Bundle BCU Performance & Finance Committee 27 October 2026

1 09:30 - PRELIMINARY MATTERS

1.1 PF26.118 Welcome & Apologies

1.2 PF26.119 Declarations of Interest

1.3 PF26.120 Minutes of the Previous Meeting - 25 August 2026
PF26.120 PFIG Unconfirmed Minutes Public 25.08.26 V1

1.4 PF26.121 Action Log & Matters Arising
PF26.121 Summary Action Log Public

2 INTEGRATED PERFORMANCE

2.1 09:40 - PF26.122 Integrated Performance Report
PF26.122.1 IQPR Coversheet
PF26.122.2 IQPR - PFIG 27102026 v2
PF26.122.3 Financial Grip and Control Feb 2026
PF26.122.4 Financial Grip and Control Action Plan
PF26.122.5 AHP Bank 2025-26 & 2026-27

2.2 10:15 - PF26.123 Planned Care
PF26.123 Planned Care

2.3 10:30 - PF26.124 Urgent & Emergency Care
PF26.124 UEC update

3 STRATEGIC

3.1 10:45 - PF26.125 Community by Design - Verbal Update

3.2 11:00 - PF26.126 Value & Sustainability
PF26.126 V&S Paper

3.3 11:15 - PF26.127 Nuclear Medicine
PF26.127 Nuclear Medicine

3.4 11:25 - PF26.128 Capital Governance
PF26.128 Capital Governance
PF26.128a Capital Governance Project Governance Final Advisory Report
PF26.128b Capital Governance Internal Audit Report Nuclear Medicine BCU-SSU-2526-45

4 11:35 - BREAK

5 GOVERNANCE, RISK & ASSURANCE

5.1 11:45 - PF26.129 Corporate Risk Register
PF26.129.1 Corporate Risk Register Report October 2026
PF26.129.2 Appendix 1-3 CRR

5.2 11:55 - PF26.130 Corporate Governance Report
PF26.130 Corporate Governance Report

6 12:00 - CLOSING BUSINESS

6.1 PF26.131 Agree Items for Referral to Board / Other Committees

6.2 PF26.132 Review of Meeting Effetiveness

6.3 PF26.133 Date of the Next Meeting - 22 December 2026

6.4 PF26.134 Resolution to Exclude the Press & Public

Betsi Cadwaladr University Health Board (BCUHB)
Unconfirmed Minutes of the Performance, Finance & Information Governance Committee
held in Public on 25 August 2026
held in the Boardroom, Carlton Court and via Microsoft Teams

Committee Members Present	
Name	**Title**
Gareth Williams	Vice Chair, Chair of PFIG
Mike Larvin	Independent Member
Chris Lothian-Field	Independent Member
Rhian Watcyn Jones	Independent Member
In Attendance	
Dr Clara Day	Executive Medical Director
Joanna Garrigan	Finance Director, Commissioning & Strategy
Nick Graham	Associate Director, Workforce Optimisation (via teams)
Stuart Keen	Director of Estates & Environment (via teams)
Justine Parry	Acting Director of Digital, Data & Technology (via teams)
Phylis Makurunje	Aspiring Board Member
Olivia Shorrocks	Director of Performance
Pam Wenger	Director of Corporate Governance
Neil Windsor	Programme Director – Value & Sustainability
Observing	
Prof Sir Stephen Powis	Independent Advisor
Kate Spargo	Head of Performance
Committee Support	
Philippa Peake-Jones	Head of Corporate Governance
Harriet Abbott	Secretariat

PRELIMINARY MATTERS

PF26.98 Welcome and Apologies

The chair welcomed members to the meeting. Apologies were received from Russell Caldicott, Executive Director of Finance & Performance.

PF26.99 Declarations of Interest

No declarations of interest were received.

PF26.100 Unconfirmed Minutes of the Meeting held on 23 June 2026

Members reviewed the minutes from the meeting hold on 23 June 2026. The following amendments were agreed:

- Under item PF26.67, additional letter to be removed under point nine.

It was clarified that further information regarding Planned Care and Urgent Emergency Care (UEC) would be included with the integrated performance report item, which would also cover the information requested regarding action PF26.87.1.

It was resolved, that the Committee:

- **APPROVED** the minutes of the meeting held on 23 June 2026, subject to the above amendments.

PF26.101 Matters Arising & Action Log

Members received the action log and noted progress against the actions:

- **Action PF26.71**: it was noted that the grip and control checklist was circulated with members on the morning of the meeting. Additional comments from members are to be submitted to the secretariat. It was emphasised that requested information should be circulated as soon as possible to allow members sufficient time for review ahead of Committee meetings. A further action was agreed that the grip and control questionnaire would return as a substantive item at the next Committee meeting.
- **Action PF26.71.2**: it was clarified that "ECR" refers to the Establishemtn Control Request process for recruiting and appointing to roles within the Health Board.

Members queried the timescale relating to the Estates Rationalisation Programme. It was clarified that an update on the estates strategy will be considered at the upcoming Planning, Population Health and Partnership (PPHP), with a separate proposal being developed through the Value and Sustainability workstream.

The following action was agreed:

- **Action PF26.101.1**: The grip and control checklist to be included as a substantive item at the next Committee meeting.

It was resolved that the Committee:

- **APPROVED** the actions proposed for closure.

Strategic Items

PF26.102 Financial Overview

The item was presented by the Finance Director for Commissioning & Strategy. The following points were highlighted:

- It was clarified that the previous benchmarking information shared with Committee had been produced as a bespoke piece of work by NHS Performance & Improvement, and so is not routinely updated nationally.
- High impact benchmarking areas are highlighted within the report, showing areas that could be reviewed by the Value & Sustainability workstream.
- Between financial years 2019/20 and 2025/26, overall corporate services expenditure has increased significantly, totalling approximately £65m.
- Areas appearing high in benchmarking include Digital, Data and Technology (DDaT), Human Resources and Corporate Governance.
- A correction was advised, stating that the reference within the paper should be Corporate Governance rather than Clinical Governance.

- It is expected that Foundations for the Future may address some high-level structural issues, but will not cover the full structure with the current proposal.

In discussing the item, the Committee:

- Were advised that national benchmarking is underway across Wales regarding DDaT, with an update on the work expected to be given to Committee in December 2026.
- Queried the accuracy of some data regarding concerns. This is to be reviewed outside of the meeting, and any corrections to be shared outside of the Committee.
- Received assurance that further benchmarking work was being undertaken regarding workforce through the Value & Sustainability Workforce Board. This is expected to cover a five-year data set period. An update on this work is expected by the end of this calendar year.
- Noted that Legal Services had moved into Corporate Governance and that additional support had been invested in this area. Legal Services does not sit within Corporate Governance within other Welsh Health Boards.
- Considered the impact that geography and multi-site working may have on the corporate services cost. It was noted that whilst there has been a significant increase in staffing and costs of central services, this has been during a period of extreme financial pressure: it was therefore essential to continue to monitor this topic.
- Clarified that the figure was inclusive of IHC finance and workforce business partner function, but not of IHC specific structures.

The following actions were agreed:

- **Action PF26.102.1**: Update on DDaT pan Wales worked to be received at December 2026 Committee.
- **Action PF26.102.2**: Update on the workforce corporate benchmarking to be received at December 2026 Committee.

It was resolved, that the Committee:

- **NOTED** the report.

PF26.103 Value & Sustainability

The item was presented by the Programme Manager for Value and Sustainability. The update was spilt into two parts, the first focusing on the savings programme, and the second on the impact of work on prevention and early intervention. The following points were highlighted:

- At the end of month four, the Health Board is forecasting green rating savings equating to £43.9m, with a significant increase noted since the last update to Committee. This represents an over delivery of £0.9m against the original plan.
- The Health Board continues to distinguish between budget relieving and non-budget relieving cost savings, as per best practice (though this is no longer done by other Health Boards).
- At the end of month four, pipeline savings equate to approximately £11.6m, however some double counting is expected within this figure, particularly within the workforce

workstream. Work is underway to remove this double count to provide a more accurate figure, which is expected to be less.
- Additional opportunities for further savings are being progressed in areas such as estates, clinical procurement and corporate non-pay.
- An increased pipeline figure has begun to be identified for 2027/28.
- The second part of the paper focused on the impact of prevention and early intervention. Targeted investment each year is used to drive projects for targeted delivery.

[Chris Lothian-Field joined the meeting].

In discussing the item, the Committee:
- Noted that a draft framework for wider value metrics was being produced for the Programme Board, and requested this be shared with the Committee at a future meeting.
- Were advised of clinical variation opportunities including theatre utilisation, outpatient activity, and the use of "See on Symptom" (SOS) and "Patient Initiated Follow Up" (PIFU). Members highlighted that the inclusion of culture was also key to improvement.
- Noted that improvements would sit within the relevant change programmes, including planned care and urgent emergency care, rather than solely within the Value & Sustainability programme. It was emphasised that the main examples included within the report are those funded directly through the V&S programme: it was essential that, if successful, these should be mainstreamed, allowing the relatively modest funding stream to be used for future development of additional saving areas. This was not something which the Health Board had traditionally done well, or done at all.

The following actions were agreed:
- **Action PF26.103.1:** V&S Values Metrics framework to be received at the next Committee meeting through the item update.

It was resolved, that the Committee:
- **NOTED** the report.

INTEGRATED PERFORMANCE

PF26.104 Integrated Performance Report

The report was presented by the Director of Performance. The update focused on the following areas covered within the paper:
- Planned Care
- Cancer Services
- Urgent Emergency Care
- Mental Health
- Diagnostics
- Quality Metrics

In discussing the item, the Committee:

- Noted improvement in the presentation and narrative of the newly updated report format.
- Referenced the reduction seen in over 104 week waits in Planned Care, noting that whilst further improvement was still required, significant progress had been made in reducing long waits.
- Raised concern that waiting list initiatives relying on internal staff and capacity, can create implementation challenges due to existing pressures.
- Highlighted significant concern regarding Endoscopy capacity, noting that the level of true demand was still unknown due to the surveillance element included. A deep dive is due to be undertaken, with an update to be received at Quality, Safety & Experience Committee once complete. A deep dive is also underway by NHS Performance & Improvement (NHS P&I), which has highlighted high Did Not Attend (DNA) rates. This was an area for improvement.
- Noted the additional short term funding allocation for Cancer Services from the Welsh Government, and emphasised the importance of sustainable internal solutions. Bid submissions were due by the end of August 2026.
- Were advised of the slight improvement seen in Urgent Emergency Care performance, but noted that performance still remains off target. Pressure in certain sites may relate to increase demand and reduced resilience during the summer holiday period. A deep dive has been requested on waits to see a doctor in ED to further understand the reason for delay. Difficulty is expected with meeting the target for 12-hour breaches, however improvements have been seen in each IHC, with local targets established. Previously, the target was to hit 0 breaches by the end of March 2027 and performance towards this goal remains on target. However, the Welsh Government had recently asked that this is met by September 2026, which creates greater challenges.
- Queried the increase in unplanned returns to the emergency department within 48 hours. This is being explored to understand the reason for the increase.
- Noted that performance against the Mental Health measure part 1a and 1b remains above the 80% target. Concerns were noted regarding CAMHS performance in East area which was at risk of decreasing below 50%, which may impact significantly on the overall CAMHS performance for the Health Board for the month. The position is expected to improve in the next months following summer. Significant concerns nationally remain regarding the wait for Neurodevelopmental Services and Psychological Therapies, with work underway to reduce three year waits by the end of March 2027.
- Highlighted that BCUHB remain an outlier in Wales regarding never events, accounting for four out of ten reported during this financial year. Updates are reported through the private QSE Committee and discussed in detail, but complexity of incidents vary, with some simpler to resolve than others. A previous issue of audit compliance was identified, which has now been corrected, however further improvement overall is needed to ensure prevent of never events.
- Noted an increase in the number of complaints received, with various factors contributing to the increase. Complaints resolution targets however, continue to be met. It was advised that an increase in complaints is being experience nationally.

The following actions were agreed:

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- **Action PF26.104.1**: A deep dive on endoscopy services to be undertaken with a update received at the Quality, Safety & Experience Committee.

It was resolved that, the Committee:

- **NOTED** the current position and assurance levels against the current metrics.

[Clara Day left the meeting].

PF26.105 Finance Report

The item was presented by the Finance Director for Commissioning & Strategy. The following points were highlighted:

- The Health Board remains in a deficit position as of the end of month four, approximately £2.1m below target. Due to this, the submitted plan has not been accepted by the Welsh Government who require submission of a balanced plan. A balanced position would provide the release of an additional £26m of Welsh Risk Pool funding, providing a further incentive for delivery.
- Key cost pressures areas include prescribing and continuing health care.
- A financial recovery plan is expected to be received at Board in September 2026, with work undertaken with IHCs to identify further cost saving opportunities.
- £108m is at risk when combining £26m Welsh risk pool funding, and £82m recurrent conditional funding. The total percentage required for savings against the total spend should be achievable.

In discussing the item, the Committee:

- Highlighted the monthly IHC variances, noting an increase to non-pay costs within month. This is being reviewed, to understand the reason for the increase.
- Were advised that additional cash support would be requested from the Welsh Government for the forecasted negative cash balance, as per usual practice if an organisation forecasts an overspend.

It was resolved, that the Committee:

- **NOTED** the report.

[Olivia Shorrocks left the meeting].

GOVERNANCE, RISK & ASSURANCE

PF26.106 Board Assurance Framework

The item was presented by the Director of Corporate Governance. The following points were highlighted:

- The Board Assurance Framework (BAF) has been aligned to the Integrated Medium-Term Plan (IMTP), with risks allocated to their relevant Committee.
- The BAF was received at the previous Audit Committee, which highlighted the need to ensure outcome-based assurance.
- A risk relating to long term financial sustainability has been added, and will be included in the update to Board in September.

In discussing the item, the Committee:

- Queried the gaps in assurance in several areas, and it was clarified that these will be addressed by associated deliverables.
- Clarified that items marked as “no update provided” refers to updates that were requested, but for which no narrative was received. This was felt to be unacceptable and it was agreed that this should be highlighted in the Committee AAA report to Board.
- Agreed for updates on several risks to be sought outside of committee ahead of receipt at Board in September. This includes areas such as UEC and Welsh Ambulance Service partnership working and dermatology services.
- Clarified that operational risks still remain within DDaT relating to staffing, capacity and resource, but that these are managed within the service.
- Noted positive progress, acknowledging that the framework will develop as further progress is made.
- Were advised that the vacant role of Head of Risk Management is due to be advertised in the coming months.

The following actions were agreed:

- **Action PF26.106.1**: risks to be reviewed and updates included ahead of Board in September.

It was resolved that the Committee:

- **RECEIVED ASSURANCE** on the item.

PF26.107 Audit Wales Strategic Assessment

The Director of Corporate Governance presented the item. The following points were highlighted:

- The report has been considered by Audit Committee. It was agreed to share the report with PFIG Committee for transparency and awareness.
- The Health Board response has been shared with Audit Wales who are satisfied with the response.

It was resolved that the Committee:

- **NOTED** the report.

PF26.108 Corporate Governance Report

The Director of Corporate Governance presented the item. The item included several documents for endorsement ahead of receipt at the Board, including:

- Committee Terms of Reference (TOR)
- Committee Cycle of Business
- Committee Self-Assessment
- Committee Annual Report

In discussing the item, the Committee:

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- Were advised further discussion is required between the Chairs of PFIG and PPHP Committees, specifically regarding Information Governance, digital and estates items to ensure items are received at the most appropriate Committee.
- Noted areas of improvement reflected within the Committee self-assessment, particularly around performance reporting. Members highlighted that response rate had been low from members and suggested that feedback from other regular attendees of the Committee might be useful.
- Requested an amendment to the first paragraph on page four of the annual report. Phrasing will be shared following the meeting for amendment from the Chair.

The following action was agreed:

- **Action PF26.108.1**: Phrasing amendments to be shared for update to the Annual Report.

[Justine Parry left the meeting].

CLOSING BUSINESS

PF26.109 Agree Items for Referral to Board / Other Committees / Chairs Assurance Report

The PFIG Committee wish to Alert members of the Board that:

- There continued to be a larger than planned in-month deficit in Month 4 with a year-to-date deficit of £22.9 million, compared to a planned deficit of £14.3 million. Despite good progress on identifying savings, these are not having a positive impact on the 'bottom line'.
- Delivery of sustainable recurrent savings remains challenging, with some opportunities dependent on additional operational capacity, data intelligence and successful implementation of the Clinical Variation Workstream, which has to address deep-rooted and systemic issues.
- Overall waiting lists have started to increase, creating a risk to the delivery of planned care trajectories and de-escalation targets.
- Cancer performance remains significantly below the national standard, with ongoing pressures in dermatology, colorectal, breast and urology pathways.
- Endoscopy capacity and quality concerns were highlighted, alongside continued challenges in urgent and emergency care performance, particularly 12-hour waits.
- An increase in Never Events and complaints was noted, requiring continued scrutiny and improvement.

The Committee was concerned that updates had not been provided against some of the key deliverables in the Board Assurance Framework during the current reporting cycle.

The PFIG Committee wish to Assure members of the Board that:

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- In relation to Value and Sustainability, the Committee was assured that robust governance and monitoring arrangements are in place, with work progressing to strengthen benchmarking, benefits realisation and the measurement of value beyond financial savings.
- There is good progress on identifying savings in the current year and, while challenging, the Welsh Government 'ask' to deliver £63 million savings in total in order to achieve breakeven is not out of reach.
- Targeted recovery plans, performance monitoring arrangements and improvement programmes are in place across all key areas of concern.
- Management demonstrated a clear understanding of the challenges, risks and required actions, with regular oversight through Health Board governance arrangements.

The PFIG Committee wish to Advise members of the Board that:

- There is a need to maintain oversight of the Value and Sustainability programme's delivery, particularly the translation of identified opportunities into sustainable savings, productivity improvements and measurable benefits for patients and services.
- Whilst progress is being made in several performance domains, significant delivery risks remain against a number of national targets and de-escalation criteria.
- Continued focus is required on planned care recovery, cancer improvement, urgent and emergency care flow, diagnostic capacity and quality and safety performance.
- The Board should maintain close oversight of recovery trajectories and the impact of improvement actions being implemented across the organisation.
- Additional Welsh Government funding (though less than requested) has been secured to support planned care, diagnostics and urgent and emergency care recovery programmes, although delivery risks remain.

PFIG received assurance and endorsed the updated Board Assurance Framework noting that:

- The Committee reviewed the refreshed Board Assurance Framework and was assured that it provides clearer alignment between Strategic Intent, IMTP objectives, risks and assurances; however, members highlighted the need for greater visibility of actions to address identified gaps in control and assurance, particularly in areas of low delivery confidence. Members also cautioned that some of the deliverables (including ones where confidence was reported as high) seemed unrealistic in the light of actual progress in addressing difficult problems.

Actions to be considered by Quality, Safety and Experience Committee:

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- A deep-dive review of endoscopy performance and quality concerns will be undertaken through the Quality, Safety & Experience Committee.

PF26.110 Review of Meeting Effectiveness

The Committee noted the improved quality of papers, and the value of the Executive Medical Director attending today's Committee. Members did however note the overall low attendance of Executive Members at today's meeting.

PF26.111 Date of the Next Meeting

27 October 2026

PF26.112 Resolution to Exclude the Press and Public

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

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Performance & Finance Committee Action Log (Public)

Updated 19.10.26

Open Actions						
Actions to remain open						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
1	PF26.69.1	23.06.26	**Value & Sustainability** Topic to be included for future development session	Corporate Governance	TBC	Remain Open Clarify at the end of the next meeting if this is still required
2	PF26.102.1	25.08.26	**Financial Overview** Update on DDaT pan Wales worked to be received at December 2026 Committee.	Acting Director of Digital, Data and Technology	December 2026	Remain Open
3	PF26.102.2	25.08.26	**Financial Overview** Update on the workforce corporate benchmarking to be received at December 2026 Committee.	Associate Director - Workforce Optimisation	December 2026	Remain Open
Proposed for Closure						
1	PF26.106.1	25.08.26	**Board Assurance Framework** Risks to be review and updates included ahead of Board in September.	Director of Corporate Governance	September 2026	Proposed for Closure Updates made
2	PF26.108.1	25.08.26	**Corporate Governance Report** Phrasing amendments to be shared for update to the Annual Report.	Director of Corporate Governance	September 2026	Proposed for Closure Updates made

3	PF26.104.1	25.08.26	A deep dive on endoscopy services to be undertaken with an update received at the QSE Committee	Executive Medical Director	December 2026	Proposed for Closure Transferred to QSE Committee forward workplan for receipt at Nov 2026 Committee
4	PF25.114.2	18.12.25	**Finance Report** Update on the AHP bank to be received at the October 2026 meeting to review progress.	Nick Graham	October 2026	Proposed for Closure Include as an appendix on the finance report/IQPR report for October's meeting
5	PF26.70.1	23.06.26	**Community by Design** Update to be given at Committee in October 2026, including proposed metrics and baseline	Chief Operating Officer	October 2026	Proposed for Closure Verbal update included on October agenda
6	PF26.101.1	25.08.26	**Matters Arising** The grip and control checklist to be included as a substantive item at the next Committee meeting.	Executive Director of Finance & Performance	October 2026	Proposed for Closure Included on October agenda under IQPR item.
7	PF26.103.1	25.08.26	**Value & Sustainability** V&S Values Metrics framework to be received at the next Committee meeting through the item update	Programme Manager, Value & Sustainability	October 2026	Proposed for Closure Included on October agenda
Closed Actions (as agreed at meeting on 25.08.26)						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
1	PF26.66.1	23.06.26	Cost of corporate centre to be added to forward workplan	Harriet Abbott	June 2026	Closed Added to forward workplan
2	PF26.71.2	23.06.26	**Finance Report** People & Culture Committee to review work underway to simplify the ECR process.	Head of Corporate Governance	October 2026	Closed 09.07.26 – shared with P&C secretariat
3	PF26.87.1	23.06.26	**Planned Care**	Chief Operating Officer	August 2026	Closed on agenda for august.

			A more detailed report on planned care to come to the next Committee, outlining proposed arrangements, delivery plans, improvement opportunities with links to the new performance report, and consideration of clinical risk and potential harm.			Additional committee meetings held in July 2026
4	PF26.74.1	23.06.26	**IG Annual Report** Primary care information on page 35-36 to be reviewed and clarification shared with members	Head of Information Governance	August 2026	Closed Information received and shared with chair for review
5	PF26.71.1	23.06.26	**Finance Report** Grip and controls checklist to be shared with members ahead of August Committee	Exec Director of Finance & Performance	August 2026	Closed Will be circulated with members ahead of the meeting.

Performance & Finance Committee

INTEGRATED QUALITY AND PERFORMANCE REPORT (IQPR)

Dyddiad y Cyfarfod **Date of Meeting**	27 October 2026
Statws Cyhoeddi **Publication Status**	Open/ Public
Enw a theitl Awdur(on) yr Adroddiad **Report Author name and title**	Olivia Shorrocks, Director of Performance Michelle Jones, Head of Financial Reporting Daniel Eyre, Head of Capital Development
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol **Lead Executive Team Member name and title**	Alan Streets Cyfarwyddwr Gweithredol Cyllid Dros Dro Interim Executive Director of Finance
Pwrpas yr Adroddiad **Report Purpose**	For noting

Crynodeb Gweithredol **Executive Summary**
This report summarises the health board's current position in relation to its agreed performance metrics and identifies key actions required to improve performance and achieve sustained improvement. It provides the health board with an objective assessment, underpinned by analysis, highlights performance issues alongside longer-term data and information on the improvements underway. Members are asked to note the current position and assurance levels against performance metrics.

Ymgysylltu (mewnol/allanol) yr ymgymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp) **Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)**		
Pwyllgor / Grŵp / Unigolion **Committee / Group / Individuals**	**Dyddiad** **Date**	**Canlyniad, Tystiolaeth a Data** **Outcome, Evidence and Data**
Not applicable for this report		

INTEGRATED PERFORMANCE AND QUALITY REPORT

1.0 Y SEFYLLFA / SITUATION

1.1 The Integrated Quality and Performance Report underpins the health board's Performance and Accountability Framework and integrates key performance indicators (KPIs) taken from:

- Key deliverables from the annual and Integrated Medium-Term Plan (IMTP)
- Special measures de-escalation criteria
- NHS Wales Performance Framework Measures
- Key deliverables in response to Welsh Government (WG), Healthcare Inspectorate Wales (HIW, Health Education and Improvement Wales (HIEW) and other formal recommendations

2.0 Y CEFNDIR / BACKGROUND

2.1 This report provides an assessment of organisational performance, outlining key achievements, areas of challenge, and the actions being taken to drive improvement against the domains of:

- Operational performance and access
- Quality, safety and patient experience
- Finance and sustainability
- People and places
- Population health and prevention

It brings together quantitative data, narrative analysis, and strategic context to present a comprehensive overview of service performance across the health board. The performance measures and targets reported within this section are aligned to Welsh Government expectations for 2026/27.

3.0 MATERION PENODOL I'W HYSTYRIED / SPECIFIC MATTERS FOR CONSIDERATION

3.1 Performance and access

Planned care remains one of our highest priorities and we continue to make progress in reducing the longest waits. The number of people waiting more than two years for treatment has fallen by around 8,000 patients since July 2024, representing a reduction of almost 80 per cent. A very small number of patients remain waiting more than three years and these patients are being actively managed and prioritised.

The September position is expected to be around 2,090 patients waiting over 104 weeks, slightly above the planned position.

A £20.24 million recovery programme is now in place to further accelerate reductions in long waits and to eliminate 104-week waits within the next eight months. Activity through insourcing, outsourcing, waiting list initiatives and additional theatre capacity will support delivery of the recovery programme.

Cancer performance was on trajectory in August with a performance of 56.5% against a profile of 56.7%. Whilst this performance is in line with plan and above de-escalation threshold it remains significantly below national target of 75%. In line with agreed protocols, quarterly resubmission resulted in February and March performance being resubmitted above the 55% threshold. Quarter 1 (April – June) data will be resubmitted in October with updated statistics to be published in December.

Challenges remain specifically within skin and breast services. Targeted commissioning in addition to internal additionality is taking place to accelerate mobilisation of recovery plans.

Diagnostic performance has continued to improve with the percentage of patients seen within eight weeks increasing from 47.1% at the end of January 2026 to 68.3% at the end of July 2026 - a reduction of around 14,500 patients waiting over 8 weeks. Capacity constraints continue within key services, particularly radiology, non-obstetric ultrasound and endoscopy, where demand from all pathways i.e. inpatient, urgent, cancer and routine demand alongside workforce pressures continue to impact performance.

Performance against the percentage of people accessing **adult psychological therapy** improved in August to 61.8% starting treatment within 26 weeks. Whilst this improvement is encouraging and further improvement expected supported by recruitment and resolution of capacity constraints achievement of the national standard remains challenging.

Access for children requiring **neurodevelopment** assessments remains below expectations at 16.2% within 26 weeks for BCUHB against an 80% target. The all-Wales performance in August 2026 was 26.4%. The number of patients waiting more than three years for assessment has reduced by 950 since 2026 and now stands at 326. Current forecasts indicate that there will remain a shortfall in capacity to clear the three year wait cohort by March with discussions taking place to secure further additionality.

Urgent and emergency care services across the Health Board continue to experience significant operational pressure, presenting ongoing risks to patient safety, patient experience, quality of care, staff wellbeing and organisational

reputation. Demand remains consistently high across all three acute hospital sites. Delayed discharges and wider system pressures continue to impact emergency department performance.

Following improvements in ambulance handover performance during July and August, performance deteriorated in September, with 1,791 handover delays over 45 minutes reported a 9% increase from August. Performance remained within the IMTP planned trajectory. A key objective for September was to achieve the de-escalation threshold for handovers exceeding one hour (970); however, performance worsened to 1,509 delays, 539 above the target.

Ambulance conveyances were unchanged from the previous month, while self-presentations to Emergency Departments reduced by 5.9% (784 attendances). Despite this reduction in demand, performance against the 12-hour Emergency Department and Minor Injury Unit measure remained static at 17%, significantly above the de-escalation target of 10%.

System-wide flow constraints, delayed discharges and capacity pressures across health and care services continue to limit improvements in urgent and emergency care performance and remain the key barriers to achieving planned trajectories.

There have been some improvements in ambulance handovers and patient flow.

- Ambulance handover delays over an hour have reduced by around 35 per cent since March 2026.
- There has been modest improvement in the proportion of patients waiting more than 12 hours in emergency departments.
- The health board has strengthened governance, leadership and oversight of the urgent and emergency care recovery programme

3.2 Quality, safety and patient experience

There are 466 open complaints (13 October 2026) - a 43.8% increase from 324 in early August. The health board is implementing a recovery programme focused on the Early Resolution First approach, streamlined handling of lower-harm complaints and targeted divisional support to reduce backlog and improve timeliness. The main themes from complaints are delays in assessment and treatment, communication, and concerns regarding care and clinical decision-making.

Overall patient experience remains positive, with 86.4% of respondents rating their experience as good or very good. Satisfaction with dignity, respect and communication in a preferred language remains above national benchmarks, although satisfaction with waiting times continues to be below target.
Patient safety incident performance remains challenging, with 5,550 open incidents, including 3,490 open for more than 30 days, creating risks to timely investigation and organisational learning. National Reportable Incident management continues to improve, with open cases reducing to 44 and BCUHB maintaining the fastest median investigation completion time and NRI's remaining open for more than 12 months in Wales.

One Never Event was reported during September 2026; (N.B a further Never Event reported early October not reflected in charts) a cumulative position of 8 (9) Never Events during 2026/27.

IPC performance remains challenged, particularly for C. difficile and MSSA, with 10 outbreaks across August and September resulting in 120 lost bed days. Improvement work continues through national collaboratives, enhanced surveillance, audit, workforce education and antimicrobial stewardship.

3.3 Finance and Sustainability

The health board's submitted financial plan identified an £89 million gap to achieve a break-even position. After incorporating a planned £46 million savings target, the Health Board's financial plan reflected a £43 million planned deficit, meaning the organisation is not currently forecast to meet its statutory financial duty.

As at Month 6 (September) the health board's planned deficit reduced from £43 million to £34.3 million reflecting an £8.7m reduction in the forecast contribution to the Welsh Risk Pool, treatment in line with Welsh Government instructions. This change does not reduce BCU's in-year financial challenge. Welsh Government had agreed to match any additional in-year Welsh Risk Pool contribution subject to the health board identifying and delivering sufficient further savings and controls to achieve a balanced financial position. The reduction does, however, improve the reported forecast position and potentially reduces future financial challenge. A risk remains that the required Welsh Risk Pool contribution could subsequently increase.

At the end of Month 6 (September) 2026, the health board is reporting a year-to-date deficit of £31.1 million, which is £14.0 million adverse to the planned year to date deficit of £17.1m. Year to date pressures predominantly relate to pay, non-pay, prescribing and CHC. Urgent action is required to identify and implement mitigating actions to contain the monthly cost overruns of circa £2.3m per month and recover the £14.0m year-to-date deficit above plan.

Delivery of the £34.3 million revised planned deficit forecast is dependent upon a number of key assumptions, including:

- Successful implementation of the recovery plan sufficient to reduce the underlying monthly run rate to planned levels and recover the year-to-date overspend. The IHC's and Services have been instructed to identify a 1% reduction in forecast run rate, close the remaining gap against budget reducing savings requirements.
- Full funding by Welsh Government of all 2026/27 pay awards and associated pay uplifts
- Receipt of all anticipated income streams.

As at September 2026, savings schemes with a forecast deliverable value of £53.0 million have been progressed, an increase of £5.5m from previous month. Of the identified schemes, only £33.6 million have been reported as budget

reducing, highlighting the need for significant further work to identify and deliver recurrent budget releasing savings and restore a sustainable financial trajectory.

Welsh Government has reiterated its expectation that the health board works to deliver its key financial duty and submit a balanced financial plan. To achieve this, the health board would need to deliver further opportunities to reduce expenditure by an additional £17m, which subject to costs returning to the revised plan would release additional Welsh Government funding and provide a credible route to support delivery of financial balance in 2026-27.

Failure to achieve the statutory financial duty places at risk access to approximately £100 million of Welsh Government funding (reduced from £108m due to the impact of the reduced Welsh Risk Pool contribution and associated funding). This would significantly increase the financial challenge facing the organisation and constrain its ability to maintain services, invest in workforce and infrastructure, and support delivery of operational recovery plans.

3.4 **People and places**

Vacancy rates improved in September to 8.8%, supported by an increase in staff in post, although vacancies remain higher than the previous year and recruitment challenges continue to impact progress, with the greatest pressures and highest vacancy rate within Additional Clinical Services (11.9%) and Estates & Ancillary (11.8%). Registered nursing vacancies totalled 433.5 WTE in September 2026, an increase of 39 WTE compared with the previous year. This figure is expected to reduce over the coming weeks as staff appointed through the Student Streamlining process take up post.

Turnover continues to improve, reducing to 6.9%, supported by a range of targeted retention initiatives, while sickness absence remains stable but elevated at 6.21%, with focused support being provided to hotspot areas.

The Workforce Planning and Efficiency Programme continues to strengthen organisational resilience through enhanced workforce planning, workforce action plans for fragile services, improved governance arrangements, workforce modelling with NHS Wales partners. The Interprofessional Education Group and NHS Wales workforce planning support are strengthening workforce modelling and future workforce supply, while the revised Consultant and SAS Job Planning Policy supports a more consistent, strategic, and productivity-focused approach to workforce planning.

4.0 ASSESSMENT

The health board continues to face significant challenges in delivering sustained recovery. Performance against national standards remains below expectation in

many services, most notably urgent and emergency care, cancer and planned care. The improvements reported against planned care and diagnostics are gradual and expected to be sustained. Alongside these operational challenges, the health board faces substantial financial risk, with delivery of the statutory financial duty critical to maintaining access to Welsh Government support funding and supporting future service sustainability. Recovery plans are in place, but delivery at pace will be critical during the remainder of 2026/27.

5.0 ARGYMHELLION / RECOMMENDATIONS

5.1 All exceptions noted in this paper are being monitored and are under ongoing scrutiny, despite this there is considerable risk that not all of the health board's trajectories will not be met this quarter. Committee members are therefore asked to provide robust oversight and challenge, ensuring that recovery plans are delivering measurable improvement and that management actions are commensurate with the scale of the operational, quality and financial challenges facing the health board.

Acronymau / Rhestr Termau **Acronyms / Glossary of Terms**	
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
CRR	Corporate Risk Register Reference
CTM	Cwm Taf Morgannwg University Health Board
ENT	Ear, Nose, and Throat
GDS	General Dental Services

GP	General Practitioner
HDda	Hywel Dda University Health Board
HEIW	Health Education and Improvement Wales
IHC	Integrated Health Community
LPMHSS	Local Primary Mental Health Support Services
MH&LD	Mental Health and Learning Disabilities
MMR	Measles, Mumps and Rubella
NHS	National Health Service
NR	non-recurrent
PADR	Performance Appraisal and Development Review
PFIG	Performance, Finance, and Information Governance Committee
QSE	Quality, Safety, and Experience Committee
SB	Swansea Bay University Health Board
SM	Special Measures
WAST	Welsh Ambulance Services NHS Trust
WG	Welsh Government
YTD	year to date

ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol **Link to Strategic Priorities**	 4. Improving quality, outcomes and experience
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Yr Egwyddorion Dylunio **Design Principles**	Equity and Accessibility Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd **Corporate Risks and Board Assurance Framework**	CRR 25-01 Timely Access to Safe and Effective Care CRR 25-06 Value Delivery and Financial Sustainability CRR 25-08 Non-Compliance with Regulatory and Legislative Requirements

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

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

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

Have you undertaken a Data Protection Impact Assessment Screening?		
Asesiad o Effaith ar Atal Twyll *A ydych chi wedi ystyried yr effeithiau ar atal twyll?* **Counter Fraud Impact Assessment** *Have you considered the counter fraud impacts*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Cyfreithiol **Legal**	Yes (Include further detail below)	
Enw Da **Reputational**	Yes (Include further detail below)	
Effaith ar Adnoddau *(Pobl / Ariannol)* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

27 October 2026

Trugaredd
Compassion

Agored
Openness

Parch
Respect

Betsi Cadwaladr University Health Board

Integrated Quality and Performance Report (IQPR)

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Introduction

This report sets out the health board's performance against the latest available data, using management information where appropriate and summarises progress against a range of national and local performance measures.

The health board is using the ‘3As assessment’ approach to highlight either an alert, advise or assure status for each key performance metrics:

- **Alert** (may require discussion): There is a lack of confidence that any action in place is sufficient to address the issue satisfactorily and/or within the scope of the operational team or executive to resolve. Engagement, action or intervention required.
- **Advise** (to monitor): There are areas of concern where assurance has been taken on actions in place but requires close monitoring. An early warning of an emerging and potentially serious concern.
- **Assure** (to note): There is confidence that actions are robust and will be sufficient to address the issue or generally operating effectively. Routine monitoring.

Due to the special measures status of the health board, an additional element to complement the 3As approach has been introduced:

- **Escalate** (Serious concerns, action required): There is limited confidence that the actions in place will address performance issues at a sustainable level. Executive level intervention is necessary to resolve the situation.

Executive Summary: Performance and access

The health board continues to make progress in reducing **planned care** waiting times. The position of 2,092 at the end of September is a significant improvement from two years ago where 10,294 were waiting over two years – a reduction of 8,202. Additional funding has been received from Welsh Government to support further reduction this financial year

Diagnostic performance continues to improve with the percentage of patients seen within eight weeks increasing from 47.1% at the end of January 2026 to 74.4% at the end of September - a reduction of around 14,500 patients waiting over 8 weeks

Cancer performance in August is above the de-escalation percentage of 55% at 56.5% in August 2026, this remains considerably below the national target of 75%. Plans are being developed to accelerate reduction in total waits and reduce the total backlog of dermatology patients, this is the area driving the volume of patients waiting longer than 62 days..

Urgent and Emergency Care services across the health board continue to experience sustained operational pressure, presenting ongoing risks to patient safety, patient experience, quality of care, staff wellbeing, and organisational reputation. During September, ambulance conveyance activity remained stable, with 52% of patient handovers completed within the 45-minute target. Self-presentations reduced by 5.9% (784 attendances) compared to August following the increase seen over the summer period. Performance against the 12-hour emergency department standard was17%, significantly above the health board trajectory, with 39% of breaches relating to patients who were not subsequently admitted. Median time to clinician was 123 minutes, exceeding the national target by 63 minutes and indicating continued pressure at the front door. Patient flow remains a key challenge. The number of patients experiencing a pathway of care delay increased to 347, with total delayed days rising to 14,244. A small cohort of four patients awaiting specialist long-term learning disability placements accounted for 21% (2,996 days) of all delayed days during September, highlighting the impact that a small number of complex cases can have on overall performance.

Adult Mental Health - Part 1 access performance remained above the national 80% standard in August 2026, with 90.2% of assessments and 91.1% of first therapeutic interventions completed within 28 days. Part 2 Care and Treatment Plan compliance has been maintained at 88% for a second month. This is below the national target of 90% with recovery actions focused on improving consistency and supporting sustained improvement.

Psychological Therapy - Psychological therapies performance improved to 61.8% in August 2026 but remained below the national 80% standard. Key capacity constraints have now been addressed, with additional clinic capacity available and increased workforce capacity supporting recovery in activity and waiting times.

Children and Adolescent Mental Health performance has fallen below the 80% standard for both the assessment (79.6%) and intervention (78.84%) metrics during August with performance expected to remain below the 80% target during September. A 20% increase in assessment demand has impacted on this performance with recovery trajectories indicating that the assessment performance will return to above 80% in October with intervention metric expected to recover by January 2027.

No health board is currently achieving the target of 80% for **Neurodevelopment Assessments** with all Wales performance in August 2026 at 26.4%. The health performance for August was 16.2%, the lowest performance in Wales. The number of three-year waits had reduced by 950 since January falling from 1,276 to 326 with further progress expected in year.

Executive Summary: Quality, safety and patient experience

Complaints

There were 466 open complaints in the week commencing 13 October 2026, this is a 43.8% increase from 324 in early August. A programme of work is underway to improve complaints performance and reduce the outstanding backlog through a stronger focus on early resolution and process efficiency. The expansion of the Early Resolution First approach, alongside streamlined handling of low-harm complaints, is intended to accelerate resolution times and reduce the number of cases progressing to formal investigation. Complaints continue to reflect themes relating to delays in clinical assessment and treatment, communication with patients/service users and concerns regarding the appropriateness of treatment or assessment. Targeted interventions continue with IHCs/Divisions to support management of the outstanding caseload and improve timely resolution.

Patient Experience

Overall patient experience remains positive, the latest reporting period indicates slight improvement across a number of experience measures. 86.40% of respondents rated their overall experience as good or very good. Satisfaction levels were high with people reporting they were 'Always' treated with dignity and respect (86.33%) and being able to communicate in a preferred language (90.87%), which exceeded the national benchmark of 85% satisfaction. Overall waiting time satisfaction levels are below the national benchmark of 85%. In August 2026, 73.18% of respondents shared a positive experience for the time they waited (42.76% shorter than expected and 30.42% about right). In September 2026, 73.86% shared a positive experience for the time they waited (43.90% shorter than expected and 29.96% about right).

Patient Safety Incidents

Open incidents as at the end September 2026 were 5,550, consistent with numbers reported at the end of August 2026. 3490 incidents have been open greater than 30 days, similar to last month. This represents a worsening position and creating risks to timely investigation, organisational learning and assurance. National Reportable Incidents (NRIs) continue to be closely monitored; The number of open NRIs has shown a gradual downward trend over the past year, decreasing from the mid-50s to 44 open cases at the end of September. Overdue NRIs have remained the same as last month, currently at 10 cases, with a slight increase in recent weeks. Overall, the trend indicates improved management of the NRI caseload, with continued focus required to address outstanding overdue cases and sustain performance. Investigation timeliness compares favourably nationally, with a median completion time of 107 days, the lowest in Wales compared with the all-Wales median of 179 days. Targeted support continues for IHCs and services through Rapid Reviews and Interim Harm Reviews, alongside strengthened oversight and organisational learning through established quality governance arrangements.

Patient Safety

One Never Event was reported during September 2026 (a further Never Event occurred in October), bringing the cumulative position to eight (nine) during 2026/27. Incidents reported during the year reflect a range of patient safety themes, eg procedural safety and retained The first Safer Surgery and Invasive Procedures Steering Group took place on 29 September 2026 providing an overview of the improvement programme to ensure that there is strengthening of the compliance with LocSSIPs and procedural checklists, targeted audit and monitoring, system wide learning dissemination, and active senior clinical governance oversight to reduce the risk of recurrence.

Infection Prevention and Control (IPC) HCAI performance remains challenging, with hospital-onset E. coli the only core measure currently below trajectory. The greatest adverse variances are seen in C. difficile (+57 cases) and MSSA (+37 cases), with MRSA, hospital-onset Klebsiella and Pseudomonas also above trajectory.

The operational impact has been significant, with 10 outbreaks reported during August and September, resulting in 5 full ward closures, three bay closures and 120 lost bed days. Improvement activity includes targeted work through the national C. difficile collaborative, strengthened surveillance and epidemiological review, audit and assurance of infection prevention practice, workforce education and antimicrobial stewardship.

Executive Summary: Population health and prevention

Public Health plays a fundamental role in delivering the health board's strategic ambition to shift care towards prevention, reduce health inequalities and improve long-term population outcomes.

Areas to note

- Smoking cessation services continue to demonstrate strong performance in supporting quit attempts and successful quits, although further improvement is required in CO-validated quit rates.
- Substance misuse treatment completion remains high.
- HPV, RSV 75+ uptake, reducing unwarranted variation, and addressing inequalities are areas of focus for the vaccination and immunisations programme.
- Digital activity for the level 2 weight service is increasing and is on trajectory to exceed the annual target.
- Building on the work established through the Well North Wales programme, the Regional Partnership Board (RPB) and Health Board have worked collaboratively with partners to co-produce a Regional Anchor Charter.

Meningitis B Vaccination Programme – 2026/27

Earlier this year, the Welsh Government announced an urgent, time-limited MenB vaccination programme. As at the latest update, 3,117 first doses (35.2%) and 2,383 second doses (26.9%) had been delivered to the eligible 17–18-year-old BCUHB cohort. Uptake varies across North Wales, with first-dose coverage ranging from 31.0% in Denbighshire to 41.2% in Conwy. The routine scheduling of second-dose appointments should support sustained growth in course completion rates, while delivery through education settings will provide additional opportunities to vaccinate eligible cohorts during the autumn.

Flu Programme – 2026/27

The 2026/27 flu campaign commenced on 1st October 2026 with delivery across North Wales supported by more than 200 primary care stakeholders alongside an integrated Health Board delivery plan. The wider programme, including vaccination for people aged 65 and over, takes a co-administration approach where eligibility for flu and COVID-19 vaccination aligns. At 13/10/26, 32.6% of residents aged 65 and over in BCU had been vaccinated.
The staff flu programme is now led by the Integrated Vaccination Service, with appointments, drop-in and peer-vaccinator sessions available. A new staff feedback and incentive initiative has also been introduced to support uptake. Data will be available from 22/10/26
Vaccination for 2- and 3-year-olds and pregnant women commenced on 1 September 2026. At 13/10/26, 28.3% of 2–3-year-olds in BCU had been vaccinated.

Diabetes Care

Foot surveillance (FS) and urine albumin (UA) remain the lowest-performing of the eight NICE diabetes care processes. UA has seen a comparative month on month increase and at Sep 26 was 2.7% higher than Sep 25. FS, although improved from 2024/25, has plateaued. Recent engagement work with GPs suggests that data and coding issues, call and recall, uptake of offer, and capacity issues may contribute to lower uptakes. A targeted letter was sent in Q2 to GP practices with the lowest uptake. This letter seeks development and submission of an action plan to improve uptake and offers support to develop this improvement plan.

Executive Summary: People and places

Vacancy Rate

In September 2026, vacancies stood at 1,825.1 WTE (8.8%). This represents an improvement of 0.4 percentage points compared with August, largely driven by an increase of 85.5 WTE in staff in post. Despite this improvement, vacancies remain 196.8 WTE higher than the same period last year, reflecting growth in the funded establishment that has outpaced workforce growth. Additional Clinical Services continues to experience the greatest pressure and currently has the highest vacancy rate at 11.9%, closely followed by Estates and Ancillary at 11.8%. Registered nursing vacancies totaled 433.5 WTE in September 2026, an increase of 39 WTE compared with the previous year. This figure is expected to reduce over the coming weeks as staff appointed through the Student Streamlining process take up post.

Recruitment challenges and delays associated with enhanced establishment controls continue to affect the organisation's ability to reduce vacancies at pace. However, progress is being supported through strengthened workforce planning, targeted recruitment campaigns, improved application filtering processes, and focused interventions in priority areas. In partnership with Finance colleagues, work is also underway to review and streamline establishment control arrangements.

Workforce Planning and Efficiency Programme

The embedding of workforce planning continues to be strengthened through targeted support for fragile services, with workforce action plans now developed to support service sustainability and mitigate workforce risks. Governance arrangements have been enhanced to ensure workforce planning is linked with all major change programme activity. The Interprofessional Education Group is working to align education commissioning and future workforce supply with workforce planning, whilst targeted support work with NHSWPI is informing future workforce modelling and planning approaches. Progress against workforce productivity priorities has continued; the ratification of the revised Consultant and SAS Job Planning Policy will enable consistent Job Planning to progress linking with service level planning going forward. Overall, progress demonstrates a more strategic, integrated, and evidence-based approach to workforce planning and productivity.

Turnover

Turnover improved to 6.9% in September 2026, representing a reduction of 0.8 percentage points year on year and 0.2 percentage points month on month. Estates and Ancillary recorded the highest turnover rate at 10.4%, despite improving by 1.4 percentage points over the year. Registered nursing turnover remains comparatively low at 4.9%. A range of targeted retention initiatives continue to support workforce stability and improve staff retention across the organisation.

Sickness Absence

Rolling sickness absence reached 6.21% in September 2026, representing an increase of 0.13 percentage points year on year and remaining broadly unchanged from August. Organisation-wide sickness reduction activity is continuing, with hotspot areas identified for targeted support work to improve attendance and deliver a sustainable reduction in absence levels across the highlighted areas.

Agency Workforce Usage

Agency utilisation reduced to 2.1% in September 2026, representing a decrease of 1.1 percentage points year on year and 0.2 percentage points month on month. Agency expenditure totaled £2.265 million. Medical and Dental remained the largest area of agency expenditure but also delivered the most significant improvement. Nursing agency expenditure also continued to improve.

Performance Appraisal and Development Review (PADR)

Overall PADR compliance stands at 80.1%, representing a decrease of 1.6 percentage points year on year and 0.2 percentage points month on month.

Mandatory Training Compliance

Level 1 Mandatory Training compliance remains above the organisational target of 85%, currently standing at 90.2%. Targeted interventions continue to focus on improving compliance among bank staff, medical staff, and areas below the required threshold.

Executive Summary: Finance and sustainability

Financial Plan

- The 2026/27 planed deficit has reduced from £43.0m to £34.3m following a £8.7m reduction in the forecast contribution to the Welsh Risk Pool. This does not attain the key duty of the health board to achieve a balanced position, and therefore the £82m conditionally recurrent allocation being at risk.

Financial Position

- As at the end of September the Health Board is reporting an in-month deficit of £1.8m, reflecting a £4.4m favourable adjustment relating to the reduction in Welsh Risk Pool contribution. Year-to-date deficit is £31.1m and £14.0m adverse to the revised year to date planned deficit of £17.1m. Year-to-date pressures predominantly relate to Pay, Non-Pay, Prescribing and Continuing Healthcare.
- The below table, summarises the monthly actual and forecast variance for 2026/27. The forecast assumes that mitigating actions can be implemented to reduce the monthly overspend against the planned deficit and recover the year to date overspend.

	2026/27 Monthly Variance													
	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	Year to Date Position £m	Full Year Forecast Outturn Position £m
Total Monthly Surplus/ (Deficit)	(5.4)	(5.6)	(6.2)	(5.8)	(6.4)	(1.8)	(2.1)	(1.6)	(0.9)	(0.7)	(0.5)	2.70	(31.1)	(34.3)

Savings and Mitigations

- As at the end of September (Month 6), the Health Board has identified £53.0m Green saving schemes, an increase of £5.5m from previous month.
- In-month savings delivery is £5.3m, with year-to-date savings delivery of £29.3m, of which £18.0m is budget releasing, resulting in a £5.0m shortfall in budget extractable savings compared to the year-to-date savings target of £23.0m ((6/12ths of the annual target of £46m). In-month delivery is £5.3m, against the £3.8m target.

Capital Programme

- The approved Capital Resource Limit (CRL) for 2026-27 is £58.0m, which is forecast to be spent in full.

Key Risks & Matters for Escalation

- Urgent action is required to identify and implement mitigating actions to contain the monthly cost overruns and recover the year-to-date deficit above plan.
- As part of the financial recovery plan. IHC's and Services have been requested to identify a 1% reduction in forecast run rate, close remaining gap against budget reducing savings requirements, and identify opportunities for review to further reduce expenditure by £17m to support delivery of financial balance.
- **Recovery actions identified to date are insufficient to restore the run rate to plan or recover the accumulated overspend and further work is urgently required.**

Section 1
Performance and access



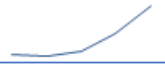
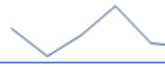
Scorecard : Performance and access (1 of 3)

REF	Measure Description	Target Suite			Wales Benchmark	Actual Performance				Status
		NT	SM	AP		Jul-26	Aug-26	Sep-26	6 Month Activity	
LMU01	Total number of ambulance coveyances to acute emergency departments	-	-	-	N/A	3538	3437	3392		Advise
3AP02	Percentage of ambulance handovers within 15 minutes	80%	-	21%	6th of 6 (at Jun 26)	15.8%	17.1%	14.7%		Escalate
3AP01	Number of ambulance patient handovers over 45 minutes	0	-	1923	7th of 7 (at Jun 26)	1549	1467	1791		Escalate
LMU02	Number of ambulance patient handovers over 1 hour	-	1710	0	6th of 6 (at Apr 26)	1233	1174	1511		Escalate
LMU03	Number of ambulance patient handovers over 4 hour	-	-	0	N/A	243	237	436		Escalate
LMU04	Median emergency ambulance response time to purple: arrest category calls	6-8 Mins	-	-	N/A	07:37	08:13	RIA		Advise
LMU05	Median emergency ambulance response time to red: emergency category calls	6-8 Mins	-	-	N/A	09:25	08:57	RIA		Advise
LMU06	Total number of attendances to Minor Injury Units (MIUs)	-	-	-	N/A	6945	6142	5841		Alert
LMU07	Total number of attendances to acute emergency departments	-	-	-	N/A	16541	16331	15536		Alert
LMU08	Median time from arrival at an emergency department to triage by a clinician	-	60	-	4th of 6 (at Mar 26)	17.00	16.00	16.00		Alert
3AP04	Median time from arrival at an emergency department to assessment by a clinical decision maker	-	-	-	5th of 6 (at Mar 26)	143.0	140.0	123.0		Escalate
NPF25	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	95%	-	0	7th of 7 (at Aug 26)	59.5%	58.9%	58.3%		Escalate
3AP03	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	0	2149	2743	7th of 7 (at Aug 26)	3842	3834	3726		Escalate
LMU09	Total number of patients who spent over 24 hours in the ED	-	-	0	N/A	1559	1428	1677		Escalate
LMU10	Total number of patients who spent over 48 hours in the ED	-	-	-	N/A	274	259	352		Escalate
LMU11	Number of patients who did not wait to be seen at the ED	-	-	-	N/A	1959	1871	1710		Escalate
LMU12	Consistently realise 33% of discharges by midday.	-	-	33%	N/A	16.4%	15.8%	15.0%		Alert
LMU13	Total number of unplanned returns to ED within 48 hours with the same complaint	-	-	-	N/A	746	688	635		Escalate

Scorecard : Performance and access (2 of 3)

REF	Measure Description	Target Suite			Wales Benchmark	Actual Performance				Status
		NT	SM	AP		Jul-26	Aug-26	Sep-26	6 Month Activity	
3AP05	Number of Pathways of Care Delayed discharges (total patients)	-	0	221	8th of 8 (at Apr 26)	325	304	347		Escalate
3AP06	Number of bed days lost to delayed pathways of care (total)	-	-	9926	N/A	12889	13647	14289		Escalate
LMS01	Stroke: percentage patients received CT scan within 20 minutes of clock start	40%	-	-	N/A	25.2%	21.6%	RIA		Escalate
LMS02	Stroke: percentage of all stroke patients thrombolysed	20%	-	-	N/A	14.4%	17.2%	RIA		Alert
LMS07	Swallow screening within 4 hours of clock start	-	-	-	N/A	78.6%	68.3%	RIA		Alert
LMS06	Stroke: percentage direct admission to ASU within 4 hours	-	-	40%	N/A	43.4%	27.9%	RIA		Alert
3BP03	Number of patients waiting more than 26 weeks for a new outpatient appointment (Welsh Patients Only)	0	-	25.0%	8th of 8 (at Aug 26)	19303	22064	RIA		Alert
3BP02	Number of patients waiting over 52 weeks for a new outpatient appointment	-	-	0	7th of 7 (at Mar 26)	4813	4794	4424		Advise
3BP01	Number of patients waiting more than 104 weeks for referral to treatment	0		2292	8th of 8 (at Aug 26)	2261	2337	2116		Alert
3BP14	Percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)	75%	55%	57%	5th of 6 (at Jul 26)	57.1%	56.5%	RIA		Escalate
3BP15	Number of patients on an active suspected cancer pathway after day 62	-	-	1093	N/A	204	193	RIA		Escalate
3BP16	Number of pathways waiting more than 8 weeks for a specified diagnostic (all ages)	0		5327	5th of 7 (at Aug 26)	7322	6695	4769		Alert
NPF28	Percentage of R1 patient pathways, which have a target date allocated, waiting within their clinical target date or within 25% beyond their clinical target date for an outpatient appointment	95%	-	-	8th of 8 (at Aug 26)	37.8%	36.8%	36.6%		Escalate
3BP04	Number of patients waiting for a follow up outpatient appointment who are delayed by over 100%	96,059	137002	131593	7th of 7 (at Aug 26)	142683	147373	150036		Escalate
3EP01	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%	-	80.0%	7th of 7 (at Aug 26)	86.9%	80.0%	RIA		Alert
3EP02	Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS (for those aged under 18 years)	80%	-	80%	7th of 7 (at Aug 26)	90.8%	78.8%	RIA		Alert
3DP01	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%	-	80.0%	5th of 7 (at Aug 26)	90.9%	90.0%	RIA		Assure
3DP02	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%	-	80.0%	4th of 7 (at Aug 26)	86.8%	91.1%	RIA		Assure

Scorecard : Performance and access (3 of 3)

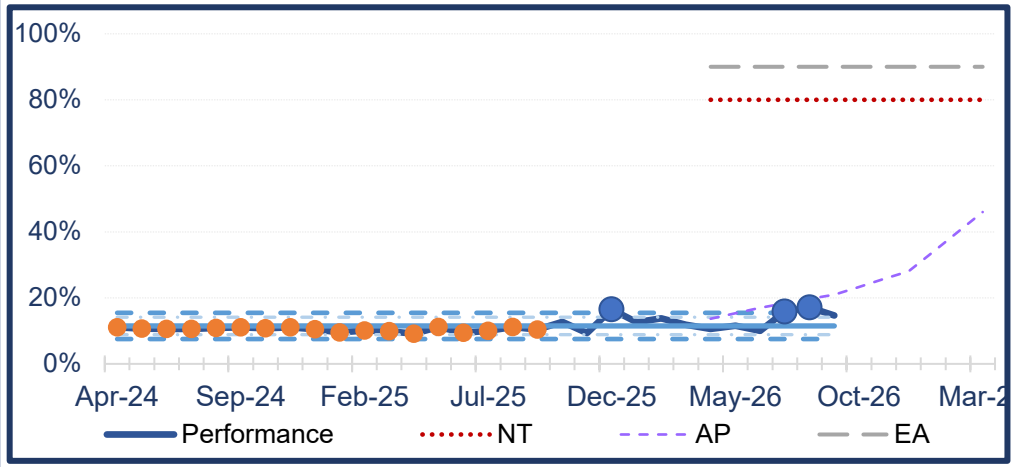
REF	Measure Description	Target Suite			Wales Benchmark	Actual Performance				Status
		NT	SM	AP		Jul-26	Aug-26	Sep-26	6 Month Activity	
LMM01	Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan (for those age 18 years and over)	-	-	83.0%	5th of 7 (at Mar 26)	88.2%	88.1%	RIA		Alert
NPF19	Percentage of patients waiting less than 26 weeks to start a psychological therapy in specialist Adult Mental Health	80%	-	72%	6th of 7 (at Aug 26)	55.1%	61.8%	RIA		Alert
3DP06	Number of Out of Area placements	-	-	9	N/A	7	9	RIA		Alert
NPF18	Percentage of children and young people waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment	80%	-	12.0%	7th of 7 (at Aug 26)	16.9%	16.2%	RIA		Alert
3BP05	Number of patients (all ages) waiting more than 14 weeks for a specified therapy (excluding audiology)	0		0	6th of 7 (at Aug 26)	1703	1687	RIA		Advise
NPF30	Number of adults waiting more than 14 weeks for all audiology pathways (to include new and existing pathways for hearing aids, tinnitus and balance)	0	-	-	3rd of 7 (at Aug 26)	40	37	28		Advise
NPF31	Number of children waiting more than 6 weeks for all audiology pathways (to include new assessment and intervention pathways)	0	-	-	6th of 7 (at Aug 26)	778	813	674		Alert
3BP11	Percentage of lists with a start time 15 minutes or more past the scheduled start time	-	-	65%	N/A	42.4%	40.8%	40.6%		Alert
FALSE	Percentage of theatre procedures finished more than 60 minutes early	-	-	75%	N/A	22.6%	25.8%	26.1%		Alert
LMP01	Number of cases per theatre session	-	-	-	N/A	2.1	2.2	2.1		Alert
LMP02	Percentage of scheduled operations cancelled either on the day or the day before the scheduled operation	-	-	0	N/A	13.0%	10.3%	12.8%		Alert
LMP03	Percentage Treat in Turn Rate (Stage 4)	-	-	-	N/A	22.0%	23.0%	21.0%		Alert
LMP04	Vascular - Emergency readmission within 28 days of first spell discharge date rate	-	-	-	N/A	11.3%	17.2%	14.1%		Assure
LMP05	Vascular surgery theatre capped utilisation	-	-	-	N/A	69.0%	79.7%	70.5%		Assure

UEC: Ambulance Handover

Metric Overview	ID	Metric	SM De-escalation	Planning / Performance Framework	Q1	Q2	Q3	Q4
	3AP02	Percentage of ambulance patient handovers within 15 minutes	N/A	90%	17%	21%	28%	46%
	3AP01	Number of ambulance patient handovers over 45 minutes	1,176	Zero	2,318	1,923	1,282	950

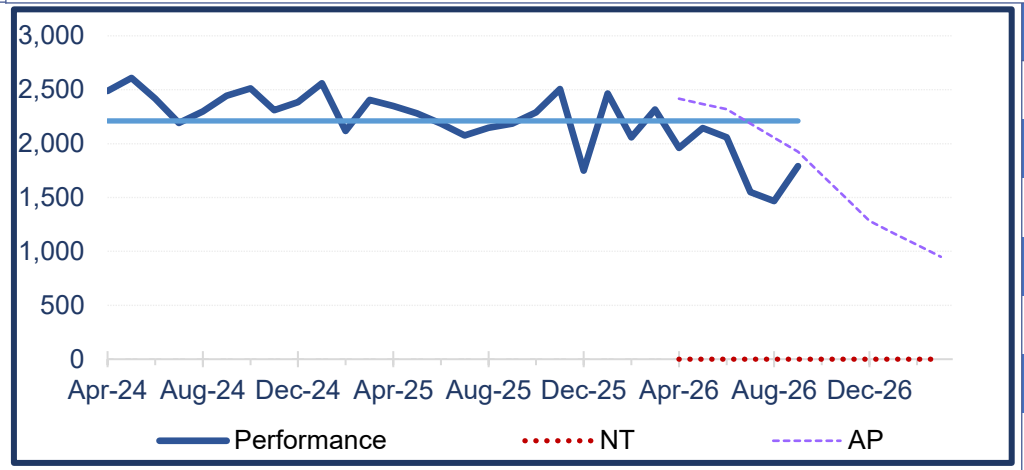
Percentage of ambulance patient handovers within 15 minutes

Latest Month	Profile	Actual	Status	Benchmark
September 2026	28%	14.1%	Escalate	BCU ranked 7th of 7 health boards as of September 2026.



