeting trajectory</td><td>improving position</td></tr></table> In summary, the report highlights that some of the key performance measures are on trajectory, a number have shown insufficient or no improvement. The key areas of concern predominantly focus around the emergency department, however poor patient flow is impacting on our ability to create the necessary capacity to be able to significantly improve on these areas.
Argymhellion: ***Recommendations:***	The Committee is asked to: • **Note** the improvement work across the UEC system and key performance indicators • **Review** the contents of the report and identify additional assurance or actions it would recommend the UEC Programme undertake.
Arweinydd Gweithredol: ***Executive Lead:***	Tehmeena Ajmal, Chief Operating Officer
Awdur yr Adroddiad: ***Report Author:***	Alison Bishop, UEC Programme Director
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐ | I Benderfynu arno *For Decision* ☐ | Am sicrwydd *For Assurance* ☒

Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☒ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Attainment of IMTP UEC targeted performance to enhance timely access to care for the local population
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Ministerial Priority, target and impacts on key duty to deliver breakeven financial duty
Yn unol â WP7 (sydd bellach yn cynnwys WP68), a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 (which now incorporates WP68) has an EqlA been identified as necessary and undertaken ?***	Not applicable
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	The following risks are associated with the UEC Programme: Corporate Risk 24-10
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Not applicable
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Not applicable

Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Not applicable
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	1.2 Risk of the provision of poor standards of care to the patients and population of North Wales, falling below the expected standards of quality and safety, resulting in deterioration of care and haem to patients and services. 1.3 Failure to effectively manage unscheduled care demand and capacity infrastructure, adversely impacting on the quality of care and patient experience
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations***	
Rhestr o Atodiadau: ***List of Appendices:*** 1. Quarter 1 UEC Report 2. Ministerial Advisory Group recommendation 15 in relation to Ambulance handovers not exceeding 45 minutes from October 2025 (MAG 45) Report	

Appendix 1 – Urgent & Emergency Care Quarter 1 Report

1. Background

The Urgent & Emergency Care (UEC) major change programme incorporates the requirements of the national 6 Goals Programme whilst ensuring that UEC services deliver safe, high-quality care at the right time and in the right place, first time.

The programme structure of the UEC Programme was restructured in November 2024 following the appointment of a Programme Director. The programme structure was reconfigured into four workstreams, in line with best practice across Wales, reporting through to the UEC Improvement Board with an integrated membership of Local Authority partners and supported by colleagues from the NHS Wales Performance & Improvement.

1. Support at the individual's front door
2. Hospital front door
3. Hospital flow
4. Discharge from hospital

2. 2025/26 Cabinet Secretary Delivery Expectations

The Cabinet Secretary expectation for health boards in 2025/26 outlined within the national planning guidance in regard to UEC is.

'Improve timely access to care, reducing the length of wait in key areas of the urgent and emergency care stream through addressing variation'.

To support this expectation there are 5 enabling actions aligned to the national 6 Goals programme for UEC, these map across to the relevant workstreams outlined above.

1. Implementation of the community based falls response (Workstream 1)
2. Implementation of the remote clinical assessment services framework - Single Point of Access (SPOA) (Workstream 1)
3. Implementation of acute frailty model (AFS) at the front door (Workstream 2)
4. Implementation of the Welsh Health Circular - Ambulance Handover Guidance (Workstream 2)
5. Implement the Optimum Hospital Flow Framework (Workstream 3)

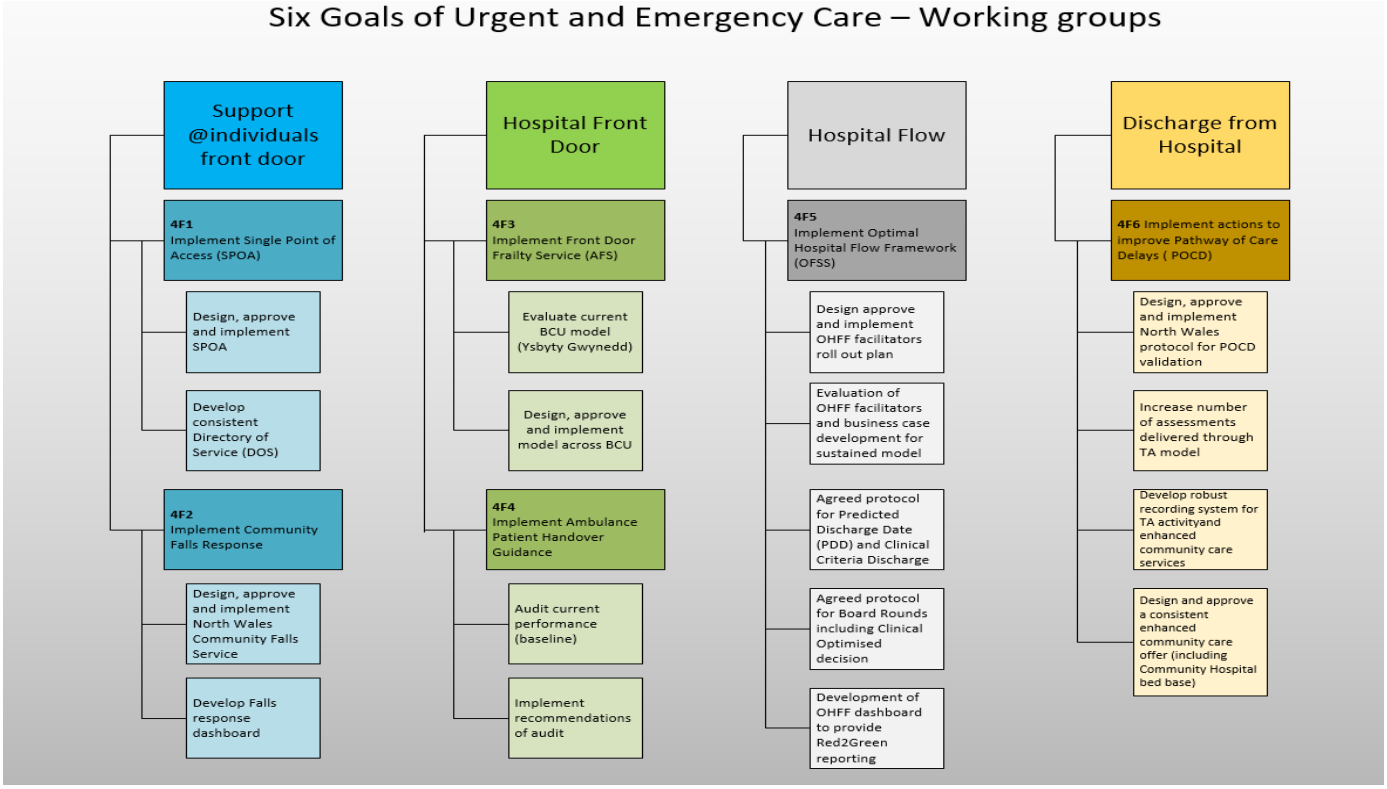
The improvements made through the UEC programme support operational delivery and therefore the special measures de-escalation performance indicators.

Cabinet Secretary Expectations – Enabling Actions	National Programme	BCU Programme/ Workstream	Relevant de-escalation Special Measure
Implementation of the Community Based Falls Response - (Six Goals Programme Framework) to enhance outcomes and experience for those who fall by improving initial response times, reducing the risk of long lies and ensuring service users access community falls pathways when appropriate	6 Goals Programme	UEC Improvement workstream 1	ambulance handover delay 12-hour breaches
Implementation of the remote clinical assessment services framework - Implement a robust 'Single Point of Access' (SPOA) for urgent and emergency care (Six Goals Programme Framework) in each health board area that simplifies access to services by offering clinicians advice and guidance to support onward referral, ensuring patients get the right care for their needs quickly and safely, to improve patient outcomes regardless of where they present	6 Goals Programme	UEC Improvement workstream 1	ambulance handover delay 12-hour breaches
Implementation of acute frailty model at the Front Door – (Six Goals Programme Framework) – integrated with community frailty services - that ensure that older people with frailty are diverted to the most appropriate services within the hospital as quickly as possible and, where possible, discharged home on the same day	6 Goals Programme	UEC Improvement workstream 2	ambulance handover delay 12-hour breaches
Implementation of the Welsh Health Circular - Ambulance Handover Guidance - to ensure timely transfer of patients from ambulance crews to emergency department staff	6 Goals Programme	UEC Improvement workstream 2	ambulance handover delay 12-hour breaches time to first clincial decision maker
Implement the Optimum Hospital Flow Framework - (Six Goals Programme Framework) to ensure people who possess a clinical need for admission to hospital are discharged home when clinically ready, with the right support and without delay. This should support a reduction in pathways of care delays	6 Goals Programme	UEC Improvement workstream 3	ambulance handover delay 12-hour breaches PoCD reduction

3. Programme Structure

Workstream leads have been appointed to oversee the each workstream, maintain pace of delivery and ensure outcomes are delivered. Whilst a clinical lead remains in place across workstreams 3 & 4, discussions are ongoing to appoint an overarching clinical lead for the programme.

Within each workstream are a number of projects focused on key areas of delivery, each project has a lead and a detailed workplan with key tasks identified with timescales; these are monitored and escalated if required alongside associated risks, issues outcomes and benefits.



The UEC Programme is developing robust governance arrangements following the substantive appointment to the Chief Operating Officer post, and this will be further strengthened by bringing together all the major change programmes into the Transformation and Strategic Planning Directorate with the sharing of a consistent approach and best practice.

4. Progress and Key Performance Indicators Against Enabling Actions

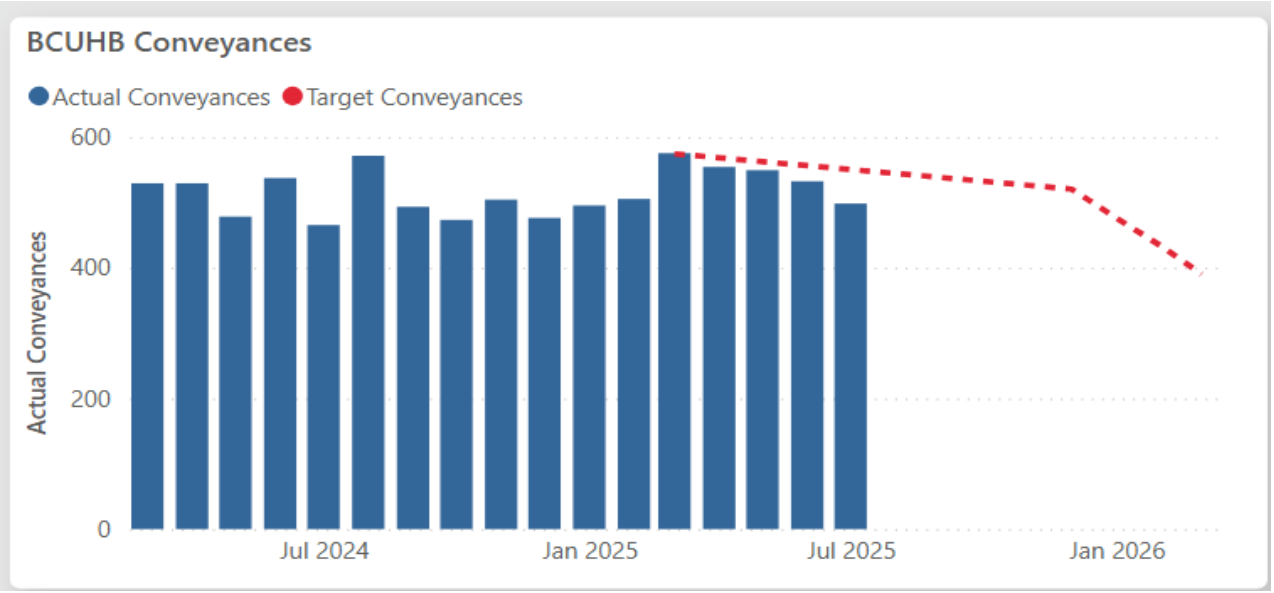
Associated with the five key enabling actions are key performance measures and trajectories. Progress against each trajectory is detailed within the report with evidence of supporting actions and plans for future developments.

a. Implementation of the Community Based Falls Response

The community falls response pathway has recently been brought under the 6 Goals umbrella in 2025 having previously been initiated through the 1000 lives plus programme back in 2013. As part of this programme each health Board established a strategic falls group and the work in 2025 builds on this existing pathway.

This community falls pathway is designed to provide support and treatment as close to the patient's home as possible, in keeping with the vision for the future of NHS services, to reduce the risk of a fall re-occurring and to avoid unnecessary admission to hospital.

The first quarter demonstrates that our conveyance rates for fallers continue to reduce and are exceeding the improvement trajectory.



Key Performance Indicator - Conveyance of L1 and L2 fallers to be reduced by 10% by end of December 2025 against a March 2025 baseline, with a further 25% reduction by the end of March 26.

Key Actions Delivered Q1

Community Falls Pathway workshop to establish expectations and approach

Care Home Falls Bundle – new care home falls bundle & post falls approved, which the latest guidance, resource tools and a new post-falls guidance. Training on the falls bundle commenced, with a total of 243 care homes receiving training during quarter 1 and will continue to be rolled out throughout the forthcoming year.

Key Actions Next Quarter

Community Falls Pathway

Map and gap the available services delivered within the Community Resource teams (CRTs) within each IHC locality which deliver an urgent care response to fallers to ensure consistent equitable service across North Wales.

The development of the SPOA aims to improve referrals to the falls pathway (and reduce conveyance) following the clinical assessment of individuals waiting for an ambulance on the WAST clinical stack or by direct clinical referral from health care professionals. This will support further reduction in conveyance of L1 & L2.

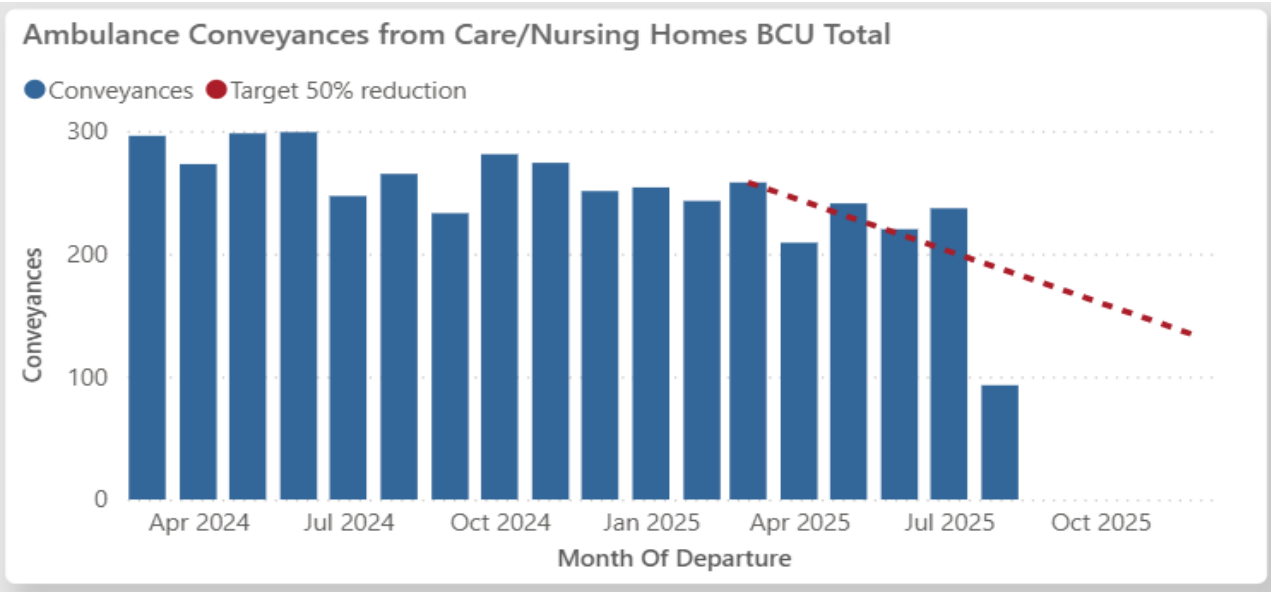
b. Implementation of the remote clinical assessment services framework - Single Point of Access (SPoA)

A Single Point of Access Framework (Wales) was developed and published through the national programme in June 2025 to reduce variation and provide consistent access to services and clinical pathways 7 days a week.

The Framework aims to simplify access for health and social care professionals to remote assessment, advice and treatment for patients under their care. (The SPoA does not provide direct access for patients and public). The expectation is to have a phased approach to delivery with the SPOA meeting the essential criteria by September 2025 in readiness for the forthcoming winter period.

Whilst the HB has existing services which meet the initial essential criteria (for example SICAT, a clinical assessment and triage service, Community Resource Teams (CRTSs) delivery wrap around care in the community), to meet the full ambitions of the framework there is further work required to create a consistent and integrated approach across North Wales.

Key Performance Indicator - Reduce conveyance from care home by ambulance to ED: no higher than 50% rate by end of December 2025, sustained until the end of March 2026



Performance over the first quarter has been on or slightly below the trajectory, with conveyance rates for care home residents in July increasing – in part due to the extremely warm weather (dehydration and UTIs).

SICAT has handled 2296 calls over quarter 1 with 86% of those calls being taken from the ambulance stack queue, 53% of which no longer required conveyance to our acute hospitals.

Key Actions Delivered Q1

Baseline assessment of current service provision within BCU against national framework.

Mapping and gapping of community and local authority services including referrals pathways to act as receiving services following their clinical assessment within the SPoA.

Review and update of the directory of service which maintain the referral pathways utilised by health care professional colleagues has been reviewed and updated.

Key Actions Next Quarter

Agreement of SPoA model for N Wales building on existing service provided. Standard Operating Procedure and Memorandum of Understanding to be developed and agreed.

Referral pathways mapping completed, and consistent referrals pathways developed to ensure SPoA can refer to current service, including community falls pathway.

Upon conclusion of mapping exercise key gaps in provision to be identified and actions put in place to mitigate risks and wherever possible close gaps in provision.

Develop and implement an approach for residential care home residents to access SPAO for clinical assessment and advice. Residential care home residents amount for 52% of all care home residents across Wales and as such provides significant opportunity to further reduce our conveyance rates.

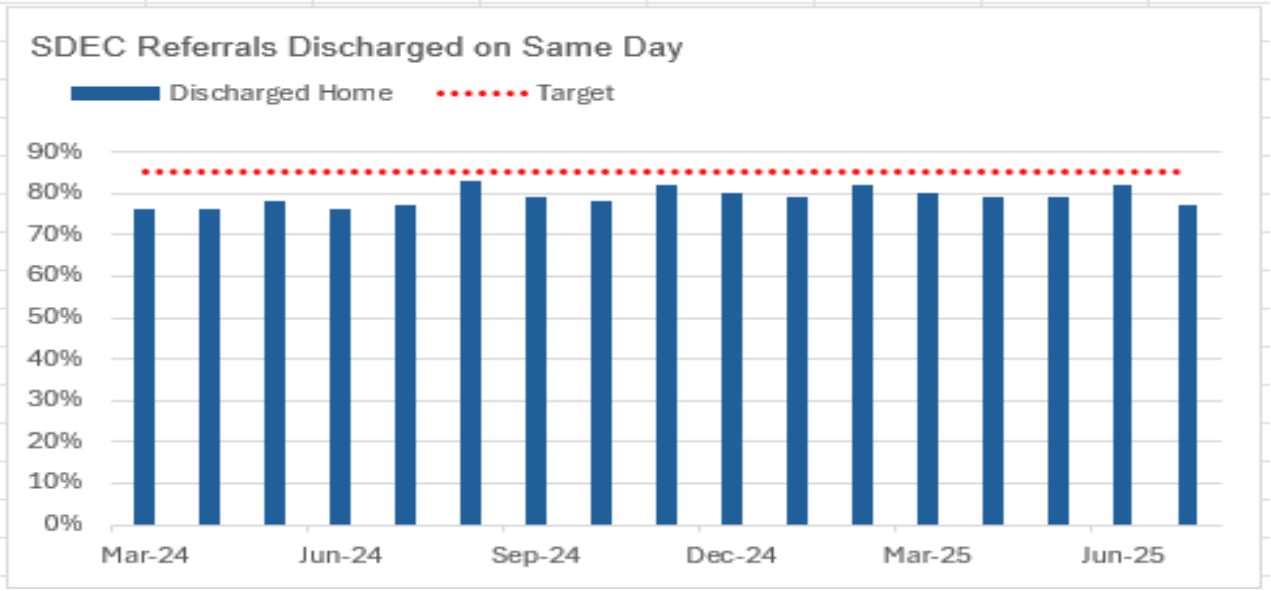
c. Implementation of Acute Frailty Service (AFS) at the Acute Hospitals

SDEC services were developed through the national 6 goals programme during the first two years of the programme.

The Front Door Acute Frailty Service (AFS) for Acute Hospitals Framework was developed and published through the national programme in May 2025. This aims to divert older people with frailty to appropriate services quickly and discharging them home on the same day where possible. Acute frailty teams will provide same day urgent and emergency care for people presenting in Emergency Departments and SDECs as an alternative to hospital admission.

Key Performance Indicator - TBC following release of acute frailty framework.

85% of Same Day Emergency Care (SDEC) referrals discharged on same day



Performance over the first quarter has been on or slightly below the trajectory, SDEC same-day discharges have however remained consistent over the period.

Key Actions Delivered Q1

Development of 'once for Betsi' approach, learning from the current service provision in East IHC and pilots delivered as part of the winter planning initiatives in 2024/25 at the remaining two IHCs.

Mapping & gapping services across primary, community and secondary care enabling baseline against the acute frailly framework to be provided to NHS Executive.

Key project leads identified and assigned to drive forward key actions to support delivery of the acute frailty framework.

Key Actions Next Quarter

Project task and finish groups established to embed the BCU approach to AFS in line with the national framework.

Same day services and referral pathways to be reviewed and a consistent approach agreed to support acute frailty, utilising SDEC to ensure that individuals can be booked into slots to help with 'scheduling' UEC services to manage demand within capacity available.

Development of hot clinics to provide capacity and support same day discharge.

d. Implementation of the Welsh Health Circular - Ambulance Handover Guidance

The Ministerial Advisory Group Report on NHS Wales Performance and Productivity April 2025 recommended

Recommendation 15

Health Boards should ensure that no ambulance handover will exceed 45 minutes, with a focus on achieving the 15 minute target wherever possible. Timescale – within 6 months.

Where the 15 minute handover time target is not possible, an absolute maximum handover time of 45 minutes should be introduced by October 2025.

Welsh government accepted this in part in relation to the timeframe for implementation and confirmed their expectations were confirmed as:

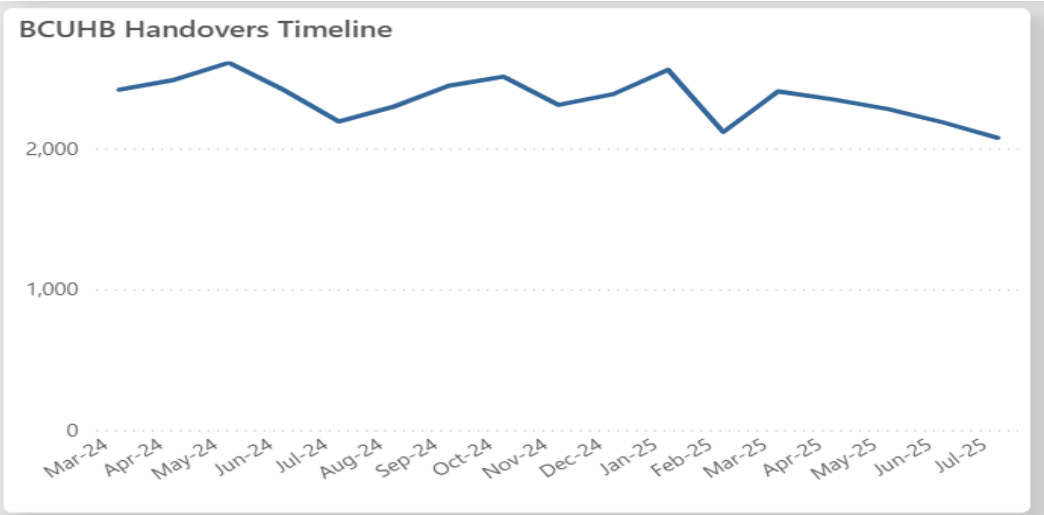
The expectation of health boards to deliver the ambulance patient handover guidance has been established as one of the enabling actions in the NHS planning framework for 2025/2026 (this guidance includes an expectation for 15-minute ambulance patient handovers).

Subsequently, a national ambulance patient handover improvement delivery group has been established and work is now underway. This is clinically led and supported by the Welsh Government and other national system leaders.

The intention is for a plan to be developed in the first quarter of 2025/26 to assess the potential readiness of NHS Wales to deliver a maximum emergency 45-minute ambulance patient handover time within six months and identify any associated delivery challenges, communications requirements, and risks.

Key Performance Indicator - In line with the Ministerial Advisory Group report, Health Boards should ensure that no ambulance handover should exceed 45 minutes, with a focus on achieving the 15 minute handover target wherever possible.

Where the 15 minute handover time target is not possible, an absolute maximum handover time of 45 minutes by October 2025.



Long ambulance handover delays are a very significant issue across North Wales with evident variation in performance. Ambulances are taking fewer people to hospital than before the pandemic, with 11,000 conveyances in January 2025 compared to 15,000 in January 2024 across Wales (Source JCC indicators). Hours lost due to ambulance handover delays have doubled for the same period. Whilst the number of ambulance handover delays remain high there has been an improvement across quarter 1.

The health board commenced a rapid improvement programme from the end of July 2025 to support implementation of the MAG 45 recommendation.

A task and finish group with representation from each IHC has been established with:

- Heads of Nursing Emergency quadrants,
- Directorate General Managers Emergency quadrants,
- Clinical leads for Emergency quadrants,
- Heads of Site management from each Acute Site,
- WAST Head of Service and Project support,
- BCUHB Associate director for Urgent and Emergency Care and Project support.
- NHS Executive – Performance and Improvement, along with Goal 4 Lead.
- Deputy Executive Medical Director.

A programme initiation document aligns 6 Goals for Urgent and Emergency Care, Ministerial priorities, and getting it right first time (GIRFT) to reduce duplication.

On 26 August 2025 NHS Performance and Improvement commence 90 day cycles of improvement that will be monitored through fortnightly MAG 45 meetings to ensure clear progress. Metrics for improvement are in the process of being developed to ensure a clear programme of improvement over the coming months.

e. Implement the Optimum Hospital Flow Framework (OHFF)

The Optimal Hospital Flow Framework was the first framework to be published by the National 6 Goals programme. The aim is to ensure the delivery of optimal outcomes and experience for people in hospital across Wales and provides operational guidance to improve patient flow and deliver timely pathways of care. The OHFF brings together the tools required to support improved patient experience and clinical outcomes, through the delivery of high quality treatment and timely transfer home or to a more appropriate setting, for adults admitted to acute or community hospital sites.

The guidance is based around four ‘what matters to me’ questions, which all professionals must be able to answer for every person within their care;

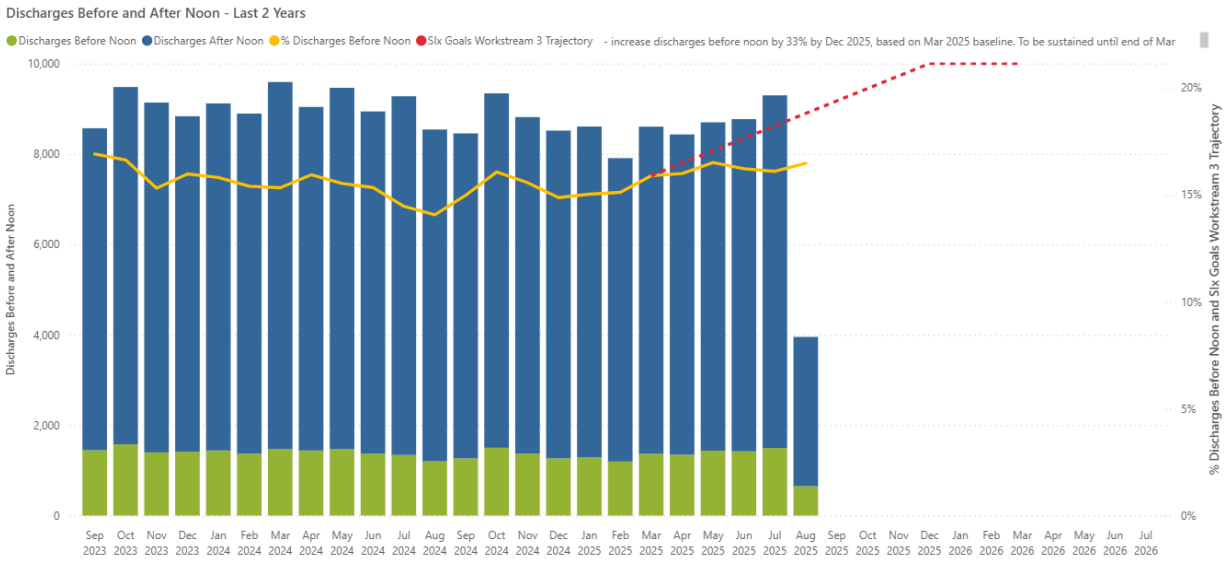
1. What do you think is wrong with me?
2. What is going to happen today?
3. What needs to happen to get me home and what can I do to speed things up?
4. When can I go home?

Patients, their families and carers must be central to all decision-making and their views should always inform the answers to these questions. These four questions are designed to ensure that people receiving care are clear on how their needs are being met by health and social care services.

It has been acknowledged across Wales that whilst the intention was for the OHFF to be utilised by front line staff, without dedicated resources to deliver front line training the rollout and improvements in patient flow were limited due to constraints of staff working within systems under extreme pressure.

Following successful negotiations with the national 6 Goals programme funding for two wte OHFF facilitators was secured and an initial rollout commenced in Ysbyty Glan Clwyd. Training involves engagement with key stakeholders, delivery of training to frontline staff over four weeks, including ward-based resources to support implementation of the OHFF. The training includes board round principles, ensuring patients have value added actions undertaken every day, and using the STREAM digital system. This is viewed as an example of good practice nationally.

Key Performance Indicator - Discharges by midday: 33% by end of December 2025, sustained until end of March 2026



The percentage of discharges before noon has remained static during the quarter and remains below the trajectory; there were slight improvements in the number of discharges before noon.

The OHFF facilitators have delivered training to a total of 193 individuals, with additional stream users stream identified and provided with access and training to ensure real time recording of patient discharge information. The recording of this patient information is now being updated on STREAM out of hours, evenings and weekends, providing clinical colleagues and operational managers with an updated position.

Key Actions Delivered Q1

Review of opportunities using the STREAM platform to assist board rounds.

Agreement of Clinically Optimised consistent recording across North Wales with health and social care colleagues to ensure consistent approach to understanding of delays for those individuals who no longer require a bed within a health care setting.

Audit of discharge to recover pathways completed, highlighting variation across North Wales against agreed national definitions within the OHFF.

All simple discharges (pathway “0” patients) now regularly discussed as part of the daily system resilience calls. Patients can be clearly identified on the Right Patient Right Place dashboard.

Key Actions Next Quarter

Development and agreement of SOP for board rounds, predicted date of discharge and clinical criteria for discharge to facilitate improved patient flow.

Audit of end-to-end discharge process, led by Transformation and Improvement Cymru colleagues to be completed (following anomalies being highlighted during the audit between acute and community hospitals and regions.

Continued roll out and evaluation of OHFF through direct training to ward resources and also through training to professional groups to further improve on roll out and understanding.

5. Key Risks To Delivery

There are risks associated with the delivery of IMTP aspirations for UEC improved performance by 31st March 2026;

- The move of the UEC Major Change Programme away from the operational directorate to be hosted within the Transformation and Strategic Planning runs the risk of the programme being more distant from operational teams. This distance risks the programme being less sighted on the latest operational pressures and could impact successful adaption and adoption of the programmes.
- The ability to deliver improvement particularly with our Local Authority Partners is impacted by the temporary nature of the funding allocated across the UEC system and annual changes in the criteria applied to its use by Welsh Government brings risks around its effectiveness. Any delays in releasing the funding puts pressure on the ability to spend it in year and its temporary nature and annual change in criteria applied to its use mean exit strategies are required find alternative sources of funding within a relatively short period of time.
- The lack of organisational maturity in prioritisation and de-prioritisation risks successful delivery of the health board strategy, as it will be necessary move resources from secondary care services to primary and community as well as prevention. A key enabler to this is sufficient intelligence and insight into where the health board currently spends its budget.
- There is a risk that the work of the Transformation and Strategic Planning team does not translate into real change and improved outcomes for the population due to issues with competing pressures, acceptance, adoption, embedding then sustaining the change. A key dependency in this is effective clinical leadership.

Summary

Key performance measure	Q1 Position	Trend
Implementation of the community based falls response		
Conveyance of L1 and L2 fallers to be reduced by 10% by end of December 2025 against a March 2025 baseline, with a further 25% reduction by the end of March 26.	meeting trajectory	improving position
Implementation of the remote clinical assessment services framework - Single Point of Access		
Reduce conveyance from care homes by ambulance to ED: no higher than 50% conveyance rate by end of December 2025, sustained until the end of March 2026	meeting trajectory	improving position
Implementation of acute frailty service (AFS) at the front door		
TBC following release of acute frailty framework. 85% of same day emergency care (SDEC) referrals discharged on same day	not meeting trajectory	static position
Implementation of the Welsh Health Circular - Ambulance Handover Guidance		
In line with the Ministerial Advisory Group report, Health Boards should ensure that no ambulance handover should exceed 45 minutes, with a focus on achieving the 15 minute handover target wherever possible.	not meeting trajectory	improving position
Implement the Optimum Hospital Flow Framework (OHFF)		
Discharges by midday: 33% by end of December 2025, sustained until end of March 2026	not meeting trajectory	improving position

The improvements made through the UEC programme support operational delivery and therefore the special measures de-escalation performance indicators summarised below

Key performance measure	Q1 Position	Trend
Ambulance Handover Delay		
(superseded by measure 4 above)		
Time to clinician		
Median time from arrival at an emergency department to assessment by a clinical decision maker should not exceed 60 minutes	not meeting trajectory	improving position
12-hour breaches in Emergency Departments & Minor Injury Units		
Continuous improvement towards no more than 10% of patients waiting over 12 hours at each individual site and across the health board	not meeting trajectory	improving position
Pathway of Care Delays (PoCD)		
Continuous reduction of 5% in pathways of care delays for 3 consecutive months and then maintained for 4 months	meeting trajectory	improving position

In summary, the report highlights that some of the key performance measures are on trajectory, a number have shown insufficient or no improvement

The key areas of concern predominantly focus on the emergency department; however poor patient flow is impacting on our ability to create the necessary capacity to be able to significantly improve on these areas.

The improvement actions are not delivering the improvement at the required pace and scale across the UEC system to address the significant impact of delays and long length of stay have on the population of North Wales.

Appendix 2 – Ministerial Advisory Group recommendation 15 in relation to Ambulance handovers not exceeding 45 minutes from October 2025 (MAG 45) Report

1. **Cyflwyniad / Cefndir / Introduction/Background**

A report from the Ministerial Advisory Group on NHS Wales Performance and Productivity was released in April 2025 with key recommendations, one being (15) that no ambulance should be held outside a hospital for greater than 45 minutes.

Part of the Welsh Government response was to ensure Health boards have plans in place to commence delivering on the request by October 2025.

2. Corff yr adroddiad / *Body of report*

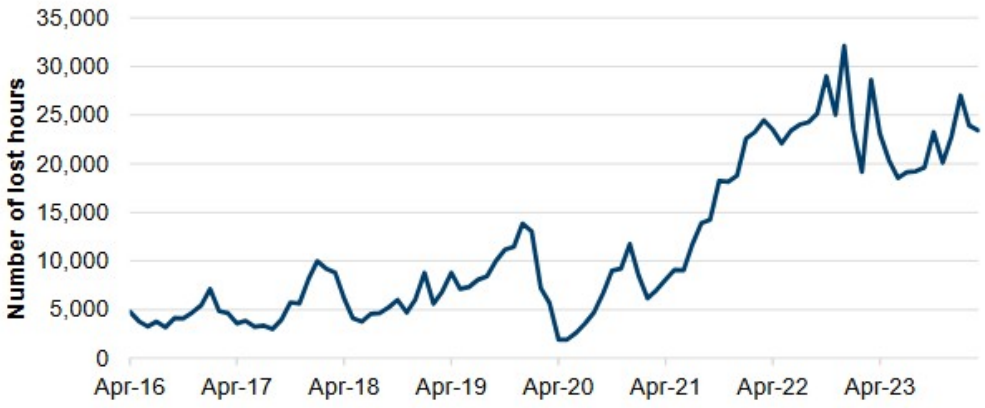
Ambulance Handovers – MAG 45

Patients using ambulance services and emergency departments are experiencing long waits and while the clinical care is generally good, these delays lead to poor experience, and hospitals in the community wait linger for an ambulance response. impact detrimentally on patient experience and outcomes.

Emergency Department (ED) attendances in 2024 were 8.7% higher than 2017 partly driven by population changes and in part by changes in how patients use the service. Ambulance call-out rates have not grown at the same rate, although there has been a recent spike in (Red) 999 calls. However, response times are 50% longer for life threatening (Red) 999 calls than in 2019. For serious but not immediately life threatening (Amber) calls they are over 200% longer, on average. Fewer than 70% of patients were admitted, discharged or transferred from the emergency departments within 4 hours in 2023/24, compared to over 82% in 2015/16, and a target of 95%. Over one in 10 attendances currently exceed 12 or more hours.

This congestion and lack of flow has a direct impact on ambulance handovers and over 260,500 hours were lost to handover delays in 2023/24 compared to 112,057 hours in 2019/20. The Welsh Ambulance Services NHS Trust (WAST) estimated that a quarter of the fleet were outside of a hospital on average throughout December 2024, with an estimated cost of £46 million of productive time lost across 2024.