Number of ambulance patient handovers over 45 minutes

Latest Month	Profile	Actual	Status	Benchmark
September 2026	1,923	1,791	Escalate	BCU ranked 7th of 7 health boards as of September 2026.



What does the data tell us? Performance against the 45-minute handover improved over July and August, supported by a focused approach to reducing delays. However, performance deteriorated during September, with 1,791 handovers exceeding 45 minutes which achieved the health board's Q2 trajectory, demonstrating progress in reducing handover delays. Performance remains below the national expectation of zero handovers over 45 minutes. A focused target in September was to achieve the de-escalation criteria for handovers over 1 hour (970), after 2 months of improvement this was not sustained and BCU were unable to meet the target with a September position of 1,509, 539 above the de-escalation threshold. Performance remains below the national expectation of zero handovers over 45 minutes. Performance against the 15-minute handover standard continues to be a significant challenge, with 14.1% of patients handed over within 15 minutes against the national target of 90%. **Actions being taken to improve –** Key actions include weekly joint BCUHB-WAST performance reviews, delivery of a pre-alert audit programme, and implementation of a SPoA integration plan for ED and WAST pathways. Front-door foundations have been established, including booking-in processes, dual-PIN working, and a refresh of escalation arrangements. These initiatives are being complemented by enhanced senior clinical decision-making at the front door, expansion of frailty and SDEC services, Trusted Assessor models, Optimal Hospital Flow Facilitators, and improved bed management and escalation processes.

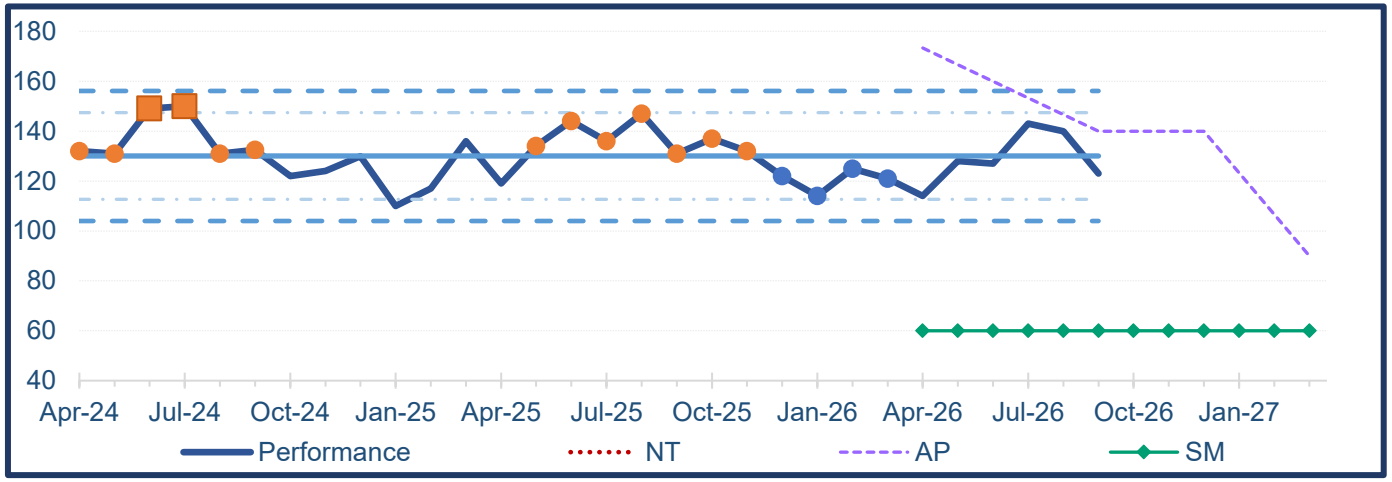
Expected impact upon forecasted performance –Performance against 15-minute handovers did not meet the expected quarter 2 target and presents a significant delivery risk for Quarter 4. While performance for handovers exceeding 45 minutes met the quarter 2 annual plan trajectory, substantial and sustained improvement will be required to achieve the national target of zero.

UEC: Median time to assessment by clinical decision maker in less than 60 minutes

Metric Overview	ID	Metric	SM De-escalation	Planning / Performance Framework	Q1	Q2	Q3	Q4
	3AP04	Median time to assessment by clinical decision maker in less than 60 minutes	<60 minutes	<60 minutes	160	140	140	90

Median time to assessment by clinical decision maker in less than 60 minutes

Latest Month
September 2026
Profile
140
Actual
123
Status
Escalate



What does the data tell us? Performance has deteriorated since the start of the financial year, with the median time to clinical decision maker increasing by 26 minutes since April. The September position has improved with the median position at 123 minutes, a 17minute improvement from the previous month. During September, 33% of patients were assessed by a clinician within 60 minutes of arrival in Emergency Departments, which remained within normal variance. While performance remains in line with the health board trajectory of 140 minutes, it is significantly above both the national target and special measures expectation of 60 minutes, representing a gap of approximately 60 minutes.

Actions being taken to improve –Time to Clinical Decision Maker will be improved through strengthened medical presence within ED, supporting earlier specialty review and timely admission or discharge decisions. Planned introduction of Senior Clinical Decision Makers at the front door, an Acute Front Door Frailty Service, and expanded SDEC pathways will accelerate assessment, improve streaming, and reduce avoidable admissions.

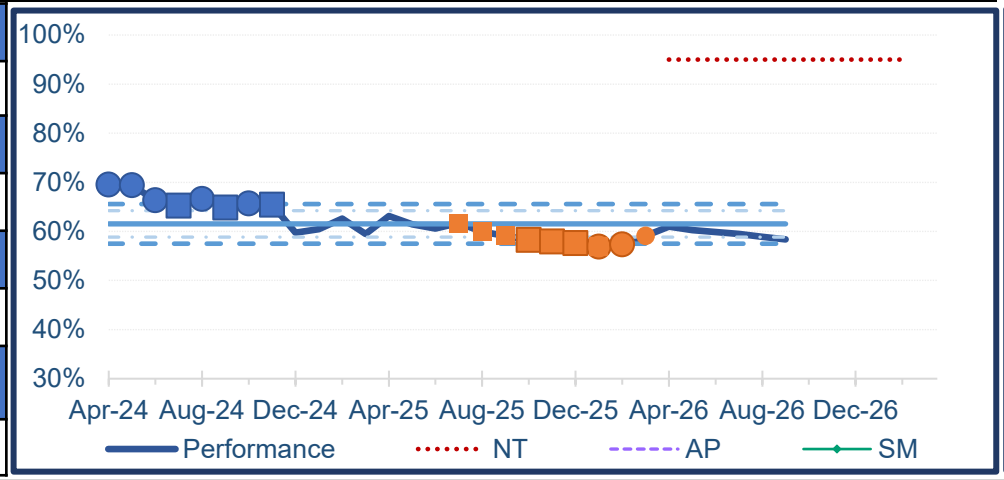
Expected impact upon forecasted performance – Although the median time to clinical decision maker remains aligned to the health board's internal trajectory following two months of improvement, sustained improvement will be required to deliver the March 2027 target. The workforce investment is expected to support improved patient flow and timeliness of clinical assessment.

UEC: Number of patients who spend less than 4 hours and 12 hours or more in all hospital major and minor emergency care facilities from arrival until admission, transfer, or discharge

Metric Overview	ID	Metric	SM De-escalation	Planning / Performance Framework	Q1	Q2	Q3	Q4
	Local	Number of patients who spend less than 4 hours in ED and MIU	N/A	95%	95%	95%	95%	95%
	3AP03	Number of patients who spend 12 hours or more in ED and MIU	<10%	Zero	3,189 (21%)	2,743 (17%)	2,297 (15%)	1,850 (10%)

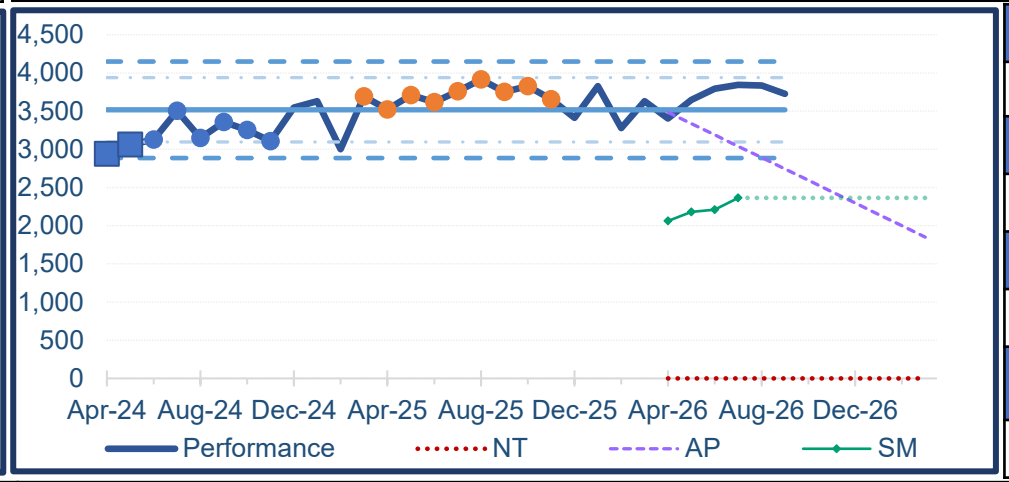
Number of patients who spend less than 4 hours in ED & MIU

Latest Month	Profile	Actual	Status
September 2026	95%	58.4%	Escalate



Benchmark BCU ranked as 7th of 7 health boards as of August 2026.

Number of patients who spend 12 hours or more in ED



Latest Month	Profile	Actual	Status
September 2026	2,297 (15%)	3,726 (17%)	Escalate

Benchmark BCU ranked as 7th of 7 health boards as of August 2026.

What does the data tell us? September performance deteriorated compared with August, with 17.2% of patients across BCUHB waiting more than 12 hours. Performance by IHC was 13.0% in the West, 17.0% in the Central area, and 23.0% in the East.. improvement actions continue through the IHC 90-day plans to support delivery of the IMTP trajectory by year-end. Performance in the East IHC remains a significant concern, holding the highest rate of 12-hour ED and MIU waits in Wales and demonstrating a three-month deterioration

Actions being taken to improve- A range of targeted initiatives are being implemented across all IHC's to improve patient flow, reduce avoidable admissions and decrease 12-hour waits. At YGC, the ED model has been redesigned with designated areas established as core ED and dedicated speciality area and a new Urgent Treatment Centre (UTC) providing both booked and walk-in access to ensure patients receive care in the most appropriate setting. Improvement is also being supported through strengthened front-door services, including senior clinical decision-makers, Acute Front Door Frailty Services, SDEC expansion, clinician streaming, and enhanced triage oversight. Alongside this, continued implementation of D2RA, board rounds, Criteria Led Discharge, Trusted Assessor models, improved bed management, escalation processes and flow facilitation is focused on accelerating discharge, increasing bed availability and reducing prolonged waits within the emergency care pathway.

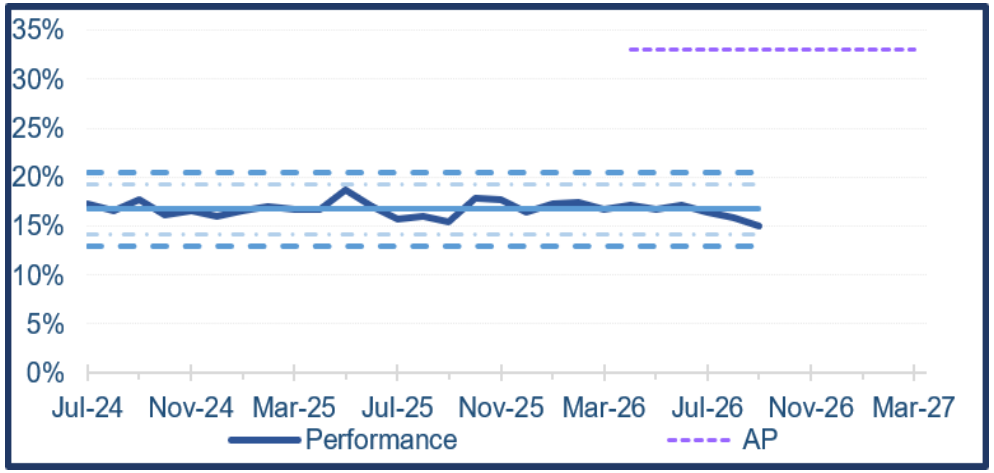
Expected impact upon forecasted performance – . Recovery of performance remains a key priority, with a focus on returning to the planned improvement trajectory required to achieve the 10% year-end target by March 2027. Sustained improvement is required across all three Integrated Health Communities, with particular focus on the East IHC, where performance challenges present a significant risk to delivery of the target.

UEC: Discharges

Metric Overview	ID	Metric	SM De-escalation	Planning / Performance Framework	Q1	Q2	Q3	Q4
	TPG-28	Discharges before midday	N/A	33% of discharges by midday	33%	33%	33%	33%
	TPG- 29	Weekend discharges	N/A	25% by the end of March 2027	15%	17%	20%	>25%

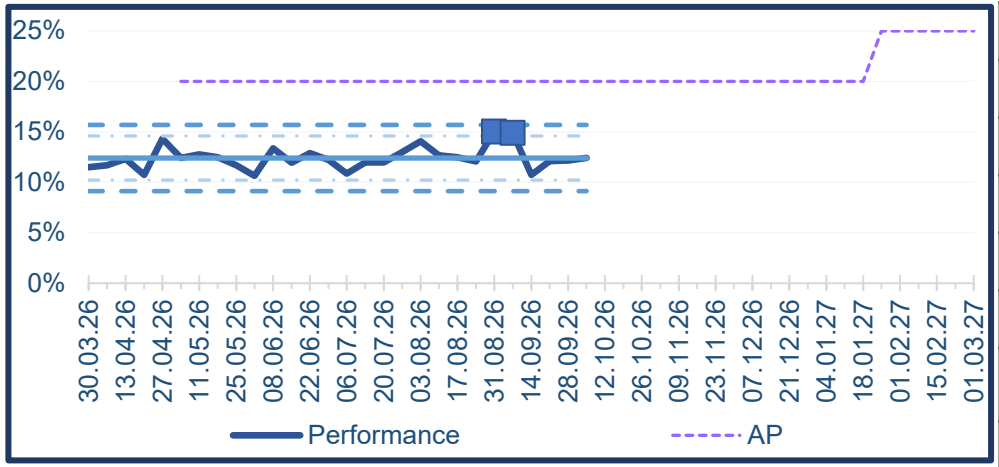
Discharges before midday

Latest Month
September 2026
Profile
33%
Actual
15.0%
Status
Alert



Benchmark	N/A

Weekend Discharges



Latest Month
w/c 5th October
Profile
20%
Actual
12.4%
Status
Alert

N/A	Benchmark

What does the data tell us? – Both metrics remain below the agreed trajectory. No significant variation can be seen in performance against either metric, thus, improvement is required against both if performance is to move towards the agreed targets.

Actions being taken to improve – A number of initiatives have been introduced over the last 12 momths to improve pre-midday discharges. These include the implementation of day-before TTO completion and the Pan-BCU Board Round SOP from 1 October 2026, both aimed at improving discharge readiness and reducing delays on the day of discharge. Integrated Discharge Hubs have also been established across all three IHCs to strengthen discharge coordination and expedite patient flow. In addition, East IHC has launched a targeted programme focused on increasing discharges before midday, while Central IHC's Ward 14 Discharge Hub and TTO improvement work are providing dedicated support to accelerate discharge processes and improve patient flow.

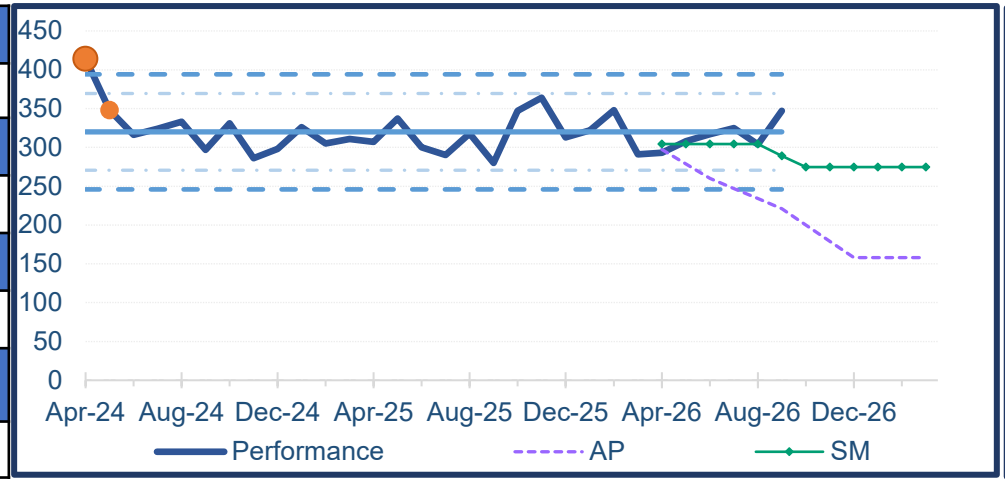
Expected impact upon forecasted performance – Based on current performance trends, discharge levels are not forecast to deliver on the planned trajectories.

UEC: Pathway of Care Delays (PoCD)

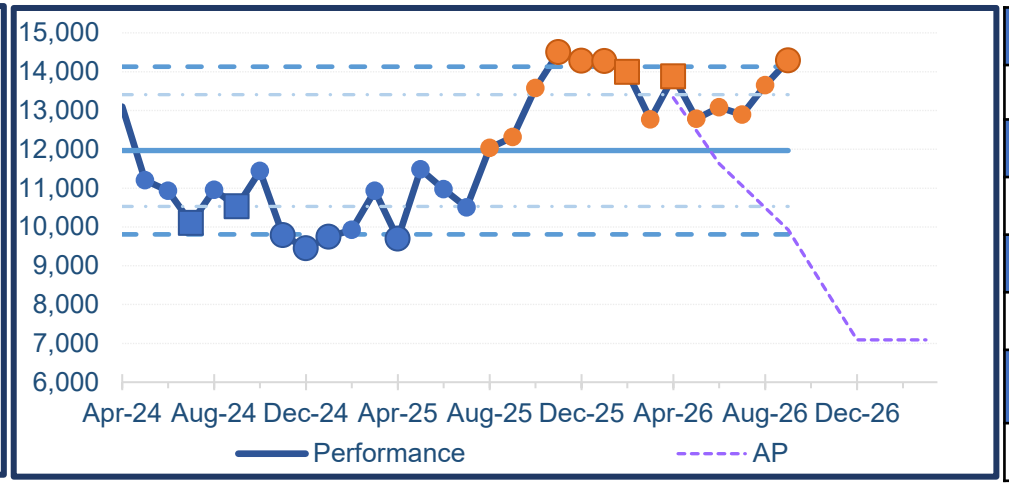
Metric Overview	ID	Metric	SM De-escalation	Planning / Performance Framework	Q1	Q2	Q3	Q4
	3AP05	Number of patients on delayed pathways of care	273	12-month reduction	260	221	158	158
	3AP06	Number of bed days lost to delayed pathways of care	N/A	12-month reduction	11,628	9,926	7,090	7,090

Number of patients on delayed pathways of care

Latest Month
September 2026
Profile
158
Actual
347
Status
Alert



Number of bed days lost to delayed pathways of care



Latest Month
September 2026
Profile
7,090
Actual
14,289
Status
Escalate

What does the data tell us? A total of 14,289 delayed bed days were recorded during the month, which is 7,199 days above the Quarter 3 profile. West IHC accounted for 47.4% (6,778 days) of all delayed bed days in September. Of these, 52.6% (3,563 days) related to patients within Mental Health and Learning Disabilities services. This reflects the disproportionate impact of a small number of individuals awaiting specialist long-term Learning Disability placements. East IHC has experienced an increase in delayed patients during September, primarily driven by capacity constraints and discharge pressures within Flintshire. While delayed patient numbers have historically been comparable across the three Integrated Health Communities, the recent increase in the East has created greater variation between areas, with September positions of East (157 patients), Central (96 patients), and West (94 patients).

Actions being taken to improve – Integrated Discharge Hubs: Implementation remains on track for mid-November, with some arears already implementing changes, supported by a suite of system-wide improvements to strengthen discharge planning and flow. the key focus is on pathway 1 patients (return home with increase in care package). Choice & Exception Guidance: A multi-agency programme is developing a streamlined assessment process for long-term care placements, targeted for implementation by December 2026. Delays in care home placements remain a key priority, accounting for approximately 38% of all delayed pathways.The review of the governance around complex / high-cost CHC cases has concluded, and training will be complete by end of October. This will target long length of stay delays including Learning Disability. Work will also continue with care homes to address market and funding challenges, while expanding trusted assessment and discharge improvement

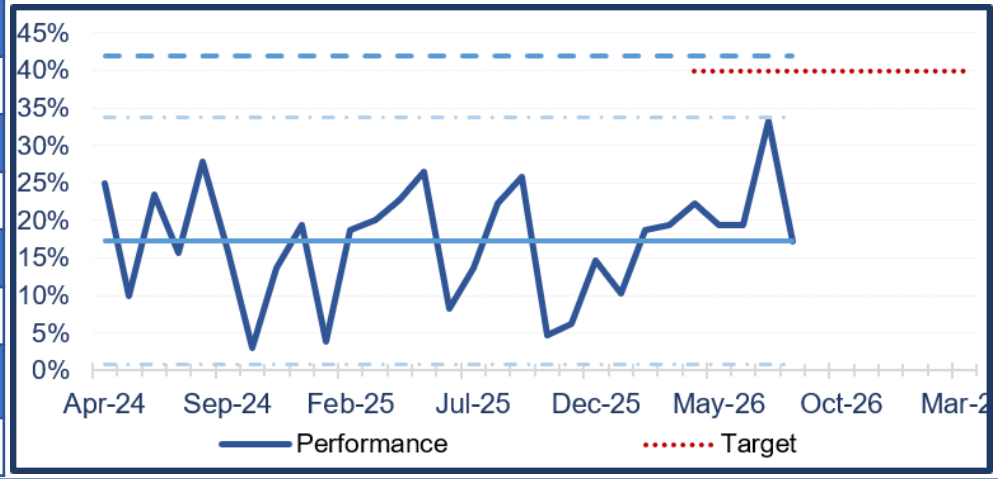
Expected impact upon forecasted performance – Continual improvement in reducing the number of delays is predicted but reducing the days delays will require focused actions.

Stroke: Scan, and Thrombolysis

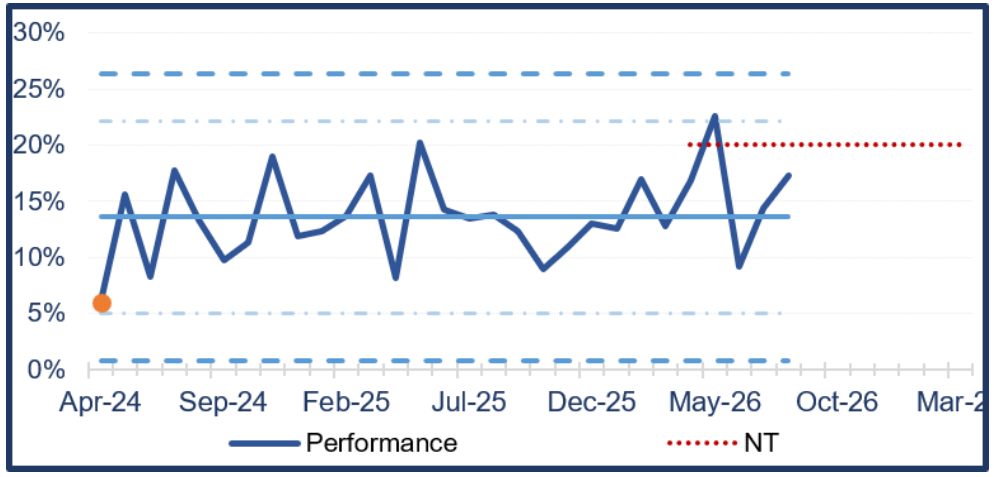
Metric Overview	ID	Metric	SM De-escalation	Planning / Performance Framework	Q1	Q2	Q3	Q4
	LMS01	CT scan within 20 minutes of clock start	N/A	N/A	40%	40%	40%	40%
	LMS02	All patients thrombolysed	N/A	N/A	20%	20%	20%	20%

CT scan within 20 minutes of clock start

Latest Month
August 2026
Target
40%
Actual
21.6%
Status
Escalate



Percentage of all patients thrombolysed



Latest Month
August 2026
Target
20%
Actual
17.2%
Status
Alert

What does the data tell us? Timely access to CT imaging is a critical component of the stroke pathway, as it enable rapid diagnosis of stroke and supports timely treatment decisions, including reperfusion treatment i.e. thrombolysis and thrombectomy. In August, CT scan within 20 minutes achieved 21.6% , against the national target of 40%. The YGC position ranked as the third best in Wales at 32.1% with Wrexham Maelor 8th at 17.1% and Ysbyty Gwynedd 9th at 7.1%. For the same period, thrombolysis rates achieved 17.2%, against a national target of 20%. While performance remains below target, it exceeds the all-Wales average of 11.7%, indicating that eligible patients are more likely to receive thrombolytic treatment than the national average. Nationally BCU acute sites rank well against other acute sites in Wales, with Ysbyty Gwynedd 2nd (21.4%), Wrexham Maelor 3rd (17.1%) and YGC 5th (15.1%).

Actions being taken to improve

Pre-hospital video triage (PhVT) is used by the 3 acute stroke teams who take calls from WAST colleagues between 09:00 – 19:45, seven days a week. Regular breach meetings are held by the 3 acute stroke teams to review compliance against a number of KPIs, including CT within 20 mins of clock start, thrombolysis, thrombectomy and admission to ASU <4 hours. In addition, the YGC team are taking part in a 12-month improvement programme with NHS Elect, focused on sustained improvements in thrombolysis and thrombectomy compliance. The learning from which will be shared with other site sin BCUHB and Wales.

Expected impact upon forecasted performance

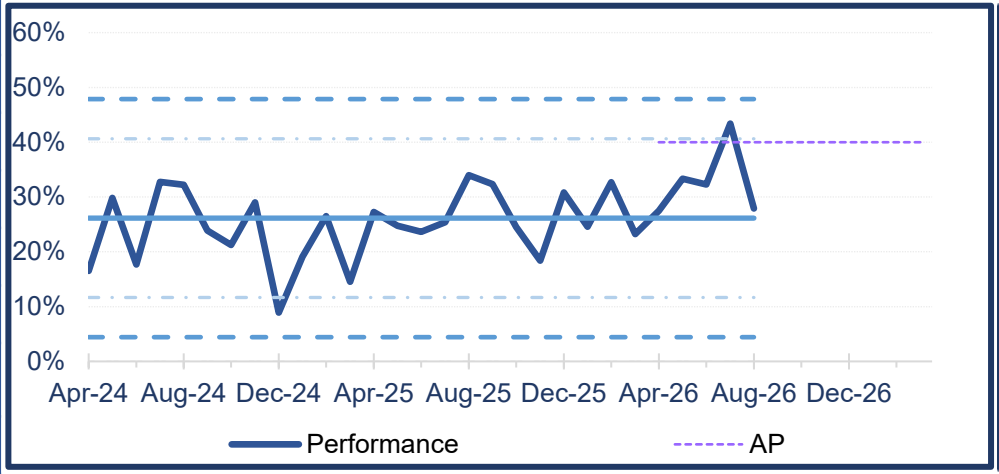
The use of PhVT is shown to have a positive impact on time to scan, which has been replicated in YGC, as it allows for patients, who are conveyed by ambulance, to be met on arrival to ED and taken straight for their CT scan. This also supports the ability to thrombolise eligible patients and supports a number of KPIs within the stroke pathway.

Stroke: Acute Stroke Unit (ASU) Admission, and Swallow Screening

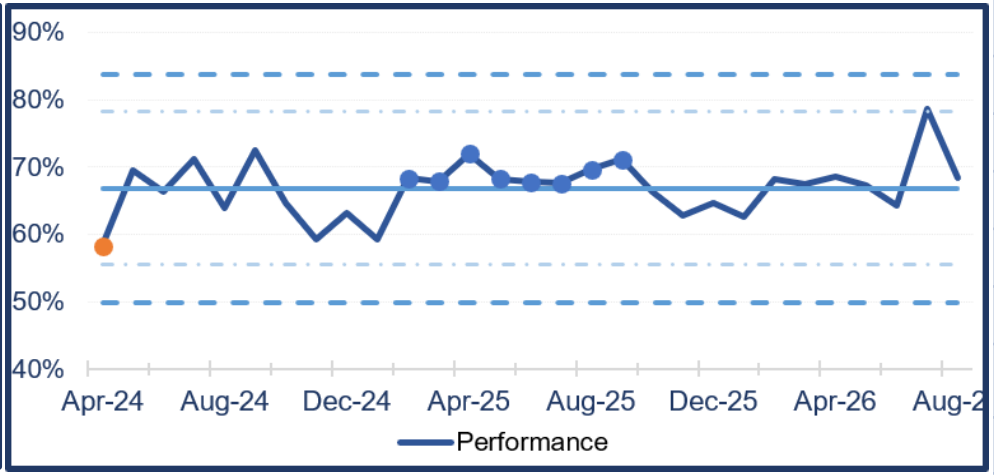
Metric Overview	ID	Metric	SM De-escalation	Planning / Performance Framework	Q1	Q2	Q3	Q4
	LMS06	Direct admission to the ASU within 4 hours	N/A	N/A	40%	40%	40%	40%
	LMS07	Swallow screening within 4 hours of clock start	N/A	N/A	-	-	-	-

Direct admission to the ASU within 4 hours

Latest Month
August 2026
Profile
40%
Actual
27.9%
Status



Swallow screening within 4 hours of clock start



Latest Month
August 2026
Target
N/A
Actual
68.3%
Status

What does the data tell us? These metrics assess the timeliness of key stroke pathway interventions. While performance remains below both the health board trajectory and the all-Wales position, there are signs of improvement with direct admissions to the Acute Stroke Unit (ASU) within 4 hours that reached 27.9% in August, against a target of 40%. This target was met in July with a position of 43.5%. The SPC analysis demonstrates a gradual improving trend since April 2025, albeit with continued month-to-month variation. Despite this improvement, performance remains significantly below the all-Wales position of 41.3%, with YG the only site achieving above the target (50.0%) and 6th in National rankings, Wrexham Maelor 9th (25.0%) and YGC 10th (22.4%). Swallow screening within 4 hours achieved 68.3% in August. Although there is no nationally set target for this measure, performance remains just below the all-Wales average of 70.9% with YG (78.6%) and Wrexham Maelor (71%) achieving above the all-Wales average and YGC achieving under with 59.5%, for Augst 2026.

Actions being taken to improve: Regular breach meetings are held by the 3 acute stroke teams to review compliance against a number of KPIs, including admission to ASU and swallow screening within 4 hours of clock start. Focus on these KPIs has led to wider discussion between the stroke management, Stie Management and Hospital Management teams to agree prioritization of stoke patients and ring fencing of beds on the ASU. The team in the ASU in WMH have been focusing on LoS and discharge planning to support this KPI, which appears to show signs of improvement. With regard to swallow screening, the ED team attend breach meetings in all 3 IHCs and if identified, additional training is provided to ED staff to ensure they are trained in the correct swallow assessment (YALE).

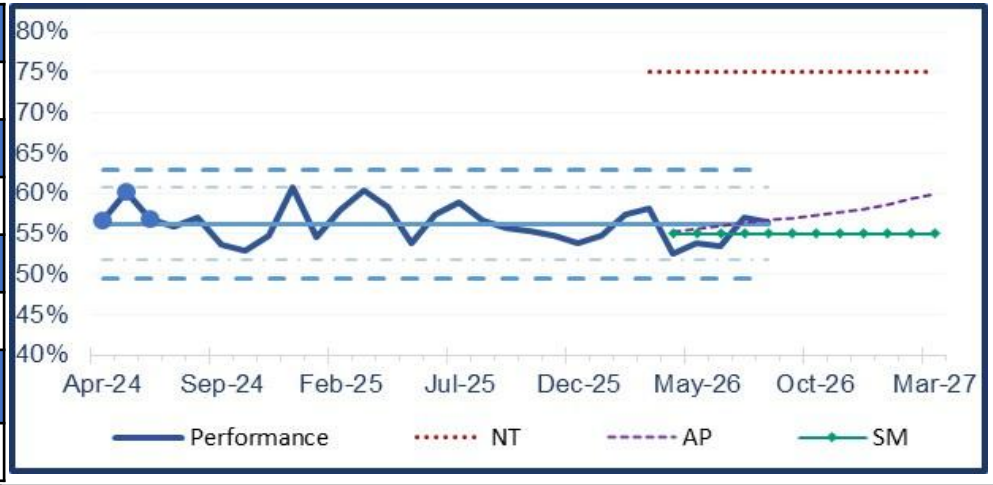
Expected impact upon forecasted performance: Given the work being undertaken by both the WMH and YGC teams, where they are endeavouring to ensure patients are admitted to their ASUs as soon as practicable. Site pressures and IPC issues impact on this KPI but teams work together to overcome these issues where possible.

Planned Care: Suspected Cancer Pathway

Metric Overview	ID	Metric	SM De-escalation	Planning / Performance Framework	Q1	Q2	Q3	Q4
	3BP14	Suspected cancer pathway 62 days wait	55% (four consecutive months)	75%	56%	57%	58%	60%
	3BP15	Number of patients on an active suspected cancer pathway after day 62	N/A	Backlog Reduction	1,286	1,093	929	789

Suspected cancer pathway 62 days wait

Latest Month
August 2026
Profile
56.7%
Actual
56.5%
Status
Escalate



Benchmark

BCU ranked 5th of 6 health boards as of July 2026

Number of patients on an active suspected cancer pathway after day 62



Latest Month
September 2026
Profile
1,093
Actual
2,712
Status
Escalate

Benchmark

BCUHB is an outlier in terms of total waits and volume of patients waiting after day 62.

What does the data tell us? - For a second month, the position against suspected cancer pathway metric is above the special measures de-escalation target of 55% at 56.5%. Health boards submit quarterly re-submission of data and management data for April – June indicates that the re-submitted position will be above 55% for each month during the period which will result in the health board being above de-escalation since February 2026 – seven consecutive months. Whilst this is encouraging, the number of patients waiting over 62 days on a suspected cancer pathway continues to increase and is driven by continued increases within the dermatology tumour site cohort. Between January and August 2026, 33,347 patients were told that they did not have cancer.

Actions being taken to improve – A revised proposal is being developed to accelerate reduction in total waits and reduce the backlog of dermatology patients as the original plan has not delivered the expected reduction in active pathways to date. Additional medical photography sessions and external support has been implemented to expedite progress supported by locum recruitment. For breast surgery theatre capacity has been restored to reduce waits during September and October which is being supported by continuation of a locum post.

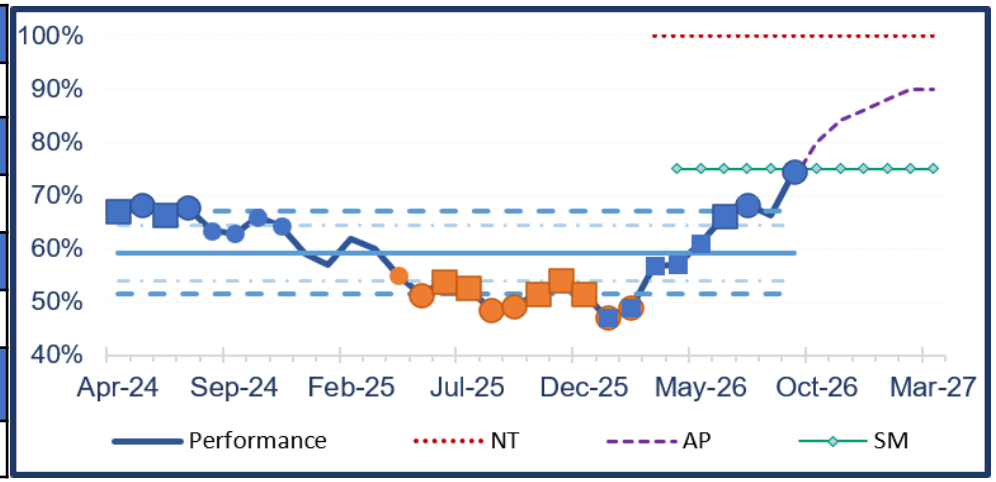
Expected impact upon forecasted performance – Confirmation of plan to support dermatology cohort is key to delivery. The continued increase in number of patients on an active pathways after day 62 places significant risk on delivery of targets and whilst the percentage seen within 62 days has met the de-escalation threshold, this remains significantly adrift of national standard.

Planned Care: 8-weeks Diagnostic Waits – Recovery Profile

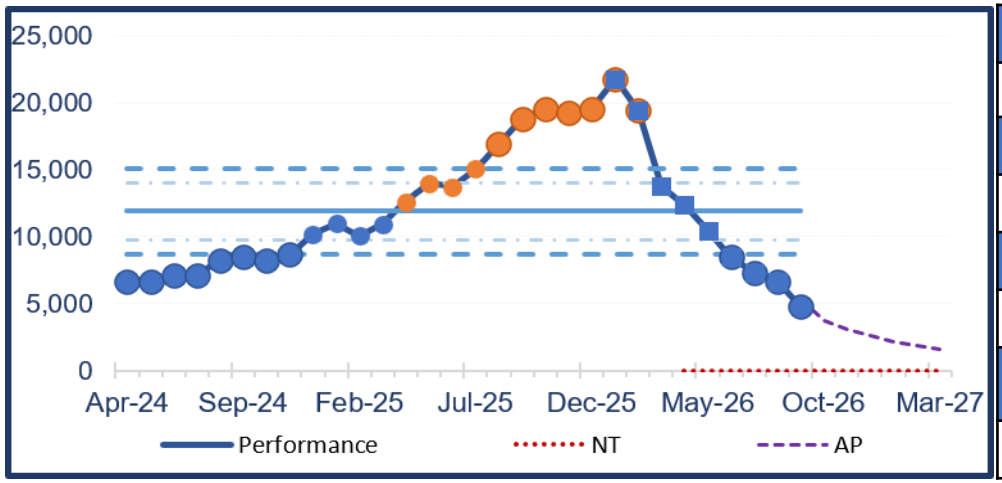
Metric Overview	ID	Metric	SM De-escalation	Planning / Performance Framework	Q1	Q2	Q3	Q4
	3BP16	8 weeks diagnostic waits	75%	100%	-	-	2,574	1,637
	3BP16	No. of patients waiting in excess of 8 weeks for diagnostic test	N/A	Zero	-	-	86%	90%

8 weeks diagnostic waits

Latest Month
September 2026
Profile
73.0%
Actual
74.4%
Status
Alert



No. of patients waiting in excess of 8 weeks for diagnostic test



Latest Month
September 2026
Profile
5,327
Actual
4,769
Status
Alert

Benchmark	BCU ranked 5th of 7 health boards as of August 2026	BCU ranked 5th of 7 and accounts for 17.5% of all Wales backlog as of August 2026	Benchmark

What does the data tell us? – At the end of September 74.4% of patients were waiting eight weeks or less for a diagnostic test. Whilst this performance was slightly below the special measures target of 75%, this is a significant improvement of over 27% from 47.1% in January 2026. During this period (January – September 2026) the number of patients waiting over eight weeks has reduced from 21,800 to 4,769 which is a reduction of 17,031.

Actions being taken to improve – There is targeted focus at modality level to further reduce the backlog position and increase the percentage compliance over the remaining six months of the fiscal year. Additionality is due to commence within cardiac physiology during September with additional capacity also being sought to further support reducing neurophysiology backlog. External additionality has been secured with NHS partners to support a cohort of non-complex endoscopy patients in addition to further internal additionality on our main sites. Improvement work continues to be supported by NHS Performance and Improvement.

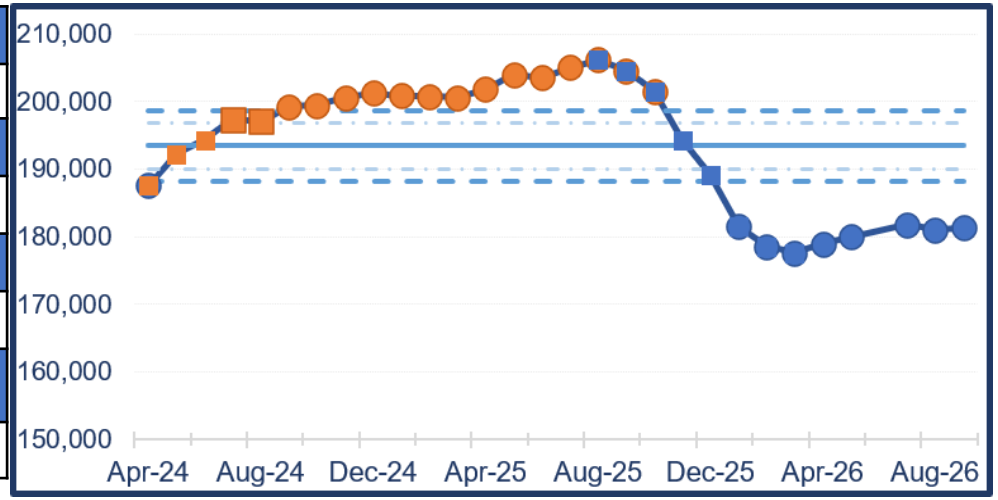
Expected impact upon forecasted performance – Ongoing monitoring of key pressure areas of endoscopy, non obstetric ultrasound and echocardiogram is key for continuation of improvement trajectory moving into the remaining months of the year. Sustainability remains a challenge.

Planned Care : Referral to Treatment Metrics

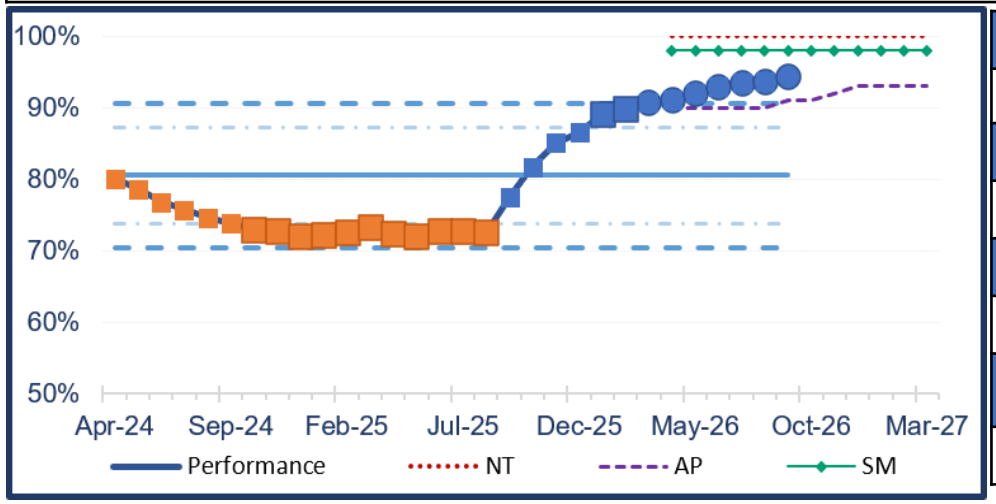
Metric Overview	ID	Metric	SM De-escalation	Planning / Performance Framework	Q1	Q2	Q3	Q4
	Local	Total RTT Pathways	N/A	N/A	Reduction	Reduction	Reduction	Reduction
	3BP02	Open outpatient pathways waiting < 52 weeks	98%	100%	90%	91%	93%	93%

Total RTT Pathways

Latest Month
September 2026
Profile
Reduction
Actual
181,349
Status
Alert



Open outpatient pathways waiting < 52 weeks



Latest Month
September 2026
Profile
90%
Actual
94.3%
Status
Advise

Benchmark	March 2026 – July 2026 – all Wales waiting list increased by c43K, with increase at all health boards	BCU ranked 8th of 8 health boards as of 12/10/26 (RTT Weekly Dashboard, NHS P&I)	Benchmark

What does the data tell us? – The overall waiting list has remained stable at approximately 181,000 over the last three months. This is an increase from the end of March position of c178,000.

Actions being taken to improve and expected impact upon forecasted performance – The health board's Planned Care Major Change Programme provides framework to integrate pathway redesign, national best practice and value-based healthcare principles with focus on specialty specific actions as part of this work. Overall waiting list volumes should fall as workstreams are mobilised as part of the operational improvement plans and the major change programme – at this point, solutions are not having the impact on overall waiting list figures.

What does the data tell us? – The % of patients waiting over 52 weeks for a first new outpatient appointment continues to improve and stands at 94.3% against a trajectory of 90% at the end of September. This is an improvement from 90.8% at the end of March 2026.

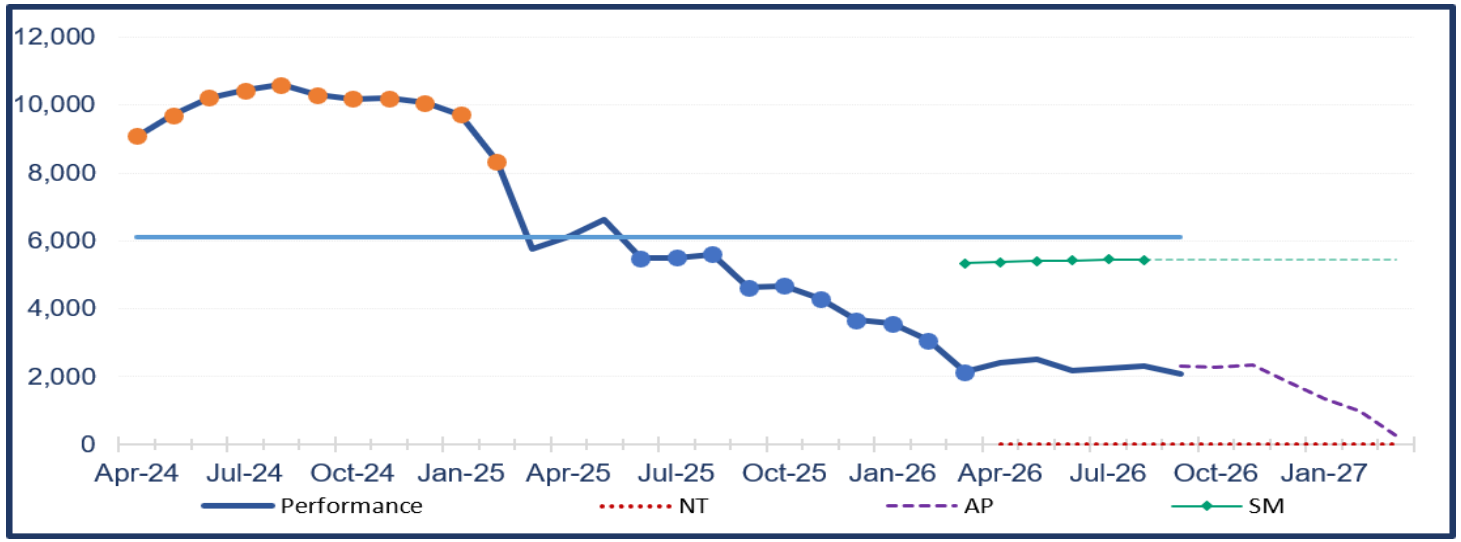
Actions being taken to improve and expected impact upon forecasted performance – The national insourcing outpatient programme supported a significant improvement in the first new outpatient performance during the period August 2025 – March 2026. Since then there has been continued focus on further reducing the extreme wait cohort with part of the Welsh Government funding received to reduce extreme waits being deployed to deliver a commissioning solution to support the pain management cohort.

Planned Care : Referral to Treatment – 104 weeks Recovery Profile

Metric Overview	ID	Metric	SM De-escalation	Planning / Performance Framework	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
	3BP01	104 weeks for referral to treatment	3% of open pathways	Zero	2,292	2,274	2,352	1,858	1,331	990	257

104 weeks for referral to treatment

Latest Month
September 2026
Profile
2,292
Actual
2,092
Status
Alert



Benchmark	BCU ranked 8th of 8 as of August 2026

What does the data tell us? – At the end of September, performance is ahead of the recovery profile by 200 patients. This is a significant improvement during the first six months of 2026 which has seen the patients waiting over two years for treatment reduce by 1,470 a reduction from 3,562

Actions being taken to improve – Confirmation of funding has been received from Welsh Government to support further reduction in two year wait patients over the remaining six months of the financial year. Delivery plans include internal additionality and commissioning solutions both internal and external. Work is progressing at pace with procurement colleagues to mobilise delivery solutions but some of the solutions will not commence until quarter 4 (January 2027).

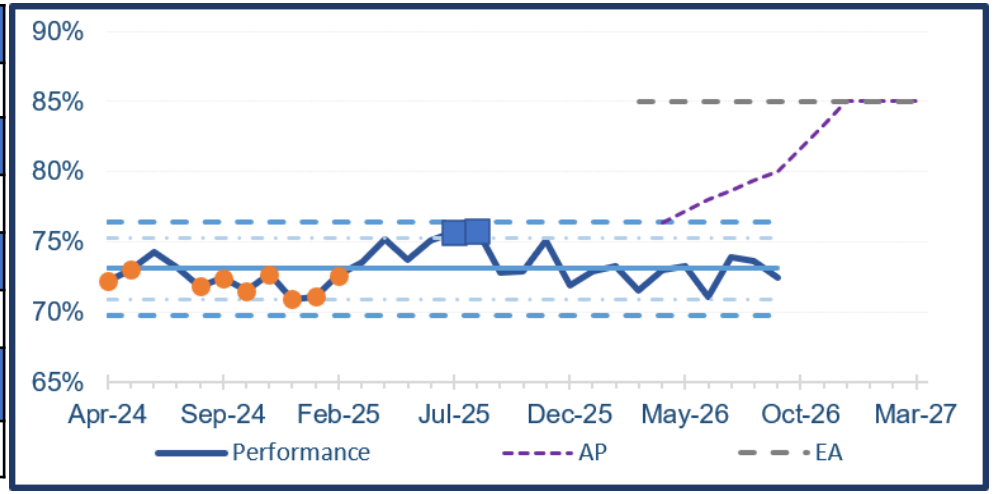
Expected impact upon forecasted performance – Delivery progress is monitored via single recovery plan with Director led meetings to ensure continued progress in line with agreed trajectories. At this stage there are some risks relating to specific cohorts of patients including uro-gynaecology and urology with further focus on solutions required to ensure continued progress towards the end of March 2027.

Planned Care : Productivity / Utilisation

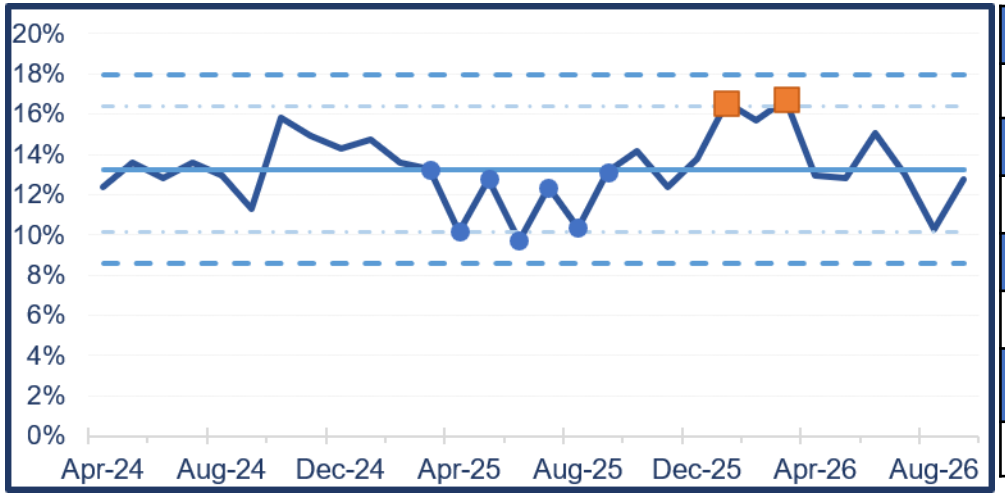
Metric Overview	ID	Metric	SM De-escalation	Planning / Performance Framework	Q1	Q2	Q3	Q4
	3BP13	Theatre session overall utilisation is reported as a key KPI to underpin the GIRFT standard	N/A	85%	78%	80%	85%	85%
	LMP02	Theatre Short Notice Cancellations	N/A	N/A	N/A	N/A	N/A	N/A

Theatre Session Overall Utilisation

Latest Month
September 2026
Profile
80.0%
Actual
72.4%
Status
Alert



Theatre Utilisation – Short Notice Cancellations



Latest Month
September 2026
Profile
N/A
Actual
12.8%
Status
Alert

What does the data tell us? – Over the last six months (April – Aug-26) **theatre utilisation** has averaged 72.9% fluctuating between 71.1% and 73.9% during this period. Performance is significantly adrift of trajectory where plan expectation is for improvement of 82% by end of quarter 2 and further improvement to 85% by end of March 2027. Current performance does not suggest stepped change being delivered to reach required level. Overall cases per sessions remains at 2.1 at health board level. **Short notice cancellations** increased from 10.3% in August to 12.8% in September but remains within normal variation.

Area	CPS
West	2.1
Central	2.1
East	2.2
BCU	2.1

Actions being taken to improve – Improvement work sits within a wider system effort including actions derived from the Clinical Implementation Network Optimisation Framework completion, and ongoing alignment of strategic plans. The actions on late starts and early finishes, alongside the specific activities supported by the NHS Exec Performance and Improvement team in the spaces of Cataracts (Ophthalmology) and General Surgery, should positively impact on overall utilisation performance.

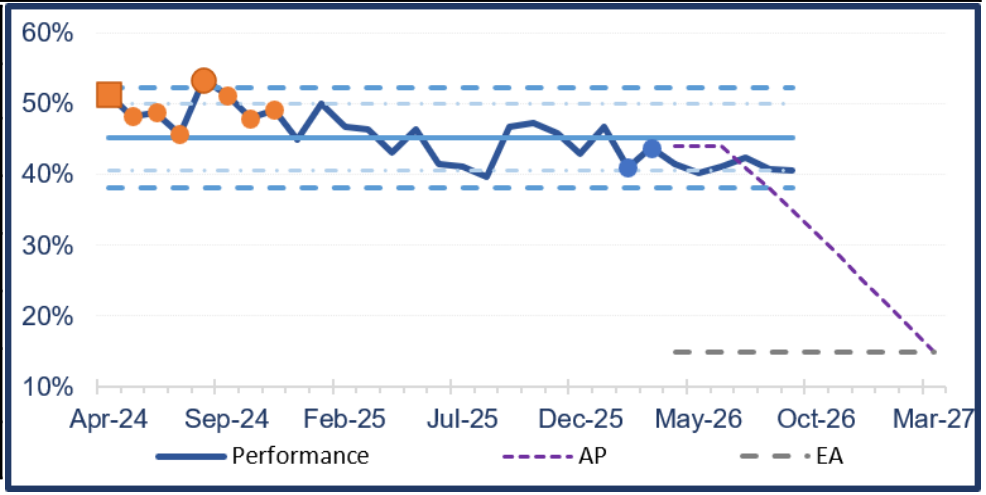
Expected impact upon forecasted performance – Based on current trend, overall theatre utilisation performance is not expected to deliver the step up required. With seasonal pressures resulting in increased cancellations last year UEC and Planned Care Recovery Directors will be reviewing and collaboratively planning as we move into winter pressures period to look to protect day of surgery admission area. Further detail on local and pan BCU actions to deliver sustained improvements will be required as part of ongoing recovery plans. These plans are expected to include measures to increase utilisation and deliver additional cases within existing establishment.

Planned Care : Productivity / Utilisation

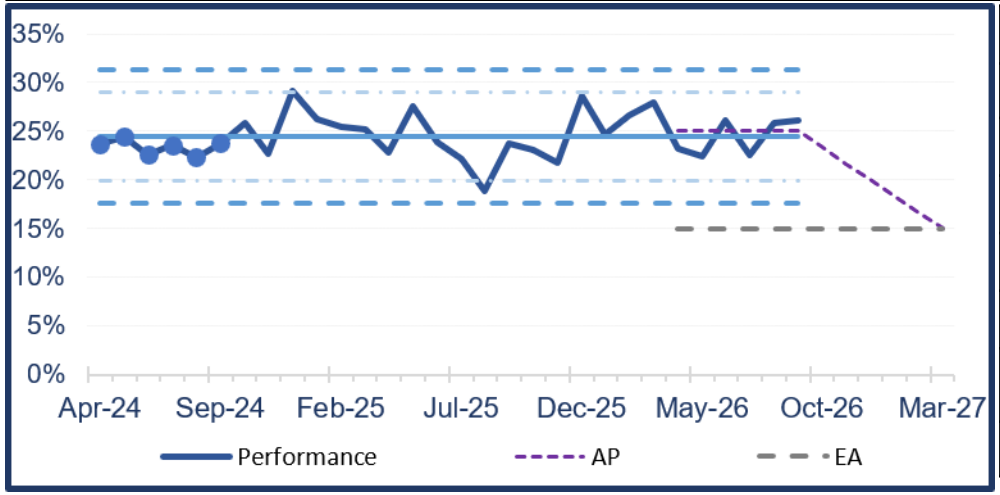
Metric Overview	ID	Metric	SM De-escalation	Planning / Performance Framework	Q1	Q2	Q3	Q4
	3BP11	Theatre session utilisation is improved to achieve GIRFT standard late starts (>15 mins)	N/A	<15%	44%	35%	25%	15%
	3BP11	Theatre session utilisation is improved to achieve GIRFT standard of early finishes (>60 minutes)	N/A	<15%	25%	25%	20%	15%

Theatre Utilisation – Late Start

Latest Month
September 2026
Profile
35.0%
Actual
40.6%
Status
Alert



Theatre Utilisation – Early Finish



Latest Month
September 2026
Profile
25.0%
Actual
26.1%
Status
Alert

What does the data tell us? –. As at the end of September, neither metric is showing the expected profile improvement to demonstrate assurance in delivery of the targeted improvement included within the health board plan this year. During the last six months (April – September), surgeon or anaesthetist delay due to reviewing patients are the main reasons noted for late starts with ophthalmology having the highest volume by specialty. For early finishes, completion of planned cases and cancellation of patients are the main reasons noted with Trauma & Orthopaedics and Ophthalmology having the highest volume of early finishes.

Actions being taken to improve – Despite work continuing to reduce avoidable early finishes through more effective list fill and improved pathway flow the health board is not on track to deliver improvement targets at this stage with improvement work sitting within a wider system effort.

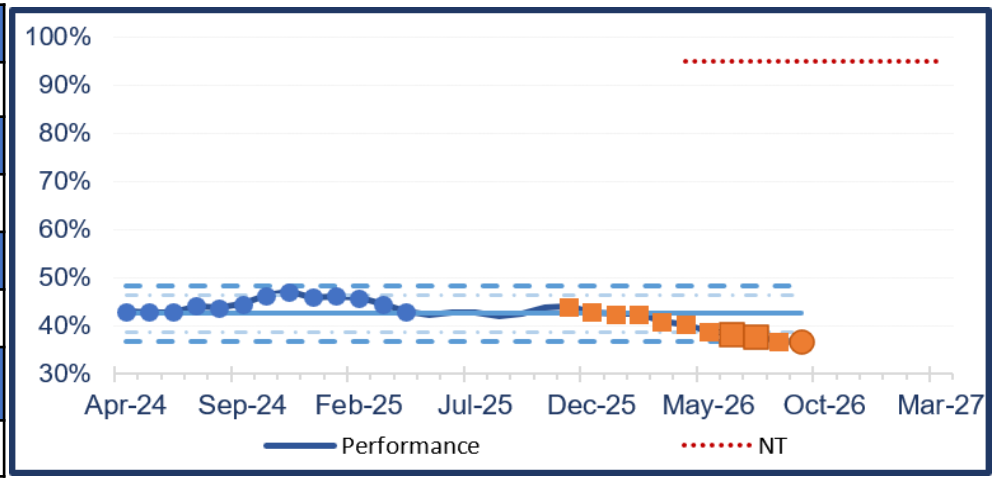
Expected impact upon forecasted performance – Levels of opportunity to increase theatre utilisation differ at specialty level dependent on procedure time and improvement work. Progress is overseen by the planned care recovery programme and Recovery Director remit.

Planned Care : Outpatient Activity

Metric Overview	ID	Metric	SM De-escalation	Planning / Performance Framework	Q1	Q2	Q3	Q4
	Local	% of R1 patient pathways, which have a target date allocated, waiting within their clinical target date or within 25% beyond their clinical target date for an outpatient appointment	N/A	12 month improvement towards national target of 95%	Improvement	Improvement	Improvement	Improvement
	3BP04	Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%	Continuous reduction	Zero	138,903 (-5%)	131,593 (-10%)	124,282 (-15%)	116,971 (-20%)

% R1 patient pathways waiting within or within 25% beyond clinical target date

Latest Month
September 2026
Profile
Improvement
Actual
36.6%
Status
Escalate



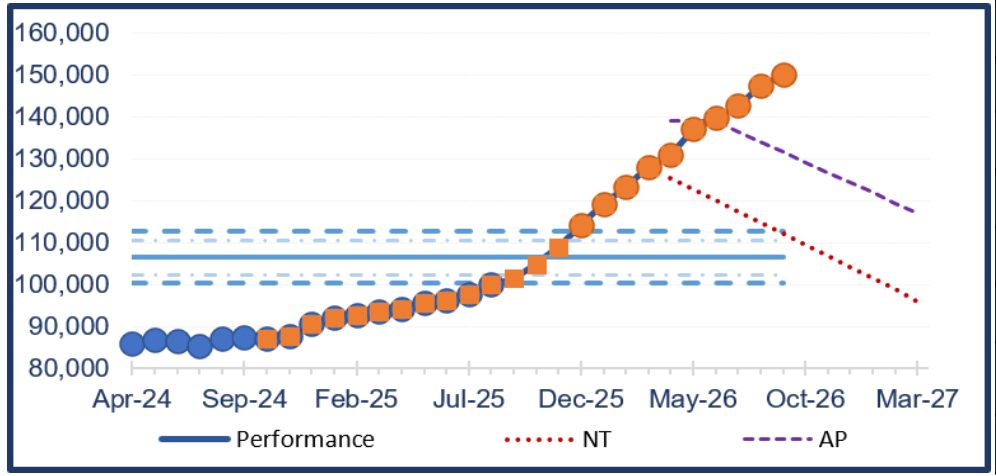
Benchmark

BCU ranked 8th of 8 health boards as of August 2026

What does the data tell us? – There continues to be a deterioration in the % of patients waiting within target with the performance reducing by 7.4% between November 2025 and September 2026. All Wales performance is at 49.7% with four areas achieving over 60%.

Actions being taken to improve and expected impact – Work continues to support re-direct / transfer of patients to WGOS pathways following clinical review with ongoing reporting and monitoring being further developed. Further work is also taking place to review data quality which will support identification of patients suitable for HVLC and WGOS pathways.

Follow Up Delayed by over 100%



Latest Month
September 2026
Profile
131,593
Actual
150,036
Status
Escalate

Benchmark

BCU ranked 7th of 7 health boards as of August 2026 – 46% of all Wales total

What does the data tell us? – Continued increase month on month with performance over 18k adverse of trajectory at the end of September 2026. There are nearly 50k more patients overdue at the end of September 2026 compared to same reporting point in 2025.

Actions being taken to improve – A clinically-led four-tier validation and pathway review approach has been established, with early implementation in Gynaecology demonstrating positive results. This approach will be applied to the recent government mandate for a policy position from the National Chief Medical Officer instructing that all patients awaiting a follow-up appointment, where a self-management SOS or PIFU pathway exists, are moved to that pathway.

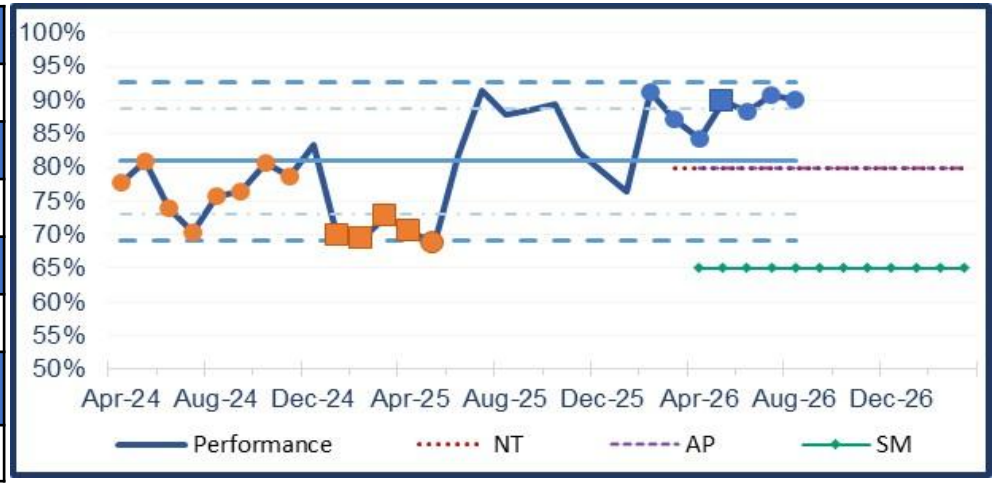
Expected impact upon forecasted performance – This area remains major priority. Further detail is expected regarding recent government announcement that will further inform recovery plans.

Adult Mental Health Measures

Metric Overview	ID	Metric	SM De-escalation	Planning / Performance Framework	Q1	Q2	Q3	Q4
	3DP01	Percentage of Local Primary Mental Health Support Service (LPMHSS) assessments undertaken within (up to and including) 28 days from the date of receipt of referral for adults aged 18 years & over	65%	80%	80%	80%	80%	80%
	3DP02	Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by Local Primary Mental Health Support Service (LPMHSS) for adults aged 18 years & over	65%	80%	80%	80%	80%	80%

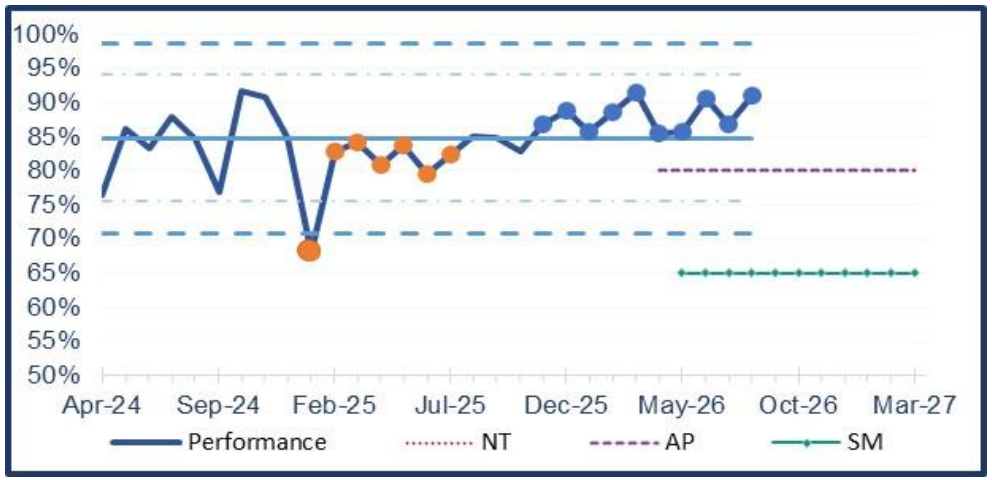
Mental Health Measure Part 1a - Assessments

Latest Month
August 2026
Profile
80%
Actual
90.2%
Status
Assure



Benchmark BCU ranked 5th of 7 health boards as of August 2026

Mental Health Measure Part 1b - 1st Intervention



Latest Month
August 2026
Profile
80%
Actual
91.1%
Status
Assure

Benchmark BCU ranked 4th of 7 health boards as of August 2026

What does the data tell us? Performance remains above the national 80% standard for both Adult Mental Health Measure Part 1 measures. In August, **90.2% of assessments were completed within 28 days**, a second consecutive months over 90%. During August 91.1% o**f first therapeutic interventions commenced within 28 days**, an increase from 86.9% in July. The overall Health Board position therefore remains positive, although locality and pathway variation continues to receive focus.

Actions being taken to improve? Operational focus is increasingly moving from recovery of the overall health board position to sustaining compliance and reducing variation across locality areas. Part 1a has focused on reduction of long waiters via a validation exercise coupled by an increase in activity. The same principles are now being applied to part 1b activity. Group intervention sessions are being offered and the use of attend anywhere to support patients with a variety of care options. There is continued performance oversight through established governance arrangements.

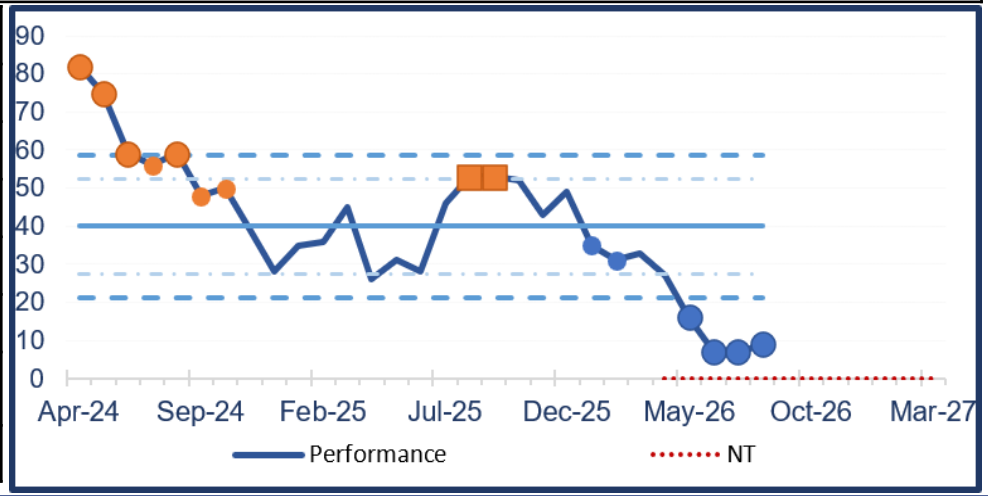
Expected impact upon forecasted performance The health board performance is expected to remain above the national standard, with continued focus on sustaining current performance and reducing unwarranted variation between localities and pathways.

Adult Mental Health Measures

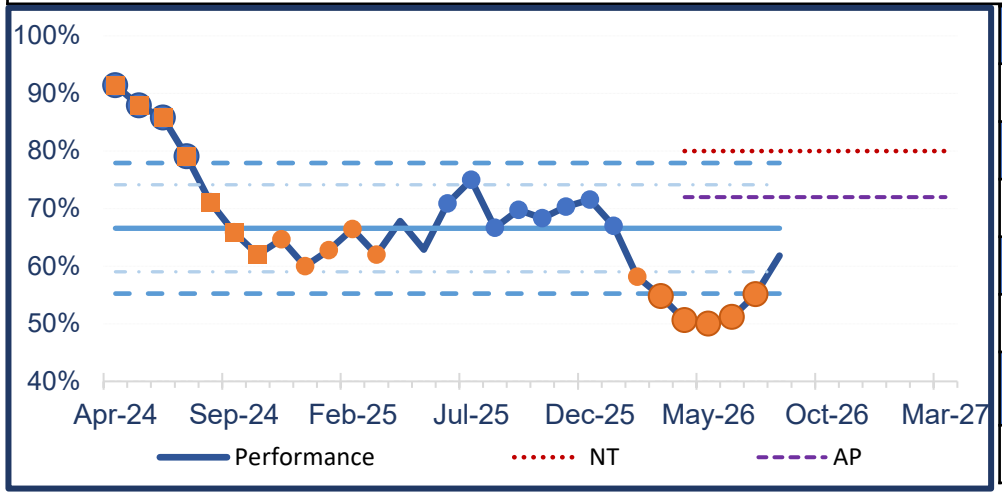
Metric Overview	ID	Metric	SM De-escalation	Planning / Performance Framework	Q1	Q2	Q3	Q4
	3DP06	Material reduction in the number of adult mental health out of area placements	N/A				TBC	TBC
	3BP05	Percentage of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health	N/A	80%	72%	72%	72%	72%

Out of Area Placements

Latest Month
August 2026
Profile
TBC
Actual
9
Status
Advise



Psychological Therapies



Latest Month
August 2026
Profile
72%
Actual
61.8%
Status
Alert

Benchmark	N/A	BCU ranked 6th of 7 health boards as of August 2026	Benchmark

What does the data tell us? Psychological therapies performance improved to 61.8% in July, compared to 55.1% in July, but remains significantly below the national 80% standard. Performance continues to be affected by variation across localities and ongoing operational capacity constraints. The out of area placements position reported for **August was 9 patients in total for the month** (as at 31st August) sustaining the significant reduction achieved in recent months.

Actions being taken to improve Recovery activity for **Psychological Therapies** as secured improved access to appropriate accommodation with further recruitment which will support restoring clinical capacity levels. For **out of area** there is continued daily review of current position and forward look with the discharge planning and admission waiting lists. Continued rigour and scrutiny at Director level through daily reporting and onward update and assurance reporting to Exec level.

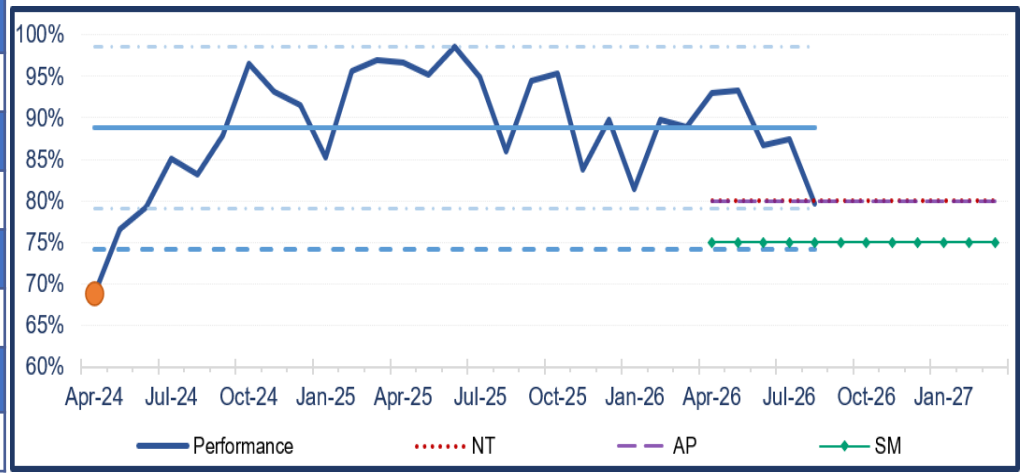
Expected impact upon forecasted performance Psychological therapies performance is expected to improve progressively as recovery actions take effect, although achievement of the national standard remains challenging. For out of area placements, the priority remains to sustain the significant improvement achieved. The Mental Health and Learning Disabilities Winter Plan and the Winter Preparedness Action plan collectively set out a comprehensive approach to maintaining safe, effective and resilient services across North Wales during Winter 2026/27.

Child and Adolescent Mental Health (CAMHS)

Metric Overview	ID	Metric	SM De-escalation	Planning / Performance Framework	Q1	Q2	Q3	Q4
	3EP01	Percentage of Local Primary Mental Health Support Service **assessments** undertaken within (up to and including) 28 days from the date of receipt of referral for people aged under 18 years	75%	80%	80%	80%	80%	80%
	3EP02	Percentage of therapeutic **interventions** started within (up to and including) 28 days following an assessment by Local Primary Mental Health Support Service (LPMHSS) for people aged under 18 years.	60%	80%	80%	80%	80%	80%

Measure – Part 1A (Assessments) – people aged under 18 years

Latest Month
August 2026
Profile
80%
Actual
79.6%
Status
Alert



Benchmark BCU ranked 7th of 7 health boards as of August 2026

Mental Health Measure – Part 1B (Interventions) – people aged under 18 years



Latest Month
August 2026
Profile
80%
Actual
78.84%
Status
Alert

Benchmark BCU ranked 7th of 7 health boards as of August 2026

What does the data tell us? – The target of 80% for the **assessment** metric (part 1A) has been constantly achieved between July 2024 and July 2026 but dipped below the 80% in August and with a 20% increase in assessment demand in comparison with the same period prior year, management data indicates that performance will remain below 80% in September 2026 but remain above the de-escalation threshold of 75%. For the **interventions** metric (1B), significant improvement was demonstrated during 2025/26 with performance improving from 40% at the start of the year to and end of March performance of 85.4%. Performance has dipped below the 80% standard in August 2026 and is currently forecast to remain below target during Q3 and return to compliance level of 80% from January 2027 onwards.

Actions being taken to improve – Performance has been challenged in the East locality and recruitment is underway with significant reliance on agency in the interim. Increase in demand for assessment and therapy is a risk to delivery. Getting Started (Psychoeducation) group have commenced although there are challenges currently in uptake of groups.

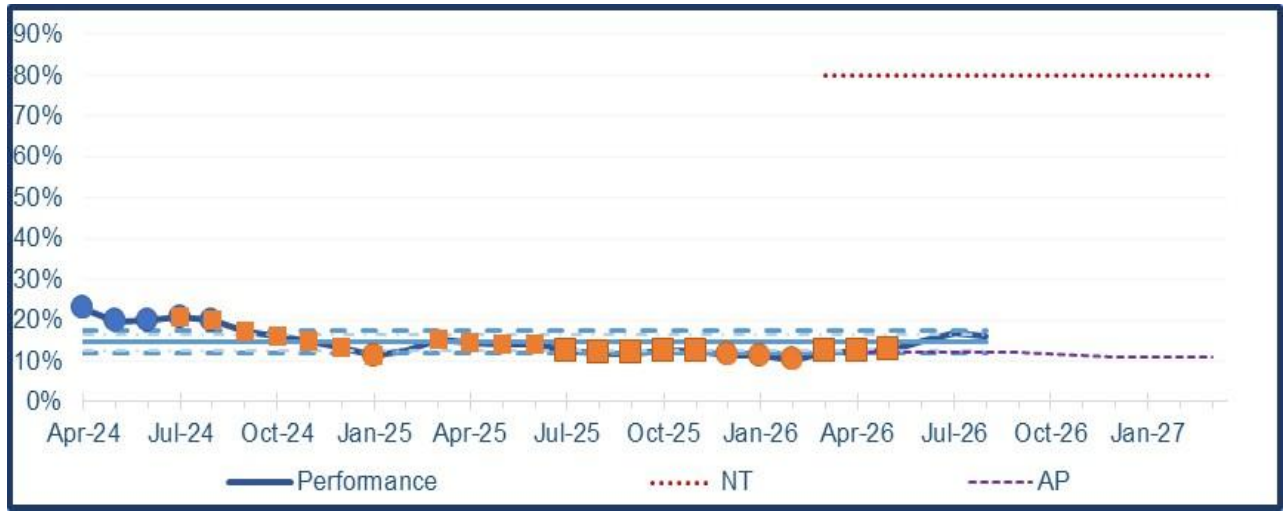
Expected impact upon forecasted performance – Part 1A is forecast to return to 80% compliance level from October at health board level with East locality expected to meet the 1A target by November. For Part 1B, whilst 80% target is expected to be met within West and Centre localities the recovery plan developed by East team will see performance return to compliance level from January – this is also when the regional position is expected to be back at 80% compliance levels.

Neurodevelopment (ND)

Metric Overview	ID	Metric	SM De-escalation	Planning / Performance Framework	Q1	Q2	Q3	Q4
	3EP03	Percentage of C&YP waiting less than 26 weeks to start neurodevelopment assessment	N/A	80%	12%	12%	12%	12%

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

Latest Month
August 2026
Profile
12%
Actual
16.2%
Status
Alert



Waiting List Profile

Month	<26 weeks	26+ weeks	ND Total	Of which 3yr+	Of which 4yr+
Jan-26	883	6,982	7,865	1,276	0
Feb-26	756	6,560	7,316	547	2
Mar-26	851	6,069	6,920	592	3
Apr-26	856	6,162	7,018	643	15
May-26	895	6,151	7,046	652	18
Jun-26	1,014	5,779	6,793	423	14
July-26	1,131	5,544	6,675	407	5
Aug-26	1,064	5,524	6,588	326	2

Benchmark	BCU ranked 7th of 7 health boards as of August 2026. No health board achieving target with all Wales performance 26.4%

What does the data tell us? – Performance is considerably below national expectation with those waiting less than 26 weeks to start an ADHD or ASD assessment at 16.2% The total waiting list has reduced by 1,277 since January 2026 and now stands at 6,588. Within this the number of patients within excess of 3 years has also reduced by 950 patients from 1,276 at end of January 2026 to 326 at end of August 2026.

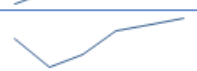
Actions being taken to improve – A report has been received following and NHS Performance and Improvement visit in June 2026 and the service is reviewing the recommendations in line with the improvement programme. The prudent assessment process has been reviewed and additional training days is arranged for November. Work is currently taking place to support additional assessments over and above current contracted values this is progressing via governance routes during quarter 3.

Expected impact upon forecasted performance – Whilst additionality continues to support reduction in extreme wait patients, given the size of the waiting list and the volume currently more than 26 weeks, the focus this financial year is on eliminating long waits over 3 years.

Section 2
Quality, safety and patient experience



Scorecard: Quality, safety and patient experience

REF	Measure Description	Target Suite			Wales Benchmark	Actual Performance				Status
		NT	SM	AP		Jul-26	Aug-26	Sep-26	6 Month Activity	
NPF39	Percentage of episodes clinically coded within one reporting month post episode discharge end date	95%	-	-	4th of 8 (at Jul 26)	95.3%	RIA	RIA		Assure
NPF49	Number of new never events	0	-	-	15th of 23 (at Jul 26)	2.0	1.0	1.0		Assure
NPF40	Nationally reportable incidents open over 12 months	0	-	-	1st of 11 (at Aug 26)	0	0	0		Assure
4HP02	12 month rolling average crude mortality rate	-	-	-	N/A	1.3	1.4	RIA		Alert
NPF41	Cumulative number of hospital onset Klebsiella spp BSI cases	19	-	-	3rd of 6 (at Sep 26)	10	13	19		Alert
NPF42	Cumulative number of hospital onset Pseudomonas aeruginosa BSI cases	1	-	-	3rd of 6 (at Sep 26)	3	4	6		Assure
NPF43	Cumulative number of hospital onset E.coli BSI cases	55	0	-	6th of 6 (at Sep 26)	36	46	57		Assure
NPF44	Cumulative number of MSSA BSI cases	63	-	-	2nd of 6 (at Aug 26)	84	96	105		Advise
NPF45	The cumulative rate of laboratory confirmed C.difficile cases per 100,000 of the population	-	-	-	5th of 6 (at Mar 26)	49.8	52.0	54.4		Advise
LMQ01	Number of new reported falls	-	-	-	N/A	372	319	325		Advise
LMQ02	Number of reported falls with actual harm (moderate and above, post review)	-	-	-	N/A	26	19	25		Advise
NPF50	Overall HB patient experience score (out of 10)	8.5	-	-	N/A	8	8	9		Assure
LMQ03	Number of avoidable hospital acquired pressure ulcers (HAPU) (post review)	-	-	-	N/A	57	47	49		Alert
LMQ04	Number of National reportable incidents (NRIs)	-	-	-	N/A	11	8	11		Alert
LMQ05	The number of complaints open	-	-	-	N/A	334	358	412		Advise
LMQ06	Percentage of complaints that are not overdue	-	-	-	N/A	84.0%	83.5%	76.5%		Assure

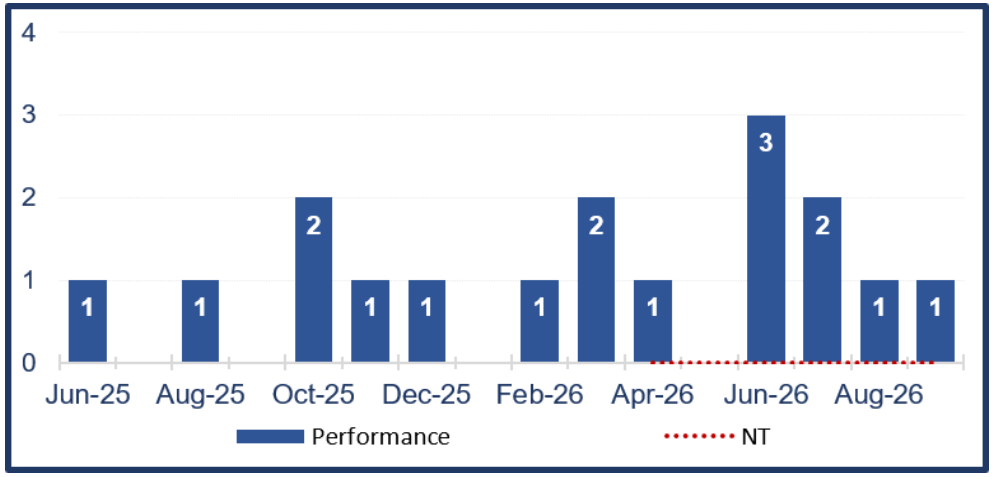
REF	Measure Description	Target Suite			Wales Benchmark	Actual Performance				Status
		NT	SM	AP		Q3 25/26	Q4 25/26	Q1 26/27	Notes	
3HP02	Gabapentin and pregabalin (DDDs per 1,000 patients)	10%↓ YoY	-	1599.7	5th of 7 (at Jun 26)	1676.5	1592.4	1623.3		TBC

Never Events

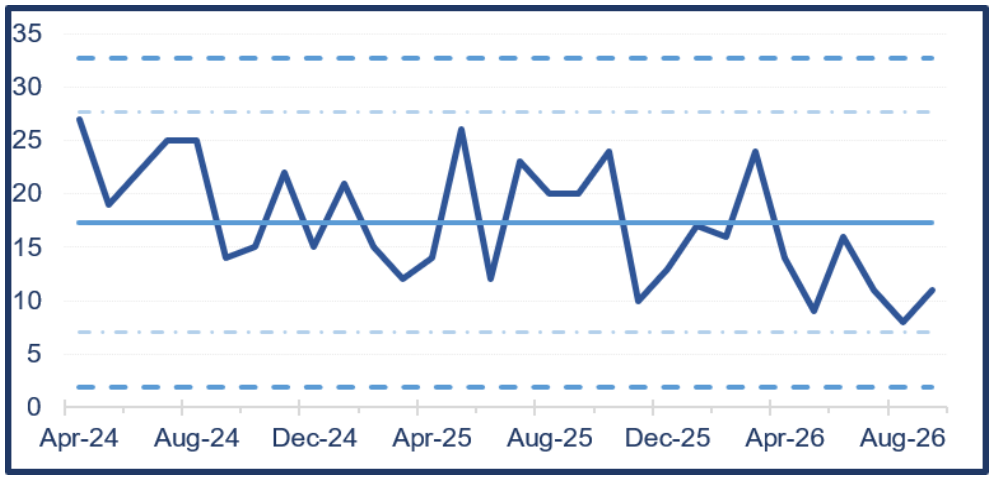
Metric Overview	ID	Metric	SM De-escalation	Planning / Performance Framework	Q1	Q2	Q3	Q4
	NPF49	Number of new never events	N/A	0	0	0	0	0
	LMQ04	Number of new National Reportable Incidents (NRIs)	N/A	N/A	-	-	-	-

Number of new never events

Latest Month
September 2026
Profile
0
Actual
1
Status
Alert



New National Reportable Incidents (NRI) by incident date (snapshot in time data)



Latest Month
September 2026
Profile
N/A
Actual
11
Status
Advise

Benchmark	BCU ranked 11th of 11 health boards as of August 2026	N/A	Benchmark

What does the data tell us? - One never event was reported during September 2026; (a further never event reported early October-not reflected in charts) a cumulative position of 8 (9) Never Events in 2026/27. Incidents reported during the year reflect a range of patient safety themes, including procedural safety, retained items and the safe use of clinical devices and implants. National Reportable Incidents (NRIs) continue to be monitored, with the reported position representing a snapshot by incident date, therefore subject to change as incidents are reviewed and reporting is updated. Based on Beacon data, BCUHB recorded the highest number of NRIs in Wales during September, with 11 reported. However, BCUHB continues to perform strongly in the timely management of incidents, holding the best position in Wales for NRIs remaining open for more than 12 months, with none outstanding. In addition, BCUHB has the lowest median number of working days to complete an investigation across Wales.

Actions being taken to improve - Robust management of serious incidents continues through established governance processes, with timely investigation, application of Duty of Candour requirements where appropriate, and implementation of targeted improvement actions arising from identified learning. Executive oversight is maintained through established quality and safety governance arrangements to ensure accountability, monitor progress, and provide assurance that learning is translated into measurable service improvements. In parallel, a health board-wide programme of work is underway to strengthen local safety standards for invasive procedures (LocSSIPs), including the review of local compliance arrangements and enhanced audit processes across clinical services to improve consistency, safety, and assurance.

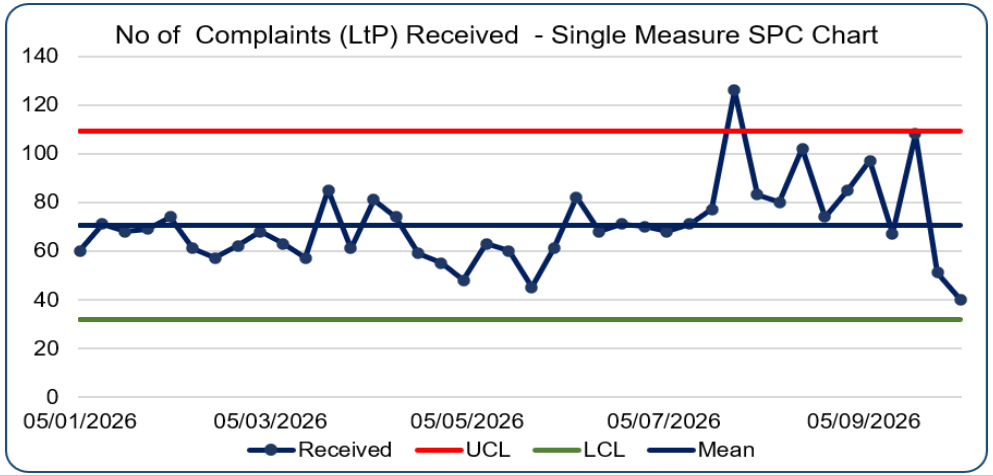
Expected impact upon forecasted performance – Strengthened oversight, consistent application of safety standards and continued organisational learning are intended to improve compliance and reduce the risk of recurrence.

Complaints

Metric Overview	ID	Metric	SM De-escalation	Planning / Performance Framework	Q1	Q2	Q3	Q4
	NPF49	Number of complaints received	N/A	N/A	N/A	N/A	N/A	N/A
	LMQ05	Number of open complaints	N/A	N/A	N/A	N/A	N/A	N/A

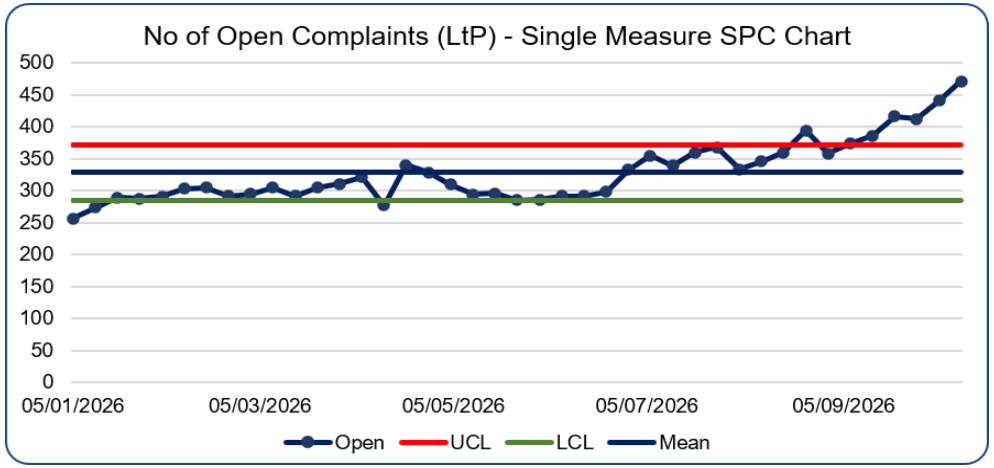
Number of complaints received (weekly)

Latest Position
w/c 5 October
Profile
N/A
Actual
40
Status
Alert



Benchmark
N/A

Number of open complaints (weekly)



Latest Position
w/c 12 October
Profile
N/A
Actual
471
Status
Advise

Benchmark
N/A

What does the data tell us? The latest position shows 466 open complaints as of 13 October, indicating that the overall volume of open complaints remains elevated, and continues to increase week on week. This represents an increase from the 324 open complaints reported in early August a 43.8% increase. The sustained level of open complaints reflects the ongoing challenge of balancing new demand with the capacity of services to investigate and respond to concerns.

Actions being taken to improve A programme of work is underway to improve complaints performance and reduce the outstanding backlog through a stronger focus on early resolution and process efficiency. The expansion of the Early Resolution First approach, alongside streamlined handling of low-harm complaints, is intended to accelerate resolution times and reduce the number of cases progressing to formal investigation. A dedicated Early Resolution and Enquiries Officer is being piloted within East IHC to support the timely management of concerns, while workforce capacity has been strengthened through recruitment to vacant posts and additional temporary support. Improvement efforts are also being targeted at services generating the highest levels of complaints and concerns, informed by patient feedback and performance intelligence. In parallel, closer collaboration between complaints, patient experience, and engagement teams is improving the identification and management of emerging issues, supporting more responsive services and improved patient experience. These actions are expected to increase early resolution rates, improve response timeliness, and reduce the overall complaints backlog.

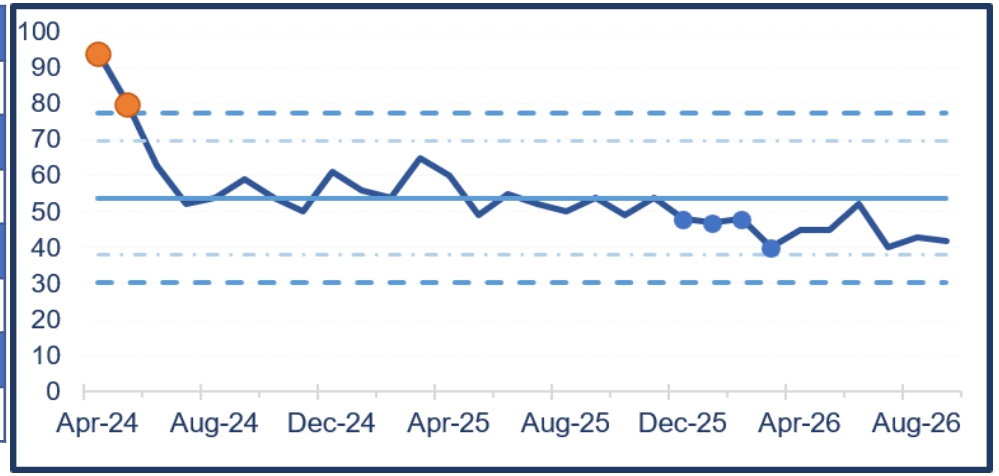
Expected impact upon forecasted performance – The improvement programme is intended to increase the timely resolution of concerns, reduce the overall number of open and overdue complaints and improve compliance.

Quality: Patient Experience and Regulation 28 notices

All open NRIs

SM De-Escalation	N/A	Framework	N/A	Latest Benchmark	N/A

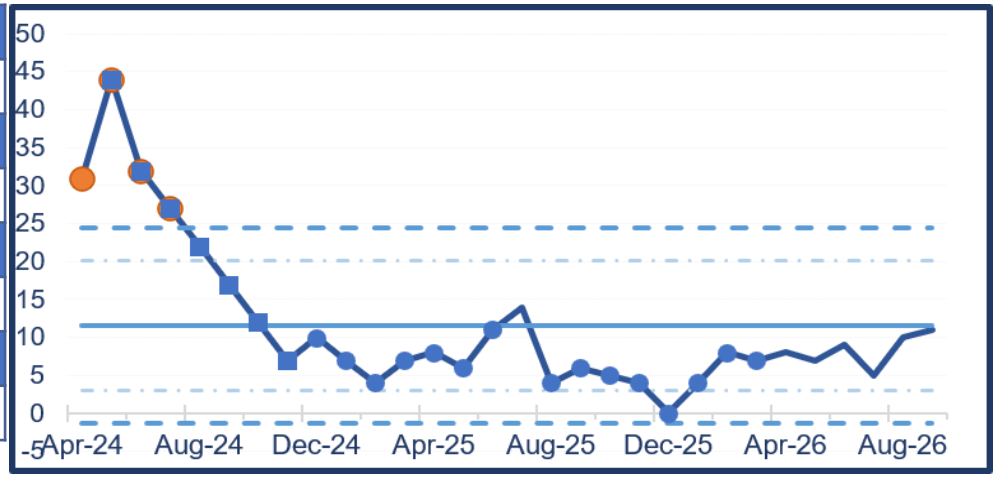
Latest Month
September 2026
Profile
N/A
Actual
42
Status
Advise



All overdue NRIs

SM De-Escalation	N/A	Framework	N/A	Latest Benchmark	N/A

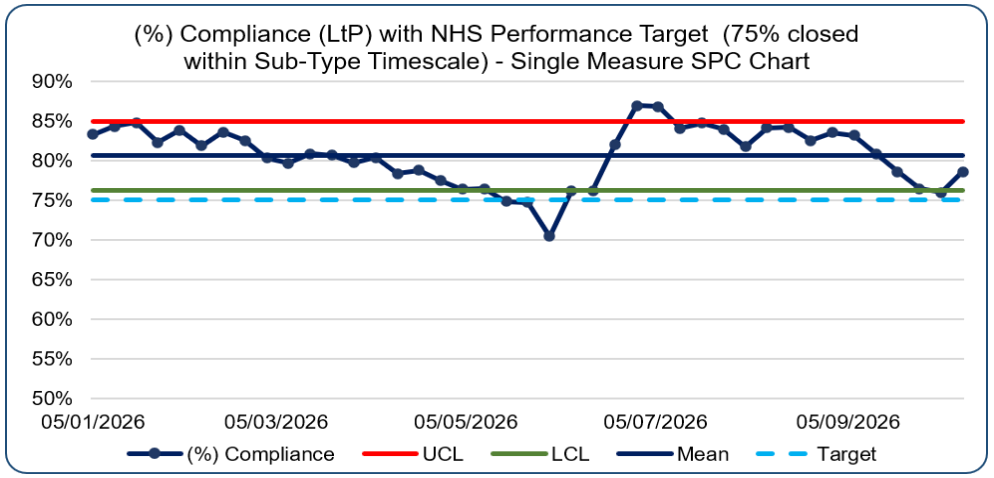
Latest Month
September 2026
Profile
N/A
Actual
11
Status
Advise



Percentage of complaints closed within agreed timescales

SM De-Escalation	N/A	Framework	N/A	Latest Benchmark	N/A

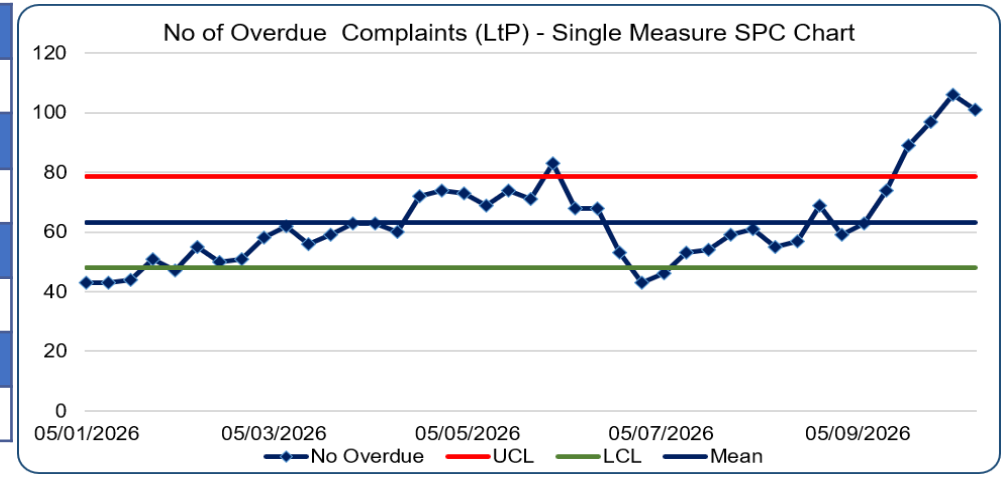
Latest Position
w/c 12 October
Profile
N/A
Actual
78.6%
Status
Assure



Number of overdue complaints

SM De-Escalation	N/A	Framework	N/A	Latest Benchmark	N/A

Latest Position
w/c 12 October
Profile
N/A
Actual
101
Status
Assure

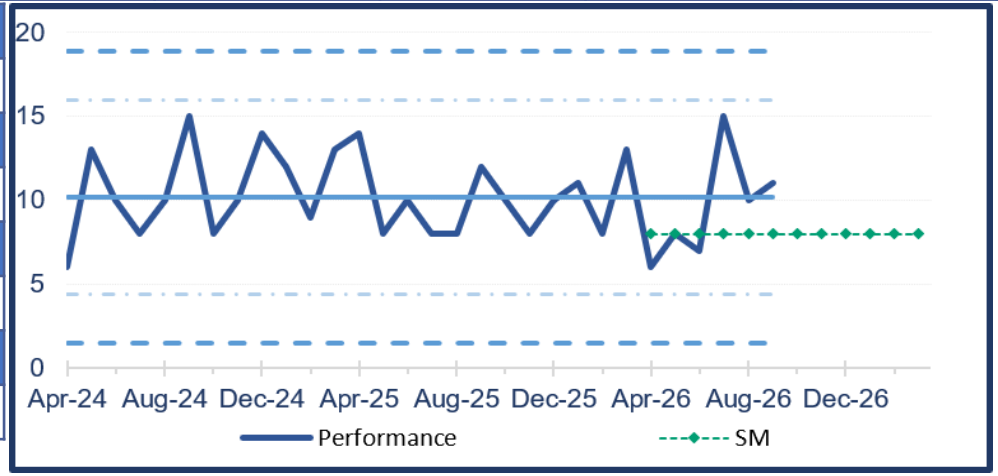


Quality: Infections

Number of hospital onset E-coli BSI cases

SM De-Escalation	8	Framework	N/A	Latest Benchmark	N/A

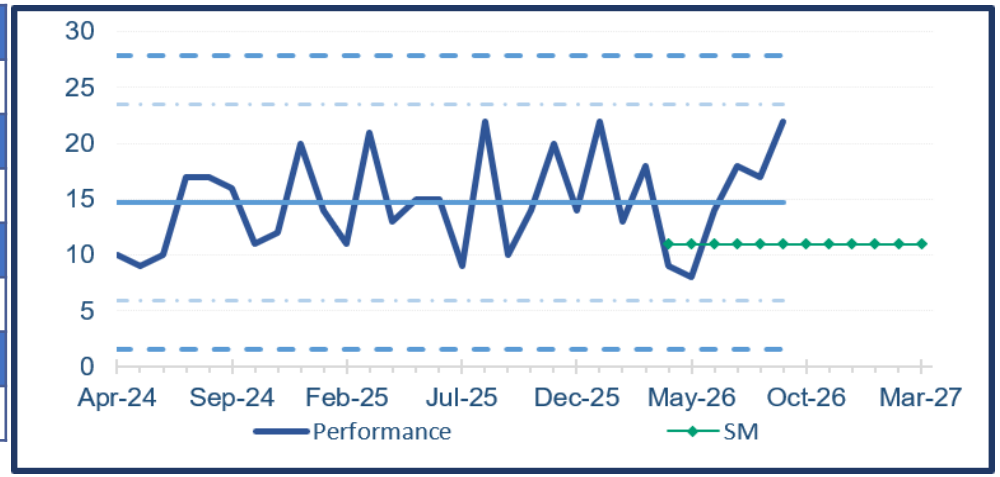
Latest Month
September 2026
Profile
N/A
Actual
11
Status
Advise



Number of hospital onset C-Diff cases

SM De-Escalation	11	Framework	N/A	Latest Benchmark	N/A

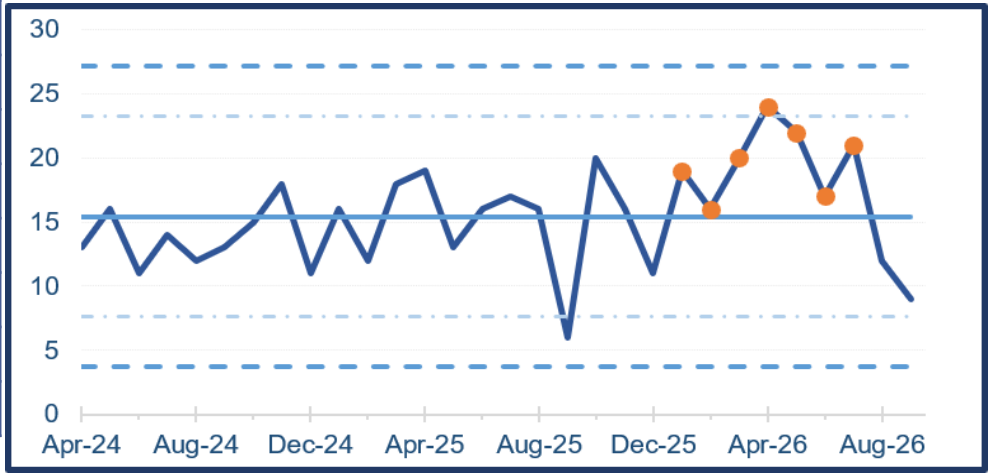
Latest Month
September 2026
Profile
N/A
Actual
22
Status
Advise



Number of MSSA cases

SM De-Escalation	N/A	Framework	N/A	Latest Benchmark	N/A

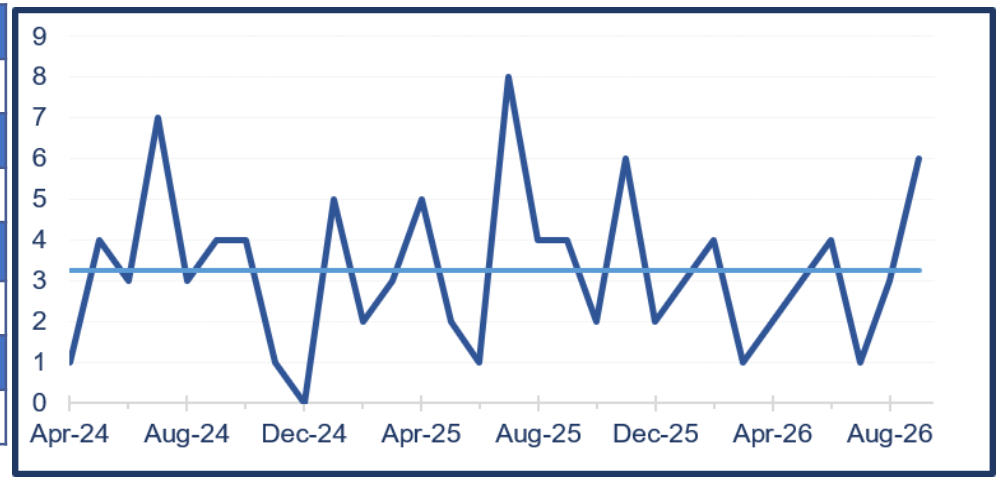
Latest Month
September 2026
Profile
N/A
Actual
9
Status
Advise



Number of hospital onset Klebsiella spp BSI cases

SM De-Escalation	N/A	Framework	N/A	Latest Benchmark	N/A

Latest Month
September 2026
Profile
N/A
Actual
6
Status
Advise

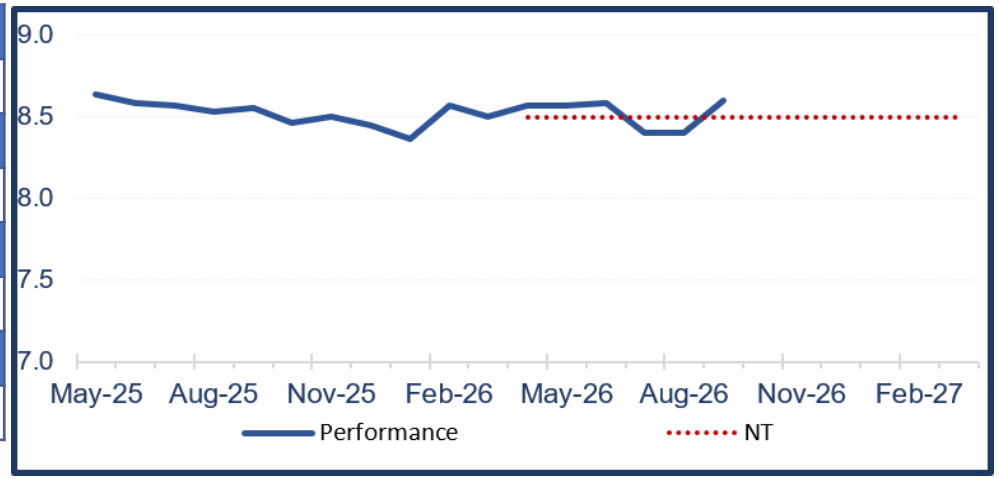


Quality: Patient Experience and Regulation 28 notices

Overall health board patient experience score

SM De-Escalation	N/A	Framework	8.5	Latest Benchmark	BCU ranked 5th out of 9 at May 2026

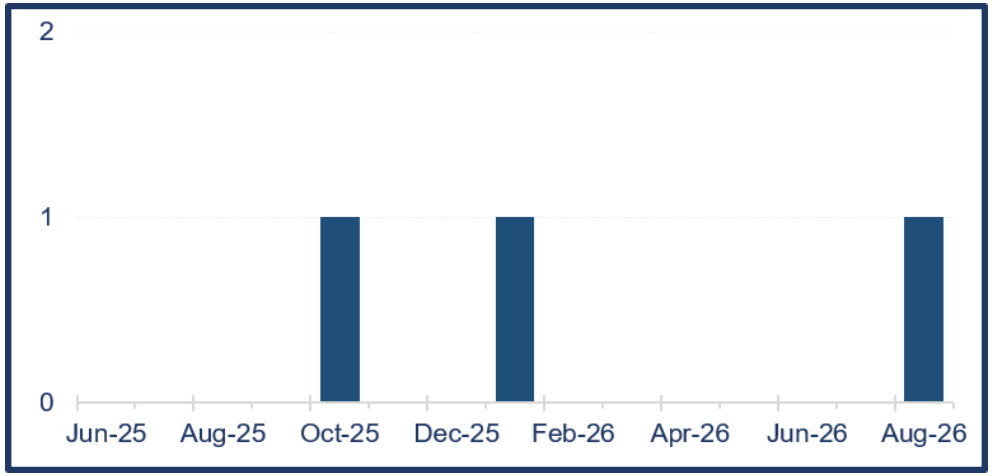
Latest Month
September 2026
Profile
N/A
Actual
8.6
Status
Advise



Regulation 28 notices (Prevention of Future Deaths reports)

SM De-Escalation	N/A	Framework	N/A	Latest Benchmark	N/A

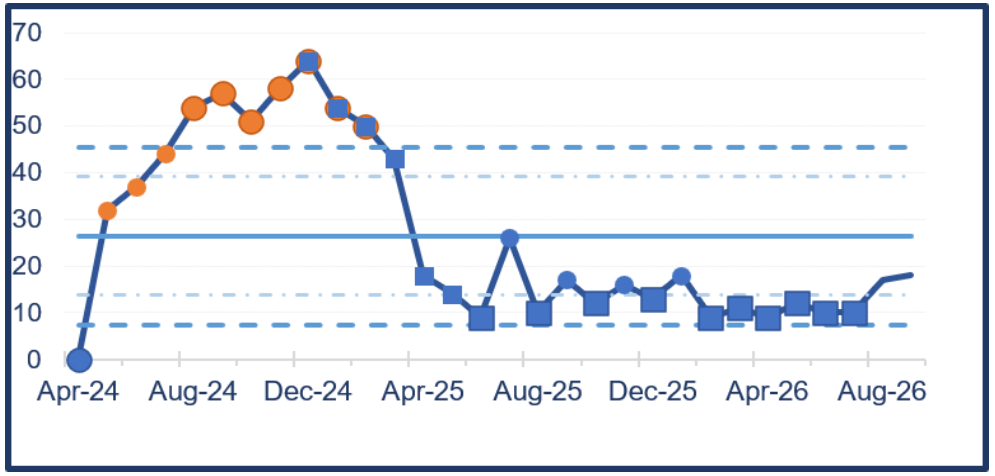
Latest Month
August 2026
Profile
N/A
Actual
0
Status
Advise



Number of overdue Learning from Event Reports (LFERs)

SM De-Escalation	N/A	Framework	N/A	Latest Benchmark	N/A

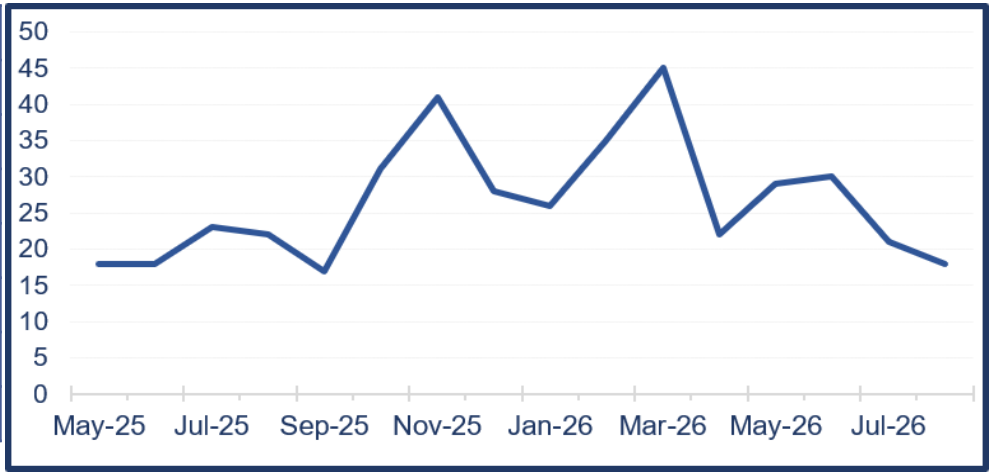
Latest Month
September 2026
Profile
N/A
Actual
18
Status
Assure



Number of new Ombudsman contacts

SM De-Escalation	N/A	Framework	N/A	Latest Benchmark	N/A

Latest Month
August 2026
Profile
N/A
Actual
18
Status
Assure



Section 3
Population health and prevention



Scorecard: Population health and prevention

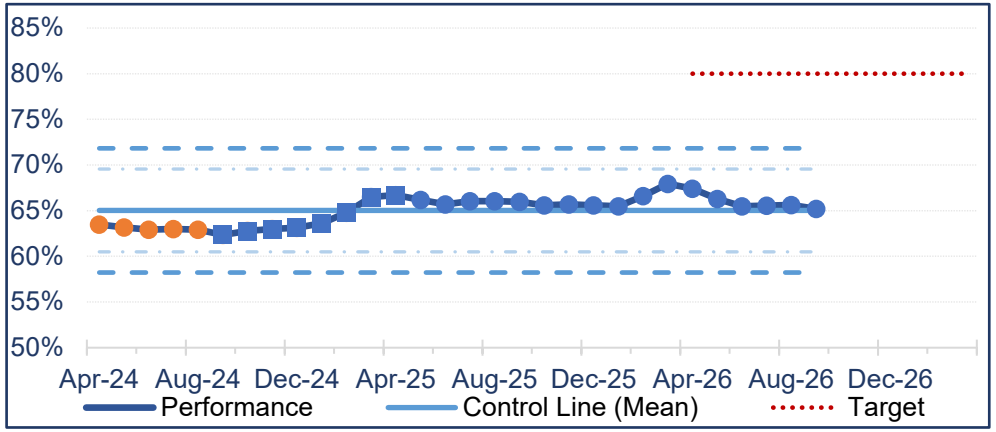
REF	Measure Description	Target Suite			Wales Benchmark	Actual Performance				Status
		NT	SM	AP		Q4 25/26	Q1 26/27	Q2 26/27	Notes	
1AP01	Percentage of adult smokers who make a quit attempt via smoking cessation services	Q2: 3.5%	-	3.5%	3rd of 7 (at Mar 26)	8.1%	1.7%	RIA	Annual Target	Assure
1AP02	Percentage of adult smokers who made a quit attempt via smoking cessation services who are CO-validated as quit at 4 weeks	40%	-	40.0%	2nd of 7 (at Jun 26)	22.5%	29.6%	RIA		Advise
1DP01	Percentage of children who are up to date with the scheduled vaccinations by age 5 ('4 in 1' preschool booster, Hib/MenC booster and second MMR dose)	95%	-	91.0%	2nd of 7 (at Jun 26)	87.6%	89.0%	RIA		Advise
1DP02	Percentage of children receiving the Human Papillomavirus (HPV) vaccination by the age of 15	90%	-	80.0%	6th of 7 (at Jun 26)	70.8%	72.4%	RIA	School year based	Advise
LMPH01	Percentage of teenagers receiving the MenACWY vaccination by the end of year 11	-	-	80.0%	N/A	74.5%	75.4%	RIA	School year based	Advise
LMPH02	Level 2 adult weight service - increase digital activity	-	-	204	N/A	370	138	259		Assure

REF	Measure Description	Target Suite			Wales Benchmark	Actual Performance				Status
		NT	SM	AP		Jul-26	Aug-26	Sep-26	6 Month Activity	
1BP02	Percentage of patients offered an index colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioner assessment appointment	90%	-	-	4th of 7 (at Jun 26)	36.8%	RIA	RIA		Alert
3DP05	Percentage of people who have been referred to health board services who have completed treatment for substance misuse (drugs or alcohol)	80%	-	-	1st of 7 (at Jun 26)	95.1%	96.2%	RIA		Assure
LMPH03	Percentage of patients (*adults) with diabetes who received all eight NICE recommended care processes	-	-	45.5%	7th of 7 (at Mar 26)	43.6%	44.1%	44.1%		Advise
1AP07	Percentage of patients (*adults) with diabetes who have had foot surveillance recorded within 15 months	80%	-	-	5th of 7 (at Sep 26)	65.5%	65.6%	65.2%		Advise
1AP08	Percentage of patients (*adults) with diabetes who have had their urine albumin recorded within 15 months	80%	-	-	5th of 7 (at Sep 26)	64.9%	65.3%	65.1%		Advise
LMPH04	Rate of babies being fed breast milk exclusively at birth (via breast or bottle)	-	-	-	N/A	50.3%	55.5%	RIA		TBC
LMPH05	Rate of babies being fed breast milk exclusively at 10 days (via breast or bottle)	-	-	48.5%	N/A	46.1%	45.8%	RIA		TBC
2AP01	Increase in % of adult populations accessing NHS Dental care over a 24 month period	-	-	-	N/A	178132	177932	178385		TBC
2AP02	Increase in % of child populations accessing NHS Dental care over a 12 month period	-	-	57.5%	N/A	54383	53588	52633		TBC
3HP01	Percentage of community pharmacies providing Pharmacist Independent Prescribing service (PIPS)	63%	-	48.0%	6th of 7 (at Aug 26)	46.2%	46.9%	RIA		TBC

Percentage of patients (*adults) with diabetes who have had foot surveillance recorded within 15 months

SM De-Escalation	N/A	Framework	80%	Latest Benchmark	N/A

Latest Month	Target	Actual	Status
September 2026	80%	65.2%	Alert

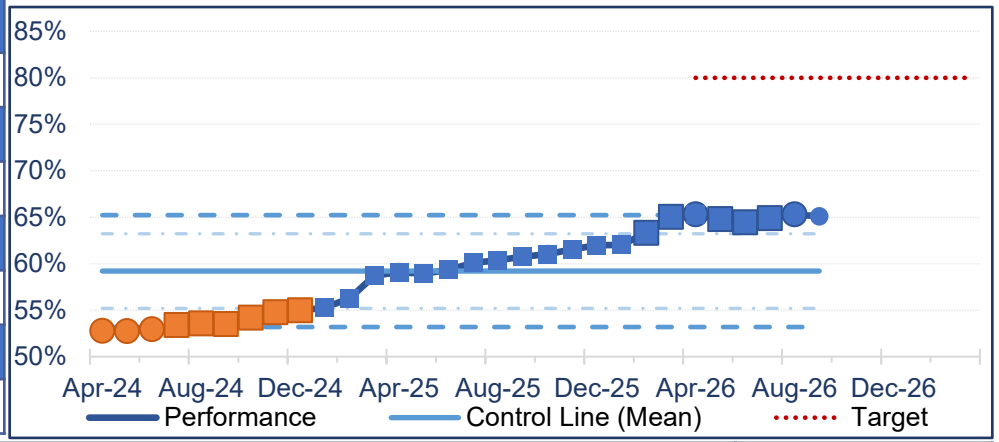


Benchmark BCU ranked 5th of 7 at September 2026

Percentage of patients (*adults) with diabetes who have had their urine albumin recorded within 15 months

SM De-Escalation	N/A	Framework	80%	Latest Benchmark	N/A

Latest Month	Target	Actual	Status
September 2026	80%	65.1%	Advise



BCU ranked 5th of 7 at September 2026 **Benchmark**

**it should be noted that data is for adults only rather than 12 years and over as stated within the Performance Framework*

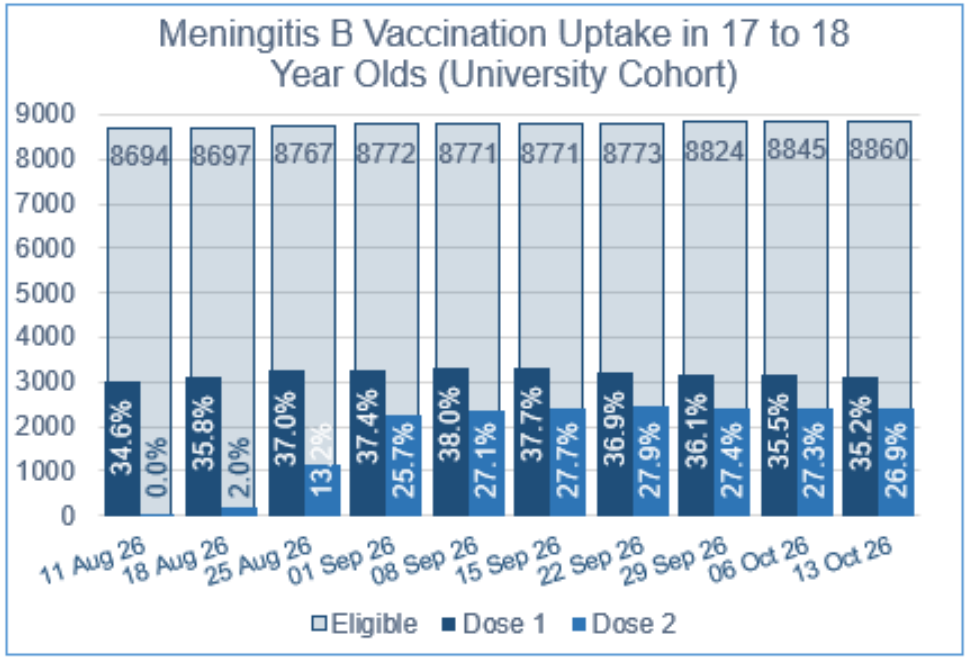
What does the data tell us? Foot surveillance (FS) and urine albumin (UA) continue to be the lowest recorded of the eight NICE recommended care processes for diabetes. UA has seen a comparative month on month increase and at Sep 26 was 2.7% higher than Sep 25. FS, although improved from 2024/25, has plateaued.