Lost hours for the ambulance service following notification to handover at emergency departments, April 2016 to March 2024



Source: Ambulance Service Indictors, Ambulance Service Indicators - NHS Wales Joint Commissioning Committee

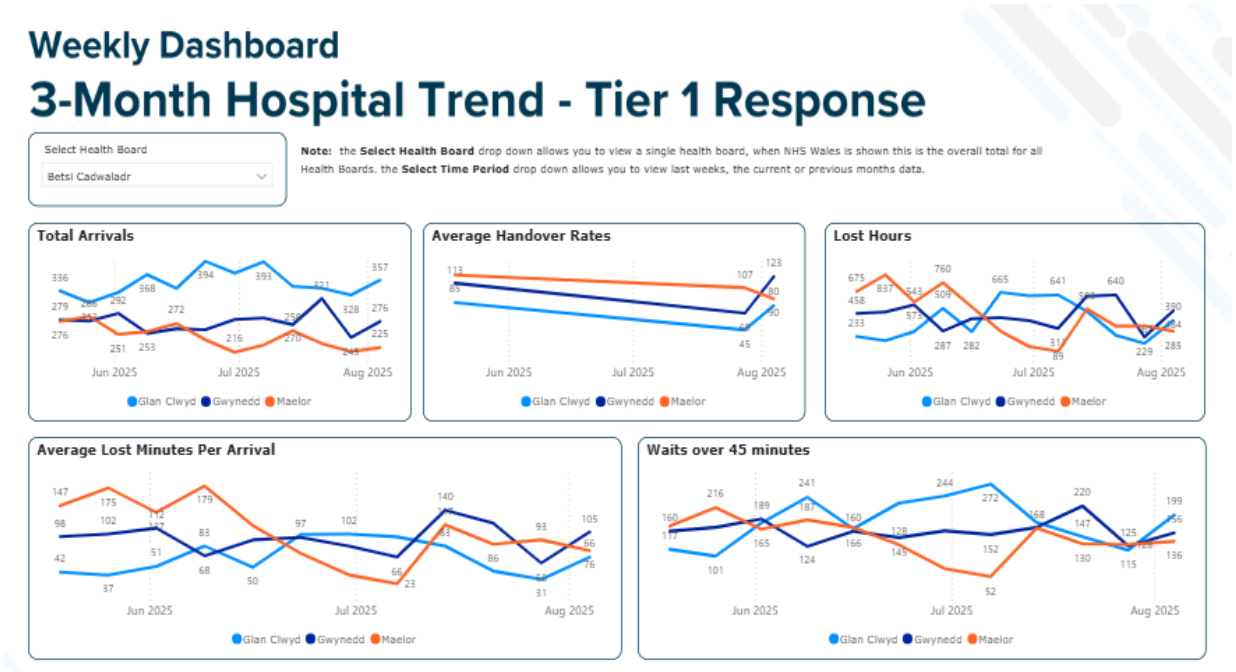
Appendix 2 – Ministerial Advisory Group recommendation 15 in relation to Ambulance handovers not exceeding 45 minutes from October 2025 (MAG 45) Report

Long ambulance handover delays are a very significant issue across North Wales with evident variation in performance. Ambulances are taking fewer people to hospital than before the pandemic, with 11,000 conveyances in January 2025 compared to 15,000 in January 2024 across Wales (Source JCC indicators). Hours lost due to ambulance handover delays have doubled for the same period.

The programme – MAG 45 does not replace the national Key performance indicator for health boards handover being 15 minutes.

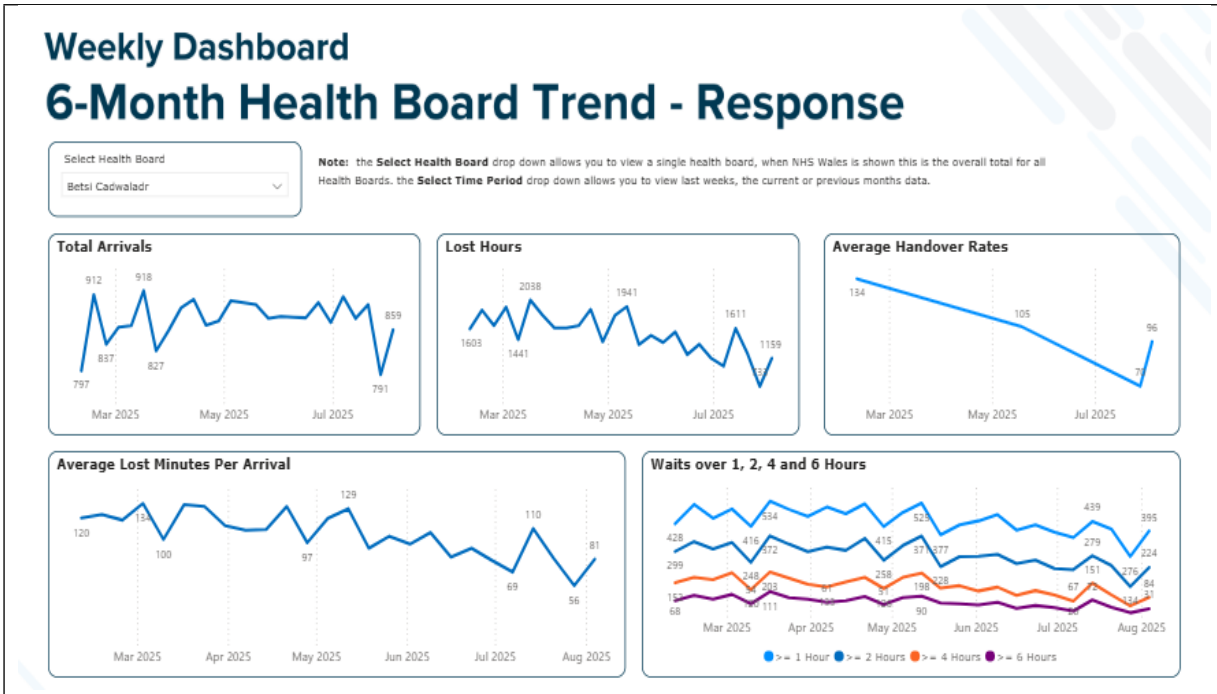
The health board commenced a rapid improvement programme from the end of July 2025 to support implementation of the MAG 45 recommendation.

Current Performance:



3 Month review of arrivals v lost hours.

Appendix 2 – Ministerial Advisory Group recommendation 15 in relation to Ambulance handovers not exceeding 45 minutes from October 2025 (MAG 45) Report



6 Month review of arrivals v lost hours.

The above data demonstrates over the last 6 months a fluctuating position in lost hours, despite periods of improvement. Noting a consistent reduction in ambulance arrivals in the East IHC and continued increasing arrivals in the Central IHC.

With the IHCs supporting the zero-tolerance approach, a marked improvement is predicted over the coming months with a reduction in lost hours across BCUHB.

Implementation of recommendations:

A task and finish group with representation from each IHC has been established with:

- Heads of Nursing Emergency quadrants,
- Directorate General Managers Emergency quadrants,
- Clinical leads for Emergency quadrants,
- Heads of Site management from each Acute Site,
- WAST Head of Service and Project support,
- BCUHB Associate director for Urgent and Emergency Care and Project support.
- NHS Executive – Performance and Improvement, along with Goal 4 Lead.
- Deputy Executive Medical Director.

A programme initiation document aligns 6 Goals for Urgent and Emergency Care, Ministerial priorities, and getting it right first time (GIRFT) to reduce duplication.

On 26 August 2025 NHS Performance and Improvement commence 90 day cycles of improvement that will be monitored through fortnightly MAG 45 meetings to ensure clear progress. Metrics for improvement are in the process of being developed to ensure a clear programme of improvement over the coming months.

Areas already completed in the first 21 days:

Appendix 2 – Ministerial Advisory Group recommendation 15 in relation to Ambulance handovers not exceeding 45 minutes from October 2025 (MAG 45) Report

High risk patients (Falls/Breathing problems)

1) Falls strategy completed to support the 10% reduction in conveyances.
2) Fall non-injury on blood thinners will be offered the opportunity to attend by appointment (if required and clinically safe) to prevent prolonged delays on the forecourts due to low acuity.
3) Breathing problems – dashboard for data awareness in place, discussions commenced with WAST clinical desks to utilise consultant connect for support / advice for chronic patients.

Hospital response to Urgent and Emergency care Pressures.

1) Acute sites have completed the first submission to review escalation processes, emergency department processes (e.g. rapid access triage) along with hourly flow, which will be the focus of a national UEC visit on the 15/16 September.

2) Acute sites are reviewing 3 schemes (1 per IHC) to support improvement:

- Shift change handover process – reduce lost hours due to shift change.
- Call before conveying – allows facility for ED clinician to screen call and guide to alternative pathway safely i.e: SDEC, acute medicine.
- Rapid access triage (RAT) – supports a rapid clinical assessment on arrival and allows for direct streaming to other services.

Summary

The aim is to ensure that from October 2025 there will be a zero tolerance to delays over 45 minutes across North Wales, supported by a process to review/escalate when delays occur that focusses on clear actions to support.

Fortnightly updates will be provided to give assurances along with an overarching monthly update to ensure clear oversight of performance across BCUHB that will support internal and external assurances on programme delivery.

3. Rheoli Risg / Risk Management

Board Assurance Framework (BAF) describes the risks that: "…*the provision of poor standards of care to the patients and population of North Wales, falling below the expected standards of quality and safety, resulting in a deterioration of care and harm to patients and service users*" and "*Failure to effectively manage unscheduled care demand and capacity infrastructure, adversely impacting on quality of care and patient experience"* Mitigating actions to reduce harm, improve patient outcomes and better patient and staff experience across the urgent and emergency care system will be aligned with the 6 Goals Programme of improvement programme work together with improvement plans and trajectories.

Teitl adroddiad: ***Report title:***	Executive Summary – Legal Report (Quarter 1, 2025/26)
Adrodd i: ***Report to:***	Performance, Finance and Information and Governance Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	26 August 2025

Crynodeb Gweithredol: ***Executive Summary:***	This report provides a comprehensive overview of legal activity and developments across BCUHB for Quarter 1 of 2025/26. It is the first in a new quarterly reporting format and offers assurance regarding the delivery of the legal services plan.
	
	Key Highlights:
	
	• **Legal Services Transformation**: Implementation of the 2024–2027 Transforming Legal Services Plan is progressing, with recruitment, professional development, and digital infrastructure enhancements underway. A legal case database and intranet site are in development, with digital referral forms launching next quarter.
	• **Clinical Negligence**: 91 new cases opened. Overdue Learning from Events Reports (LFERs) reduced from 86 to 7, reflecting improved internal processes.
	• **Personal Injury**: 12 new cases opened, with an estimated £122,000 in cost avoidance. A thematic risk around hand/arm vibration injuries was identified and addressed.
	• **Redress**: Proposed changes to NHS Redress Regulations include doubling the financial threshold and halving the resolution timeframe. A separate paper has been submitted to the Executive Committee.
	• **Inquests**: Two cases involved findings of neglect, one resulting in a Regulation 28 Prevention of Future Death Notice. Concerns were raised about the quality and dissemination of internal investigations.
	• **Commercial & Fraud**: A new Case Resolution and Recovery Agreement was developed, showcasing the value of in-house legal support.
	• **Employment**: Legal support continues in sensitive matters
	• **Governance & Regulatory**: The Health Board was fined £250,000 following an HSE prosecution. A judicial review challenging EMRTS reconfiguration was dismissed.
	• **Legal Updates**: The report outlines key legislative developments including:
	  ○ Mental Health Bill 2025
	  ○ Delay to Liberty Protection Safeguards
	  ○ UK Supreme Court ruling on the legal definition of “woman”
	  ○ Digital regulation and employment rights reforms
	  ○ Martyn’s Law (Terrorism Protection of Premises Act)
	
	The report reinforces the Legal Services Department’s role as a strategic partner in supporting organisational learning, risk mitigation, and legal compliance.

Argymhellion: ***Recommendations:***	The Committee is asked to **NOTE** this report.
Arweinydd Gweithredol: ***Executive Lead:***	Pam Wenger, Director of Corporate Governance

Awdur yr Adroddiad: ***Report Author:***	Matthew Joyes, Deputy Director for Legal Services			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☐	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☒ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
N/A				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Objective 1 - Building an effective organisation.			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	This report provides a Legal Report; the paper itself contains data and commentary on legal matters.			
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	No adverse equality impacts have been identified.			
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	No adverse socio-economic impacts have been identified.			

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)***	This report provides a Legal Report; the paper itself contains data and commentary on legal risks.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	This report provides a Legal Report; the paper itself contains data and commentary on legal related financial matters.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	No adverse workforce impacts have been identified.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	N/A
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	N/A
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	This paper contains information subject to commercial confidence, legal advice privilege and litigation privilege.
Camau Nesaf: ***Next Steps:*** N/A	
Rhestr o Atodiadau: ***List of Appendices:*** N/A	

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Quarterly Legal Report

Quarter 1 – 2025/26

Produced by:

Legal Services Department
Corporate Governance Directorate

Non-Confidential Version

CONTENTS

EXECUTIVE SUMMARY

This report provides the Committee with an overview of legal activity and developments for Quarter 1 of 2025/26.

It marks the first iteration of the new quarterly reporting format and feedback is welcomed to support its ongoing refinement.

Key highlights include:

Legal Services Transformation: The Legal Services Department continues to implement the 2024–2027 Transforming Legal Services Plan, with progress in recruitment, professional development, and digital infrastructure. A new legal case database and intranet site are in development, and digital referral forms will be launched next quarter.

Clinical Negligence: 91 new cases were opened. Overdue Learning from Events Reports (LFERs) have significantly reduced from 86 to 7.

Personal Injury: 12 new cases were opened, with an estimated £122,000 in cost avoidance. A thematic risk around hand/arm vibration injuries was identified and addressed.

Redress: Proposed changes to the NHS Redress Regulations include doubling the financial threshold and halving the resolution timeframe. A separate paper has been submitted for Executive Committee consideration.

Inquests: Two cases involved findings of neglect, with one resulting in a Regulation 28 Prevention of Future Death Notice. Concerns were raised about the quality and dissemination of internal investigations.

Mental Health Law: Some fundamental errors in the Mental Health Act were identified due to procedural errors. Immediate mitigations have been implemented, and the matter will be formally reported to governance committees.

Commercial and Fraud: A new Case Resolution and Recovery Agreement has been developed, demonstrating the value of in-house legal support.

Employment: Legal support continues in sensitive matters, including a harassment case involving a former employee now facing criminal charges.

Governance and Regulatory: The Health Board was fined £250,000 following a Health and Safety Executive prosecution. A judicial review challenging the EMRTS reconfiguration was dismissed by the High Court.

Legal Updates: The report outlines key legislative developments, including the Mental Health Bill 2025, delays to Liberty Protection Safeguards, and the UK Supreme Court's ruling on the legal definition of "woman." Updates also cover digital regulation, employment rights, and Martyn's Law.

The report provides significant assurance regarding the delivery of legal services and highlights the department's growing role as a strategic partner in supporting organisational learning, risk mitigation, and legal compliance.

LEGAL IMPROVEMENTS

The **Legal Services Department** operates within the **Corporate Governance Directorate** and is led by the Deputy Director for Legal Services, reporting to the Director of Corporate Governance. The Deputy Director role includes lead professional supervision of the legal function and oversight of legally qualified staff. The Deputy Director is a member of the Chartered Institute of Legal Executives (CILEX) and is a regulated legal professional under CILEX Regulation (CRL).

Since its integration into the Corporate Governance Directorate, the department has been implementing the *Transforming Legal Services Plan (2024–2027).* The initial phase, spanning 2024 and 2025, focuses on strengthening internal capacity and legal processes. The long-term vision is to establish a high-performing, professional in-house legal team capable of meeting the complex and evolving needs of the Health Board as a strategic legal partner.

Following the Executive Team's approval of the Case for Change in January 2025, the department is now progressing with the recruitment of in-house legal professionals. A structured professional development programme is also underway to support internal staff in achieving formal qualifications and regulatory status as Paralegals, Chartered Paralegals, or Chartered Lawyers. Over the next three years, the department aims to support approximately 12 staff members through this pathway, with up to 8 expected to qualify as regulated lawyers.

To support these developments, the department has secured access to a professional legal research platform. In the coming quarter, digital legal advice and case referral forms will be introduced to streamline the intake process. Additionally, work is ongoing to develop a legal case database, either within Datix or through a bespoke solution in the Microsoft O365 environment. A new Legal Services intranet site is also in development to provide staff with quick and easy access to legal guidance and resources.

To further support organisational learning, the department is producing biannual *Legal Learning Reports* covering key areas such as claims, inquests, and redress.

It is important to remind the Committee that, at present, any service within the organisation may engage directly with NWSSP Legal and Risk Services or external law firms. As a result, the Legal Services Department is not routinely informed of all legal matters, and this report should not be considered exhaustive. The department is currently working to implement the Executive Team's decision to introduce a gatekeeping and oversight process. This new approach (dependent on the development of electronic forms and a case management system) is expected to be operational by 01 October 2025.

CLINICAL NEGLIGENCE

Overview

During the quarter, 91 new clinical negligence cases were opened of which 11 were confirmed cases (the remainder being potential cases). 18 cases were closed during the last quarter.

Learning from Events Reports (LFERs) - *also applicable to redress and PI cases*

Under the Welsh Risk Pool (WRP) Reimbursement Procedures, the Health Board is required to complete a Learning from Events Report (LFER) for each claim or redress case. These reports are a critical mechanism for identifying issues, evidencing how they have been addressed, and demonstrating actions taken to reduce the risk and impact of similar events recurring in the future.

Like several other NHS bodies in Wales, the Health Board has faced ongoing challenges with the timeliness of LFER submissions. Delays often occur within services that struggle to provide robust evidence of learning and sustained improvement – particularly given that the time between an adverse event and the settlement of a claim can span several years.

However, significant progress has been made. At the end of Quarter 1, the number of overdue LFERs had reduced to 7 – down from 86 at the beginning of the year. This substantial improvement reflects the concerted efforts to clear the backlog and the positive impact of the new process introduced by the Legal Services Department in January 2025.

The department has also shared its approach and learning at national forums, contributing to wider improvement efforts across NHS Wales.

PERSONAL INJURY

Overview

During the quarter, 12 new personal injury cases were opened of which 10 were confirmed cases (the remainder being potential cases). 5 cases were closed during the last quarter.

The Legal Services Department estimate around £122,000 has been "saved" in personal injury claims in the quarter. This includes £85,000 from a claim redirected to another organisation, around £10,000 from negotiations on costs and £18,000 from claims withdrawn after serving a robust defence.

Theme: Hand Arm Vibration

A theme was identified with hand/arm vibration injuries in one estates team – as a result targeted advice was offered to the estates team and health and safety team to help minimise the risk of future personal injury claims.

REDRESS

Overview

A separate paper has been written for the Executive Committee in August 2025 proposing changes to the Redress process.

Proposed changes to the NHS Redress Regulations

The Welsh Government has proposed a series of changes to the NHS Wales Redress Scheme, as part of a broader review of the Putting Things Right (PTR) process. These changes aim to modernise how concerns and complaints about NHS care are raised, investigated, and resolved, ensuring the system is fit for current and future needs.

The key changes that are proposed for Redress include an increase in the maximum financial threshold, from £25,000 to £50,000 and a reduction in the time available to complete Redress from 12 months down to 6 months (180 days).

It is understood the Senedd will vote on these changes on 14 October 2025.

A further impact assessment will be considered in due course, in partnership with other teams affected by wider changes to PTR such as the Complaints Team.

CORONER INVESTIGATIONS AND INQUESTS

Prevention and Future Death Notices

The Health Board received one Regulation 28 Prevention of Future Death (PFD) Notice, in May 2025. In this case, the Coroner also determined death (which occurred in July 2023) was contributed to by Neglect.

The Coroner found there were missed opportunities to identify concerns on the midwifery led unit including properly conducting holistic assessments, properly completing partogram and manual palpation of maternal pulse, which would also likely have resulted in earlier detection of distress and successful delivery. In the PFD the Coroner raised concerns that:

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

Findings of Neglect

In addition to the case above, a further Neglect rider was determined at an inquest which concluded in June 2025 which related to a patient who died of physical health complications at Ty Llewellyn medium secure mental health unit in 2021. The Inquest Jury found death was contributed to by

Neglect and a number of issues in care were identified in physical health care monitoring and escalation. No PFD was issued.

In coronial proceedings, a “neglect rider” refers to a formal finding that neglect contributed to a person’s death. It does not imply legal negligence in the civil or criminal sense, but rather denotes a gross failure to provide basic care to someone who was dependent on others. For such a finding to be made, the coroner or jury must be satisfied, on the balance of probabilities, that this failure materially contributed to the death. Neglect findings are particularly significant in healthcare settings, as they highlight systemic or procedural shortcomings.

HEALTHCARE

Mental Health Act

A recent audit identified six instances of fundamental errors in the application of Section 3 of the Mental Health Act 1983, due to procedural errors in the renewal process. Specifically, the statutory requirement for two professionals from different disciplines to complete the renewal (HO15) forms was not met - each case involved signatories from the same profession, rendering the detentions legally invalid.

The affected patients were promptly reassessed and lawfully re-detained once the issue was discovered. Apologies and explanations were issued to the individuals and their Nearest Relatives. While the quality of clinical care and statutory safeguards remained intact throughout, the procedural breach constitutes a violation of the Mental Health Act.

The root cause analysis highlights failures by clinicians involved to comply with the Act, failure of unit managers to scrutinise paperwork, and significant staffing pressures within the Mental Health Act Team which led to lapses in secondary scrutiny and delayed detection. Immediate mitigations include the issuance of a joint memo clarifying legal requirements, restoration of audit functions, and a review of the team’s staffing model to ensure future resilience.

This matter will be formally reported to the Executive Team and Mental Health Legislation Committee in August 2025.

COMMERCIAL, PROPERTY AND INFORMATION

Case Example: Fraud Agreement

The Legal Services Department has worked in partnership with the Local Counter Fraud Team to develop a Case Resolution and Recovery Agreement (a legally enforceable framework designed to support the recovery of funds obtained through fraudulent means).

This example demonstrates the value of a responsive and cost-effective in-house legal function in supporting fraud prevention and financial recovery efforts.

EMPLOYMENT

Overview

The Director of Corporate Governance and Deputy Director for Legal Services met with the senior leadership of People and OD Services to explore the increased governance being applied to legal services. Further information on employment matters will be included in later reports.

GOVERNANCE AND REGULATORY

HSE Prosecution

In April 2025, the Health Board was fined £250,000 following a prosecution by the Health and Safety Executive (HSE) for failing to adequately manage the risk of patient falls within its hospitals. The case arose from the deaths of three elderly patients between 2022 and 2023 at Ysbyty Gwynedd and Wrexham Maelor Hospital.

The court found that the Health Board had not implemented effective falls risk assessments or provided sufficient staff training, despite previous enforcement actions and repeated warnings. The Health Board pleaded guilty to breaching Section 3(1) of the Health and Safety at Work etc. Act 1974 and was also ordered to pay £11,766 in costs.

This case underscores the critical importance of robust patient safety systems and the need for sustained compliance with regulatory requirements.

Judicial Review of the EMRTS Decision

On 19 June 2025, the High Court dismissed a judicial review brought by Lowri Evans (a resident of North Wales) challenging the decision by the NHS Wales Joint Commissioning Committee (JCC) to restructure the Emergency Medical Retrieval and Transfer Service (EMRTS), which operates in partnership with the Welsh Air Ambulance Charitable Trust. The reconfiguration involved consolidating two existing air ambulance bases in Welshpool and Caernarfon into a single North Wales site with extended operating hours.

All seven health boards were named as the defendants, given the JCC is a joint committee of those organisations.

The claimant argued that the decision was irrational, particularly because it failed to account for the costs and implications of a parallel proposal to develop a bespoke road-based critical care service in remote areas. This, she contended, was a necessary mitigation for the closure of the existing bases. However, the court accepted the defendant position that the road-based service was a separate initiative and not integral to the EMRTS restructuring decision.

Mr Justice Turner emphasised a pragmatic approach to judicial review, cautioning against overly technical readings of decision-making documents. He concluded that the JCC had acted within its powers and had not breached consultation obligations or the public sector equality duty. The judgment reinforces the principle that courts should focus on the substance of public authority decisions rather than minor textual inconsistencies.

An appeal was submitted by the claimant and on 01 July 2025; the application was dismissed by the court on all grounds. The claimant has now appealed to the Court of Appeal.

LEGAL UPDATES

Mental Health Bill

The UK Government has introduced the Mental Health Bill 2025, which proposes significant reforms to the Mental Health Act 1983. These reforms are grounded in the recommendations of the Independent Review led by Professor Sir Simon Wessely and are designed to modernise mental health legislation in England and Wales. The overarching aim is to enhance patient autonomy, improve safeguards, and ensure that the use of compulsory powers is more proportionate and justified.

A central feature of the proposed changes is the strengthening of patient rights. The Bill places greater emphasis on involving individuals in decisions about their care and treatment. It introduces statutory principles that prioritise choice and autonomy, therapeutic benefit, the least restrictive option, and respect for the individual. These principles are intended to guide all decisions made under the Act and to ensure that patients are treated with dignity and respect.

The criteria for detention under sections 2 and 3 of the Act are being revised to require a demonstrable risk of serious harm to the individual or others. This change introduces a higher threshold for compulsory admission, with two new tests that must be satisfied: the likelihood of serious harm and the necessity of detention. These measures are designed to reduce inappropriate or unnecessary detentions and to ensure that the use of the Act is more targeted and justified.

The Bill also addresses the longstanding issue of inappropriate detention of individuals with learning disabilities and autism. Under the proposed reforms, such individuals will no longer be detained under the Act solely on the basis of their condition, unless there is a co-occurring mental health disorder that justifies such action. This change reflects a broader commitment to person-centred care and the reduction of institutionalisation.

In response to concerns about racial disparities in the application of the Act, the reforms include measures aimed at tackling inequalities in detention and treatment. This includes improved data collection and monitoring, as well as initiatives to ensure culturally appropriate care and greater community engagement.

The Bill is entering its final stages of debate in the House of Commons. The UK government has set out an indicative plan for implementing the bill. The first priority would be the new code of practice (which would take a year) and the secondary legislation, which would provide further detail on aspects of the legislation. Wales has its own code of practice so implementation may vary.

There would be training of the existing workforce in 2026-27 and commencement of the “first major phase of reforms in 2027”. The government estimates it will take up to 10 years to fully implement the bill.

Liberty Protection Safeguards

The UK Government has confirmed that the implementation of the Liberty Protection Safeguards (LPS) will not proceed during the current parliamentary term. Originally introduced under the Mental Capacity (Amendment) Act 2019, the LPS were intended to replace the Deprivation of Liberty Safeguards (DoLS) with a more streamlined and robust framework for authorising the deprivation of liberty for individuals aged 16 and over who lack capacity to consent to their care arrangements.

This decision has been met with widespread concern from stakeholders across the health and social care sector. Advocacy organisations, local authorities, and the Welsh Government have criticised the delay, highlighting the continued reliance on the outdated DoLS framework. Critics argue that this postponement undermines efforts to protect the rights of individuals who may be unlawfully deprived of their liberty under current arrangements.

In the absence of LPS implementation, health and social care providers are expected to continue using the DoLS system and ensure that appropriate authorisations are in place. The situation remains under review, but no further commitments have been made by the current government regarding the future of the LPS.

UK Supreme Court Decision on the Definition of “Woman”

On 16 April 2025, the UK Supreme Court delivered a landmark judgment in the case of *For Women Scotland Ltd v The Scottish Ministers.* The case centred on the legal definition of the term “woman”

under the Equality Act 2010 (EA 2010), particularly in the context of the Gender Representation on Public Boards (Scotland) Act 2018. The Scottish legislation aimed to improve gender balance on public boards and had defined “woman” to include individuals with the protected characteristic of gender reassignment, including those who live as women or hold a Gender Recognition Certificate (GRC).

The Supreme Court unanimously ruled that, for the purposes of the Equality Act 2010, the term “woman” refers to biological sex. The Court held that while the Gender Recognition Act 2004 allows individuals to change their legal gender, this does not alter the interpretation of “sex” under the EA 2010. Consequently, the legal protections and provisions related to sex discrimination in the Equality Act apply based on a person’s biological sex, not their acquired gender.

The judgment provides legal clarity and consistency in the application of the Equality Act, particularly for employers, service providers, and public authorities. It confirms that sex-based rights and protections—such as the ability to provide single-sex services—must be interpreted with reference to biological sex. However, the Court also reaffirmed that transgender individuals retain protection under the Equality Act through the separate protected characteristic of gender reassignment.

This decision has significant implications for equality law, public policy, and the provision of sex-based services. It underscores the importance of precise statutory interpretation and the limits of devolved legislative competence in areas reserved to the UK Parliament, such as equal opportunities.

Digital Regulation

The UK has seen significant movement in digital regulation. The Online Safety Act entered a new phase of implementation, placing enhanced duties on tech platforms to protect users (particularly children) from harmful content. Ofcom’s enforcement powers have expanded, and platforms must now demonstrate proactive risk assessments and content moderation systems.

Additionally, the Data (Use and Access) Act introduced a new criminal offence for creating or sharing "purported intimate images" without consent, closing a loophole in existing image-based abuse laws. While not UK legislation, the EU AI Act has extraterritorial implications for UK businesses offering AI services in the EU, requiring compliance with strict transparency, risk classification, and prohibited use provisions.

Employment Rights Bill

The Employment Rights Bill made substantial progress through Parliament. It proposes to enhance protections for “gig economy” and zero-hours contract workers, including the right to request predictable working patterns and improved enforcement of holiday pay and sick leave entitlements. The Bill also aims to make flexible working a default right from day one of employment, reflecting post-pandemic shifts in workplace expectations.

Terrorism (Protection of Premises) Act

The Terrorism (Protection of Premises) Act, also known as "Martyn’s Law", was passed in April. It introduces a tiered duty on public venues to implement proportionate security measures against terrorist threats. Following scrutiny in the House of Lords, the final version includes safeguards to limit ministerial overreach and ensure proportionality in enforcement. The Act will impact NHS facilities that fall under the definition of "qualifying premises". This means NHS bodies will need to assess their premises and events to determine if they are subject to the requirements of the Act. The Act will be implemented after a 24-month period, during which time statutory guidance will be published to help those responsible for premises and events understand their obligations.

Archwilio Cymru
Audit Wales

Tackling the Planned Care Challenges – Betsi Cadwaladr University Health Board

Date issued: May 2025

Document reference: 4664A2025

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Contents

Summary report

About this report

1 This report sets out the findings of work on planned care recovery that we have undertaken at Betsi Cadwaladr University Health Board (the Health Board) to examine the progress it is making in tackling its planned care challenges and reducing its waiting list backlog. The work has been undertaken to help discharge the Auditor General's statutory duty under section 61 of the Public Audit (Wales) Act 2004 to be satisfied that the Health Board has proper arrangements in place to secure the efficient, effective, and economic use of its resources. Our work was delivered in accordance with INTOSAI[1] audit standards. This report excludes any examination of waits relating to cancer diagnosis and treatment, which are the subject of a separate examination by the Auditor General.

2 Tackling the planned care waiting list backlog is one of the biggest challenges facing the NHS in Wales. NHS waiting time targets in Wales have not been met for many years and the COVID-19 pandemic made an already challenging situation considerably worse as planned care services were initially postponed and then slowly re-started to allow the NHS to focus its attention on dealing with those seriously ill with the virus. Since the onset of the pandemic, the overall size of the NHS waiting list has grown significantly and at the end of February 2025 there were 614,150 individual patients waiting for treatment.

3 In April 2022, the Welsh Government published its Programme for Transforming and Modernising Planned Care and Reducing Waiting Lists in Wales. The programme includes £170 million recurring funding to support planned care recovery, together with an additional £15 million funding per year over four years to support planned care transformation. Welsh Government subsequently allocated a further £50 million between September 2024 and October 2024 to reduce the longest waiting times[2]. The programme includes specific targets and Ministerial priorities:

- that no one should wait longer than a year for their first outpatient appointment by the end of 2022 (**target date revised to December 2023**[3]);
- to eliminate the number of people waiting longer than two years in most specialties by March 2023 (**target date revised to March 2024**);
- people should receive diagnostic testing and reporting within eight weeks and therapy interventions within 14 weeks by Spring 2024; and

[1] INTOSAI is the International Organization of Supreme Audit Institutions

[2] Health Secretary response to latest NHS Wales performance data. The £50 million additional allocation comprised £28 million in September and £22 million in October 2024.

[3] Health Boards did not achieve the original targets for first outpatient appointment and number of people waiting longer than two years for treatment. As a result, the Welsh Government agreed to set interim targets (**in bold**, above).

- to eliminate the number of people waiting longer than one year in most specialties by Spring 2025.

4 In May 2022, the Auditor General for Wales published a commentary on "Tackling the Planned Care Backlog in Wales" which estimated that it could take up to seven years for the overall waiting list in Wales to return to pre-pandemic level. The commentary highlighted key areas for action, including:

- having strong and aligned local leadership to deliver the national vision for recovering planned care services;
- having a renewed focus on system efficiencies and new technologies;
- building and protecting planned care capacity; and
- communicating effectively with patients who are waiting for treatment and having systems in place to manage the clinical risks to those patients while they are waiting.

5 Our work has considered the progress Heath Board is making in tackling its planned care challenges and reducing its waiting list backlog, with a specific focus on:

- action that the Health Board has taken to tackle the planned care backlog;
- waiting list performance; and
- understanding and overcoming the barriers to improvement.

6 We undertook our work between October 2024 and February 2025. The methods we used are summarised in **Appendices 1 and 2**. **Appendix 3** provides some additional data analysis on planned care services and **Appendix 4** contains the Health Board's response to any recommendations arising from our work.

7 The Health Board is currently at Level 5 escalation under the NHS Wales escalation and oversight framework and it continues to rely on significant additional non-recurrent strategic funding allocation. Its financial position has a direct bearing on the affordability, sustainability and recovery of planned care services.

Key facts

£114.5m the amount of additional funding the Health Board has received from Welsh Government between 2022-23 and 2024-25 to support planned care improvement.

199,249 the overall size of the waiting list at February 2025.

103% the percentage growth in the overall waiting list between April 2019 and February 2025.

29,553 the number of patient pathways waiting more than 1 year for their first outpatient appointment at February 2025 against a national target of zero waiting. The number of 1 year waits for an outpatient appointment has increased by 22%, since April 2022.

8,304 the number of patient pathways waiting more than 2 years for treatment at February 2025 against a national target of zero waiting. The number of 2-year waits has reduced by 53% since April 2022.

62% the percentage diagnostic test waits that are within 8 weeks at February 2025 against a national target of 100%. The number of ‘over 8 weeks’ diagnostic waits has increased by 23% since April 2022.

89% the percentage of therapy waits that are within 14 weeks at February 2025 against a national target of 100%. The Health Board has achieved an 73% reduction of ‘over 14 weeks’ therapy waits since April 2022.

54,096 number waiting more than one year for treatment at February 2025 against a national target of zero for most specialties by Spring 2025. This has increased by 30% since April 2022.

Key messages

Overall conclusion

8 Overall, we found that **there are significant numbers of long patient waits indicating that the action the Health Board is taking to address this is not having the necessary overall effect. It needs to improve service efficiency, develop sustainable planned care improvements to meet growing demand, and strengthen reporting of harm that occurs as a result of a delay.**

Key findings

Action that the Health Board is taking to tackle the planned care challenge

- Whilst the Health Board has set out plans for securing short-term waiting list improvements, it has yet to sufficiently describe actions needed to secure more sustainable improvements to planned care services.
- Despite a clear structure, the Health Board's Planned Care Program Board lacks delegated decision-making authority to set direction and allocate resources. It needs to strengthen how it uses business cases to drive improvement initiatives and link these cases effectively to an agreed planned care improvement programme. Lack of continuity of senior planned care leadership has been detrimental to improvement.
- The Health Board has received a total of £114.5 million in additional Welsh Government funding. However, this has been allocated primarily towards short-term reactive solutions without investment in longer term service transformation.
- Whilst the Health Board has begun to implement the Getting It Right First Time (GIRFT[4]) recommendations, there remain opportunities to improve efficiencies, particularly in relation to improving utilisation of theatres and outpatient services to improve efficiency and productivity.
- The Health Board is making effective use of day surgery, with 83% of elective surgery performed as day case, the highest in Wales.
- The Health Board has been slow to implement the Welsh Government's Promote, Prevent and Prepare policy fully. Reporting on the incidence of harm associated with planned care waits needs to be improved.

[4] Getting It Right First Time (GIRFT) is a programme that aims to improve the quality and efficiency of hospital care.

Waiting list performance – Is the action taken resulting in improvement?

- In overall terms, the continued growing backlog of people waiting to be treated presents a substantial problem for the Health Board. The size of the waiting list has increased from 98,190 in April 2019 to 199,249 treatment pathways in February 2025.
- The Health Board has not met the recent national planned care recovery targets:
  - The number waiting over a year for their first outpatient appointment has increased from 24,265 patient pathways in April 2022 to 29,553 in February 2025.
  - The number waiting over 2 years for treatment has reduced from 17,500 patient pathways in April 2022 to 8,304 on February 2025.
  - The Health Board did not meet the target of increasing the speed of diagnostic testing and reporting to eight weeks and 14 weeks for therapy interventions by Spring 2024. In February 2025, there remained 10,067 patients waiting over 8 weeks for diagnostics and 1,565 patients waiting for therapies over 14 weeks.

Barriers to improvement

- There are a number of barriers to further planned care improvement. These include growing service demand, capacity to support service transformation and absence of clinical leadership. The Health Board recognises these challenges but has not yet developed an overarching strategy to address these. Initiatives which aim to address immediate capacity challenges are relatively new and short term in nature. Further work is required to develop sustainable and transformative solutions to ensure the Health Board does not continue to face the same or greater challenges in future.

Recommendations

9 We have set out recommendations arising from this audit in **Exhibit 1**. The Health Board's is currently developing its management response.