Actions being taken to improve: Recent engagement work with GPs suggests that data and coding issues, call and recall, uptake of offer, and capacity issues may contribute to lower uptakes. A regular eight care processes cluster meeting offers shared-learning and support around improving uptake. A newsletter has been produced for each cluster providing performance data and inviting clusters to explore uptake within the cluster and offers support around identifying actions they can consider to improve uptake.
A targeted letter was sent in Q2 to GP practices with the lowest uptake, this letter will seek development and submission of an action plan to improve uptake and will make an offer of support to develop this improvement plan. A delivery, governance and assurance structure to support quality improvement and transformation change elements within the Diabetes Programme in North Wales is currently being implemented.

Expected impact upon forecasted performance: The actions outlined are expected to support a gradual improvement in uptake of the eight care processes during 2026/27, including FS and UA. However, any impact on forecast performance is likely to be incremental and may take time to be reflected in reported outcomes.

Uptake of MenB vaccination in individuals aged 17 to 18 years of age					
Time-Limited Programme	N/A	**Framework**	N/A	**Latest Benchmark**	N/A

Latest Data
13-10-26
Target
N/A
Actual
35.2% / 26.9%
Status
Advise



*Please note these figures are based on those alive and resident in Wales as at 12/10/2026. There is potential for uptake figures to decrease compared to previous reports due to movements in and out of Wales and vaccinations received elsewhere not being recorded in WIS.

Benchmark	13th October 2026 Dose 1: BCU ranked 7th of 7 Health Boards Dose 2: BCU ranked 7th of 7 Health Boards

What does the data tell us?

As at the latest update, **3,117 first doses (35.2%) and 2,383 second doses (26.9%)** have been delivered to the eligible 17–18-year-old BCUHB cohort. First-dose uptake remains variable across North Wales, ranging from 31.0% in Denbighshire to 41.2% in Conwy, indicating opportunities to improve coverage. Encouragingly, second-dose uptake is progressing as individuals reach the required interval between doses. The wider PHW data also demonstrate a socioeconomic gradient in uptake, with lower coverage amongst those living in the most deprived communities.

Actions being taken to improve

A further invite letter has been sent to cohort one (17- and 18-year-olds) reminding them of their eligibility regardless of their further education pathway. Letters will be arriving week commencing 12th October and therefore impact is yet to be determined.

Population health communication officers have created a short YouTube video aimed at young adults reminding them of eligibility and the importance to come forward for vaccination.

Availability of clinics are advertised on Betsi net and accessed via a QR code within the aforementioned letter. Young adults can attend on a walk-in basis, no appointment necessary to provide accessible support.

We continue to work closely with both Bangor and Wrexham universities and other further education establishments to extend the offer to young adults (cohort one and cohort two)

Expected impact upon forecasted performance

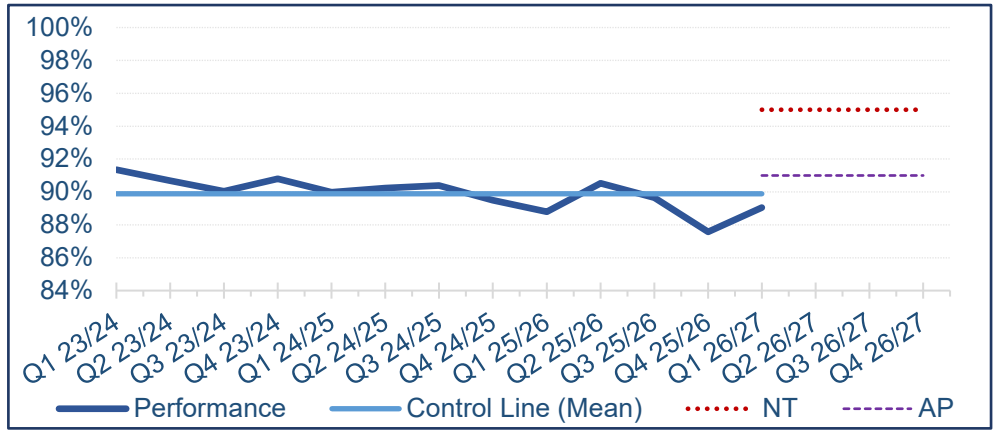
Targeted follow-up of individuals who have not yet attended and continued clinic delivery are expected to improve first-dose uptake. The routine scheduling of second-dose appointments should support sustained growth in course completion rates, while delivery through education settings will provide additional opportunities to vaccinate eligible cohorts during the autumn.

Variation in uptake remains the key performance risk, particularly within more deprived communities, and will require continued targeted intervention to improve equitable coverage and overall programme performance.

Percentage of children who are up to date with the scheduled vaccinations by age 5

SM De-Escalation	N/A	Framework	95%	Latest Benchmark	BCU ranked 2nd out of 7 at Q1 26/27

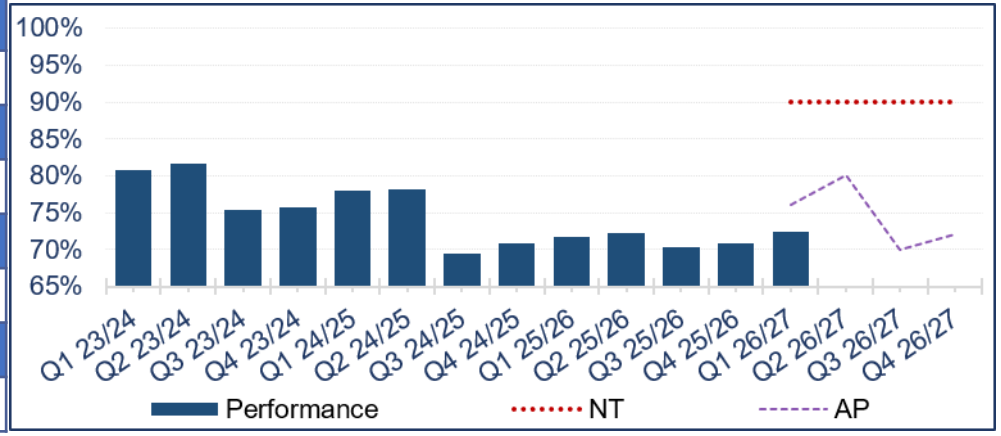
Latest Month	Profile	Actual	Status
Q1 2026/27	N/A	89.0%	Advise



Percentage of children receiving the HPV vaccination by the age of 15

SM De-Escalation	N/A	Framework	90%	Latest Benchmark	BCU ranked 5th out of 7 at Q1 26/27

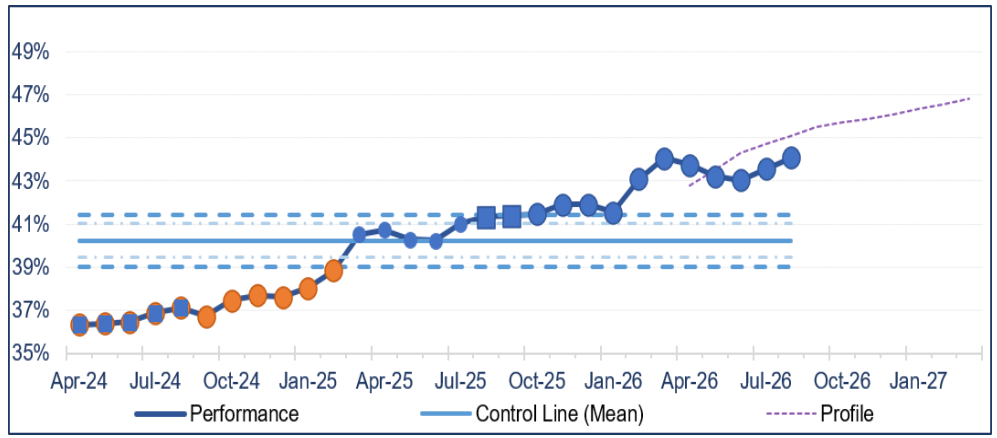
Latest Month	Profile	Actual	Status
Q1 2026/27	N/A	70.8%	Advise



Percentage of patients (*adults) with diabetes who received all eight NICE recommended care processes

SM De-Escalation	N/A	Framework	N/A	Latest Benchmark	N/A

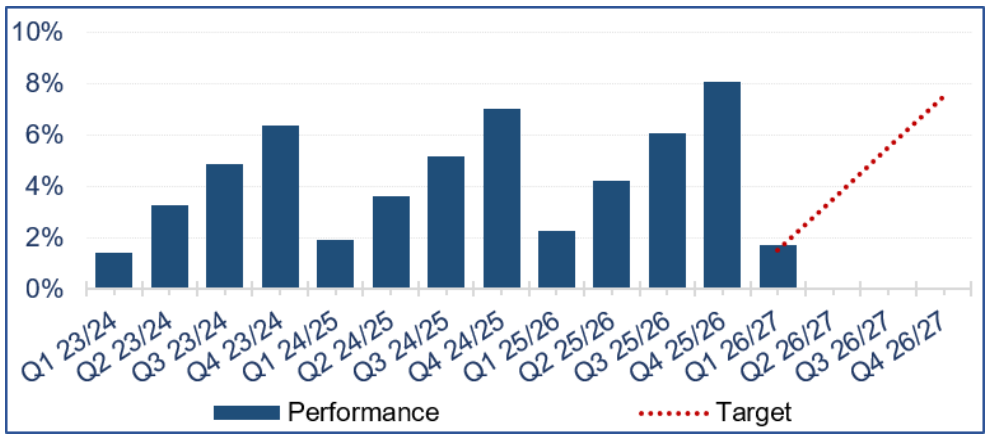
Latest Month	Profile	Actual	Status
September 2026	45.5%	44.1%	Alert



Percentage of adult smokers who make a quit attempt via smoking cessation services

SM De-Escalation	N/A	Framework	7.5% Annual	Latest Benchmark	BCU ranked 3rd out of 7 at Q1 26/27

Latest Month	Profile	Actual	Status
Q1 2026/27	1.5%	1.7%	Assure



Section 4
People and places



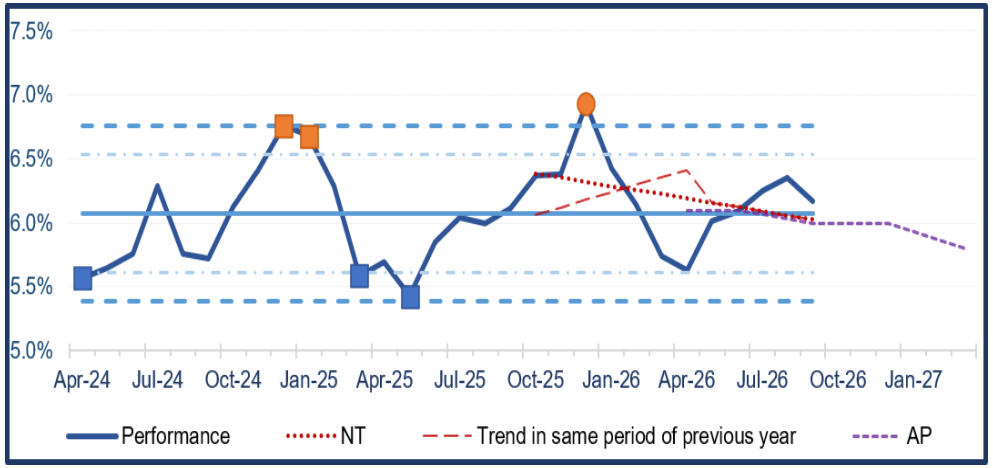
Scorecard: People and places

REF	Measure Description	Target Suite			Wales Benchmark	Actual Performance				Status
		NT	SM	AP		Jul-26	Aug-26	Sep-26	6 Month Activity	
NPF36	Percentage of sickness absence rate of staff (month by month)	YoY↓	-	6.0%	7th of 13 (at Jul 26)	6.25%	6.35%	6.17%		Advise
LMW05	Percentage of headcount by organisation who have had a Personal Appraisal and Development Review (PADR) in the previous 12months (excluding medical appraisal,	-	-	-	6th of 13 (at Jan 26)	79.9%	80.3%	80.1%		Assure
LMW06	Percentage compliance for all completed level 1 competencies of the Core Skills and Training Framework by organisation	-	-	-	N/A	90.5%	90.3%	90.2%		Assure
LMW07 (NPF37*)	Turnover rate for nurse and midwifery registered staff leaving BCUHB (monthly, not 12 month rolling figure)	-	-	-	N/A	0.60%	0.56%	0.60%		Assure

Percentage of sickness absence rate of staff (month by month data)

SM De-Escalation	N/A	Framework	*comparative 12-month reduction	Latest Benchmark	BCU ranked 3rd of 13 at April 2026

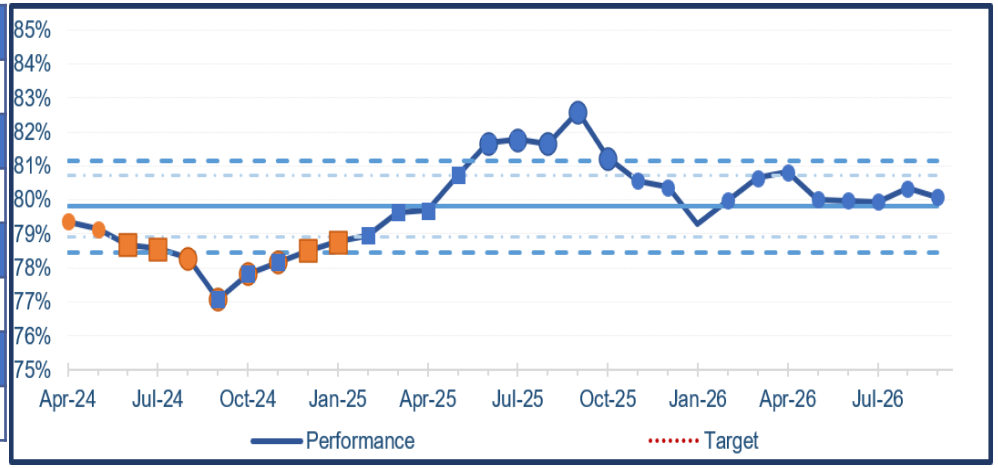
Latest Month
Sept 2026
Profile
6.1%
Actual
6.1%
Status
Alert



Percentage of Performance Appraisal Development Reviews (PADRs) undertaken

SM De-Escalation	N/A	Framework	N/A	Latest Benchmark	N/A

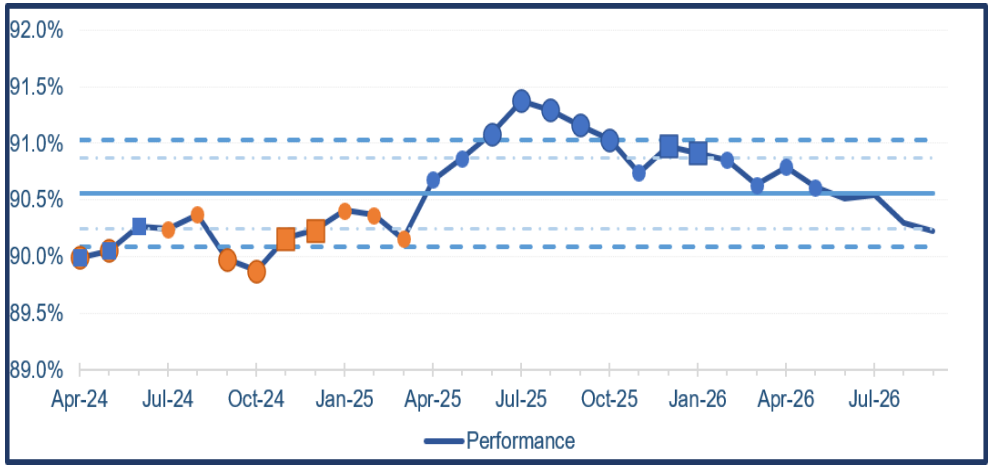
Latest Month
Sept 26
Profile
N/A
Actual
80.1%
Status
Advise



Percentage of staff who are up to date with all appropriate L1 mandatory training

SM De-Escalation	N/A	Framework	N/A	Latest Benchmark	N/A

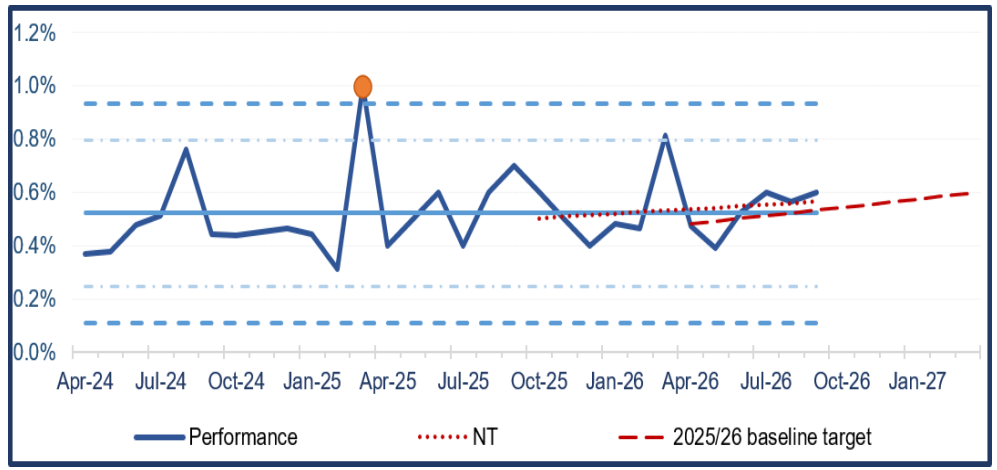
Latest Month
Sept 26
Profile
N/A
Actual
90.2%
Status
Advise



Turnover Rate of those leaving BCUHB (month by month data)

SM De-Escalation	N/A	Framework	*comparative 12-month reduction	Latest Benchmark	N/A

Latest Month
Sept 26
Profile
N/A
Actual
0.60%
Status
Advise



Section 5
Finance and sustainability



Scorecard: Finance and sustainability (1 of 2)

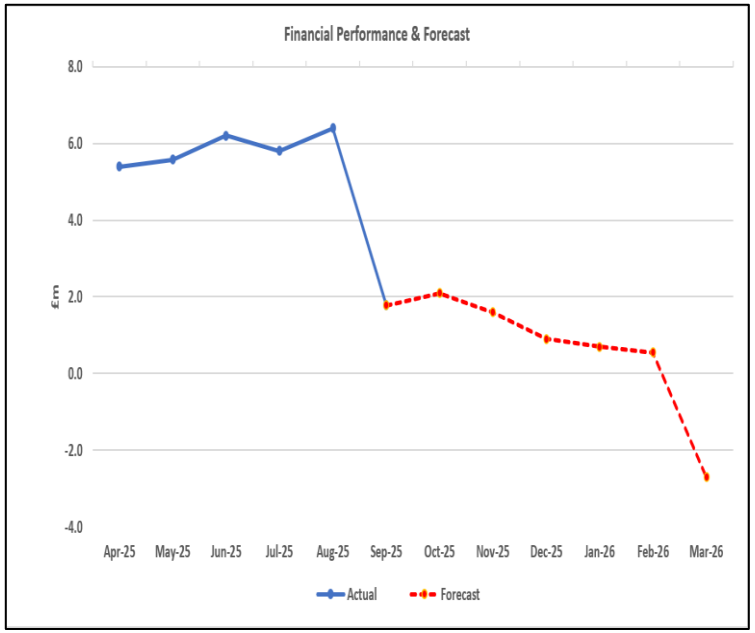
REF	Measure Description	Target Suite			Wales Benchmark	Actual Performance				Status
		NT	SM	AP		Jul-26	Aug-26	Sep-26	6 Month Activity	
LMF01	In-month revenue position (expenditure over planned deficit of £3.6m per month £m)	3.6	-	-	N/A	2.2	2.8	2.6		Escalate
LMF	Year to date revenue position (expenditure over planned year to date deficit) (£m)	-	-	-	N/A	8.6	11.4	14.0		Escalate
LMF	Year to date pay position (expenditure over planned year to date deficit) (£m)	-	-	-	N/A	2.7	5.5	6.8		Escalate
LMF	Year to date non pay position (expenditure over planned year to date deficit) (£m)	-	-	-	N/A	8.0	8.5	10.8		Escalate
LMF	Year to date income position (income over planned year to date deficit) (£m)	-	-	-	N/A	-2.1	-2.6	-3.6		Assure
LMF	In-month accountancy gains (£m)	-	-	-	N/A	1.1	0.7	0.1		Assure
LMF03	Budget releasing savings (£m)	46	-	-	N/A	28.2	31.8	33.6		Escalate
LMF	Full year effect of recurrent budget releasing savings (£m)	46	-	-	N/A	23.0	27.3	27.9		Escalate
4GP01	Deliverable green schemes full year forecast (including accountancy gains) (£m)	46	-	-	N/A	43.9	47.5	53.0		Assure
LMF	Forecast delivery against identified green savings plans	100%	-	-	N/A	102.0%	104.2%	105.8%		Assure
LMF	Full year effect of recurrent green deliverable savings (£m)	46	-	-	N/A	31.5	32.6	33.2		Escalate
LMF02	Value and sustainability forecast (including red and pipeline) (£m)	46	-	-	N/A	55.6	58.4	58.2		Assure
NPF38	Agency forecast reduction (30% reduction in 2026-27 from 2025-26 outturn)	-30%	-	-	13th of 13 (at Aug 26)	-21.1%	-23.2%	-22.4%		Escalate
LMF	Additional clinical services agency expenditure (£'000)	-	-	-	N/A	0.3	0.0	0.1		Escalate
LMF	A&C agency expenditure (£'000)	-	-	-	N/A	0.1	0.4	0.6		Escalate

Scorecard: Finance and sustainability (2 of 2)

REF	Measure Description	Target Suite			Wales Benchmark	Actual Performance				Status
		NT	SM	AP		Jul-26	Aug-26	Sep-26	6 Month Activity	
LMF	Estates & facilities agency expenditure (£'000)	-	-	-	N/A	0.0	-0.5	0.0		Assure
LMF	Forecast closing cash balance (£m)	-	-	-	N/A	-36.5	-36.5	-27.7		Escalate
LMF04	Year to date capital spend (£m)	58.6	-	-	N/A	2.8	7.1	9.1		Assure
LMF	Forecast capital spend (£m)	60.0	-	-	N/A	60.0	60.0	60.0		Assure
LMF	Accountability agreements - % signed	100%	-	-	N/A	91.0%	91.0%	92.0%		Advise
LMF	Invoices on hold quantity	-	-	-	N/A	8112	7754	8403		Alert
LMF	Invoices on hold value (£m)	-	-	-	N/A	14.6	13.9	14.8		Alert
LMF	No PO no pay quantity	0	-	-	N/A	875	1035	973		Alert
LMF	No PO no pay value (£'000)	0	-	-	N/A	2.0	1.9	1.8		Alert
LMF	PO breaches (£'000)	0	-	-	N/A	1.7	0.3	0.4		Alert
LMF	Staff overpayments (£'000)	0	-	-	N/A	0.05	0.06	0.03		Assure
LMF05	Cumulative PSPP Target: Non-NHS invoices paid within 30 days by number	95%	-	-	N/A	-	-	97.3%	Quarterly	Assure
LMF06	Cumulative PSPP Target: Non-NHS invoices paid within 30 days by value	95%	-	-	N/A	-	-	98.4%	Quarterly	Alert
LMF07	Cumulative PSPP Target: NHS invoices paid within 30 days by number	95%	-	-	N/A	-	-	88.3%	Quarterly	Assure
LMF08	Cumulative PSPP Target: NHS invoices paid within 30 days by value	95%	-	-	N/A	-	-	96.8%	Quarterly	Alert

Revenue Position

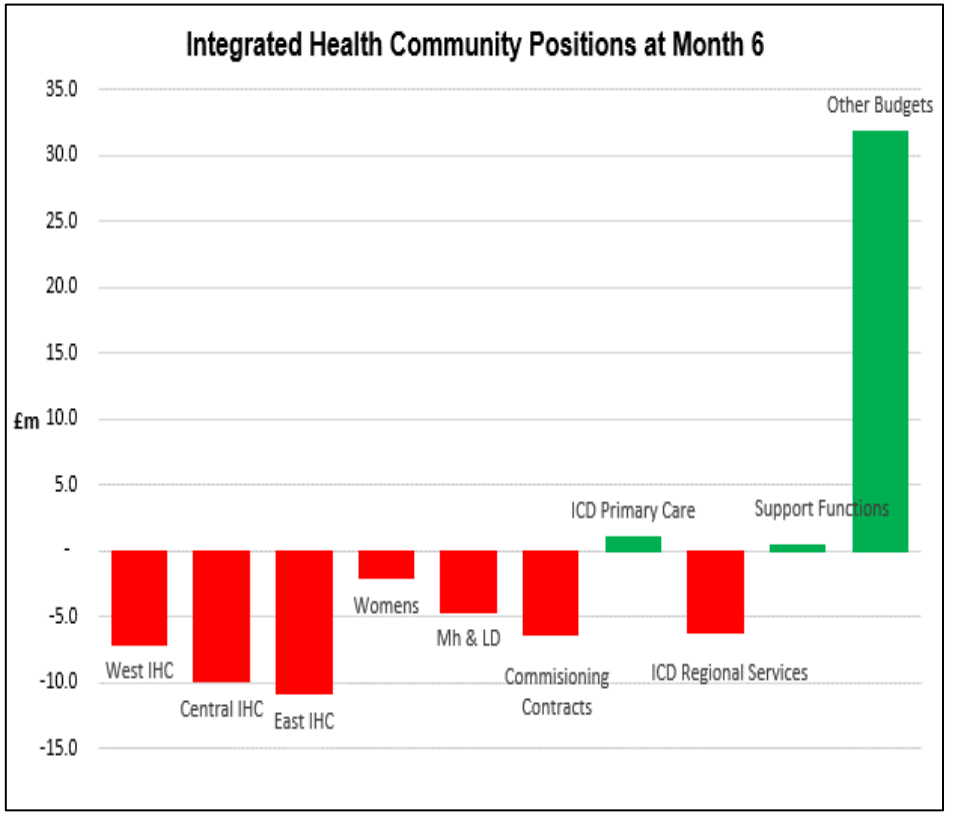
	Actual						Forecast						2026/27 Cumulative against Plan			
	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	Budget	Actual	Variance	Variance
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	%
Revenue Resource Limit	(197.0)	(197.3)	(200.1)	(202.7)	(201.4)	(205.5)	(201.4)	(200.4)	(202.3)	(201.2)	(199.1)	(209.4)	(1,204.1)	(1,204.1)	**0.0**	0.0%
Miscellaneous Income	(14.7)	(15.4)	(15.3)	(16.1)	(15.7)	(16.1)	(15.7)	(15.7)	(15.6)	(15.8)	(15.7)	(18.5)	(89.6)	(93.2)	**(3.6)**	4.0%
Health Board Pay Expenditure	101.6	102.4	104.9	102.9	103.4	103.7	100.3	100.1	99.9	100.3	99.8	100.1	612.1	618.9	**6.8**	1.1%
Non-Pay Expenditure	115.5	115.9	116.7	121.7	120.1	119.6	119.0	117.7	119.0	117.4	115.5	125.0	681.6	709.5	**27.9**	4.1%
Total Deficit / (Surplus)	**5.4**	**5.6**	**6.2**	**5.8**	**6.4**	**1.8**	**2.1**	**1.6**	**0.9**	**0.7**	**0.5**	**(2.7)**	**0.0**	**31.1**	**31.1**	
Planned Deficit	**3.6**	**3.6**	**3.6**	**3.6**	**3.6**	**(0.8)**	**2.9**	**2.9**	**2.9**	**2.9**	**2.9**	**2.9**	**17.1**	**0.0**	**17.1**	**100.00%**
Total Deficit / (Surplus) above Plan	**1.8**	**2.0**	**2.6**	**2.2**	**2.8**	**2.6**	**(0.8)**	**(0.7)**	**(2.0)**	**(2.2)**	**(2.3)**	**(5.6)**	**17.1**	**31.1**	**14.0**	



- The planned deficit has reduced from £43.0m deficit to £34.3m, following a £8.7m reduction in the forecast contribution to the Welsh Risk Pool, treatment in line with Welsh Government instructions.
- As at the end of September the Health Board is reporting an in-month deficit of £1.8m, following the £4.4m favourable adjustment arising from the Welsh Risk Pool contribution. Year-to-date deficit is £31.1m, and £14.0m adverse to plan demonstrating that the underlying financial performance remains a significant challenge. Recovery actions identified to date are insufficient to restore the run rate to plan or recover the accumulated overspend and further work is urgently required.
- A recovery plan is being developed with IHC's and Services requested to identify a 1% reduction in forecast run rate, close the remaining gap against budget reducing savings requirements. These actions are intended to support a reduction in the current monthly cost overrun of circa £2.3m and recover the £14.0m year to date deficit above plan. As the recovery plan is still being developed, delivery remains subject to a high degree of risk.
- In parallel, identification of further opportunities are also required to reduce expenditure by an additional £17m, which subject to costs returning to the revised plan, would release additional Welsh Government funding and provide a credible route to support delivery of financial balance in 2026-27.

Divisional Positions

	In Month				Cumulative				Forecast Year End Variance against the Planned Deficit
	Budget £m	Actual £m	Variance to Plan £m	Variance to Plan %	Budget £m	Actual £m	Variance to Plan £m	Variance to Plan %	
WG RESOURCE ALLOCATION	(205.5)	(205.5)	0.0	0%	(1,204.1)	(1,204.1)	0.0	0%	0.0
WEST INTEGRATED HEALTH COMMUNITY									
Management	0.1	0.1	0.0		0.7	0.7	0.0		0.2
West Area	18.6	19.2	(0.6)		110.9	113.5	(2.5)		(6.8)
Ysbyty Gwynedd	12.6	13.3	(0.7)		75.5	79.7	(4.2)		(8.7)
Facilities	1.2	1.3	(0.1)		7.4	7.8	(0.4)		(0.8)
Total West	32.5	33.9	(1.4)	-4%	194.5	201.6	(7.1)	-4%	(16.1)
CENTRAL INTEGRATED HEALTH COMMUNITY									
Management	0.1	0.1	0.0		0.9	0.8	0.0		0.0
Central Area	24.6	25.6	(1.0)		145.0	149.1	(4.1)		(12.1)
Ysbyty Glan Clwyd	15.7	16.9	(1.1)		93.3	98.9	(5.7)		(13.2)
Facilities	1.5	1.6	(0.0)		9.2	9.3	(0.2)		(0.4)
Total Central	42.0	44.1	(2.1)	-5%	248.3	258.3	(9.9)	-4%	(25.7)
EAST INTEGRATED HEALTH COMMUNITY									
Management	0.1	0.1	0.0		0.6	0.6	0.0		0.1
East Area	27.1	28.3	(1.2)		162.0	167.8	(5.9)		(13.5)
Ysbyty Wrexham Maelor	13.5	14.2	(0.8)		80.2	85.0	(4.8)		(9.7)
Facilities	1.4	1.4	(0.0)		8.4	8.6	(0.2)		(0.4)
Total East	42.1	44.1	(2.0)	-5%	251.1	262.0	(10.9)	-4%	(23.5)
Total Midwifery and Women's Services	4.4	4.8	(0.4)	-10%	26.6	28.7	(2.1)	-8%	(3.7)
Total Mental Health and LDS	16.4	17.1	(0.7)	-4%	99.6	104.3	(4.7)	-5%	(9.6)
Total Commisioning Contracts	26.6	27.1	(0.5)	-2%	163.7	170.1	(6.4)	-4%	(14.5)
INTEGRATED CLINICAL DELIVERY PRIMARY CARE									
Dental North Wales	2.6	3.0	(0.4)		18.2	17.9	0.4		0.0
Community Dental Services	0.6	0.6	(0.0)		3.8	3.6	0.2		0.4
Other Primary Care	0.1	(0.2)	0.4		0.7	0.3	0.4		0.3
Total Integrated Clinical Delivery Primary care	3.4	3.4	(0.1)	-2%	22.8	21.8	1.0	4%	0.7
INTEGRATED CLINICAL DELIVERY REGIONAL SERVICES									
Provider Income	(1.9)	(2.2)	0.2		(11.5)	(13.5)	2.0		3.1
Diagnostic and Specialist Clinical Support	7.8	8.4	(0.6)		45.8	50.4	(4.5)		(10.3)
Cancer Services	6.5	7.2	(0.7)		38.2	41.8	(3.6)		(6.6)
Total Integrated Clinical Delivery	12.3	13.4	(1.1)	-9%	72.6	78.7	(6.1)	-8%	(13.8)
Total Service Support Functions	15.7	15.5	0.1	1%	91.9	91.5	0.5	1%	(0.8)
Total Other Budgets	9.4	3.7	5.7	61%	50.0	18.3	31.8	64%	107.0
Total Health Board Position	**(0.8)**	**1.8**	**(2.6)**		**17.1**	**31.1**	**(14.0)**		**0.0**



- Year-to-date position is reporting a deficit of £31.1m, £14.0m adverse to the planned year to date £17.1m deficit.
- As at Month 6 the 2026/27 forecast position has reduced from the £43.0m deficit to a planned deficit of £34.3m.
- Further detail on Pay and Non-Pay spend is reported in Slide 6 and 11.

Expenditure – Pay & Non-Pay

Pay Costs	2026-27												Cumulative			Full Year Forecast
	Actual						Forecast									
	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	YTD Budget	YTD Actual	YTD Variance	
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Administrative & Clerical	14.0	13.9	13.9	13.7	13.9	13.8	14.4	14.4	14.3	14.4	14.3	14.4	94.9	83.2	11.6	175.0
Medical & Dental	23.3	23.5	25.5	24.5	24.9	24.5	22.6	22.6	22.5	22.6	22.5	22.6	135.1	146.2	(11.1)	275.2
Nursing & Midwifery Registered	31.2	31.5	31.9	31.2	31.3	31.7	30.9	30.8	30.8	30.9	30.7	30.8	185.6	188.7	(3.2)	375.4
Additional Clinical Services	15.3	15.6	15.6	15.9	15.9	15.6	15.2	15.2	15.2	15.2	15.1	15.2	90.2	93.9	(3.7)	185.0
Add Prof Scientific & Technical	4.4	4.4	4.4	4.3	4.3	4.5	4.0	4.0	4.0	4.0	4.0	4.0	27.3	26.3	1.0	48.8
Allied Health Professionals	6.8	6.8	6.9	6.7	6.6	6.9	6.6	6.6	6.6	6.6	6.6	6.6	39.0	40.7	(1.7)	80.7
Healthcare Scientists	1.9	1.9	1.9	1.9	1.9	1.9	1.7	1.7	1.7	1.7	1.7	1.7	11.4	11.3	0.1	20.6
Estates & Ancillary	4.6	4.7	4.7	4.6	4.6	4.8	4.7	4.7	4.7	4.7	4.7	4.7	28.0	28.0	0.0	57.6
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	0.6	0.5	0.0	1.1
Health Board Total	**101.6**	**102.4**	**104.9**	**102.9**	**103.4**	**103.7**	**100.3**	**100.1**	**99.9**	**100.3**	**99.8**	**100.1**	**612.1**	**618.9**	**(6.8)**	**1219.4**
Other Services (Incl. Primary Care)	3.2	3.2	3.3	3.3	3.1	3.4	3.2	3.2	3.2	3.2	3.2	3.2	17.3	19.4	(2.1)	38.9
Total Pay	**104.7**	**105.6**	**108.2**	**106.3**	**106.5**	**107.1**	**103.5**	**103.3**	**103.2**	**103.5**	**103.1**	**103.4**	**629.4**	**638.4**	**(8.9)**	**1258.3**

Non-Pay Costs	2026-27												Cumulative			Full Year Forecast
	Actual						Forecast									
	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	YTD Budget	YTD Actual	YTD Variance	
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Primary Care Contractor (excluding drugs, including non resource limited expenditure)	22.3	22.2	22.0	22.5	22.8	22.4	22.6	22.6	22.6	22.7	22.7	22.7	136.9	134.3	2.6	270.3
Primary Care - Drugs & Appliances	11.1	10.6	11.8	12.8	12.3	12.7	11.7	11.2	12.1	11.2	10.8	11.4	68.2	71.3	(3.1)	139.7
Provider Services - Non Pay (excluding drugs & depr	20.1	19.6	20.1	20.8	18.5	21.1	20.2	20.5	20.5	20.1	19.8	16.6	98.3	120.1	(21.7)	237.8
Secondary Care - Drugs	9.2	9.1	9.3	10.6	8.9	10.0	9.1	8.9	9.2	8.9	8.6	8.9	57.4	57.0	0.4	110.6
Healthcare Services Provided by Other NHS Bodies	33.4	33.9	33.7	33.9	36.3	33.7	34.2	34.0	33.9	33.9	33.9	34.4	203.7	204.8	(1.1)	409.2
Continuing Care and Funded Nursing Care	11.9	12.4	12.6	13.0	12.9	11.8	12.0	11.7	12.0	12.0	11.1	12.0	72.5	74.6	(2.1)	145.5
Other Private & Voluntary Sector	3.5	3.5	2.8	3.2	2.8	2.7	4.1	3.8	3.7	3.6	3.6	3.6	17.7	18.6	(0.9)	41.1
Joint Financing and Other	0.5	0.4	0.4	0.3	0.4	0.4	0.3	0.3	0.3	0.3	0.3	0.3	1.6	2.3	(0.7)	4.1
Losses, Special Payments and Irrecoverable Debts	0.3	0.3	0.6	0.2	0.9	0.6	0.4	0.4	0.4	0.4	0.4	0.4	1.5	2.9	(1.4)	5.1
Non-pay costs	**112.3**	**112.1**	**113.2**	**117.4**	**115.6**	**115.3**	**114.7**	**113.4**	**114.7**	**113.2**	**111.2**	**110.3**	**657.9**	**685.9**	**(27.9)**	**1363.3**
AME/DEL Depreciation	3.2	3.9	3.5	4.3	4.5	4.3	4.3	4.3	4.3	4.3	4.3	14.7	23.6	23.6	(0.0)	59.8
Total non-pay	**115.5**	**115.9**	**116.7**	**121.7**	**120.1**	**119.6**	**119.0**	**117.7**	**119.0**	**117.4**	**115.5**	**125.0**	**681.6**	**709.5**	**(27.9)**	**1423.1**

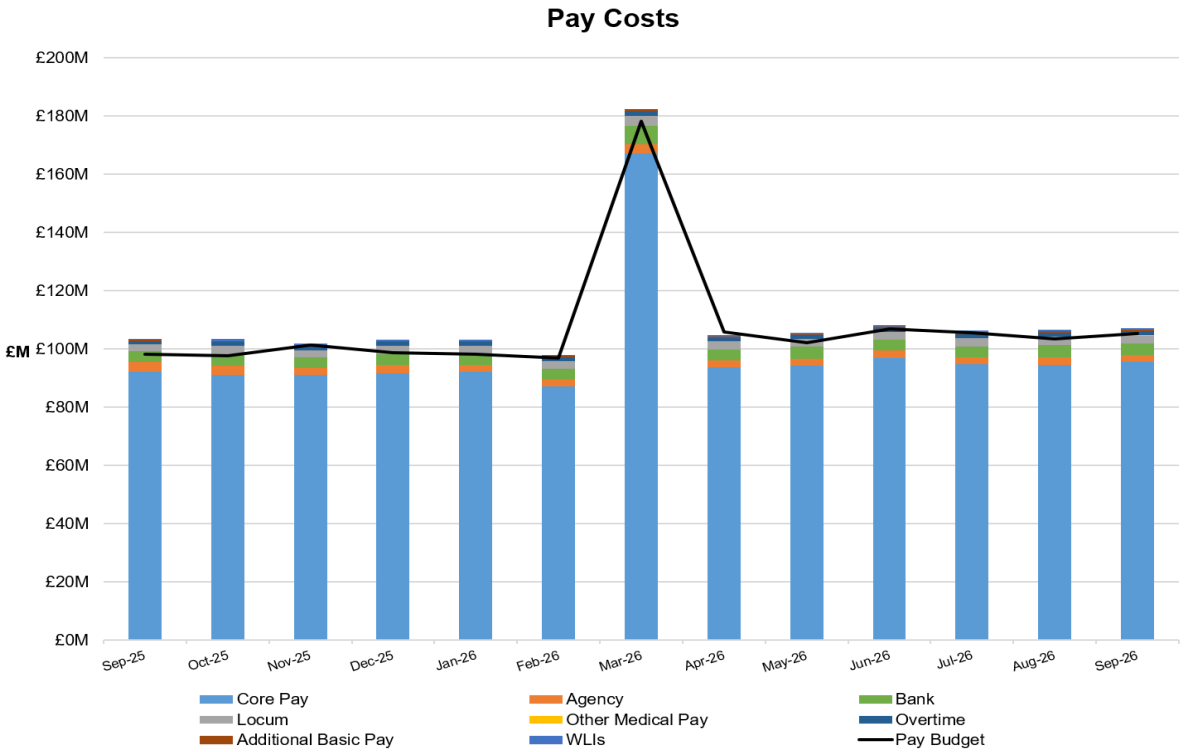
Health Board Pay:

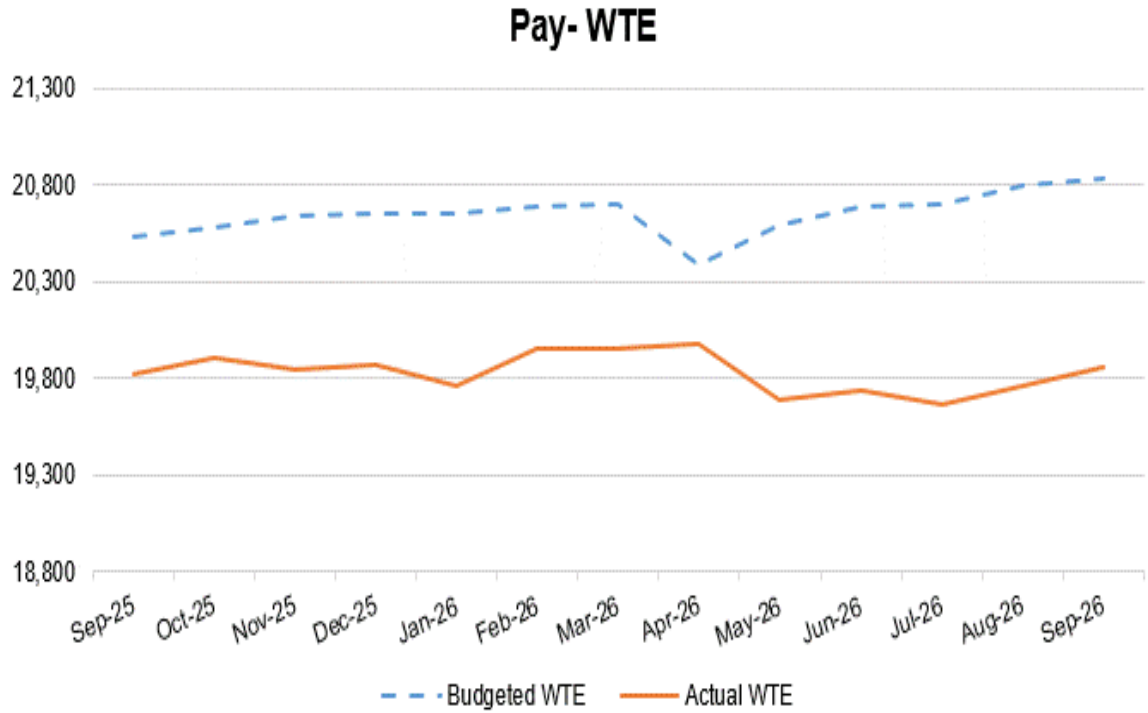
- Month 6 Provider Services Pay increased by £0.3m (0.3%) from previous month with the increase being predominantly reported in core pay.
- Variable Pay totals £11.4m for September, a reduction of £0.5m from previous month driven by reductions of £0.2m Agency, £0.2m Bank and £0.2m Locum, offset by an increase £0.1m in Overtime.
- Other detail on Variable Pay is reported in Slide 7 and Agency in Slide 9.

Non-Pay Expenditure (excluding Depreciation):

- Total Non-Pay expenditure (excluding AME/DEL Depreciation) decreased by £0.3m from previous month.
- Further detail on Non-Pay expenditure movements is reported in Slide 11.

Expenditure - Pay





Variable Pay	2025-26 M11 £m	2025-26 M12 £m	2026-27 M01 £m	2026-27 M02 £m	2026-27 M03 £m	2026-27 M04 £m	2026-27 M05 £m	2026-27 M06 £m	Total £m
Agency	2.3	3.1	2.5	2.5	2.6	2.4	2.5	2.3	14.8
Overtime	1.4	1.6	1.2	1.2	1.3	1.3	1.4	1.4	7.7
Locum	2.5	3.3	2.7	2.8	2.6	2.9	2.9	2.7	16.6
WLIs	0.4	0.4	0.4	0.4	0.5	0.7	0.5	0.5	3.1
Bank	3.7	6.5	3.7	4.0	3.8	3.7	4.2	4.0	23.4
Other Non Core	0.1	0.5	0.0	0.1	0.0	0.1	0.0	0.0	0.3
Additional Hours	0.4	0.4	0.5	0.4	0.4	0.4	0.5	0.5	2.7
Total	**10.8**	**15.8**	**11.1**	**11.3**	**11.4**	**11.5**	**11.9**	**11.4**	**68.6**

- September budgeted WTE increased 33 WTE from August. See Slide 8 for further detail.
- Variable Pay totals £11.4m for September, a reduction of £0.5m from previous month, driven by reductions of £0.2m Agency, £0.2m Bank and £0.2m Locum, offset by a £0.1m increase in Overtime.

Pay - WTE

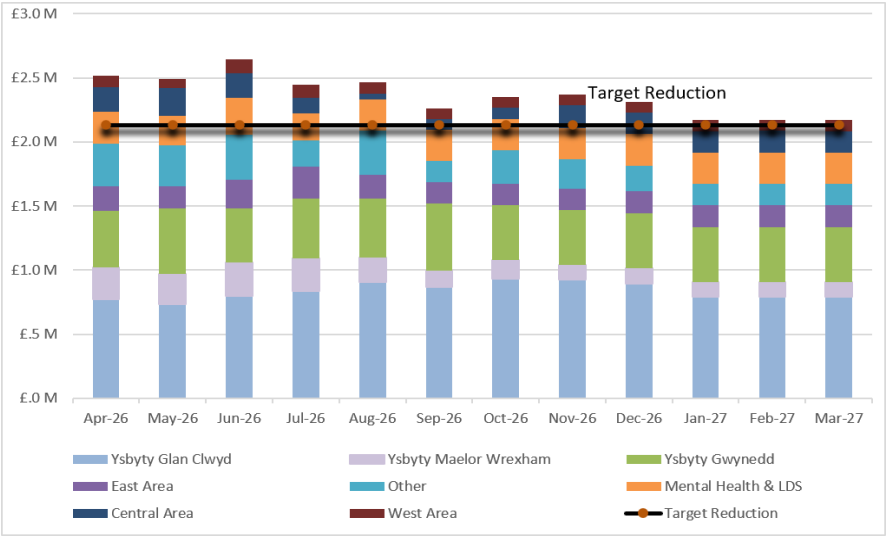
	2025/26						2026/27						
	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Movement M4 V M3
Budgeted WTE	20,575	20,637	20,649	20,656	20,693	20,705	20,384	20,593	20,688	20,704	20,794	20,827	33
Actual WTE	19,907	19,844	19,869	19,767	19,952	19,951	19,978	19,691	19,740	19,663	19,764	19,853	89

- Budgeted WTE increased by 33 WTE in September from previous month, with the below table providing further detail on Budgeted WTE movements.
- Actual worked in September is 19,853, an increase of 89 WTE from August.

	25/26 WTE Budget							26/27 WTE Budget							
	M06 Sep	M07 Oct	M08 Nov	M09 Dec	M10 Jan	M11 Feb	M12 Mar	M01 Apr	M02 May	M03 Jun	M04 Jul	M05 Aug	M06 Sep	In Month Movement	Explanation of movements (>5wte) from previous month
West IHC - Management	8	8	8	8	8	8	8	8	8	8	8	8	8	0	
West IHC - West Area	1,568	1,575	1,572	1,572	1,572	1,573	1,573	1,567	1,585	1,589	1,590	1,595	1,586	-9	-8.32wte budget transfer with contra in Corporate (Vaccination team) and net effect nil to BCU,-0.50WTE negative budget housekeeping, -0.60WTE correction to contract funding and 0.20WTE skill mix virement
West IHC - Ysbyty Gwynedd	1,829	1,839	1,838	1,840	1,841	1,846	1,855	1,836	1,885	1,913	1,912	1,908	1,920	12	Virement to correct WTE in line with deanery funded posts, SLE Spec Reg +10WTE, F2 +1WTE, F1 +1WTE, Spec Reg -1.72WTE, additional 0.61WTE drawn for EC business case and budget for 1.00WTE Band 7 not drawn down in M5 (VBHC Funding)
West IHC - Facilities	380	382	382	382	382	382	382	382	382	382	382	382	382	0	
Centre IHC - Management	7	8	8	8	8	14	14	15	15	17	17	17	17	0	LLGH Hub: +0.60 wte new recruitment with funding from reserves
Centre IHC - Central Area	2,304	2,312	2,310	2,309	2,303	2,307	2,307	2,263	2,296	2,296	2,293	2,295	2,302	7	3.75WTE new posts funded from HEIW (Pharmacy, GMS & PCSM), 2.16WTE posts funded from Workforce Capacity (GMS), 0.99WTE skill mix to aid recruitment (across IHC)
Centre IHC - Ysbyty Glan Clwyd	2,239	2,241	2,243	2,245	2,245	2,248	2,250	2,243	2,256	2,258	2,260	2,257	2,257	0	
Centre IHC - Facilities	422	422	422	421	421	419	419	420	420	420	420	420	420	0	
East IHC - Management	10	10	10	10	10	10	10	10	10	10	10	10	10	0	
East IHC - East Area	2,466	2,476	2,483	2,485	2,481	2,485	2,484	2,470	2,479	2,508	2,513	2,513	2,515	2	
East IHC - Ysbyty Wrexham Maelor	1,896	1,906	1,954	1,962	1,970	1,971	1,972	1,908	1,963	1,962	1,964	2,046	2,052	6	3.80WTE ED Housekeepers omitted from Business Case; 1.00WTE escalated beds funding; 1.00WTE Anaesthetics business case funding
East IHC - Facilities	365	365	365	365	365	365	366	365	365	365	366	366	366	0	
Midwifery & Womens Services	694	694	695	696	696	696	695	684	687	693	695	694	694	0	
Mental Health & LDS	2,320	2,319	2,327	2,327	2,326	2,327	2,331	2,299	2,324	2,347	2,348	2,346	2,348	2	
COVID Programmes	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Dental GDS	14	14	14	14	14	14	14	14	14	15	15	15	15	0	
Dental CDS	169	168	168	167	165	165	165	166	166	166	166	166	167	1	
Other Primary Care	15	15	15	15	15	15	15	15	15	15	15	15	15	-1	Audiology training posts - Offset with income via HEIW
Diagnostics & SCS	1,020	1,024	1,028	1,028	1,029	1,031	1,030	1,023	1,023	1,024	1,024	1,027	1,034	7	Audiology Training Posts – Offset with income via HEIW
Cancer Services	424	423	423	423	424	423	423	423	425	425	425	425	424	-1	
Corporate	2,255	2,251	2,249	2,249	2,255	2,269	2,265	2,147	2,146	2,151	2,152	2,154	2,162	8	8.32WTE Vaccination Team transfer from West Area
Med ED/R&D	122	123	124	125	125	125	127	126	126	123	132	135	135	0	
Health Board Total	**20,527**	**20,575**	**20,637**	**20,650**	**20,656**	**20,693**	**20,705**	**20,384**	**20,591**	**20,688**	**20,704**	**20,794**	**20,827**	**33**	

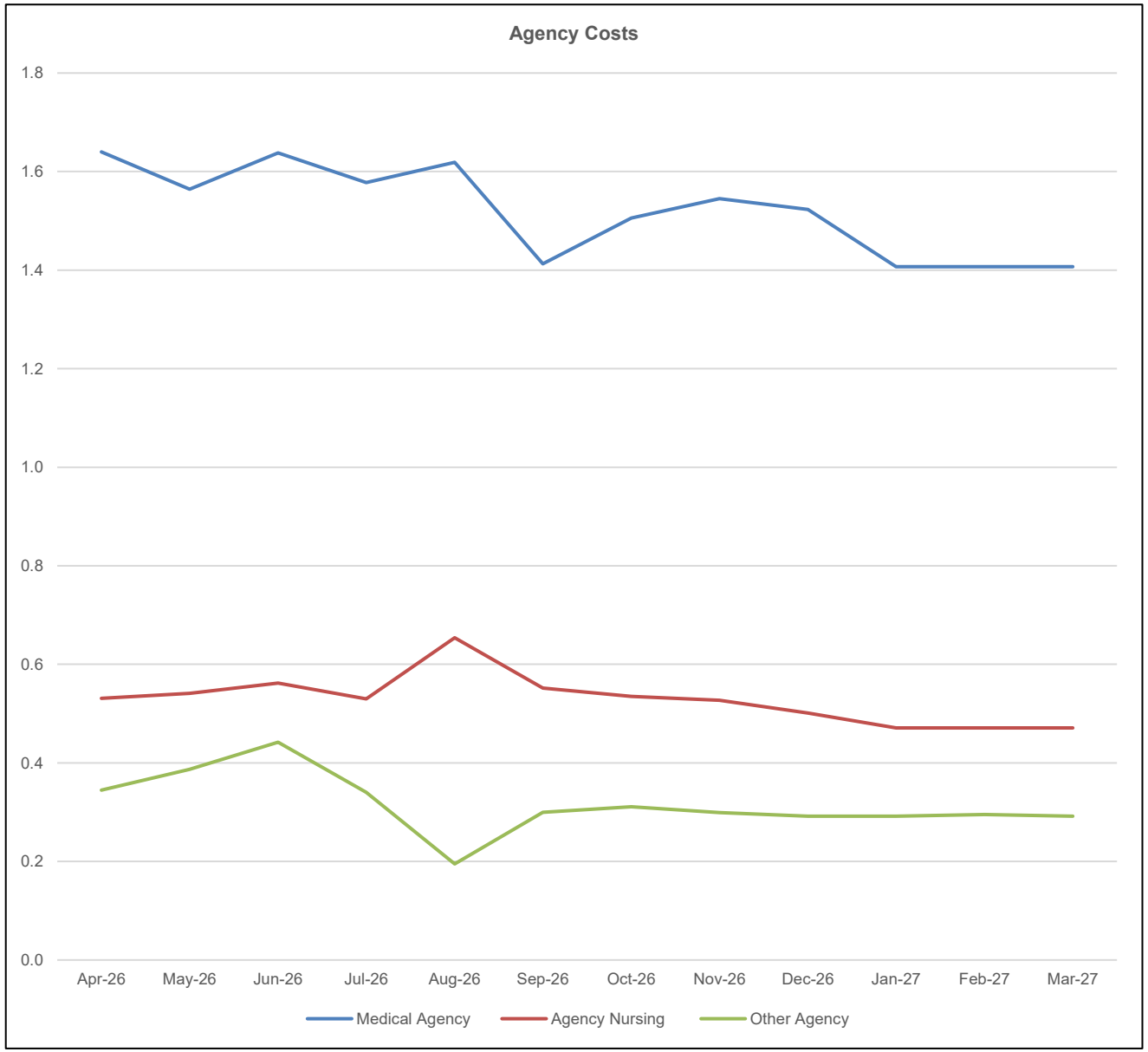
Pay Costs - Agency

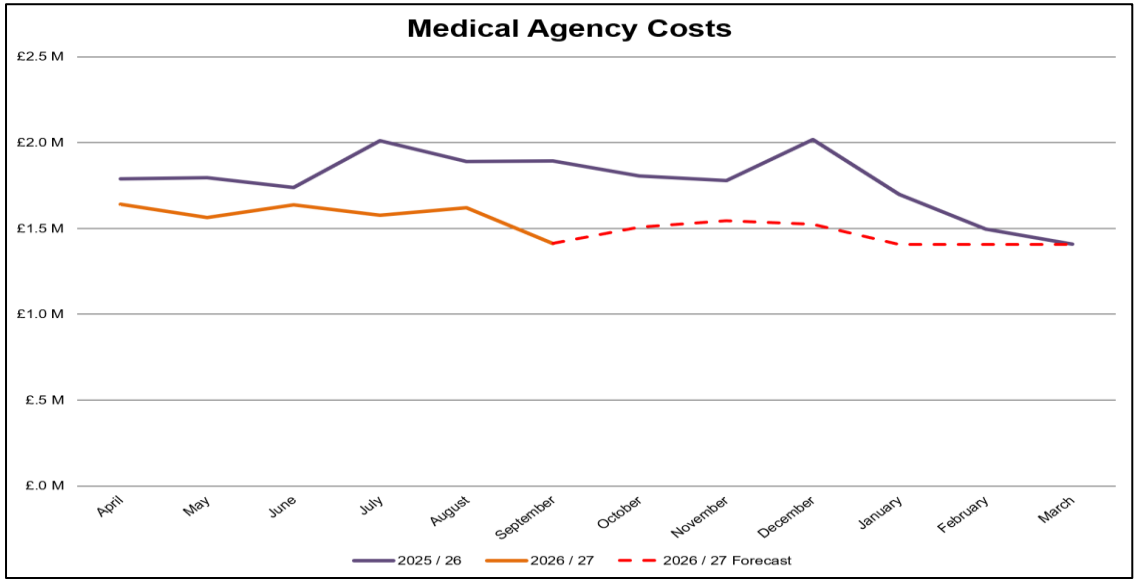
	2026-27 Agency Spend £m												YTD Expenditure £m	2026/27 Forecast £m
	Actual						Forecast							
	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27		
West Area	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.5	1.1
Central Area	0.2	0.2	0.2	0.1	0.0	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.8	1.8
East Area	0.2	0.2	0.2	0.3	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	1.0	2.2
Ysbyty Gwynedd	0.4	0.5	0.4	0.5	0.5	0.5	0.4	0.4	0.4	0.4	0.4	0.4	2.3	5.4
Ysbyty Glan Clwyd	0.8	0.7	0.8	0.8	0.9	0.9	0.9	0.9	0.9	0.8	0.8	0.8	4.0	10.0
Ysbyty Maelor Wrexham	0.3	0.2	0.3	0.3	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.1	1.2	2.0
Mental Health & LDS	0.2	0.2	0.3	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	1.2	2.9
Womens	0.1	0.1	0.1	0.1	0.1	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.6	1.0
Other incl pan BCU Cancer Servcies and Corporate	0.2	0.2	0.2	0.1	0.2	0.2	0.2	0.2	0.1	0.1	0.1	0.1	0.9	1.9
Total Agency	**2.5**	**2.5**	**2.6**	**2.4**	**2.5**	**2.3**	**2.4**	**2.4**	**2.3**	**2.2**	**2.2**	**2.2**	**12.6**	**28.4**

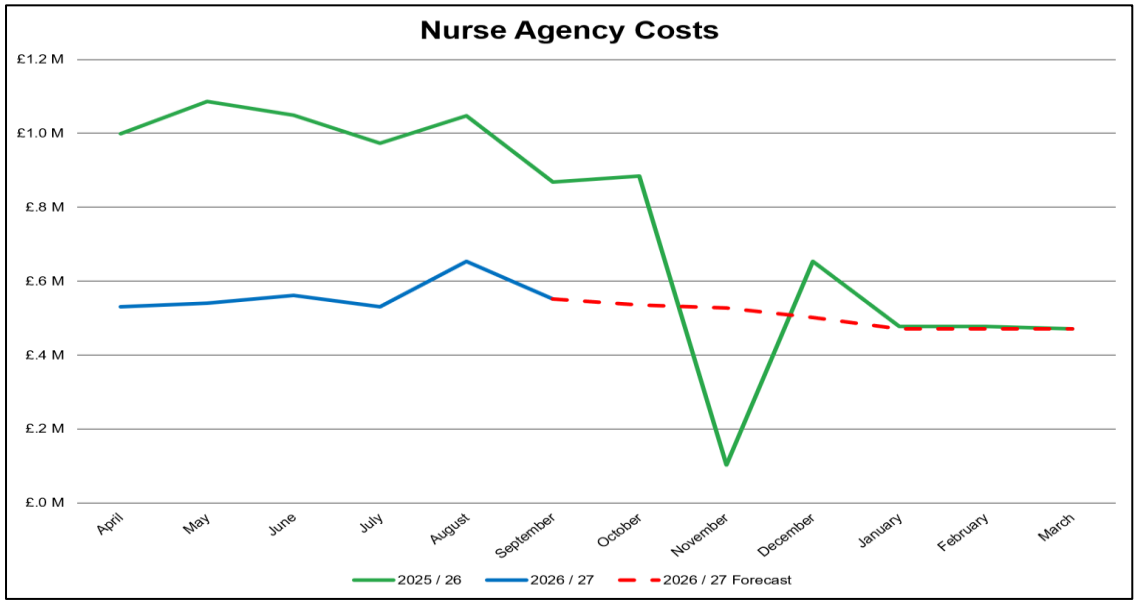


- Agency expenditure for September (Month 6) is £2.3m (2.1% of total pay). In-month spend is reporting a £0.2m reduction from previous month and is £0.8m less compared to the 2025/26 monthly average of £3.0m. 2026/27 Full year Agency forecast outturn is £28.4m (2.3% of total pay), a £0.3m increase from the £28.1m forecast outturn reported at Month 5.
- The 2026/27 agency forecast outturn is forecast to reduce by £8.2m (22.4%) compared to the 2025/26 Agency full year spend of £36.6m. Further reductions of £2.8m (total reduction of £11.0m) would be required to achieve the cabinet secretary enabling target of 30%.
- September (Month 6) Medical Agency expenditure is £1.4m, a reduction of £0.2m from previous month. The monthly average medical agency expenditure for 2025/26 was £1.8m. In-month Medical Agency spend is predominantly within Ysbyty Glan Clwyd (£0.6m), Ysbyty Gwynedd (£0.4m), Mental Health (£0.2m) and Ysbyty Maelor Wrexham (£0.1m) covering medical vacancies and sickness.
- Registered Nurse agency costs totalled £0.6m for the month, a reduction (£0.1m) from previous month spend. In-month Nurse Agency spend is predominantly within Ysbyty Glan Clwyd (£0.3m), Ysbyty Maelor Wrexham (£0.1m), and Ysbyty Gwynedd (£0.1m).
- Other agency costs totalled £0.3m in September, an increase (£0.1m) from previous month spend and is £0.2m less than the 25/26 monthly average. Other Agency costs mainly consist of Allied Health Professionals spend of £0.3m in August.

Pay Costs - Agency







Expenditure – Non-Pay

- **Primary Care Contractor:** September in-month expenditure decreased by £0.4m (1.8%) and is £0.2m less than forecast for the month being predominantly due to a reduction in General Ophthalmic Service expenditure.

- **Primary Care Drugs:** Expenditure is £0.4m higher than previous month and £0.8m higher than forecast, of which £0.3m relates to an under accrual relating to previous months and recent drug tariff updates continue to exert upward pressure on primary care prescribing expenditure.

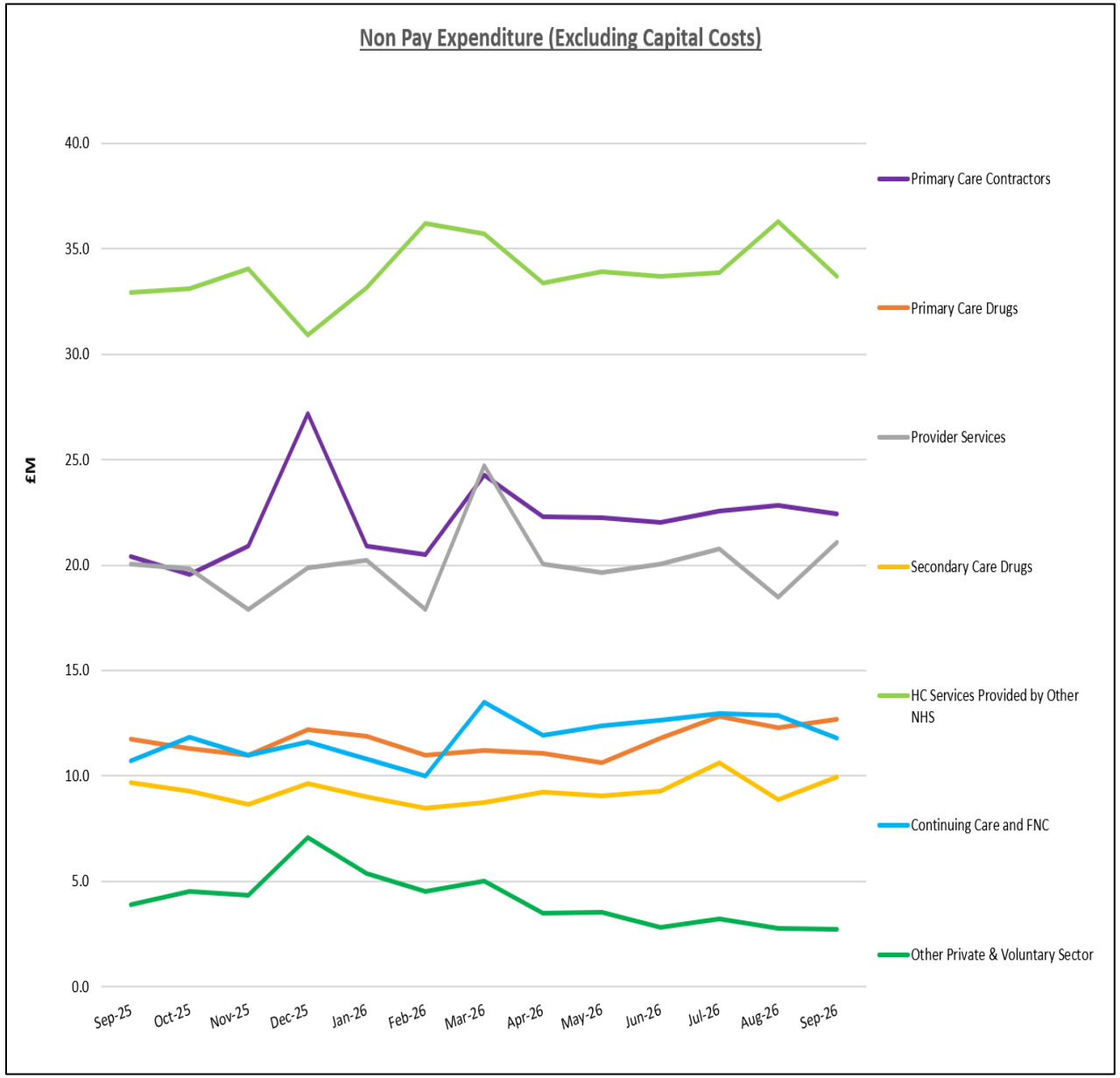
- **Provider Services Non-Pay:** Provider Services Non-Pay spend increased by £2.6m (14.0%) in-month, of which £1.4m is increase in Clinical Services & Supplies spend, 0.4m increase in General Services & Supplies and £0.4m increase in Premises and Fixed Plant expenditure.

- **Secondary Care Drugs:** Expenditure increased by £1.1m (12.2%) from previous month and is £0.9m higher than forecast, of which £0.5m increase is reported in Cancer Services and £0.6m increase reported within Rheumatology and Dermatology specialties across the Area Teams.

- **Healthcare Services provided by Other NHS Bodies**: Expenditure decreased by £2.6m (7.2%) from previous month and is £0.2m less than forecast for the month, with the in-month reduction being due to the £2.4m JCC Vertex backdated quarter 1 spend reported in previous month (August) which was fully funded by WG.

- **Continuing Health Care (CHC) and Funded Nursing Care (FNC):** In-month expenditure decreased by £1.1m and is £0.2m less than forecast for the month, with the reduction being predominantly within MHLD care packages.

- **Other Private & Voluntary Sector:** Expenditure relates to a variety of providers, including Hospices, Mental Health organisations and planned care activity providers.



Risks

- The below are risks to the Health Board's financial position for 2026/27. Where it is clear of specific costs for risks and opportunities, these are incorporated into the forecast position.

	£m	Level
Risks – Pressures not assumed in Forecast Outturn		
Risk of conditionally recurrent funding removed	£82.0m	Low
Risk that Prescribing costs may rise by up to 4% when growth of certain items is included	£2.0m	Medium
Expenditure run rate continues above plan	£12.0m	Medium
Welsh Risk Pool increases above current forecast	£8.8m	Medium
Resident Doctors New contract impact	TBC	High
Impact of new contracts for Dental, GMS and Community Pharmacy	TBC	Medium
Risks – Benefits assumed in the Forecast Outturn		
Non-Delivery of Unplanned Additional required mitigations yet to be finalised	£14.0m	Medium
Total Risks	**£118.8m**	
Opportunities not factored into the Forecast Outturn		
Retaining Band 2/3 Balance Sheet opportunities (Estimated value)	£1.3m	Medium
Conversion of Red & Pipeline Opportunities to Savings	£5.3m	Medium
Additional Opportunities identified as part of the 1% run rate reduction	£9.1m	Medium
Submission from Divisions: Options towards the £17m stretch	£7.0m	Medium
Total Opportunities	**£22.7m**	

Balance Sheet & Cash

- Closing cash balance as at 30th September 2026 was £11.180m, which included £7.324m cash held for revenue expenditure and £3.856m for capital projects.
- The Health Board is currently forecasting a closing cash balance for 2026-27 of (£27.705m) made up of (£31.764m) revenue cash and £4.059m capital cash.
- The forecast closing cash balance assumes working balance support of £4.013m for capital payments relating to Right of Use Assets and £22.935m for movements in revenue balances.
- The Health Board is also currently anticipating that it will need to request £34.271m strategic cash support to match the forecast out-turn position and to return the revenue cash position to the opening balance of £2.507m. All opportunities to reduce this requirement will continue to be explored before the formal submission deadline later in the year.

	Opening Balance Beginning of Apr-26 £'m	Closing Balance End of Sep-26 £'m	Forecast Closing Balance End of Mar-27 £'m
Non-Current Assets			
Property, plant and equipment	812.0	798.5	812.4
Intangible assets	1.2	1.0	1.2
Trade and other receivables	185.3	185.1	185.3
Non-Current Assets sub total	998.5	984.5	998.9
Current Assets			
Inventories	21.7	21.7	21.7
Trade and other receivables	140.7	121.3	122.7
Other financial assets	0.0	0.0	0.0
Cash and cash equivalents	8.0	11.2	-27.7
Non-current assets classified as held for sale	0.0	0.0	0.0
Current Assets sub total	170.4	154.1	116.7
TOTAL ASSETS	1168.9	1138.6	1115.6
Current Liabilities			
Trade and other payables	245.2	207.7	216.9
Borrowings (Trust Only)	0.0	0.0	0.0
Other financial liabilities	0.0	0.0	0.0
Provisions	49.6	31.5	31.6
Current Liabilities sub total	294.8	239.3	248.5
NET ASSETS LESS CURRENT LIABILITIES	874.1	899.4	867.1
Non-Current Liabilities			
Trade and other payables	21.2	21.2	21.2
Borrowings (Trust Only)	0.0	0.0	0.0
Other financial liabilities	0.0	0.0	0.0
Provisions	185.8	185.8	185.8
Non-Current Liabilities sub total	207.0	207.0	207.0
TOTAL ASSETS EMPLOYED	667.1	692.4	660.1
FINANCED BY:			
Taxpayers' Equity			
General Fund	412.6	437.9	405.7
Revaluation Reserve	254.5	254.5	254.5
PDC (Trust only)	0.0	0.0	0.0
Retained earnings (Trust Only)	0.0	0.0	0.0
Other reserve	0.0	0.0	0.0
Total Taxpayers' Equity	667.1	692.4	660.1

Capital

BUDGET 2026/27		
Capital Resource Limit 2026/27	**£m**	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).
WG Discretionary Capital	14.1	
All Wales Scheme	43.9	
CRL	**58.0**	

CAPITAL PROGRAMME 2026/27	Initial Programme (£m)	Year to Date (£m)	Forecast Outturn (£m)	Current Over/Under Commitment (£m)	Comments
Divisions	4.5	3.0	5.9	1.4	Programmed planned works progressing supported by tenders/purchase orders.
Operational Estates	1.6	0.3	1.6	0.0	Programmed planned works progressing supported by tenders/purchase orders.
Medical Devices	5.0	1.6	5.0	0.0	Programmed planned works progressing supported by tenders/purchase orders.
Informatics	2.5	0.0	2.5	0.0	Programmed planned works progressing supported by tenders/purchase orders.
Mental Health	0.0	0.0	0.0	0.0	Programmed planned works progressing supported by tenders/purchase orders.
All wales funding brokerage to be re-provided from discretionary	0.6	0.0	0.6	0.0	Brokerage managed within the programme.
WG Discretionary Capital	**14.1**	**4.8**	**15.5**	**1.4**	**Over Commitment**

- Approved Capital Resource Limit (CRL) for 2026/27 is £58.0m which is forecast to be spent in full.
- As previously agreed with Welsh Government the prior year expenditure of £1.377m for Royal Alexander Hospital – Phase 1 is to be re-provided to discretionary from the All-Wales allocation.
- Donated Income of £2.197m has been reported from Month 4 onwards. This is made up of £800k donated income and £1.397m in relation to the Ysbyty Gwynedd Helipad Redevelopment.

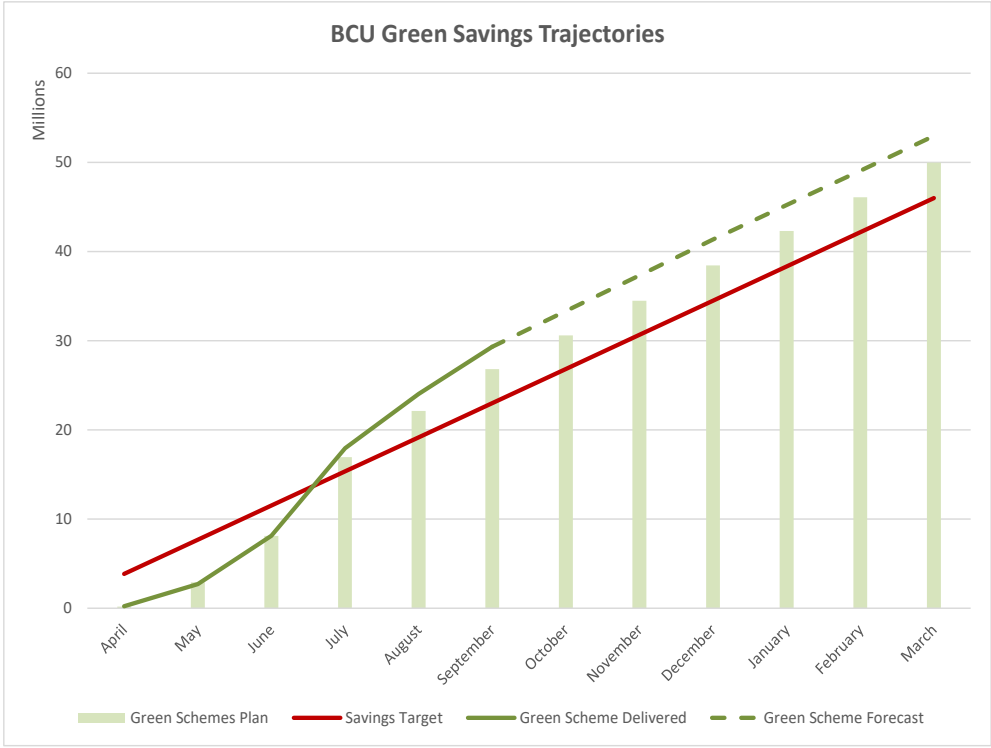
Capital

MAJOR CAPITAL SCHEMES (with in year spend)	Programme (£m)	Year to Date (£m)	Forecast Outturn (£m)	Current Over/Under Commitment (£m)	Comments
Royal Alexander Hospital - Phase 1	20.1	0.1	18.7	(1.4)	The principal contractor, MTX, has been appointed and commenced on site as planned. The demolition contractor has started as scheduled in August. A revised integrated programme has
Replacement Diagnostic and Treatment Equipment	1.6	0.8	1.6	0.0	Both Linac have now been installed with the second due to be commissioned imminently. The programme for purchase of service lead equipment is being reviewed with the procurement
Electrical Infrastructure upgrade - Ysbyty Glan Clwyd	4.5	1.2	4.5	0.0	Construction works are progressing well, remain on programme, and are currently within budget. Work is ongoing to finalise the legal lease agreements with the electrical supplier for
TEF - Fire	2.4	0.5	2.4	0.0	The TEF funding is distributed across a number of projects and is being delivered through a two-year programme. The fire safety elements remain on track in terms of expenditure and
TEF - Infrastructure	5.0	0.5	5.0	0.0	The TEF funding is distributed across a number of projects and is being delivered through a two-year programme. The Infrastructure elements remain on track in terms of expenditure and
TEF - Decarbonisation	0.4	0.1	0.4	0.0	The TEF funding is distributed across a number of projects and is being delivered through a two-year programme. The fire safety elements remain on track in terms of expenditure and
TEF - Mental Health	2.1	0.0	2.1	0.0	The TEF funding is distributed across a number of projects and is being delivered through a two-year programme. The Mental Health elements remain on track in terms of expenditure and
TEF - Infection Prevention Control	0.6	0.0	0.6	0.0	The TEF funding is distributed across a number of projects and is being delivered through a two-year programme. The fire safety elements remain on track in terms of expenditure and
TEF - Decontamination	0.8	0.1	0.8	0.0	The TEF funding is distributed across a number of projects and is being delivered through a two-year programme. The Decontamination elements remain on track in terms of expenditure
Redevelopment the Hospital Helipad at Ysbyty Gwynedd	1.0	1.0	1.0	0.0	The contractor is progressing in accordance with the approved programme and budget, with project completion anticipated during Q3. Mitigation measures relating to the adjacent footpath
Diagnostic Equipment 2026-27	2.5	0.0	2.5	0.0	The tender documentation is in the final stages of completion and is being submitted to Procurement for review and approval. It is noted that the installation and enabling works are
End of Year Digital Funding 2025-26	0.4	0.4	0.4	0.0	Complete.
Mental Health Quality and Safety Schemes 2026-27	0.7	0.0	0.7	0.0	Both schemes are progressing into the procurement stage, with tendering activities being undertaken in line with the approved programme. Construction works are scheduled to
North Wales Medical School Fees	0.4	0.2	0.4	0.0	Works to prepare business case is ongoing. We are targeting business case submission to be quarter 4.
Digital Backlog Funding	1.5	0.0	1.5	0.0	The funding is to procure legacy hardware and data centre resilience works that will be delivered by 31 March 2027.
All Wales Capital	**43.9**	**4.8**	**42.5**	**-1.4**	
Donated	**0.8**	**0.2**	**0.8**	**0.0**	
Donated - YG Helipad Redevelopment	**1.4**	**0.0**	**1.4**	**0.0**	
Total	**60.2**	**9.8**	**60.2**	**0.0**	

Savings Performance against Target

- The Health Board's financial plan has set a target of £46.0m to be delivered in 2026/27, profiled on an equal twelfth's basis with savings identification, reporting and monitoring developed through a Value and Sustainability thematic model.
- Full year value of Green Schemes total £53.0m, of which £24.8m is recurring, with a full year effect of £33.2m. £43.1m is cash releasing, £4.3m are accountancy gains, £3.9m is income generation and £1.8m are cost avoidance schemes. Of the full year value only £33.6m of these savings have been identified as budget releasing, with a full year recurrent impact of £27.9m.
- Year to date savings delivery target totals £23.0m (6/12ths of the annual target of £46m) with savings delivered to date totalling £29.3m. However, of these savings £18.0m is budget releasing resulting in a £5.0m shortfall in budget extractable savings verse that targeted year to date. In-month delivery is £5.3m, against the £3.8m target.
- Red schemes and pipeline opportunities total £5.3m, work is progressing to convert into green schemes.

			Budget Releasing Savings						
Services	Total Saving YTD £m	Total Saving Forecast £m	Recurring Target £m	Forecast - Delivery £m	Forecast - Variance (+ve = adverse) £m	FYE Savings forecast £m	YTD - Target £m	YTD - Delivered £m	YTD - Variance (+ve = adverse) £m
West Integrated Health Community	3.8	7.7	7.1	6.0	1.0	5.9	3.5	2.8	0.7
Central Integrated Health Community	6.4	10.1	9.6	8.4	1.2	5.9	4.8	4.9	-0.1
East Integrated Health Community	4.8	9.2	9.1	7.0	2.2	7.2	4.6	3.1	1.4
MHLD	2.8	5.2	4.3	5.1	-0.8	5.8	2.2	2.6	-0.4
Womens Services	0.7	1.2	1.1	0.8	0.3	0.0	0.5	0.6	-0.1
Commissioning Contracts	0.0	0.3	7.0	0.3	6.7	0.8	3.5	0.0	3.5
Diagnostic and Specialist Clinical Support	1.2	1.6	1.9	1.1	0.8	0.1	1.0	0.8	0.2
Cancer Services	1.4	2.5	1.8	1.7	0.1	1.5	0.9	1.0	-0.1
Dental Services	0.1	0.3	0.2	0.3	-0.1	0.0	0.1	0.1	0.0
Service Support Functions & Other Budgets	2.6	3.4	3.9	2.9	1.0	0.8	1.9	2.1	-0.2
Grip and Control Savings	5.3	10.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Saving Total	**29.3**	**53.0**	**46.0**	**33.6**	**12.4**	**27.9**	**23.0**	**18.0**	**5.0**
Non Budget Releasing Savings				15.1	-15.1	5.4		7.0	-7.0
Accountancy Gains			0.0	4.3	-4.3	0.0	0.0	4.3	-4.3
Total	**29.3**	**53.0**	**46.0**	**53.0**	**-7.0**	**33.2**	**23.0**	**29.3**	**-6.3**



Appendices

- Interpreting Statistical Process Control (SPC) Charts
- How to interpret the Integrated Performance Scorecard
- Abbreviations
- Further Information



Interpreting Statistical Process Control (SPC) Charts

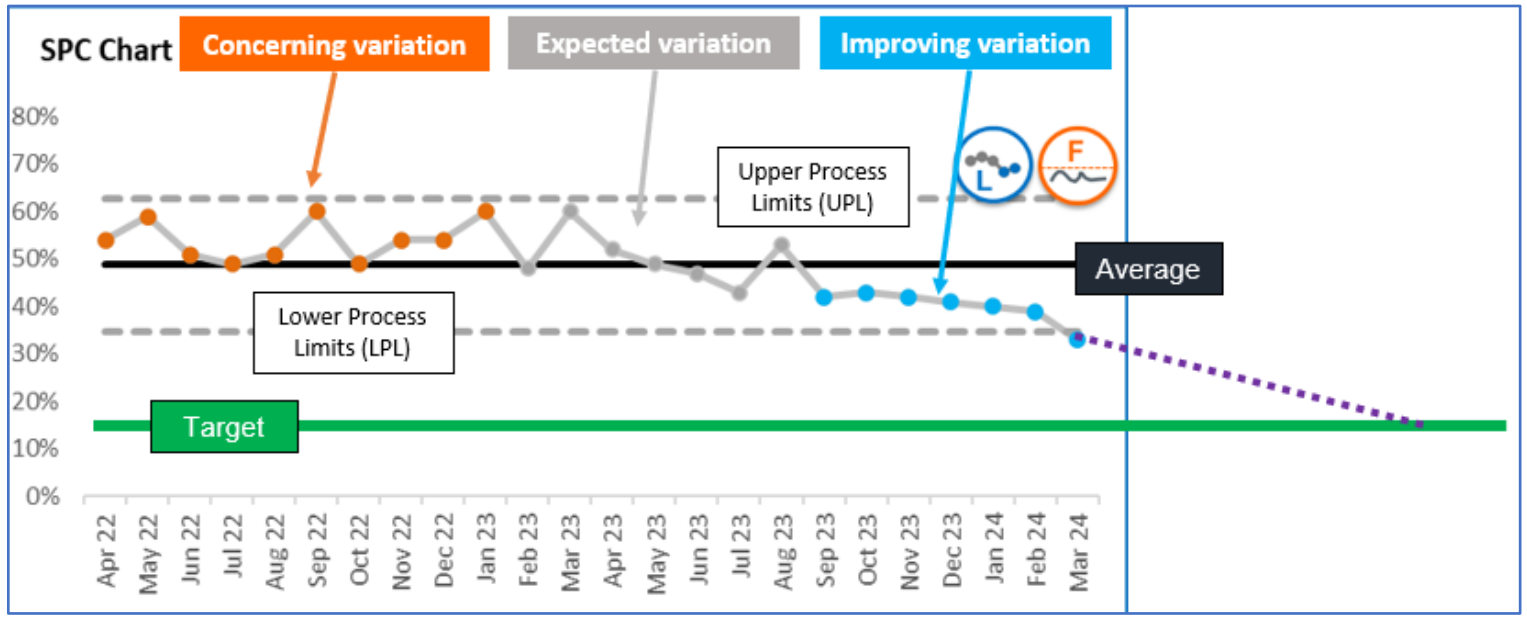
A statistical process control (SPC) chart is a useful tool to help distinguish between signals (which should be reacted to) and noise (which should not as it is occurring randomly).

The following colour convention identifies important patterns evident within the SPC charts in this report.

Orange – there is a concerning pattern of data which needs to be investigated, and improvement actions implemented

Blue – there is a pattern of improvement which should be learnt from

Grey – the pattern of variation is to be expected. The key question to be asked is whether the level of variation is acceptable



The dotted lines on SPC charts (upper and lower process limits) describe the range of variation that can be expected.

Process limits are very helpful in understanding whether a target or standard can be achieved always, never (as in this example) or sometimes.

SPC charts therefore describe not only the type of variation in data but also provide an indication of the likelihood of achieving target.

Summary icons have been developed to provide an at-a-glance view. These are described on the following page.

Key

Status		
	Escalate	Escalate (Serious concerns, action required): There is no confidence that the actions taken in place will address performance issues. Executive level intervention is necessary to resolve the situation.
	Alert	Alert (may require discussion): There is a lack of confidence that any action in place is sufficient to address the issue satisfactorily and/or within the scope of the operational team or executive to resolve. Engagement, action or intervention required.
	Advise	Advise (to monitor): There are areas of concern where assurance has been taken on actions in place but requires close monitoring. An early warning of an emerging and potentially serious concern.
	Assure	Assure (to note): There is confidence that actions are robust and will be sufficient to address the issue or generally operating effectively. Routine monitoring.

How to interpret the Integrated Performance Scorecard

Diagram and description of Scorecard elements

Target Suite:
NT = Nationally Mandated Target
SM = Special Measures De-escaltion Target
AP = current Month Trajectory (where we planned to be at this point)

Actual Performance Window

Month: Actual position for previous 3 months to date
Trend to Date: Trend graph for previous 6 months
Variance & Assurance: SPC Indicators

Delivery Assurance:
Based on data, intelligence etc, what is our level of confidence that the stated performance inprovement will be delivered.

REF	Measure Description	Target Suite			Wales Benchmark	Actual Performance				Status
		NT	SM	AP		Apr-26	May-26	Jun-26	6 Month Activity	
LMU01	Total number of ambulance coveyances to acute emergency departments	-	-	-	N/A	3237	3580	3340		Advise
3AP02	Percentage of ambulance handovers within 15 minutes	80%	-	-	6th of 6 (at Apr 26)	10.6%	11.6%	10.0%		Escalate
3AP01	Number of ambulance patient handovers over 45 minutes	0	-	-	N/A	1960	2143	2059		Escalate
LMU02	Number of ambulance patient handovers over 1 hour	-	1710	-	6th of 6 (at Apr 26)	1697	1820	1755		Escalate
LMU03	Number of ambulance patient handovers over 4 hour	-	-	-	N/A	569	582	527		Advise
LMU04	Median emergency ambulance response time to purple: arrest category calls	6-8 Mins	-	-	N/A	07:46	07:36	RIA		Advise

Measure Reference Numbers
Prefix
NPF = NHS Wales Performance Framework
LMU = Local Measure Urgent & Emergency Care
LMP = Local Measure Planned Care
LMQ = Local Measure Quality, Safety & Experience
LMW = Local Measure Workforce & Organisational Development
LMF = Local Measure Finance
LMPH = Local Measure Preventiuon & Population Health
All other Prefixes are from the Annual Delivery Plan

Full Measure Description

Benchmark of Performance compared to rest of Wales

BCUHB position compared to other Welsh NHS Organisations

Abbreviations

Please see below a list of abbreviations commonly found within this report:

Abbreviation	Definition
3As	alert, advise or assure
A&E	Accident and Emergency
ADHD	Attention Deficit Hyperactivity Disorder
AHP	Allied Health Professional
ASD	Autistic Spectrum Disorder
ASU	Assessment and Support Unity
BCUHB	Betsi Cadwaladr University Health Board
BSI	Bloodstream Infection
C&YP	Children and Young People
CD	Controlled Delivery
CO	Carbon Monoxide
CRL	Captial Resource Limit
D2RA	Discharge to Assess and Recover
DOSA	Day of Surgery Admission
ED	Emergency Department
FTE	Full Time Equivalent
HPV	Human Papilloma Virus
IHC	Integrated Health Community
IMTP	Intergrated Medium Term Plan
L1	Level 1
LFER	Learning from Event Reports
LocSSIP	Local Safety Standards for Invasive Procedures
LPMHSS	Local Primary Mental Health Support Service
LTP	Listening to People
MDT	Multi-disciplinary Team
MDU	Medical Decision Unit

Abbreviation	Definition
MenACWY	Meningococcal A, C, W, and Y
MHLD	Mantal Health and Learning Disabilities
MIU	Minor Injuries Unit
N/A	Not Applicable
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NMQS	Nursing and Midwifery Quality Standards
NRI	National Reportable Incident
PADR	Performance Appraisal and Development Review
PIPS	Pharmacist Independent Prescribing Service
PoCD	Pathways of Care Delays
PSA	Patient Safety Alerts
PSPP	Public Sector Payment Policy
Q	Quarter
QMS	Quality Management System
RSV	Respiratory Syncytial Virus
RTT	Referral to Treatment
SDEC	Same Day Emergency Care
SPC	Statistical Process Control
TBC	To Be Confirmed
UEC	Unscheduled and Emergency Care
V&S	Value and Sustainability
WM	Weight Management
WTE	Whole Time Equivalent
YoY	Year on Year

Additional Information

Integrated Quality and Performance Report
Betsi Cadwaladr University Health Board

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

Regular updates on how we improve healthcare services for patients can be found on social media:

follow @bcuhb

http://www.facebook.com/bcuhealthboard

Financial Grip and Control measures across NHS Wales

Financial Planning and Delivery Directorate

Objective:

To provide organisations with a consolidated schedule setting out the core financial, workforce and procurement grip and control measures to safeguard financial stability during periods of significant financial pressure.

Background:

At M09 2025/26 six health boards in Wales report deficits totalling £206m, (1.9% of the reported Revenue Resource Limit).

Given the scale of the pressure, it is essential that the NHS Wales Finance Function can demonstrate that the financial governance and financial control environment mechanisms are robust and sufficient assurance is received on their effectiveness.

Scope:

The tool is designed to help organisations assess their financial grip and control. It is not an exhaustive list but is predicated on common themes and areas of risk identified through NHS Wales.

The key focus for the grip and control schedule is the practical controls, processes and actions that should be in place in year to avoid excessive or inappropriately approved financial commitments; reduce waste; and improve in year expenditure run-rates. The tool will help organisations to strengthen the underpinning financial governance and control measures that support improved financial performance.

As a first step, the focus has been placed on core financial, workforce and procurement processes and systems. There is more limited literature available on best practice grip and control within specific expenditure areas such as commissioning, CHC and prescribing systems and processes.

Preparation approach:

The schedule has been prepared by Financial Planning and Delivery by examining and consolidating examples from various sources including:-

- Grip and Control presentation report (Financial Planning and Delivery May 2022)
- Financial Grip and Control Checklist (NHS England December 2022)
- Establishment Control (HFMA May 2025)
- Budgetary Framework and Grip and Control Discussions (Directors of Finance Forum July 2024)

Structure of the document:

The schedule includes both **financial controls (in black)** that organisations should have in place and **grip actions (in blue)** that will support the reduction of expenditure run rates.

The financial grip and control measures are categorised across eight themes:- Framework and Guidance, Vacancies, Sickness and Leave, Rostering and Rotas, Bank and Agency, Other Staff Payments, Procurement and Other items.

The document includes both a summary schedule and a detailed schedule. The summary schedule identifies key thematics and the highest impact actions from the detailed schedule.

Other financial governance reference documents:

The checklist may be used in conjunction with:

- HFMA's "Improving NHS financial sustainability: are you getting the basics right?" checklist tool Improving NHS financial sustainability: are you getting the basics right? (hfma.org.uk) – focus on key overarching financial processes such as planning, budget setting, reporting, financial governance, training and development
- Financial Management Maturity Model (NAO January 2010)
- Model Standing Orders, Reservation and Delegation of Powers and Model Standing Financial Instructions – NHS Wales (issued by Welsh Government)
- The Finance Academy's 'Financial Control Procedures Governance Best Practice Principles Guide' - available on the learning and development platform

All are valuable tools to support organisations to consider if they have the controls and processes in place to achieve best value for money.

Completion and next steps:-

Complete the checklist to consider whether the relevant policy or process exists and secondly to consider operational delivery and compliance. This may require input from representatives from several areas workforce, procurement, efficiency, finance and audit.

Agree priority issues and how proposed actions to address the issues identified will be taken forward. This may require assembling a working group including representatives from workforce, procurement, efficiency, finance.

Key findings from the exercise to be shared through the Director of Finance forum to identify any national areas of focus.

1. Summary Schedule

Framework and Guidance	Establishment and Vacancies	Sickness and Leave Management	Rostering, Rotas and Job Planning
• Clear and Up to Date Standing Financial Instructions and guidance. • Clear procedures & process notes. • Budget holders and all financial administrators have received up to date training on their roles & responsibilities • Clear governance process for new investment. • Delegation letters issued and signed. • Internal Escalation process in place.	• Ensure robust budgeted establishments are in place and regularly reviewed and reconciled. • Regular vacancy control panel (VCP). • Automated weekly head count tracker. • Ensure managers notify HR of leaving dates. • Review all current vacancies with a view to remove or freeze posts.	• Enforce compliance with the All Wales Sickness policy. • Adherence to the requirements of agreed attendance at work policies and the all-Wales Occupational Health minimum service levels. • Monitor absence and sickness on individual, service line, divisional and organisation level. • Monitor medical annual leave. • Policies to limit carry forward of significant leave balances	• E-rostering fully deployed. • Rosters approved 12 weeks in advance (as per the Agency workforce reduction programme and control framework). • Contracted hours to be fully rostered. • Job planning policy implemented with > 90% of all Consultants having an agreed job plan in place at all times; and alignment of rota to job capacity plans.

Temporary Staffing	Other Staff Payments	Procurement	Other items
• Temporary Staffing Policy in place. • Clear process for booking, and compliance with process. • Review bank and agency authorisation levels – seniority and consistency across sites. • No off-contract agency & locum. • Auto enrolment for new starters onto the bank. • Review pay rates and consider weekly pay for bank as an incentive. • Ensure appropriate deduction for agency staff breaks.	• Implement prior approval for overtime and enhanced payments. • A monthly 'audit' of the highest overtime earners and expenses claimants. • Non-clinical overtime controls in place. • Enhanced authorisation process for WLIs with clear demonstration that existing Programmed Activities (PAs) have been utilised before WLIs awarded. • Review process in place for additional sessions allocated.	• Monitor use of Single Tender Waivers. • Consolidate a list of supplier discounts. • Robust contract management processes in place. • Enforce the 'No PO No Pay' policy. • Review and reduce those able to requisition and order. • Targeted approach for clinical preference variation (as identified by V&S procurement group).	• Review and ensure all eligible VAT is being reclaimed. • Income management policies to minimise costs of bad debt. • Stock management policies to minimise wastage. • Review all credit balances on the Balance sheet for potential over accrual. • Journals are based on latest relevant data and assumptions.

2. Detailed Schedule

1. Framework and Guidance	Controls / Processes in place	Assurance that processes are operational
Clear and Up to Date Standing Financial Instructions • SFIs are up to date and readily accessible to all relevant officers.	• Standing Financial Instructions (SFIs), Scheme of Delegation and financial governance (SoRD) frameworks are up to date, Board approved and accessible via the intranet.	• The SFIs are reviewed annually as part of the formal governance process or updated upon the receipt of a relevant Welsh Health Circular (WHC). (e.g. WHC/2025/12). • The latest versions of the SFIs were approved at the Board meeting on 26th of March 2026 and are within the public papers pack. • A notice was shared in the weekly bulletin on the 27th of April to inform staff of the update together with the link to the relevant intranet page.
Clear Process Notes • All Financial Control Procedures are up to date, accessible and minimum provision aligns with the Finance Academy best practice guide. (e.g. month end close down processes, financial reforecasts). • All Financial Control Procedures are widely available to all relevant team members. • Adequate training is provided to all relevant staff members to ensure awareness and understanding of relevant financial control procedures.	• Financial control procedures are established and aligned to recognised best practice. • These are accessible to all staff via the BCU intranet and are subject to periodic review to ensure they remain current and effective. • Communication of any updates and amendments dependent upon type of document. • Formal policies and procedures go through a period of formal consultation before adoption. • Training is available to budget managers both formally and informally through the finance teams (see below for more detail). • For standard operating procedures, training is via the chief finance officer who will disseminate down to their teams. • For complex changes or processes, lunch and learn sessions may be scheduled to train, inform and	• Compliance is demonstrated through regular internal audit work, internal structured sample testing (e.g. authorisation, journals, virements), and finance team review. Instances of non-compliance are identified, reported, and escalated. • Examples of some of the relevant procedures and Standard Operating procedures: - o F19 – Procedure on Budgetary Control. Next due for review 1/12/27 (Formal procedure – had formal consultation through BCU prior to adoption). o FDP05 – SOP on Budget Movements (Virements). next

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	educate relevant finance staff to enable them to support budget managers appropriately.	formal review date due 01/01/28. o FDP06 – SOP on completion, uploading and posting of journals. Next review date due 01/10/27. • All procedures and SOPS can be updated before the review date if areas of improvement are identified.
Roles and Responsibilities • Roles and responsibilities of budget holders clearly defined and clearly communicated, including responsibilities with respect to core budgets, cost reduction element of their budgets and procurement. • Delegation letters have been issued and have been signed. • All budget holders have objectives supporting the delivery of financial objectives in Performance appraisal process. • Budget holders receive training on their roles responsibilities and objectives at reasonable intervals and monitoring of this can be demonstrated. • Consider whether the number of budget holders is appropriate - reduced budget holders can improve control over expenditure.	• Roles, responsibilities and delegated financial authority are clearly defined and communicated to budget holders. • Formal Accountability Agreements are issued and supported by training and guidance materials. • Performance management processes reinforce accountability for financial delivery. • Budget holders receive training on their roles and responsibilities in a variety of ways: - o the budget managers handbook is available to refer to on the internet. This is an easy-to-read document which gives links to more detail if a manager requires. o 1:1 training provided by the local Finance team on request, particularly for new staff. Meetings with managers are also used to train, for example if a manger is struggling with using the finance reporting system Qlik, they are often asked to share screen and instructed on how to access their report. o Formal training is scheduled and provided jointly between finance and procurement colleagues which covers both SFIs, SoRD and procurement best practice.	• Performance management processes reinforce accountability for financial delivery. • 25/26 Accountability agreements had a 97% sign off rate in 25/26, with most of the remainder relating to long term sick, maternity leave, etc. The 5 who did not sign were escalated to the CEO. • 26/27 Accountability Agreements were distributed on the 8th of May and to date (27/5/26) 75 have signed off (44%). Chief finance officers are meeting with the remaining budget managers to work through any issues and provide additional clarity where needed. • The system for recording the Accountability Agreements also documents the formal training attended by the budget holders. Out of the 172 budget holders, 55 have received the formal joint finance and procurement training. The attendance to the scheduled training sessions has been low in recent months, and this is

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	○ Requisition, Purchase order and receipting training is provided annually by NWSSP. This has reference to SoRD, SFIs and best practice. • Budget holders have been reviewed in March / April 26 in conjunction with the relevant IHC management team and have been reduced from 432 to 172. This has been achieved by aiming to have a consistent approach to identification of who is a budget holder and therefore the appropriateness of receipt of an Accountability Agreement for sign off. • Budget holders are reviewed regularly and as a minimum once a year prior to the new financial year.	an area we need to target to ensure increased attendance to ensure managers are aware of their responsibilities. • The Internal Audit report on Budget setting, which concluded in March 26 had a 'Reasonable Assurance' rating. • The Internal Audit report on Budgetary Control which concluded in June 25 had a Reasonable Assurance rating.
Investments and Business Cases • Clear Business Case review procedures for reviewing and approving any new projects across the organisation. • The above includes a relevant committee structure where robust review and challenge takes place. • Post implementation benefit realisation reviews process in place. • Review previous 12 months of business cases to ensure savings/benefits realisation. • Establish list of ongoing and planned projects and determine what can be ceased or delayed.	• The organisational approach to Business cases is an area where the Health Board recognised improvements were needing. A draft revised process has been drawn up and was submitted to Executive committee on the 3rd of June with a view to clarify approval routes and standardisation of business cases and the linkages back to the Integrated Planning Framework. • The current approval for Business Cases are Operational Leadership Team, Executives, then depending on value (in accordance with the SoRD), on to PFIG and/or Board. • Post implementation reviews are now an agenda item in the Performance, Finance and Information Governance committee and to include benefits realisation.	• A discussion paper on Business Case Approach was presented and welcomed by Executive Committee on the 3rd of June, with a view for this to be finalised and presented to a future PFIG meeting • Included as part of this discussion paper was a first draft of a stocktake of current work / business cases identified by IHCs, this will require further work to confirm definition of business cases and streamlining of the stocktake projects in progress versus business as usual. DRAFT%20-%20Business%20Cases%20Di FINAL - Health Board - Integrated Planning

Colour Key:- **financial controls** are black **grip actions** are blue

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Internal Escalation • Clear internal escalation processes in place for service areas that are not delivering their financial plans with appropriate financial or non-financial controls or remedial actions applied.	• Procedure F019 clearly describes the processes for managers to follow where forecasts deviate from plan, with escalation through the organisational hierarch as necessary and documented recovery plans. • More recently a revised performance and accountability framework has been approved at Board on the 28/05/26. This goes further in linking performance to PADRs, defining tolerances of variance to plan, defining the formal performance monitoring regularity and the relevant escalation / de-escalation process, together with the oversight.  26.971 Performance Frame Work (1).pdf	• Escalation is evidenced through divisional and executive performance reviews, with recovery actions tracked and monitored to support improved financial grip. (e.g. Creation of the Finance Oversight Group, and implementation of additional actions). • The new framework will strengthen the existing processes and procedures and provide additional clarity as it becomes embedded into the organisation.

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Colour Key:- **financial controls** are black **grip actions** are blue

2. People Costs – Establishment and Vacancies	Controls / Processes in place	Assurance that processes are operational
Policy and Procedure • Criteria in place for annual and other leave (e.g. study and parental leave) to be notified to the organisation and signed off (where applicable) with sufficient notice to minimise impact on rotas. • Processes in place to ensure compliance with the All Wales Sickness policy - Rigorous sickness policy and procedure is in place and communicated to minimise absences (inc. return to work meeting). • Consider increasing sign off levels for sick leave to ensure transparency.	• Workforce policies and procedures are available on the Health Board intranet pages and are aligned to the All Wales policies. These are managed by the Workforce and Organisational Development Policy team and a regular programme of work is in place to renew and refresh as required, this work is done in conjunction with the governance team who ensure the review policies and procedures is carried out in accordance with the organisational schedule. • The increased sign off levels are in place for Agenda for Change staffing who are on the rostering system. Work is ongoing to improve medical rostering to ensure the same level of robustness is in place for this staff group.	• Policies are routinely reviewed and compliance is monitored through workforce and finance reporting, with exceptions escalated as required. • Sickness performance is reported and monitored through both local management groups and People and Culture meetings and pan BCU committees (Integrated Planning and Executive Delivery Group, and to Planning, Finance and Information Governance Committee, and People and Culture committees. BCUHB IPEDG - Workforce (1).pptx Executive Summary- People Services and C • Increased sign off and hotspots are monitored through the focussed support from People Service teams and reported through to the Healthy Workforce Group for improvement plans to be put in place. 26_07%20Healthy%20Workforce%20Hotsp

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Colour Key:- **financial controls** are black **grip actions** are blue

Establishment (Establishment control | HFMA) • Workforce plans are in place, are of a sufficiently granular level of detail (for example, by service, workforce type and substantive/ temporary); and align to approved establishment levels and budget. • Workforce plans are regularly reviewed by service and divisional leads to ensure compliance with or action to move to compliance against both establishment and budget. • Reconciliation process in place to ensure that WTEs per financial and HR systems reconcile.	• Historic Workforce plans in place but need further review. • Service and divisional leads have access to a comprehensive set of workforce intelligence dashboards to support regular reviews of workforce plans. These align to currents budgets and cost centres. • A reconciliation is routinely carried out to ensure alignment to funded establishment and budgets between the ledger and Electronic Staff Record data to ensure accuracy.	• Actions are underway to strengthen and improve vacancy control panel effectiveness. • Workforce Planning Dashbaords are available to support services to develop workforce plans and provides data regarding workforce metrics. Work is being strengthened with Planning, Finance and Workforce to provide more triangulated workforce data. IMTP deliverable 4J.7 is being progressed Implement in partnership strategic workforce planning across the organisation, improving alignment with Clinical Service Plans, use of technology, Financial Plans linked to IMTP objectives. • The Strategic WFP Framework now in place in the organisation. Reviews have commenced with identified services but this needs to be more systematic and robust across the organisation. Strategic-Workforce-Planning-Framework- • Consistent workforce reconciliation between Electronic Staff Record and financial systems is in place, and enhanced reporting of vacancy gaps is available across the organisation. There has been a focused piece of

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Colour Key:- **financial controls** are black **grip actions** are blue

2. People Costs – Establishment and Vacancies	Controls / Processes in place	Assurance that processes are operational
		work on this and the discrepancies have reduced significantly.
Vacancy Review (Establishment control | HFMA) • Establish a regular vacancy control panel (VCP) or equivalent to check and challenge recruitment to ensure all vacancies remain within authorised budgetary limits. • Ensure the VCP terms of reference enable flexibility to avoid operationally delaying opportunities for savings and considering clinical need. • Implement an automated weekly head count tracker (temporary and substantive). • Assess the recruitment process and remove blockers/ bottle necks that may lead to higher agency & locum costs. • Review all current vacancies with a view to remove or freeze posts. • Focus on long term/ 6-month vacant posts – can these be removed or re-engineered? • Review the establishment to remove partial posts not required and identify unfunded posts. • Implement non-clinical recruitment freeze unless it can be evidenced that role is business critical or key for financial/ quality and safety improvement.	• A formal Vacancy Control Panel is in place to review and challenge recruitment decisions against financial and operational priorities. • The process is designed to allow posts of high clinical need to progress through at pace when required where funding is in place. • The Headcount tracker is in placed but is currently monthly • The recruitment process is currently complex and elongated and is in the process of being streamlined to make it more efficient and effective. • Recruitment challenge processes and targeted vacancy freezes are being actively progressed to improve control. • Long term vacant posts and partial posts are being reviewed as part of additional measures that could be introduced going forward. • For non-clinical recruitment, requests need to be accompanied by a supporting e-mail from the relevant Executive, justifying the service need for the posts. This was part of increased grip and control actions implemented in January 2026	• The Enhanced Establishment Control process consists of executive oversight for recruitment approvals. This is carried out through virtual voting and a weekly panel meeting to review more complex and urgent requests. 2026 01 Establishment Control WP4 - Establishment Control Procedure .pd • All Recruitment approvals are tracked and monitored, with evidence of challenge and scrutiny applied to ensure affordability and value for money.

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2. People Costs – Establishment and Vacancies	Controls / Processes in place	Assurance that processes are operational
Leavers • Processes in place to ensure line managers notify HR of leaving dates and any other pay-impacting staff changes in a timely manner to reduce risk of overpayments.	• Regular circulation of deadlines from payroll. • Process is in place, with a mechanism to capture details of overpayments / errors, with these also being reported to Audit Committee.	• The processes are operational with guidance available on the organisation's intranet for all managers. • Overpayment breaches are reported both at local level, with the IHC management teams, and at HB level in the Audit committee and will be added to the developing performance reporting.
Workforce management monitoring (Establishment control | HFMA) • Process in place to review levels of poorly performing staff and consider options for more rapid improvement and/ or staff exit. • Periodical review of actual temporary staff rates against rates charged to identify and address issues (specific and themes).	• There is a formal performance process which is available to all managers on the organisation's intranet. • Temp staffing rates reviewed periodically (RAMS – looks at the rate escalation above rate card for medical staff with both finance and workforce involvement. There is a specific rate escalation process for nursing which goes through the EDONs office.	• Specific work underway in this area across the HB. Regular reporting is provided across the organisation. ⍰⍰ • Specific rate review work is underway with plans to revise these through the V&S Workforce Programme – this is also linking with work focusing on long standing agency usage with the recruitment to established roles. There is an established RAMS fortnightly meeting which reviews all escalated rates above the rate card. There are ongoing efforts to amend the rate card. There is evidence of every request that has come through for Tier 1, Tier 2 and Tier 3.

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3. People Costs – Sickness and Leave Management	Controls / Processes in place	Assurance that processes are operational
Monitoring and Reporting • Monitor adherence to the requirements of agreed attendance at work policies and the all-Wales Occupational Health minimum service levels. • Monitor absence and sickness on individual, service line, divisional and organisation level. • Sickness is regularly reviewed at the board level, and problem areas identified and examined. • There is a set % target for staff off sick at any time and performance is measured against this target. • There is a set % target for staff on leave at any time and performance is measured against this target. • Monitor staff compliance with core organisational HR policies (e.g. annual leave requests, sickness absence) and ensure outliers are identified and addressed through appropriate routes. • Monitor medical annual leave. • Limits to the amount of annual leave, training and other influenceable absences that can be taken at any time. • Global policies for the management of leave to prevent excessive use of annual leave at the end of the year or carry forward of significant balances.	• People Service teams ensure that the Managing Attendance at Work policy is adhered to across the organisation. • This is carried out as part of operational meetings focusing on sickness absence hotspots which include, senior operational lead and workforce teams. A sickness absence hotspot report is utilised and monitored as part of these meetings. • Sickness is reported to the People and Culture Committee at each meeting through the People Operations report and through to the Board via the IPR. • The current target the organisation monitors is 4.4%, this is monitored at both a local and BCU level through the appropriate Planning, Finance and Information Governance Committee meetings. • A % target for staff on leave is specifically monitored for nursing staff through the rostering system. For other staff there is guidance issued for managers to ensure staff take leave appropriately and proportionally across the year. There is no set target at this time outside of nursing rosters within the organisation. • Staff compliance is monitored as above and reported and addressed through current performance and management lines. • The elements in blue are under consideration but have not been implemented at this time.	• Enhanced monitoring arrangements are being implemented, including strengthened reporting to Board and Executive teams. Clear performance targets and escalation triggers are being embedded, alongside focused interventions in high absence areas to drive improvement and reduce cost impact. Healthy%20Workforce%20Group%20Meet Sickness Actions Deep Dive V.6 with co

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4. Rostering, Rotas and Job Planning	Controls / Processes in place	Assurance that processes are operational
General rostering and rota • E-rostering is fully deployed • Rosters are approved 12 weeks in advance (as per the Agency workforce reduction programme and control framework), and minimal changes to rosters once approved, for all staff grades. • Processes to ensure contracted hours are fully rostered. • Clear timeline for submission of rotas.	• E-Rostering has been fully deployed for nursing staff across the organisation. It is also in place for Resident and SAS doctors. Some areas of Estates and Facilities and A&C staff use rostering but not across all areas of the organisation. • The compliance policy and process with 12 week roster approval for nursing is in place. Further work is underway to ensure this is the same for medics going forward starting with Resident Doctors. • Forward planning requirements to ensure all contracted hours are fully rostered are in place. • The nursing rostering policy and guide clearly state the timeline for roster submission and is managed through the senior nurse teams. This will be implemented for medics going forward.	• Actions are underway to ensure compliance with 12-week roster approval for medics is in place. This already happens for nursing. • The Health Board is also awaiting for the national medical rostering procedure to be finalised and published. • Minimal changes to rosters happen now for nursing and this will be applied to medical rosters as part of the ongoing work through the Resident Doctor contract implementation. • This is monitored and reported through nursing lines and through the People Operations Report that goes to the People and Culture Committee. • This is monitored and reported through nursing lines and through the People Operations Report that goes to the People and Culture Committee.

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4. Rostering, Rotas and Job Planning	Controls / Processes in place	Assurance that processes are operational
Robust Nursing Rota Management • Staff levels are matched to patient demand patterns to avoid waits and avoidable admissions. • Weekly monitoring for shift requests vs. shift fill rate and any associated care and safety issues. • Review staffing levels against patient ratios vs current guidelines (inc. safer staffing tools) and provide constructive challenge to clinical leads on achieving efficiency while maintaining quality. • Review specialing policy, approvals, and tracking process to ensure standardised approach linked to patient need/acuity. • Review nursing agency & locum use before, during and after school holiday periods (tests the strength of rota planning). • Review options for: o reduced handover periods; o back-to the ward for nursing management staff for a number of shifts per week; and o specialist nurses to provide a number of clinical shifts on wards to reduce agency & locum bill, cover vacancies, and improve staff rotation.	• The nurse rosters are aligned with SafeCare and as such this approach regarding staffing levels and acuity etc are fully taken into consideration in this area of decision making by senior nurse teams. • Weekly monitoring of requests and fill are reviewed as part of the above process. • The first 2 elements in blue already take place as part of the staff deployment work carried out across nursing rosters. • The review of all agency use across nursing is carried out through the EDONs office on a weekly basis. • The final elements under the last point in blue are under consideration	• This work is fully operational and is reviewed daily by senior nursing teams to deliver patient care across the organisation. • Please see details of national acuity reports  Grip%20and%20Control%20National%20A • The shift requests and fill are reviewed as part of senior nurse meetings to ensure safe staffing levels across wards. • The first 2 elements in blue already happen across wards and nursing areas. • Whilst agency usage is monitored, a specific focus will be taken around the school holiday periods to test rota planning specifically. • Specific work will be taken forward with the EDONs office to review the options outlined in the final blue bullet point.

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4. Rostering, Rotas and Job Planning	Controls / Processes in place	Assurance that processes are operational
Robust Medical Job Planning Management • Job planning policy implemented with > 90% of all Consultants having an agreed job plan in place at all times. • Process in place to ensure alignment of rota to job plans. • Monitoring in place to support Medical Director leadership track medical productivity for example:- o job plan delivery (individual and then team job plans); o PAs over 12; o % Direct Clinical Care; and o theatre/clinic throughput. • Review consultant job planning compliance (assess current level of rollout) to identify opportunities for greater productivity (review of low and high Professional Activity "PA" staff). • Improve transparency of medical workforce holiday planning to core planning teams, linking to theatre and clinic planning. • Review on-call run rate for utilisation trends	• The policy is still being finalised but has been endorsed in principle by the LNC locally. • There is a process being developed to support the alignment of rotas and jobs as part of the job plan policy implementation. • The Elements around job plan monitoring are being put in place to enable Medical Director leadership. The elements around theatre and clinic throughput are already in place. • These elements in blue are not currently in place but will be reviewed as part of ongoing work	• Work is ongoing to deliver the job planning policy and improve compliance. The Job Planning Protocol is awaiting sign off, it has been approved by Executive's, but is awaiting LNC/BMA before final release for Q2/Q3. • Rotas and job plans are not currently aligned • Consistent triangulated monitoring is not in place • Theatre and Outpatients dashboards are in place and once the job plan information is in place a full monitoring process will be developed to support medical productivity tracking. • Plans will be developed going forward to support all elements in blue.
Other Clinical Staff • Review compliance with / introduce Clinical Nurse Specialist and Allied Health Professional job planning process to identify opportunities for greater productivity.	• This is not currently in place but will be reviewed as part of ongoing work through the V&S Workforce Programme	• This is not operational at this time

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5. People Costs – Temporary staffing including Bank and Agency & Locum	Controls / Processes in place	Assurance that processes are operational

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Policy, procedures, roles and responsibilities • An organisation wide temporary Staffing Policy in place and up to date. • There is a clearly communicated process in place for bank / agency & locum booking. • Monitoring controls in place to monitor compliance with the process for bank / agency & locum booking. • Governance process exists to oversee temporary staffing with clear ToR (either at overall level or by key staffing group e.g. nursing, medical, corporate). • Limit who can authorise bank and agency & locum staff to increase transparency; follow up on all short notice use. • Review consistency of authorisation levels and approach across sites.	• A comprehensive policy and governance framework is in place covering bank, agency and locum usage, including approval controls and monitoring mechanisms. • The processes are in place bank/agency and locum bookings which is clearly communicated across the organisation. • Monitoring controls are in place through the temporary staffing teams and through regular reporting through to local senior management teams. • The governance processes are in place for nursing, medics and corporate areas to ensure full compliance. These are overseen by workforce teams across the organisation. • This is in place for nursing, with rate escalation oversight is place for medics through the RAMS process.	• Regular monitoring reports and dashboards are reviewed by senior management, with variances challenged and actions implemented to reduce reliance on high-cost staffing. For nursing this is done by the office of the EDON and for medics it is done through RAMS chaired by EMD or their Deputy. • Delivery is being strengthened through tighter authorisation controls for Locums, weekly oversight of agency usage, and targeted plans to reduce agency dependency. • Tighter controls over authorisation will also be strengthened by the implementation of all medical temporary staffing requests through rostering with a look to move to a closer roster governance process similar to a end for change rostering. • Expansion of bank utilisation and conversion of long-term agency usage to substantive roles are key priorities currently in progress. • Authorisation levels are in place for nursing, and tighter controls are

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5. People Costs – Temporary staffing including Bank and Agency & Locum	Controls / Processes in place	Assurance that processes are operational
		being looked at for medical through direct management of agency requests going through the medical bank team.