Exhibit 1: recommendations

Recommendations
Planning R1 Over and above the commitments signalled within its annual plans, the Health Board should develop a detailed Planned Care improvement plan. This should aim to both design and deliver sustainable planned care services in the medium to longer term and to take advantage of opportunities for further regional working. The plan should be costed, with realistic but challenging milestones within it. **(Exhibit 2)**
Demand and capacity R2 The Health Board should ensure that its demand and capacity modelling approach is consistently applied across the organisation and its specialties and used to inform short-term service capacity planning and longer-term service design. This should consider continued growth or expected changes in population demand for planned care services **(Exhibit 2).**
Programme governance and programme business cases R3 The Health Board should strengthen its Planned Care Programme Board to ensure it has the authority to set direction and deliver both transformational change and short-term capacity improvement by: 3.1 Strengthening the Programme Board's delegated authority arrangements to ensure it is the primary forum for all transformational and short-term capacity improvement funding **(Exhibit 3).** 3.2 Developing a clear planned care improvement programme for delivery, monitoring and associated accountability **(Exhibit 3).** 3.3 Improving training for planned care business case development to ensure quality of business cases and timely approval **(Exhibit 3).** 3.4 Prepare business cases earlier in the year or cyclically to align with a multi-year planned care programme to avoid implementation delays **(Exhibit 3).**

Recommendations

Programme Board clinical leadership

R4 The Health Board should review and strengthen its Planned Care Programme Board leadership arrangements by:

- 4.1 Developing a clear remit, authority and accountability for the role of the Clinical Director of Planned Care **(Exhibit 3).**
- 4.2 Appointing clinical leads for all specialties to the Programme Board to support the development of integrated speciality plans **(Exhibit 3).**

Risk management

R5 The Health Board should review and update the Planned Care risk register to ensure controls are effective and that the overall risk levels start to reduce in the next 6 months **(Exhibit 3).**

Monitoring impact of additional funding

R6 The Health Board should strengthen its monitoring of the use and impact of the additional Welsh Government planned care funding **(Paragraph 24).**

Recommendations

Efficiency and productivity

R7 Our work has identified there are opportunities for further efficiency and productivity improvements. The Health Board should:

- 7.1 Ensure there is clear monitoring and reporting on the completion of recommendations arising from the Getting it Right First Time (GIRFT) reviews **(Exhibit 6).**
- 7.2 Develop enhanced measures to reduce the number of short notice surgical cancellations **(Exhibit 6).**
- 7.3 Improve the recording accuracy of surgical cancellation reasons to enable the Health Board to understand and address the root cause of surgical cancellations **(Exhibit 6).**
- 7.4 Develop and implement a plan to improve theatre utilisation rates across the Health Board, with realistic improvement trajectories, with the aim of achieving the GIRFT recommendation of 85% **(Exhibit 6).**
- 7.5 Develop and rollout approaches to increase the use of "virtual" outpatient appointments, where clinically appropriate **(Exhibit 6).**
- 7.6 Develop job planning policy and guidance **(Exhibit 6).**
- 7.7 Ensure job plans are completed annually, utilising team-based job planning where it is appropriate to align consultant capacity to meet service demand **(Exhibit 6).**
- 7.8 Roll out pooled waiting lists across the Health Board particularly focusing on challenged services to ensure it treats its patients in turn **(Exhibit 6).**

Promote, Prevent and Prepare for Planned Care policy

R8 The Health Board complete the establishment of the 'Promote, Prevent and Prepare (3P's) for Planned Care' contact centre and ensure it covers all specialties **(Exhibit 7)**.

Recommendations

Risk of harm

R9 In order to strengthen its arrangements for managing the clinical risks associated with long waits, the Health Board should:

- 9.1 Develop and implement a consistent methodology for assessing the risk of harm to patients caused by long waits across specialties **(Exhibit 7).**
- 9.2 Develop a routine report to be presented at the Quality and Safety Committee that effectively reports risks and actual incidents of harm resulting from delays in access to treatment **(Exhibit 7).**
- 9.3 Develop and implement clinical plans for all challenged services to ensure higher risk patients are prioritised **(Exhibit 7).**

Detailed report

Action that the Health Board is taking to tackle the planned care challenge

10 We considered whether the Health Board is effectively planning and delivering planned care improvement, is appropriately utilising and monitoring the impact of Welsh Government funding and is supporting patients who are at most risk of harm as a result of a delay.

11 We found that **the Health Board's Annual Delivery Plan describes actions for planned care, however these are short-term in nature and lack detail on how successful delivery will be measured. The absence of a dedicated and costed, longer-term plan for planned care recovery means the Health Board has not determined the action needed to deliver more sustainable improvements to planned care services**.

Planned care improvement plans and the programme to deliver them

12 It is important that the Health Board has a clear plan for tackling the waiting list backlog and delivering sustainable planned care improvement. We considered whether the Health Board has:

- clear, realistic and costed improvement plans for planned care that align with the national recovery plan ambitions and Ministerial priorities; and
- appropriate programme management arrangements to support planned care improvement, supported by clear accountabilities and clinical leadership and reporting to committees and the Board.

Planned care improvement plans

13 We found that **the Health Board has appropriately set out its short-term planned care improvement initiatives in its 2025-28 Integrated Medium-Term Plan. However, there is a notable absence of a dedicated short and longer-term plan that supports waiting list recovery and the development of efficient and sustainable planned care services. This is likely to affect the pace of improvement.**

14 The findings that underpin this conclusion are summarised in **Exhibit 2**.

Exhibit 2: the Health Board's approach to planned care improvement planning

Audit question	Yes / No / Partially	Comments
Has the Health Board developed a clear plan to support planned care recovery?	**No**	The Health Board's Annual Plan 2024-25 sets out the priorities for planned care. However, this is overly short-term focussed and lacks the necessary detail on longer-term sustainable planned care services. The Health Board has included planned care improvement requirements for 2025 onwards in its 2025-2028 three-year plan. This sets out six planned care workstreams that focus on short-term improvements and some limited pathway improvements. This includes workstreams on referral management, waiting list management, and outpatient, pre-operative and theatre efficiencies, and development of specialty level improvement plans. At present however, there is no stand-alone planned care recovery plan aligned to a clinical strategy. As a result, there is insufficient planning detail to address growing demand and reshaping services so that they are financially affordable **(Recommendation 1).**
Is the approach for delivering planned care improvement costed and affordable?	**No**	The Annual Plan 2024-25 provides a financial plan for the organisation and sets out the Health Board's over-arching financial position. However, there is no costed planned care plan or route-map to financially sustainable services. This creates a lack of transparency on the affordability of current planned care service delivery **(Recommendation 1).** In the absence of a costed planned care improvement plan, the Health Board relies on short-term business cases which are of varying quality and additional Welsh Government funding.
Are the Health Board's planned care priorities appropriately aligned to the national planned care recovery plan and Ministerial priorities?	**Yes**	The Annual Plan 2024-25 and the more recently developed 2025-2028 three year plan are both sufficiently aligned to the ministerial priorities and the national 'transforming and modernising planned care and reducing NHS waiting lists' recovery plan.

Audit question	Yes / No / Partially	Comments
Has the Health Board set out realistic yet challenging targets and milestones for planned care?	**Partially**	The Health Board has developed improvement trajectories and system indicators aligned to Welsh Government escalation requirements. The improvement trajectories focus on eliminating the number of patients waiting more than 104 weeks. While the Health Board has made ongoing progress by increasing capacity, it is unlikely to meet this target. The Health Board's targets for addressing the growing number of patients waiting more one year are not credible based on growing demand and deteriorating performance.
Are the Health Board's planned care priorities informed by analysis and modelling of capacity and demand?	**Partially**	The Health Board's approach to capacity and demand modelling has focused on improving the quality of waiting list data to assess current and future demand. This analysis has been undertaken by the data performance and planning workstream but has not been rolled out across the organisation and all specialties. Further work is needed to understand core capacity and plan for additional capacity to meet immediate and longer-term requirements. **(Recommendation 2)**
Has the Health Board set out how it will transform its clinical service models to make them more sustainable in the future?	**No**	The Health Board has not set out how it will transform its clinical service models to make them more sustainable in the future. As outlined in its 2025-28 three-year plan, the Health Board intends to develop clinical services in line with its 10-year strategy and clinical services plan. This work will be commencing in 2026.
Are plans for planned care improvements aligned to other key corporate plans such as the IMTP and plans for workforce, digital and estates?	**Partially**	The 2025-28 three-year plan outlines some limited digital, workforce and estates initiatives that will help improve some aspects of planned care service delivery, such as the new orthopaedic facility in Llandudno. However, the plan does not contain the level of detail needed for wider enabling services to support sustainable planned care service development.

Source: Audit Wales fieldwork

Planned care programme delivery and oversight

15 We found that **the current planned care programme arrangements are not effective in delivering planned care improvements. The Programme Board lacks authority and direction and there is insufficient clinical leadership and engagement. The absence of a standalone plan for planned care recovery and transformation compounds the issue**.

16 The findings that have led us to this conclusion are summarised in **Exhibit 3**.

Exhibit 3: the Health Board's approach to the programme management of planned care improvement

Audit question	Yes / No / Partially	Comments
Does the Health Board have a clear and appropriately resourced improvement programme to support planned care recovery?	**No**	The Health Board's Planned Care Programme Board has a clear structure. However, over the last year, the arrangements have lacked sufficient delegated decision-making authority to set direction and allocate resources. It is working in an environment where funding decisions can by-pass the Programme Board, with funding directly provided to the Health Board's Integrated Healthcare Communities. Consequently, the Programme Board has served as a discussion forum without being sufficiently able to provide leadership and direction needed to facilitate change **(Recommendation 3.1).** The Programme Board has lacked clarity on its programme of work due to the absence of an agreed overarching plan. Consequently, the draft terms of reference have been developed in isolation, and do not provide clarity of purpose. Members have raised issues regarding unclear reporting structures. There is no forward work programme to provide adequate assurance on overall progress delivery beyond updates from individual work streams. (**Recommendation 3.2).** Over the last year, the Programme Board has presented several business cases to the Executive team for approval. These cases have varied in quality, resulting in some not being approved. As some of these business cases for new initiatives are developed during the year, the lack of approval can delay implementation, impacting the timeliness of improvement. The Health Board needs to both: • strengthen its training approach for the development of planned care business cases (**Recommendation 3.3**); • prepare business cases much earlier in the year, or ideally on an ongoing cycle linked to a multi-year planned care programme (**Recommendation 3.4**).

Audit question	Yes / No / Partially	Comments
Is planned care recovery supported by clearly defined operational accountabilities and effective clinical leadership?	**No**	There has been a lack of continuity of senior leadership for planned care over the last year. This has seen responsibility move from the Integrated Healthcare Community Director (East) to the Executive Medical Director, then to the Executive Director of Finance in summer of 2024 then to the newly appointed Chief Operating Officer. In addition, in March 2025, the Health Board's Assistant Director for planned care left. There is an urgent need to review Planned Care Programme Board leadership arrangements (**Recommendation 4**). The Heath Board appointed a Clinical Director for Planned Care in October 2024, however, there is limited clarity on this role or remit **(Recommendation 4.1).** Our work also suggests that given the longstanding absence of clinical strategy, that there is a real need for substantive speciality level clinical leads. These leads need to build consensus through the development of integrated specialty plans and drive efficient and affordable pathway changes to sustainably meet growing demand (**Recommendation 4.2**).
Has the Health Board undertaken a risk assessment to understand the issues that could prevent delivery of planned care improvement aims?	**Partially**	The planned care workstreams identify and report risks to the Programme Board, through a risk register. Higher rated risks are effectively escalated to the Executive Team to approve actions to address the risks. The Health Board also identifies planned care risks in the corporate risk register. However, the risk rating has not changed in the last twelve months and remains above risk appetite indicating current controls are not effective. The Health Board needs to ensure that the actions it is taking to address risks are effectively evaluated and monitored and appropriately challenge the impact of actions taken **(Recommendation 5).**
Is performance on planned care recovery routinely reported to the appropriate committee/s and to the board?	**Partially**	Planned care performance is reported to the Board and Performance, Finance and Information Governance Committee. However, with the significant increase in demand and the deterioration in performance, oversight and challenge will need to be strengthened. This will ensure better outcomes and allow for a thorough evaluation of the measures implemented to improve performance.

Source: Audit Wales fieldwork

Utilisation of additional Welsh Government funding

17 We have looked at the Health Board's use of the additional planned care allocation that it has received from the Welsh Government. This section considers:

- the overall amount of additional planned care funding the Health Board has received from Welsh Government over the last three years;
- how the Health Board spent the money; and
- the Health Board's arrangements for overseeing how it has spent additional funding.

Use of additional funding

18 We found that **since 2022-23 the Health Board has received a total of £114.5 million in additional Welsh Government funding. The Health Board is directing its additional Welsh Government funding towards tackling extremely long waits. There is limited use of the funding to support specialty level service transformation**.

19 To support planned care recovery over and above existing funding, the Health Board received a total additional Welsh Government allocation of £114.5 million between 2022-23 and 2024-25 (**Exhibit 4**).

Exhibit 4: the Welsh Government's allocation to the Health Board to support planned care improvement

Financial year	Annual allocation (£m)
2022-23	38.4
2023-24	34.3
2024-25	34.5
Additional in-year Welsh Government allocation	7.3[5]
Total allocated	**114.5**

Source: Health Board financial self-assessment returns

20 The Health Board can appropriately account for the Welsh Government planned care funding it has received. We reviewed the use of the funding in 2023-24 in greater detail (**Exhibit 5**). During that year, the Health Board predominantly used the funding on short-term initiatives rather than service transformation to enable lasting improvement. It used £18.2 million or 64% of total funding allocation on insourcing and outsourcing activity to increase capacity in the short-term.

[5] In December 2024, Welsh Government allocated a further £7.3 million in non-recurrent funding to reduce some of the longest planned care waits in the Health Board.

21 The Health Board continued to adopt the short-term funding model throughout 2024-25. While this will have contributed to limiting further growth in very long waits, it is not providing the sustainable solution needed.

Exhibit 5: use of the 2023-24 Welsh Government additional financial allocation, Betsi Cadwaladr University Health Board

	Performance improvement funding (£m)	Transformation fund (£m)
Mixed specialty insourcing (general surgery, ENT, urology, minor operations and pre-operative assessment)	1.5	
Dermatology contract extension	0.3	
Orthopaedics outsourcing	2.7	
Ophthalmology outsourcing	2.3	
Radiology recovery plan	4.6	
Endoscopy insourcing	5.9	
Planned care corporate capacity	0.7	
Stage 4 efficiencies	0.6	
Waiting list initiatives	1.6	3.8
Regional treatment centre closure	0.2	
Orthopaedic planned care sessions	0.5	
Validation and booking	0.4	
Insourcing internal support costs	1.2	
Additional activity - primary & secondary care drugs		3.2
Abergele high volume low complexity orthopaedics		0.2
Funding as a commissioner[6]	4.5	
Total allocated	**27.0**	**7.2**

Source: Health Board self-assessment returns

[6] This includes specialised services commissioning of £2.85 million and commissioning £1.6 million of planned care services from NHS England.

Monitoring impact of additional funding

22 We have considered the extent that Health Board oversees the use of the Welsh Government planned care financial allocations. We found that the **Health Board has reasonable arrangements to oversee the use of the additional Welsh Government planned care financial allocation, we have not seen evidence of monitoring its expected impact**.

23 The Planned Care Programme Board receives a financial report which provides a breakdown of planned spend for individual schemes from the sustainability fund, including any revised forecasts. The report indicates where planned spend is subject to further business case approval.

24 The Health Board also provides reports on proposed allocation of planned care funding at the Performance Finance and Information Governance Committee. While this reporting includes cost estimates, we have not seen any evidence of a more detailed monitoring whether the proposed investments have delivered the expected improvements **(Recommendation 6).**

Operational management of planned care

25 Alongside the well-planned use of additional funding, health boards' ability to secure meaningful and sustainable planned care improvements will be dependent on them optimising their routine operational arrangements for planned care. In this section we consider the actions the Health Board is taking:

- to maximise its use of existing resources; and
- to protect and increase its planned care capacity.

Maximising the use of existing resources

26 We have examined some opportunities that exist for the Health Board to improve efficiency and productivity, and the actions it is taking to maximise the use of its existing resources. We found **that the Health Board is starting to implement the Getting it Right First Time recommendations and while it has been effective in its use of day case surgery, there remains significant opportunity to improve efficiency.**

27 **Exhibit 6** identifies efficiency and productivity opportunities that could help maximise the use of existing resources within the Health Board to support planned care improvements.

Exhibit 6: efficiency and productivity opportunities

Opportunity area	Audit findings
Responding to Getting it Right First time (GIRFT) reports	The Health Board have received reviews on general surgery, ophthalmology, orthopaedics, urology, gynaecology and operating theatre reviews. It has made variable progress in responding to GIRFT reviews, however the pace of delivery needs to improve particularly in relation to ophthalmology and orthopaedics. Whilst GIRFT was a specific workstream reporting into the Planned Care Programme Board, this has now ceased. Responsibility for implementing the recommendations is delegated to individual services. Consequently, there is now a loss of central reporting and assurance to the Planned Care Programme Board on progress in implementing GIRFT recommendations (**Recommendation 7.1**).
Arrangements for measuring and managing productivity of services	The Health Board has established an Elective Optimisation Programme. This oversees key performance metrics and a number of projects to review and monitor performance and standardise policies and procedures. Task and finish groups have been established with clear aims and performance measures these include: • Theatre dashboard – to monitor theatre utilisation including late starts and early finishes, high flow lists[7] and surgical cancellations. • Policies and procedures – to review policies, standardise and implement best practice across to the Health Board. • Reviewing all sub-speciality pathways to ensure standardised way of working. • Reviewing demand against current capacity to meet future demand. Our analysis of efficiency data below and in **Appendix 3** indicates there remain significant opportunities for improvement in efficiency.

[7] Delivering High Flow Lists - Getting it Right First Time Guidance for Health Bodies

Opportunity area	Audit findings
Reducing the number of cancelled operations	The Health Board, through its Elective Optimisation Programme has begun to scrutinise the high volume of surgical cancellations. **Exhibit 20** shows the total number of cancellations almost reached 4,700 for the 12-month period to February 2025 **(Recommendation 7.2)**. This is the highest of all Welsh health boards. **Exhibits 21** shows the cancellation reasons with "other" being the highest category recorded. This approach to recording cancellations does not assist the Health Board in understanding and addressing the underlying causes of short-term cancellations. The Health Board should prioritise accuracy in reporting to ensure the actions it plans to take are effective and resources allocated appropriately. **(Recommendation 7.3)**
Improving operating theatre utilisation	Whilst the Health Board has strengthened its arrangements for monitoring theatre utilisation, these are yet to improve performance. The Elective Optimisation Programme group is responsible for overseeing theatre utilisation through monitoring of the Theatre Dashboard metrics. The GIRFT target for theatre utilisation stands at 85%. The Health Board's integrated performance report indicates that monthly performance varies between 74% and 67% in the last twelve months with no meaningful improvement. Key contributors affecting theatre utilisation are late and early finishes which have remained significantly above GIRFT targets. **(Recommendation 7.4)**
Making use of "virtual" outpatient appointments	Virtual outpatient appointments can have a positive impact in reducing the need for travel and the risk of healthcare acquired infections. The Health Board recognises the variance in take up and engagement across services post-Covid and the risk of not being able to meet the target of increasing the volume of virtual appointments. **Exhibit 19** shows that virtual appointments are not well adopted by the Health Board, currently the lowest in Wales at 12.2% of all outpatient appointments in the 12-month period to February 2025. **(Recommendation 7.5)**

Opportunity area	Audit findings
Reducing non-attendance at outpatient appointments	The Health Board is working to reduce non-attendance at outpatient appointments. The Health Board introduced its Patient Access to Planned Care Policy in January 2025. This sets out implications for non-attendance and policy exceptions. Weekly reporting and escalation to Access Meetings ensures oversight of "Did Not Attend" (DNA) rates. The Health Board is developing standardised operating procedures (SOPs) for the management, monitoring and reporting of DNAs supported by a move to a centralised management of booking services. **Exhibit 18** shows some recent improvement in outpatient "did not attend" rates to around 5.5% of total outpatient clinic activity. This equates to around 38,400 lost patient appointments in the most recent 12-month period to February 2025 representing a lost opportunity cost of around £5.8 million.
Making more use of day case surgery	The Health Board is performing effectively in its use of day case surgery. **Exhibit 22** indicates that the 83% of the Health Board's elective surgery is day case and is positively the highest in Wales.
Effective consultant job-planning	The Health Board does not have effective consultant job-planning arrangements. At the time of our review there was no agreed Job planning policy in place **(Recommendation 7.6**). A recent internal audit report in January 2025 indicated compliance with Welsh Government requirements[8] for annual job plan review is at 66% against a target of 90%. **(Recommendation 7.7).**
Pooled lists within a Health Board speciality to ensure it treats its patients in turn	There is limited evidence to demonstrate the use of pooled lists by the Health Board, noting some progress in dermatology. The Health Board has identified that it needs to fully roll out the Welsh Admin Portal to enable it to effectively manage and pool waiting lists across Integrated Healthcare Communities. **(Recommendation 7.8).**

Source: Audit Wales fieldwork including analysis of NHS Wales data and Health Board self-assessment and data returns

[8] National consultant contract in Wales

Protecting and increasing planned care capacity

28 We examined the actions that the Health Board is taking to protect planned care capacity by separating out elective and emergency activity. We also looked at the actions the Health Board is taking to increase its planned care capacity.

29 We found that **the Health Board is taking measures to protect its elective capacity, but it needs to do more. Whilst it has secured additional capacity through insourcing, outsourcing and waiting list initiatives, these measures are unsustainable in the longer term.**

30 The Health Board has had some success protecting planned care capacity from wider service pressures in a small number of areas. This is particularly notable where services are physically separated from the major hospital sites. This includes orthopaedics and ophthalmology services in Abergele Hospital and surgical services in Llandudno General Hospital. As highlighted previously, the reasonably high level of day-case surgery also helps to protect planned care services from wider unscheduled care and medical pressures. Nevertheless, short-term surgical cancellation data indicates that the Health Board cancels operations because of unscheduled care pressures and wider capacity issues in hospitals.

31 To further protect services, the Health Board is planning a new elective orthopaedic hub at Llandudno General Hospital. The aim of this initiative is to reduce pressure on planned care services from unscheduled emergency care and reduce waiting times for this challenged service. The Health Board has secured £29.4 million additional Welsh Government capital funding in November 2023. While work is progressing on this facility, it is delayed and the original ambition to open in early 2025 has not been met. It is now unlikely that this will be achieved by the end of 2025.

32 The Health Board is insourcing and outsourcing services as a means to increase planned care capacity to help meet its short-term needs. In 2023-24, the Health Board spent £6.8 million on insourcing and outsourcing contracts for six key specialties, primarily for orthopaedics and ophthalmology with a further £5.9 million allocated to endoscopy diagnostics and £4.6 million on radiology recovery. The Health Board allocated £3.8 million to transform planned care services however it is not clear which initiatives were implemented from this additional funding. The Health Board continues to utilise premium weekend working to increase capacity in the short-term. This is neither financially sustainable nor is it an effective means of improving efficiency and risks reducing staff resilience.

Managing clinical risk and harm associated with long planned care waits

33 Long patient waits increases the risk of preventable irreversible harm. Patients' health may deteriorate while waiting, they may be waiting in pain and with anxiety and uncertainty not knowing when they will finally receive treatment. They may also not be able to work or support or care for others while they are waiting. We considered whether the Health Board has sound arrangements to:

- identify, manage, and report on clinical risk and harm associated with long waits; and
- effectively communicating with patients who are on a waiting list and to manage potential inequalities in access to care.

34 We found that **the Health Board is starting to take action to implement the Welsh Government's Promote, Prevent and Prepare policy, but is yet to be fully rolled out across all specialties. Overall engagement in the implementation of the policy needs to increase with strengthened reporting on actual harm resulting from delays.**

35 The findings which have led us to this conclusion are summarised in **Exhibit 7**.

Exhibit 7: the Health Board's approach to managing clinical risks and communicating with patients on waiting lists

Audit question	Yes / No / Partially	Comments
Has the Health Board implemented the first phase of the Welsh Government's Promote, Prevent and Prepare for Planned Care policy[9]?	**Partially**	The Health Board has been slow to implement the first phase of Welsh Government's Promote, Prevent and Prepare policy (3Ps). Its "Self-Care While You Prepare" service is currently only available to patients in four specialties: general surgery, orthopaedics, ophthalmology and dermatology. The Health Board has experienced delays in recruiting clinical and administrative staff to effectively meet demand and manage risk of harm resulting from delays. The Health Board needs to complete its recruitment and ensure the service covers all specialties **(Recommendation 8).**

[9] Promote, Prevent and Prepare for Planned care policy to ensure that support and information is easily accessible to those waiting for appointments and interventions

Audit question	Yes / No / Partially	Comments
Is the Health Board assessing the risk to patients waiting the longest?	**Partially**	The Health Board uses the DATIX system to record clinical risk resulting from a delay in treatment. However, there is no consistent methodology throughout specialties to assess risk and inform reporting on the risk of harm or instances of recorded harm **(Recommendation 9.1)**.
Is the Health Board capturing and reporting evidence of harm resulting from waiting list delays and is reporting on it to the Quality and Safety Committee?	**No**	We found insufficient arrangements for routinely reporting clinical risks associated with waiting list delays to the Board and its committees. Despite the largest waiting list and some of the longest waits in Wales, there have been no reports to the Quality, Safety and Experience Committee regarding patient harm as a result of delayed treatment **(Recommendation 9.2).**
Is the Health Board effectively balancing the tension between eliminating long waits and managing clinical risks in its approach to prioritising patients?	**No**	The Health Board's primary focus is eliminating long waiting lists. The Health Board should ensure the development of clinical plans for all challenged services to ensure higher risk patients are prioritised appropriately **(Recommendation 9.3)**
Does the Health Board monitor and record how many patients are leaving planned care waiting lists in favour of private treatment?	**No**	The Health Board does not have a mechanism for monitoring and recording the number of patients leaving planned care waiting lists in favour of private treatment.

Source: Audit Wales fieldwork

Waiting list performance – Is the action taken resulting in improvement?

36 We analysed current 'Referral to Treatment'[10] waiting list performance and trends to determine whether the Health Board is:

- reducing the overall levels of waits; and
- meeting Ministerial priorities and Welsh Government national targets.

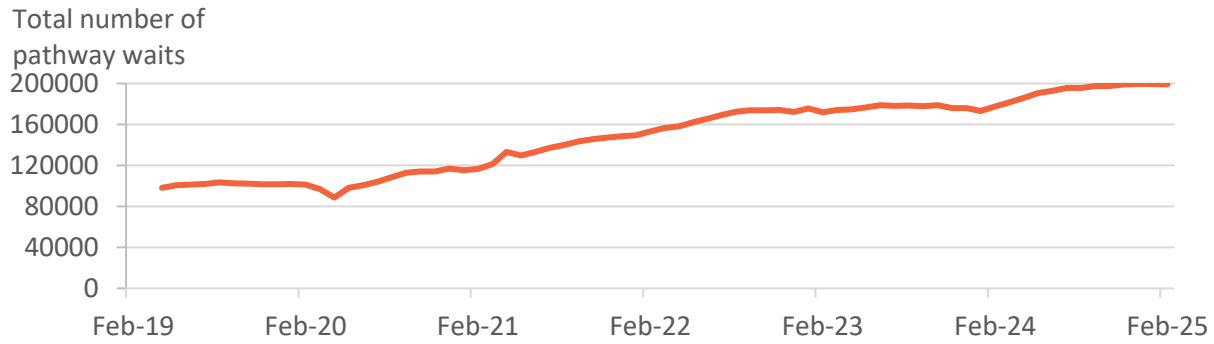
37 We found that **the Health Board has increasing numbers of waits and at the same time is not meeting Welsh Government performance targets. The growing number numbers of patients waiting over a year for treatment is of significant concern**.

The scale of the waiting list

38 Across Wales, the scale and extent of waits substantially increased following the Covid-19 pandemic. We have looked at these changes in terms of the overall size of the waiting list. We have also considered both the volume of waits for diagnostics and therapy services and trends in referral rates. We found that **the continued growing backlog of people waiting to be treated presents an increasing and significant challenge for the Health Board. There are now nearly 200,000 open treatment pathways[11].**

39 **Exhibit 8** shows the overall trend of planned care waits for the Health Board since April 2019. This shows an increase in the size of the waiting list from 98,190 in April 2019 to 199,249 treatment pathways in February 2025. The action that the Health Board is taking to reduce the overall numbers of people waiting is not resulting in sufficient impact.

Exhibit 8: Planned care waiting list size, Betsi Cadwaladr University Health Board

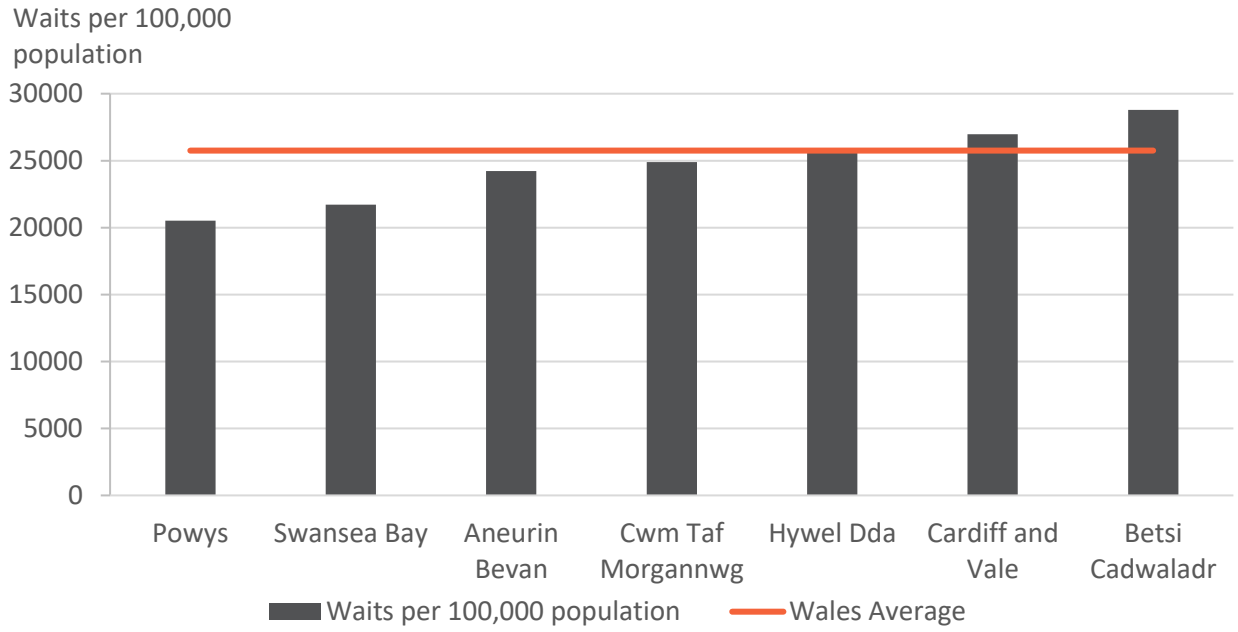


Source: Welsh Government, Stats Wales

[10] Referral to Treatment is how the NHS records the timeliness of planned care. It starts when a Health Board receives a referral and finishes when it has treated the patient. During that patient pathway, the NHS records distinct stages, including new outpatient appointment, diagnostic, follow up appointment or therapeutic intervention and treatment.

40 **Exhibit 9** provides a comparative picture of the volume of waits across Wales. It shows that the Health Board has a higher proportion of waits compared with other health boards in Wales.

Exhibit 9: Waits per 100,000 population, by health board of residence, February 2025



Source: Welsh Government, Stats Wales. Note: Powys data is for December 2024.

Performance against national targets/priorities

41 We looked at the progress that the Health Board is making against the Welsh Government's aims[12]. These are:

- No one waiting longer than a year for their first outpatient appointment by the end of 2022 (**target date revised to December 2023**[13]).
- Eliminate the number of people waiting longer than two years in most specialties by March 2023 (**target date revised to March 2024**[6]).
- Increase the speed of diagnostic testing and reporting to eight weeks and 14 weeks for therapy interventions by Spring 2024.
- Eliminate the number of people waiting longer than one year in most specialties by Spring 2025.

[12] We have not included the Welsh Government performance on Cancer services as this is outside the scope of this review.

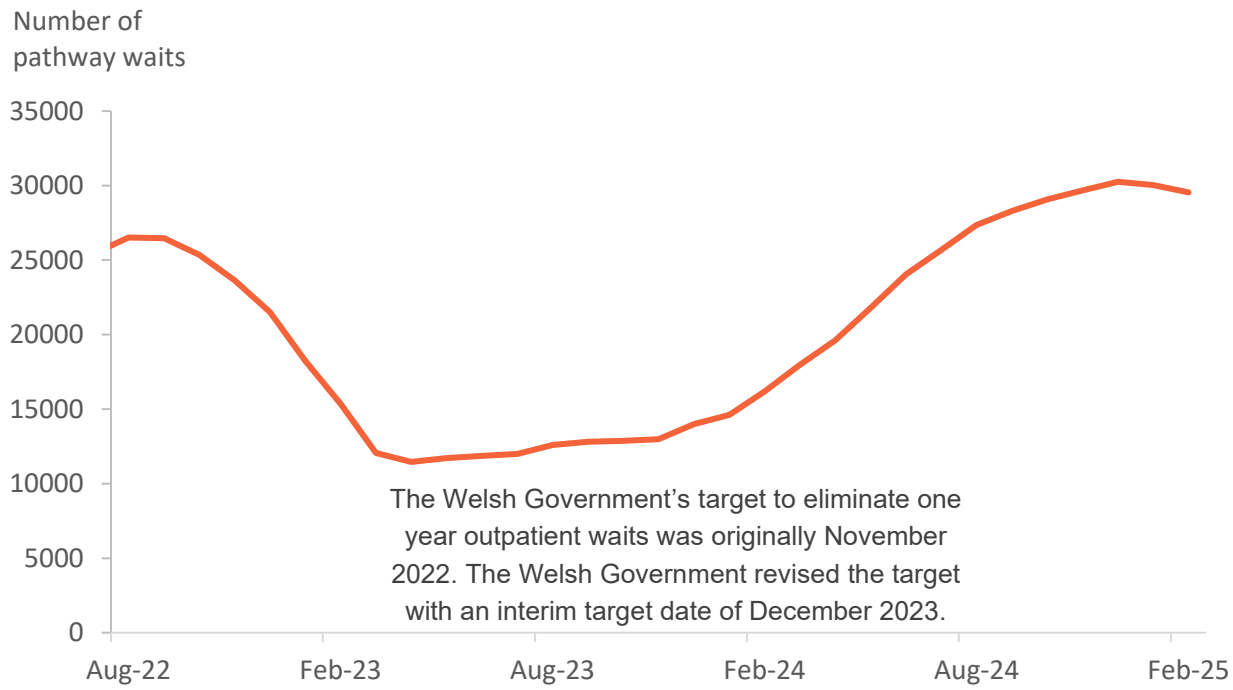
[13] Health boards did not meet the original targets for first outpatient appointment and number of people waiting longer than two years. As a result, the Welsh Government agreed to set interim targets (**in bold**, above).

42 We found that **the Health Board did not meet the Welsh Government's targets and despite making reasonably good progress initially performance has recently deteriorated.**

No one waiting longer than a year for their first outpatient appointment

43 **Exhibit 10** shows Health Board waiting list performance for first (new) outpatient appointments. The Health Board failed to meet the revised December 2023 Welsh Government target to ensure no one waited more than a year for their new outpatient appointments. While initially improving, the Health Board did not achieve the Welsh Government's target to eliminate outpatient waits that are over a year. Performance substantially deteriorated during 2023 and 2024, and it is only recently starting to marginally improve.

Exhibit 10: the number of first (new) outpatient appointments waits that are over a year since referral, Betsi Cadwaladr University Health Board



Source: Welsh Government, Stats Wales

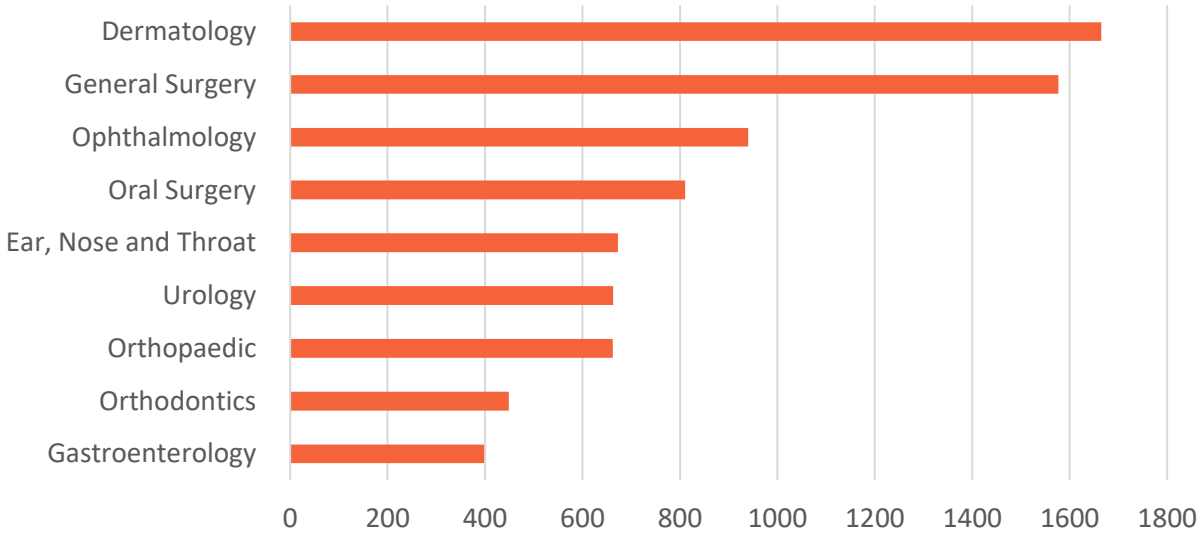
Eliminate the number of pathways longer than two years in most specialties by March 2023

44 **Exhibit 11** shows that the Health Board did not meet the revised Welsh Government target to eliminate waits over 2 years by March 2024 and early performance improvement has not been maintained. Of those waits currently over 2 years, **Exhibit 12** shows that extreme waits are across a range specialties, but include dermatology, general surgery, ophthalmology and oral surgery.

Exhibit 11: the number of planned care waits over 2 years, Betsi Cadwaladr University Health Board

Source: Welsh Government, Stats Wales

Exhibit 12: the number of planned care waits over 2 years by specialty as of February 2025, Betsi Cadwaladr University Health Board

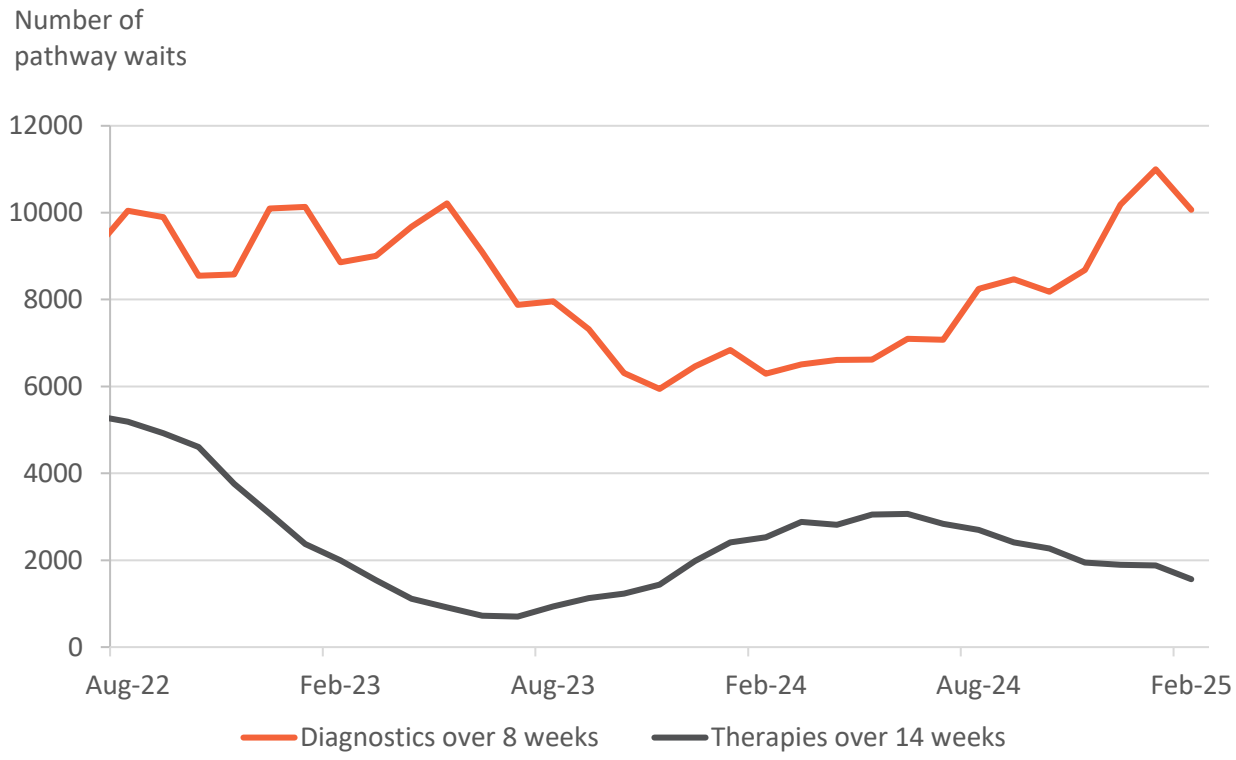


Source: Welsh Government, Stats Wales

Increase the speed of diagnostic testing and reporting to eight weeks and 14 weeks for therapy interventions by Spring 2024

45 The Welsh Government sought to increase the speed of diagnostic testing and reporting to eight weeks and 14 weeks for therapy interventions by Spring 2024. The Health Board is not meeting its targets for therapy or diagnostic waits (**Exhibit 13**). Of its diagnostic services, diagnostic endoscopy and to an extent neurophysiology diagnostics are of greatest concern because of the volume and proportion of very long waits in these areas. Physiotherapy waits also appear to be a challenge for the Health Board.

Exhibit 13: the number of diagnostic and therapy pathway waits that breach Welsh Government targets (Diagnostic waits is an 8-week target, therapies waits is a 14 week target), Betsi Cadwaladr University Health Board

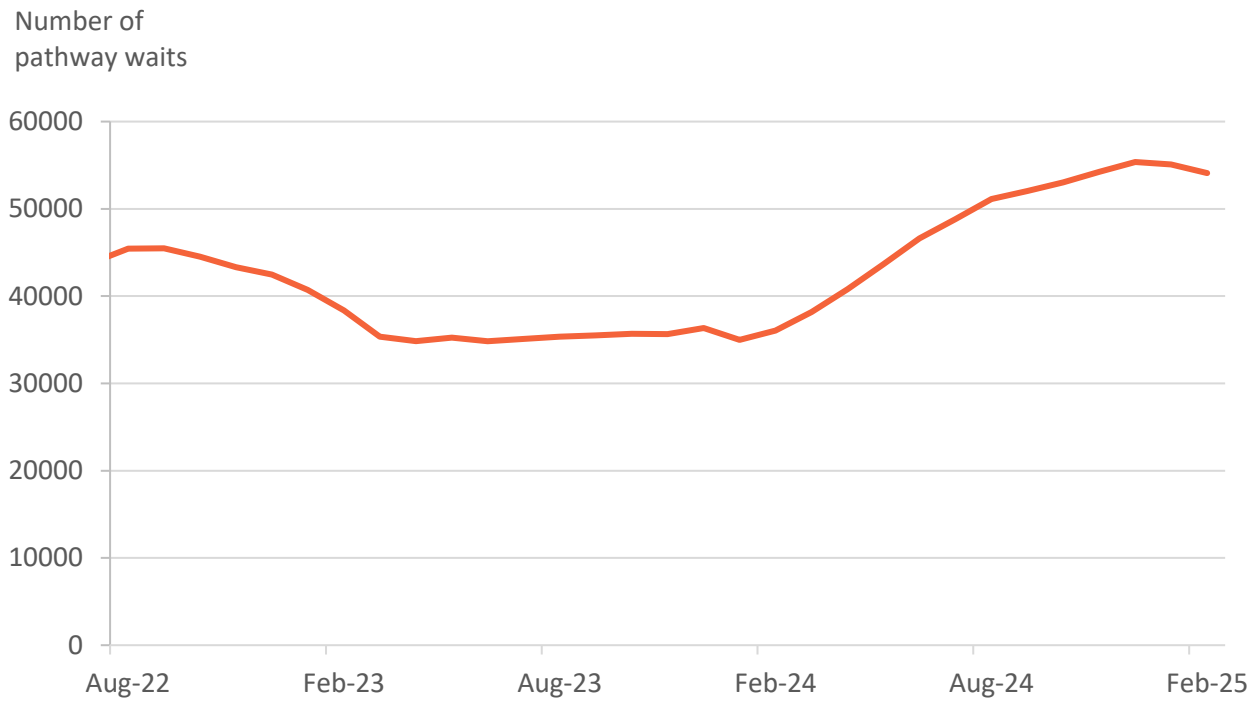


Source: Welsh Government, Stats Wales

Eliminate the number of people waiting longer than one year in most specialties by Spring 2025

46 The Welsh Government's longer-term ambition was to eliminate waits over 1 year in most specialties by the Spring of 2025. **Exhibit 14** shows deterioration in performance in 2024 reaching the highest ever recorded level of one year waits at the Health Board in December 2024. The position has marginally improved since.

Exhibit 14: the number of pathway waits that are over a year, Betsi Cadwaladr University Health Board



Source: Welsh Government, Stats Wales

Barriers to further improvement

47 We have considered the factors that are affecting the Heath Board's ability to tackle its waiting list backlog and secure sustainable improvements in planned care, together with actions that it is taking to address them.

48 We found that the Health Board recognises the barriers to improvement but is significantly affected by increasing service demand, capacity pressures and a lack of clinical leadership to drive change and recovery.

49 Our fieldwork has found challenges in the following areas:

- **Demand for planned care services** – There is significantly increasing demand for services. The Health Board is making some progress in reducing the number of extreme waits, however referral levels are increasing (**Exhibit 16, Page 39**). At the same time, our analysis of the levels of medical and surgical admissions indicates that service activity is slightly lower than 2019 levels (**Exhibit 17, Page 39**). This suggests an increasing gap between demand and supply which the Health Board must address.
- **Workforce capacity** – The Health Board has identified that staffing issues are a further challenge to delivery. This includes recruitment to key roles such as anaesthetists and some wider theatre staffing. This has contributed to difficulties optimising theatre capacity.
- **Capacity to support transformation** - The Health Board has deliberately focused on addressing immediate demand and reducing waiting lists without appropriate analysis of its core capacity. This alongside wider resourcing challenges is limiting opportunities for more long-term transformation work and the ultimate need to implement sustainable modernised services.
- **Clinical leadership –** The absence of a Medical Director and shortage of clinical leadership in the planned care programme, particularly for challenged services has impeded delivery progress.
- **Clinical strategy –** The Health Board does not have an overall clinical strategy and individual service plans for challenged services to support planned care recovery. As a result, the Health Board is adopting an ineffective reactive approach which lacks clarity and consistency across the Integrated Health Communities.

50 The Health Board has begun to take action to address some of these barriers. To address issues with theatre utilisation it has established the Elective Optimisation Programme to scrutinise performance and drive change, as described in **Exhibit 6.** The Health Board is also taking action to increase the use of the Abergele hospital for ophthalmology procedures.

51 The Health Board has recently identified short-term measures to address capacity issues in response to increased demand in dermatology including additional locum recruitment and the use of minor operation procedures at Connah's Quay Health Centre.

52 The actions the Health Board has taken, including the appointment of an Interim Medical Director are at their early stages and further work is required to ensure the Health Board does not continue to face the same or greater challenges in future.

Appendix 1

Audit methods

Exhibit 15 sets out the methods we used to deliver this work. Our evidence is based on the information drawn from the methods below.

Exhibit 15: audit methods

Element of audit methods	Description
Documents	We reviewed a range of documents, including: • Planned care programme initiation document. • Annual plan. • Performance, Finance and Information Governance committee papers • Planned care programme board papers • Quality, Safety and Equality Committee papers • Public Board meeting papers. • Executive team papers • GIRFT reviews • Corporate risk register • Planned care programme risk register • Performance reports • Terms of reference • Internal audit reports
Self-assessment	We issued and then analysed a self-assessment completed by the Health Board.
Interviews	We interviewed the following: • Interim Director of Finance – Senior Responsible Officer for planned care. • Interim Chief Operating Officer • Assistant Director for planned care. • Integrated Health Community – Planned Care Director. • Lead Clinical Director for planned care • Outpatient Lead • Finance Lead for planned care • Quality, Safety and Equality Committee Chair

Element of audit methods	Description
	• Promote, Prevent, Prepare Lead
Observations	We observed the Planned Care Programme Board in December 2024.
Data analysis	We analysed key data on: • waiting list performance; • financial spend; and • outpatient and inpatient efficiencies.

Appendix 2

Audit criteria

Main audit question: **Is the Health Board effectively managing its planned care challenges?**

Level 2 questions	Level 3 questions	Audit Criteria (what good looks like)
Is the Health Board's waiting list performance improving?	What is the scale of the challenge? Is the Health Board meeting Welsh Government targets/ambitions?	The Health Board has: • made progress reducing the overall number of referral to treatment waits for planned care services; and • met Ministerial priorities and national targets that were set by the Welsh Government.
Does the Health Board have a clear plan and a programme of action to support planned care waiting list recovery?	Does the Health Board have a clear, realistic, and funded plan in place for planned care recovery? Is there a clear programme structure to deliver planned care improvement?	The Health Board has: • clear, realistic and funded plan in place for planned care recovery in the short and longer-term; and • a programme structure that appropriately supports the delivery of the plan.

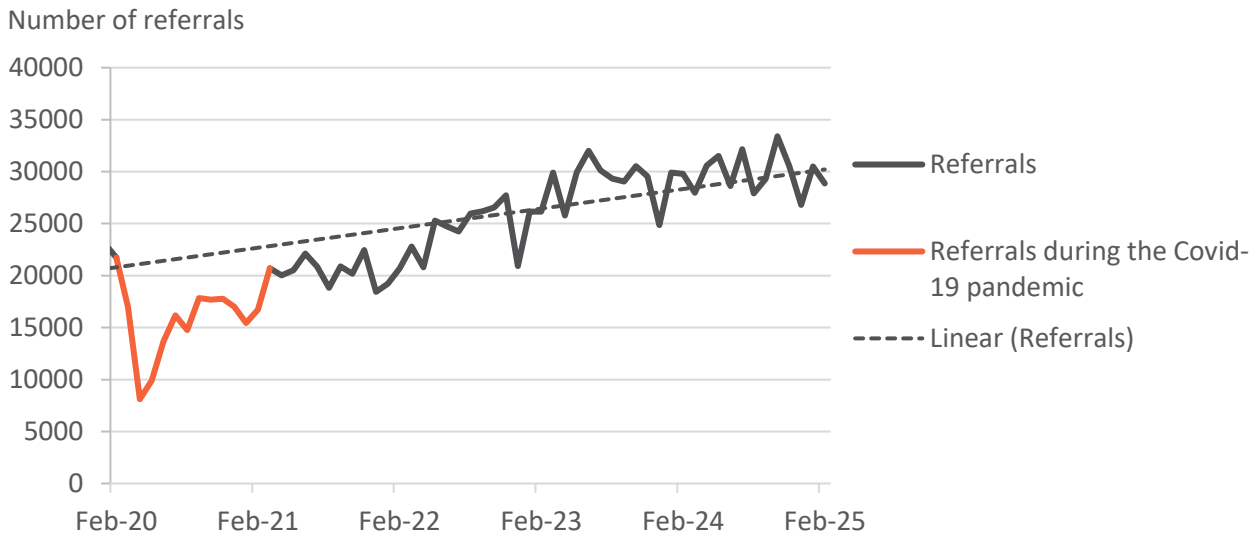
Level 2 questions	Level 3 questions	Audit Criteria (what good looks like)
Is the Health Board maximising the impact of its funding to address the planned care backlog?	Is it clear what additional monies have been received by the Health Board? Is it clear what the additional waiting list monies has been spent on? Did the Health Board aim to use all the money on planned care improvement? Can the Health Board clearly demonstrate that the money has resulted in performance improvement, enabled service efficiency and/or new ways of working? Is the Health Board's overall financial position affecting its ability to deliver sustainable planned care recovery?	• There is sufficient evidence that the Health Board spent the money as intended by the Welsh Government (i.e. addressing waits and transforming services). • The Health Board can clearly demonstrate that the spend has resulted in improvement. • The Health Board's overall financial position is not affecting its ability to support planned care recovery.
Does the Health Board have effective operational management arrangements to drive improvement and	Is the Health Board improving its operational management of planned care services? How does the Health Board capture information on clinical risk relating to long planned care waiting lists?	The Health Board is: • improving the operational management of planned care services; and • capturing information and managing clinical risks and harm related to long planned care waiting lists.

Level 2 questions	Level 3 questions	Audit Criteria (what good looks like)
management of clinical risks?	How does the Health Board capture information on clinical risk relating to long planned care waiting lists? Is the Health Board sufficiently managing clinical risks resulting from delays to treatment? Is the Health Board proactively ensuring clear routes of communication when patients are concerned that they are deteriorating?	The Health Board: • has sound arrangements to identify, capturing, and report on clinical risk and harm associated with long waits; • is proactively managing clinical risks resulting from delays to treatment and effectively communicating with patients.
Does the Health Board sufficiently understand barriers to improvement and what needs to be done to address them?	Does the Health Board understand the barriers it has experienced to improvement in planned care performance? (Capacity, funding, recruitment & retention, estates/use of facilities, commissioning external healthcare?) What mechanisms and interventions have been put in place by the Health Board to address these barriers? Is the Health Board learning and sharing good practice where things have gone well?	The Health Board has: • identified its risk and barriers and acted on these to address long planned care waiting lists in the short-term and sustainable service models in the longer term. • good arrangements for seeking good practice and sharing and applying learning to improve planned care services.

Appendix 3

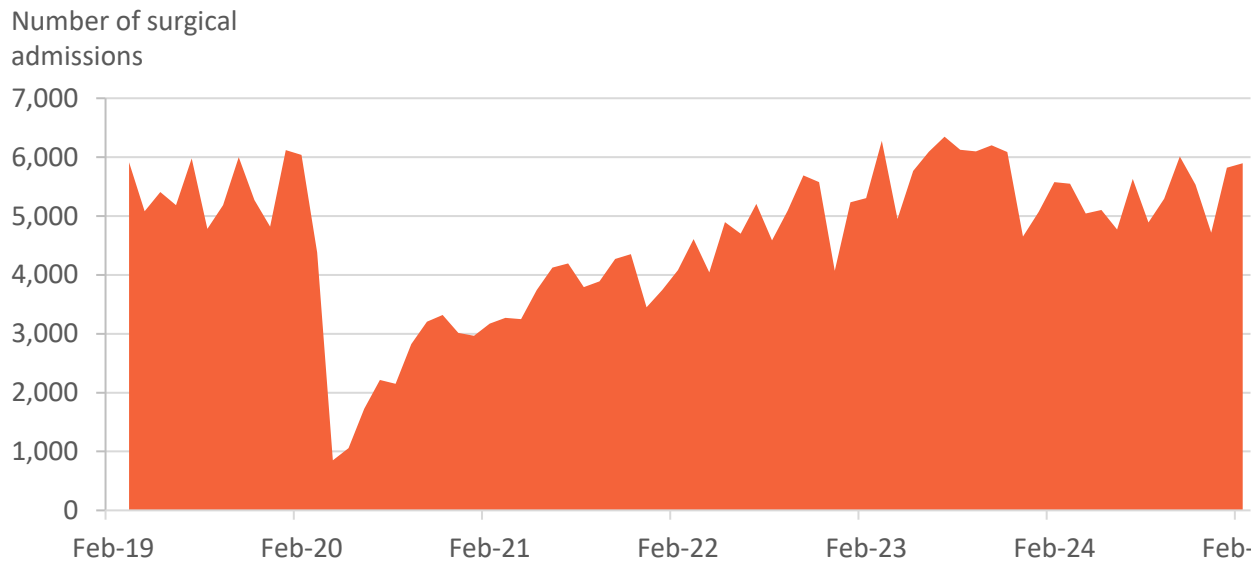
Additional data analysis on planned care

Exhibit 16: trend of monthly referrals to Betsi Cadwaladr University Health Board



Source: Welsh Government, Stats Wales

Exhibit 17: monthly elective medical and surgical admission levels, Betsi Cadwaladr University Health Board

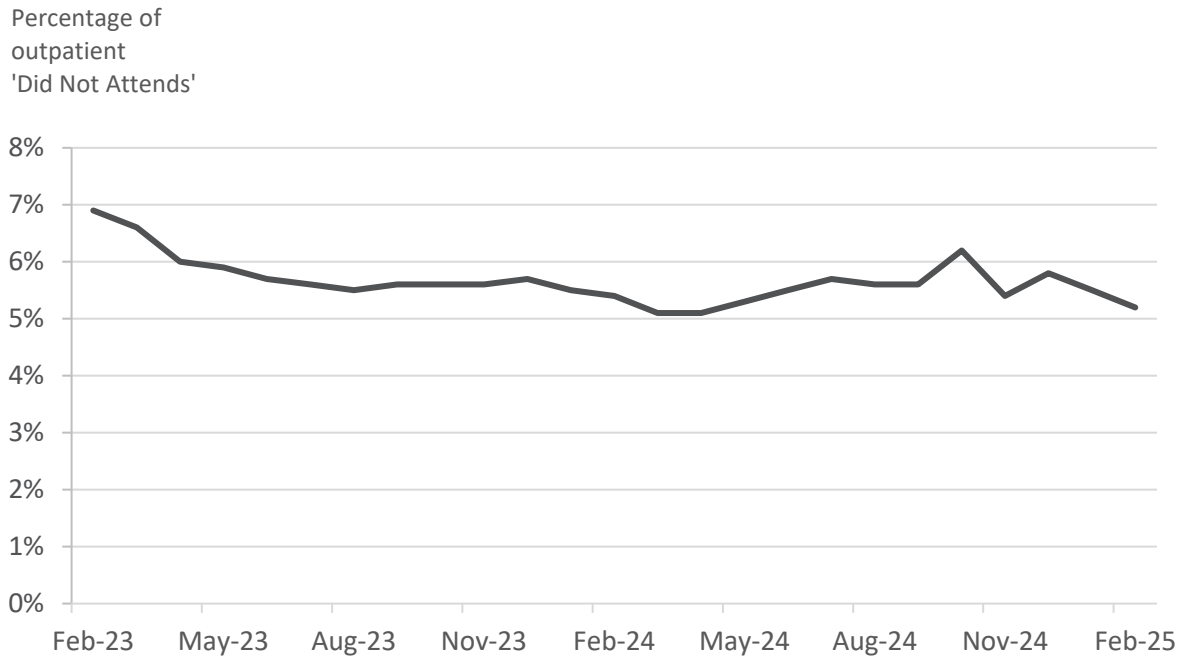


Source: Digital Health and Care Wales secondary care dashboard

Outpatient services

53 Outpatient appointments where a patient 'did not attend' is inefficient. **Exhibit 18** shows that the Health Board's 'Did Not Attends' is around 5.5% of total outpatient clinic activity. This equates to around 38,400 lost patient appointments in the most recent 12-month period to February 2025. It represents a lost opportunity cost of around £5.8 million (£150 per appointment[14]). If the Health Board could reduce its outpatient Did Not Attends by 20%, it could potentially save around £1.15 million.

Exhibit 18: the number and percentage of outpatient 'Did Not Attends', Betsi Cadwaladr University Health Board

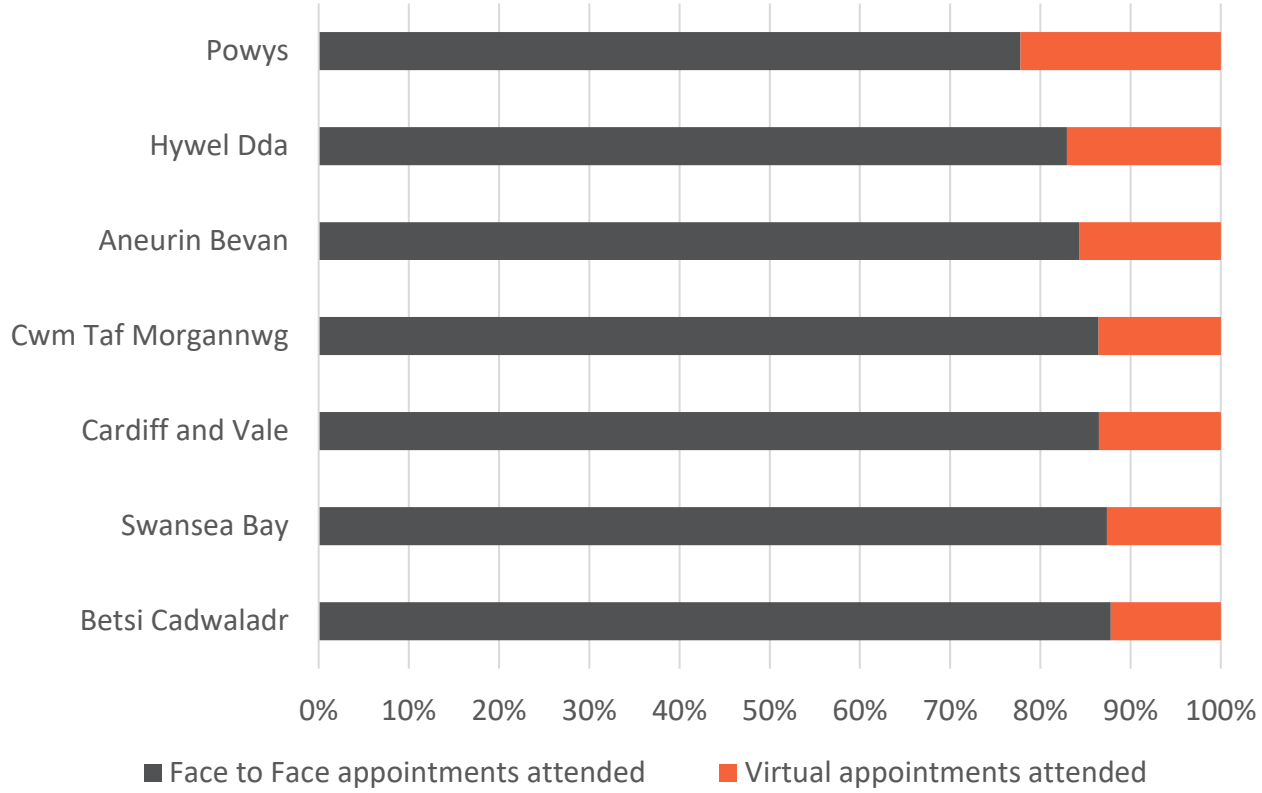


Source: Digital Health and Care Wales secondary care dashboard and datasets

54 NHS bodies can use virtual outpatient appointments for some but not all patients. **Exhibit 19** shows that the 'virtual' consultation approach is not well-adopted in most health boards and is the lowest in Betsi Cadwaladr University Health Board.

[14] We have adjusted the 2018 NHS England cost of an outpatient appointment (£120) by Bank of England CPI rates to estimate current average outpatient costs in 2024.

Exhibit 19: proportion of outpatient attendances that are virtual appointments, from April 2024 to February 2025

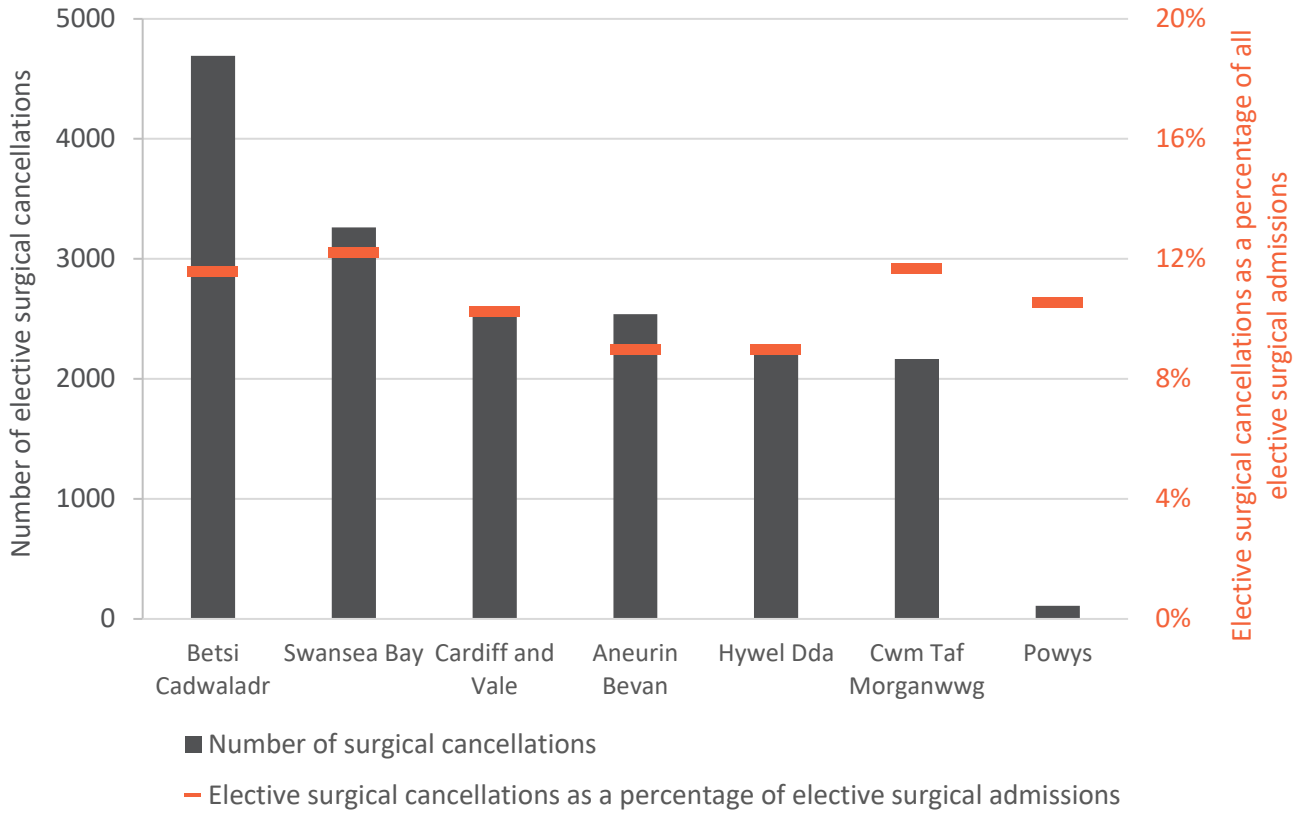


Source: Digital Health and Care Wales secondary care dashboard and datasets

Surgical cancellations

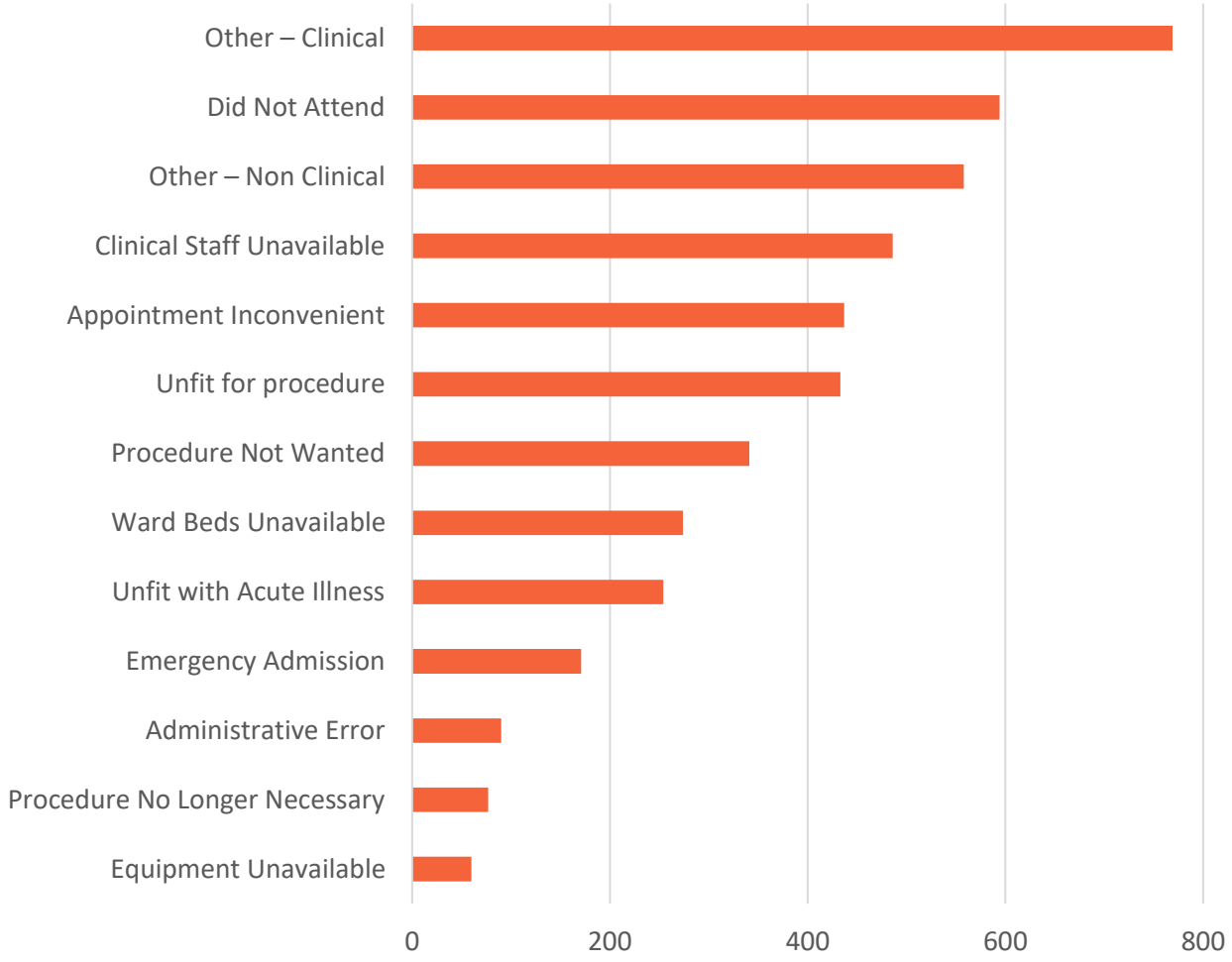
55 Short notice cancellations result in significant inefficiency because operating theatre sessions cannot be easily backfilled with other patients. The total number of surgical cancellations for the Health Board was almost 4,700 for the latest 12 month published data (March 2024 to February 2025) (**Exhibit 20**). **Exhibit 21** identifies the cancellation reasons.

Exhibit 20: the number of short notice (within 24 hours) surgical cancellations alongside cancellations as a percentage of all elective surgical admissions, March 2024 to February 2025



Source: Health Board submissions to the Welsh Government and Digital Health and Care Wales

Exhibit 21: number of short notice (within 24 hours) surgical cancellations for the latest 12-month reporting period (March 2024 to February 2025), by reason, Betsi Cadwaladr University Health Board

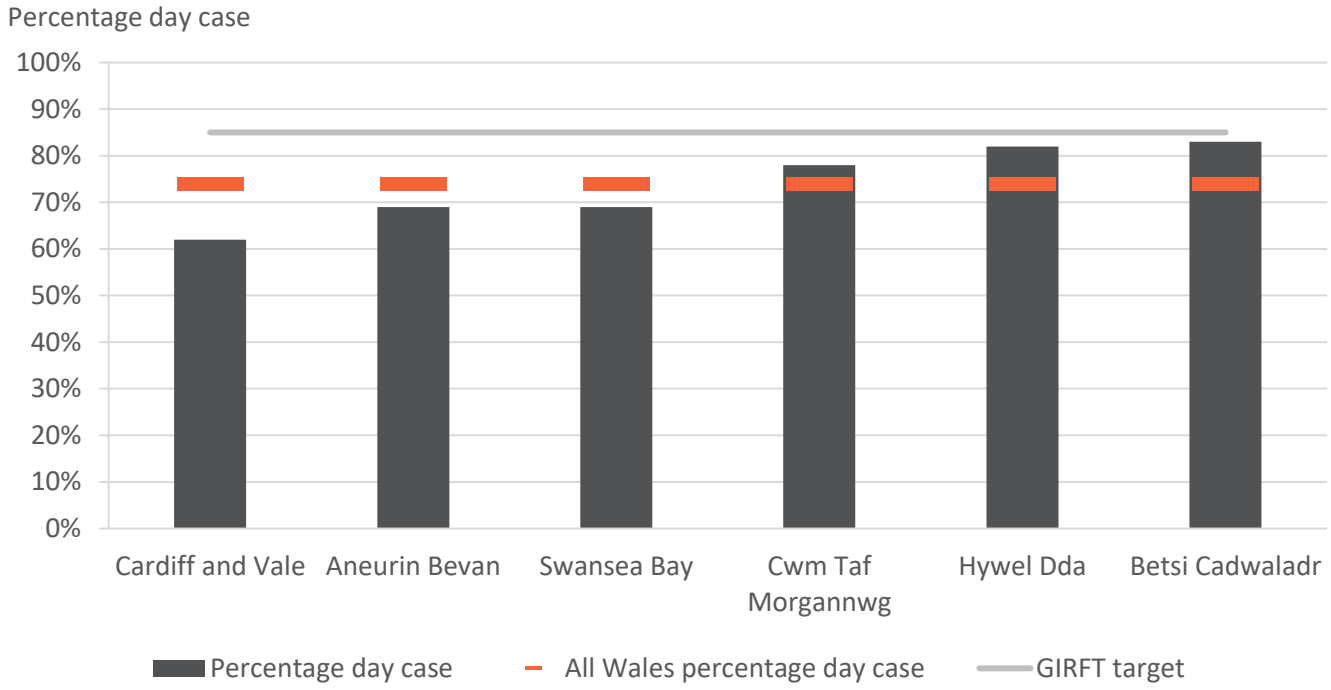


Source: Health Board submissions to the Welsh Government

Day case surgery

56 Day case surgery offers the potential for improved efficiency, lower costs, lower carbon footprint per patient[15] and a better patient experience when compared with inpatient services. Getting It Right First Time recommends that on average 85% of all elective[16] surgery should be day case[17]. Our analysis in **Exhibit 22** indicates that 83% of the Health Board's elective surgery is day case and positively is the highest in Wales.

Exhibit 22: proportion of elective surgery undertaken by Health Boards as day case for the period April 2024 to February 2025



Source: Digital Health and Care Wales secondary care dashboard and datasets

[15] Paper outlines GIRFT's 'unique position' in supporting the NHS drive for net zero carbon emissions - Getting It Right First Time - GIRFT

[16] Elective surgery is the type of surgery associated with a planned care patient pathway.

[17] Getting it Right First Time - Elective Recovery High Volume Low Complexity guidance for health systems

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We welcome correspondence and telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

The management response to audit recommendations

Exhibit 23 below sets out the Health Board's response to our audit recommendations.