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5. People Costs – Temporary staffing including Bank and Agency & Locum	Controls / Processes in place	Assurance that processes are operational
Bank utilisation • All relevant staff groups are auto enrolled on the bank. • Review actual temporary staff rates against rates charged periodically to identify and address issues. • Implemented and promoted a medical bank; and an Administration and Clerical bank. • Promote bank staff as an alternative to agency & locum. • Review pay rates and consider financial incentives for bank staff to increase bank usage, for example consider weekly pay as an incentive.	• Staff auto enrolment is not currently in place for bank. • The work around rates is reviewed currently through the office of the EDON for nursing and RAMs for medics. • BCU wide medical bank in place. The current A&C banks run as local only • There are regular active recruitment drives to increase bank staff numbers for nursing. This work is starting for medics. • Weekly pay does exist within the organisation and Wagestream was put in place to support staff to access bank shift payments in a timely manner. • This has been considered and is kept under review	• Staff auto enrolment to bank to be looked at for all staff groups with specific work for medics going forward, initially for Resident Doctors. This is not currently automatically happening, medical staff member has to request a bank assignment. • Rate review work is ongoing and links in with national work in this area. • Plans to expand the medical bank are ongoing and a review of bank solutions for other staff groups are being considered as part of the V&S Workforce programme. • There has been an active push to increase bank staff numbers for nursing. This work is starting for medics now the medical bank is in house. • Bank incentives are operational and promoted on a regular basis.

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5. People Costs – Temporary staffing including Bank and Agency & Locum	Controls / Processes in place	Assurance that processes are operational
Agency and Locum controls • Robust controls over agency & locum usage for example:- o self-imposed cap on agency & locum expenditure; o senior sign off of agency & locum expenditure; o senior sign off of off-framework expenditure; o clear Board accountability defined and communicated across organisation; o improved communication of planned clinic cancellations to agency/bank teams; and o no direct approach for agency. • Process in place to ensure non-framework or off-contract agency staff are not engaged. • An organisation process in place for long term agency & locum use. • Seek local agreement of agency & locum pay rates with surrounding trusts / explore use of a collaborative bank. • Evaluate opportunities for moving from use of agency & locum to internal organisation resource and / or bank.	• Robust controls for nursing agency usage are in place as described previously. Nursing caps are in place as we only use agency on the all-Wales framework. Sign off is through the EDON and no off-framework agencies are used as a rule. Accountability is clear for nursing and reported through existing governance frameworks. For medics whilst oversight at a senior medical level is in place it is not as robust as it is for nursing. • The process for non-off-framework usage for all staff groups is in place. • Long term agency usage is discouraged. A robust process does exist for nursing only. • The elements in blue are being considered where appropriate for the relevant staff groups with medics being a primary opportunity. • The opportunities are being evaluated as part of the ongoing work through the V&S Workforce Programme	• Robust controls for medical agency to fully mirror those in place for nursing are being developed and will be rolled out across the next quarter. • Rates via the Crown Commercial Services are now via the Government Commercial Agency frameworks. Medacs have an agreed all Wales contract. • The non-off-framework process is robustly followed for most staff groups. More work is required for medics and this is in train through work being carried out via the value and sustainability Workforce Programme team. • Plans are being developed to reduce reliance on long term medical agency usage across the organisation. • A collaborative bank opportunity for medics is being considered and further work around the establishment of banks for AHPs etc are being explored.

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5. People Costs – Temporary staffing including Bank and Agency & Locum	Controls / Processes in place	Assurance that processes are operational
Timesheet and expenses management • Ensure breaks and hours claimed are accounted for correctly in timesheets (i.e. agency workers are only paid for time worked, in accordance with HB policies). • Ensure appropriate deduction for agency & locum staff breaks (lunch). • Ensure mileage claims are only for required intra-site travel.	• This process is in place for both nursing and medics through the workforce temporary staffing teams in accordance with HB polices • This is in place as part of the terms of engagement for all agency workers through the all-Wales framework for nursing and the manged service provider for medics. • Mileage claims are managed through the electronic system and are only signed off for specific required travel.	• This is operational and robustly enforced and audited through electronic systems. PS-TS-SOP7 Process for running agency pa • The deduction of breaks is robustly monitored via temporary staffing teams and via the KPIs set for the managed service contract for medics. PS-TS-SOP7 Process for running agency pa • Travel bureau requests are regularly reviewed at an enhanced level as part of the enhanced non-pay controls currently in place.
Restrictions on non-clinical temporary staff • Review and implement exit strategies for all non-clinical temporary workers. • Temporary ban on usage of non-clinical agency staff, with exceptions authorised by executive director.	• This is in place and is kept under review • This is in place and can only be authorised by the CEO and then by Welsh Government in line with the WG circular	• There is robust monitoring of this area and executive oversight through an exec panel. • The exec panel can only sign off on non-clinical temporary staff by exception and with direct support of the CEO.

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5. People Costs – Temporary staffing including Bank and Agency & Locum	Controls / Processes in place	Assurance that processes are operational
Effective monitoring • Senior leads monitor weekly dashboard summaries of temporary staff usage, cost and trends to provide early warning signs and demonstrate progress with issues arising. • Track number of interims, termination dates, delivery of objectives, and daily rates. Focus on reducing number and costs. Consider options for contract terms that enables the organisation to offer substantive role after x months use:- e.g. offer locums a suitable package to convert from locum to substantive contracts. • Identify medical rotas with the highest use of temporary and bank staff and set out a plan to address • Hold weekly agency & locum meetings across all staffing groups with agency & locum overspends, attended by finance and key stakeholders, to review and control agency & locum expenditure.	• This takes place as part of regular meetings across senior teams. • Tracking of the number of interims is in place across the organisation and is visible as part of the Enhanced Establishment Control process. • Medical rotas are under review • Weekly meetings are under review	• Dashboards are in place to monitor this. There is work ongoing to ensure clear actions are in place to support reduction in this area. • Plans are being developed to systematically tackle this for medics in a similar way as it was carried out for non-clinical staff previously. • Plans are being developed to review high temporary staffing usage areas and reduce usage accordingly. • This will be built into plans going forward.

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6. People Costs – Other Staff Payments	Controls / Processes in place	Assurance that processes are operational
Overtime and enhanced payments controls • Ensure breaks and hours claimed are accounted for correctly in timesheets. • Perform a monthly 'audit' of the top 10 highest overtime earners by division. • Implement prior approval for overtime and enhanced payments - monitor and reduce. • For non-clinical staff - implement non-clinical overtime controls to limit expenditure in this area (e.g. Exec director authorisation required).	• Controls are defined for overtime, expenses and waiting list initiatives, including requirements for prior approval and monitoring. • This is currently under review • The elements in blue are currently under review as part of the V&S programme of work for workforce improvements.	• These processes are operational, and greater oversight of this area of expenditure is being developed. PS-TS-SOP7 Process for running agency pa • Plans are being put in place to carry out the audit and develop reports that will be included in divisional Planning, Finance and Information Governance meetings going forward. • The elements in blue are being considered but are not operational at this time.
Expenses Monitoring • Monthly monitoring of the highest mileage and expenses claimants.	• This is not systematically carried out are across the organisation	• Plans are being looked at to put this in place and would be reported through local Planning, Finance and Information Governance meetings across divisions.
Waiting List Initiatives (WLIs) controls • Ensure consistent process across organisation including compliance with the WLI rate across the organisation. • Appropriate review process in place for additional sessions allocated. • Enhanced authorisation process for WLIs, with checks are undertaken before WLIs are awarded to ensure that :-	• All Wales waiting list initiatives rate in place for medical workforce and Agenda for Change rates for other staff, including Admin and Clerical. • Electronic system introduced, c 2 years ago to consider all requests for WLIs with various levels of authorisation Divisional Senior Leadership Teams then to Executive level final	• Operational for circa 2years now and maintains an audit of requests and outcomes and is available for review by teams. • The system does not currently close the loop on recording the actual activity undertaken but can be matched back to information sources on clinical systems.

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○ WLIs offer financial benefit or are operationally critical before approving, and ○ existing Programmed Activities (PAs) have been utilised. • Benchmark WLI rate against other Health Boards.	approval by Office of Medical Director, Chief Operating Officer and Finance Director • WLI requests are assessed for need (against PTL) and appropriate source of funding, i.e., CORE or Planned Care resource. • The requests ask services to declare that the activity is outside of planned PA and that planned PA activity has been achieved. This is a self-declaration by the IHC / Service, and a separate check is not undertaken at this time. • Services are also requested to self-declare if current services are being undertaken in line with GIRFT recommendations. • The current system calculates a cost per patient based on the proposed cost and number of patients to be booked; this acts as a benchmark / indication of value for money for the list proposed. • The rate for WLI sessions are consistent as this is an Wales agreed rate for this work.	• Chief finance officers and their teams use the database to be able to call down reserves from the planned care resource is appropriate approval has been granted. • Partially operational • Partially operational

7. Procurement	Controls / Processes in place	Assurance that processes are operational
Procurement – Clarity of Roles • Clear documentation and communication of roles between local managers, the procurement function and Shared Services.	• Procurement activity is governed by Standing Financial Instructions and undertaken in line with statutory requirements to ensure transparency and value for money.	• Training is provided to Directors and Budget Managers on the role of Procurement Services and the functions that they carry out on behalf of the Health Board.

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7. Procurement	Controls / Processes in place	Assurance that processes are operational
	• The NWSSP Procurement Services is incorporated into the SFIs and there are Service Level Agreements (SLAs) in place with NWSSP covering procurement.	• Guidance documents, for example the e-Procurement Manual, are available on the HB and NWSSP Intranet pages. • Regular 'Local P2P' meetings take place between HB finance and systems staff and colleagues from NWSSP Procurement Services and Accounts Payable teams. • HB staff also attend 'All-Wales P2P Group' meetings. • Audit review procurement activity and highlight any issues or areas of non-compliance with the SFIs or Standing Orders. • NWSSP Procurement Services operates in accordance with both UK Procurement Legislation and its internal Document Management System which provides standard operating procedures for all procurement activities that are carried out on behalf of NHS Wales. • NWSSP's adherence with procurement policies and procedures is regularly audited by both NWSSP's Business Quality Team and colleagues from Audit & Assurance Services.
Procurement - Tender process • Approval limits are periodically and regularly reviewed where appropriate. • All new contracts awarded in compliance with Statutory Regulations and SFIs. • All new contracts (including agency & locum staff) are procured via appropriate tendering	• The SFIs are based on the model SFIs issued by Welsh Gov and were last updated in September 2025. • SFIs are approved by Board with copies available on the Health Board website and intranet pages.	• Periodic report presented to Audit Committee regarding breaches.

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7. Procurement	Controls / Processes in place	Assurance that processes are operational
procedures to ensure best value for money is attained. • Single Tender Waivers controlled to minimise use. • Whole Life Costings are applied to evaluate tenders. • Appropriate SLAs and T&Cs are applied to ALL contracts to enable appropriate and effective contract management. • Breaches are reported to the relevant Executive Director and included in financial performance monitoring arrangements.	• Annual review is undertaken by the Board. • SLA in place with Procurement Services to carry out tender procedures and relevant competitions for the Health Board in line with the SFIs and to ensure best value for money. • Additional control procedures were included in the Health Board's SFIs relating to Single Tender Waivers. • Single Tender Waiver database used for recording and approving of Waivers in line with SFIs. Healthcare Contracting Team and NWSSP Procurement Services support divisions / services with contract awarding and management, including tenders and renewals. • Financial approval limits are operated in line with HB Standing Financial Instructions and the HB Scheme of Delegation. Tenders are carried out by NWSSP Procurement Services in accordance with both UK Procurement legislation and NWSSP's internal Document Management System. The use of Single Tender Waivers is discouraged in favour of following competitive procurement exercises. All Breaches are reported to the HB Audit Committee.	
Procurement – Call Off • Contract pricing is reviewed annually to attain any further increased banding cost advantages through life of contract. • Product catalogues reviewed (both NHS Supply Chain and Local Catalogues) to remove	• Contract pricing is reviewed regularly by NWSSP Procurement Services and is benchmarked against other Health organisations across the UK. Product catalogues are updated in line with contract renewal dates and any related savings are	• NWSSP Procurement Services operates in accordance with both UK Procurement Legislation and its internal Document Management System which provides standard operating procedures for all

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7. Procurement	Controls / Processes in place	Assurance that processes are operational
duplicate items on catalogue (e.g. pens) to ensure value for money. • Consolidate a list of supplier discounts and penalties for early / late payments (in alignment with contract register) - set out plans to recover / avoid these and share with accounts payable team to enact.	shared with HB Finance colleagues via the monthly Savings Reports.	procurement activities that are carried out on behalf of NHS Wales. • NWSSP Procurement Services maintains and online e-Contract Management System which flags any contracts which are due for renewal/expiry well in advance. The Procurement Team also proactively monitors HB spend to identify potential savings opportunities and areas for further online automation.
Procurement - Contract management • Robust contract management processes are in place, including a complete and up to date contract register. • Regular contract reviews to ensure SLAs are being met - with specific focus on PFI contracts where relevant. • When contracts expire, these are retendered in accordance with the statutory regulations rather than rolled over, and explore options for efficiencies/price reduction. • Contract terms are relative and proportionate to the contract matter and that there is a clear understanding of the risks transferred. • Service specifications are reviewed and ensure SLAs are being achieved or amend where suitable and do not directly affect patient care (e.g. reduce frequency of window cleaning etc.)	• NWSSP Procurement Services record details of contracts that they have procured on their database. • Services and divisions maintain their records of contracts under their management and control. • The Health Board is in the final stages of developing a pan-BCU Contract Register for use by staff to record copies and details of any contracts that they manage / control. • Unless otherwise agreed, contract management is the responsibility of the relevant HB department. NWSSP Procurement Services will seek confirmation from departmental leads regarding renewal of specific contracts. • NWSSP Procurement Services maintains an online e-Contract Management System of the contracts for which it has responsibility for managing, which flags any contracts which are due for renewal/expiry well in advance. Regular Contract Review meeting dates are	• NWSSP and the Healthcare Contracting Team support services to ensure robust contract management processes are in place. • NWSSP Procurement Services operates in accordance with both UK Procurement Legislation and its internal Document Management System which provides standard operating procedures for all procurement activities that are carried out on behalf of NHS Wales.

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7. Procurement	Controls / Processes in place	Assurance that processes are operational
	also recorded against each relevant contract on the e-Contract Management System. • Contracts are let in accordance with NHS Standard T's & C's and are proportionate to the subject matter of the contract. All contracts/specifications are reviewed and refined in advance of tendering activity by a Working Group consisting of both HB staff and members of the Procurement Team.	
Procurement – Purchase to Pay • Establish a robust purchase ordering (PO) system to enable the implementation of a 'no PO no payment' rule and no retrospective POs , in collaboration with Accounts Payable, to help control expenditure. • Invoices that fail three way match (PO, goods receipt, invoice) are rejected and returned. Source of error are identified and contract managed appropriately. • Payments are only processed following sign off from the appropriate level. • Sample audit batches for any possible out of policy expenditure. • Continuous review of all open purchase orders that feed the monthly goods received not invoiced (GRNI) accrual for accuracy and appropriateness, ensuring any no longer valid items are removed/closed. • Consider limiting and refining approval limits of requisitioners where appropriate.	• Oracle financial system is in place for managing purchase requisitions and raising Purchase Orders. • All Wales 'No PO, No Pay' policy adopted and enforced across the Health Board. Breaches are reported to both the IHC management team and the Audit Committee. • Service Level Agreement in place with NWSSP Accounts Payable (AP). • Creditor statement reconciliations undertaken by AP. • SFIs and SoRD approved by Board and detail financial controls and processes and levels of delegation for approval of expenditure.	• Regular 'Local P2P' meetings take place between HB finance and systems staff and colleagues from NWSSP Procurement Services and Accounts Payable teams. • HB staff also attend 'All-Wales P2P Group' meetings. • Regular reports received from accounts payable and reviewed by finance colleagues, for example, Invoices on Hold reports including No PO holds. • Schemes of Delegation are reviewed at local level for appropriateness and levels applied with decision making and approval processes, for example, in approving of contracts or purchase requisitions. • Hierarchy system built into Oracle in line with SoRD and delegated limits for approvers. • Segregation of duties controls applied to ensure distinct roles of requisitioners and approvers etc. • Review of management accounts by finance teams and budget holders to help identify errors.

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7. Procurement	Controls / Processes in place	Assurance that processes are operational
		• Audit review procurement and expenditure activity and highlight any issues or areas of non-compliance with the SFIs or SoRD. • Review and processing of journals by finance teams. • Training provided to Budget Holders and Oracle users on correct application of processes and use of system. • Audit review of NWSSP AP and Procurement Services.
Procurement – Other • Process in place to identify any "off contract" and consultancy expenditure. A strategy in place to review and market test costs to ensure best value. • Contract pipeline clearly identified (and shared with NWSSP) to enable economies of scale. • Ensure the number of purchasing cards in the organisation is right-fitted and balances the process efficiencies against the risk that the use of these bypasses procurement processes. • Targeted approach for clinical preference variation (as identified by V&S procurement group).	• The Procurement Team proactively monitors HB spend to identify potential savings opportunities, disaggregation of spend and areas for further online automation. Any savings related opportunities are shared with HB Finance colleagues monthly via the monthly Savings Reports. • A policy exists for Purchase cards (F08) which is due for review on the 01/09/2027. This policy sets out the users responsibilities, lists of types of purchases which are not appropriate use and the methods of monitoring the use of purchase cards. Users are required to maintain a log of transactions and sign an agreement. • Savings opportunities which have been flagged via the Value and Sustainability Non pay & Procurement Subgroup are also shared with Health Board Finance colleagues monthly, either during monthly touch point meetings or via Savings Reports.	• Review of management accounts by finance teams and budget holders to help identify errors and any expenditure not approved in line with SFIs and SoRD. • NWSSP Procurement Services operates in accordance with both UK Procurement Legislation and its internal Document Management System which provides standard operating procedures for all procurement activities that are carried out on behalf of NHS Wales. • An Internal Audit on Petty Cash and Purchasing cards has recently been undertaken, with the outcome of 'Reasonable Assurance' due to be presented to the June Audit Committee.

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7. Procurement	Controls / Processes in place	Assurance that processes are operational
Procurement – Signalling • Organisation has considered placing a hold on certain items (e.g. external venue hire). Although the savings will be low, can act as a signalling mechanism.	• Various 'Grip and Control' measures were implemented and remain in place to manage expenditure as necessary including the review and approval of non-pay expenditure by chief finance officers and the Office of the Executive Director of Finance.	• Additional approval processes established, for example, within Oracle and establishment control review group, to review and approve expenditure prior to it being committed. This included all expenditure subjective codes deemed to be discretionary and non-clinical in nature. All items in these categories requiring clear justification for expenditure and impact of not spending.

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Colour Key:- **financial controls** are black **grip actions** are blue

8. Other Items	Controls / Processes in place	Assurance that processes are operational
VAT recovery management • Review latest contracted out services guidance to ensure all eligible VAT is being reclaimed.	• Internal VAT assessments undertaken on all capital projects. • External consultant reviews and provide quarterly reports on all Contracted out Services headings. • NHS Wales Capital Technical Accounting group shares opportunities and good practice.	• VAT monthly reconciliation and reclaim. • Quarterly report and annual report from external consultant.

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8. Other Items	Controls / Processes in place	Assurance that processes are operational
Income and Debt management • A NHS visitor and migrant cost recovery programme in place. • Bad debt cost management process in place e.g.:- o Ensure debtors categorised logically (e.g. NHS, Non-NHS, Private Patients, Overseas, Salary Sacrifice, Prescriptions, Salary Overpayments, etc.) with agreed risk based, proportionate approach to collection for each category. o Identify strategy for key debtors, and set collection targets for team members. o Review processes in place to ensure invoices are issued in real time or as soon as possible. o Consider payment in advance/on delivery where appropriate or the use of pro forma invoices in areas such as private patients backed with settlement facilities available at point of delivery. o Identify and address internal issues that are preventing timely collections i.e. unresponsive / untimely resolution of queries by divisions. o Scrutinise requests to write-off salary overpayments (if historic practice shows these are material). o Ensure prompt referral to external debt recovery agencies where necessary.	• Private patients and overseas visitors managed by income with cost recovery actively managed by the accounts receivable team. • Debtors are categorised in a variety of different ways, with a formal escalation process. • Risk based approach is applied considering age and value of invoices, taking account of staff debt. • Electronic process of raising invoices are in place. • N/A – not able to invoice until the procedure is complete and costed in full. • The team have processes that includes managing and resolving issues. • Yes, 3 stage approval process with check and balances with final approval with the Director of Finance. • Referral to debt collection agency actively managed, meet monthly and access to portal for reports.	• Regular Conformance report to the Audit Committee which provides the age profile, with additional detail regarding debts over £10,000 and 6 months old.

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8. Other Items	Controls / Processes in place	Assurance that processes are operational
Stock Management • Ensure appropriate stock rotation processes are in place and being followed to minimise wastage. Agree process with suppliers to swap out short shelf life items or use consignment. • Review stock level minimum and maximum thresholds in line with current usage to minimise wastage. • Review delivery charges, triggers and schedules and implement changes to reduce any carriage charges where possible (e.g. standing orders, minimum order values, 3 day delivery rather than next day). • Review controls on consignment stock.	• The Pharmacy stock system is designed to avoid wastage. • Ward stock is managed in the main via the Omnicell scanning system, which considers most optimal levels of ward stock and enables ordering of top up efficiently and effectively via a handheld scanner. • A review of delivery charges and carriage is being undertaken as part of the Value and Sustainability non pay theme, under the procurement heading as we recognise this is an area which offers potential opportunities.	• Pharmacy stock write offs amounted to £0.7m in 25/26, against as secondary care drugs spend of £107.7m (0.6%), so this does offer some potential to review and reduce. • Other stock write off amounted to £8K, which given the value of stocks held and passing through the organisation is minimal.
Estates • Review outliers identified from benchmarking overall running costs for facilities and estates (inc. estates footprint use) (see the VAULT). • Ensure appropriate maintenance schedules in place to ensure asset kept in good working order. • Ensure an estates strategy is in place and regularly reviewed, to include estate rationalisation consideration to determine where savings might be delivered. • Establish list of ongoing and planned estates and maintenance projects and ensure it has been prioritised and has Board approval.	• A review of Vault benchmarking for estates and facilities has been undertaken, but it has been determined that incorrect information has been submitted. This issue has been highlighted to FD & P, and the correct information is being pursued, to allow correction if possible, or at least meaningful comparison. • A formal estates strategy has been discussed, but due to the links to the recently revised clinical services strategy, has not yet been fully developed, so is ongoing. • The Director of Estates has identified some Estates opportunities, and these are currently being worked up. • Further work is needed on establishing a list of planned estates and maintenance projects.	

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8. Other Items	Controls / Processes in place	Assurance that processes are operational
Journal Approvals • Internal journal review process in place and regular accruals and prepayments have been reviewed to ensure they remain current and the method of calculation is based on up to date assumptions. • Controls over journals are appropriate including posting authorisation levels, review and sign off process.	• A documented Standard Operating Procedure (FDP06) governs the review and approval of journals exceeding £100K which impact on the position. • Segregation of duties is embedded within the journal review process. • All central accruals, provisions and significant balance sheet estimates are recalculated monthly using the latest available information and assumptions. • Monthly balance sheet reconciliations are completed across all control accounts, with escalation processes in place for unreconciled or aged balances. • Periodically a central review is undertaken to challenge the consistency and appropriateness of material accruals, provisions and balance sheet estimates across all Integrated Health Communities.	• Compliance with journal control procedures is routinely monitored, tested and reported within Finance. • Monthly reviews are undertaken of material accruals, provisions and significant balance sheet movements by CFOs to ensure values remain current and supportable. In addition periodic reviews are undertaken by the senior management team. • Balance sheet reconciliations are completed in accordance with agreed timetables, with outstanding issues tracked and resolved through local and central finance review processes. • Independent assurance over the effectiveness of financial controls is obtained through Internal Audit reviews and the annual external audit of the financial statements. • The Health Board received an unqualified audit opinion on its most recent financial statements, providing assurance over the operation of the underlying financial control framework.

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8. Other Items	Controls / Processes in place	Assurance that processes are operational
Fixed Assets and Capital • Fixed asset register is in place and regularly updated including a fixed asset verification exercise. • Review capital programme for subsequent revenue affordability, deferring, reducing or stopping schemes as appropriate. • Asset lives regularly reviewed to ensure appropriate and that depreciation is consistent with consumption. • Consider reprioritising the capital programme to prioritise spend-to-save projects. • Review assets held on SoFP (buildings, equipment etc) and dispose of any no longer in use or needed. • Consider VfM of ownership options such as lease v purchase.	• Fixed asset register and verifications are maintained in line with the Wales MfA. • Capital schemes include revenue consequences and if within budget. • N/A as lives are per the MfA and depreciation is centrally funded. • The prioritisation of the annual programme includes consideration of any potential spend to save. • We have a rationalisation programme in place and agree with Welsh Government. • All leases are now within IFRS16 and applications are reviewed/endorsed at Capital Investment Group (CIG) and approved at Executive Committee.	• 3 Year Verification plan, verification is documented in the asset register. • Prioritisation criteria are documented and consistently applied. • 2 year Capital Prioritisation Plan approved. • WGagreed rationalisation plan is monitored and reported. • IFRS 16 assessments are independently reviewed by Finance. • CIG and Exec oversight ensures valueformoney scrutiny.
Balance Sheet Review • Ensure all balance sheets are reconciled at appropriate intervals, and action is taken to address historical balances. • Monthly assessment of existing provisions to determine whether these can be released during year as opposed to later in the year/year end. • Review all credit balances on the Balance sheet for potential over accrual (e.g. Annual Leave Accrual or GRNI balances).	• All balance sheet codes are reconciled monthly as part of the control account reconciliation processes. • Apart from control accounts, suspense accounts and centrally held balances reviews of accruals and provisions are calculated by the team supporting the Chief Finance Officers. Values over £100K need specific sign off by the relevant Chief Finance Officer (SOP FDP06). • In addition to this, a central overview of these local accruals is undertaken on a regular basis to test for consistency across the IHCs and appropriateness. • For pan BCU accruals these are also reviewed on a regular basis to ensure they are reasonable, with many being recalculated each month (e.g. Agency and Bank nursing).	• An unqualified audit opinion was received in relation to the 24/25 Financial Accounts.

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Financial Grip and Control Improvement Action Plan

Theme	Weakness	Action	Proposed Executive Lead	Proposed Operational Lead	Proposed Due Date	RAG
Framework & Guidance	Budget holder training	Assess budget holder knowledge via a questionnaire, signpost and support with training packages, assess impact through compliance.	Director of Finance	Finance Teams	Dec-26	Amber
Framework & Guidance	Business case governance	Implement revised business case process	Director of Planning / Finance	Planning Team	Dec-26	Amber
Framework & Guidance	Escalation framework	Embed performance and escalation framework	Director of Finance / COO	Performance Team	Dec-26	Amber
Workforce Planning	Planning not systematic	Implement Strategic Workforce Planning Framework linked to clinical strategy	Exec Director Workforce	AD Workforce Planning	Dec-26	Red
Recruitment	Recruitment delays	Streamline recruitment process	Exec Director Workforce	Recruitment Team	Dec-26	Red
Vacancy Control	Control needs strengthening	Enhance vacancy control scrutiny and implement vacancy reduction plan.	Exec Director Workforce	IHC Leads	Nov-26	Amber
E-Rostering	Incomplete deployment	Complete roll out of e-rostering across all relevant staff groups	Exec Director Workforce	Operational Leads	Dec-27	Red
Rostering	12 week compliance	Full compliance with 12 week rostering	Operational Directors	Service Leads	Dec-26	Amber
Medical Job Planning	Low compliance	Achieve >90% compliance	Medical Director	Clinical Directors	Mar-27	Red

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Medical Productivity	Monitoring not established	Implement productivity dashboard and reporting	Medical Director / COO	Medical Workforce Team/ operational leads	Jun-27	Red
Rota Alignment	Rotas not aligned	Align rotas to job plans	Medical Director	Operational Directors	Sep-27	Red
Workforce Governance	Governance fragmented	Establish integrated workforce governance framework	Exec Director Workforce & OD	AD Workforce Planning	Mar-27	Red
Temporary Staffing	Medical controls weaker	Implement equivalent agency governance	Medical Director / Workforce	Temporary Staffing Team	Nov-26	Red
Agency Usage	Off framework risks	Implement and ensure full compliance with framework controls – zero off framework.	Workforce / Procurement	Procurement Team	Nov-26	Red
Bank Staffing	Bank opportunities	Expand bank mode for relevant staff groups – medical, AHP, A& C, etc	Workforce	Workforce Leads	Sep-27	Amber
Overtime	Controls not operational	Introduce pre-authorisation controls	COO / Workforce	Divisional Teams	Aug-26	Red
Overtime Monitoring	No systematic review	Monthly audit of overtime	Finance / Workforce	Finance Teams	Dec-26	Red
WLI Governance	Reliance on self-certification	Independent validation and oversight	COO	Operational Teams	Dec-26	Amber
Procurement	Contract register incomplete	Complete and validate contract register	COO	Operational Teams	Dec-26	Amber
Estates	Strategy incomplete	Finalise Estates Strategy, linked to clinical strategy.	Director of Estates	Estates Team	Dec-26	Amber

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Allied Health Professionals Bank Spend

Period Year	Subjective Combo	P01	P02	P03	P04	P05
2025-26	2C950-Allied Health Prof - Bank	£609	£7,578	£3,640	£692	£1,064

Period Year	Subjective Combo	P01	P02	P03	P04	P05
2026-27	2C950-Allied Health Prof - Bank	£7,001	-£457	£11,382	£6,022	£930

P06	P07	P08	P09	P10	P11	P12	Total 2025/26	Avg per Month
£4,580	£7,467	£4,114	£3,881	£2,169	£8,149	£4,537	**£48,480**	**£4,040**

P06	Year to Date 2026/27	Avg per Month
£11,022	**£35,898**	**£5,983**

Period Year	Subjective Combo	CC Level 5	P01	P02	P03
2026	2C950-Allied Health Prof - Bank	AX21-Central Area	£349	-£156	£393
		CDSZ-Dental: CDS	£110	-	£110
		HX21-Ysbyty Glan Clwyd	£1,269	£1,036	-
		HX80-Diagnostics & Specialist Clinical Su	-£1,778	£5,695	£2,776
		MX01-Mental Health & LDS	-	£797	£153
		YX31-WF&OD Executive	-£38	-£16	£0
		YX53-Exec Director of Transformation, S	£697	£222	£209
		ZX03-Holding and Technical Adjustments	-	-	-
		Total	**£609**	**£7,578**	**£3,640**

Period Year	Subjective Combo	CC Level 5	P01	P02	P03
2027	2C950-Allied Health Prof - Bank	AX21-Central Area	£1,777	£318	£1,885
		CDSZ-Dental: CDS	-	£248	£104
		HX80-Diagnostics & Specialist Clinical Su	£5,190	-£2,368	£7,996
		MX01-Mental Health & LDS	£41	£540	-£118
		YX31-WF&OD Executive	-£7	-£2	-£6
		YX53-Exec Director of Transformation, S	-	£807	£1,520
		ZX03-Holding and Technical Adjustments	-	-	-
		Total	**£7,001**	**-£457**	**£11,382**

P04	P05	P06	P07	P08	P09	P10	P11	P12	2025/26 Total
£390	-£624	£261	£213	-£227	£14	-£633	£656	-£656	**-£20**
-	£4	-	£202	-	-	-	-	£126	**£552**
-	£31	-	-	-	-	-	-	-	**£2,336**
-£576	£694	£3,689	£5,922	£3,249	£3,168	£1,949	£7,500	£1,495	**£33,783**
£193	-£138	-£28	£261	£206	-£413	£206	-	-	**£1,239**
-£18	-£13	-£2	-£20	-£11	-£9	-£8	-£7	-£5	**-£147**
£705	£1,110	£660	£888	£896	£1,122	£654	-	£1,077	**£8,239**
-£1	-£1	-	-	-	-	-	-	£2,499	**£2,497**
£692	**£1,064**	**£4,580**	**£7,467**	**£4,114**	**£3,881**	**£2,169**	**£8,149**	**£4,537**	**£48,480**

P04	P05	P06	Total	
£519	-£282	£2,872	**£7,088**	
-	£562	-	**£914**	
£2,942	-£476	£7,080	**£20,365**	Radiography - Additional demand above core activity
£213	-£427	£213	**£463**	
-£1	-£3	-£4	**-£23**	
£2,352	£1,555	£860	**£7,094**	
-£4	-	-	**-£4**	
£6,022	**£930**	**£11,022**	**£35,898**	

Radiography - Additional demand above core activity

Performance & Finance Committee

PLANNED CARE UPDATE ON PROGRESS INCLUDING ADDITIONAL RESOURCE

Dyddiad y Cyfarfod **Date of Meeting**	27 October 2026
Statws Cyhoeddi **Publication Status**	Open/ Public Not Applicable
Enw a theitl Awdur(on) yr Adroddiad **Report Author name and title**	Michael Kaiser, Recovery Director, Planned Care Recovery Programme
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol **Lead Executive Team Member name and title**	Matt Powls, Interim Chief Operating Officer

Pwrpas yr Adroddiad **Report Purpose**	For Assurance

Crynodeb Gweithredol / Executive Summary

The Health Board is progressing a targeted programme of additional elective and diagnostic capacity in order to eliminate the number of patients waiting more than 104 weeks and achieve compliance with the eight-week diagnostic standard by March 2027. The programme is an important component of the Health Board's responsibility to restore timely access to care, mitigate the risks associated with prolonged waits and improve the experience of patients across North Wales.

There has been encouraging movement in the reported position. September 2026 closed with 2,092 patients waiting more than 104 weeks, ahead of the agreed recovery trajectory. Diagnostic breaches reduced from 4,769 in September to 4,089 at 18 October, a reduction of 680 (14.3%), with eight-week compliance reported at 77%. These improvements are welcome, but the scale of the remaining challenge requires sustained additional activity and rigorous control of delivery assumptions.

The financial basis of the programme has changed materially. Initial funding notifications totalled £25,360,522; the subsequently confirmed allocation is £20,236,784, a difference of £5,123,738. Welsh Government has separately indicated that up to £950,000 may be used for the deployment team, with year-end assurance to be sought if fully utilised. Financial commitments and the pace of mobilisation must therefore be managed against the confirmed allocation, with the conditional element separately visible.

Operational mobilisation is advancing through validation, waiting list initiatives, outsourcing and the procurement of insourcing services. However, the insourcing programme remains exposed to a compressed delivery window, particularly as insourced activity is not expected to commence until mid-January 2027, and to the outstanding appointment of a dedicated Insourcing Operational Lead. The revised year-end trajectories also require a single agreed baseline against which progress and forecast outcomes can be assessed consistently.

The executive assessment is one of partial assurance: the direction of travel is positive and enabling arrangements are being progressed, but delivery against the full year-end ambition is not yet demonstrably secured. The next phase will require tighter integration of clinical prioritisation, specialty-level capacity, expenditure, procurement milestones and continued reductions in waiting times. The Committee is invited to recognise progress while maintaining close scrutiny of these dependencies.

Ymgysylltu (mewnol/allanol) yr ymgymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp) **Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)**		
Pwyllgor / Grŵp / Unigolion. Committee / Group / Individuals	**Dyddiad Date**	**Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data**
BCU Private Board	24/09/2026	On 24 September 2026, the Board supported a paper highlighting the additional activity required utilising the funding from Welsh Government to reduce the 104 week waiters.

Acronymau / Rhestr Termau / Acronyms / Glossary of Terms	
WG	Welsh Government
IHC	Individual Health Community
BCUHB	Betsi Cadwaladr University Health Board
IP/DC	In-patient / Day Case
WLI	Waiting List Initiative
ECR	Establishment Control Request
ITT	Invitation to Tender

PLANNED CARE UPDATE ON PROGRESS INCLUDING ADDITIONAL RESOURCE

1. Y SEFYLLFA / SITUATION

1.1. The planned care recovery programme is directed towards two priority outcomes: eliminate the cohort waiting more than 104 weeks for elective treatment and improving access to diagnostics within eight weeks. The approach combines targeted additional activity with the operational infrastructure required to mobilise, oversee and evaluate delivery.

1.2. The September closing position of 2,092 patients waiting over 104 weeks is ahead of the agreed trajectory. The reported diagnostic position at 18 October was 4,089 breaches, compared with 4,769 in September. The programme must now convert this improvement into a sustained rate of reduction sufficient to meet the March 2027 expectations.

1.3. The 104-week trajectory has been revised during October. The original narrative refers to 267 breaches at March 2027, while the detailed update describes a reprofiled position of 100 from a previous figure of 256, Welsh Government expectations are described as zero. These figures must be reconciled and one formally agreed trajectory established. Until that is completed, the year-end forecast cannot be presented as a settled delivery commitment.

1.4. The diagnostic ambition has similarly been strengthened from 90% to 100% compliance with the eight-week standard by March 2027. This is a substantial acceleration from the reported 77% position and will require clear modality-level plans, sufficient clinical and reporting capacity and robust weekly monitoring of demand and clearance.

2. Y CEFNDIR / BACKGROUND

2.1. Following the July 2026 recovery submission, the Health Board received a funding notification of £5,459,942 on 21 August and a further notification of £19,900,580 on 8 September, together amounting to £25,360,522. On 23 September, the total allocation was clarified as £20,236,784. On 15 October, further correspondence indicated that up to £950,000 could be used to support administration and the deployment team, subject to the stated year-end assurance arrangements.

2.2. The revised allocation represents a reduction of £5,123,738 against the aggregate value of the initial notifications and is material to the assumptions underpinning programme delivery. Accordingly, the Health Board's approach is to align the phasing of activity, contractual commitments and supporting infrastructure to the confirmed funding position, while maintaining clear visibility of expenditure dependent upon further approval.

2.3. Financial oversight will need to bring together the allocation by intervention, committed and actual expenditure, forecast outturn, planned and delivered activity and the associated cost of additional capacity. This will enable the Committee to assess whether investment is translating into demonstrable reductions in waiting times and to identify variances requiring timely corrective action. A fully reconciled expenditure and activity profile is required to provide that assurance.

2.4. The Health Board has progressed preparatory work during the period of funding clarification to avoid unnecessary delay. A programme of validation, WLIs and outsourcing has commenced. On 24 September 2026, the Board supported the principle of substantive staff undertaking work through insourcing providers under PAYE employment arrangements rather than personal service companies. This is an important workforce enabler, subject to appropriate clinical governance, workforce safeguards and assurance that core service delivery is not adversely affected.

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

Recovery trajectories and performance

3.1. The reported improvement in the 104-week cohort is encouraging, but assurance must rest on a validated trajectory that reconciles the opening cohort, new patients crossing the threshold, completed treatment and other legitimate waiting-list movements. A consistent view by specialty and Integrated Health Community will allow management attention and additional capacity to be directed where they can have the greatest impact.

3.2. For diagnostics, the reduction of 680 breaches is positive. The remaining 4,089 breaches and the revised requirement for full eight-week compliance demand detailed plans by modality, with transparent assumptions on demand, staffing, equipment availability, reporting capacity and the weekly volume of additional tests required.

3.3. The operational priority is to move rapidly from the identification of opportunities to confirmed sessions and completed patient pathways, with a particular emphasis on reducing the longest waits safely and equitably. Activity should be demonstrably additional to core provision and assessed for its effect on workforce availability and routine productivity.

Insourcing procurement and mobilisation

3.4. The procurement timetable provides for Invitation to Tender (ITT) publication on 21 October, closure on 11 November, evaluation during November, standstill from 30 November to 10 December and contract signature on 11 December. Subject to the procurement process and mobilisation

requirements, the earliest practical commencement of insourcing activity is anticipated in mid-January 2027. Please refer to Table 1 below.

3.5. This leaves a limited period in which insourcing can contribute to the March 2027 recovery objectives. Successful contract award will therefore be only one measure of readiness. The programme will also need to secure clinical specifications, provider staffing, available theatre and diagnostic capacity, patient selection and scheduling, information flows, quality assurance and agreed mobilisation milestones. Procurement challenge remains a recognised risk and will be managed through a robust, properly documented evaluation process.

Table 1: Insourcing Procurement Timetable

Stage	Timeline	Responsibility
Specification clarifications completed	16/10/26 (midday)	BCUHB
Contract Briefing Produced & Signed off	19-20/10/2026	Procurement / BCUHB
ITT Published (3 weeks)	21/10/2026	Procurement
Tender Closes	11/11/2026 (midnight)	Procurement
Bids Collated	12-13/11/2026	Procurement
Evaluation (Technical & Quality)	16-20/11/2026	BCUHB
Evaluation (Commercial & Social Value)	16-20/11/2026	Procurement
Evaluation returned to Procurement	20/11/2026	BCU HB
Commercial Evaluation & Technical / Quality collated / Production of Procurement Outcome Report	23-27/11/2026	Procurement
Award placed into Standstill	30/11/2026	Procurement
Standstill ends	10/12/2026	Procurement
Contract Award (Signature)	11/12/2026	BCU HB

Programme capacity and operational accountability

3.6. Recruitment to the deployment team is progressing through the Health Board's establishment control arrangements, including internal and bank routes where appropriate. The Insourcing Operational Lead will be a critical appointment, and the recovery programme will agree the appropriate leadership capacity by the end of October.

3.7. Dedicated operational leadership is essential to convert procured capacity into safely delivered patient activity. Pending substantive appointment, clear interim ownership of mobilisation, contractual interfaces, clinical governance and performance reporting will be required. The programme will maintain a single integrated delivery schedule with named accountability for each dependency.

3.8. A separate report is being presented to QSE in October as an additional update to the February 2026 report on delivery and key quality matters arising from The National Outpatient Insourcing Programme devolved to BCUHB by WG from August 2025. This sets out key learning from the

programme that major commissioned initiatives require dedicated Quality, Patient Safety and Medical Leadership resource to provide proportionate oversight, assurance and governance, ensuring quality and safety considerations are effectively managed throughout delivery.

Delivery assurance and sustainability

3.9. The recovery programme will be governed through a consistent weekly assessment of planned against delivered activity, changes in the waiting-list cohorts, workforce constraints, financial commitments and emerging clinical risks. Reporting to the Committee should distinguish leading indicators of mobilisation from the outcomes that matter to patients: completed pathways, fewer excessive waits and improved diagnostic access.

3.10. The longer-term position requires equal attention. Non-recurrent additional activity can reduce the backlog, but the improvement will not be sustained unless underlying demand, productivity, capacity and pathway constraints are addressed. The proposed external sustainability support remains a dependency requiring a timely decision and a clear statement of its intended contribution, cost and accountability.

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

4.1. Delivery against the revised trajectories. The scale of the remaining backlog, the strengthened March ambitions and the short time available for insourcing create a material risk of under-delivery. Mitigation requires a validated specialty-level activity plan, agreed trajectories and weekly exception management.

4.2. Financial affordability and control. The revised funding envelope creates a risk that previously planned commitments may exceed confirmed resources. Commitments should be reviewed against the £20,236,784 allocation, with conditional deployment team expenditure identified separately and a reconciled forecast provided through finance governance.

4.3. Procurement and mobilisation. Any challenge to contract award or slippage in the mobilisation period would further reduce available delivery time. Procurement compliance, readiness planning and explicit escalation of milestone variance are essential.

4.4. Workforce and clinical capacity. Delayed appointment of the Insourcing Operational Lead and competition for substantive clinical staff could constrain delivery or affect core services. Interim leadership, workforce controls and clinically led scheduling are required.

4.5. Sustainability and patient impact. Without parallel improvement in recurrent capacity and pathway productivity, reductions in long waits may not be

maintained. Continued lengthy waits also carry risks of clinical deterioration, inequity and poor patient experience; clinical prioritisation and patient communication must remain integral to the programme.

5. ARGYMHELLION / RECOMMENDATIONS

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

5.1. NOTE the improvement reported in the 104-week and diagnostic waiting positions and the continuing scale of the recovery requirement.
5.2. NOTE the confirmed allocation of £20,236,784 and the separate, conditional arrangements concerning up to £950,000 for deployment-team support.
5.3. RECOGNISE the material delivery dependencies associated with insourcing mobilisation, programme leadership and the revised March 2027 trajectories.
5.4. SEEK ASSURANCE that a single reconciled trajectory and an integrated financial, activity and mobilisation plan will underpin subsequent performance reporting.
5.5. SUPPORT continued executive focus on clinically safe additional activity, financial control and sustainable improvement in timely access to care.

ASESIAD / ASSESSMENT	
Cysylltiad â'r Bwriadau Strategol **Link to Strategic Intentions**	3. Improve Access, Outcomes and Experience If more than one applies, please list below:
Yr Egwyddorion Dylunio Design Principles	Equity and Accessibility
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd **Corporate Risks and Board Assurance Framework**	CRR25-01 Timely Access to Safe, Effective Care BAF 24-07 Timely Access to care

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

Human Rights Act *Have Human Right based concerns been addressed within WP8a*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
Compliance to the Welsh Language requirements? *Have you undertaken an Impact Assessment*	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Naddo/No: ☒
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Compliance to giving 'Due Regard' to the principles of the Armed Forces Covenant *Have the principles of the Armed Forces Covenant been addressed within WP8a*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Ansawdd *A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Galluogwyr Ansawdd Enablers of Quality Choose an item. Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals	A Resilient Wales	
Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	

	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Asesiad o Effaith ar Ddiogelu Data *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?* **Data Protection Impact Assessment** *Have you undertaken a Data Protection Impact Assessment Screening?*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Asesiad o Effaith ar Atal Twyll *A ydych chi wedi ystyried yr effeithiau ar atal twyll?* **Counter Fraud Impact** *Have you considered the counter fraud impacts*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Cyfreithiol **Legal**	There are no specific legal implications related to the activity outlined in this report.	
Enw Da **Reputational**	Yes (Include further detail below)	
	There is a risk to the reputation of the Health Board as a result of poor patient experience and potential harm from enduring long waits for review and / or treatment	
Effaith ar Adnoddau *(Pobl / Ariannol)* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

Performance & Finance Committee

URGENT & EMERGENCY CARE – UPDATE ON IMPLEMENTATION OF IMPROVEMENT PLAN

Dyddiad y Cyfarfod **Date of Meeting**	27 October 2026
Statws Cyhoeddi **Publication Status**	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad **Report Author name and title**	Bridget Elliott, Recovery Director Urgent & Emergency Care
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol **Lead Executive Team Member name and title**	Matt Powls, Interim Chief Operating Officer

Pwrpas yr Adroddiad **Report Purpose**	For Assurance

Crynodeb Gweithredol
Executive Summary

Urgent and Emergency Care (UEC) remains one of the Health Board's most significant operational and strategic challenges, with continued pressures on patient flow, ambulance handovers, emergency department performance and timely discharge. Following the Healthcare Inspectorate Wales (HIW) inspection of the Emergency Department at Ysbyty Glan Clwyd, which resulted in a designation of Significant Improvement, the Health Board has progressed a comprehensive programme of recovery and improvement aligned to both regulatory requirements and wider system priorities.

Since Board approval of UEC recovery investment in July 2026, significant progress has been made in moving from planning to implementation. Strengthened governance arrangements are now in place, including enhanced executive oversight, daily operational reviews, weekly performance monitoring and formal assurance processes. Additional nursing and medical workforce capacity has been recruited, quality monitoring arrangements have been strengthened, and a number of operational improvements have been introduced to support patient flow, safety and service resilience. Learning from the HIW inspection has been reviewed and applied across all emergency departments to ensure a consistent organisational response.

The Board-approved UEC Improvement Plan, finalised in September 2026, now provides a single overarching framework for urgent and emergency care improvement across North Wales. Importantly, actions arising from the HIW inspection are fully integrated within the wider improvement programme rather than being managed separately, recognising that the underlying issues are system-wide and require whole-system solutions. The plan aligns WG priorities, local Integrated Health Community (IHC) delivery plans and regulatory actions within a single governance structure focused on sustainable improvement.

Revised governance arrangements are being implemented to provide greater operational grip and accountability including fortnightly UEC performance and delivery reviews across all IHCs, led jointly by the UEC Recovery Director and key programme leads. These arrangements will support the development of a future BCUHB UEC Operating Model and the introduction of Health Board-wide UEC standards to improve consistency in quality, performance and patient experience.

The Health Board has identified three immediate priorities where focused intervention is expected to have the greatest impact on patient safety, patient flow and operational performance:

- Frailty services and optimisation of Same Day Emergency Care (SDEC).
- Discharge to Recover and Assess (D2RA) and Integrated Discharge Hub development.
- Clinical engagement and accountability for patient flow across all specialties.

In addition, longer-term priorities are also being developed, including a strengthened Single Point of Access model, enhanced falls and frailty provision and further development of SDEC services. Opportunities are currently being explored to repurpose existing resources to support a broader multidisciplinary community access model and strengthen integration with discharge services.

While progress has been made in establishing the foundations for improvement, performance challenges remain significant and sustained delivery will be required to achieve the improvements expected in patient flow, ambulance handovers, 12-hour waits, discharge timeliness and compliance with regulatory requirements.

The Board is asked to:

- Note the progress made in implementing the UEC Improvement Plan and actions arising from the HIW inspection.
- Receive assurance regarding the strengthened governance, oversight and delivery arrangements now in place.
- Support the establishment of a formal UEC Operational Delivery and Improvement Group to oversee implementation of the Improvement Plan and development of a future BCUHB UEC Operating Model.
- Note that progress will continue to be monitored through key measures including patient flow, ambulance handover performance, 12-hour waits, discharge timeliness and compliance with HIW requirements.

Ymgysylltu (mewnol/allanol) yr ymgymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp) **Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)**		
Pwyllgor / Grŵp / Unigolion **Committee / Group / Individuals**	**Dyddiad** **Date**	**Canlyniad, Tystiolaeth a Data** **Outcome, Evidence and Data**

Acronymau / Rhestr Termau **Acronyms / Glossary of Terms**	
UEC	Urgent & Emergency Care
IHC	Integrated Health Communities
WG	Welsh Government
HIW	Healthcare Inspectorate Wales
ED	Emergency Department
SDEC	Same Day Emergency Care
D2RA	Discharge to Recover then Assess
SPOA	Single Point of Access
YGC	Ysbyty Glan Clwyd
IDH	Integrated Discharge Hub
ICB	Integrated Care Board
SICAT	Single Integrated Clinical Assessment & Triage
POCD	Pathway of Care Delays

URGENT & EMERGENCY CARE – UPDATE ON IMPLEMENTATOIN OF IMPROVEMENT PLAN

1. Y SEFYLLFA / SITUATION

1.1 Urgent and Emergency Care (UEC) remains one of the Health Board's highest operational and strategic priorities, reflecting ongoing performance challenges, patient safety risks and the requirements arising from both external review and regulatory scrutiny.

1.2 This report provides an update on the implementation of the Urgent and Emergency Care (UEC) Improvement Plan, approved by the Health Board, including progress against agreed priorities, delivery of investment approved by the Board, integration of actions arising from the Healthcare Inspectorate Wales (HIW) inspection at Ysbyty Glan Clwyd (YGC), and the strengthening of governance arrangements to support sustainable improvement.

1.3 Actions implemented to date include strengthened quality monitoring and executive review arrangements, increased substantive nursing and medical staffing, improvements in patient flow processes, the introduction of standard operating procedures for forward waiting and care in undesignated areas, and more consistent daily operational oversight. Quality reviews have also been undertaken across all Health Board emergency departments against the immediate actions identified following the HIW inspection to ensure learning is applied consistently across the organisation.

1.4 The Health Board has been clear that the response to the HIW findings should not be managed as a standalone regulatory action plan. Many of the issues identified reflect broader and longstanding pressures across the urgent and emergency care system, including patient flow, workforce capacity, discharge arrangements and operational leadership. Consequently, actions arising from the inspection are being incorporated within the wider Urgent and Emergency Care Improvement Plan to ensure that improvements in quality, safety, flow and service resilience are delivered through a single and coherent programme of work.

2 Y CEFNDIR / BACKGROUND

2.1 Following an unannounced inspection of the Emergency Department (ED) at YGC in May 2026, HIW designated the service as requiring Significant Improvement and issued an Immediate Assurance and Improvement Plan. The findings highlighted a range of concerns relating to patient safety, operational effectiveness, leadership, workforce culture and the clinical environment, requiring urgent and coordinated action by the Health Board.

2.2 In response, the Health Board established a comprehensive improvement programme designed to deliver rapid and sustainable improvements in the quality, safety and performance of the service. The programme is

underpinned by strengthened governance arrangements, including daily operational oversight, weekly performance reviews and formal monthly assurance processes. Senior leadership visibility and presence within the department have been significantly enhanced to support timely decision-making, proactive risk management and escalation of emerging issues.

2.3 BCUHB has been under the highest level of intervention held under NHS Performance & Improvement, which has resulted in weekly performance review and assurance sessions against delivery. The appointment of a UEC Recovery Director was identified to support the Health Board with this focus and post was recruited to in August.

2.4 Working alongside NHS P&I Colleagues, UEC immediate objectives and priorities were identified to support the development of BCUHB UEC Improvement Plan for 2026/27, which sets out the Health Board's strategic direction for improving urgent and emergency care services across North Wales. The plan is focused on delivering sustainable improvements in patient flow, reducing avoidable delays, improving length of stay, and strengthening whole-system collaboration across health, social care, ambulance services and the third sector.

2.5 At the heart of this plan is a commitment to ensuring patients receive the right care, in the right place, at the right time. By increasing the number of patients discharged within 48 hours of becoming clinically optimised, the Health Board will release much-needed inpatient capacity, reduce ED overcrowding, minimise ambulance handover delays, and improve both patient outcomes and experience.

2.6 The plan brings together the strategic and operational context for UEC, the findings and recommendations arising from the recently commissioned independent review (completed between January and April 2026), and the current positions of each IHC. Collectively, these elements provide a clear assessment of current challenges and opportunities and establish a coordinated approach to delivery across the Health Board during 2026/27.

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

3.1 At its July 2026 meeting, the Board recognised the scale and urgency of the challenges facing urgent and emergency care services and approved investment to support recovery and improvement. Since that decision, the focus has moved from approval to implementation, ensuring that agreed investment is translated into additional workforce capacity, strengthened operational arrangements and measurable improvements in patient care. The Board will continue to receive assurance regarding the deployment of investment and the measurable benefits achieved in patient outcomes, safety and operational performance.

3.2 The Health Board's UEC Improvement Plan has also been finalised and approved by the Board in September 2026. The plan establishes a single framework for delivering urgent and emergency care improvement across North Wales and aligns Welsh Government priorities, local Integrated Health Community (IHC) plans, and actions arising from the HIW inspection. This has also been shared more widely with all colleagues to ensure there is transparency and inclusion for all those working in the UEC pathways.

3.3 The Improvement Plan provides a comprehensive account of:

- progress against agreed actions and milestones;
- implementation of the investment approved by the Board;
- incorporation of actions arising from the HIW inspection;
- key delivery risks and dependencies;
- evidence of impact on quality, safety, patient flow and patient experience;
- areas where progress remains insufficient or where further intervention is required.

3.4 The Board is also considering the Integrated Performance Report elsewhere on this agenda, which provides the detailed assessment of urgent and emergency care performance, including operational indicators, trajectories and emerging trends. This report does not seek to duplicate that information. The Integrated Performance Report and the UEC Improvement Plan should therefore be read together.

3.5 Recognising the need for immediate action alongside longer-term transformation, all IHC's have now refreshed and begun working towards their individual 90 day improvement plans all refreshed on the 1st October. These plans have all been mapped against the strategic and ministerial priorities to assess efficacy against delivery.

Major Change Programmes and Operational Delivery

3.6 During development of the UEC Improvement Plan, it became evident that current governance arrangements do not provide a dedicated forum for coordinating and overseeing the operational development of urgent and emergency care across the Health Board.

3.7 As a result, there is currently no single mechanism through which a shared Health Board-wide vision for urgent and emergency care can be defined, implemented and assured. In addition, IHC Directors have been leading a number of major change programmes, whilst the Health Board's Transformation and Improvement resources have not always been aligned consistently to support delivery across all three IHCs. The existing UEC Programme Board has also experienced challenges in defining and agreeing its role and purpose.

3.8 To address these issues, the current governance structure is strengthened through the establishment of a fortnightly IHC UEC 90 Day reviews with the

attendance of UEC Recovery Director, 3 Pillars Programme Director, and Head of Performance. This group would provide operational grip, coordination and oversight across urgent and emergency care services and would support development of a future BCUHB UEC Operating Model.

3.9 This refreshed approach to UEC Improvement is aimed at establishing a common organisational framework for urgent and emergency care across the Health Board, supported by a suite of BCUHB Core UEC Standards. These standards would define non-negotiable expectations relating to access, patient flow, admission avoidance, emergency care, discharge processes and leadership. The intention is to ensure greater consistency in quality, performance and patient experience irrespective of location, whilst retaining sufficient flexibility to respond to local population needs and operational circumstances.

3.10 The proposed governance arrangements would also strengthen alignment between operational delivery and the Health Board's wider improvement programmes, including the Three Pillars Programme and Community by Design. Regular collaboration between programme leads will help ensure that interdependent workstreams are coordinated effectively, duplication is reduced and available resources are utilised more efficiently.

3.11 The ambition is to establish a single BCUHB urgent and emergency care system, delivered through locally responsive Integrated Health Communities, operating to a common set of standards, pathways and outcomes that ensure every citizen receives the right care, in the right place, first time.

UEC Recovery and BCUHB Priorities

3.12 BCUHB has established 3 immediate priorities which are aligned to the national ministerial priorities to reflect both deliverability and the scale of patient safety and flow risk each currently presents.

UEC Improvement Strategic Priorities

3.13 Immediate priorities are:

- Frailty
- Discharge to Recover then Assess (D2RA)
- Clinical Engagement

3.14 Medium term priorities are:

- Single Point of Access (SPOA)
- Falls and Frailty Provision
- Same Day Emergency Care (SDEC)

3.15 Priorities have been ranked using a consistent set of criteria rather than service preference or historical precedent. Each priority was assessed against:

- The scale and immediacy of patient safety risk
- The strength of evidence linking the priority to flow, handover and 12-hour breach performance
- Deliverability within current workforce and funding envelopes
- The degree to which BCUHB can influence outcomes directly versus being dependent on whole-system partners, including pace of projects.

Frailty and Same Day Emergency Care

3.16 **Aim:** Comprehensive frailty assessment services implemented consistently across all three acute hospital sites, ensuring frail older adults have equitable access to timely Comprehensive Geriatric Assessment (CGA) at the point of presentation, regardless of which site they attend.

3.17 **Current position**: Progress on the frailty programme has been slowed by uncertainty regarding available funding. This position has now been clarified and teams understand that no additional investment is currently available. The UEC Improvement Plan identifies frailty as a priority for future investment should funding opportunities arise or efficiencies be identified through cost improvement programmes.

3.18 All IHCs currently provide a level of frailty support. The Transformation & Improvement Team is undertaking a gap analysis and this will link to the ambitions around SDEC facilities to understand the current model in each area and identify opportunities to strengthen provision within existing resources during 2026/27.

3.19 All IHCs have SDEC facilities in place; however, utilisation remains inconsistent, with many areas failing to realise the intended operational benefits and efficiencies. The Transformation & Improvement Team is undertaking a detailed review of current provision and opportunities for improvement. This work will inform a delivery plan next month to maximise utilisation of SDEC capacity and support improved patient flow across the system.

3.20 Furthermore the ED Workforce business case will also support the next phase for each IHC being able to resource for their Frailty models.

Discharge to Recover and Assess (D2RA)

3.21 **Aim:** A Board-wide, standardised approach to discharge management, accelerating the transition to a D2RA model across all three IHCs. Current Patients with No Criteria to Reside (POCD) levels of 108–163 patients represent the largest single contributor to 12-hour waits and ambulance handover delays, with beds occupied by patients no longer meeting criteria to reside remaining unavailable for new admissions.

3.22 **Current position:** An Integrated Discharge Director has been successfully appointed, the post is funded through the Regional Partnership Board and hosted by BCUHB. Lisa Marshall, formerly of Nottinghamshire ICB, joined three weeks ago and is already making a significant contribution to the development of Integrated Discharge Hubs (IDHs) and the transformation of our D2RA pathways.

3.23 East IHC commenced a soft launch of its IDH ahead of the other areas. While this has highlighted some operational issues and temporary impacts on discharge flow, it has provided valuable learning that will inform implementation in the remaining IHCs. The Integrated Discharge Director is leading work to address these issues and ensure a more effective rollout across the Health Board.

Clinical Engagement

3.24 **Aim**: Strengthened clinical engagement and accountability for patient flow across all specialties, through agreed length-of-stay targets (from the intervention work carried out in Spring 2026), embedded Criteria Led Discharge protocols, and clear clinical ownership of admission, review and discharge decisions.

3.25 **Current Position:** Clinical engagement remains a critical priority, although success is more difficult to measure as it requires sustained cultural change. Importantly, our approach extends beyond medical engagement and seeks to strengthen involvement and ownership across the wider multidisciplinary workforce.

3.26 Several initiatives are supporting this objective:

3.26.1 UEC Annual Summit: Planning is underway for the first UEC Summit, bringing together colleagues from across the system alongside external speakers to share learning and develop solutions to common challenges.

3.26.2 Emergency Medicine Network: Karen Mottart, Clinical Lead for UEC, has begun work with Emergency Department clinical leaders to establish a pan-BCU Emergency Medicine Network

3.26.3 UEC Times Newsletter: The first edition will be published end of this week, creating a platform for sharing improvement work, good practice and team achievements across the organisation.

Single Point of Access (SPOA)

3.27 **Aim:** A phased Single Point of Access model, building on the existing Single Integrated Clinical Assessment & Triage (SICAT) service, providing a consistent, seven-day route into community-based care.

3.28 **Current position**: SPOA represents one of the most significant opportunities for system transformation this year. Following a quick review of the SICAT service and the appointment of the Integrated Discharge Director, I believe there is a realistic opportunity to deliver a strengthened model by Q4.

3.29 Current arrangements include approximately £500k associated with the SICAT service and a further £250k supporting GPOOH activity. The existing SICAT model is largely focused on GP support to the 111 service and is not delivering the wider benefits originally envisaged. I will therefore bring forward proposals to repurpose these resources to support a broader multidisciplinary approach aligned to both SPOA and Integrated Discharge Hub development.

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

4.1 While progress has been made in establishing the foundations for improvement, performance challenges remain significant and sustained delivery will be required to achieve the improvements expected in patient flow, ambulance handovers, 12-hour waits, discharge timeliness and compliance with regulatory requirements.

4.2 The Board will continue to receive regular assurance on implementation of the Improvement Plan, deployment of approved investment and evidence of impact on patient care, safety and operational performance.

5 ARGYMHELLION / RECOMMENDATIONS

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

- Note the progress made against the HIW Improvement Plan and wider UEC Improvement Programme.
- Receive assurance regarding the strengthened governance and delivery arrangements now in place.
- Support the establishment of a formal UEC Operational Delivery and Improvement Group to oversee delivery of the UEC Improvement Plan and future operating model development.
- Note that improvement will continue to be monitored against key indicators, including patient flow, ambulance handover performance, 12-hour waits, discharge timeliness and compliance with HIW requirements.

ASESIAD / ASSESSMENT	
Cysylltiad â'r Bwriadau Strategol **Link to Strategic Intentions**	3. Improve Access, Outcomes and Experience If more than one applies, please list below:
Yr Egwyddorion Dylunio **Design Principles**	Equity and Accessibility
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd **Corporate Risks and Board Assurance Framework**	CRR25-01 BAF24-07

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

Human Rights Act *Have Human Right based concerns been addressed within WP8a*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
Compliance to the Welsh Language requirements? *Have you undertaken an Impact Assessment*	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Naddo/No: ☒
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Compliance to giving 'Due Regard' to the principles of the Armed Forces Covenant *Have the principles of the Armed Forces Covenant been addressed within WP8a*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Ansawdd *A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Galluogwyr Ansawdd Enablers of Quality Choose an item. Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals	A More Equal Wales	
Effaith Amgylcheddol / Cynaliadwyedd (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	

Environmental /Sustainability Impact (5Rs)	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Asesiad o Effaith ar Ddiogelu Data *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?* **Data Protection Impact Assessment** *Have you undertaken a Data Protection Impact Assessment Screening?*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Asesiad o Effaith ar Atal Twyll *A ydych chi wedi ystyried yr effeithiau ar atal twyll?* **Counter Fraud Impact** *Have you considered the counter fraud impacts*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Cyfreithiol **Legal**	There are no specific legal implications related to the activity outlined in this report.	
Enw Da **Reputational**	Yes (Include further detail below)	
	There is a risk to the reputation of the health board as a result of delays to patients and poor experience	
Effaith ar Adnoddau *(Pobl / Ariannol)* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Performance & Finance Committee

VALUE & SUSTAINABILITY PROGRAMME – M6 UPDATE

Date of Meeting	27 October 2026
Publication Status	Open/ Public
	Not Applicable
Report Author(s) name and title	Neil Windsor: Programme Director for Value & Sustainability
Lead Executive Team Member name and title	Alan Streets: Interim Executive Director of Finance, Dr Clara Day: Executive Medical Director

Report Purpose	For Noting

Executive Summary

Purpose:

This paper provides PFIG with an update on the Health Board's savings delivery at Month 6 (split by individual value workstream) and seeks to assure members that work is underway to evolve programme reporting from a predominantly financial focus towards a broader assessment of value. This recognises that sustainable improvement requires not only the delivery of financial savings, but also demonstrable gains in productivity, efficiency, outcomes, experience and environmental sustainability. Whilst this approach is still in its formative stages, the paper describes the progress made to date and the actions being taken to ensure that these non-financial dimensions of value become increasingly visible and integral to decision-making and performance oversight.

Headline Summary of Issues:

- In total, the current identified savings opportunity is £58.2m (including Red RAG and Pipeline schemes).
- Assured Green RAG-rated savings total £53m, although only £33.6m is categorised as 'budget releasing'.
- Work is progressing to map non-financial metrics of value, particularly from the 'Major Change Programmes (MCP's).

Key Findings:
The V&S Programme is strategically aligned to national policy and integrates financial, clinical, operational and workforce considerations into a single value framework.

At Month 6:

- At M6, the savings are split as follows; £33.6m Green (Budget Releasing), £19.4m Green (Non Budget Releasing), £0.6m (Red), £4.7m (Pipeline).

Savings Plan by V&S Workstream

Workstreams	Green * (Budget Releasing)	Green * (Non Budget Releasing)	Red	Pipeline	TOTAL
1. Workforce	7,534,193	13,726,353	232,813	2,421,967	23,915,327
2. Medicines Management	12,477,776	2,742,317	0	0	15,220,093
3. Non-Pay & Procurement	4,441,293	1,627,125	229,033	939,180	7,236,631
4. Continuing Health Care (CHC)	5,683,720	0	0	0	5,683,720
5. Clinical Value & Service Reconfiguration	2,304,945	0	0	1,000,000	3,304,945
Other	1,116,938	1,304,939	143,711	320,000	2,885,588
TOTAL	**33,558,865**	**19,400,734**	**605,557**	**4,681,147**	**58,246,303**

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 validated SSD's (non budget releasing)
Green RAG	Savings opportunities fully profiled with validated SSD's (budget releasing)

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

2027/28	2028/29
Pipeline	Pipeline
£3.8m	£0m

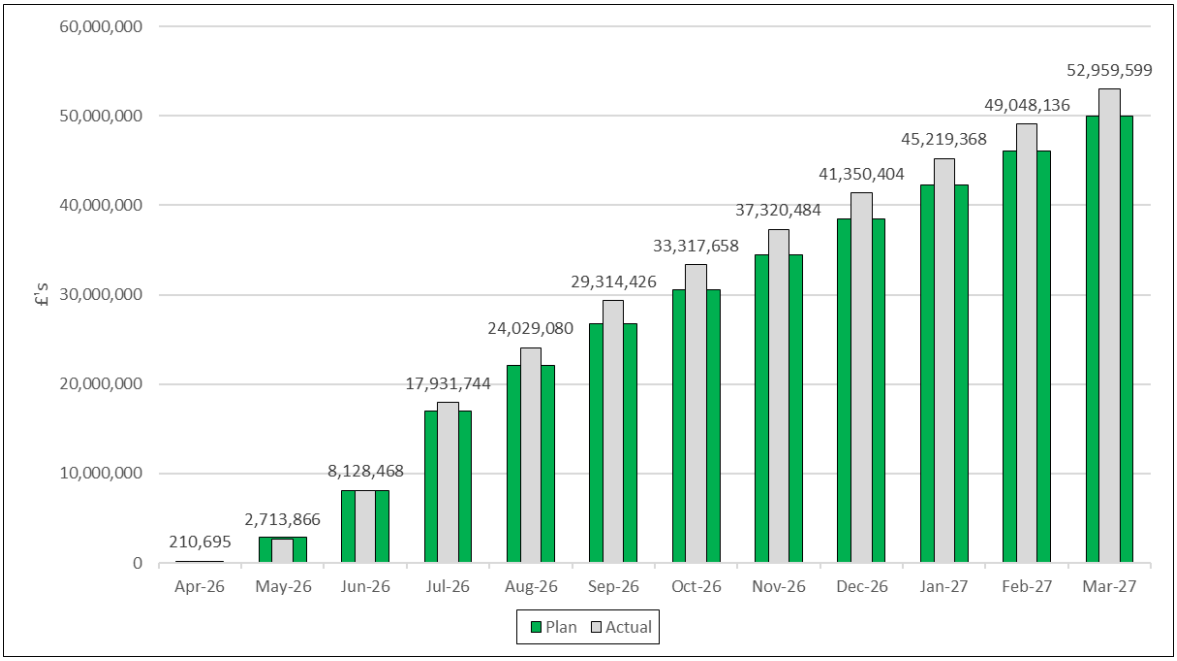
The Green RAG-rated profile has improved by £5.5m in month, however the additional savings are largely non-budget releasing, which highlights the need to convert the remaining pipeline opportunities and Red RAG schemes into assured value and continue to identify additional savings schemes to mitigate the gap.

Additional high-value opportunity areas have been identified but require further quantification and therefore do not form part of the current pipeline of opportunities at M6. These include:

- Estates Rationalisation
- Clinical Procurement Standardisation (requires invest to save funding)
- Additional CHC initiatives (requires invest to save funding)
- Other Corporate Non-Pay Opportunities
- Commissioning
- GIRFT-type Productivity & Efficiency
- Other Workforce Opportunities (i.e. additional grip & control)

From a delivery perspective, we are forecasting to over-deliver against original plan by £3m at year end (see fig 1).

Fig 1 - Forecast delivery Profile at M6



Work is continuing, to capture non-financial value benefits, particularly in regards to measures of productivity, efficiency, outcomes and environmental sustainability, with support provided to the other Major Change Programmes (MCP's) to map and report benefits, via a more comprehensive value reporting tool.

Risks & Implications:

- **Financial risk:** Failure to identify additional saving schemes to close gap of £12.4m in Green RAG 'budget releasing' delivery.
- **Delivery risk:** Ability to transition the remaining pipeline into Green RAG savings and deliver in Q3/4.
- **Strategic risk:** Capacity/capability to transition GIRFT-type opportunities to improve efficiency and productivity.

Actions Undertaken or In Progress:

- Meetings held with Programme Directors to begin mapping value opportunities within Major Change Programmes (MCP's), this will continue for the remainder of Q3.
- Work continues to validate and transition remaining pipeline opportunities.

Ask of the Group:

The Committee is asked to:

- **Note** the scale of the identified opportunities (including Green RAG), which now exceed the original £46m target.
- **Note** the emerging work to map non-financial metrics of value into the programme, particularly from the 'Major Change Programmes' (MCP's).

Engagement (internal/external) undertaken to date (including receipt/ consideration at Committee/Group) *Detail in here the engagement that has already been undertaken, for example discussed at QSE on [date], where the proposal was approved in principle*		
Committee / Group / Individuals	**Date**	**Outcome, Evidence and Data**
Not applicable for this report		

Acronyms / Glossary of Terms *Include in here all the acronyms included in the paper to aid the reader. Do not assume that everyone will be aware of the terminology used.*	
M6	Month 4
PFIG	Performance, Finance & Information Governanace
V&S	Value & Sustainability
RAG	Red, Amber, Green
CHC	Continuing Health Care
MCP's	Major Change Programme
GIRFT	Getting It Right First Time
Q3/4	Quarter 3-4
IHC's	Integrated Health Communities
BAF	Board Assurance Framework

Value & Sustainability Programme

1. SITUATION

1.1. This paper provides PFIG with an update on the Health Board's savings delivery at Month 6 (split by individual value workstream) and seeks to assure members that work is underway to evolve programme reporting from a predominantly financial focus towards a broader assessment of value.

1.2. The programme recognises that sustainable improvement requires not only the delivery of financial savings, but also demonstrable gains in productivity, efficiency, outcomes, experience and environmental sustainability. Whilst this approach is still in its formative stages, the paper describes the progress made to date and the actions being taken to ensure that these non-financial dimensions of value become increasingly visible and integral to decision-making and performance oversight.

2. BACKGROUND

2.1 During Month 6 (M6), the primary focus of the Value & Sustainability Programme has been on strengthening delivery confidence against the £46m savings target through targeted intervention to transition the remaining schemes from pipeline and red-rated status into green-rated delivery.

2.2 Simultaneously, the workstreams (and IHC's as part of their 2% savings plan) have continued to identify and develop financial recovery plans to address the remaining financial gap.

2.3 Work has continued to mature the programme from a traditional savings-based approach towards a broader value-based framework by mapping the initiatives within the Major Change Programmes (MCP's) that deliver against the wider definition of value (productivity, efficiency, outcomes, experience and sustainability).

3. SPECIFIC MATTERS FOR CONSIDERATION

3.1 Overall Programme Position

At Month 6 of 2026/27, the programme has identified (see Fig. 1) a total savings opportunity of **£58.2m**, against a target of £46m comprising of:

- £33.6m Green (Budget Releasing) RAG schemes
- £19.4m Green (Non-Budget Releasing) RAG schemes
- £0.6m Red RAG schemes
- £4.7m Pipeline schemes

Fig 1 – M6 Savings Profile by V&S Workstream

Savings Plan by V&S Workstream					
Workstreams	**Green *** (Budget Releasing)	**Green *** (Non Budget Releasing)	**Red**	**Pipeline**	**TOTAL**
1. Workforce	7,534,193	13,726,353	232,813	2,421,967	23,915,327
2. Medicines Management	12,477,776	2,742,317	0	0	15,220,093
3. Non-Pay & Procurement	4,441,293	1,627,125	229,033	939,180	7,236,631
4. Continuing Health Care (CHC)	5,683,720	0	0	0	5,683,720
5. Clinical Value & Service Reconfiguration	2,304,945	0	0	1,000,000	3,304,945
Other	1,116,938	1,304,939	143,711	320,000	2,885,588
TOTAL	**33,558,865**	**19,400,734**	**605,557**	**4,681,147**	**58,246,303**

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 validated SSD's (non budget releasing)
Green RAG	Savings opportunities fully profiled with validated SSD's (budget releasing)

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

2027/28	2028/29
Pipeline	Pipeline
£3.8m	£0m

Work continues with the IHC's to review and translate the remaining, reprofiled workforce opportunities from pipeline to green.

In addition, further unquantified opportunities exist in the following areas: -

- Estates Rationalisation
- Clinical Procurement Standardisation (requires invest to save funding)
- Additional CHC initiatives (requires invest to save funding)
- Other Corporate Non-Pay Opportunities
- Commissioning
- GIRFT-type Productivity & Efficiency
- Other Workforce Opportunities (i.e. grip & control)

Proactive discussions have taken place to develop plans for 27/28, with £3.8m of pipeline opportunities already identified.

3.2 Non-Financial Metrics of Value – Work to Date

Over recent months, focused work has been undertaken with the Programme Directors leading the Health Board's the major change programmes to establish a consistent approach to identifying, measuring and reporting value beyond traditional financial metrics. Using an agreed Benefits Framework as the foundation, a series of collaborative programme reviews have been completed to map the wider determinants of value generated through initiatives within each programme. This has included defining and aligning benefits across a number of domains, including patient outcomes, patient and carer experience, staff experience, equity of access, quality and safety, productivity, system flow, prevention, sustainability and financial stewardship. The work has sought to move the organisation from a narrow focus on savings delivery towards a more balanced assessment of whether programmes are delivering meaningful improvements for patients, staff and the wider system.

Each programme has begun identifying schemes that map against the main drivers of value and measures that demonstrate progress against these drivers.

The primary drivers of value we are mapping each programme against are: -

1. **Delivery of High Value, Evidence-Based Care** - Consistently deliver evidence-based care that improves outcomes, while reducing unwarranted variation and low-value activity.

Success Measures: Reduced unwarranted variation, improved clinical outcomes, reduced low-value activity (through adoption of best practice, evidence-based pathways).

2. **Reduced Avoidable Demand (Current & Future)** - Ensure the right care is delivered in the right place and at the right time, whilst increasing the use of interventions that reduce future system demand.

Success Measures: Reduced 'avoidable' demand (current via advice and guidance, alternative pathways of care, referral management, revised follow-up pathways, future via prevention and early intervention strategies).

3. **Optimise Capacity & Productivity** - Maximise value from our workforce, estate and resources by optimising productivity and maximising capacity with population need.

Success Measures: Increased throughput, improved flow, improved clinical outcomes, improved patient experience (through theatre productivity programme, outpatient improvement, patient flow and improved length of stay initiatives).

4. **Effective Stewardship of Our Resources** – Reduce waste, use our resources wisely and ensure every pound spent maximises value.

Success Measures: Cost avoidance, improved clinical outcomes and carbon reduction (through waste reduction, better estates utilisation, optimising packages of care, effective medicines management, reduction in agency and premium pay expenditure and non-pay & procurement).

This approach is helping to create a common language of value across the Health Board, improve transparency of programme impact and support more informed decision-making, by demonstrating how transformational initiatives contribute to the delivery of better outcomes, improved experiences, greater sustainability and more efficient use of resources.

4. KEY RISKS / MATTERS FOR ESCALATION

4.1 Savings Gap & Pipeline Maturity

Green RAG-rated savings exceed the £46m target, however only £33.6m is budget releasing, leaving a gap of £12.4m.

Alignment to Corporate Risk Register / BAF:
- Financial sustainability / failure to achieve financial balance

Potential Impact
- Failure to meet statutory financial duties
- Increased in-year deficit and need for non-recurrent measures
- Reduced confidence from Welsh Government and stakeholders

Board / Committee ask:
- **Note** the work to close the 'budget releasing' gap and to identify additional in-year opportunities to deliver financial balance.

4.2 Ability to Map & Capture Wider Measures of Value

Failure to define and track the non-financial benefits delivered through major change programmes may result in an incomplete assessment of value.

Alignment to Corporate Risk Register / BAF:
- Quality and outcomes improvement

Potential Impact
- Failure to realise/report opportunities to improve outcomes, efficiencies and productivity

Board / Committee ask:
- Note the continued work to widen value reporting to include non-financial metrics, which should conclude by the end of Q3.

5. RECOMMENDATIONS

5.1. The Committee/Meeting/Group is asked to:

- **NOTE** and **COMMENT** on the paper

ASSESSMENT	
Link to Strategic Priorities	
	2. Developing strategy and long-lasting change
	4. Improving quality, outocmes and experience
Design Principles	Wise Spending Simplify, Standardise, and Adopt Best Practices
Corporate Risks and Board Assurance Framework	**BAF24-03** - Not Achieving Long Term Financial Sustainability **BAF24-06** - Not Delivering the Required Improvements to Transform Care and Enhance Outcomes **BAF24-08** - Not Implementing Evidenced Based Improvement and Innovation
Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales
	A Globally Responsible Wales A Prosperous Wales A Resilient Wales

IMPACT ASSESSMENTS		
Equality *Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)*	Yes: ☐	No: ☒
	Outcome:	N/A
	If no, please include rationale:	This report is purely administrative in nature and submitted for information only.
Socio-Economic Impact Assessment *Have you undertaken a Socio-Economic Impact Assessment*	Yes: ☐	No: ☒
	Outcome:	N/A.
	If no, please include rationale:	This report is purely administrative in nature and submitted for information only.
Quality *Have you undertaken a Quality Impact Assessment Screening?*	**Enablers of Quality** All Apply	**Domains of Quality** All Apply
Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales	
Environmental /Sustainability Impact (5Rs)	Yes - Reduce	
	Yes - Recycle	
Armed Forces Covenant Due Regard Duty Have you considered the Armed Forces Covenant Due Regard Duty?	Yes: ☐	No: ☒
	Outcome:	N/A.
	If no, please include rationale:	This report is purely administrative in nature and submitted for information only.
Data Protection Impact Assessment *Have you undertaken a Data Protection Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	N/A.
	If no, please include rationale:	This report is purely administrative in nature and submitted for information only.
	Yes: ☐	No: ☒

Counter Fraud Impact Assessment *Have you considered the counter fraud impacts*	Outcome:	N/A.
	If no, please include rationale:	This report is purely administrative in nature and submitted for information only.
Legal	There are no specific legal implications related to the activity outlined in this report.	
	N/A.	
Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
	N/A.	
Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	
	N/A	

Update on the Internal Audit for Nuclear Medicine Consolidation

Helen Hughes

Professional Service Manager Radiography/ADAHPHS

Nuclear Medicine Consolidation Project Director

Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	**Project Performance:** Consideration of performance against project objectives (e.g. time, cost, benefits, critical success factors etc.).	1,5	**Unsatisfactory**
2	**Governance:** To assess whether the project's governance framework is clearly defined, effectively operated, and provides robust management and control by reviewing programme management arrangements, the adequacy and effectiveness of workstreams, the operation of approval processes, and the project's overall readiness to proceed.	2,3	**Limited**
3	**Financial:** To evaluate whether the project's financial management arrangements are robust and well-governed by reviewing the adequacy of financial approvals and budget-setting processes; the effectiveness of financial monitoring and cost control (including use of Project Bank Accounts); the management of contingency and cost-related risks; and the arrangements for ongoing tracking and reporting of project costs.	4,5	**Unsatisfactory**
4	**Technical:** To evaluate whether the project's technical management is robust and compliant by assessing programme management arrangements, the determination and validation of target and actual costs, the adequacy of tender evaluations and contractual arrangements, the quality and completeness of site surveys, and compliance with acceptable framework conditions.	-	**Reasonable**
5	**Advisers:** To provide confirmation that advisers to the project were procured fairly and in line with procurement rules through review of procurement route for each adviser. Assurance that advisers were appropriately appointed with defined forms of contracts.	6	**Reasonable**
6	**Design:** To assess whether the project's design at Full Business Case stage is robust, affordable, and compliant with required standards by evaluating the management of derogations, the impact of value engineering and affordability decisions, adherence to design warranties, the adequacy of design sign-off and approval processes, and the effectiveness of change-management arrangements.		**Substantial**
7	**Planning:** To determine whether planning activities for the project are effective and compliant by assessing the status and management of planning approvals, the delivery of planning conditions and requirements, the adequacy of communication and coordination processes, and the effectiveness of arrangements for managing objections.	7	**Reasonable**
8	**Information:** To assess whether information management systems supporting the capital project are reliable, effective, and fit for purpose by evaluating the adequacy of processes, controls, and systems used to store, manage, and share project information		**Substantial**

Update on unsatisfactory and limited assurance items

Assurance Items 1 & 3

These relate to the delays caused by the delay to BCU submitting the scrutiny questions in relation to the revenue queries from Welsh Government. Unfortunately there was a delay of 7 months that was outside the control of the project board who made multiple escalations. Re-costing exercises and tendering are underway.

Assurance Item 2

This relates to attendance of the previous project director and the meeting of project team and board being joined to reduce duplication. New project Director in place and the meetings have been divided.

An action plan is in place to address all actions raised and is being monitored via the project board.

Performance and Finance Committee

CAPITAL GOVERNANCE

Dyddiad y Cyfarfod **Date of Meeting**	27 October 2026
Statws Cyhoeddi **Publication Status**	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad **Report Author name and title**	Pam Wenger, Director of Corporate Governance
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol **Lead Executive Team Member name and title**	Pam Wenger, Director of Corporate Governance

Pwrpas yr Adroddiad **Report Purpose**	For Assurance

Crynodeb Gweithredol
Executive Summary

This report sets out an emerging approach to strengthening the Health Board's capital governance arrangements, informed by the findings of the Capital Governance Advisory Review and, more recently, the Nuclear Medicine Internal Audit. The work responds to identified issues around clarity of accountability, financial and project oversight, organisational visibility and the timely reporting and escalation of capital risks.

The proposed direction is to strengthen the role of the Capital Investment Group (CIG) as the principal executive forum for capital investment scrutiny and oversight of the capital programme, providing clearer visibility of delivery, financial performance, risk and matters requiring escalation. Strategic Planning and Service Change would retain an important complementary role in setting the strategic, service and IMTP context for investment, rather than becoming an additional routine approval or reporting tier.

The emerging model seeks to establish a clearer distinction between strategic alignment, investment scrutiny, formal decision-making, delivery accountability and assurance, with decisions taken at the appropriate delegated level and escalation by exception. It also proposes a single lead scrutiny route for proposals with both capital and revenue implications, avoiding unnecessary duplication between governance forums.

Importantly, the proposals are not presented as a final governance model and have not yet been considered collectively by the Executive Team. They are being brought forward at this stage to support discussion and engagement, with the intention that the arrangements are refined through that process before being finalised.

The Committee is therefore asked to note the report and emerging approach, and to agree the establishment of a capital report for its next meeting, strengthening the Committee's visibility of capital delivery, affordability, significant risk and control.

Ymgysylltu (mewnol/allanol) yr ymgymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp) **Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)**		
Pwyllgor / Grŵp / Unigolion **Committee / Group / Individuals**	**Dyddiad** **Date**	**Canlyniad, Tystiolaeth a Data** **Outcome, Evidence and Data**

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

CAPITAL GOVERNANCE

15. Recommendations

- ENDORSE the proposed direction of travel for the Health Board's capital governance arrangements.
- SUPPORT the strengthening of CIG as the principal executive forum for capital investment scrutiny, gateway oversight, capital portfolio management and delivery accountability.
- AGREE that Strategic Planning and Service Change should set the strategic and IMTP context for investment but should not operate as a routine reporting or approval tier between CIG and Executive Committee.
- AGREE complementary responsibilities and defined interaction points between Strategic Planning and Service Change and CIG.
- SUPPORT one lead scrutiny route for proposals with both capital and revenue implications.
- AGREE that formal approvals remain with the officer or body holding the relevant authority under the Scheme of Reservation and Delegation and Standing Financial Instructions.
- AGREE escalation to Executive Committee by exception where collective judgement is required or authority, tolerance or strategic parameters are exceeded.
- SUPPORT PFIG as the principal Board-level assurance route and agree that a separate Capital Board should not be established at this stage.
- REQUEST revision of the relevant terms of reference, decision and escalation matrix, reporting arrangements and Capital Procedure Manual.

16. Proposed decision

The Executive Committee endorsed the proposed direction of travel and supported the strengthening of CIG as the principal executive forum for capital investment scrutiny, gateway oversight, portfolio management and delivery accountability. It agreed that Strategic Planning and Service Change should establish the strategic and IMTP context but should not form a routine reporting or approval tier. Formal approvals will remain with the authorised officer or body, with escalation to Executive Committee focused on material strategic choices, exceptions and matters outside delegation or tolerance. PFIG will provide the principal Board assurance route and a separate Capital Board will not be established at this stage.

1. Y SEFYLLFA / SITUATION

1.1 This paper proposes revised capital governance arrangements for the Health Board. The proposition is to strengthen accountability and decision-making without creating additional routine reporting layers.

2. Y CEFNDIR / BACKGROUND

2.1 The Health Board has recognised the need to strengthen its arrangements for the governance, oversight and delivery of capital investment. This follows recurring issues identified through the delivery and review of major capital schemes, including delays, additional costs and weaknesses in project governance. The Chief Executive subsequently commissioned an advisory review of the Health Board's capital governance arrangements, specifically prompted by issues arising from the Llandudno Hospital Orthopaedic Development.

2.2 The final advisory review found that a number of the issues identified were not new. The review therefore concluded that there was a need to reset capital governance arrangements and associated procedures, with clearer and consistently applied roles, responsibilities and accountabilities for the development and delivery of capital projects and programmes.

2.3 The review also identified a need to refresh the Health Board's Capital Procedure Manual so that it reflects current organisational arrangements, external requirements and recognised practice, supported by improved accessibility, communication and training. It further recommended development of standard documentation and project tools to support consistent compliance with national and local capital requirements.

2.4 This work needs to be considered alongside the Health Board's existing governance framework. The current Capital Projects Manual places the Executive Team, supported by the Capital Investment Group (CIG), at the centre of oversight of the capital programme and development of business cases, with formal approval operating through the Health Board's established governance arrangements.

2.5 There is therefore an opportunity to use the findings of the advisory review not simply to respond to individual recommendations, but to clarify the capital governance system as a whole. In particular, the revised arrangements should provide clear separation between strategic alignment, investment scrutiny, formal decision-making and delivery accountability, while ensuring decisions are taken at the lowest appropriate level within delegated authority and escalated where authority, tolerance or strategic significance requires it. This is the principle underpinning the proposed arrangements set out in this paper.

2.6 This also addresses the need to avoid introducing unnecessary additional approval layers. Strategic Planning and Service Change has an important role in establishing the strategic, service and IMTP context for investment, but the proposed approach is that it should complement CIG rather than operate as a routine additional reporting or approval tier between CIG and Executive Committee.

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

3.1 Proposed governance principles

	Principle	Application
1.	Strategy drives investment	Capital priorities should flow from the IMTP, agreed service strategies and organisational priorities.
2.	Clear accountability	Each group should have a distinct role, authority and expected outcome.
3.	Decisions at the lowest appropriate level	Decisions should be taken within formal delegation and agreed tolerances.
4.	Escalation by exception	Matters should move upwards only where authority, tolerance or strategic significance requires it.
5.	One lead route	Mixed capital and revenue proposals should have one lead scrutiny group, with input from the other.
6.	Management and assurance are distinct	Executive governance manages and decides; Performance and Finance Committee and the Board scrutinise assurance and reserved matters.

3.2. Proposed Governance

The model is not a sequential reporting chain. It defines the accountability of each forum and the points at which matters interact or escalate.

Forum	Primary accountability	Core question
Strategic Planning and Service Change	IMTP, strategic priorities and material service reconfiguration	Is this the right strategic priority?
Capital Investment Group	Capital scrutiny, gateways, portfolio management and delivery accountability	Is it affordable, deliverable and controlled?
Revenue Investment / Service Reconfiguration Group	Revenue investment and service reconfiguration scrutiny	Are the revenue and service consequences robust?
Executive Committee	Corporate decisions, strategic choices and material exceptions	Is collective Executive action or decision required?
Performance and Finance	Board-level scrutiny and assurance	Are delivery, affordability and risk appropriately controlled?
Board	Strategy, accountability and reserved decisions	Is a reserved decision required and is assurance sufficient?

3.3 Strategic Planning and Service Change

Strategic Planning and Service Change has an important role in ensuring that investment is grounded in the Health Board's strategic priorities, service plans and IMTP.

Its role should be to:

- establish the strategic and planning context for investment;
- ensure service priorities and significant service change are appropriately reflected in the IMTP;
- identify investment requirements arising from agreed service plans;
- consider material issues of strategic alignment or service configuration; and
- ensure agreed investment requirements are connected into the appropriate capital or revenue governance route.

To keep the overall governance arrangements proportionate and avoid duplication, routine capital portfolio oversight and individual project monitoring would sit through the established capital governance arrangements, with Strategic Planning and Service Change engaged where there is a material strategic, planning or service configuration issue.

3.4. Strengthened role of Capital Investment Group

CIG should be the principal executive management and investment scrutiny forum for the capital programme, operating within the Scheme of Reservation and Delegation and Standing Financial Instructions.

3.4.1 Capital investment scrutiny

The Group will provide scrutiny of capital investment proposals and ensure that proposals are appropriately developed before progressing through the relevant capital governance and approval route. It will:

- scrutinise capital investment proposals and associated business cases;
- assess affordability, deliverability, value for money and whole-life financial and operational consequences;
- confirm alignment with strategic priorities established through the IMTP and agreed service plans;
- oversee proportionate capital investment gateways and required corporate sign-off;
- determine whether capital proposals are sufficiently developed to progress; and
- endorse or recommend proposals for approval in accordance with the Scheme of Delegation.

3.4.2 Capital portfolio oversight and reporting

The Group will provide oversight of the approved capital programme, with a particular focus on **delivery, financial control, risk and organisational visibility**. It will:

- oversee delivery of the approved capital programme and Capital Resource Limit;
- monitor expenditure, forecasts, slippage, milestones, risks, dependencies and planned benefits;
- hold SROs to account for delivery and require recovery action where appropriate;
- oversee programme reallocations and change control, subject to the relevant delegated authority;
- ensure clear and proportionate reporting of the overall capital portfolio, including delivery, financial position, risks and emerging issues**;**
- address matters within its delegated remit and agreed tolerances; and
- escalate significant matters, including those outside delegated authority or agreed tolerances, through the appropriate governance route.

3.5 Relationship with strategic planning

Strategic Planning and Service Change establishes the strategic, service and IMTP context from which investment requirements arise. CIG provides the capital investment scrutiny, portfolio oversight and reporting necessary to maintain organisational visibility of how those requirements translate into capital investment and how the approved programme is subsequently delivered.

3.6. Relationship between Strategic Planning and CIG

The relationship should be complementary and two-way, not hierarchical.

Strategic Planning to CIG	CIG to Strategic Planning
Agreed IMTP priorities; strategic context; service-model decisions; prioritised service requirements.	Referral only where investment requires a material service-model decision, strategic reprioritisation or reconsideration of IMTP alignment.

Information should pass between the groups only where it informs a defined decision or requires intervention. Routine capital management reporting should remain with CIG.

3.7. Alignment with revenue investment and service reconfiguration

CIG should operate alongside the new revenue investment and service reconfiguration arrangements as part of one organisational approach to investment.

Nature of proposal	Lead route
Predominantly capital	CIG
Predominantly revenue	Revenue Investment / Service Reconfiguration Group
Material service reconfiguration	Revenue Investment / Service Reconfiguration Group
Mixed capital and revenue	One designated lead group, with input from the other
Material strategic or IMTP issue	Strategic Planning and Service Change
Corporate decision or material exception	Executive Committee
Outside Executive authority	Performance and Finance, Board or Welsh Government, as applicable

For mixed proposals, one lead group should be identified at the outset, a single assessment produced and one approval route followed.

3.8. Alignment with the Scheme of Delegation

The arrangements do not create a separate source of financial authority for CIG or another Executive Delivery Group. Formal approval and commitment of resources must remain with the officer or body holding the relevant authority under the Scheme of Reservation and Delegation and Standing Financial Instructions.

3.9. Executive Committee

Executive Committee should focus on corporate accountability and collective judgement rather than repeat detailed CIG scrutiny.

Executive Committee should consider:

- material reprioritisation that cannot be managed within the approved programme;
- significant changes to strategy, scope, benefits or service model;
- issues spanning Executive portfolios;
- material revenue, workforce or operational consequences;
- matters outside delegated authority or agreed tolerance; and
- recommendations requiring PFIG or Board consideration.

Executive Committee should receive a concise decision and exception report, not the full CIG management dashboard.

3.10. Decision and escalation model

Route	Purpose	Examples
CIG manages	Within programme, delegation and tolerance	Routine gateways; delivery recovery; manageable programme adjustments.
CIG reports	Executive visibility, but no duplicate approval	Recoverable slippage; controlled risk; use of contingency; manageable forecast movement.
Strategic referral	A substantive strategy, service-model or IMTP decision is required	Strategic alignment unclear; agreed service plan materially affected.

Route	Purpose	Examples
Executive escalation	Collective decision, intervention or higher authority is required	Major reprioritisation; cross-portfolio issue; material revenue impact; tolerance exceeded.
Performance and Finance Committee / Board	Assurance or reserved decision	Significant portfolio risk; matter reserved under the Scheme; approval above delegation.

3.11. Assurance and reporting

One integrated capital portfolio report should provide the source of information, tailored to each forum's accountability:

- CIG: detailed management, project, gateway, financial and risk information.
- Strategic Planning and Service Change: only matters requiring strategic, IMTP or service-model decisions.
- Executive Committee: decisions, material exceptions, cross-organisational issues and matters outside tolerance.
- Performance and Finance Committee: assurance on delivery, affordability, significant risk and control effectiveness.
- Board: reserved decisions and strategic assurance.

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

The emerging approach set out in this report is being brought forward in the context of the issues identified through the Capital Governance Advisory Review and, more recently, the Nuclear Medicine Internal Audit. These reviews reinforce the need for greater clarity in the Health Board's capital governance arrangements, including the visibility and escalation of capital risks, clarity of accountability, the robustness of financial and project oversight, and timely reporting through the appropriate governance routes.

The Nuclear Medicine audit provides a particularly relevant illustration. It identified significant matters relating to unresolved capital and revenue pressures, timely reporting to the Board and its sub-committees, project accountability and ongoing cost reporting. The report explicitly identifies the relationship between a number of these findings and those previously identified through the Capital Governance Advisory Review.

Against that background, the proposals in this report should be viewed as an emerging direction of travel rather than a final governance model. They seek to provide greater clarity around the respective roles of strategic planning, capital investment scrutiny, portfolio oversight, decision-making, reporting and escalation.

Importantly, the proposed model has not yet been considered collectively by the Executive Team. It is therefore being brought forward to support discussion and engagement and should be refined through that process before revised governance arrangements are finalised.

The key risks to be addressed through that engagement include:

- avoiding duplication or additional governance layers;
- ensuring clear accountability between strategic planning, capital scrutiny, approval and delivery;
- strengthening organisational visibility of capital performance and risk;
- establishing clear and timely reporting and escalation arrangements;
- ensuring that capital and associated revenue consequences are considered together at the appropriate stage; and
- ensuring that revised arrangements are understood and owned by the relevant Executive Directors and governance groups.

The immediate priority is therefore engagement and clarification, rather than implementation of a predetermined structure. This provides an opportunity to respond to the themes arising from the audit work while ensuring that the final arrangements are proportionate, collectively owned and provide a clear line of sight from individual capital schemes through Executive oversight to Board assurance.

5. ARGYMHELLION RECOMMENDATIONS'

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

- **NOTE** the report and emerging approach; and
- **AGREE** the establishment of a capital report to the next meeting of the committee.

ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol **Link to Strategic Priorities**	4.Create a Modern, People Centred Healthcare System
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:

Yr Egwyddorion Dylunio **Design Principles**	Simplify, Standardise, and Adopt Best Practices Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd **Corporate Risks and Board Assurance Framework**	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)

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Equality Act 2010 **Public Sector Equality Duty:** **Has BCUHB provided evidence of 'Due Regard' to compliance with the three parts of the Public Sector Equality Duty (General Duty):** https://www.gov.wales/public-sector-equality-duty-htmlPublic Sector Equality Duty [HTML] | GOV.WALES	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	Not required
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Equality Act 2010 - Socio-economic Duty *Has BCUHB provided evidence of 'Due Regard' to compliance of ther Socio-economic Duty when making strategic decisions?*	Do/Yes: ☒	Naddo/No: ☒
	Canlyniad/Outcome:	Not required
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Have you completed an Integrated Equality Impact Assessment WP8a? *WP8a Template*	Canlyniad/Outcome: Do/Yes:	Naddo/No:
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale: Canlynaid/Outcome:	Not required
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	

Human Rights Act *Have Human Right based concerns been addressed within WP8a*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	Not required
Compliance to the Welsh Language requirements? *Have you undertaken an Impact Assessment*	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Naddo/No: ☒
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not required
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Compliance to giving 'Due Regard' to the principles of the Armed Forces Covenant *Have the principles of the Armed Forces Covenant been addressed within WP8a*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	Not required
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Ansawdd *A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	Not required
	Galluogwyr Ansawdd Enablers of Quality Choose an item. Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals	Not Applicable	

Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Asesiad o Effaith ar Ddiogelu Data *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?* **Data Protection Impact Assessment** *Have you undertaken a Data Protection Impact Assessment Screening?*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Asesiad o Effaith ar Atal Twyll *A ydych chi wedi ystyried yr effeithiau ar atal twyll?* **Counter Fraud Impact** *Have you considered the counter fraud impacts*	Do/Yes: ☒	Naddo/No: ☐
	Canlyniad/Outcome:	Counter Fraud have full access to the Declare system so they are able to scrutinise declarations.
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Cyfreithiol **Legal**	There are no specific legal implications related to the activity outlined in this report.	
Enw Da **Reputational**	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith ar Adnoddau *(Pobl / Ariannol)* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

Capital Governance Arrangements

Advisory Report

2025/26

Betsi Cadwaladr University Health Board



Advisory Report

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Review Reference	BCU-SSU-2526-26
Fieldwork	December 2025 – March 2026
Executive Sign Off	16th July 2026
Audit Committee	18th August 2026
Executive Lead	Carol Shillabeer, Chief Executive Officer
Audit Team	Huw Richards, Deputy Director, SSu
	Paul Stocker, Audit Manager

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

This advisory review was requested by the Health Board's Chief Executive, recognising the delivery issues (delays/additional costs) arising at the Llandudno Hospital Orthopaedic Development.

It is not intended that this review would replace a formal Post Project Evaluation of the Llandudno Hospital Orthopaedic Development.

The overall objective of this advisory review was to evaluate the arrangements currently in place within the Betsi Cadwaladr University Health Board (herein referred to as the UHB) to successfully oversee and manage major capital projects. The review considered the adequacy of current arrangements, assessed compliance against national guidance, comparisons against best practice examples and where appropriate identified any areas for improvement. This review was also informed by a series of interviews with key stakeholders involved in the capital management processes operating within the UHB (See **Appendix A**).

Overview

The UHB is currently undertaking a review of its organisational structure through the 'Foundations for the Future' strategic redevelopment programme. This programme is expected to result in changes to future arrangements for planning, capital development, and accountability for the delivery of capital projects.

Against this backdrop, this advisory review has identified several key management considerations aimed at strengthening assurance over the governance, management, and delivery of capital projects, and informing future structural and accountability frameworks.

This review represents the second advisory engagement commissioned by the UHB in response to issues arising from the delivery of a major capital project. The first review was undertaken in 2014 following concerns regarding cost escalation and significant governance failings in relation to the Ysbyty Glan Clwyd Redevelopment. A review of the findings from that engagement indicates that many of the issues identified at that time have also been observed in more recent reviews, including the Llandudno Hospital Orthopaedic Development.

Whilst a number of items have been raised for management consideration within this advisory report, the primary issues relate to the need to reset capital governance arrangements, associated procedures and the need to apply clearly defined and accepted roles and responsibilities at the delivery of capital projects/programmes.

Scope & Assurance Summary

	Objectives	Related Considerations
1	**Capital Governance arrangements:** To consider the adequacy and appropriate application of the UHB's existing Capital Governance controls.	1 - 7
2	**Roles and Responsibilities:** To consider the determination, assignment and delivery of key project roles and responsibilities, the allocation and acceptance methodologies and performance review mechanisms etc.	8 - 11
3	**Monitoring and Reporting:** To consider project monitoring and reporting arrangements established within the UHB. To include an assessment of both regular reporting arrangements (approvals, monitoring / project scrutiny, and reporting including quality and regularity of information, standing agenda items, mechanisms adopted) and adequacy of escalation processes etc.	2, 12 - 14
4	**Contractor and Adviser Appointments –** To ensure appropriate mechanisms are applied in the appointment and management of the UHB's project advisers and contractors (when not utilising the NHS Wales National framework arrangements).	15 - 19

Key Considerations

19

Themes



Risk Types

Financial Loss

Quality or Safety Issues

Legal & Regulatory Non-Compliance

Findings & Management Considerations

1.0 Capital Governance Arrangements

Objective 1.1: Governance Structures

Overview / Summary of Observations

The UHB is currently reviewing its organisational structure through the Foundations for the Future programme, which is expected to influence future arrangements for planning, capital development and accountability for major capital projects.

The existing governance structure—set out within the Capital Procedure Manual—has been in place for several years and governs the development, approval and expenditure of capital business cases for projects exceeding £5m. The key structure/approval process is summarised below:

Step	Body / Group	Purpose
1	Capital Investment Group (CIG)	Review and approval of scoping document
2	Welsh Government	Approval of scoping document
3	Capital Investment Group (CIG)	Initial review of SOC, OBC and FBC
4	Executive Team	Executive oversight and assurance
5	Performance, Finance Integrated Group (PFIG)	Financial and performance scrutiny
6	UHB Board	Final approval and authorisation

A paper was presented to UHB's Executive Committee on 8 April 2026 seeking formal approval of the revised Executive Delivery Group (EDG) structure. The revised arrangements aim to strengthen Tier 1 governance by "*clarifying decision-making responsibilities, improving alignment with Standing Orders and the Scheme of Reservation and Delegation, and ensuring that papers submitted to the Executive Committee are fully developed and evidence-based.*" The Strategic Planning and Service Change Group (SPSCG) will form one of six core EDGs. The Group will be responsible for the scrutiny, monitoring, and oversight of capital investment projects and programmes. The Terms of Reference were in development at the time of reporting (**MC1**/**MC2**).

A core governance document for every project is the Project Initiation Document (PID) or Project Execution Plan (PEP), which sets out project purpose, scope, governance arrangements and delivery approach. Under PRINCE2 methodology, this should be maintained as a live document throughout the project lifecycle. Previous audits indicate that 50% of major projects reviewed since 2019 had weaknesses in the completeness or quality of their PEPs.

Projects should establish a Project Board (or Programme Board where several related projects exist) at inception (**MC3**). Meetings should be supported by accurate minutes, action logs and timely circulation of papers. Recent audits—including the Llandudno Orthopaedics Project—identified recurring weaknesses, including inconsistent meeting frequency and variable quality of minutes and agendas.

Enhancements to strengthen these governance arrangements have been identified **(See Appendices B,C & D)**.

Management Consideration 1: Formulisation of Key Terms of Reference

The Terms of Reference for the SPSCG should incorporate the specific role and responsibilities for its oversight of capital projects/programmes, and ensure that governance requirements are appropriately communicated and reflected within the UHB's Capital Procedure Manual etc.

Management Response:

The Health Board will review the arrangements for capital in accordance with the Scheme of Delegation and in discussion with the Executive Team on the approach to the management of capital (Director of Environment and Estates) Please refer to **MC12**.

Management Consideration 2: Reporting to Executives

The formal line of sight between capital project delivery and Board level strategic assurance should be strengthened. In particular:

- Reporting expectations at Board level (frequency, format, content) are not clearly defined.
- There is no consolidated capital programme report providing an overview of delivery risk, affordability and interdependencies.
- There is limited evidence showing how project level risks inform the Board Assurance Framework (BAF).

Management Response:

1. Confirmation of the reporting against the Capital Programme for inclusion in the Cycle of Business to the Performance, Finance and Information Governance Committee through reports from the Executive Committee (whilst the arrangements for the management of capital are worked through) (Lead: Director of Environment and Estates)
2. The Board Assurance Framework will be reviewed to ensure appropriate linkage to the Capital Programme and Capital Investment Group (Lead : Director of Environment and Estates)

Management Consideration 3: Project/Programme Boards

Project and Programme Boards should be formally established at project initiation, with clear Terms of Reference, defined membership and agreed meeting schedules. Key governance meetings should occur at a minimum prescribed frequency and be supported by complete and timely minutes capturing decisions, actions, risks and ownership. Periodic quality assurance should be introduced to ensure consistent compliance across all capital projects.

Management Response:

These requirements are to be included within the updated Capital Manual (Lead: Director of Environment and Estates)

Objective 1.2: Policies & Frameworks

Overview / Summary of Observations

The UHB's Capital Procedure Manual, first developed in 2014 and last updated in December 2020, no longer reflects current organisational structures, operational practices, or external requirements, including the use of updated contractor frameworks and contract forms such as New Engineering Contract (NEC). Recent Internal Audit reviews have also highlighted the need for a comprehensive revision (**MC4**).

Discussions held during this advisory review, including with Executive Directors, confirmed that refreshing the Manual is recognised as a priority. While the Manual is viewed as a key reference document by Senior Project Managers and Project Managers, there is limited evidence of consistent awareness or use across the wider organisation.

Given its purpose—to provide clear and consistent guidance on governance, roles, responsibilities, and processes—it is essential that all staff involved in the initiation, development, and delivery of capital schemes are familiar with the Manual and apply it in day-to-day practice.

The review identified an opportunity to strengthen capital delivery through the introduction of dedicated project management software or standardised project development checklists. These tools would help ensure consistent application of processes across varying delivery frameworks, contracts, and service level agreements.

Development of this would support compliance with Standing Orders and Standing Financial Instructions and help staff navigate evolving procurement requirements, including those relating to the appointment and management of supply chain partners and professional advisers (**MC5**).

Management Consideration 4: Capital Procedure Manual Refresh

The UHB should prioritise updating the Capital Procedure Manual to ensure it reflects current organisational structures, external requirements, and recognised best practice. The revised manual should be supported by improved communication, accessibility, and training to promote consistent understanding and application of capital governance processes across all relevant staff.

Management Response:

The Capital Procedure Manual will be reviewed and implemented (Director of Environment and Estates, December 2026)

Management Consideration 5: Project Management Tools

To develop standard documentation and checklists to comply with both national and local capital delivery requirements and that these should be easily available e.g. via project toolkits etc.

Management Response:

To develop a toolkit with standard documentation to ensure compliance with the Capital Procedure Manual (Director of Environment and Estates, March 2027)

Objective 1.3: Approval Pathways

Overview / Summary of Observations

Experience across NHS and wider public sector capital programmes shows that early-stage business cases are particularly susceptible to optimism bias, including understated costs and risks and overstated benefits and deliverability. Independent validation reviews provide an important early challenge to these assumptions before commitments become difficult or costly to reverse.

The UHB has an established process for developing business cases, supported by the Assistant Director – Strategic and Business Analysis, a qualified Better Business Case Practitioner. This role provides end to end guidance aligned to HM Treasury's Green Book and the Five Case Model. Additional capacity is provided by the Planning Manager within the Planning Team.

Historically, validation reviews undertaken by Executive and senior management provided independent challenge to project proposals, helping to counter optimism bias and prevent consensus forming without sufficient scrutiny (**MC6**).

These reviews formed an important control to ensure projects were not progressed prematurely without adequate due diligence and stakeholder engagement. In their absence, there is an increased risk that projects may advance on the basis of untested assumptions, with potential downstream implications for affordability, deliverability and overall outcomes. Issues arising from the expedited Llandudno Project illustrate the consequences of insufficient early-stage challenge (**MC7**).

The 2024 audit of the Llandudno Orthopaedics Project also identified delays and inefficiencies in the approval of contract awards, with multiple work packages awarded separately to the same Supply Chain Partner.

Previous reviews have also highlighted inconsistent use of formal change control processes; for example, three variations exceeding £150k in the 2025 Llandudno review lacked adequate audit trails demonstrating compliance with the Capital Procedure Manual and Standing Orders/Standing Financial Instructions.

Management Consideration 6: Business Case Validation Reviews

The UHB should reinstate validation reviews to reinforce a structured, stage-gated approach to capital investment. This would help ensure that projects progress only when they remain achievable, affordable, aligned to strategic priorities, and supported by robust and tested assumptions.

Management Response:

It is acknowledged that there is no current gateway review process associated with capital investment together with an inconsistent approach to developing business cases with confusion regarding the use of SBAR's often confused with business cases. The updated Capital Procedure Manual will provide guidance on the core requirements for business cases based on a scaled version of the 5-case model with internal gateways and reporting. (Director of Environment and Estates, December 2026).

Management Consideration 7: Business Case Sign Off

Executive leads should provide clear sign-off, acceptance, and ownership of their respective components of each business case (e.g., service, finance, IM\&T, estates). This should complement existing committee approvals and ensure stronger accountability across all functional areas.

Relevant national guidance includes:

- NHS Wales Infrastructure Investment Guidance;
- NHS Building for Wales Framework Guidance;
- NHS Wales Capital Investment Manual;
- Better Business Cases and
- National Infrastructure and Service Transformation Authority etc.
- Construction Playbook

Management Response

The business cases presented to HB are signed off by the relevant governance forums in accordance with the Scheme of Delegation and reflected in the updated Capital Manual.

2.0 Roles and Responsibilities

Objective Finding 2.1: SRO and Project Director

Overview / Summary of Observations

The Senior Responsible Officer (SRO)—referred to as the Project Executive in PRINCE2—is the single point of accountability for a capital project and is responsible for ensuring its successful delivery. The UHB's Capital Procedure Manual states that the SRO must ensure the project meets its objectives, delivers the required outcomes, and realises the intended benefits. The role requires strategic leadership, active sponsorship, and sufficient seniority to influence decision making across organisational boundaries.

The Manual requires the Chief Executive to identify an SRO for all capital projects over £1m, with seniority determined by project value.

Threshold	SRO
£1m to £5m	Senior Manager
£5m to £10m	May be senior manager or executive director dependent upon the complexity and/or risk of the project
Above £10m	Executive Director

SROs are expected to be appointed for the full project lifecycle, with responsibilities, authority, time commitment and handover arrangements clearly documented.

The Project Director is responsible for day-to-day operational delivery. Early appointment of an experienced Project Director is essential for establishing effective controls, maintaining momentum, and ensuring clear accountability. Continuity in this role supports programme stability and delivery confidence.

Concerns raised at the Capital Investment Group (May 2025) noted that three Integrated Regional Care Fund major capital projects were progressing without an appointed SRO. A 2024 Gateway Review also identified weaknesses in SRO arrangements. The Building for Wales 2 Framework reinforces the importance of timely Project Director appointment and sustained oversight. Similar issues were highlighted in the 2025 Orthopaedic Surgical Hub Llandudno Hospital Audit Report (**MC8**).

Management Consideration 8: SRO and Project Director Roles

Capital project governance would benefit from more consistent and formalised arrangements for appointing and operating both the SRO and Project Director roles. Management should:

- Clearly document the appointment process, delegated authority, tenure expectations and handover arrangements, supported by a Responsible, Accountable, Consulted, Informed (RACI) matrix to define responsibilities and decision-making authority.
- Identify and provide any required training or structured support to ensure individuals in these roles are fully equipped to meet their responsibilities.

Improved clarity and capability across these key roles would strengthen decision making, continuity, and assurance over major capital project delivery.

Management Response:

This recommendation is accepted; the documentation review should clearly indicate the governance forum in regard to the appointment and responsibilities for the SRO and Project Director roles. To include the scope of what is being required for each of the projects. This will be reflected in the updated Capital Procedure Manual with staff training supplemented.

Objective 2.3: Role Clarity & Segregation of duties

Overview / Summary of Observations

This advisory review examined the roles, responsibilities, and capacity of UHB staff involved in the day-to-day management and delivery of capital projects.

Responsibility for capital delivery sits within the Directorate of Environment and Estates. While the Director has a broader remit beyond capital, accountability for capital projects is exercised through established governance and management arrangements.

Operational capital project delivery is led by the Head of Capital Development, who is responsible for the discretionary capital programme, chairs the Capital Planning Management Team (CPMT), and represents the UHB at Welsh Government and NWSSP:SES forums. Monthly updates on capital activity and progress are reported to the Capital Investment Group (CIG).

The UHB operates across three geographical areas—West, Central, and East—with a Senior Project Manager assigned to each. These managers' report directly to the Head of Capital Development and oversee day to day management of their allocated schemes. Each is supported by a Project Manager, an Assistant Project Manager, and administrative staff.

Team members generally hold appropriate professional qualifications, with Assistant Project Managers forming part of longer-term workforce development plans. Capacity is supplemented by a specialist Project Manager for radiology related schemes and two in house mechanical and electrical engineers who act as supervisors for non-Building for Wales (B4W)2 projects.

Team members reported confidence in managing Joint Contracts Tribunal (JCT) contracts but identified a need for additional training and ongoing professional development in NEC contract management, which is the standard form under the B4W2 framework. Strengthening NEC contract knowledge would enhance project administration, risk management, and compliance. Training requirements should be routinely captured through annual personal development reviews. (**MC9**)At the time of review, the team was supporting more than 70 capital projects. Although IRCF funded schemes were intended to have dedicated project managers, resource pressures have required these schemes to be absorbed into the existing workload. While the team is experienced and professional, overall capacity is constrained by the volume and complexity of projects and by the need for Senior Project Managers to provide additional oversight and support to less experienced colleagues. A comprehensive workforce review has not been undertaken recently. Such a review would help assess current capability and capacity, determine future workforce requirements, and ensure the estate is maintained effectively without compromising future investment (**MC10**).

Management Consideration 9: Training Needs Analysis

Training needs should be clearly identified through annual appraisals (including contract/procurement requirements).

Management Response:

Agreed but the Training Needs Assessment relates to all staff working on capital projects, including digital and operational, finance and planning colleagues. Action: Director of Environment and Estates to facilitate

Management Consideration 10: Review of Resources

A capital/estates workforce review should be undertaken to analyse the current position in terms of capability, capacity, and future requirements. Following this, a clear financial model for the revenue support needed in the estate should be developed.

Management Response:

Agreed. Action: Director of Environment and Estates. Timescale January 2027 pending Foundations for the Future impact for relevant banded staff.

Objective 2.4: Documentation & Accountability

Overview / Summary of Observations

Roles and responsibilities for capital project delivery are defined through several mechanisms. For substantive UHB Capital staff, job descriptions generally outline expectations for project management and delivery.

However, for key stakeholders at Project Board level—such as Senior Responsible Owners (SROs) and Project Directors—responsibilities are not always formally documented due to the absence of role acceptance or appointment records. This can lead to inconsistent understanding of responsibilities across individuals and projects (MC7). Similar gaps apply to other board or team members providing oversight or specialist input.

Responsibilities are also expected to be defined within the Project Initiation Document (PID) or Project Execution Plan (PEP). These documents, typically produced by contract administrators or advisers, are often generic and do not provide sufficient clarity on decision making authority or accountability. Audit reviews also found limited evidence that PIDs/PEPs are routinely updated to reflect changes in governance, roles, or project requirements (**MC11**).

Overall, governance arrangements rely heavily on the experience and goodwill of individuals, rather than consistently applied, documented processes. This presents risks where roles change or projects increase in complexity.

Management Consideration 11: PIDs/PEPs

The organisation should strengthen the development and ongoing maintenance of PIDs/PEPs by introducing minimum quality standards, defined review and update requirements, and clear accountability for their accuracy. These documents should remain current, complete, and actively used as core components of project governance and assurance throughout the project lifecycle.

Management Response:

Agreed and to be reflected within the updated Capital Procedure Manual. Action: Director of Environment and Estates.

3.0 Monitoring and Reporting

Objective 3.1: Programme/Project Reports

Overview / Summary of Observations

Audit work undertaken over a number of years has identified the provision of project highlight reports, cost reports, project management reports, and supply chain partner reporting across major capital projects. Reporting formats and frequency have remained broadly stable, providing a common basis for monitoring progress, cost, and delivery risks.

Project reporting had generally been produced on a regular and predictable cycle, supporting routine review by Project Boards and other governance forums. This had provided stakeholders with ongoing visibility of project status, progress against milestones, and key issues.

Across the reporting reviewed, there was consistent inclusion of core delivery information, including cost position, forecast outturn, programme milestones, and high-level risks. Supply chain partner reports generally aligned with internal reporting, enabling triangulation of delivery information.

The reporting arrangements in place appear well embedded as part of routine project management activity. However, evidence suggests that reporting is primarily focused on status updates rather than being consistently used as a forward-looking governance tool to support challenge, decision-making, and assurance.

Audits undertaken in respect of the Llandudno Orthopaedic Project observed limited regular reporting beyond the Project Board.

While reporting was generally consistent in structure and content, the level of narrative insight and explanation varied between projects. In some cases, reports focused on factual updates with limited commentary on the implications of issues, risks, or changes for overall project objectives.

See **MA2** re: Executive/ Committee reporting.

Objective 3.2: Board & Committee Oversight

Overview / Summary of Observations

A monthly Capital Programme Report is produced by the Capital Accountant and Head of Capital and submitted to the Capital Investment Group (CIG). The report provides an update on the approved capital programme, including exception-based updates on major schemes and expenditure against the Welsh Government set Capital Resource Limit (CRL).

This report was previously a standing item at the Performance, Finance and Integrated Governance Committee; however, only selected elements now feature within the Director of Finance's routine report. The remit of the recently formed Strategic Planning Service Change Group (SPSCG) in relation to capital projects—particularly those aligned to wider clinical programmes—remains under development.