Recommendation	Management response	Completion date	Responsible officer
Planning R1 Over and above the commitments signalled within its annual plans, the Health Board should develop a detailed Planned Care improvement plan. This should aim to both design and deliver sustainable planned care services in the medium to longer term and to take advantage of opportunities for further regional working. The plan should be costed, with realistic but challenging milestones within it. (Exhibit 2)	The Health Board has identified Planned Care as a Major workstream (one of four) with the Chief Executive to Chair the Planned Care Project Board that will oversee delivery of the major program with 6 workstreams; 1- RTT Waiting List Management 2- Referral Management 3- Booking 4- Pre-operative and post operative effectiveness 5- Follow ups 6- Integrated Planned (Planned Care, Diagnostics & Cancer) The Planned Care Board will oversee development and implementation of plans.	October 2025	Executive Director of Transformation and Improvement
Demand and capacity R2 The Health Board should ensure that its demand and capacity modelling approach is consistently applied across the organisation and its specialties and used to inform short-term	The Operational teams are (in conjunction with the Director of Performance) developing demand and capacity plans to support in year and future modelling of Integrated Medium Term Plans (IMTP).	December 2025	Chief Operating Officer (COO)

Recommendation	Management response	Completion date	Responsible officer
service capacity planning and longer-term service design. This should consider continued growth or expected changes in population demand for planned care services **(Exhibit 2).**			
Programme governance and programme business cases R3 The Health Board should strengthen its Planned Care Programme Board to ensure it has the authority to set direction and deliver both transformational change and short-term capacity improvement by: 3.1 Strengthening the Programme Board's delegated authority arrangements to ensure it is the primary forum for all transformational and short-term capacity improvement funding **(Exhibit 3).** 3.2 Developing a clear planned care	The Planned Care Board will oversee the development of Planned Care enhanced delivery in 2025/25 (see R1). It is of note that the Planned Care Programme Board is to be Chaired by the Chief Executive, with delivery of improvements through the Executive Director of Transformation and Delivery. In addition, this Committee has Welsh Government membership and will oversee use of the Planned Care Fund totalling £34m. 3.1 to be reviewed in conjunction with the revisions to the Standing Orders and scheme of Reservation and Delegation	October 2025 Plan developed October 2025	Executive Director of Planning, Transformation and Improvement Director of Corporate Governance

Recommendation	Management response	Completion date	Responsible officer
improvement programme for delivery, monitoring and associated accountability **(Exhibit 3).**	As noted previously	See above	See above
3.3 Improving training for planned care business case development to ensure quality of business cases and timely approval **(Exhibit 3).**	Business Case development is being pursued within the Directorate for Transformation and Improvement, with a Business Case proforma under review.	January 2026	Executive Director of Planning, Transformation and Improvement
3.4 Prepare business cases earlier in the year or cyclically to align with a multi-year planned care programme to avoid implementation delays **(Exhibit 3).**	The Planning cycle will engage with the wider organisation as an ongoing as opposed to an annual process, this change key in determining the ability of the Health Board to prioritise resources for future financial years, aligning to Strategic Plans.	January 2026	Executive Director of Planning, Transformation and Improvement
Programme Board clinical leadership R4 The Health Board should review and strengthen its Planned Care Programme Board leadership arrangements by:	Programme Board formed and appointments / governance and oversight of the leadership with progress in regards to appointment of clinical leads continuing		

Recommendation	Management response	Completion date	Responsible officer
4.1 Developing a clear remit, authority and accountability for the role of the Clinical Director of Planned Care **(Exhibit 3).**	Clinical Director of Planned Care appointed and remit clarified within the Programme Boar.	August 2025	Chief Executive Officer
4.2 Appointing clinical leads for all specialties to the Programme Board to support the development of integrated speciality plans **(Exhibit 3).**	Progress made in appointments for Clinical leads, further appointments to be completed.	December 2025	Chief Executive Officer
Risk management R5 The Health Board should review and update the Planned Care risk register to ensure controls are effective and that the overall risk levels start to reduce in the next 6 months (Exhibit 3).	Planned Care Delivery is referenced within the Corporate Risk Register. A delivery Director appointed to monitor delivery and report on performance and operational delivery the responsibility of the Chief Operating Officer	October 2025	Executive Director of Finance & Chief Operating Officer
Monitoring impact of additional funding **R6** The Health Board should strengthen its monitoring of the use and impact of the additional	Planned Care Fund utilisation is reported within the Planned Care Program Board, with allocation and use supported through the Integrated Performance, Executive Delivery	Ongoing	Executive Director of Finance

Recommendation	Management response	Completion date	Responsible officer
Welsh Government planned care funding (Paragraph 24).	Group and the Performance, Finance and Information Governance Committee.		
Efficiency and productivity R7 Our work has identified there are opportunities for further efficiency and productivity improvements. The Health Board should:	The below improvements are contained within the overall planning. These workstreams referred to in section R1 will deliver against the specific elements listed below;		
7.1 Ensure there is clear monitoring and reporting on the completion of recommendations arising from the Getting it Right First Time (GIRFT) reviews **(Exhibit 6).**	Speciality demand and capacity plans to include reference to GIRFT and optimum levels of performance (access and quality of care) for our local population. This will feature within the demand and capacity modelling.	December 2025	Chief Operating Officer
7.2 Develop enhanced measures to reduce the number of short notice surgical cancellations **(Exhibit 6).**	Planned Care Programme Board to review utilisation of clinics in addition to factoring improvements into demand and capacity modelling.	October 2025	Chief Operating Officer
7.3 Improve the recording accuracy of surgical cancellation reasons to enable the Health Board to understand	Planned Care Programme Board to review utilisation of clinics in addition to factoring improvements into demand and capacity modelling.	October 2025	Chief Operating Officer

Recommendation		Management response	Completion date	Responsible officer
	and address the root cause of surgical cancellations **(Exhibit 6).**			
7.4	Develop and implement a plan to improve theatre utilisation rates across the Health Board, with realistic improvement trajectories, with the aim of achieving the GIRFT recommendation of 85% **(Exhibit 6).**	As above	November 2025	Chief Operating Officer
7.5	Develop and rollout approaches to increase the use of "virtual" outpatient appointments, where clinically appropriate **(Exhibit 6).**	As above	November 2025	Chief Operating Officer
7.6	Develop job planning policy and guidance **(Exhibit 6).**	Reporting to Planned Care Programme Board, the newly appointed Medical Director will lead in this area.	December 2025	Medical Director
7.7	Ensure job plans are completed annually, utilising team-based job planning where it is appropriate to align	A rolling process of review will be put in place.	January 2026	Medical Director

Recommendation	Management response	Completion date	Responsible officer
consultant capacity to meet service demand **(Exhibit 6).** 7.8 Roll out pooled waiting lists across the Health Board particularly focusing on challenged services to ensure it treats its patients in turn **(Exhibit 6).**	Treat in turn is a key element of delivery of improved access for routine patients waiting an extreme amount of time. Pooled lists for BCUHB and then booking based on treat in turn essential as we look to deliver improved access to our local population. Initially we would look to complete this during 2025/26. However, Foundations for the Future will support delivery through changing operational structures.	November 2025	Chief Operating Officer
Promote, Prevent and Prepare for Planned Care policy R8 The Health Board complete the establishment of the 'Promote, Prevent and Prepare (3P's) for Planned Care' contact centre and ensure it covers all specialties **(Exhibit 7).**	Work has progressed in regards to development of the '3P's' for the Health Board, the policy being developed at this time. Work to continue into 2025/26 and complete in the later quarter of the financial year.	November 2025	Chief Operating Officer
Risk of harm R9 In order to strengthen its arrangements for managing the clinical risks associated with long waits, the Health Board should:			

Recommendation		Management response	Completion date	Responsible officer
9.1	Develop and implement a consistent methodology for assessing the risk of harm to patients caused by long waits across specialties **(Exhibit 7).**	This methodology is currently being worked on with the Clinical Executive of the Health Board.	October 2025	Executive Director of Nursing
9.2	Develop a routine report to be presented at the Quality and Safety Committee that effectively reports risks and actual incidents of harm resulting from delays in access to treatment **(Exhibit 7).**	The Health Board reports routinely to the Quality, Health & Safety Committee matters. As above.	November 2025	Executive Director of Nursing
9.3	Develop and implement clinical plans for all challenged services to ensure higher risk patients are prioritised **(Exhibit 7).**	Plans under development with a focus placed upon challenged specialities.	November 2025	Chief Operating Officer

Teitl adroddiad: ***Report title:***	Board Assurance Framework
Adrodd i: ***Report to:***	Performance, Finance & Information Governance Committee (PFIG)
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 26 August 2025
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this paper is to provide assurance to the committee on the progression of the Board Assurance Framework (BAF) risks. Over a quarter of risk actions have been completed and 70% progressing. PFIG do not have any oversight of delayed actions to which they are responsible for. The committee continue to require further assurance from Chief Operating Officer, Lead Executive, in relation to the progression and independent assurance of '*BAF24-07: Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk*', previously agreed as unsatisfactory assurance by the committee (little evidence for assurance that the current risk treatment strategy is effectively managing the threat). The Risk Scrutiny Group has held deep dives on risks associated with the BAF and those related to PFIG will be reviewed at the following meeting. N.B. The Board Assurance Framework will only be submitted to the Board in September 2025 by point of escalation to the Board through the Audit Committee chair's assurance report as per cycle of risk reporting (bi-annually to the Board, next BAF report in full to the Board Jan 2026).
Argymhellion: ***Recommendations:***	The Committee is asked to**:** • To **receive** and **consider** the contents and assurance rating of the Board Assurance Framework.
Arweinydd Gweithredol: ***Executive Lead:***	Pam Wenger, Director of Corporate Governance
Awdur yr Adroddiad: ***Report Author:***	Nesta Collingridge Head of Risk Management

Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☒	Am sicrwydd *For Assurance* ☐

Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth

	darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	*No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this: N/A***	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Detailed in the BAF report and how the CRR aligns to the revised BAF
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	It is essential that the Board has robust arrangements in place to assess, capture and mitigate risks, as failure to do so could have legal implications for the Health Board.
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	Not applicable for this report
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary ben undertaken?***	Not applicable for this report
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	Board Assurance Framework paper
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The effective and efficient mitigation and management of risks has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality, less waste and no claims.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Failure to capture, assess and mitigate risks can impact adversely on the workforce.

Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Risk Scrutiny Group feedback 09/07/2025 The Risk Scrutiny Group held a deep dive on the 'Not Delivering Strategic Development and Digital Transformation' risk. Suggested updates on the controls and actions are yet to be completed and will be completed prior to committee (to be updated 13th Aug). Wider suggestions made by the group around the impact score not being reduced for the target will be feedback when requesting updates.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	Board Assurance Framework risks linked to corporate risks
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	

Camau Nesaf:

Next Steps:

1. Delayed risk actions to be monitored (not in relation to PFIG actions as all are progressing/completed).
2. The actions within the BAF will all be reviewed in line with the final version of the Strategic Plans to ensure full alignment.
3. Business as usual reporting and monitoring: Bi-monthly Review at Risk Scrutiny Group and Executive Committee, monitoring of actions within risks. Reporting to Committee quarterly and Board bi-annually as per Risk Management Framework.

Rhestr o Atodiadau:

List of Appendices:

Appendix 1 – Full Board Assurance Framework

GIG CYMRU NHS
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Board Assurance Framework

Board Assurance Framework Report

Purpose

The Board Assurance Framework (BAF) serves as a strategic tool, designed to support the Health Board (BCUHB) in achieving its overarching goals and objectives. The BAF provides a structured approach for identifying, managing, and mitigating risks that may impact the successful delivery of our strategic priorities. Through clear alignment with our organisational strategy and key initiatives, the BAF enables us to maintain an accountable, transparent, and proactive approach to risk management.

The purpose of this BAF is threefold:

- To provide assurance that effective controls are in place to manage risks to our strategic objectives.
- To support informed decision-making by presenting clear, current risk insights to the Board and stakeholders.
- To align risk management efforts across the organisation, ensuring consistency with our vision of delivering high-quality, accessible healthcare services.

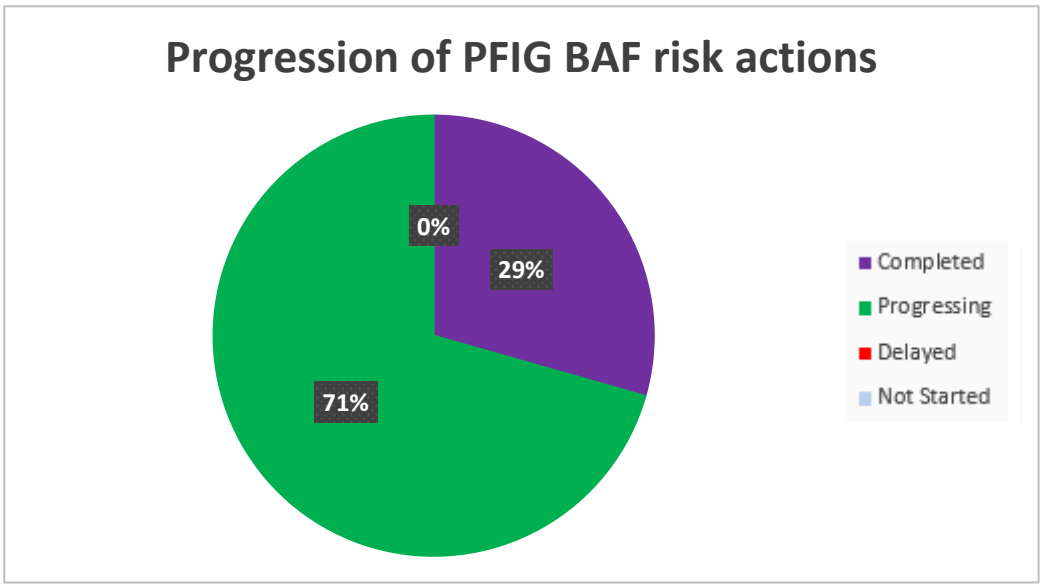
By integrating the BAF with our strategic priorities and operational plans, we can ensure that our risk management efforts directly support our mission to improve health outcomes, enhance patient safety, and foster a culture of accountability within BCUHB.

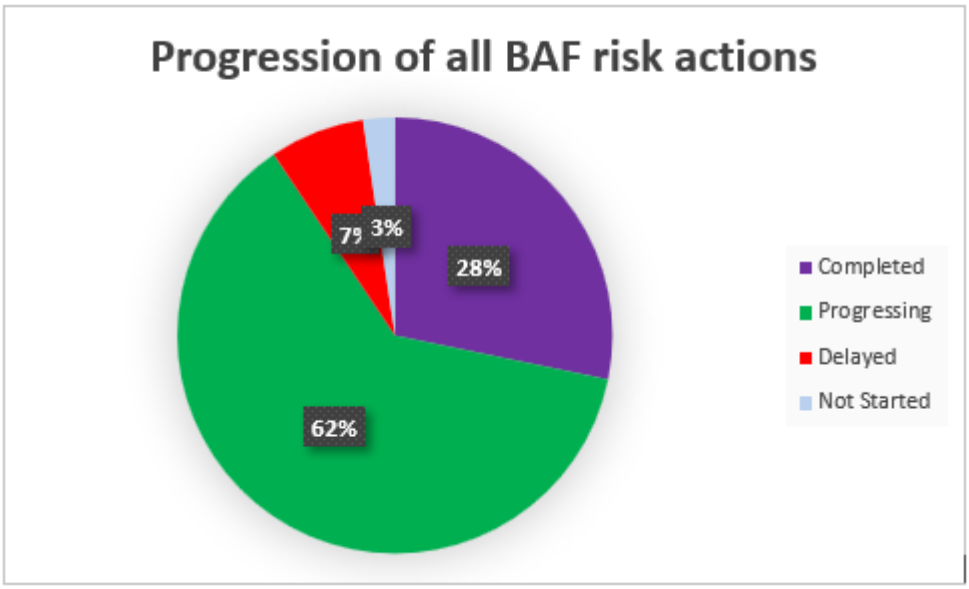
The purpose of this paper is to seek the Board's agreement on the proposed assurance ratings for each of the Board Assurance Framework (BAF) risks, following review by the Committee's responsible for the risks.

Board Assurance risks were developed by the Executive Team based on the Health Board's 5 strategic objectives. The BAF was approved by the Board 30 Jan 2025 and will be subsequently updated by action handlers and Executives on an on-going basis.

Key Highlights

Over a quarter of BAF actions have been completed since the last report to the committee, demonstrating good progress. The committee continue to require further assurance from Chief Operating Officer, Lead Executive, in relation to the progression and independent assurance of *'BAF24-07: Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk'*, previously agreed as unsatisfactory assurance by the committee (little evidence for assurance that the current risk treatment strategy is effectively managing the threat).





Next Steps

- Delayed risk actions to be monitored by the Risk Scrutiny Group and Executive Committee.
- The actions within the BAF will all be reviewed in line with the final version of the Strategic Plans to ensure full alignment.
- The Board Assurance Framework will be maintained and reported to the Risk Scrutiny Group; Executive Committee (bi-monthly) and Committees (quarterly) and Board (bi-annually) as per the Risk Management Framework.

Board Assurance Framework (BAF): June 2025

The key elements of the BAF are:

- A description of each Principal (strategic) Risk, that forms the basis of the HBs risk framework (with corresponding corporate and operational risks)
- Risk ratings – current (residual), tolerable and target levels. Risks are scored in line with the HB approved scoring matrix.
- Clear identification of strategic threats and opportunities that are considered likely to increase or reduce the Strategic Risk, within which they are expected to materialise
- A statement of risk appetite for each threat and opportunity, to be defined by the Lead Committee on behalf of the Board (Averse = aim to avoid the risk entirely; Minimal = insistence on low-risk options; Cautious = preference for low risk options; Open = prepared to accept a higher level of residual risk than usual, in pursuit of potential benefits)
- Key elements of the risk treatment identified for each threat and opportunity, each assigned to an Risk Lead and individually rated by the lead committee for the level of assurance they can take that the strategy will be effective in treating the risk (see below for key)
- Sources of assurance incorporate: (1) Management (those responsible for the area reported on); (2) Risk and compliance functions (internal but independent of the area reported on); and (3) Independent assurance (Internal audit and other external assurance providers).
- Unlike corporate risks where target dates are key for mitigation, risks will remain reported as the Board seeks assurance accordingly until the risk is sufficiently mitigated. Actions are based on quarters for the year.
- Board committees should review the BAF with particular reference to comparing the tolerable risk level to the current exposure risk rating.
- The RACI clarifies roles and responsibilities for tasks and deliverables and is utilised for sub-risks however the responsibility of the overall BAF risks of the lies with the **Executive Team** and accountability lies with the lead committee.

Likelihood score and descriptor					
	Very unlikely 1	**Unlikely 2**	**Possible 3**	**Somewhat likely 4**	**Very likely 5**
Frequency How often might/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally or there are a significant number of near misses / incidents at a lower consequence level	Will probably happen/recur, but it is not a persisting issue/ circumstances	Will undoubtedly happen/recur, possibly frequently
Probability Will it happen or not?	Less than 1 chance in 1,000 (< 0.1%)	Between 1 chance in 1,000 and 1 in 100 (0.1 - 1%)	Between 1 chance in 100 and 1 in 10 (1- 10%)	Between 1 chance in 10 and 1 in 2 (10 - 50%)	Greater than 1 chance in 2 (>50%)

Key to lead committee assurance ratings:

 **Substantial Assurance**	The Committee is satisfied that there is reliable evidence supporting the effectiveness of the current risk treatment strategy in mitigating the threat, with minimal gaps in control. While the majority of actions have been addressed, some minor actions may still require completion before the risk score is reduced. However, the Committee has good assurance regarding action progress. Likelihood of risk materialising: Low.
 **Reasonable Assurance**	The Committee has seen sufficient evidence that the most significant actions to reduce the risk have been completed. There is assurance that the planned actions within the current risk treatment strategy are appropriate, with the majority of control and assurance gaps having been addressed. Likelihood of risk materialising: Low to moderate.
 **Limited Assurance**	The Committee does not have sufficient evidence for assurance that the current risk treatment strategy is effectively mitigating the threat. There remains to be some key gaps in controls that require management attention, and further external validation is needed. Until further controls are in place, there remains a number of actions to reduce the score. Likelihood of risk materialising: Moderate.
 **Unsatisfactory Assurance**	The Committee has no/little evidence for assurance that the current risk treatment strategy is effectively managing the threat. There remains to be several key gaps in controls that require management attention, and further external validation is needed. Until further controls are in place, there remains a number of actions to reduce the score. Likelihood of risk materialising: High

This BAF includes the following Risks to the HBs strategic priorities:

Reference	Principal risk: There is a risk of…	Lead Executive	Lead Committee	Initial date of assessment	Last reviewed by Executive Team	Previous risk score (at previous review/update) C x L	Current risk score C x L	Target risk score C x L
BAF24-01	Not Fully Building an Effective and Accountable Organisation	Director of Corporate Governance and Executive Team oversight	Performance, Finance and Information Governance	20/10/2024	21/07/2025	4x 3= 12	**4x 3= 12**	2x 2= 4
BAF24-03	Not Achieving Long Term Financial Sustainability	Executive Director of Finance	Performance, Finance and Information Governance	20/10/2024	21/07/2025	5x 4= 20	**5x 4= 20**	3x 3= 9
BAF24-07	Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk	Chief Operating Officer	Performance, Finance and Information Governance	20/10/2024	21/07/2025	4x 4= 16	**4x 4= 16**	4x 2= 8

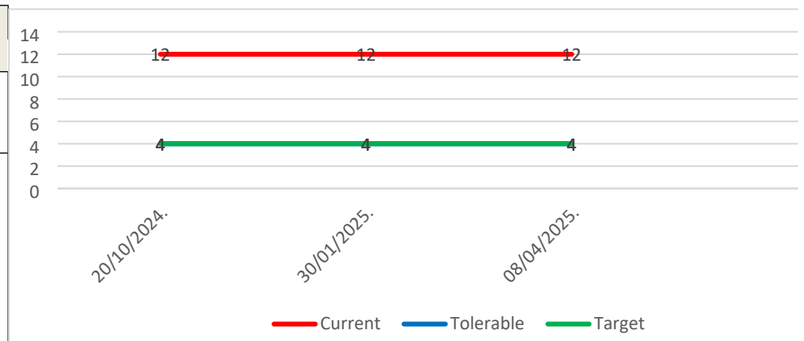
1: Building an effective organisation

Objective area 1 recognises the importance of governance and effective procedures and decision making in high functioning Healthcare organisations. This will better ensure that decisions are made in a timely way, using appropriate information, and that the right people have been involved to ensure the right decisions are made first time.

Principal risk (what could prevent us achieving this strategic objective)	**BAF24-01: Not Fully Building an Effective and Accountable Organisation** Ineffectively delivering interconnected governance, operational, performance, and legislative challenges that could impede the Health Board's ability to develop a high-functioning, accountable, and cohesive organisation.			**Strategic objective**	1. To Build an Effective Organisation (1A & 1B: Governance (Board Effectiveness / Risk Management) 1C Operating Model; 1D Performance and Accountability Framework;1F: Legislative Improvements)
Lead Committee	Performance, Finance and Information Governance Committee	**Risk type**	Compliance/Regulatory		
Risk Lead	Director of Corporate Governance with Executive Committee Oversight	**Risk appetite**	Open <16		
Related Corporate Risks:	CRR24-15 Health and Safety				

Board Assurance Framework (BAF): June 2025

Risk rating				Review Dates	
	Current exposure	**Tolerable**	**Target**		
Consequence	**4. Major**	2. Minor	2. Minor	**Initial date of assessment**	20/10/2024
Likelihood	**3. Possible**	2. Unlikely	2. Unlikely	**Last reviewed by Committee:**	29/04/2025
Risk rating	**12. Moderate**	**4. Low**	**4. Low**	**Last updated by Executive:**	08/04/2025



N.B. Tolerable and Target score lines stacked as both are 4.

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues**	**Assurance rating**
Responsible: Head of Covid-19 Inquiry and Thirlwall Inquiry/Assistant Director of Occupational Health, Safety And Security/ EPRR Lead		Accountable: Executive Committee			
Threat: the HB may not be compliant. This could lead to poor decision-making, unaddressed performance gaps, and a lack of ownership over key outcomes, ultimately reducing the Health Board's ability to deliver its strategic goals effectively.	• Health and Safety Policy • HS03 General Risk Assessment Procedure • HSG65 Plan, Do, Check, Act process for continuous improvement • Service Sector Health and Safety Self-Assessment and Health and Safety Reviews • Security Assessment of Premises • Some Civil Contingencies and Emergency Preparedness plans • Annual emergency preparedness evaluations improvement	• Remaining gaps in civil contingency planning post-pandemic • Incomplete integration of HSE recommendations into operational plans	**Management:** Health and Safety compliance reporting to Strategic Occupational Safety and Health Group (SOSHG) Monthly reviews of Health, Safety and Security KPIs **Risk and compliance:** Risk Register reporting but noted gap on the Gap analysis reporting for compliance and gaps of general legislative gap analysis **Independent assurance:** • HSE audit and compliance checks • Civil Contingencies Act compliance review	• Gap analysis reporting general legislative gap analysis • Limited Assurance Internal Audit report for Health and Safety & Corporate Legislative Compliance. Improvement action plan in place and monitored at SOSHG.	**Limited Assurance**

Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?)	**Action Handler**	**Status of Actions**	**Date when action will be completed**
Approval and progression of the gap analysis for health and safety measures as set out in the updated Health and Safety Strategy and Plan 2024-2026 dated September 2024.	Lynne Bushell	Complete	30/09/2024
New approach for Health and Safety Management System being developed aligned to NHS Employers Health and Safety Standards, to include Violence Prevention and Reduction Standards	Lynne Bushell	Progressing	31/12/2025

Responsible:	Director of Performance and Commissioning	Accountable:	Director of Corporate Governance/CEO

Board Assurance Framework (BAF): June 2025

Threat: the Performance and Accountability Framework may not effectively establish clear lines of accountability and provide consistent, real-time performance monitoring. This could lead to poor decision-making, unaddressed performance gaps, and a lack of ownership over key outcomes, ultimately reducing the Health Board's ability to deliver its strategic goals effectively.	• Integrated Performance Framework • Integrated Performance reports aligned • Clear accountability matrix and escalation for senior and mid-level management • Performance scorecards for service delivery units	• Inconsistent application of performance tools across departments • Review Integrated Performance Framework to re-align with new strategic objectives Triangulation with risk management	**Management:** • Reviews of performance metrics at Executive Team level • Regular reporting to Committees **Risk and compliance:** • Monthly accountability reviews if in escalation for services SLT • Performance Reviews held by the CEO • Monthly performance reviews by Welsh Government **Independent assurance**: • External NHS Wales and Health Boards performance benchmarking and NHS benchmarking network	• Reports on performance at IHC • Commissioning reports on out of area	**Limited Assurance**

↑	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Action Handler**	**Status of Actions**	**Date when action will be completed**
	Finalise the redesign of reporting structures/timings to enhance transparency	Stephen Powell	Progressing	30/06/2025
	Improved Risk triangulation with concerning trajectories	Nesta Collingridge	Progressing	31/09/2025

Responsible:	Director of Corporate Governance	Accountable:	CEO

Threat: the Health Board's operating model may become inefficient or fragmented, leading to unclear roles, duplication of efforts, and siloed working. This could result in reduced operational effectiveness, slower decision-making, and diminished quality of care,	• Current definitions of operating model roles and structures in place • Business Partnering approach for clinical and corporate leadership • Staff co-producing a new Operating Model	• Delays in decision-making due to leadership duplication • Lack of integrated systems reducing efficiency • Service reconfiguration plans based on population health needs • Digital tools (Microsoft 365) to streamline operations	**Management:** • Service-level performance audits **Risk and compliance:** • Assessments of operating model efficiency and insight reports **Independent assurance:** • Operating model effectiveness review by internal and external stakeholders • Internal Audit report on duplication of roles and decision-making timelines	• Limited Assurance Internal Audit report for Operating Model & Effective Governance (IHC) Central	**Limited Assurance**

↑	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Action Handler**	**Status of Actions**	**Date when action will be completed**
	Completion of the discovery phase reviewing of the operating model based on stakeholder feedback	Julie Parry	Complete	30/11/2024
	Implement a streamlined decision-making protocol by Q3 and looking a re-design phase	Pam Wenger	Progressing	31/10/2025
	Review of the Scheme of Delegation and establishment of a formal Executive Committee with reporting groups with clear delegations. Scheduled to for presentation at the next Audit Committee 04/03/2025 - Formal Executive Committee approved as part of the CEO report by Board 30/01/2025. For approval July Board.	Philippa Peak Jones	Progressing	31/07/2025

Responsible:	Head Of Corporate Affairs/Head of Risk Management	Accountable:	Director of Corporate Governance

Threat: the Health Board's has weak Governance and Ineffective Risk Management Practices	• Risk Management Framework updated for improved escalation pathway to Risk Scrutiny Group. • Risk Appetite set 24/25 • Board Development Programme	• Gaps in risk governance maturity, with some areas requiring support and more training to integrate the Risk Framework and Procedures. • Policy Management system and overdue policies.	**Management:** • Risk reporting at local level and strategic level. **Risk and compliance:**	• Limited Assurance Internal Audit reports for: Review of Board Effectiveness & Standards of Business	**Limited Assurance**

	• Internal Audit Tracking of Recommendations • Board committee structure now all in place	• Self-assessment of board effectiveness • Robust Internal Audit Tracking software and systems. • Incomplete recruitment of executive roles. • Equality Impact Assessment Process integrated within Impact Assessment Impact Screening Tool to ensure compliance	• Risk reporting to the Executive Team and Committees Key Performance Indicators (KPIs) on risk management performance **Independent assurance:** • Internal Audit Reporting • Audit Wales Structured Assessment Report and other Audit Wales Reports	Conduct - Declarations of Interest, Gifts and Hospitality & Risk Management • Audit Wales governance recommendations	

Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?)	**Action Handler**	**Status of Actions**	**Date when action will be completed**
Improved Scrutiny of Corporate Risks. & Development of the BAF	Nesta Collingridge	Complete	30/01/2025
Improved Data Analytics of Governance around Risk (Dashboard) and driving improvement of metrics. N.B This work will be ongoing now to ensure the KPIs remain in tolerance (risks being updated) and reported to Audit Committee quarterly.	Nesta Collingridge	Complete	30/01/2025
Review of the current system once progress has been made on the overdue policies. System approved for procurement which will support automated tracking.	Glesni Driver	Progressing	31/03/2026
Reviewing current systems to have a more effective way of tracking and reporting audit recommendations. Corporate Governance (policies/tracking) /Risk Management and System approved for procurement 22/01/25, new software in place by 30/12/25 but piloted in 2026 which will support automated tracking. This will not be embedded until 2026-2027.	Glesni Driver	Progressing	30/09/2026
Executive Team recruitment ongoing with some progress made on appointments.	Georgina Roberts	Progressing	31/03/2026

2: Developing strategy and long-lasting change

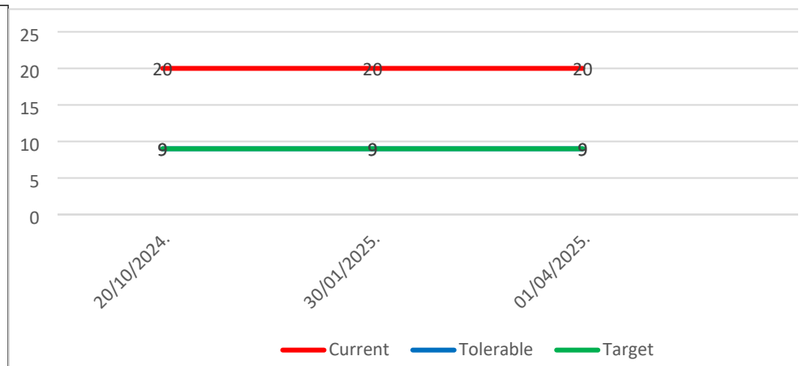
Objective area 2 draws upon the need for the Health Board to be clear about population needs in North Wales and that services are configured in a way to get the highest value from the resources available to us. In this way the Health Board can provide services that are reliable, more cost-effective, and that make the best use of healthcare professionals.

Principal risk (what could prevent us achieving this strategic objective)	**BAF24-03: Not Achieving Long Term Financial Sustainability**			**Strategic objective**	2. Developing strategy and long-lasting change (2I Finance Governance Environment; 2D Capital Priorities: Supporting Change)
Lead Committee	Performance, Finance and Information Governance Committee		**Risk type**	Finance	
Risk Lead	Executive Director of Finance		**Risk appetite**	Open <16	
Related Corporate Risks:	CRR24-05 Financial Sustainability /CRR24-06 Suitability and Safety of Sites				

Risk rating				**Review Dates**	
	Current exposure	**Tolerable**	**Target**		
Consequence	**5. Catastrophic**	3. Moderate	5. Moderate	**Initial date of assessment**	20/10/2024

Board Assurance Framework (BAF): June 2025

Likelihood	**4. Somewhat likely**	3. Possible	2. Possible	**Last reviewed by Committee:**	29/04/2025
Risk rating	**20. High**	**9. Medium**	**10. Medium**	**Last updated by Executive:**	**01/04/2025**



N.B. Tolerable and Target score lines stacked as both are 9.

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps**	**Assurance rating**
Responsible:		Interim Director of Finance	**Accountable**:	Executive Director of Finance	
Threat: Health Board key financial duty is to attain a break-even financial position. Failure to achieve the key duty results in cash depletion and a lack of ability to pay employees and suppliers of goods and services. A reduction in funding or change in financial trajectory or unexpected event resulting in an increased Financial Improvement Plan (FIP) requirement to reduce the scale of the financial deficit, without having an adverse impact on quality and safety	• Annual Plan details requirements for further controls and required controls detailed in 'Gaps in controls' • Monthly reporting of financial performance, articulating risk to delivery, drivers of any financial risk and suggested actions in place to mitigate risk • Monthly reporting to Welsh Government financial performance each month, again articulating drivers of risk to delivery and mitigating actions • Corporate risk for shorter term sustainability in place	• Financial governance framework aligned with the organisation's strategic priorities. • An endorsed Clinical Strategy that articulates demand and capacity modelling by speciality. • Financial capital resource availability • Integration of financial planning with performance and risk management processes • The Health Board has a planned deficit in year, not achieving the key 1st duty to attain break-even. This presents a current unmitigated risk to balancing financial allocations with spending in year. Inconsistent alignment between financial planning and strategic service goals	**Management:** • Monthly financial reporting and budgetary controls **Risk and compliance:** • Oversight by Audit Committee • Annual audit of financial governance effectiveness • Regular financial performance reviews **Independent assurance**: • Internal and external audit reports on financial controls • Annual review of compliance with Welsh Government financial guidelines • Monthly oversight of financial performance by Welsh Government	• Limited Assurance Internal Audit report for Delivery of Health Board Transformational Savings & Budgetary Control • Limited assurance report on budgetary control environment • Head of Internal Control Opinion articulating limited assurance over systems of internal control • Qualification of accounts 2022/23 and Qualification for regulatory breach 2024/25 • All containing actions to address gaps	**Limited Assurance**

Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?)	**Action Handler**	**Status of Actions**	**Date when action will be completed**
Implementation of Value Based Healthcare and a Value and Sustainability approach to savings development. Implemented and principle approach agreed, savings will be developed through Executive leads through transactional and transformational schemes.	Joanna Garrigan	Progressing	31/03/2026
Strengthen financial forecasting and integrate financial risks into operational planning. Progressing through IMTP production.	Joanna Garrigan	Progressing	30/09/2025

	Develop further the control environment for addressing planned position and implementation of any corrective actions. Additional control actions have been implemented to support the HB .	Joanna Garrigan	Complete	31/03/2025
	Enhanced Accountability & Performance framework to hold officers to account for delivery. Areas for escalation have been identified and separate meetings held with services chaired by CEO.	Joanna Garrigan	Complete	27/12/2025

Responsible:	Head Of Capital Development	Accountable:	Executive Director of Finance

Threat: Inadequate Capital Investment to Support Organisational Change	• Estates Strategy • Capital prioritisation programme aligned with strategic objectives that involves operational and clinical teams in prioritisation of limited resources • Project management for capital investments, the Health Board having substantial material schemes in train • Prioritisation of investments in infrastructure to support clinical services and statutory requirements • Capital Manual • Capital prioritisation for urgent projects • Six facet survey being completed for all provider infrastructure	• Delays in capital project approvals and implementation. • End of year wrap up report on overheads and programme progress. • Implement stronger project management controls to track capital investments. • Discretionary capital use in prioritisation between medical equipment, IM&T and Estates works (relative prioritisation between asset classes not undertaken) • Prioritisation of substantial business cases within the plans of the Health Board that aligns to Clinical Strategy	**Management:** • Monthly financial reporting of plan verse actual expenditure and budgetary controls **Risk and compliance:** • Some reviews to assess the alignment of capital investments with strategic goals Board **Independent assurance:** • Internal Governance of capital project progress and expenditure and reporting up to Committee and Welsh Government. • Welsh Government monthly reviews of plans for expenditure in year verse allocated resources.	• Reports on alignment of capital investments with strategic goals Board • Prioritisation plans being endorsed through Executive for inclusion within the IMTP endorsed through Health Board and Committees. • External support secured to service major capital developments. • Capital Investment Group formed, reporting into Executive on Capital works.	**Limited Assurance**

Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?)	**Action Handler**	**Status of Actions**	**Date when action will be completed**
Decarbonisation Board reporting of key objectives through to Committee (PPHP) completed, articulating goals and objectives through to Health Board. Revised NHS Wales decarb plan due for review in 2025, once finalised the HB will produce and action plan.	Stuart Keen	Progressing	31/03/2026
Ongoing development of Estates strategy to be informed by completion of six facet survey (review of estates which will take 12* months) with the view of generating capital through disposals.	Stuart Keen	Progressing	31/03/2026
Monthly reporting of this year's expenditure verse plans in order to ensure delivery of this year's capital programme, fully embedded and forms new control.	Executive Director of Finance	Complete	31/03/2026
Prioritisation of major capital works within the strategy for the Health Board in completion of the three-year IMTP. Schemes and priorities discussed at Execs.	Ian Howard	Progressing	31/03/2026

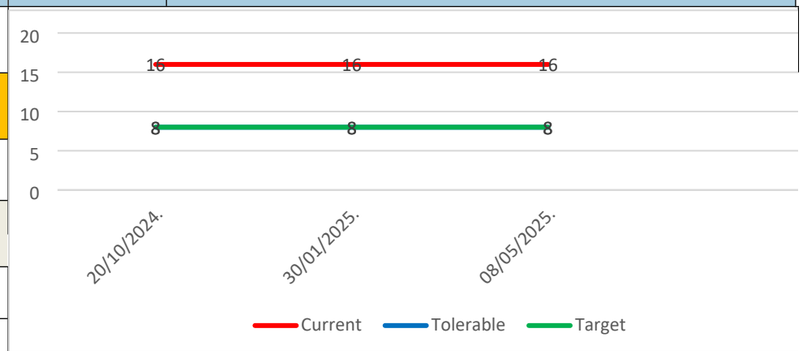
4: Improving quality, outcomes and experience

Objective area 4 covers a large thematic area where improvements are required to improve clinical performance across a number of key areas. The Health Board wishes to build further upon good work commenced that takes a pathway focused approach to this.

Board Assurance Framework (BAF): June 2025

Principal risk (what could prevent us achieving this strategic objective)	**BAF24-07: Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk** Risk of ineffectively delivering timely access to care resulting in potential clinical harm, poor delivery of performance targets and reputational risk			**Strategic objective**	4. To Improve Quality, Outcomes and Experience 4E: Planned Care; 4F: Cancer Care; 4G: Urgent and Emergency Care; 4H: Diagnostics; 4ICAMHS and Neurodevelopment)
Lead Committee	Performance, Finance and Information Governance Committee	**Risk type**	Quality		
Risk Lead	Interim Chief Operating Officer	**Risk appetite**	Open <16		
Related Corporate Risks:	CRR24-10 Urgent Emergency Care/ CRR24-11 Planned Care/ CRR24-12 Areas of Clinical Concern /CRR24-13 Timely Diagnostics				

Risk rating				**Review Dates**	
	Current exposure	**Tolerable**	**Target**		
Consequence	**4. Major**	4. Major	4. Major	**Initial date of assessment**	20/10/2024
Likelihood	**4. Somewhat likely**	2. Unlikely	2. Unlikely	**Last reviewed by Committee:**	01/05/2025
Risk rating	**16. High**	**8. Medium**	**8. Medium**	**Last updated by Executive:**	08/05/2025



N.B. Tolerable and Target score lines stacked as both are 8.

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Responsible: Interim Associate Director for Emergency Care/ Associate Director of Planned Care/ Professional Service Manager Radiography/ Assistant Area Director – Children		Accountable: Chief Operating Officer	Responsible Committee: Performance, Finance and Information Governance Committee		
Threat: The Health Board faces significant risks related to the ability to meet national and local performance targets related to access to timely care. The increased patient acuity, backlog of long waiting times, lack of standardised processes and robust demand and capacity planning at service level may negatively impact the delivery of consistent quality of care. Without strategic planning and robust controls, these risks could lead to reduced public confidence, increased colleague fatigue, ineffective use of resources and failure to achieve regulatory compliance or national standards.	• Initiation of demand capacity plans at specialty/service level • Improved planning including the Winter Resilience Plan with clear principles to protect urgent and planned care pathways • Major change programmes for Urgent and Emergency Care (UEC) and Planned Care • Strengthening preventative support through integrating services such as SICAT and GP out of hours with active community pathways • Strengthening capability and capacity to lead and deliver services with clear executive Senior Responsible Officers (SRO) in place supported by clinical and operational leads • Cancer recovery plan • Planned care delivery plan against the agreed trajectories supported with resource allocations • Diagnostics delivery plan against the agreed trajectories supported with resource allocations • Governance framework for accountability including weekly executive led progress reviews for UEC and Planned Care • Chief Operating Officer and Director of Performance and commissioning collective leadership oversight for operational performance with support from the executive team • Clear workstreams (4) for UEC incorporated into operational planning and delivery as a framework aligned to the national 6 goals for UEC	• Clinical variations and lack of standardised operational processes across the Health Board • Limited integration of pathways and care processes between primary, community and secondary care • Insufficient capacity in challenged services and Neurodevelopment • Strategic approach for equipment replacement scheme to ensure service efficiency and sustainability • Estates strategy to address service needs • Challenges in workforce retention and gaps in critical roles affecting service delivery Need for enhanced digital infrastructure to support predictive analytics and proactive planning	**Management:** • Integrated Quality Performance Delivery • Tracking referrals and waiting times • Performance tracking on ambulance handovers • Monthly Performance monitoring • Strategic Improvement Development Groups. • Reviewing consistency in triage processes **Risk and compliance:** • Performance reports to Integrated Performance Executive Delivery Group & Board • Corporate Risk reporting • Patient-reported outcome measures (PROMs) and Patient-reported experience measures (PREMs) data	• Independent reviews (focused on areas of concern) • Daily Health Board wide oversight grip in control for UEC performance and reporting • Health Board resource plan for seven-day UEC care model • Health Board workforce plan to align demand and capacity on a seven-day basis • Clear structure and delivery for pathways of care delays for North Wales as a system • Ensuring compliance with Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation. • Lack of consistent and reliable performance data at daily and weekly level. • Health Board workforce plan at modality level.	**Unsatisfactory**

	• Optimised hospital flow through SAFER programmes and discharge protocols ensuring resilience to protect planned care pathways • Access to care based on clinical urgency and then chronological wait across all programmes of care • Developing close partnership working with the 6 Local Authorities, Welsh Ambulance Service Trust (WAST), third sector and other providers to maximise care outcomes • Effective utilisation through planning and robust governance for use of nationally allocated resources for planned care and UEC • Regional approach in strategic planning through the Regional Partnership Board ensuring a North Wales approach for delivering services for our citizens		**Independent assurance:** • Internal Audit findings demonstrating substantial assurance • Welsh Government Targets • Joint Executive Team WG • UEC Programme Board with WG attendance • NHS Executive touch points • Significant guidance and steer with National Imaging Programme • CAMHS & Neurodevelopment National Programme links established. National Specification being worked towards. • Regional ND, CAMHs meetings for improvement. • CAMHS & Neurodevelopment Enhanced Monthly NHS Exec meeting with performance leads.	• Specific diagnostics assurance process to delivery national patient standard for wait levels. • CAMHS & Neurodevelopment Improvement programme reporting to be defined and governance structure	

Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?)	**Action Handler**	**Status of Actions**	**Date when action will be completed**
Major change programmes for UEC and planned care aligned to the Six Goals for Urgent and Emergency Care (UEC) framework and national objectives (such as timely access to care and building community capacity). Governance structure completed, all workstreams now all aligned.	Alison Bishop	Complete	31/03/2025
UEC improvement programme review to ensure the necessary improvements and outcomes are having the required impact on quality and safety of UEC services. Sept midway review.	Alison Bishop	Progressing	30/09/2025
Use of data analytics to identify high-risk populations (completed) and optimise resource allocation, as a part of workstream one, needs aligning to enhanced community care.	Alison Bishop	Progressing	31/03/2026
Deployment of live dashboards for real-time monitoring (complete) of performance and governance metrics. Standardise data collection and reporting processes to reduce variability in decision-making. Review of various dashboards to align input criteria and date. Data quality and alignment to data dictionary review ongoing. Dashboard designs work ongoing. Design phase to be complete by 31/07/2025. Once designed, build and deployment to take place with timescale tbc	Alison Bishop/ David Hutton	Progressing	31/06/2025
Strengthen digital capabilities to support service teams (such as e-triage, further roll out of home adaptations particularly rural areas, single patient tracking lists). Align digital plan to UEC plans.	Alison Bishop/Danielle Edwards	Progressing	31/03/2026
Standardising care pathways across the Health Board. Current mapping exercise. Sits within clinical service strategy, community health pathways being rolled out for development in elective care.	Alison Bishop/Vicky Freeman	Progressing	31/03/2026
Winter Resilience Plan milestones and adherence to ministerial requirements for capacity building, plan complete evaluation and lessons learnt. Winter learning and planning events have been held. Planning phase has started. 31/08/2025	David Hutton	Complete	31/05/2025
Revised Access policy to ensure standardised practice across the Health Board	Rhys Blake	Complete	30/01/2025
Re-enforce specialty level planning cycle through service line demand and capacity plan across the Health Board. Reinforced with services, complete. To be evidenced in April 2026 through Plans	Stephen Powell/Kathryn Lang	Progressing	31/03/2026
Strengthened workforce planning for key areas linked to challenged services	Tracey Rosco/Paolo	Progressing	31/03/2026
Telehealth care to strengthen out of hospital care including home systems and video facilitated care forms workstream 1 or 4 for UEC	Alison Bishop	Progressing	*TBC*
Continued efforts to further strengthen collaboration with local authorities and voluntary sectors for integrated care delivery models. Milestones to be reported	Chief Operating Officer	Progressing	31/03/2026

	Incorporate public health needs analysis to service planning (such as deprivation links to access for UEC, Planned Care, CAMHS and Womens services)	Chief Operating Officer /Executive Director of Public Health	Progressing	31/03/2026
	Regional approach for services such as Child and Adolescent Mental Health (CAMHS)	Louise Bell	Progressing	31/09/2025

Betsi Cadwaladr University Health Board
Performance, Finance and Information Governance Committee

Cycle of Business

(1 April 2025 – 31 March 2026)

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

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

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

The role of the Performance, Finance and Information Governance Committee is set out in the Terms of Reference which is available here: [Insert here]

Committee Chair	**Independent Members**	**Executive Members**	**In Attendance**
Gareth Williams	Mike Larvin	Russell Caldicott (Executive Director of Finance)	Pam Wenger (Director Corporate Governance)
	Christopher Lothian Field	Tehmeena Ajmal (Chief Operating Officer)	Stuart Keen (Director of Environment & Estates)
Committee Vice Chair	Rhian Watcyn Jones	Dylan Roberts (Chief Digital and Information Officer)	Stephen Powell (Director of Performance & Commissioning)

PERFORMANCE, FINANCE AND INFORMATION GOVERNANCE COMMITTEE CYCLE OF BUSINESS 2025-26

Item of Business	Executive Lead	Reporting period	Q1			Q2			Q3			Q4			2026-27	
			April 2025	May 2025	June 2025	July 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	April 2026	May 2026
Preliminary Matters																
Minutes of the previous Board Meeting	Director of Corporate Governance	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑		⚑	
Action Log	Director of Corporate Governance	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑		⚑	
Governance, Risk & Assurance																
Corporate Governance Report: • Committee Cycle of Business • Committee Terms of Reference • Committee Annual Report • Committee Self-Assessment *(Going forward these documents will go to the Committee in March)*	Director of Corporate Governance	As Required	⚑													
Corporate Risk Register Report	Director of Corporate Governance	Quarterly	⚑		⚑				⚑				⚑			
Board Assurance Framework Report	Director of Corporate Governance	Bi-Annually	⚑				⚑				⚑					
Finance Report	Executive Director of Finance	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑		⚑	
Integrated Performance Report	Director Performance & Commissioning	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑		⚑	
Information Governance Strategy	Chief Digital & Information Officer	Bi-Annually														
Adoption of Corporate Policies • TBC	Director of Corporate Governance															
Strategic Item 2 – Developing Strategy and Long-Lasting Change																
Estates Plan 2025/2028	Director of Environment & Estates	Annually											⚑			
List Business Cases related to Key Programmes for approval																
Planning, Performance and Strategy																

Item of Business	Executive Lead	Reporting period	Q1			Q2			Q3			Q4			2026-27	
			April 2025	May 2025	June 2025	July 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	April 2026	May 2026
Integrated Medium Term Plan (Drafts & Approval)	Executive Director of Transformation & Strategic Planning	Annually / As Required									⚑		⚑			
IMTP Progress Report	Executive Director of Transformation & Strategic Planning	End of year regular update							⚑		⚑		⚑			
Performance Management Framework	Director Performance & Commissioning	Annually									⚑					
Key Programmes																
Mental Health Electronic Health Records (EHR)	Chief Digital & Information Officer															
Electronic Healthcare Record (EHR)	Chief Digital & Information Officer						⚑									
Maternity Electronic Health Record (EHR)	Chief Digital & Information Officer															
LIMS and RISP replacement programmes	Chief Digital & Information Officer															
ePMA programme	Chief Digital & Information Officer															
ePMA programme	Chief Digital & Information Officer															
Llandudno Orthopaedic Hub	Director of Environment & Estates															
Ablett Mental Health Unit	Director of Environment & Estates															
Royal Alexandra Hospital	Director of Environment & Estates															
Well-being hubs: Caledfryn, Conwy West, Holyhead, Bangor, Penygroes	Director of Environment & Estates															
Major Programmes																
Planned Care	Chief Executive Officer															
Urgent and Emergency Care	Chief Operating Officer															
Value and Sustainability	Executive Director of Finance															
Foundations for the Future																
Strategic Item 4 – Improving Quality, Outcomes and Experience																
Progress against Planned Care Performance Targets (4Da)	Chief Executive		⚑		⚑		⚑		⚑		⚑		⚑		⚑	

Item of Business	Executive Lead	Reporting period	Q1			Q2			Q3			Q4			2026-27	
			April 2025	May 2025	June 2025	July 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	April 2026	May 2026
Urgent and Emergency Care Programme Board (4E)	Chief Operating Officer		⚑		⚑		⚑		⚑		⚑		⚑		⚑	
Procurement of Dental Services (4O)	Chief Operating Officer															
For Information																
Summary of Business to be reported from Private	Director of Corporate Governance	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑		⚑	
Forward Work Plan	Director of Corporate Governance	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑		⚑	
Cycle of Business	Director of Corporate Governance	Annually	⚑													
Closing Business																
Agree Items for Referral to Board / Other Committees	Chair		⚑		⚑		⚑		⚑		⚑		⚑		⚑	
Review of meeting effectiveness	Chair	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑		⚑	
Date of the next meeting	Chair	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑		⚑	
Resolution to exclude the Press and Public	Chair	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑		⚑	
Private Agenda																

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

PERFORMANCE, FINANCE AND INFORMATION GOVERNANCE COMMITTEE

Annual Report 2024-25

FOREWORD

I am pleased to present the 2024-25 Annual Report of the BCUHB Performance, Finance and Information Governance Committee which outlines the activity for the period 1 April 2024 – 31 March 2025.

Gareth Williams
Chair of the Performance, Finance and Information Governance Committee

PERFORMANCE, FINANCE AND INFORMATION GOVERNANCE COMMITTEE Annual Report 2024 - 2025

1. Introduction

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

1.2 The Committee's Annual 'Business Cycle' was reviewed on in January 2024 and was a key component in ensuring that the Committee effectively carried out its role during 2024 – 25.

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

2. Role and Responsibilities

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

2.1.1 Advise and assure the Board in discharging its responsibilities with regard to its current and forecast financial position and performance.

2.1.2 Oversight, delivery and monitoring of financial strategy, planning, policies and performance including capital and external contracting.

2.1.3 Oversight, delivery and monitoring of performance strategic, framework, policies, Welsh Government / local targets and performance reports.

2.1.4 Monitoring the performance of external contracts including shared services and primary care. The Committee will provide advice on the adoption of a set of key indicators of quality of care against which the Health Board performance will be regularly assessed and reported on.

2.1.5 To seek assurance on the management of principle risks within the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) allocated to the Committee and provide assurance to the Board that risks are being managed effectively and report any areas of significant concern.

2.1.6 To monitor the performance and oversight of Information Governance.

3. Agenda Planning Process

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

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

3.3 The secretariat for the meeting is provided by Philippa Peake-Jones.

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

4. Operating Arrangements

4.1 Only very minor amendments were considered necessary in respect of the Terms of Reference and Operating arrangements for the Performance, Finance and Information Governance Committee.

4.2 The new Committee Cycle of Business for the Performance, Finance and Information Governance Committee is being presented for approval on 26 August 2025, however the agenda for each meeting is sufficiently flexible to allow the Committee to consider any emerging issues.

5. Membership, Frequency and Attendance

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

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

Name	(XX) Committee (out of xx possible meetings)
Gareth Williams (Committee Chair)	Six out of six meetings
Chris Lothian-Field	Six out of six meetings
Rhian Watcyn Jones	Six out of six meetings
Mike Larvin	Five out of six meetings

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

6. Committee Activity

6.1 The Committee fulfilled its work plan for 2024-2025 covering a wide range of activity. This work can be summarised as follows;

a) To advise and assure the Board in discharging its responsibilities with regard to its current and forecast financial position and performance.
b) Oversight, delivery and monitoring of financial strategy, planning, policies and performance including capital and external contracting.
c) Oversight, delivery and monitoring of performance strategies, framework, policies, WG / local targets and performance reports.
d) Monitoring the performance of external contracts including shared services and primary care. The Committee will provide advice on the adoption of a set of key indicators of quality of care against which the Health Board performance will be regularly assessed and reported on.
e) To seek assurance on the management of principle risks within the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) allocated to the Committee and provide assurance to the Board that risks are being managed effectively and report any areas of significant concern.
f) To monitor the performance and oversight of Information Governance

7. Key Achievements/Benefits:

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

a. Successful establishment and operation of the Committee with full engagement from members and supporting officers.

b. Consistent reporting on Finance, Performance and Information Governance
c. Conducted a self-assessment.
d. Identified areas of progress and opportunities for improvement.
e. Covered a wide range of governance and assurance activities including:
f. Financial accounts and audit reports.
g. Risk management and control frameworks.
h. Policy and compliance oversight.
i. Fraud prevention
j. Regular 'AAA Reports' submitted to the Board.
k. Transparent publication of minutes and papers on the Health Board's website.

8. Key Challenges

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

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

9. Committee Effectiveness & Performance

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

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

9. Reporting the Committee's Work

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

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

10. Conclusion and way forward

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

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

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

11. Further Information

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

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Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Performance, Finance & Information Governance Committee Self-Assessment Results

Corporate Governance

August 2025

Purpose

- Present results of the 2024–25 Performance, Finance and Information Governance Committee self-assessment.
- Provide insights into strengths gaps, and opportunities.
- Recommend next steps for continuous improvement.

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

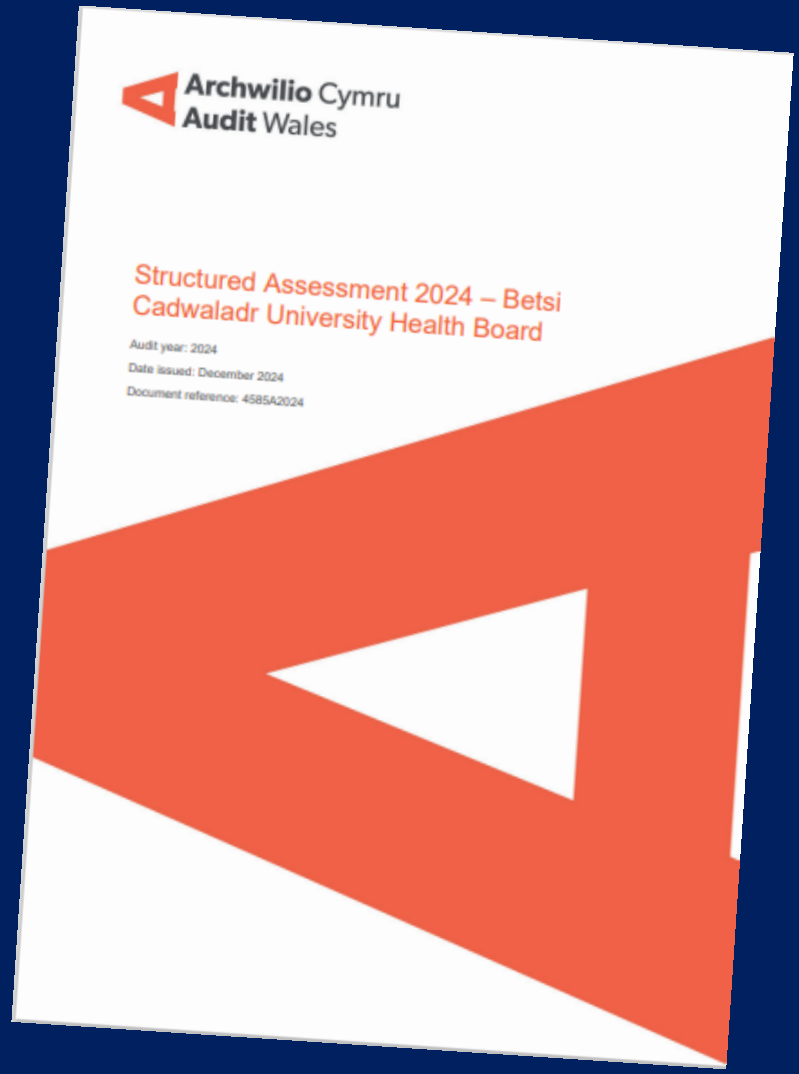
➢ This self-assessment ensures the Committee function effectively, driving continuous improvement and delivering better outcomes.

Why It Matters

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

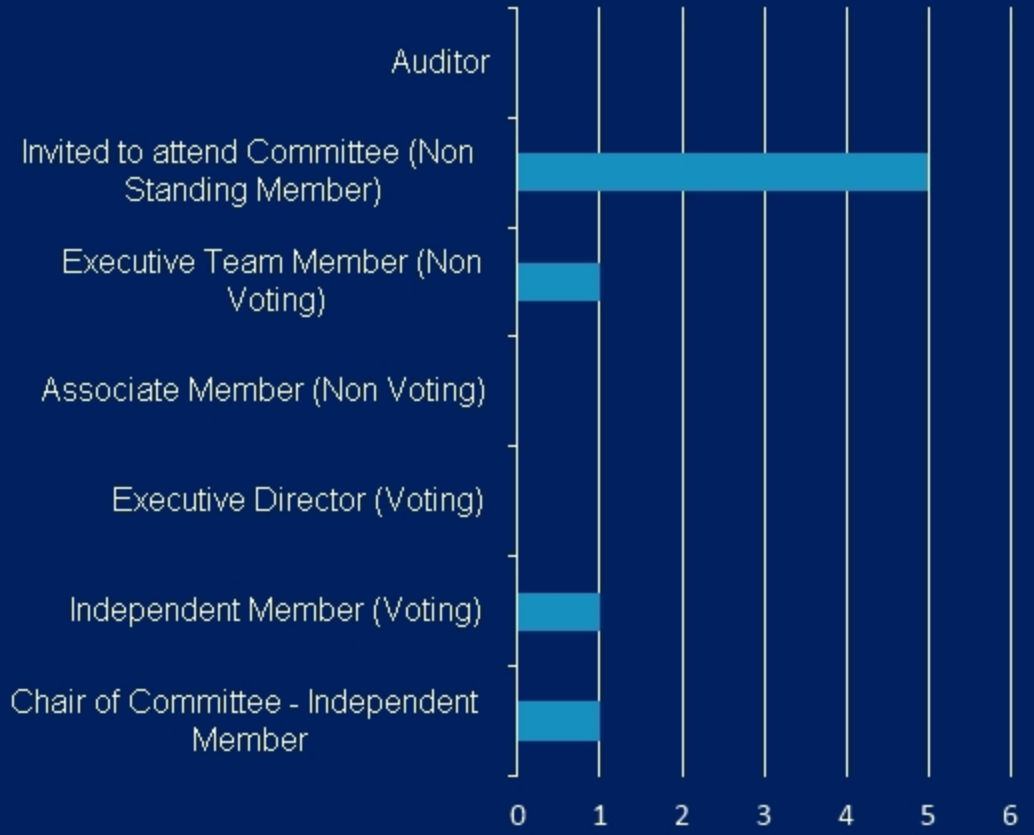
Ensuring 'Sound Governance'

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

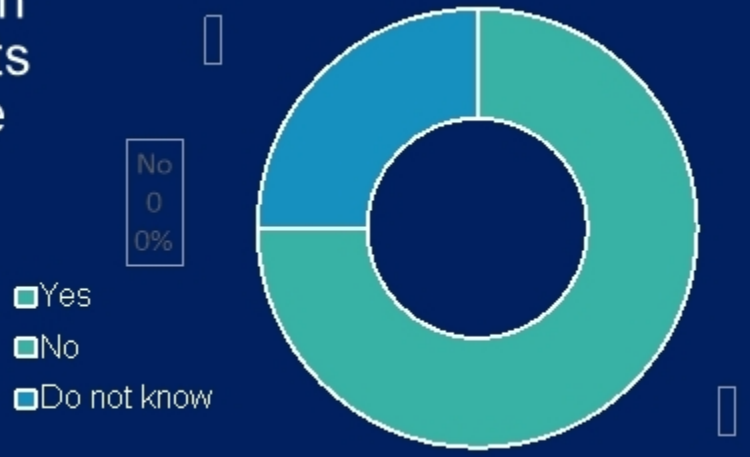


Role Response

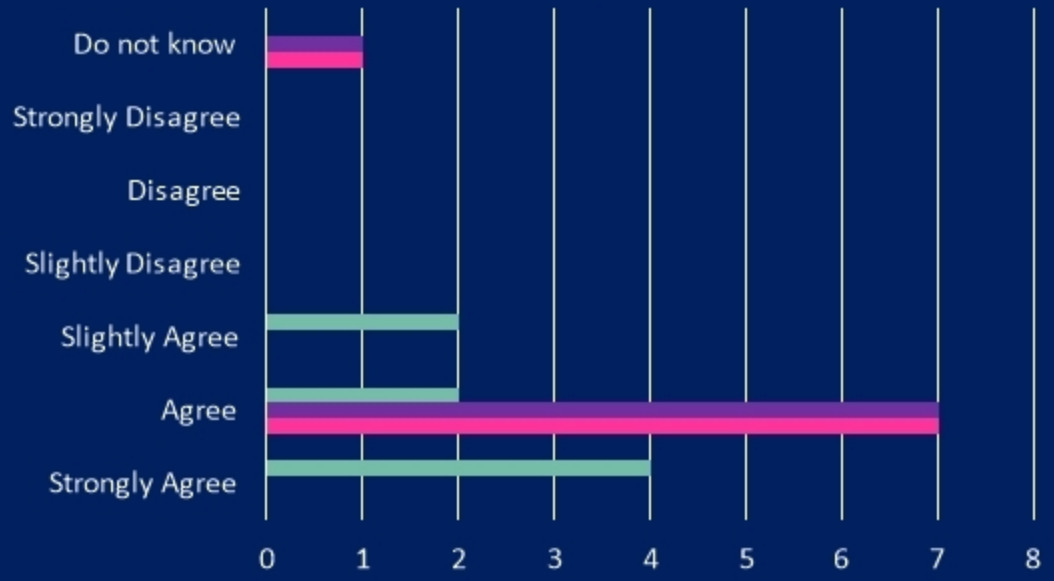
Role Response Breakdown



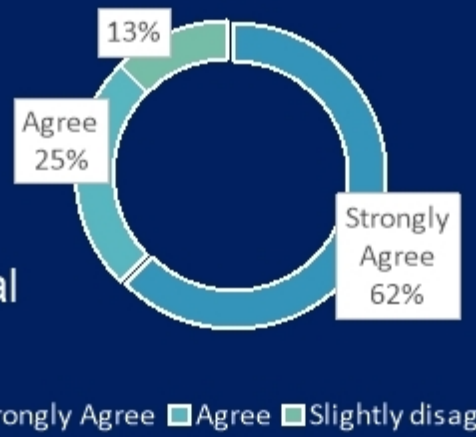
Does the Committee have written Terms of Reference, which adequately define its role in accordance with Welsh Government guidance?



Role Response



The behaviour of all members and attendees is courteous and professional



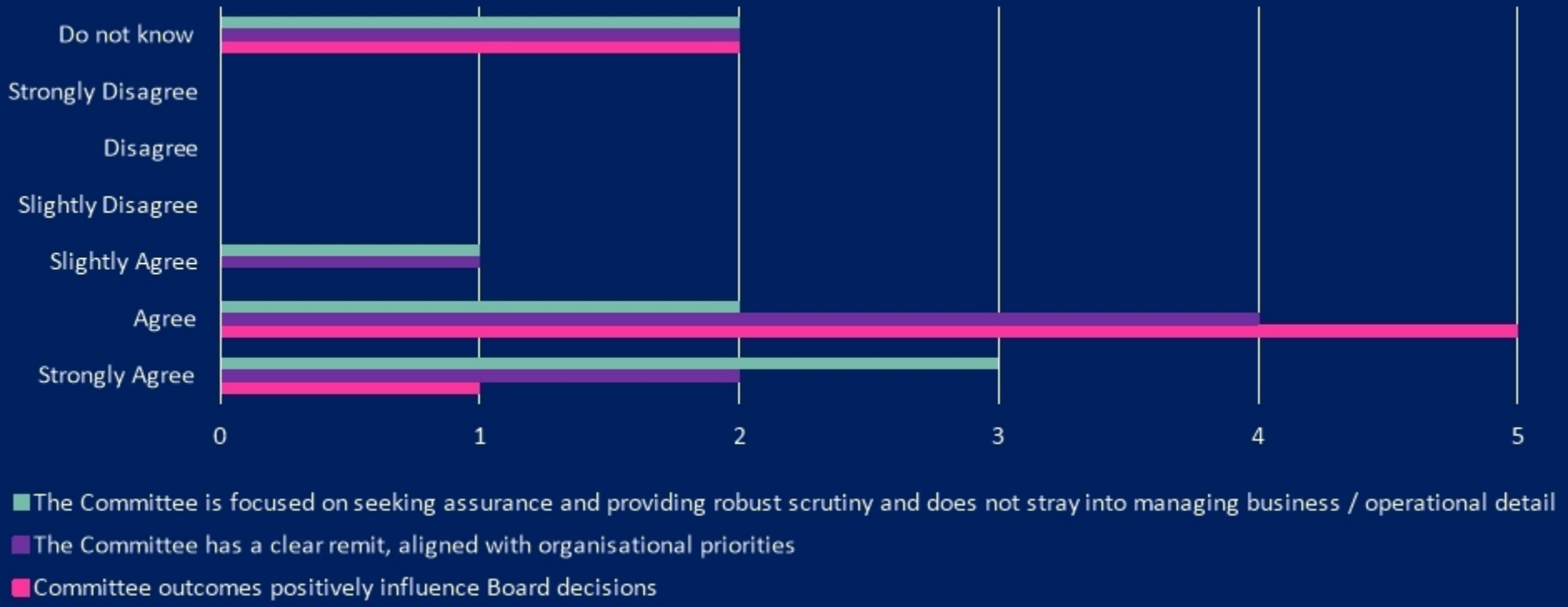
Response	Percentage
Yes	50%
No	12.5%
Do not know	37.5%

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

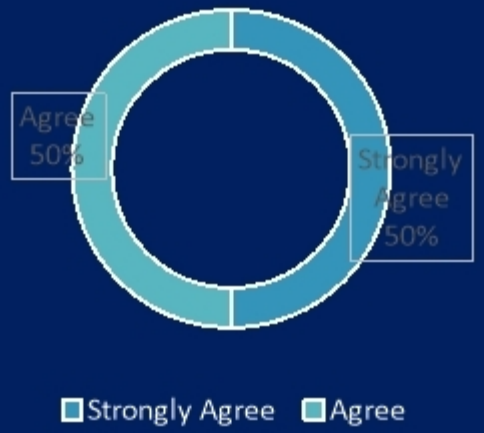
Has the Committee established a cycle of business to be dealt with across the year?

Yes – 62.5%
Unsure – 37.5%

Committee Response



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



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Key Findings – Governance & Function

- 62.5% agreed that the written Terms of Reference are reviewed annually taking into account governance developments and the remit of other Committees. 37.5% were unsure.
- Mixed feedback was received relating to private meetings being used appropriately, 50% of responders were unsure, whilst the remaining 50% agreed that they were used appropriately.
- 100% agreed that meetings are chaired effectively, 75% agreed that the Committee Chair provides clear information to the Board on the activities of the Committee and 87.5% agreed that the Committee is adequately supported by the secretariat.
- The assessment highlighted that the Committee is adequately supported by the Executive Directors in terms of attendance, quality and length of papers and response to challenges and questions.

Key Findings – Information & Risk

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

Key Findings - Training & Development

- Most felt confident in fulfilling their role and do not require additional training. 12.5% felt they required additional training.

Improvements

Of 28 questions, there were…

Response	Number of responses
Do not know	37
Slightly Disagree	1
Disagree	0

Do Not Know

- *Where private meetings are held, whether these were used appropriately*
- *The committee has reviewed the robustness & effectiveness of the content of the organisations internal assurance system.*
- *The committee effectively monitors the implementation of management actions from audit reports*

Comments:

In relation to Committee Effectiveness

Feedback highlighted that members felt that they were listened to and points were acknowledged, however it was noted that feedback following discussion or outcomes would be helpful.

In relation to Committee Leadership & Support

Feedback highlighted that further engagement with Directors on the committee would be helpful. Others felt that the performance element of the agenda/meeting would benefit from more time for discussion to allow clarity of queries to be sought within the meeting, as well as ensuring there is quantified data and intelligence to aid this.

In relation to Internal Controls and Risk Management

Feedback noted that members felt that over the past 12 months there has been improvement in the reporting element of the committee, and that providing greater intelligence, application of objective assurance and trajectories would aid this further. Others felt that mechanisms used to ensure the committee is aware of required actions from audit could be strengthened.

In relation to Composition, Establishment and Duties

Feedback was received suggesting some ways in which the committee could be improved, which included ensuring there are clear time frames or deadlines on improvement solutions, as well as ensuring formality and/or professionality of the meeting.





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

Performance, Finance & Information Governance Self-Assessment

Corporate Governance

August 2025

Diolch yn Fawr

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

Teitl adroddiad: ***Report title:***	**CORPORATE GOVERNANCE REPORT**			
Adrodd i: ***Report to:***	Performance, Finance and Information Governance Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 26 August 2025			
Crynodeb Gweithredol: ***Executive Summary:***	The objective of this report is to provide the Committee with an update on key Corporate Governance matters and to provide an update to the Committee on a range of corporate governance matters as well as assurance.			
Argymhellion: ***Recommendations:***	Members are asked to: • **APPROVE** the Performance, Finance and Information Governance Cycle of Business 2025-2026; • **APPROVE** the Committee Annual Report; • **NOTE** and **DISCUSS** the Committee Self-Assessment.			
Arweinydd Gweithredol: ***Executive Lead:***	Russell Caldicott – Executive Director of Finance			
Awdur yr Adroddiad: ***Report Authors:***	Philippa Peake-Jones – Head of Corporate Governance			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☒	Am sicrwydd *For Assurance* ☐	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

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

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

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

CORPORATE GOVERNANCE REPORT

1. INTRODUCTION

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

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

The Business Cycle for the Performance, Finance and Information Governance Committee for 2025-26 is attached at **Appendix 1**

3. DRAFT COMMIITTEE ANNUAL REPORT

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

4. COMMITTEE SELF ASSESSMENT

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

5. RECOMMENDATIONS

Members are asked to:

- **APPROVE** the Performance, Finance and Information Governance Cycle of Business 2025-2026;
- **APPROVE** the Committee Annual Report;
- **NOTE** and **DISCUSS** the Committee Self-Assessment

Teitl adroddiad: ***Report title:***	IG1 Information Governance Strategy Review			
Adrodd i: ***Report to:***	Performance, Finance and Information Governance Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 26 August 2025			
Crynodeb Gweithredol: ***Executive Summary:***	The strategic aims and purpose of this strategy is to describe the governance arrangements that will deliver Information Governance and assurance within BCUHB and will set out the overall principles that will promote a culture of best practice around the processing of information and the use of information and systems.			
Argymhellion: ***Recommendations:***	The Committee is asked to **Approve** the Information Governance Strategy (IG1)			
Arweinydd Gweithredol: ***Executive Lead:***	Dylan Roberts - Chief Digital and Information Officer			
Awdur yr Adroddiad: ***Report Author:***	Carol Johnson – Head of Information Governance			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	

Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	The arrangements set out in this document will underpin the Health Board's strategic objectives and ensure that the information needed to support and deliver their implementation is available, accurate and easy to understand.

<table>
<tr><td></td><td>

- Building an effective organisation.
- Developing strategy and long-lasting change.
- Creating compassionate culture, leadership and engagement.
- Improving quality, outcomes and experience.
- Establishing an effective environment for Learning.

</td></tr>
<tr><td>Goblygiadau rheoleiddio a lleol:

Regulatory and legal implications:</td><td>Data Protection Act and Freedom of Information Act</td></tr>
<tr><td>Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?

In accordance with WP7 has an EqIA been identified as necessary and undertaken?</td><td>See appendix 2</td></tr>
<tr><td>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?

In accordance with WP68, has an SEIA identified as necessary been undertaken?</td><td>Not applicable</td></tr>
<tr><td>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)</td><td>Non-compliance with the legislation can lead to penalties imposed by the Information Commissioner and loss of confidence by the public in the Health Board’s ability to protect the privacy of their information.

<table>
<tr><td colspan="5">Risk Register Tier 2</td></tr>
<tr><td>D3801 Failure to develop and improve the Asset Register System</td><td>9</td><td>6</td><td>4</td><td>Decreased</td></tr>
<tr><td>D4306 Data Flow Mapping and Records of Processing Activity (ROPA)</td><td>9</td><td>9</td><td>6</td><td>Unchanged</td></tr>
<tr><td>ID5238 Development and ongoing management of Corporate Records Management function</td><td>9</td><td>9</td><td>9</td><td>Unchanged</td></tr>
<tr><td>ID5239</td><td>9</td><td>9</td><td>9</td><td>Unchanged</td></tr>
</table>
</td></tr>
</table>

	BCU site wide audit to identify health and corporate records store in vulnerable locations				
	Risk Register - Tier 3				
	ID2803 Data Protection Legislation / Freedom of Information Act 2000	9	6	6	Unchanged
	ID3803 MS Office 365 - 12 8 6 Unchanged Management of HB Records	12	8	6	Unchanged

Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Non-compliance with the legislation can lead to significant fines imposed by the Information Commissioners office.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Not applicable
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Approved by Justine Parry, Data Protection Officer on behalf of Dylan Roberts, Chief Digital and Information Officer. Circulated for comment and virtually approved by the Information Governance Group May 2025. Reviewed at the Executive Team Meeting Wednesday 9th July 2025.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	**Board Assurance Framework** **BAF-SP13 -** There is a risk of failing to meeting the Health Board's strategic and operational objectives caused by having inadequate arrangements for the identification, commissioning and delivery of Digital, Data and Technology enabled projects and change. **Corporate Risk Register** **CRR24-07 –** Availability and Integrity of Patient Information **CRR24-17 –** ICT Failure and Cyber

Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** To be reviewed at the Performance, Finance and Information Governance Meeting 26th August 2025.	
Rhestr o Atodiadau: ***List of Appendices:*** Appendix 1 – IG1 Information Governance Strategy Appendix 2 – Equality Impact Assessment Appendix 3 - Integrated Assessment Screening Tool	

IG1 V 10.0

IG1 INFORMATION GOVERNANCE STRATEGY

Author & Title	Carol Johnson, Head of Information Governance
Responsible Dept / director:	Chief Digital and Information Officer Digital, Data and Technology (DDaT)
Approved by:	Information Governance Senior Team Meeting – 06/05/2025 Information Governance Group – 23/05/2025 Performance, Finance and Information Governance Committee – 25/06/2025
Date approved:	TBC
Date activated (live):	17/11/2014
Date IAST completed:	01/05/2025
Date EQIA completed	01/05/2025
Documents to be read alongside this document:	Risk Management Strategy, Policy and Procedures Information Governance Policies and Procedures Estates Strategy People Strategy and Plan 2022/25 Digital Strategy and Roadmap Clinical Services Strategy
Date of next review:	June 2028

First operational:	17/11/2014									
Previously reviewed:	April 2015	April 2016	Sept 2017	Jan 2018	May 2019	Dec 2020	Dec 2021	April 2023	June 2024	May 2025
Changes made yes/no:	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes - Full periodic review as aligned	Yes - Full periodic review as aligned

									with the Health Boards Objectives	with the Health Boards Objectives

N.B. Employees/workers should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.

Contents

1. INTRODUCTION

1.1 This Strategy sets out the Strategic approach that Betsi Cadwaladr University Health Board (BCUHB) will adopt to provide a robust Information Governance framework for the management of information.

1.2 Information is a vital asset, both in terms of the clinical management of individual patients and the efficient management of services and resources. It plays a key part in clinical governance, service planning and performance management. Information is critical to decision making, it enables the most appropriate decisions for direct patient care to be made and allows the Health Board to make informed choices around how limited money is invested for the best results to deliver its services across North Wales. This Strategy links into all these aspects and sets out the approach to be taken across BCUHB to provide a robust information governance framework. It is therefore of paramount importance to ensure that information is efficiently managed, and that appropriate policies, procedures and management accountability and structures are in place to provide a robust governance framework for information management, both now and in the future.

1.3 Information Governance (IG) is about setting high standards for the handling of information and giving organisations the tools to achieve those standards. The ultimate aim is to demonstrate that an organisation can be trusted to maintain and demonstrate that personal information is being handled legally, securely, efficiently and effectively, in order to deliver the best possible care. It additionally enables organisations to put in place procedures and processes for their corporate information that support the efficient location and retrieval of corporate records where and when needed, in particular to meet requests for information and assist compliance with contractual and regulatory requirements.

1.4 The Welsh Information Governance Toolkit is a self-assessment tool which enables organisations to measure their level of compliance against national Information Governance standards and legislation. It aims to deliver a greater level of transparency and provide the public with confidence in how their information is being used, shared and protected. The annual self-assessment and reporting tool allows the Health Board to identify where improvements are required and to put the appropriate measures in place to meet the standards. This will lead to 'year on year' improvements.

1.5 The NIS Regulations are the 'Network and Information Systems Regulations 2018' which came into force on 10 May 2018.

BCUHB is designated as an Operator of Essential Services under the Network and Information Systems Regulations 2018 (NIS-R). NIS-R aims to ensure the resilience of critical national infrastructure and several responsibilities on the Health Board in relation to the provision of critical services and to:

- Manage risks posed to the security of the network and information systems

- Prevent and minimise the impact of incidents on the delivery of essential services

- Report serious network and information incidents that impact on provision of the essential service.

BCU's compliance with NIS-R is regulated by the Cyber Resilience Unit (CRU) on behalf of Welsh Government who are the "Competent Authority". Failure to comply with the NIS-R can result in significant monetary penalties.

1.6 This strategy includes the continuing development, implementation and embedding of a robust information governance framework. The information governance arrangements will underpin the requirements set out by the Well-being of Future Generations (Wales) Act 2015 and the Health Board's strategic objectives by ensuring the integrity, availability and confidentiality of the information needed to support and deliver its services.

1.7 BCUHB is committed to securing the best quality health care for the population of North Wales. In doing so, it acknowledges that this can only be achieved through the skills and continuing commitment of its staff and those of its partner organisations.

1.8 BCUHB will support its employees by providing the skills and knowledge to deliver the organisations' strategic objectives and priorities, thus giving them the confidence to make the right choices at the right time.

2. STRATEGY STATEMENT

2.1 This strategy outlines the Health Board's aims and objectives to enable and maintain compliance with its Information Governance responsibilities and duties. The Health Board understands how important accurate, timely and relevant information is vital to support day to day clinical and business operations and the effective management of the Board's services and resources to deliver high quality health care and to operate effectively.

The Health Board will therefore ensure that:

- Information is valued as an asset of the Board which plays a critical part in corporate and clinical governance, and in strategic risk, service planning and performance management.
- Accurate timely and relevant information is available at the time and place where it is needed.
- All staff understand their respective responsibility to ensure that information is complete and up to date and that it is used proactively to support the business of the organisation.

2.2 The Board has put in place an Information Governance Framework and a series of best practice guidelines and principles in relation to the handling of information. This shall apply to all personal information, including sensitive information, of both employees and patients and to the management of the Board's corporate information.

2.3 The Information Governance Framework sets out the Board's approach within which accountability, standards, policies and procedures are developed and implemented.

3 STRATEGIC AIM

The strategic aim of this strategy is to describe the governance arrangements in place that will deliver Information Governance and assurance within BCUHB and will set out the overall principles that will promote a culture of best practice around the processing of information and the use of information and systems.

The strategy has been developed from:

- General Data Protection Regulation (GDPR) 2016;
- Data Protection Act 2018 (DPA 2018);
- UK GDPR following the UK exit from the European Union;
- The All-Wales Information Governance Toolkit;
- Caldicott Principles;
- The Security of Network & Information Systems Regulations 2018 (NIS Regulations).

3.2 All Wales Information Governance Toolkit

The Health Board will complete a self-assessment against the objectives for the toolkit by the 31st March of each year. Completing the toolkit will identify the gaps in the Health Board's Information Governance systems and an action plan will be drawn up with proposed solutions and timescales. The Information Governance Group will monitor these actions to ensure continual improvement and report through to the Performance, Finance and Information Governance Committee for assurance.

The Welsh Information Governance Toolkit is formed of several assessments, each assessment is reflective of an area of information governance responsibility as set out in legislation and/or national information governance standards.

3.3 NIS Regulations

BCUHB's ongoing compliance with the NIS Regulations is reviewed and benchmarked by the Welsh Cyber Resilience Unit (CRU) using the National Cyber Security Centre's (NCSC) Cyber Assessment Framework (CAF) document. The CAF lists a series of organisational and technical controls in relation to Cyber Security best practice, with the organisation required to record its state of compliance against each.

BCUHB will complete a Cyber Assessment Framework for each group of IT systems on a minimum of an annual basis; the results from this exercise will be used to identify areas for improvement and will inform the Cyber Security Work Programme.

The Cyber Security and Compliance Team will be responsible for leading the CAF process, monitoring compliance and reporting on progress.

3.4 Data Protection legislation

Data protection legislation is the most fundamental piece of legislation that underpins Information Governance. BCUHB is registered with the Information Commissioner's Office (ICO) and will seek to fully comply with all legal requirements of this legislation. A Data Protection Officer has been appointed to support the fulfilment of this requirement under the legislation.

BCUHB has in place an Information Asset Register (IAR) and a process has been adopted to ensure that a review of all current and new information assets and systems will be carried out. Where there is a requirement to process personal data the impact of this will be assessed via a Data Protection Impact Assessment. All the elements of this assessment with actions will be completed and captured within the lifecycle of that asset on the register.

3.5 Risk Management

Information plays a key part in corporate governance, strategic risk, clinical governance, service planning and performance management. This strategy links into all these aspects and sets out the approach to be taken across BCUHB to provide a robust information governance framework.

Information Governance risks have been identified in the BCUHB Corporate Risk Management Framework and in local department risk registers. The implementation of this strategy will facilitate and maintain a reduction in the level of current identified risks.

3.6 Incident Management

Information Governance related incidents must be reported via the Incident Management Procedures. These incidents will have active involvement from the IG Team who will risk assess the incident to establish whether it reaches the severity rating as reportable to the Information Commissioner's Office (ICO) and Welsh Government using the adopted Health & Social Care Information Centre (HSCIC) risk scoring matrix and the NHS Wales Guidance for the Categorisation and Notification of Personal Data Breaches. Any such reporting must be done within 72 hours of knowledge of the incident in line with legislative requirements. Significant incidents will be subject to a full Root Cause Analysis (RCA) investigation and reporting actions.

IG incidents may include, but are not limited to, breaches of policy, breaches of confidentiality and issues related to IT security.

3.7 Accountability Framework Structure

An Information Governance Group (IGG) has been established which provides assurance to the Performance, Finance and Information Governance Committee (PFIG) of the Health Board. This Group has delegated authority to oversee information governance issues, operational information risk management and the management of information governance work plans and associated responsibilities.

4 OBJECTIVES

4.1 The arrangements set out in this document will underpin the Health Board's strategic objectives and ensure that the information needed to support and deliver their implementation is available, accurate and easy to understand.

- Building an Effective Organisation
- Developing Strategy and Long-lasting Change
- Creating Compassionate Culture, Leadership and Engagement
- Improving Quality, Outcomes and Experience
- Establishing an Effective Environment for Learning

The BCU Information Governance team and the wider Digital, Data and Technology (DDaT) areas work collaboratively to ensure that we not only protect our patient data but also have measures in place which allows for the appropriate access and lawful processing of data, in line with Data Protection regulations, for other purposes including innovation and research. This allows the Health Board to make improvements to its services across the whole Health Board and contributes to the overall delivery of the above objectives. Data should be available in the right format, at the right time for the appropriate use and sharing.

4.2 The Health Board will continue to build on previous strategies and to have in place the ability, flexibility and skillset to adapt to the ever changing Information Governance landscape and the challenges it brings.

4.3 The Health Board will continue to work closely with local authorities, partner organisations and third party providers to enable the safe sharing of information and continue to work collaboratively to make improvements for the benefit of our patients and service users.

4.4 The Information Governance Strategy is aligned to the Health Board's strategic objectives as set out in the Annual Delivery Plan.

4.5 The Strategy is also aligned with the Digital, Data and Technology (DDaT) mission and work streams to:

"Empower our staff and populations through high-quality digital, data and technology services to improve health outcomes".

4.6 The supporting information governance objectives will be achieved by ensuring there is an effective Information Governance framework in place by:

- Ensuring that BCUHB meets its legal and statutory obligations as defined in the Data Protection Act 2018, UK GDPR and European GDPR 2016 and the Freedom of Information Act 2000 (FOI Act):
  a) Continue to develop and improve systems for Records of Processing Activity (ROPA);
  b) Ensure privacy by design and default is considered at all stages of service design, system procurement and partnership working;

- Ensure IG Strategies, policies, procedures and training plans are all updated to reflect best practice and changes in legislation including social media and Artificial Intelligence (AI).
- Develop and implement a system and process for the regular review of information sharing agreements / protocols both nationally and locally.
- Continually look at ways to improve, monitor for assurance and report on the Systems and Records Assets held within the Information Asset Register
- Continue to meet the Information Governance training national target of 85% to help improve staff understanding and continuous awareness.
- Strengthen relationships with IHC clusters to improve Information Governance compliance with Primary Care Contractors.
- Increase service user and Regulator confidence in the Health Board and its staff with increased visibility and working relationships, including a refresh of the IG Webpages and the exploration of introducing IG Champions.
- Encourage and support the professional development of team members by providing opportunities for training, skill enhancement, and knowledge acquisition in relevant areas and to include the development of training programmes.

5 SCOPE

5.1 This strategy applies to all employees, contractors, volunteers and students working for, or supplying services for, the Health Board.

5.2 Any GP Managed Practices that fall within the responsibility of the Health Board will be subject to Information Governance audits to ensure the principles within this strategy are being applied.

5.3 Primary Care Contractors are independent to the Health Board; however it is recognised and acknowledged that the principles and legal obligations within this strategy will be reflected in their own working practices in line with regulatory and legal requirements.

6 ROLES AND RESPONSIBILITIES

6.1 **Chief Executive** - The Chief Executive takes overall responsibility for the Health Board's information governance performance and in particular is required to ensure that:

- The Health Board can demonstrate accountability against the requirements within the Data Protection Act;
- Decision-making is in line with the Board's policy and procedure for information governance and any statutory provisions set out in legislation;
- The information risks are assessed and mitigated to an acceptable level and information governance performance is continually reviewed;
- Suitable action plans for improving information governance are developed and implemented;
- IG training is mandated for all staff and is provided at a level relevant to their role.

To satisfy the above, the Chief Executive has delegated this responsibility to the Chief Digital and Information Officer who will be accountable for the Board's overall information governance arrangements.

6.2 **The Chief Digital and Information Officer** has responsibility for ensuring that the Board corporately meets its legal responsibilities, and for the adoption of internal and external information governance requirements. They will act as the conscience for information governance on the Board and advises on the effectiveness of information governance management across the organisation. The Chief Digital and Information Officer has overall responsibility for the technical infrastructure to ensure the security and data quality of the information assets and systems held within the Health Board.

6.3 **Caldicott Guardian** - The Executive Medical Director has been nominated as the Board's Caldicott Guardian and is responsible for protecting confidentiality and reflecting patients' interests regarding the use of patient identifiable information. They are responsible for ensuring patient identifiable information is shared in an appropriate, ethical and secure manner. The Caldicott Guardian is the Chair of the Information Governance Group.

6.4 **Executive Medical Director** - The Executive Medical Director has been nominated by the Board to have overall responsibility for the management of all patient record types.

6.5 **Executive Lead for Corporate Records** - This role is responsible for the overall management and performance of the Corporate Records Management function within BCUHB. This role currently sits with the Chief Digital and Information Officer. It has been acknowledged that additional resources are needed to improve in this area, however whilst there is executive support there is a lack of funding available. This has been captured on the Health Board's Risk Register. The Information Governance team continue to provide limited support and guidance to all staff.

6.6 **Senior Information Risk Owner (SIRO)** - The current SIRO is the Chief Digital and Information Officer (CDIO). The SIRO has overall ownership of the information risks and plays a key role in successfully raising the profile of information risks and embedding information risk management into the Health Board's culture. The SIRO has undertaken additional training specific to the role

6.7 **Data Protection Officer (DPO)** - The Assistant Director of Compliance and Business Management undertakes the designated role of the Health Board's Data Protection Officer. They are responsible for providing the Health Board with independent risk-based advice to support its decision-making in the appropriateness of processing 'personal and Special Categories of Data' as laid down in the General Data Protection Regulation (GDPR) and the UK Data Protection Act. The DPO is required to provide advice and guidance on all data protection legislation queries to staff, patients and the Board. The Health Board recognises its obligations and accountability responsibilities with the GDPR and Data Protection Laws.

The Information Governance structure sits within this area.

6.8 **Information Governance Team** - The Head of Information Governance will be responsible for the development, communication and monitoring of policies, procedures and action plans ensuring the Board adopts information governance best practice and standards. This role will report to the Assistant Director of Compliance and Business Management and will be supported by the Information Governance Team who will also work in collaboration with the Information Governance Leads and Information Asset Owners.

6.9 **Assistant Director / Chief Technology Officer (CTO)** – Leads on all matters relating to the Health Boards ICT infrastructure security and regulatory compliance. Furthermore, provides strategic direction and expert advice on all technical matters relating to sustained compliance and conformance against the NHS Wales Code of Connection and NIS Directive.

6.10 **Cyber Security and Compliance Manager** - Acts as the Health Board's expert on cyber security protection, detection, response, and recovery. The Cyber Security and Compliance Manager is responsible for the strategic approach to cyber threat management and leads the strategic planning of current and future IT security solutions. The Cyber Security and Compliance Manager leads and advises on compliance with the NIS Directive and Cyber Essentials certification.

6. 11 **Assistant Director of Patient Records Management** – This role is responsible for the overall management and performance of the Health Records Service within BCUHB including the provision of organisation-wide access to health records and providing assurance against record management standards across all patient record types both paper and digital.

6.12 **Executive Directors/ Directors/ Integrated Health Community Directors (IHC)** - Each Director is responsible for the information within their area and therefore must take responsibility for information governance matters. In particular they must identify an Information Governance lead/champion.

6.13 **Information Governance Leads** – The Information Governance Leads work with the Information Governance team to ensure compliance with corporate Information Governance policies, procedures, standards, legislation and to promote best practice within their areas.

6.14 **Information Asset Owners (IAO) -** Are senior/responsible individuals involved in the running of the relevant services. Their role is to understand what information assets are held, and for what purpose.They should have an understanding of how the information held in the asset is created, amended added to, quality assured and processed. They will know who has access to the information and why, and be responsible for any identified risks and provide assurance to the SIRO. They will have overall responsibility to understand procurement requirements around contracts and licencing; put in place and test business continuity and disaster recovery plans, control access permissions and ensure the system asset record is regularly reviewed and updated on the asset register.

6.15 **Information Asset Administrator (IAA) –** Are staff who normally use the system as part of their daily routine. They will recognise actual or potential security incidents, consult with their IAO on appropriate incident management, access controls and system level security issues and ensure that information asset registers are accurate and up to date.

6.16 **All Staff** - All employees, contractors, volunteers and students working for, or supplying services for, the Health Board are responsible for any records or data they create and what they do with information they use.

All staff have a responsibility to adhere to information governance policies and procedures and standards which are written into the terms and conditions of their contracts of employment and the organisation's Staff Code of Conduct.

6.17 **Third Party Contractors** – appropriate contracts and confidentiality agreements shall be in place with third parties where potential or actual access to the Health Board's confidential information assets is identified.

7 IMPLEMENTATION AND MONITORING

7.1 BCUHB have implemented a number of Information Governance policies and procedures which are regularly reviewed and updated. These are published in line with the Corporate Policy on Policies and awareness is raised via communication channels such as the Corporate Bulletin, IG Bulletin, staff alerts and IG training which are all included in the IG Communications plan.

The key policies relate to:

- Information Governance (Data Protection & Confidentiality)
- Information Management and Technology (IM&T) Security (including incident management)
- Access to Information (including Freedom of Information and Subject Access Requests)
- Records Management (corporate and personal records)

All Information Governance policies can be accessed via the Corporate Policy pages of the intranet.

7.2 All staff will have access to a programme of training and awareness to enable them to comply with these policies.

7.3 Robust controls and auditing processes have been put in place to monitor compliance and manage any incidents with regard to data security breaches.

7.4 Non-compliance with Data Protection and Freedom of Information legislation is robustly monitored by the Information Governance team and reported in the first instance to the service leads to enable improvements to be made. In the event there is continued non-compliance the Information Governance team will escalate to the Senior Leadership Teams, and where necessary escalate to the Executive Leadership Teams. Improvement plans are implemented which are closely monitored by the Information Governance Department.

Compliance and non-compliance with both the Data Protection and Freedom of Information legislation is routinely reported as part of the Information Governance quarterly key performance indicator reports which are presented to the Performance, Finance and Information Governance Committee with the Committee Chairs Report highlighting compliance issues through to the Board.

In addition, the direct escalation route in the event of a major breach, externally reportable incident or continued non-compliance would be escalated directly to the Data Protection Officer (DPO) who would inform the Chief Executive who would then advise the Board.

7.5 Quarterly Key Performance Indicator (KPI) reports are presented to the Information Governance Group and then reported to the Performance, Finance and Information Governance Committee.

7.6 The Information Governance operational plan will be managed by the Information Governance Team, monitored via the Information Governance Group and issues of significant escalated to the Performance, Finance and Information Governance Committee.

7.7 Annual self-assessment against the All Wales Information Governance Toolkit will be carried out and presented to the Performance, Finance and Information Governance Committee.

7.8 An IG Annual report will be presented to the Performance, Finance and Information Governance Committee to demonstrate assurance against the Information Governance Framework, its associated policies and the Information Governance Toolkit.

8 RESOURCES

8.1 Departments should ensure that their appointed Information Governance Leads, Information Asset Owners and System Owners have sufficient time and resource in order to execute the requirements within these job roles.

9 TRAINING

9.1 All staff within BCUHB are mandated to undertake Information Governance training. This training must be renewed every two years.

9.2 In addition to induction and mandatory training requirements, there are job roles which require specialised training in order to fulfill their duties, for example: Caldicott Guardian, Data Protection Officer (DPO), Senior Information Risk Information Risk Owner (SIRO), IG Team, IAO, IAA, System Owners and staff who manage subject access requests.

9.3 The Information Governance Team are responsible for developing and delivering the IG training programme which is supported by a three-year IG Training Strategy and action plan.

9.4 In 2018 NHS Wales has put in place a national compliance target of 85% for Information Governance training. The 3-year IG Training Strategy has been reviewed and updated, with measures put in place to continue to achieve and maintain compliance with the national target.

10 IMPACT ANALYSES

10.1 **Equality**

In accordance with equality duties, an Equality Impact Assessment has been carried out on this Strategy. There is no evidence to suggest that the Strategy would have an adverse impact in relation to race, disability, gender, age, sexual orientation, religion and belief or infringe individuals' human rights. However, this Strategy can demonstrate that it will have a positive impact on the enhanced protection of 'special category' data as required under the new data protection legislation.

10.2 **Welsh Language**

The Information Governance Team has responded to the requirements within the Welsh Language Standards document by ensuring that:

- All correspondence received from the public will be responded to in the language in which it was received;
- All telephone calls will be answered bilingually. If an individual wishes to continue in Welsh the call can either be put through to the IG Manager in the West or the Welsh Translation Team;
- Out of hours, all phones will be transferred to an answering machine with a bilingual message;
- All information developed specifically for the public is available bilingually;
- All offices will have bilingual door signs on entry;
- All staff members have bilingual ID badges;
- All staff members have fully bilingual email signatures for internal and external emails;
- Any new policies and procedures developed will use the new BCUHB template which ensures that Welsh language is considered;
- All staff can request access to Cysgair and Cysillt software which can assist with informal translation;
- The IG training handout for staff is available in Welsh.

10.3 **Well-being of future generations**

The five ways of working have been interwoven within this Strategy, those being:

- **Long term** – balancing short-term needs with long-term needs.
- **Prevention** – stopping problems happening or getting worse.
- **Integration** – thinking about how this strategy works with other plans.
- **Collaboration** – working together with other services to meet our goals.
- **Involvement** – involving people so they have a say in decisions.

10.4 **Environmental**

A new confidential waste contract was put in place in April 2021. The successful bidder is working with the Health Board to improve its carbon

footprint by locally sourcing, recycling and a strong respect for conservation. In addition, they provide a secure confidential waste service which complies with data protection obligations.

11 AUDIT

11.1 Internal Audit will provide an independent and objective opinion on Information Governance risk management, control and governance arrangements by measuring and evaluating their effectiveness.

11.2 The Health Board will continue to work with the ICO to progress any recommendations and to appropriately plan and engage with any future audits that may be required.

11.3 The IG Team will carry out audits to:

a) review IG compliance across departments and teams within BCUHB;
b) review and risk assess the IG elements of the Information asset register submissions;
c) assess the data protection impact of all new or revised systems, service or pathway developments.

11.4 **Information Asset Owners Group** - There will be an Information Asset Owners group created to replace the System Owners Group, it will be led by Digital, Data and Technology. A joint programme of training and accountability responsibilities will be put in place for the Information Asset Owners/ Administrators to ensure they fully understand and are able to discharge their responsibilities.

The Information Asset Register remains under constant review and will be managed by the Information Asset Owners, ICT and the Information Governance team.

12 REVIEW

This Strategy will be reviewed in three years. An earlier review may be required in response to exceptional circumstances, organisational change or changes to legislation / guidance.

13. LEGISLATION AND COMPLIANCE WITH STANDARDS

13.1 The legislation and guidance supporting this strategy includes:

- Freedom of Information Act 2000
- Environmental Information Regulation 2004
- Data Protection Act 2018
- General Data Protection Regulation 2016
- UK General Data Protection Regulation 2020
- Human Rights Act 1998
- Access to Health Records Act 1990
- Common Law – duty of confidence
- Computer Misuse Act 2000
- Copyright, designs and Patents Act 1988 (as amended by the Copyright Computer programs regulations 1992)

- Network and Information Systems (NIS) Directive
- Crime and Disorder Act 1998
- Privacy and Electronic Communications Act 2003
- Regulation and Investigatory Powers Act 2000

13.2 **References**

- Lord Chancellor's Code of Practice on the Management of Records Under Section 46 of the FOI Act 2000
- Records Management: NHS Code of Practice
- Caldicott Report
- Caldicott: Principles into Practice (C-PIP) Foundation Manual for Caldicott Guardians
- National Data Guardian Standards
- Information Security ISO/IEC 27001:2005; ISO/IEC 27001:2013
- Confidentiality: Code of Practice for Health & Social Care in Wales
- Wales Accord for Sharing Personal Information (WASPI)

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Betsi Cadwaladr
University Health Board

EQUALITY IMPACT ASSESSMENT FORMS
PARTS A and B: SCREENING AND OUTCOME REPORT

Introduction:
These forms have been designed to enable you to record, and provide evidence of how you have considered the needs of all people (including service users, their carers and our staff) who may be affected by what you are writing or proposing, whether this is:

- a policy, protocol, guideline or other written control document;
- a strategy or other planning document e.g. your annual operating plan;
- any change to the way we deliver services e.g. a service review;
- a decision that is related to any of the above e.g. commissioning a new service or decommissioning an existing service.

This is not optional: Equality Impact Assessment is a specific legal requirement on public sector organisations under equalities legislation and failure to comply could result in a legal challenge to a decision or strategy. More importantly, equality impact assessment helps to inform better decision-making and policy development leading to improved services for patients. **This form should not be completed by an individual alone, but should form part of a working group approach.**

The Forms:
You must complete:

- **Part A** – this is the Initial Screening that is always undertaken and consists of Forms 1 to 3; these forms are designed to enable you to make an initial assessment of the potential impact of what you are doing, and decide whether or not you will need to proceed to a Full Impact Assessment (Part C);

AND

- **Part B** – this is the Outcome Report and Action Plan (Form 4) you will need to complete whether or not you proceed to a Full Impact Assessment;

Together, these forms will help to provide evidence of your Impact Assessment and how you have shown “due regard” to the duties.

You may also need to complete **Part C** (see separate Form) – if parts A and B indicate you need to undertake a Full Impact Assessment. This enables you to fully consider all the evidence that is available (including engagement with the people affected by your document or proposals) to tell you whether your document or proposal will affect people differently. It also gives you the opportunity to consider what changes you may need to make to eliminate or mitigate any adverse or negative impact you have identified.

Remember that these forms may be subject to external scrutiny e.g. under a Freedom of Information request.

To enter text, click on the grey box in the part of the form you are completing. Help text will appear in the status bar at the foot of the page. Some boxes have drop-down lists from which you can select options. Others may simply be a box to answer a question. Once completed, the EqIA Forms should accompany your document or proposal when it is submitted to the appropriate body for approval.

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Part A

Form 1: Preparation

1.	What are you equality impact assessing? What is the title of the document you are writing or the service review you are undertaking?	Information Governance Strategy	
2.	Provide a brief description, including the aims and objectives of what you are assessing.	The Health Board aims to achieve a high level of excellence in information governance by ensuring information is dealt with legally, securely, efficiently and effectively in the course of its business, in order to support high quality patient care. The strategy supports the Board to deliver a positive culture of information governance management and ensures that all staff recognise “information governance as everyone’s business”. It supports decision making in a way in which contributes to the achievement of the organisation's purpose, values and corporate objectives.	
3.	Who is responsible for the document/work you are assessing – i.e. who has the authority to agree/approve any changes you identify are necessary?	Dylan Roberts - Chief Digital Information Officer	
4.	Who is Involved in undertaking this EqIA? Include the names of all the people in your sub-group.	Name	Title/Role
		Justine Parry	Assistant Director Of Compliance And Business Management
		Carol Johnson	Head of Information Governance
5.	Is the Policy related to, or influenced by, other Policies/areas of work?	Risk Management Strategy, Policy and Procedures Information Governance Policies and Procedures Estates Strategy People Strategy and Plan 2022/25 Digital Strategy (2021/2024) Clinical Services Strategy	

6.	Who are the key Stakeholders i.e who will be affected by your document or proposals?	The Board and all employees.
7.	What might help/hinder the success of whatever you are doing, for example communication, training etc?	Information Governance training is a mandatory requirement for all staff however it is difficult for managers to find time to release staff from clinical duties to attend the training

Form 2: Considering the potential impact of your document, proposals etc in relation to equality and human rights

Characteristic or other factor to be considered	Potential Impact by Group. Is it:-		Please detail here, for each characteristic listed on the left:- (1) any Reports, Statistics, Websites, links etc. that are relevant to your document/proposal and have been used to inform your assessment; and/or (2) any information gained during engagement with service users or staff; and/or (3) any other information that has informed your assessment of Potential Impact.
	Positive (**+**) Negative (**-**) Neutral (**N**) No Impact/Not applicable (**N/a**)	Scale (see Table A on next page)	
Age	(N/a)	No impact/Not applicable (N/a)	
Disability	(N/a)	No impact/Not applicable (N/a)	
Gender Reassignment	(N/a)	No impact/Not applicable (N/a)	
Pregnancy & Maternity	(N/a)	No impact/Not applicable (N/a)	
Race / Ethnicity	(N/a)	No impact/Not applicable (N/a)	
Religion or Belief	(N/a)	No impact/Not applicable (N/a)	
Sex	(N/a)	No impact/Not applicable (N/a)	
Sexual Orientation	(N/a)	No impact/Not applicable (N/a)	
Welsh Language	(+)	Medium positive (+)	The strategy includes the Health Boards inclusion of the Welsh Language Standard and the measures in place to meet those standards.
Human Rights	(+)	Medium positive (+)	It ensures that privacy by design and default is considered at all stages of service design, system procurement and partnership working to ensures patient and staff privacy rights are considered in accordance with both data protection laws and Article 8 of the Human Rights Act 1998.

Guidance on completing Form 2: For each of the characteristics listed, and considering the aims and objectives you detailed in Q2 on Form 1, you need to consider whether your document or proposal likely to affect people differently, and if so, will this be in a positive or negative way? For example, you need to decide:

- will it affect men and women differently?
- will it affect disabled and non-disabled people differently?
- will it affect people in different age groups differently? - and so on covering all the protected characteristics.

Use the table below to indicate the scale of any impact identified. The factors used to determine an overall assessment for each characteristic should include consideration of scale and proportionality as well as potential impact.

Table A

High negative	Note: It is important to understand that we will be required to demonstrate what we have considered and/or done in order to mitigate or eliminate any negative impact on protected groups identified within the assessment. Details should be recorded in sections 3a/3b in the Action Plan in Form 4.
Medium negative	
Low negative	
Neutral	
Low positive	
Medium positive	
High positive	
No impact/Not applicable	

Form 3: Assessing Impact Against the General Equality Duty

As a public sector organisation, we are bound by the three elements of the "General Duty". This means that we need to consider whether (if relevant) the policy or proposal will affect our ability to:- • Eliminate unlawful discrimination, harassment and victimisation; • Advance equality of opportunity; and • Foster good relations between different groups	
1. Describe here (if relevant) how you are ensuring your policy or proposal does not unlawfully discriminate, harass or victimise	The Information Governance Strategy is aligned to the Standing Orders which include the development of a robust governance framework to achieve the highest standards of patient safety and public service delivery, improve health and reduce inequalities and achieve the best possible outcomes for it's citizens, in a manner that promotes human rights.
2. Describe here how your policy or proposal could better advance equality of opportunity (if relevant)	N/A

3. Describe here how your policy or proposal might be used to foster good relations between different groups (if relevant)	N/A

Part B:

Form 4 (i): Outcome Report

Organisation:	BETSI CADWALADR UNIVERSITY HEALTH BOARD

1. What is being assessed?	Information Governance Strategy

2. Brief Aims and Objectives:	The aim of this document is to set out the commitment of the Health Board to ensure the effective management of information and identify how this will be achieved. It will specify who is responsible at each stage of the process. The Health Board considers that its approach to information governance is integral to achieving its strategic objectives and corporate priorities. The Health Board aims to achieve a high level of excellence in information governance by ensuring information is dealt with legally, securely, efficiently and effectively in the course of its business, in order to support high quality patient care. All information processing will be undertaken in accordance with relevant legislation, standards and best practice. The Health Board will set policies and procedures to ensure that appropriate standards are defined, implemented and maintained. The Health Board aims to reduce the risks arising from information handling processes, these being: • Legal action due to non-compliance with statutory and regulatory requirements • Loss of public confidence in the Health Board • Contribution to clinical or corporate negligence

	• Damage or stress to individuals. The Health Board aims to provide support to its staff to be consistent in the way they handle information and to avoid duplication of effort. This will lead to: • Improvements in information handling activities; • Improving patient confidence in the Health Board; • Increasing staff knowledge and awareness in information governance to empower them to make appropriate decisions; • Embed a culture of good information governance practice across the Health Board.

3a. Could the impact of your decision/policy be discriminatory under equality legislation?	Yes ☐	No ☒
3b. Could any of the protected groups be negatively affected?	Yes ☐	No ☒
3c. Is your decision or policy of high significance – consider the scale and potential impact across BCUHB including costs/savings, the numbers of people affected and any other factors?	Yes ☒	No ☐

4. Did the assessment of potential impact on Form 2, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Yes ☐	No ☒	
	Record Reasons for Decision i.e. what did the assessment of scale on Form 2 indicate in terms of positive and negative impact for each characteristic? N/A		
5. If you answered 'no' above, are there any issues to be addressed e.g. mitigating any identified minor negative impact?	Yes ☐	No ☒	Not applicable ☐
	Record Details:		

6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your document or proposal?	Yes ☒	No ☐
	How is it being monitored?	Information Governance Team and Information Governance Group
	Who is responsible?	
	What information is being used?	E.g. will you be using existing reports/data or do you need to gather your own information? i) An annual self-assessment is carried out against the Information Governance Toolkit with the results presented to the Performance, Finance and Information Governance Committee (PFIG). ii) IG operational plan is actioned and updated by the IG Team and monitored by the IGG with issues of significance escalated to the Performance, Finance and Information Governance Committee (PFIG). ii) Information Governance Team produce quarterly IG KPI reports which are submitted to the Information Governance Group with issues of significance reported to the Performance, Finance and Information Governance Committee(PFIG).
	When will the EqIA be reviewed? (Usually the same date the policy is reviewed)	Every year.

7. Where will your decision or policy be forwarded for approval?	Performance,Finance and Information Governance Committee

8. Describe here what engagement you have undertaken with stakeholders including staff and service users to help inform the assessment	Engagement has taken place with the Assistant Director of Compliance and Business ManagementDylan and the IG Team to help inform the assessment.

	Name	Title/Role

9. Name/role of person responsible for this Impact Assessment	Carol Johnson	Head of Information Governance
10. Name/role of person approving this Impact Assessment	Dylan Roberts	Chief Digital Information Officer
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Form 4 (ii): Action Plan
This template details any actions that are planned following the completion of EqIA including those aimed at reducing or eliminating the effects of potential or actual negative impact identified.

	Proposed Actions	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:	N/A		
2. What changes are you proposing to make (or have already made) to your document or proposal as a result of the EqIA?	N/A		
3a. Where negative impact(s) on certain groups have been identified, what actions are you taking or are proposed to mitigate these impacts? Are these already in place?	N/A		

	Proposed Actions	Who is responsible for this action?	When will this be done by?
3b. Where negative impact(s) on certain groups have been identified, and you are proceeding without mitigating them, describe here why you believe this is justified.	N/A		
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	N/A		

NOTE: If your decision recorded above is that you will need to proceed to a Full Equality Impact Assessment, then you should refer to the Full Impact Assessment Forms (Part C)

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Note: For detailed guidance on the completion of these forms, please refer to Chapter 3 of the Toolkit that is available on the Equality pages of the BCUHB Intranet site.

Appendix 1: BCUHB Integrated Assessment Screening Tool

Each of the Assessments below must be considered. Where screening indicates a more than negligible impact or you are unsure of a specific area, you should liaise with the BCUHB specialty lead (detailed below at section 11) and conduct a more thorough assessment in that area. Not all assessments will be applicable though you should consider each in turn.

Please ensure that any additional impact assessments / evidence is retained in the event that the responsible director / approving group or committee requests them.

The term 'Written Control Document' (WCD) includes, but is not limited to, strategies, business cases, projects, policies, protocols, procedures, guidelines etc.

1. Document Details:

New document or review?	*Review*
Title of WCD Proposed:	*Information Governance Strategy*
Type of WCD	*Strategy*
Author name and Job Title:	*Carol Johnson* *Head of Information Governance*
Responsible Director	*Dylan Roberts* *Chief Digital and Information Officer – Director of Digital (DDaT)*
Division/Department	*Digital, Data & Technology*
Date of Assessment/Screening	*01/05/2025*

2. Equality Impact Assessment

Equality Impact Assessments (EqIAs) are a ***mandatory*** requirement for all BCUHB wide WCDs/projects as per the Procedure for Equality Impact Assessment (WP7). Failure to comply with the requirements may result in legal challenge/Judicial Review. EqIAs help to inform better decision-making and policy development leading to improved services for patients, carers and staff. The EqIA should commence as early as possible in the decision making process. **Further information and template is available here:** EqIAs - Equality Impact Assessments (sharepoint.com)
Date EqIA completed: 01/05/2025

3. Socio-Economic Impact Assessment

A Socio-economic Impact Assessment (SEIA) is required for strategic decisions and includes strategic decisions which are subject to review. In general, strategic decisions will be those which effect how Health Board fulfils its intended statutory purpose (its functions in regards to the set of powers and duties that it uses to perform its remit) over a significant period of time and will not include routine 'day to day' decisions. SEIA helps to inform better decision-making by aiming to deliver better outcomes for people that experience socio-economic disadvantage. SEIA should commence as early as possible in the decision making process. **Links:** List of documents which require an SEIA**.** **Template and further information:** Socio-Economic Duty (SED) (sharepoint.com)
SEIA Completed – Y/N. No – Local service strategy which does not impact or affect SED
Date SEIA completed: *'N/A'*

4. Welsh Language

The Welsh Language Standards are a set of statutory requirements that place a duty on BCUHB to provide bilingual services to patients and the public.
Under the Standards, we must not treat the Welsh language less favourably than the English language. BCUHB aims to provide an "Active Offer", meaning services should be provided in Welsh without the person having to ask for it. Enabling our patients and the public to receive high-quality, language appropriate care is paramount to the way we provide and plan our services, as well as encouraging other users and providers to use and promote the Welsh language in the health sector.

If you produce a document (but not a form) which is available to one or more individuals, you must produce it in Welsh if; (a) the subject matter of the document suggests that it should be produced in Welsh, or (b) if the anticipated audience, and their expectations, suggests that the document should be produced in Welsh.

Does the subject of the document deal with Welsh language issues or an area of particular interest in terms of the Welsh language?	N
Is the document one that will be publicly displayed?	N
Is the document likely to attract public response and attention (e.g. on social media)?	N
Is the document a document which individuals are required to respond to?	N
Is the subject of the document related to a matter that is relevant to, affects or is of importance to a large number of individuals (defined as residents of Wales acting in their personal capacity)?	Y
Do you know that a percentage or a large number of the predicted audience (individuals and organisations in North Wales) are Welsh speakers, and for whom the Welsh language is an important consideration to them or they operate through Welsh.	N
Has more than one person asked for the document to be available in Welsh?	N
Outcome – does document require translating Y/N	**Y**

Further Considerations: *In addition to the requirement to translate documents, consideration should also be given to the nature of the document:*

- *Will there be an impact on services offered to Welsh speaking patients?*
- *Is there an opportunity to identify the preferred language of patients/service users to ensure that their care needs are fully met in line with the Welsh Language Standards?*

A recent case (*Swansea Council v Welsh Language Commissioner* (TyG/WLT/21/01)) has emphasised that any organisational 'policy' decision, **MUST** consider the impact on the Welsh Language. This means more than just a written policy document, and can include decisions made regarding the exercise of an organisation's functions.

If you are in any doubt as to whether your WCD constitutes a 'policy decision', please contact the Welsh Language Team.

5. Rights of Children and Young People

Guidance: The UN Convention on the Rights of the Child (CRC) sets out the fundamental human rights that all children should have, so that every child is able to have a good childhood and develop to their full potential. The Social Services and Wellbeing (Wales) Act 2014 (SSWBA) places a duty that decision makers must have regard to the convention. Children have needs and rights that are separate and different to adults. You should carefully consider whether the proposed WCD/project will have any impact on children and whether it will effectively protect and implement the rights expressed in the UNCRC.
Detail your considerations here: *N/A*

6. Older Person and/or People living with Dementia (including young onset dementia).

Guidance: BCUHB have a duty to ensure older people have their rights respected and are involved in decisions. All WCDs/projects should be developed using a person centered approach. WCDs/projects should ensure an evidence based approach in relation to the older adult and/or those with dementia (who may be under the age of 50 years). Due regard should be given to the United Nations Principles for Older Persons. **Further reference points include the Good Work Dementia Learning and Development Framework, All Wales Dementia Strategy and Dementia Friendly Hospital Charter.** If necessary, separate clinical WCDs should be developed with input from experts.
Detail your considerations here: N/A

7. Carers

Guidance: A carer is a person, of any age, who provides unpaid support to a family member or friend who could not manage without their help. The Social Services and Well-being (Wales) Act 2014 places a statutory obligation upon local authorities to assess carers where it appears they have a need for support. The legislation places a responsibility on health staff to identify unpaid carers, acknowledge their importance as an equal partner in care and provide them with information, advice and assistance.
Detail your considerations here: N/A

8. Environment

Guidance: BCUHB have legislative duties to comply with Environmental legislation. The purpose of which is to protect the environment we occupy and to ensure the public are given early and effective opportunity to participate in our decision making procedures. The Health Board is accredited to the Environmental Management System, (EMS) ISO 14001, which is the internationally recognised standard for managing the environment. The EMS provides a framework for managing environmental impacts associated with the Health Board's activities
Detail your considerations here: N/A

9. Data Protection

Data protection impact assessments (DPIAs) are tools which will assist organisations in identifying the most effective way to comply with their data protection obligations and meet individuals' expectations of privacy. Carrying out a data protection impact screening assessment is a systematic way of doing this to establish if a full Data Protection Impact Assessment (DPIA) is required. **Should you answer yes to any of the DPIA Screening questions below, please contact a member of the Information Governance Team** for support in deciding if a full DPIA is required.

Will the WCD involve the collection of new information about individuals?	**N**
Will the WCD compel individuals to provide information about themselves?	**N**
Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information?	**N**
Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?	**N**
Does the WCD involve using new technology which might be perceived as being privacy intruding for example biometrics or facial recognition?	**N**
Will the WCD result in you making decisions or taking action around individuals in ways which could have a significant impact on them?	**N**
Is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For example health records, criminal records, or other information that people are likely to consider as private?	**N**
Will the WCD require you to contact individuals in ways which they may find intrusive?	**N**

Have you answered 'Yes' to any of the questions above? If so, then please contact a member of the Information Governance Team	**N**

10. Screening Summary

After completing the screening areas, you should now document where you have identified that further assessment is required and/or where engagement with the relevant Corporate Lead / other experts may be necessary. Additional impact assessments and evidence should then be used to inform the plan, project or written control document development.

Please ensure that any additional impact assessments / evidence is retained in the event that the responsible director or approving group requests them.

Impact Assessment	Further Assessment Undertaken / Consultation with Relevant Lead?
Equality Impact	Mandatory
Socio-economic	No
Welsh Language	No
Children	No
Older Person	No
Environment	No
Data Protection	No
Carers	No

11. Corporate Lead Contact Information

Impact Area	BCUHB Lead Name & Title	Contact
Equality	Steve Doore, Equality and Inclusion Manager	Stephen.doore@nhs.wales.uk
Socio-economic	Jennifer Dowell-Mulloy, Equality and Inclusion Manager	Jennifer.dowell-mulloy@nhs.wales.uk
Welsh Language	Alaw Griffith, Welsh Language Standards Compliance Officer	Alaw.Griffith@wales.nhs.uk
Older Person and/or People living with Dementia (including young onset dementia).	Tracey Williamson Consultant Nurse - Dementia & Honorary Professor of Patient and Family Engagement	Tracey.Williamson@wales.nhs.uk
Children	IHC Operational Managers	Jessica.Jones@wales.nhs.uk Jo.Douglas@wales.nhs.uk Christina.Billingham@wales.nhs.uk
Safeguarding	Generic account	Bcu.safeguardingregionalbusinessteam@wales.nhs.uk

Teitl adroddiad: ***Report title:***	Information Governance Quarter 4 2024/25 Key Performance Indicators (KPI) Report.			
Adrodd i: ***Report to:***	Performance, Finance and Information Governance Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 26 August 2025			
Crynodeb Gweithredol: ***Executive Summary:***	BCUHB has a responsibility to ensure robust information governance systems and processes are in place to protect patient, personal and corporate information. This report is to provide assurance across the key areas of information governance including, but not limited to, confidentiality, data protection, and requests for information, information security and training. The report identifies areas of weaknesses, further actions and recommendations required to address the weaknesses, lessons learnt and good practice.			
Argymhellion: ***Recommendations:***	The Group is asked to receive assurance on compliance with the Data Protection and Freedom of Information Legislation.			
Arweinydd Gweithredol: ***Executive Lead:***	Dylan Roberts - Chief Digital and Information Officer			
Awdur yr Adroddiad: ***Report Author:***	Carol Johnson – Head of Information Governance			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	• Ensuring that BCUHB meets its legal and statutory obligations as defined in the Data Protection Act 2018, UK GDPR and European GDPR 2016; a) Develop and implement system for Records of Processing Activity (ROPA) b) Ensure privacy by design and default is considered at all stages of service design, system procurement and partnership working. c) Transform and implement a revised Data Protection Impact Assessment processes. d) Implement the revised Compliance Audit Programme. • Ensure IG Strategies, policies, procedures and training plans are all updated to reflect best practice and changes in legislation including social media and AI. • Develop and implement a system and process for the regular review of information sharing agreements / protocols. • Implement, monitor and report on compliance with the Asset Register. • Improve overall compliance with Freedom of Information and Subject Access request response times in line with legislative requirements by supporting governance leads, and raising awareness and improving overall availability and publication of information to enable improved transparency to the public; • Support the proposals outlined in the Corporate Records Management Report and findings where resources permit. • Continue to meet the Information Governance training national target of 85% to help improve staff understanding and continuous awareness with the introduction of a new training programme. • Design and implement new ways of working with Primary Care Contractors. • Support the Health Board's move towards a 'Digital Future' by working collaboratively with each area of the Digital, Data and Technology (DDaT) team. • Learn from outcomes and put improvement plans in place to ensure lessons can be learnt and acted upon to avoid reoccurrence, including participation in the Health Board Datix working group. • Support the W&OD Division to develop proposals for the implementation a fully digital staff record including the development of standardised templates. • Review, refresh and commence reporting in line with the corporate calendar reporting requirements. • Increase service user and Regulator confidence in the Health Board and its staff with increased visibility and working relationships, including a refresh of the IG Webpages. • Encourage and support the professional development of team members by providing opportunities for training, skill enhancement, and knowledge acquisition in relevant areas and to include the development of training programmes.

<table>
<tr><td>Goblygiadau rheoleiddio a lleol:

Regulatory and legal implications:</td><td>Data Protection Act and Freedom of Information Act</td></tr>
<tr><td>Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal?

In accordance with WP7 has an EqlA been identified as necessary and undertaken?</td><td>Not applicable</td></tr>
<tr><td>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?

In accordance with WP68, has an SEIA identified as necessary been undertaken?</td><td>Not applicable</td></tr>
<tr><td>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)</td><td>Non-compliance with the legislation can lead to penalties imposed by the Information Commissioner and loss of confidence by the public in the Health Board’s ability to protect the privacy of their information.

<table>
<tr><td colspan="5">Risk Register - Tier 2</td></tr>
<tr><td>ID3801 – Failure to develop and improve the Asset Register System</td><td>9</td><td>6</td><td>4</td><td>Decreased</td></tr>
<tr><td>ID4306 – Data Flow Mapping and Records of Processing Activity (ROPA)</td><td>9</td><td>9</td><td>6</td><td>Unchanged</td></tr>
<tr><td>ID5238 - Development and ongoing management of Corporate Records Management function</td><td>9</td><td>9</td><td>9</td><td>Unchanged</td></tr>
<tr><td>ID5239 - BCU site wide audit to identify health and corporate records store in vulnerable locations</td><td>9</td><td>9</td><td>9</td><td>Unchanged</td></tr>
<tr><td colspan="5">Risk Register - Tier 3</td></tr>
<tr><td>ID2803 - Data Protection Legislation / Freedom of Information Act 2000</td><td>9</td><td>6</td><td>6</td><td>Unchanged</td></tr>
</table></td></tr>
</table>

	ID3803 - MS Office 365 - Management of HB Records	12	8	6	Unchanged	

Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Non-compliance with the legislation can lead to significant fines imposed by the Information Commissioners office.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Not applicable
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Information Governance – Q4 KPI 2024/25 circulated to the Information Governance Group on the 19th May 2025 – with feedback received from the Finance directorate to provide further information with regards to reasoning for decrease in FOI compliance in quarter 4 for finance related requests. *Executive Committee 9th July 2025 – Happy with the report, further engagement needed around NIIAS for professional staff eg Medical, Nursing, AHPs*
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	**Board Assurance Framework** BAF-SP13 - There is a risk of failing to meeting the Health Board's strategic and operational objectives caused by having inadequate arrangements for the identification, commissioning and delivery of Digital, Data and Technology enabled projects and change. **Corporate Risk Register** CRR24-07 – Availability and Integrity of Patient Information CRR24-17 – ICT Failure and Cyber
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable

Next Steps:

1) Target areas with continued low FOI compliance
2) Activity to be undertaken to ensure we have the correct Information Asset Owners and understand their responsibilities for the Information Asset Register.
3) Continue to target areas with low mandatory training compliance.

List of Appendices:

Appendix 1 – Information Governance Quarter 4 2024/25 Key Performance Indicators (KPI) Report.

Atodiad 1 - Dangosyddion Perfformiad Allweddol

Chwarter 4 – Ionawr i Mawrth 2025

Appendix 1 - Key Performance Indicators

Quarter 4 – January to March 2025

GIG CYMRU NHS WALES

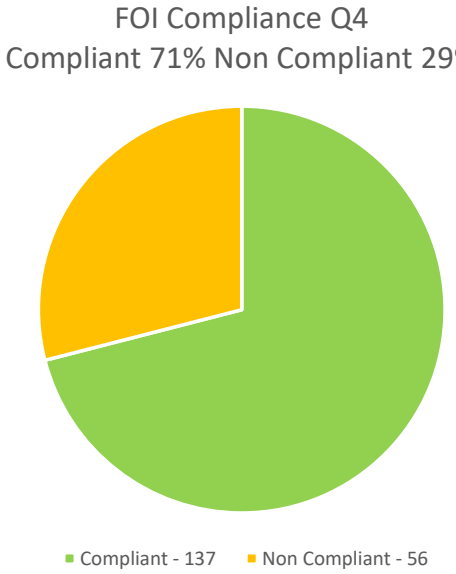
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

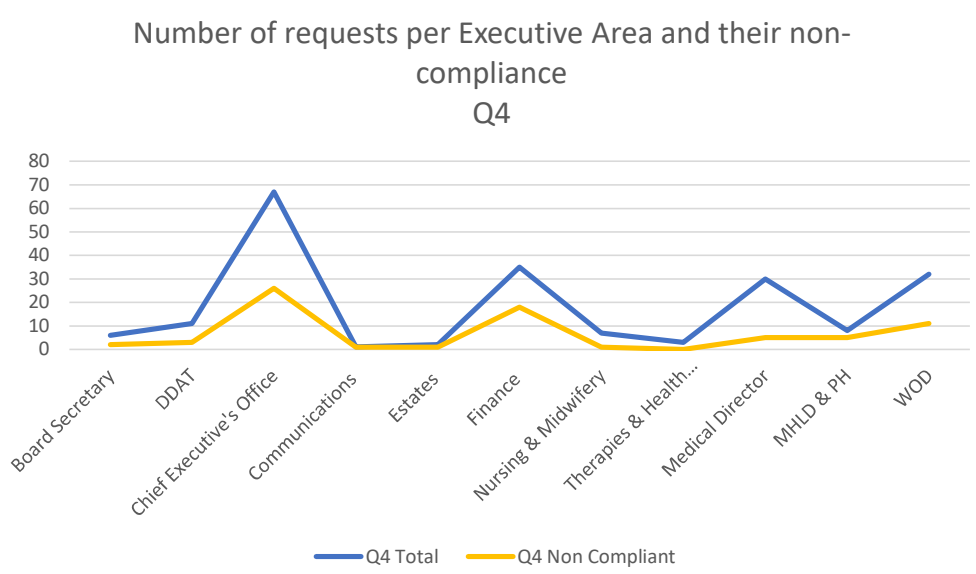
Appendix 1 - Key Performance Indicators: Quarter 4 – January to March 2025

Freedom of Information (FOI) Compliance

There has been an increase in total number of Freedom of Information requests received from previous quarter. A total of **193** requests were received during Quarter 4 in comparison to 190 in Quarter 3. Compliance has decreased slightly to **71%** from 76% reported during Quarter 3 of 2024/25.

Requests received into the Health Board are continuing to be complex in nature, The total hours spent processing requests this quarter was **684** hours which equates to **£17,100** under the Freedom of Information act this is a slight decrease compared to quarter 3. During Quarter 4 a FOI Lead Workshop was successfully undertaken with 40 leads attending the session and was well received from the leads.





FOI Exemption and internal reviews- Please note due to the timeframe permitted under the Act for applicants to request an internal review, some reviews may not be captured in time for this report, however they will be captured within the Information Governance Annual Report.

Exemption	Exemption Category	Total	Internal Review	Upheld/ Overturned
Section 12 – Cost Limit Exceeded	Absolute – No Public Interest Test Required	17	0	
Section 21 - reasonably accessible to an applicant by other means.	Absolute – No Public Interest Test Required	4	0	
Section 31 - Law Enforcement	Public Interest Test applied	1	0	
Section 40 - Personal Information	Absolute – No Public Interest Test Required	6	0	
Section 43 – Commercially Sensitive	Public Interest Test applied	2	1	Overturned
No Exemption applied	N/A	163	1	Partially Overturned

Freedom of Information: Three highest reported reasons for delays/breaches

- 18 delays reported due to receiving the information from Divisional Leads.
- 34 delays due to Executive approval.
- 1 delay due to the request being of a complex nature.
- 2 delays due to formulation of response from IG Team.
- 1 delay due to consideration for an exemption to be used.

The Divisions with the lowest percentage of compliance

- Partnership, Engagement & Communications - 1 out of 1 (100%) non-compliant.
- Mental Health & Learning Disabilities - 5 out of 8 (62%) non-compliant.
- Director of Finance – 18 out of 35 (51%) non-compliant.
- Director of Estates – 1 out of 2 (50%) non-compliant.
- Chief Operating Office - 26 out of 67 (38%) non-compliant.

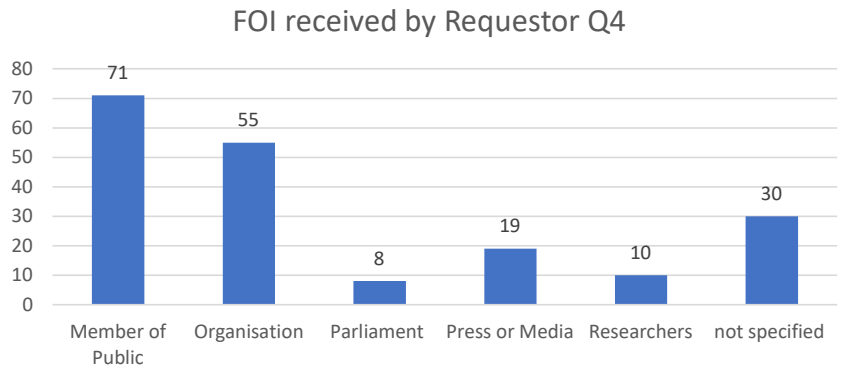
Trends in Freedom of Information Subject

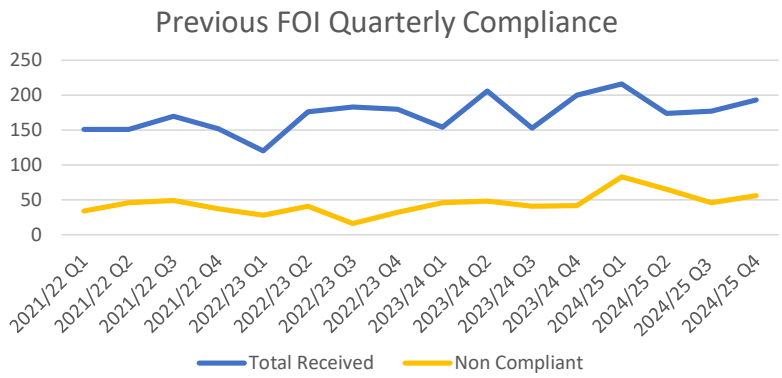
- 24 requests regarding number of drugs/medicines issued.
- 15 requests regarding the Health Board spend on agency staff.
- 11 requests regarding waiting list numbers and waiting times.
- 4 requests for Policies & Procedures.
- 7 requests regarding GP Practices.
- 4 requests regarding Health Board Mortuaries.
- 3 requests regarding Penley Hospital closure.
- 5 requests regarding breast cancer treatment.

2025/26 Improvement Actions

During Quarter 1 of 2025/26, the Information Governance Team will be undertaking the following actions to try and increase compliance with Freedom of Information requests:

- Meet with Finance to discuss FOI process and look at ways to try and improve FOI compliance.
- Meet with Mental Health & Learning Disabilities to discuss FOI process and look at ways to try and improve FOI compliance.
- Streamline process with Estates to ensure consistent process with retrieving information. FOI Lead to be nominated.
- Continue to work with People Services to increase their compliance, and streamline their approval process.
- Continue to review what information can be included on the Health Board publication scheme.





Subject Access Request Compliance

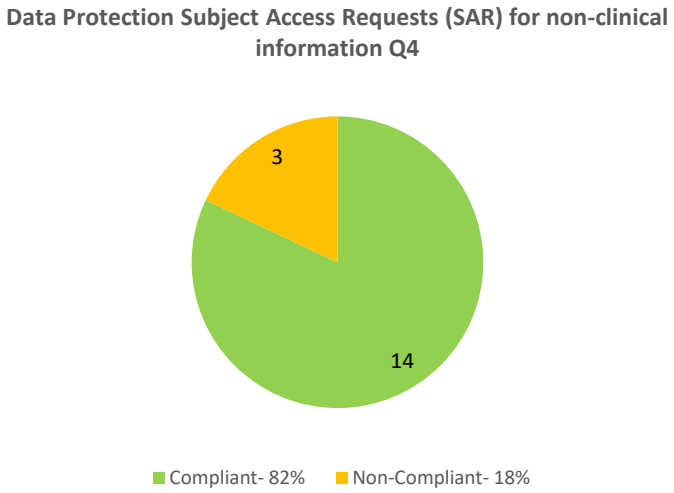
During Quarter 4, the compliance for Subject Access Requests (SAR) has increased slightly from 98% in Quarter 3 to **99%**, with requests for non-clinical information being 82% this quarter. This figure reflects overall compliance for all departments that deal with request for information under Data Protection legislation.

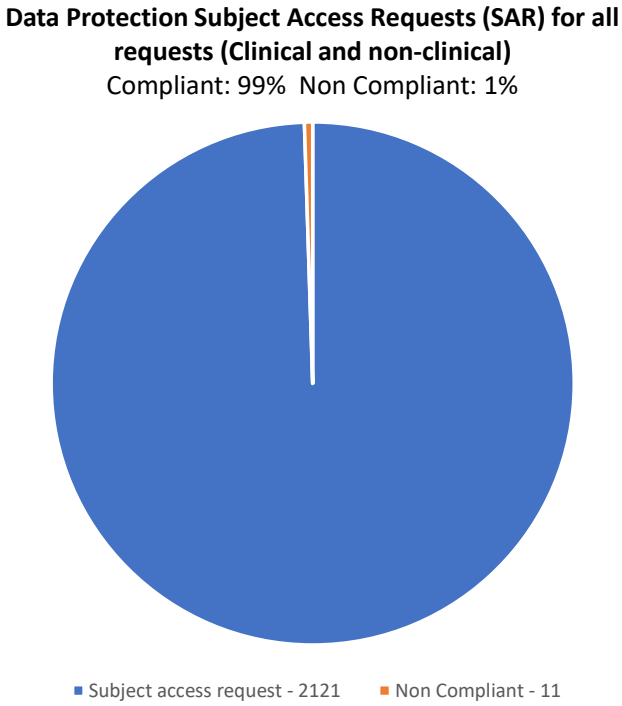
The requests received during this quarter include all requests received into the Access to Health Record Team, Information Governance Team, Managed GP Practices and HMP Berwyn.

2025/26 Improvement Actions

During Quarter 4, Information Governance and Access to Health Records Teams have continued to meet to discuss any complex requests that span both services to ensure consistency and to share lessons learnt etc.

The Information Governance Team will also continue to work closely with the Health Boards Complaints Team for any complex complaints which stem into requests for information.





Incident Category	Sub Category	Number of incidents	Self-Reported to Information Commissioners Office (ICO) / Welsh Government (WG)	Number of complaints
Confidentiality Breach (External)	PPI in public place	3	-	-
	Email	10	-	-
	External Mail	16	-	1
	Inappropriate Access	1	-	-
	Records	17	-	-
	Prescription Error	4	-	-
Confidentiality Breach (Internal)	PPI in public place	5	-	-
	Email	3	-	-
	Internal Mail	1	-	-
	Records	8	-	-
Information Management & Technical Security	Hardware	4	-	-
	ID Badge Loss	9	-	-
	BCU Device Loss	3	-	-
	Inappropriate Access	6	-	-
Non Compliance	IG01 – Records Management Policy	30	-	-
	IG13 – Confidentiality Code of Conduct	3	-	-
	IG15 - Safe storage & transport of Personal Data	17	-	-
	IG17 – Photography, Video & Audio Recording Procedure for a Non-Clinical Purpose	3	-	-
	IG04 – Access to Information Policy	0	-	3
Total		143	0	4

There has been an decrease in the number of incidents reported in Quarter 4 compared to 195 in Quarter 3 (<27%). The Information Governance Team continue to monitor trends in reported incidents and disseminate information to staff members and also include when undertaking audits.

Outcomes

- Consent process to be reviewed when recording patients through any recording device.
- Case of exception approved by Caldicott Guardian over use of WhatsApp
- All staff to be reminded about checking wristbands before handing over to the patient.
- School Nursing team- central - raising awareness across the team for check and re-check of handling confidential information, reminder sent to all team members.

Near Misses	**Legal Claims**
0 near misses reported in Quarter 4.	1 new claim in Quarter 4 which relates to assessment reports regarding a child being sent to another patient in error. There were 0 settled claims in Quarter 4.

Complaints

4 Data Protection complaints was made during Quarter 4. This has decreased from the 11 reported in Quarter 3. All 4 complaints have been responded to and closed. Please see below for further information regarding the complaints received.

Complaints Received

- Letter arrived to patient's address that had already been opened
- 3 x Complaints relating to a Subject Access Request received by a Managed GP Practice.

Lessons Learnt:

1. Managed Practice to strengthen their internal processes for manging requests in line with the Health Boards Policies and Procedures for dealing with SAR's. The Information Governance Team and Access to Health Records Team will provide input on current Standard Operating Procedures used to ensure practices are consistent with the Health Boards and are in line with the legislation and there are no gaps in process to avoid instances like these from occurring in future.
2. Access to Health Records Business Manager will visit the site to review their SAR process to ensure consistent with requests for information for clinical information
3. IG Compliance Audit to be undertaken

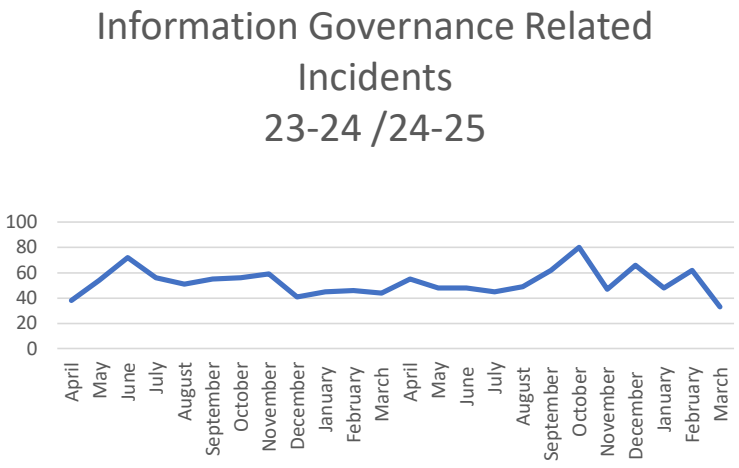
Information Commissioners Office (ICO) Complaints

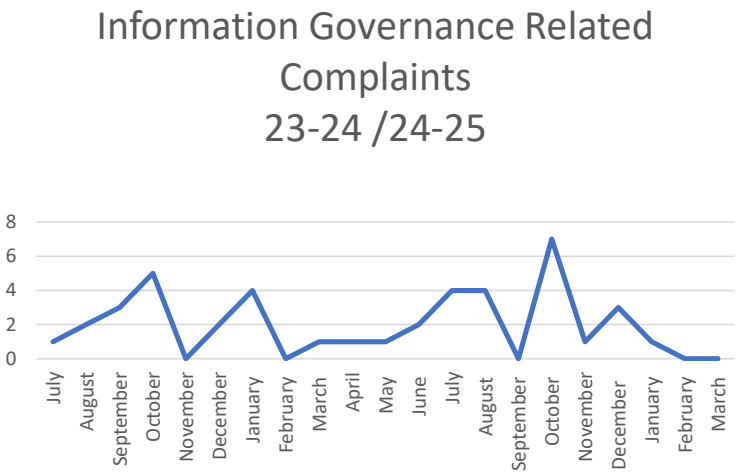
Self-reported incidents to the Information Commissioners Office Quarter 4

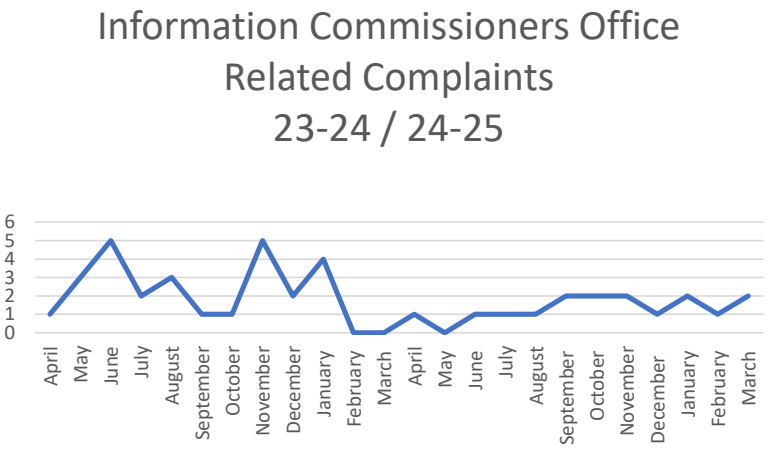
During Quarter 4, there have been 0 self reported incidents to the Information Commissioners Office.

Complaints received from the Information Commissioners Office Quarter 4

During Quarter 4, there has been **1** complaint notifications received, a decrease from 5 in the number of complaint notifications received from the Information Commissioners Office from those reported in Quarter 3. A decision notice was issue by the ICO, with the response being overturned by ICO with a full breakdown of cost to be provided in response to an FOI request.







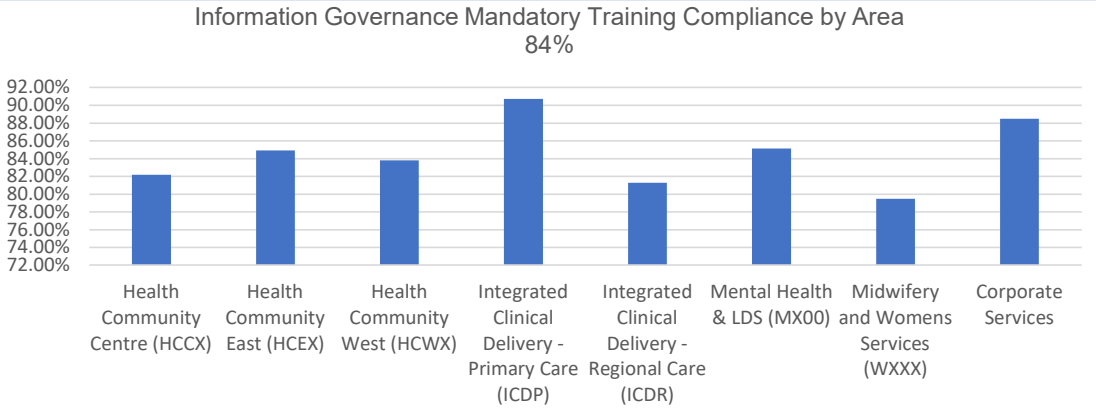
Information Governance Training and Budget Information Quarter 4

Information Governance Mandatory Training

Virtual mandatory training sessions have continued via MS Teams with 6 taking place in Quarter 4 with a total number of 96 staff attending. This is an increase from the 67 who attended in Quarter 3. Training sessions have now changed to run fortnightly, reduced from the previous weekly sessions to help increase the number of attendees in each session and in turn increase interaction between delegates. 1 face to face session has been held with a total of 7 staff attending. An additional 2,472 staff have completed their online E-Learning, which has increased since previous quarters.

The overall compliance for mandatory Information Governance training across the Health Board is **84%.**

During Quarter 4 we undertook an exercise targeting those departments with compliance less than 50%, reminding them to ensure staff members undertake Information Governance training in order to meet the national target and escalated to the Executive lead where appropriate. We will be offering further training sessions to increase compliance within services tailored to their needs and be monitoring compliance via Information Governance compliance audits. We will also begin to escalate to the Executive leads with areas of lower compliance.



Information Governance Budget (including Cost Improvements)	Annual Budget (pay and non-pay)	Year To Date actual spend (pay and non-pay) as at end of December 2024	Year To Date Variance
T410	851,441	605,934	245,507 underspend (not a true reflection, please see below comments)

Please note that the reason for the underspend this quarter is due to:

1. Covering post on maternity within existing structure;
2. Delay in invoicing for confidential waste expenditure;
3. Contiued agile / home working thus reducing travel costs;
4. Service reduced run rate to support overall Health Board Financial Position with scrutiny of spend.

Onsite compliance audits / due diligence checks / face to face training delivery has recommenced which will increase travel costs and will reduce the level underspend in 2025/26. Also considering supporting the Corporate Records Management and / or AI programmes of work where current financial underspends permit.

National Intelligent Integrated Auditing Solution (NIIAS), Service Desk and IG10 Information Quarter 4

IG10

14 IG10 requests in Quarter 4, all of these were approved, please see a breakdown below of these requests:
CCTV – 5
Body Worn Video – 1
Door Swipe Access – 1
Email Access – 1
System Access – 2
Login Audit - 3
IP Address Search – 1
The IG10's approved in this quarter were from a number of different areas and no trends were identified.

Service Desk – Information Governance Portal

The total number of Halo queries decreased to **79** from 130 reported in Quarter 3, this decrease may be due to the change over to the new ICT portal Halo and the ability to share tickets with other services. Some key trends identified during the quarter were:

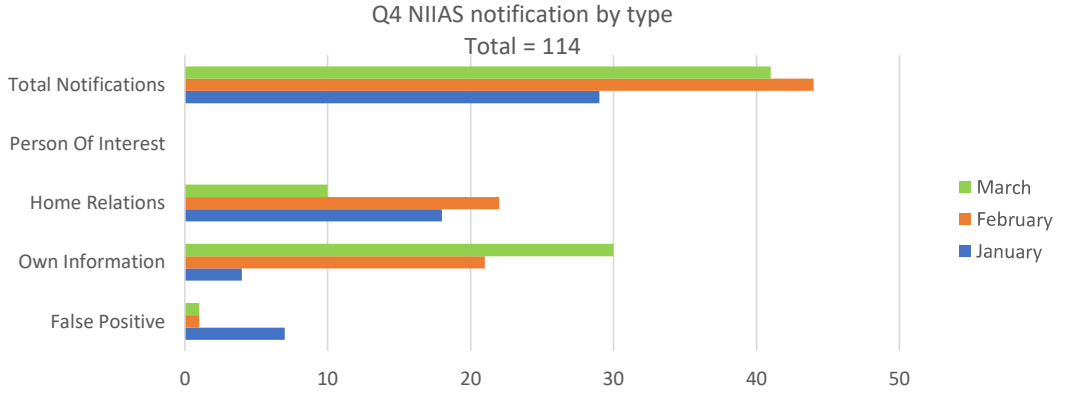
- Surveys
- CCTV
- Information Sharing Agreements
- Privacy Notices

NIIAS (National Intelligent Integrated Auditing Solution)

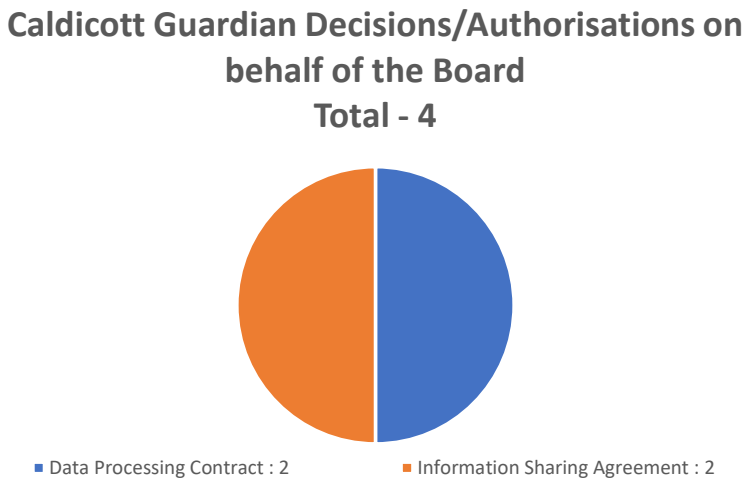
During Quarter 4 there were 114 NIIAS notifications received for staff inappropriately accessing records on Health Board systems.

Please find a breakdown below of the cases with People Services involvement:

Area	Case Not proven	Informal Action	No Case to Answer	Referred to Hearing	To be confirmed
Central	0	0	1	0	2
East	0	0	0	0	1
West	0	2	2	0	1



Caldicott Guardian Decisions, Data Protection Impact Assessments, Compliance Audits & Asset Register Quarter 4 – January to March 2025.



Asset Register

A full review and re-launch of the Information Asset Register is underway. Changes are currently being made by Encodian which have been submitted by both IG and Cyber and we are currently in the UAT stage of the changes that have been requested. Once approved, engagement will be pushed across the organisation. The changes will improve the overall functionality and the ability to capture meaningful data within the register. The review includes:

- A review of the ownership and mapping of all areas.
- A review of all guidance, website, SOPs etc
- Benchmarking against other Health Boards.
- Communication plan in development.
- Training plan to be developed for IG officers to deliver further training focusing on Asset Owner responsibilities.
- Re-engagement and confirmation of responsibilities within DDaT between ICT, IG and Cyber.
- Written procedure will be finalised with the aim to present to IGG in May.

Compliance Audits

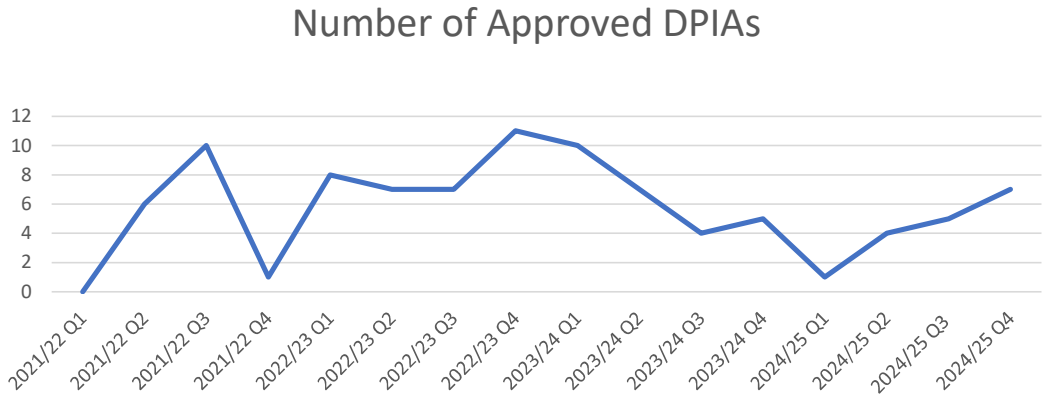
During Quarter 4, there has been **1** face to face compliance audits completed, however 18 departments have completed the Information Governance review forms which are being used as a tool to establish if the department requires an Information Governance face-to-face compliance audit or any further support. A further 5 departments have been sent assessments for completion.

Data Protection Impact Assessments (DPIAs)

There have been **7** Data Protection Impact Assessments approved during Quarter 4, which is an increase in comparison to 5 in quarter 3. There are currently 29 under review either with IG or with the lead for further comment or not progressed.

The Information Governance Team will continue to work closely with the Project Leads to progress their Impact Assessments through those stages during 2025/26.

During Quarter 1 we be actively publishing on the Health Boards Internet site a list of approved DPIAs in line with the Information Commissioners Office Publication Scheme and Welsh Health Board's Information Governance Toolkit requirements.



Teitl adroddiad: ***Report title:***	**Summary of business considered in private session to be reported in public**			
Adrodd i: ***Report to:***	Performance, Finance and Information Governance Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 26 August 2025			
Crynodeb Gweithredol: ***Executive Summary:***	The Finance, Performance and Information Governance Committee considered the following matters in private session at the meeting held on 25 June 2025: • Contract Award for Roslin • Planned Care - Paper Update • BJC Replacement of 2 Linear Accelerators NWCTC 200525			
Argymhellion: ***Recommendations:***	The Committee is asked to note the report			
Arweinydd Gweithredol: ***Executive Lead:***	Pam Wenger, Director of Corporate Governance			
Awdur yr Adroddiad: ***Report Author:***	Philippa Peake-Jones, Head of Corporate Governance			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

		mechanisms / objectives		

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	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
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	Not required for a report of this nature. Items discussed in private session are supported by appropriate documentation.
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	Not required for a report of this nature. Items discussed in private session are supported by appropriate documentation.
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	Not required for a report of this nature. Items discussed in private session are supported by appropriate documentation.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Not required for a report of this nature. Items discussed in private session are supported by appropriate documentation.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Not required for a report of this nature. Items discussed in private session are supported by appropriate documentation.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Not applicable
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	Not required for a report of this nature. Items discussed in private session are supported by appropriate documentation.
Rheswm dros gyflwyno adroddiad i bwyllgor cyfrinachol (lle bo'n berthnasol)	

Reason for submission of report to confidential Committee (where relevant)	Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations*** Advised in private session reports where appropriate	
Rhestr o Atodiadau: Dim ***List of Appendices:*** None	