Previous assurance work indicates that CIG discussions tend to focus on smaller discretionary schemes and leases. While major business cases are submitted to the Group, evidence of systematic scrutiny or challenge is limited. Best practice within other NHS Wales organisations includes operating a broader capital board that brings together senior leadership and an Independent Member to strengthen oversight (**MC12**).

Management Consideration 12: Capital Board

The UHB should consider establishing a dedicated Capital Board as a formal sub-committee of the Board. This would align with effective models used elsewhere in NHS Wales and would include senior leadership and an Independent Member to strengthen scrutiny of major capital schemes. Introducing this structure would improve visibility, governance, and assurance and would complement the role of the Strategic Planning Service Change Group. An example Terms of Reference and sample Agenda is provided at **Appendices B & C.**

Management Response:

Accepted noting that the Executive Delivery Groups do not include Capital. The Performance, Finance and Information Governance Committee currently hold this responsibility.

Objective 3.3: Quality & Assurance

Overview / Summary of Observations

The UHB applies the Three Lines of Defence model, as outlined in the Capital Procedure Manual, to provide structured operational, oversight, and independent assurance.

First Line of Defence – Operational Management

Operational assurance is delivered through the Project Board, Project Team, and where applicable, the Project Supervisor. While the UHB benefits from experienced engineers, the Llandudno Project highlighted areas requiring improvement, including timely updates of required certifications and gaps in specialised assurance.

Second Line of Defence – Internal Governance

Oversight is provided through the Board and its sub committees. Ongoing organisational changes may alter future governance arrangements for major capital projects.

Third Line of Defence – Independent Assurance

Independent assurance is provided through Internal Audit, Gateway Reviews, and other external scrutiny. The Llandudno audit identified limited evidence of routine reporting to Executive Directors and the Board, indicating a need for stronger visibility and higher quality governance reporting.

Integrated Assurance and Approval Plans (IAAPs) are required under *NHS Wales Infrastructure Investment Guidance;* however, their development has been inconsistent (**MC13**). National expectations also include proportionate use of audit, Gateway Reviews, post project evaluations, and lessons learned. PRINCE2 similarly emphasises early consideration of lessons from previous projects (**MC14**).

Management Consideration 13: Integrated Assurance and Approval Plans

The UHB should ensure that Integrated Assurance and Approval Plans are fully developed and included within all business case submissions to Welsh Government, in line with *NHS Wales Infrastructure Investment Guidance*.

Management Response:

To be included as a requirement within the updated Capital Procedure Manual with links to be agreed to BAF and Capital Investment Board. Lead: Director of Environment and Estates

Management Consideration 14: Post Project Evaluations

Assurance across all three lines would be strengthened through consistent completion of post project evaluations, lessons learned reviews, audit actions, and performance reporting. Consolidating these outputs and using them to inform the development of future schemes would enhance operational oversight and support continuous organisational learning.

Management Response:

To be included as a requirement within the updated Capital Procedure Manual with links to be agreed to BAF and Capital Investment Board. Lead: Director of Environment and Estates

4.0 Contractor and Adviser appointments

Objective 4.1: Procurement Pathways, Contract Strategy & Market Engagement

Overview / Summary of Observations

NHS Wales organisations use a range of procurement frameworks and mechanisms to appoint professional advisers and Supply Chain Partners (SCPs). These include national and regional frameworks, call off arrangements, specialist multi-disciplinary frameworks, and open market procurement where appropriate. The introduction of the Procurement Act 2023 (effective February 2025) places greater emphasis on social value, sustainability and SME participation through the Most Advantageous Tender (MAT) approach.

A range of contract forms may be applied depending on project scale and risk. Under Welsh Government frameworks such as Design for life (D4L) / B4W2, NEC4 ECC Option C is the standard form for SCP appointments, with NEC4 PSC used for professional advisers. JCT contracts and SLAs continue to be used for smaller or lower risk schemes, although SLAs offer reduced protection compared to formal NEC/JCT contracts.

Previous assurance work has identified recurring weaknesses, including:

- use of contract forms not aligned to project complexity (e.g. JCT at the Llandudno Orthopaedics Project);
- incomplete adviser appointment documentation;
- use of local frameworks beyond intended scope; and
- repeated absence of signed contracts prior to works commencing.

Market engagement reviews also indicate limited competition for some adviser roles. For example, a Cost Adviser ITT attracted eleven expressions of interest but resulted in only three acceptable bids, contributing to ongoing reliance on a small supplier base.

These issues highlight the need for a more consistent, strategic, and market aware approach to procurement and contracting (**MC15/16/17**).

Management Consideration 15: Procurement Pathways

Procurement routes should be selected as part of a broader contracting strategy, assessing the advantages and disadvantages of all available options.

Management Response:

Agreed. To be included as a requirement within the updated Capital Procedure Manual with explanations of requirements, route to advice and governance. Lead: Director of Environment and Estates

Management Consideration 16: Contract Strategy

All projects should adopt a clear contract strategy identifying the most appropriate contract form, with decisions supported by specialist advice and aligned to project complexity, risk, and governance requirements.

Management Response:

Agreed. To be included as a requirement within the updated Capital Procedure Manual with explanations of requirements, route to advice and governance. Lead: Director of Environment and Estates.

Management Consideration 17: Market Engagement

Management should review factors contributing to limited adviser tender responses—such as market engagement, scope, commercial terms or contract duration—to broaden competition and strengthen value for money.

Management Response:

Agreed. To be included as a requirement within the updated Capital Procedure Manual with explanations of requirements, route to advice and governance. Lead: Director of Environment and Estates.

Objective 4.2: Performance Management

Overview / Summary of Observations

The Construction Playbook sets clear expectations for performance management across public sector construction projects. It requires contracting authorities to establish measurable performance outcomes and KPIs at contract award, maintain continuous performance monitoring, allocate risk appropriately, and use standardised contract frameworks that support effective evaluation throughout delivery. Clear specifications and well aligned KPIs are essential to drive the behaviours and outcomes required for successful project delivery. When applied consistently, they help minimise unintended incentives and support constructive supply chain collaboration.

The NEC suite provides a structured approach to performance management, including Schedule 3 (Performance Monitoring) and, where relevant, Option X20 (Key Performance Indicators). Under NEC4 Option C, good practice is to use Schedule 3 for general monitoring and reserve Option X20 for a small number of critical KPIs that demonstrably add value. In contrast, JCT contracts do not include embedded KPI mechanisms, meaning performance measures must be added through bespoke amendments or external frameworks. Where these are not formally incorporated, there is an increased risk of inconsistency and reduced enforceability (**MC18**).

Management Consideration 18: Key Performance Indicators

While the UHB should select the most appropriate framework and contract for each project, it is essential that KPIs are applied consistently to monitor adviser and supply chain partner performance.

Management Response:

Agreed. To be included as a requirement within the updated Capital Procedure Manual with explanations of requirements, route to advice and governance. Lead: Director of Environment and Estates.

Objective 4.3: Value for Money

Overview / Summary of Observations

Value for money in appointing the Supply Chain Partner (SCP) is primarily informed by the professional judgement of the UHB's appointed advisers, who establish the cost envelope used to assess bidder submissions.

For the Llandudno Orthopaedics Project, works commenced before the design was fully developed, agreed, and formally signed off. This increased the likelihood of design changes during construction—particularly for Mechanical and Electrical (M&E) systems—leading to:

- Variations priced at premium rates
- Abortive installation works
- Additional design and consultancy costs

These unplanned costs reduce cost certainty and risk undermining the original value for money justification for the project (**MC19**).

Management Consideration 19: Formal Acceptance

Management should ensure that formal sign off and confirmation of readiness to proceed at key project stages—by all relevant parties, including key users, the SRO, Project Director, Finance Lead, and advisers—is clearly documented.

Management Response:

Agreed. To be included as a requirement within the updated Capital Procedure Manual with explanations of requirements, route to advice and governance. Lead: Director of Environment and Estates. See also **MC6.**

Appendix A

Key individuals interviewed as a part of this advisory review

Arwel Hughes	Head of Operational Estates
Carol Shillabeer	Chief Executive
Dan Eyre	Head of Capital Development
Denise Roberts	Head of Capital, Governance & BI.
Fiona Mash	Head of Organisational Portfolio Management Office
Ian Howard	Assistant Director - Strategic and Business Analysis
Iolo Jones	Senior Project Manager
Kevyn Breese	Senior Project Manager
Pam Wenger	Board Secretary
Russell Caldicot	Executive Director of Finance
Ruth Stiles	Senior Project Manager
Stuart Keen	Director For Environment and Estates

Note: Example Documents provided at the following Appendices have been shared with kind permission.

Appendix B
Capital Sub Committee – Example Agenda

1 - Meeting Governance

1.1 - Apologies

1.2 - Declaration of Interests

1.3 - Minutes of Previous Meeting

Attachments

1.3 - DRAFT Capital Sub Committee Minutes (Previous meeting)

1.4 - Matters Arising from previous meeting

1.5 - Committee Key Actions

1.6 - Capital Sub-Committee Annual Report 2025-26

2 - Capital Planning, Monitoring & Governance

2.1 - Capital Resource Limit, Capital Financial Management and Capital Programme 2025/26

Attachments:

Paper 2.1a - Capital Update

Paper 2.1b - Annex 2 - Sealing schedule

2.2 - Capital Projects Governance

Attachments:

Paper 2.2a - Capital Governance Report March 2026

Paper 2.2b - Appendix 1 - Capital Project Reporting Process

Paper 2.2c - Appendix 2 - Capital Project Highlight Reports – Bi-Monthly Reports

Paper 2.2d - Appendix 3 - Capital Highlight Reports

2.3 - Welsh Government Dashboards

Attachments:

Paper 2.3a - WG Project Dashboards March 2026

2.4 – Targeted Estates Fund Update Report

Attachments:

Paper 2.4a - WG TEF Projects 2025 26 March 2026 (Final)

Paper 2.4b - Appendix 1 TEF Tracker February 2026

2.5 - Capital Programme 24-25 Lessons Learnt Update

Attachments

Paper 2.5 - Capital programme 24-25 lessons learnt - March 26

2.6 - Capital Planning Group & Capital Monitoring Forum Terms of Reference for approval

Attachments

2.6a - Capital Planning Group ToR v6

2.6b - Capital Monitoring ToR V5 March 2026

3 - Capital Planning Developments

3.1 – Major Programmes

Attachments:

3.1 – Major Programmes Update Feb 26

3.2 - Infrastructure Investment Plan

3.2 - Arts and Health Update

Attachments:

3.2 - Improving_Healthcare_Environments_Presentation

4 - Papers for Information

4.1 – Welsh Government Capital Review Meeting

4.2 - Capital Planning Group

4.3 - Capital Monitoring Forum

Attachments:

Paper 4.3a – Capital Monitoring Forum Minutes 11th November 2025 (Final)

Paper 4.3b - Capital Monitoring Forum 13th January 2026 (Final)

Paper 4.3c - Capital Monitoring Forum 10th February 2026 (Final)

4.4 - Capital Sub-Committee Terms of Reference

4.5 - Property Lease arrangements update

5 - Any Other Business

6 - Date & Time of Next Meeting

Appendix C

Capital Sub Committee – Example terms of reference

CAPITAL SUB-COMMITTEE

1. Constitution

The Capital Sub-Committee (CSC) has been established as a Sub Committee of the Board and constituted from (x date).

2. Membership

2.1 The membership of the Sub-Committee shall comprise:

Title

Executive Director of Strategy and Planning (Chair)

Assistant Director of Strategic Planning and Development (Deputy Chair)

Independent Member

Director of Estates or Deputy

Programme Director(s)

Discretionary Capital Projects Manager

Head of Property

Senior Business Partner (Finance) (Delegated on behalf of the Director of Finance)

Head of Facilities

Deputy Director of Operations

Assistant Director, Medical Directorate (Delegated on behalf of the Medical Director)

Digital Director

Assistant Director of Primary Care

Assistant Director of Assurance and Risk

Head of Procurement

Head of Capital Planning (Sub Committee Lead)

Chair of Medical Devices Group

Director of Nursing and Control of Infection representative

In Attendance

Committee Support/Secretary

Head of Internal Audit (or representatives)

Director of Mental Health and Learning Disabilities

Capital Programme Manager

General Manager, Women and Children's Directorate

Head of Radiology

Project Manager, Capital Planning

Head of Pathology

Head of Property Performance

Capital Programme Manager, Regional Partnership Board

Clinical Director of Pharmacy and Medicines Management

Head of Maintenance and Engineering

Papers sent for Information

Clinical Care Group Service Directors – Community and Integrated Medicine

Assistant Directors

2.2 The membership of the Capital Sub-Committee will be reviewed on an annual basis.

3. Quorum and Attendance

A quorum shall consist of no less than a third and must include as a minimum the Chair or Vice Chair of the Sub-Committee.

An Independent Member shall attend the meeting in a scrutiny capacity. The scrutiny role of Independent Members on Sub-Committees is to ensure their effectiveness in terms of processes and outcomes, and in particular that their work is organised and undertaken in accordance with their terms of reference, that they have clarity about the limits of their delegated powers and responsibilities, and that they understand fully their relationship with and reporting responsibilities to their parent Committee.

Any senior officer of the University Health Board or partner organisation may, where appropriate, be invited to attend, for either all or part of a meeting to assist with discussions on a particular matter.

The Sub-Committee may also co-opt additional independent external 'experts' from outside the organisation to provide specialist skills.

Should any member be unavailable to attend, they may nominate a suitably briefed deputy to attend in their place. Where attendance is delegated, the nominated representative is responsible for informing discussions where relevant and reporting back to the named member accordingly.

The Head of Internal Audit shall have unrestricted and confidential access to the Chair of the Capital Sub-Committee.

The Sub-Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

4. Purpose

4.1 The purpose of the Capital Sub-Committee is to:

4.1.1 Oversee the delivery of the Health Board's capital programmes and projects included in the planning cycle (in year and longer term).

4.1.2 Recommend to the Board,), the use of the Health Board's Capital Resource Limit (CRL), in line with the HB's financial scheme of delegation

4.1.3 Review, on an annual basis, the Discretionary Capital Programme (DCP) for the following financial year.

4.1.4 Oversee the development of the Estates Strategy and Infrastructure Investment Enabling Plan aligned to the Estate Strategy for consideration by *Board/Committee*, prior to Board approval.

4.1.5 Oversee the development and delivery of implementation plans for the Estates Strategy agreeing corrective actions where necessary and monitoring its effectiveness.

5. Operational Responsibilities

Develop recommendations to the Board, via the *Board/Committee* and Executive Team, on the use of the Health Board's Capital Resource Limit (CRL), for approval.

Develop prioritised recommendations for discretionary capital sums and All Wales Capital Schemes and receive investment proposals, in response to an assessment of the organisation's risks, and to support the Health Board's Estate Strategy (including delivery plans) and vision for healthcare and its strategic objectives, including performance and financial improvement.

Provide a co-ordinated approach to overseeing delivery of the Health Board's capital programmes and projects included in the planning cycle (in year and longer term) enabling the Health Board to understand the overall delivery commitments and risks and proposing changes as appropriate.

Provide assurance that capital projects are managed and governed in accordance with mandatory requirements, best practice and the latest Welsh Government capital guidance, ensuring that revenue consequences associated with capital projects are explicit at project scoping stage.

Provide assurance around the effective management of the Health Board's CRL, ensuring expenditure is in line with Standing Orders and within the agreed programme.

Scrutinise and quality assure major capital business cases prior to submission to *Board/Committee* including those developed in partnership with other organisations such as, Local Authorities, GP partners and Third Sector organisations.

Ensure a robust disposal policy for redundant estate is in place.

Consider options for the acquisition or disposal of estate and agree recommendations for the Board, via the *Board/Committee*.

Review and recommend the appropriate delegated limits for capital expenditure authorisation and authorisation for other funding sources.

5.10 Present and review a schedule of projects/schemes within the Health Board's Capital Plan where there may be associated works contracts that require sealing.

5.11 Make recommendations on capital expenditure in relation to Digital, medical & non-medical equipment, estates statutory and infrastructure, contingencies and other provisions.

5.12 To receive timely post project evaluation and project closure reports which will include a review of the effective application of capital resources and scrutinise the final use against original business justification objectives and monitors the initial improvement impacts of strategic investment.

5.13 Provide assurance to *Board/Committee* that risk is considered as part of prioritisation of capital expenditure items and that where risks are not addressed by capital funding, these risks have been reviewed to assess whether further mitigation actions should be taken (to minimise the impacts should the risk materialise), contingency measures can be strengthened (in case the risk materialises to minimise disruption) and reflect whether the risk is being tolerated or further treated.

5.14 Agree the Annual Audit Plans and monitor action against recommendations contained within audit reports issued by Audit and Assurance.

5.15 To receive regular progress updates on the Housing with Care Fund and Integrated Rebalancing Capital Funds Capital bids and schemes being progressed through the Regional Partnership Board

5.16 Agree issues to be escalated to the *Board/Committee* with recommendations for action.

5.17 Agree an annual work plan for the Sub-Committee for review and approval by the *Board/Committee*.

6. Agenda and Papers

The Sub-Committee Secretary is to hold an agenda setting meeting with the Chair and/ or Vice Chair and the Lead Executive/Assistant Director at least six weeks before the meeting date.

The agenda will be based around the Sub-Committee work plan, identified risks, matters arising from previous meetings, issues emerging throughout the year, and requests from Sub Committee members. Following approval, the agenda and timetable for papers will be circulated to all Sub-Committee members.

All papers should have relevant sign off before being submitted to the Sub-Committee Secretary.

The agenda and papers for meetings will be distributed seven days in advance of the meeting.

The minutes and action log will be circulated to members within ten days to check the accuracy.

Members must forward amendments to the Sub-Committee Secretary within the next seven days. The Sub-Committee Secretary will then forward the final version to the Sub-Committee Chair for approval.

7. Frequency of Meetings

The Sub-Committee will meet bi-monthly and shall agree an annual of meetings. Any additional meetings will be arranged as determined by the Chair of the Sub-Committee.

The Chair of the Sub-Committee, in discussion with the Sub-Committee Secretary shall determine the time and the place of meetings of the Sub- Committee and procedures of such meetings.

8. Accountability, Responsibility and Authority

The Sub-Committee will be accountable to the *Board/Committee* for its performance in exercising the functions set out in these terms of reference.

The Sub-Committee shall embed the UHB's vision, corporate standards, priorities and requirements e.g. equality and human rights, through the conduct of its business.

The requirements for the conduct of business as set out in the UHB's Standing Orders are equally applicable to the operation of the Sub-Committee.

9. Reporting

The Sub-Committee, through its Chair and members, shall work closely with the *Board/Committee* and other committees, including joint /sub committees and groups to provide advice and assurance to the Board through the:

9.1.1 joint planning and co-ordination of *Board/Committee* and Committee business;

9.1.2 sharing of information.

9.2 In doing so, the Sub-Committee shall contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

9.3 The Sub-Committee may establish groups or task and finish groups to carry out on its behalf specific aspects of Sub-Committee business. The following groups have been established:

9.3.1 Capital Planning Group (CPG)

9.3.2 Capital Monitoring Forum (CMF)

9.4 The Sub-Committee will receive an update following each Group's meetings detailing the business undertaken on its behalf.

9.5 The Sub-Committee will also receive updates from the regular Capital Review meetings held with Welsh Government representation.

9.6 The Sub-Committee Chair, supported by the Sub-Committee Secretary shall:

9.6.1 Report formally, regularly and on a timely basis to the *Board/Committee* on the Sub-Committee's activities. This includes the submission of a Sub-Committee update report, as well as the presentation of an Annual Report within 6 weeks of the end of the financial year

9.6.2 Bring to the *Board/Committee's* specific attention any significant matter under consideration by the Sub - Committee.

10. Secretarial Support

The Sub-Committee Secretary shall be determined by the Lead Director.

11. Review Date

These terms of reference shall be reviewed on at least an annual basis by the Sub Committee for approval by the *Board/Committee*.

Appendix D

Example Capital Highlight Reporting Process

As part of a continuous improvement of capital governance and reporting structures, this reporting process has been developed to ensure that a timely and consistent capital project reporting mechanism is in place for each Project Director on behalf of Project Groups to report on project progress.

The process is outlined as follows:

Individual capital highlight project report templates, in Powerpoint slide format, are developed by Project Managers to provide a progress update and are reviewed by the Project Director and Senior Responsible Officer on the scheme before being submitted to the Capital Planning Team.

In the case where projects are led by other organisations, the capital highlight report is developed by the Project Manager from the lead organisation and reviewed by the Health Board Project Lead, Project Director and Senior Responsible Officer on the scheme before being submitted to the Capital Planning Team.

Detail is included in the highlight reports to enable the Sub Committee to note the bimonthly RAG rating of all capital projects.

This tracker includes updates on all major capital new and existing projects as follows:

- Projects in construction phase
- Projects at business case stage
- Projects at feasibility stage
- Projects at post project evaluation stage



The Capital Planning team collate the reports, develop the Capital Governance Report and include the individual capital highlight reports as an appendix to the paper.



The Capital Governance Report is presented to the Capital Sub Committee on a bi-monthly basis and where necessary by exception to the Strategic Development and Operational Delivery Planning Committee (SD&ODC).

Progress on smaller projects funded through the UHB discretionary capital programme are managed through the Capital Monitoring Forum.

The Capital Governance Report provides a summary of the status of the capital projects, with specific reference to projects reporting a red (Alert) or amber (Advise) RAG status. This report is accompanied by:

Addendum 1 – Assurance Definitions (RAG Ratings)

Addendum 2 – Bi-monthly RAG tracker listing all the Capital Projects, the appointed Senior Responsible Owner and Project Director. The RAG status for each project is reflected via a current rating, reflecting the project's position within the reporting cycle, the definition of which includes:

Addendum 3 – Capital Highlight Reports (single slide format)



A summary update report on capital schemes is submitted to *Board/Committee* at the bi-monthly meetings of the Committee.

Addendum 1 – Assurance Level Definitions (RAG Ratings)

Definitions	
Assurance Level	
Assurance Level: High = **ASSURE**	Project Group wish to assure members of the Capital Sub Committee that the scheme: <u>To be green/assure</u> • The project is generally on track, within agreed budget and timeline and there are no major risks/issues of concern that require escalation. • Actions are robust and effectively addressing any issues. • There are no significant concerns and performance is consistently on target. • Risks are managed effectively with appropriate mitigation <u>For the highlight report:</u> • Provide details of the key 3 or 4 matters you wish the CSC to be **assured of** • Include a brief description of planned activities that have been completed successfully.
Assurance Level: Moderate = **ADVISE**	Project Group wish to advise members of the Capital Sub Committee that the scheme: <u>To be amber/advise</u> • The project or programme is within agreed budget, however there is concern over risks and issues which may affect programme and/or cashflow. • Planned activities are on track / completed successfully, but risks / issues of concern are apparent that require noting to the sub-committee. Mitigation should be place for these risks / issues. • Actions are in place but require close monitoring and additional efforts. <u>The highlight report should</u> • Provide details of the key 3 or 4 matters you wish the CSC to be **advised of**. • Include a brief description of the matter and what you would like the CSC to do. • Include a brief description of planned activities that are on track / completed successfully, but risks / issues of concern are apparent that require noting to the sub-committee. Mitigation should be place for these risks / issues.

Assurance Level: Low = **ALERT**	Project Group wish to alert members of the Capital Sub Committee that the scheme: To be red/alert: Project is delayed/overrun, outturn exceeds the agreed budget, significant risks / issues not mitigated. • Planned key milestones/activities not achieved during this period and no mitigation in place to achieve next period. • Actions are insufficient or not effectively addressing the issue. • Significant concerns exist, and there is a high risk of not meeting target For highlight report should: • Provide details of the key 3 or 4 matters you wish the CSC to be **alerted** to. • Include brief description of the matter and what you would like the CSC to do. i.e. where planned key milestones / activities have not been achieved during this period and no mitigation in place to achieve in next period.

Addendum 2 - Capital Project – Bi-Monthly Risk Assessment Tracker

PROJECT	PROJECT VALUE	SRO/ Project Director	RAG Indicator											
Month			ALERT, ADVISE or ASSURE	June 24	July 24	Sept 24	Nov 24	Jan 25	March 25	May 25	July 25	Sept 25	Nov 25	Jan 26
Projects led by Health Board														
				No report required	No report required	No report required	No report required							
											No report required	No report required	No report required	No report required
				No report required	No report required	No report required	No report required							
Projects led by other organisations														
				On hold	On hold	On hold	On hold	On hold	On hold	On hold	On hold	On hold	On hold	On hold
												No report required	No report required	No report required

Addendum 3 - Capital Highlight Reports (Slide Format)

SRO	Stage	Author: PM/PD
PD	Next key milestone	

Project A

Project Description

Current RAG	ASSURE ADVISE ALERT

SOC		OBC		BJC		Construction		Commissioning		Total Value of Scheme	

Activities Completed	Activities Planned	Matters for sub-committee attention
		UHB Risks Risks / Mitigating Actions
		UHB Issues
UHB Comments		

Appendix E

Assurance Opinion

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

Prioritisation of Findings

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

Disclaimer

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

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

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

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

Public Sector Internal Audit Standards

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



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

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Nuclear Medicine Consolidation

Final Internal Audit Report

2025/26

Betsi Cadwaladr University UHB



Unsatisfactory Assurance

Contents

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Review Reference	BCU-SSU-2526-45
Fieldwork	February - April 2026
Executive Sign Off	27th July 2026
Audit Committee	18th August 2026
Executive Lead	Teresa Owen, Executive Director of Allied Health Professionals and Health Science
Audit Team	Huw Richards, Head of Internal Audit
	Murray Gard, Deputy Head of Internal Audit
	Paul Stocker, Audit Manager

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

This audit reviewed the delivery and management arrangements in place to progress the Nuclear Medicine Consolidation project during the Full Business Case (FBC) stage. The audit was commissioned in accordance with the agreed Integrated Audit Plan provided within the approved Outline Business Case (OBC) and was the first audit of the project. Further audits are planned within the updated Integrated Audit Plan provided to management for inclusion within the FBC.

Overview

Following Welsh Government approval of the OBC in June 2025, development of the FBC identified increased revenue costs driven by revised activity assumptions and commissioning arrangements. The updated model indicates an initial funding shortfall of c.£255k in 2028/29, improving to break-even by 2033/34 as activity levels increase and economies of scale are achieved.

Cost pressures reflect growth in PET-CT activity commissioned via NHS Wales Joint Commissioning Committee (NWJCC), with a cost-per-case funding model resulting in higher expenditure for the Health Board irrespective of provider. Revised, lower early-year demand assumptions have delayed efficiency gains and increased unit costs compared to the OBC, with tariff and funding discussions ongoing as part of Welsh Government scrutiny.

Notwithstanding these pressures, the UHB progressed the FBC, which was subsequently approved by the UHB Board in January 2026, with the proviso that the issue of the anticipated revenue shortfall would be addressed via planned discussion with NWJCC scheduled for February 2026. This approval reaffirmed the project's strategic importance and its alignment with organisational priorities.

The FBC was submitted to WG in January 2026, with an anticipated construction start date of March 2026. Following submission, the UHB was required to respond to a series of scrutiny questions raised by the Welsh Government and its agents. However, the UHB failed to resolve and respond to all of the WG scrutiny questions (key being the increased revenue implications). This effectively meant that the UHB was unable to complete the WG scrutiny process ahead of the pre-election period. As a result, the project did not secure funding within the current approval cycle and is now subject to delay.

Any delay in progressing the scheme may result in increased capital costs due to inflationary pressures and could necessitate elements of the business case being revisited. In addition, future funding decisions will be dependent on the priorities of the incoming government.

In summary, while the project continues to be regarded as strategically important and is supported in principle, the timing of key approvals and unresolved financial considerations have impacted the UHB's ability to progress funding at this stage, therefore increasing the risk and uncertainty on the successful delivery of the scheme at this point in time. We have therefore concluded **unsatisfactory assurance** at the time of the current audit.

The significant matters requiring management attention include:

- determination whether the project is economically viable given revenue and capital cost pressures;
- the timely reporting to the Board/Sub-Committees re: the risk of missed external funding opportunities and potential adverse impact on delivery of this strategically important project;
- appointment of Project Director and formalised acceptance of accountabilities.
- appointment of Cost Adviser and development of ongoing cost reporting; and
- resolution of difficulties that have delayed recruitment of the Cost Adviser and NEC Supervisor.

A number of the above issues align with those identified in the previous Llandudno Orthopaedic Audit and were also highlighted within the recently issued Capital Governance Advisory Review. It is recognised that these matters will be addressed through the wider actions being developed by the UHB Executive Team in response to the Advisory Review.

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

Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	**Project Performance:** Consideration of performance against project objectives (e.g. time, cost, benefits, critical success factors etc.).	1,5	**Unsatisfactory**
2	**Governance:** To assess whether the project's governance framework is clearly defined, effectively operated, and provides robust management and control by reviewing programme management arrangements, the adequacy and effectiveness of workstreams, the operation of approval processes, and the project's overall readiness to proceed.	2,3	**Limited**
3	**Financial:** To evaluate whether the project's financial management arrangements are robust and well-governed by reviewing the adequacy of financial approvals and budget-setting processes; the effectiveness of financial monitoring and cost control (including use of Project Bank Accounts); the management of contingency and cost-related risks; and the arrangements for ongoing tracking and reporting of project costs.	4,5	**Unsatisfactory**
4	**Technical:** To evaluate whether the project's technical management is robust and compliant by assessing programme management arrangements, the determination and validation of target and actual costs, the adequacy of tender evaluations and contractual arrangements, the quality and completeness of site surveys, and compliance with acceptable framework conditions.	-	**Reasonable**
5	**Advisers:** To provide confirmation that advisers to the project were procured fairly and in line with procurement rules through review of procurement route for each adviser. Assurance that advisers were appropriately appointed with defined forms of contracts.	6	**Reasonable**
6	**Design:** To assess whether the project's design at Full Business Case stage is robust, affordable, and compliant with required standards by evaluating the management of derogations, the impact of value engineering and affordability decisions, adherence to design warranties, the adequacy of design sign-off and approval processes, and the effectiveness of change-management arrangements.		**Substantial**
7	**Planning:** To determine whether planning activities for the project are effective and compliant by assessing the status and management of planning approvals, the delivery of planning conditions and requirements, the adequacy of communication and coordination processes, and the effectiveness of arrangements for managing objections.	7	**Reasonable**
8	**Information:** To assess whether information management systems supporting the capital project are reliable, effective, and fit for purpose by evaluating the adequacy of processes, controls, and systems used to store, manage, and share project information		**Substantial**

Management Actions

3	4
High Priority	Medium Priority

Themes



Risk Types

Financial Loss

Legal & Regulatory Non-Compliance

Nuclear Medicine - At a Glance



The current Nuclear Medicine service is delivered across three acute hospital sites, each equipped with a Gamma Camera, alongside a mobile PET-CT unit operating on a part-time basis for three days per week at Wrexham Maelor Hospital.

The proposed project provides an opportunity to enhance service quality, improve operational resilience, and achieve greater cost efficiency. The preferred option is the consolidation of services into a single Centre of Excellence for Nuclear Medicine at Ysbyty Glan Clwyd Hospital. The proposed Centre would house two Gamma Cameras and a permanently installed PET-CT scanner.

As part of this project Gamma Cameras procured in 2022 for Wrexham Maelor Hospital and 2025 for Ysbyty Gwynedd – would be relocated as per the proposed service reconfiguration.

The FBC had been prepared and had been progressed within pre-defined timescales through internal governance and approval processes culminating in Board Approval on the 29th of January 2026 and submission the following day (30th January 2026) to Welsh Government (WG). Following this the Project Board Members and Project Team worked to address the questions posed as part of the scrutiny undertaken by WG. At the time of reporting a number of these remained open (inc. revenue assumptions, tender validity etc). The fundamental issue around the shortfall in revenue funding implications which had been communicated throughout the internal FBC approval process was not resolved by the UHB leadership before the WG closed down as part of the pre-election process.

Findings & Agreed Action Plan

Objective 1: Project Performance — Unsatisfactory

Overview / Summary of Observations

Time

Milestone Activity	OBC Target Dates (source OBC)	FBC Target Dates (source FBC)
FBC submission to WG	December 2025	January 2026
WG approval of FBC	December 2025 - March 2026	April 2026
Commence construction	March2026	May 2026
Construction completion	February 2027	August 2027
Facility operational	May 2027	September 2027

The project has experienced delays against the key milestones established within the OBC.

The delay in progressing the project has been primarily attributed to unresolved affordability considerations, which resulted in the UHB missing the current funding window. This has introduced uncertainty in relation to future funding approval, alongside risks of further delay to project delivery and benefits realisation. In addition, extended timescales increase exposure to inflationary pressures and create a risk that assumptions underpinning the FBC may require revision. There is also a risk of diminished value arising from resources already invested, together with a potential adverse impact on stakeholder confidence should delays continue.

Cost

The OBC (OBC), developed in 2024, identified anticipated capital funding requirements of £19.2 million. At FBC stage, the total project cost has reduced to £17.1 million, remaining within the overall £20 million funding envelope agreed with WG. The capital cost position had been reviewed and validated by the UHB's appointed Cost Advisers, providing assurance that the scheme was deliverable within the approved capital limits.

Notwithstanding the favourable capital position, key issues would need to be resolved:

- the revised revenue assumptions identified at the FBC stage indicated reduced patient throughput relative to earlier forecasts. This has resulted in a projected net revenue pressure of approximately £255k in the first year of operation, with ongoing financial impact extending to 2035.
- Recognising the delays in addressing scrutiny questions associated with the revenue shortfall, the Contractor's submitted prices were only fixed till the 31st March 2026 and the tender offer will therefore be reviewed and resubmitted with an inevitable impact on the capital cost assumptions and the potential financial viability of the scheme.

In the context of the of the UHB's current financial position and the requirement to achieve financial balance, these projected revenue pressures have contributed to a pause in the progression of the scheme.

Quality

At FBC stage, the project demonstrated an appropriate level of design development. Evidence was reviewed confirming that clinical and technical requirements had been incorporated into the emerging design. Stakeholder engagement had been demonstrated with relevant clinical and operational groups, and feedback had been used to inform design evolution. At the time of the current review the technical design was being evaluated as part of the wider scrutiny of the FBC.

Conclusion

Although the project demonstrates appropriate design development informed by stakeholder engagement, delays arising from the unresolved revenue affordability have led to significant slippage against key milestones, a pause in progression, and ultimately uncertainty over the delivery of the scheme resulting in **unsatisfactory assurance** over project performance to date.

Key Findings: Project Performance		Risk & Impact	Agreed Management Action
1	The NHS Infrastructure Investment Guidance states that "*The indicative timescale for the initial review and feedback by the Welsh Government of business cases is a minimum of 30 working days (it should be noted, however, that in most cases business cases take several months to go through the scrutiny and feedback process).*" The FBC was approved by the UHB and submitted to WG on the 30th January 2026. The scrutiny questions were received from WG on the 4th March 2026 (23 working days). The completed scrutiny grid was returned by the UHB to WG on the 19th March 2026 with a number of key issues remaining open e.g. recurring revenue costs, tender validity etc. This effectively meant that the UHB was unable to complete the WG scrutiny process ahead of the pre-election period. As a	The lack of timely visibility by the Board/Sub-Committees, increases the risk of missed external funding opportunities and potential adverse impact on delivery of this strategically important project.	**Agreed Action:** The following action was completed prior to issue of the Report; The Project Manager's Highlight Report presented to the joint Project Team/Board meeting on 27th April 2026, moved the project status from an amber to a red status and noted that `*Initial responses to the essential queries were returned to Welsh Government on 19th March 2026. The query requesting assurance on the revenue implications was in draft form and not agreed as yet at DoF level,* ` and made multiple references to the delay to the programme and risk increases including to the current operational service. The risk associated with FBC approval was also increased to its highest possible score of 25. The delay was also reported to the Capital Development Team meeting held on the 8th April 2026 and noted in those minutes.

	result, the project did not secure funding within the current approval cycle and is now subject to delay. A review of minutes and supporting papers from relevant governance and oversight committees (e.g Board and/or its Sub-Committees) identified no evidence that the delay, or the associated risks and implications for funding of project delivery, were reported, discussed, or formally escalated. This indicates that controls in place to monitor and report key capital programme milestones were not operating effectively, limiting timely visibility of a critical issue and reducing the ability of the Board and Sub-Committees to provide oversight or intervene in relation to this strategically important project. *Note: Issues associated with the Health Board's capital reporting and escalation arrangements have been highlighted within the Capital Governance Advisory Review.*		The delay was again reported to the Project Board on the 6th July 2026 and subsequently a letter escalating the issues has been issued by the Project Director to the SRO. The SRO is continuing to liaise with the Directors of Finance and Corporate Governance in relation to the revenue approval assurance. A formal update on the change in position from the Board meeting on 29th January 2026 is in draft form and under review prior to sharing with the Executive Team. This update provides the current status, notes that the key risks associated with the business case needs remain and provides the background along with an assessment and series of recommendations. **Expected Evidence of Implementation:** • Copy of the update report and minutes of the Executive Team meeting. • Copy of the evidence or assurance associated with the revenue within the FBC scrutiny grid response after submission to WG. • Copy of subsequent Project Manager Highlight reports and all documentation which evidence the progress associated with progressing the recommendations set out within the update report.
		High Priority	**Officer: SRO** **Target Implementation Date:** 28th August 2026
	Theme: Governance	Control Operation	

Objective 2: Governance	Limited

Overview / Summary of Observations

Governance arrangements had been defined within the OBC and updated within the FBC, as supported by a detailed Project Execution Plan (PEP). Key roles were defined, including the Senior Responsible Officer and Project Director. External advisers were appointed to provide project management support, with cost advisory services in the process of appointment at the time of the audit.

However, the assignment of key roles differed at the PEP, noting that this is the key tool in defining project controls. This can cause ambiguity over accountability and reduced assurance that the project is being managed in line with the approved / intended governance structure.

The governance structure provides for a Project Team and defined workstreams with oversight by a Project Board reporting to WG via the Executive Team and Senior Responsible Owner. In practice, the Project Board and Project Team have operated as a combined forum, which may reduce the separation between delivery and oversight / scrutiny / independent challenge. This requires clear terms of reference and documentation of scrutiny and decisions to ensure the maintenance of effective controls.

The audit identified inconsistent attendance by the Project Director at Project Board meetings, with representation often provided by a deputy, and an impending retirement creating a further risk to continuity of leadership.

In addition, at a strategic level of reporting, the delay in addressing the WG scrutiny question around revenue funding was not formally escalated to the Board or relevant Sub-Committees until the Board meeting of the 29th March 2026, by which time the window of opportunity had closed due to WG shutdown for purdah.

	Key Findings: Governance	Risk & Impact	Agreed Management Action
2	The Project Director has not consistently attended the Project Board meetings, with representation typically provided by a deputy. Whilst this has supported continuity, it may have limited the level of direct senior oversight and engagement at key stages of decision-making. In addition, the planned retirement of the Project Director introduces a further risk to continuity of leadership at a critical point in the project. Without appropriate arrangements, this may affect the continuity of knowledge and established stakeholder relationships. Overall, this highlights the importance of maintaining clear governance arrangements and ensuring a well-planned handover to support continued oversight, momentum, and delivery confidence.	Potential risk to continuity of governance and oversight. Timeliness of decision making, clarity of direction, and stakeholder confidence, with potential implications for project momentum and delivery if not effectively managed.	**Agreed Action:** Following the retirement of the previous Project Director the deputy chair of the Project Board has now been appointed as the Project Director, and this will be formalised within an appointment letter. **Expected Evidence of Implementation:** Copy of appointment letter with countersignature of acceptance.

	Note: Issues associated with the Health Board's capital reporting and escalation arrangements have been highlighted within the Capital Governance Advisory Review.		
		High Priority	**Officer:** SRO
	Theme: Governance	Control Operation	**Target Implementation Date:** 31st July 2026
3	The Project Execution Plan (PEP) defines a clear two-tier governance structure, with the Project Board providing strategic direction, oversight and challenge, and the Project Team responsible for operational delivery. However, in practice, these groups were operating as a single combined forum to support attendance. While pragmatic, this arrangement departs from the approved governance framework and reduces the separation between oversight and delivery functions. of project governance and assurance. Effective separation between oversight and delivery is a key element of timely and robust decision-making. The current combined governance arrangements may have limited this separation, potentially impacting the pace of escalation, challenge, and approval, and thereby contributing to delays in progressing the Full Business Case. The Project Director has advised that this model was to be reconfigured once the next stage of the project was initiated, understanding that the construction stage would require enhanced level of scrutiny and oversight.	Potential risk that independent challenge and scrutiny are diminished, accountability for decisions is less clearly defined, and there is an increased risk that issues are not subject to appropriate escalation or objective review.	**Agreed Action:** The existing arrangements to support attendance and reduce impact on clinical staff is for the Project Team meeting with wider workstream attendance to immediately precede the Project Board meeting with limited representation in line with the Procedure Manual for Managing Capital Projects. Decisions required from the Project Team meeting are taken forward to the later Project Board meeting along with any other matters. This is reflected in the notes of these meetings. The proposed actions which are commensurate to the position pre FBC approval are; • Review the Project Team terms of reference including membership Complete the same for the Project Board. • Separate the diary invitations for the 2 meetings. • Amend the PEP to accurately reflect the terms of reference, membership and meeting arrangements. The above steps will need to be repeated once FBC approval is complete and the project moves into the construction phase. Programme Project board July 2026 meeting agreed that the meetings would divide into separate meetings going forwards **Expected Evidence of Implementation:** The following actions will be implemented as part of the August meetings and will be ongoing; • The terms of reference of the Project Board and Team will be updated (and brought to the August meetings for adoption). • The meeting agendas and minutes will clearly state the meeting name, record attendance and discussion to

			demonstrate the separate matters that the two meetings cover. The project PEP will be reviewed and updated to reflect the current membership of the Project Team and Board as well as to record workstreams and the wider current status of the project. This updated PEP will be brought to the September Project Team and Board meetings.
		Medium Priority	**Officer:** Project Director
	Theme: Governance	Control Operation	**Target Implementation Date:** 28th August 2026

Objective 3: Financial	**Unsatisfactory**

Overview / Summary of Observations

At FBC stage, the project had an approved capital cost envelope of £17.1 million, which had been validated by the UHB's appointed Cost Advisers. Despite this, progression of the project has been paused pending the resolution of wider organisational financial pressures related to revenue affordability.

The Cost Advisers had been engaged during the development of the OBC and FBC through existing appointment arrangements. However, the appointment of Cost Advisers under a new contract was delayed following FBC submission. As a result, monthly cost reports were only produced by specific request during this period.

In the absence of regular cost reporting, there was limited evidence of a formal mechanism to monitor ongoing cost movement, risk exposure, or changes to key assumptions such as inflation, scope, or market conditions during the post-submission period. While project expenditure has been reported through existing financial reporting arrangements, the lack of structured financial input reduces assurance that emerging financial risks will be identified and managed in a timely manner.

	Key Findings: Financial	**Risk & Impact**	**Agreed Management Action**
4	Management should ensure that a proportionate and structured cost reporting regime is maintained established for the following stages current phase of the project. This should include regular monthly or exception-based financial reporting.	Emerging cost pressures or changes in underlying assumptions may not be identified in a timely manner.	**Agreed Action:** The FBC has not been approved as yet so the project has not proceeded to the construction phase where higher expenditure requires more detailed cost reporting. There is a relatively small residual approved OBC stage budget which will be expended, primarily on fees, in the Qtr 1 and 2 periods of 2026/27 for which a cost report will be requested from the now appointed Cost Advisor. This cost report will be shared with the Project Board and Project Director. **Expected Evidence of Implementation:** Monthly project cost reporting to both the project team and Project Board throughout the delivery of the project's lifecycle.
		Medium Priority	**Officer:** Project Director **Target Implementation Date:** Immediately
	Theme: Finance Management & Control	Control Operation	
5	The Board approved the FBC for the project, confirming strategic alignment and organisational commitment. However,	Delayed project progression.	**Agreed Action:** A letter escalating the issues has been issued by the Project Director to the SRO. The SRO is continuing to liaise with the

	a known increase in associated revenue costs was not resolved in a timely manner. As a consequence, the project has not secured funding within the current approval window. This creates a material risk to delivery timelines and overall affordability. Any delay is likely to expose the scheme to significant inflationary pressures. Furthermore, there is a risk that a future government may revise funding priorities, which could result in reduced or withdrawn support for the project. The UHB should look to resolve this as a matter of urgency and decide the course of action going forward with this project.	Cost Inflation	Directors of Finance and Corporate Governance in relation to the revenue approval assurance. A formal update on the change in position from the Board meeting on 29.01.26. is in draft form and under review prior to sharing with the Executive Team. This update provides the current status, notes that the key risks associated with the business case needs remain and provides the background along with an assessment and series of recommendations. The intent is that the assurance in relation to the revenue is provided and the update report and its recommendations finalised for the Executive Team no later than the meeting due to be held on 12.08.26.
			Expected Evidence of Implementation: • Copy of the update report and minutes of the Executive Team meeting. • Copy of the evidence or assurance associated with the revenue within the FBC scrutiny grid response after submission to WG.
		High Priority	**Officer:** SRO **Target Implementation Date:** End of August 2026
	Theme: Approvals	Control Operation	

Objective 4: Technical	**Reasonable**

Overview / Summary of Observations

The target cost for the scheme was subject to review, with evidence that it had been considered and formally approved by the board in accordance with the UHB's governance process.

Site surveys relevant to the development had been completed and had informed the preparation of the design. The outputs from these surveys were included within the tender documentation pack issued to potential supply chain partners, supporting a more informed basis for pricing.

While these arrangements are consistent with expected practise and provide a level of assurance over cost development and procurement readiness, the extent to which all site related risks have been fully mitigated will only become clear up through subsequent delivery phases.

Assurance for this objective has been deemed as reasonable noting that the preconstruction and enabling works were omitted from the original tender with this being addressed post FBC approval by the Board.

Objective 5: Advisers	Reasonable

Overview / Summary of Observations

The audit reviewed the procurement and appointment of project advisers to assess compliance with relevant procurement requirements and the appropriateness of contractual arrangements. The Full Business Case (FBC) set out a clear procurement strategy for both the Supply Chain Partner and professional advisers, including a defined rationale for the selected forms of contract.

The procurement of the Project Manager was undertaken in conjunction with NHS Wales Shared Services – Procurement Services, with responses evaluated against established criteria and subject to formal approval. This approach provides assurance that the procurement process was conducted in a fair, transparent, and compliant manner. It was also confirmed that advisers have been, and are being, appointed using standard NEC contracts, with roles and responsibilities clearly defined.

An initial delay was experienced in appointing the Project Manager due to the need to re-run the Invitation to Tender (ITT) process; however, this was subsequently completed within a reasonable timeframe. Further delays have been noted in the appointment of key professional advisers, including the Supervisor and Cost Advisor roles.

While these delays have the potential to impact project timelines, it is recognised that overall project slippage has provided a degree of flexibility for these appointments to be progressed without immediate adverse impact. On this basis, the level of assurance has been assessed as reasonable, reflecting that appropriate procurement processes are in place and being applied, albeit with some delays in implementation.

	Key Findings: Advisers	Risk & Impact	Agreed Management Action
6	The Supervisor and Cost Advisor are core roles in NEC managed capital projects, underpinning contract administration, cost control, and assurance. Management should in partnership with NWSSP Procurement engage to strengthen procurement planning and oversight for capital projects by establishing clear timelines, accountabilities and escalation routes for all key appointments post FBC approval.	Delays in appointing two key project roles create a risk for timely project mobilisation and effective governance.	**Agreed Action:** This commentary was included prior to issue of the report; The Procurement processes are now complete however the overall length of time they took is also very much a reflection of the lack of resource available within Procurement Services to progress these in a timely manner. The overall length of time it took to complete them (the procurement processes)was not in the Health Board's control. From our experience NWSSP Procurement Service do not have the adequate resource to support clear timelines even when agreed, with the ITT and other dates quoted to us being missed. The proposed action is that a timeline of procurement processes is maintained to support future procurements. This travelling file note could include activities such as; • Completion of any prior approval to issue of tender • Agree tender strategy • Collation period for tender documentation

			• Development of ITT • Publication of ITT and so forth with a set of dates agreed with NWSSP Procurement Services and a record of any changes to these dates or the steps involved. Both the Project Manager and Cost Advisor procurement processes here were also delayed by the need to issue a further clarification question which necessitated new technical and commercial returns because the submitted resource schedules did not provide assurance. The Supervisor procurement was repeated in its entirety because no responses were received initially. An additional proposed action is that the highlight report issued to the Project Team and Board not just reports these delays but prompts a review of the associated risk in the risk register to the delay. The implication of delays in appointments and agreement of alternative interim arrangements is to be escalated by the Project Director as appropriate.
			Expected Evidence of Implementation: • Draft timeline milestones file note for any later procurements in the project. • Reference to any later procurements in future highlight reports and meeting notes.
		Medium Priority	**Officer:** Project Director **Target Implementation Date:** On going
	Theme: Contractual	Control Operation	

Objective 6: Design	**Substantial**

Overview / Summary of Observations

A review of documented evidence at the FBC stage confirmed ongoing involvement of key clinical stakeholders in the design process. This included email correspondence confirming stakeholder satisfaction with clinical layouts (e.g. room configurations) and minutes from both the Project Board/Project Team meetings demonstrating regular updates, discussion of design elements, and stakeholder input into decision-making.

These arrangements provide assurance that relevant stakeholders were appropriately consulted and that requirements were incorporated into the design, reducing the risk that the completed facility would not meet clinical or operational needs.

While adequate design sign-off, approval processes, and change management arrangements were in place, the project ultimately stalled due to unresolved increases in forecast revenue costs between OBC approval and development of the FBC.

Objective 7: Planning	**Reasonable**

Overview / Summary of Observations

Planning permission for the proposed development was granted by Denbighshire County Council approximately six months prior to submission of the FBC to WG. Approval under the Sustainable Drainage Approval Body (SAB), in accordance with the Flood and Water Management Act 2010, had also been secured at that time.

At the time of audit, a single pre-commencement planning condition remained outstanding this being :

- A condition related to ecological Reasonable Avoidance and Mitigation Measures (RAMS). The Project Highlight Report dated 27 March 2026 confirmed that an ecologist had undertaken a further site survey, and an updated RAMS was awaited to support discharge of this condition.

Until this condition is formally discharged by the Local Planning Authority, there remains a risk that commencement of construction works may be delayed. In particular, no development may commence until a RAMS Method Statement for mammals and amphibians has been submitted to and approved in writing by the Local Planning Authority.

Project representatives confirmed that engagement with the Local Authority and relevant specialists was ongoing to facilitate discharge of the outstanding condition.

	Key Findings: Planning	Risk & Impact	Agreed Management Action
7	Whilst noting the current hiatus in respect of the progress of WG approval of the project, to ensure a timely ability to meet any positive outcome in this regard, management should ensure that: priority is given to progressing the discharge of the outstanding planning conditions, including timely submission of all required supporting information.	Delays in securing formal discharge of the outstanding pre-commencement conditions may delay the start of construction works, resulting in potential programme slippage and associated cost and delivery risks.	**Agreed Action:** The outstanding discharge of a condition is dependent on the submission of ecology RAMS to the Local Authority which has been delayed as the RAMS proposed by the incumbent ecologist were highly onerous with high levels of watching briefs and resource. The proposed action is that a new approach is agreed between the Project Manager and Design teams along with ecologist input prior to agreed RAMS being submitted. The specific focus relates to the removal of trees and shrubs alongside a culvert and given these are deciduous new RAMs could be produced in Oct-Nov 2026 for submission. This will not delay the start of construction works as this timeline is not a critical path activity and sits well within the overall FBC stage costing, approval and construction phase mobilisation stages. **Expected Evidence of Implementation:** • Copy of submitted ecology RAMS
		Medium Priority	**Officer:** Project manager for estates development

	Theme: Planning, Delivery & Deadline Management	Control Operation	**Target Implementation Date:** In line with FBC approval

Objective 8: Information	**Substantial**

Overview / Summary of Observations

This review assessed the adequacy and effectiveness off the information management systems supporting the capital project, with particular consideration given to whether the systems were reliable, effective, and fit for purpose. The review focused on the governance, storage, retention, and sharing arrangements in place for project information and documentation.

The project team maintained a structured SharePoint based file management system within Microsoft 365. Appropriate processes and controls had been implemented to support the secure storage, organisation, and management of project records through the project lifecycle. Access permissions and information sharing arrangements were found to be appropriately managed, supporting collaboration while maintaining control over sensitive information.

Overall, the review concluded that the existing information management arrangements provide a reliable and effective framework to support the delivery and governance of the capital project no significant weaknesses were identified that would impair the accessibility integrity or management of project information.

Appendix A

Assurance Opinion

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

Prioritisation of Findings

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

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Shared Services Partnership
Audit and Assurance Services

Performance & Finance Committee

CORPORATE RISK REGISTER

Dyddiad y Cyfarfod **Date of Meeting**	27 October 2026
Statws Cyhoeddi **Publication Status**	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad **Report Author name and title**	Anthony Hughes, Risk Assurance Manager Jody Evans, Assistant Head of Risk Management
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol **Lead Executive Team Member name and title**	Pam Wenger, Director of Corporate Governance

Pwrpas yr Adroddiad **Report Purpose**	Endorse for Board Approval

Crynodeb Gweithredol
Executive Summary

The Committee is asked to receive assurance on the three Corporate Risks within its remit and oversight:

- CRR25-06 – Value Delivery and Financial Sustainability
- CRR25-09 – Safe Environment
- CRR25-10 – Health and Safety

All 3 risks have been reviewed and updated to reflect current position. There are no proposed changes to risk scores, and all three risks remain above the Health Board's risk appetite.

Whilst governance and oversight arrangements continue to mature, there has been limited movement in residual risk scores. Future reporting will place greater emphasis on risk trajectory, delivery of mitigating actions and evidenced risk reduction, rather than solely focusing on the maturity of governance arrangements. Whilst assurance can be taken from the strengthening of risk management processes and governance oversight, overall assurance regarding the effectiveness of current controls remains moderate, reflecting the limited

movement in risk scores and the number of risks that continue to operate outside the Health Board's agreed risk appetite.

A programme of risk-specific meetings with Executive Leads is being established to further refine individual risks, to ensure actions are sufficiently targeted, and support delivery of measurable reductions in risk scores within the agreed risk appetite.

The Committee is asked to:

- Review the current risks and level of assurance provided
- Provide feedback to support further refinement ahead of submission to the Board

Ymgysylltu (mewnol/allanol) yr ymgymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp) **Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)**		
Pwyllgor / Grŵp / Unigolion **Committee / Group / Individuals**	**Dyddiad** **Date**	**Canlyniad, Tystiolaeth a Data** **Outcome, Evidence and Data**
Risk Scrutiny Group (RSG)	08/09/2026	Risk Scrutiny Group stood down due to lack of quoracy for the meeting. The report was subsequently reviewed by the Executive Team.
Executive Committee (EC)	23/09/2026	Full CRR presented to the Executive Committee.
Executive Committee (EC)	21/10/2026	Full CRR to be presented to the Executive Committee

Acronymau / Rhestr Termau **Acronyms / Glossary of Terms**	
CRR	Corporate Risk Register
RSG	Risk Scrutiny Group
BAF	Board Assurance Framework

CORPORATE RISK REGISTER

1. Y SEFYLLFA / SITUATION

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

Three consolidated Corporate Risks will fall under the remit and oversight of the Performance, Finance and Information Governance Committee:

- CRR25-06 'Value Delivery and Financial Sustainability '
- CRR25-09 'Safe Environment'
- CRR25-10 'Health and Safety'

2. Y CEFNDIR / BACKGROUND

The Committee is asked to scrutinise and endorse three Corporate Risks within its remit prior to submission to the Board:

Three Corporate Risk Risks fall within the remit of the Performance, Finance & Information Governance Committee. Significant work has been undertaken to strengthen the quality, consistency and assurance provided through the Corporate Risk Register, including the development and implementation of a revised reporting template that more clearly articulates risk exposure, controls, assurance gaps and mitigating actions.

All risks have been mapped over to the newly approved Corporate Risk Register template. This provides improved clarity and consistency in the articulation of risk position, and strengthens the alignment between identified control gaps, mitigating actions and intended outcomes.

The Committee is invited to review the risks in their current form and provide feedback to support further refinement ahead of Board consideration.

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

Risks above Health Board appetite

All three risks reported to the Committee score outside the tolerance range set within the Health Board's risk appetite.

Risk Ref	Risks	Lead Exec Director	Current Risk Score	Risk Tolerance Range in Appetite Score
CRR25-06	Value Delivery and Financial Sustainability	Executive Director of Finance	**20**	Quality <15
CRR25-09	Safe Environment	Director of Environment and Estates	**20**	Regulatory <15
CRR25-10	Health and Safety	Director of Environment and Estates	**16**	Regulatory <15

Action Plan status of Corporate Risks

Out of the 3 corporate risks, 26 actions have been developed to mitigate the risks, with 26 open actions progressing and on track.

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

All Corporate Risks within the Committee's remit have been reviewed, with no proposed changes to the current risk scores. The current scores remain outside the tolerance levels established through the Board's agreed risk appetite.

Nine of the eleven Corporate Risks remain above the Board's agreed risk appetite. The focus must therefore be on demonstrable risk reduction, including whether mitigating actions are improving the risk trajectory and reducing residual risk exposure.

To strengthen accountability for delivery, it is proposed that detailed scrutiny of Corporate Risks and Board Assurance Framework risks is undertaken through the relevant Executive Delivery Groups, aligning responsibility for managing risk with the executive arrangements responsible for delivery and performance.

The Risk Scrutiny Group would provide corporate oversight of the effectiveness and consistency of risk management, including risk maturity, emerging and cross-cutting risks and appropriate challenge to significant risks.

The Performance and Finance Committee would retain strategic oversight and assurance of the significant risks within its remit, with reporting focused on material changes in risk exposure, trajectory, delivery of key mitigations and matters requiring escalation or intervention.

Subject to approval through the appropriate governance route, the Risk Management Framework, reporting and escalation arrangements and relevant Terms of Reference will be updated to reflect these responsibilities.

5. ARGYMHELLION RECOMMENDATIONS

5.1 Gofynnir i'r Pwyllgor:
The Committee is asked to:

- **REVIEW** and **SCRUTINISE** the corporate risks set out in the Appendix, including consideration of the current risk position, existing controls, and identified gaps.
- **ENDORSE** the risks for submission to the Board, noting that the risks remain above the Health Board's risk appetite and therefore represent a continued exposure.
- **NOTE** the programme of risk-specific meetings with Executive Leads is being established to further refine individual risks, ensure actions are sufficiently targeted, and support delivery of measurable reductions in risk scores within the agreed risk appetite.

ASESIAD / ASSESSMENT	
Cysylltiad â'r Bwriadau Strategol **Link to Strategic Intentions**	3. Improve Access, Outcomes and Experience If more than one applies, please list below:
Yr Egwyddorion Dylunio Design Principles	People First
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd **Corporate Risks and Board Assurance Framework**	Corporate Risk Register and Board Assurance Framework - Betsi Cadwaladr University Health Board

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Equality Act 2010 Public Sector Equality Duty: **Has BCUHB provided evidence of 'Due Regard' to compliance with the three parts of the Public Sector Equality Duty (General Duty):** https://www.gov.wales/public-sector-equality-duty-htmlPublic Sector Equality Duty [HTML] | GOV.WALES	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	No impacts identified – administrative report
Equality Act 2010 - Socio-economic Duty *Has BCUHB provided evidence of 'Due Regard' to compliance of ther Socio-economic Duty when making strategic decisions?*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	No impacts identified – administrative report
Have you completed an Integrated Equality Impact Assessment WP8a? *WP8a Template*	Canlyniad/Outcome: Do/Yes:	Naddo/No:
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale: Canlynaid/Outcome:	No impacts identified – administrative report

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

Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales	
Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	Choose an item.	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Asesiad o Effaith ar Ddiogelu Data *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?* **Data Protection Impact Assessment** *Have you undertaken a Data Protection Impact Assessment Screening?*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	No impacts identified – administrative report
Asesiad o Effaith ar Atal Twyll *A ydych chi wedi ystyried yr effeithiau ar atal twyll?* **Counter Fraud Impact** *Have you considered the counter fraud impacts*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	No impacts identified – administrative report
Cyfreithiol **Legal**	There are no specific legal implications related to the activity outlined in this report.	
Enw Da **Reputational**	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith ar Adnoddau *(Pobl / Ariannol)* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	As per detail relating to resources within risk and actions.	

Appendices 1 – 3:

1: Dashboard

2: Heatmap

3: Corporate Risks

Corporate Risk Register

Performance and Finance Committee – 27th October 2026



GIG CYMRU NHS WALES

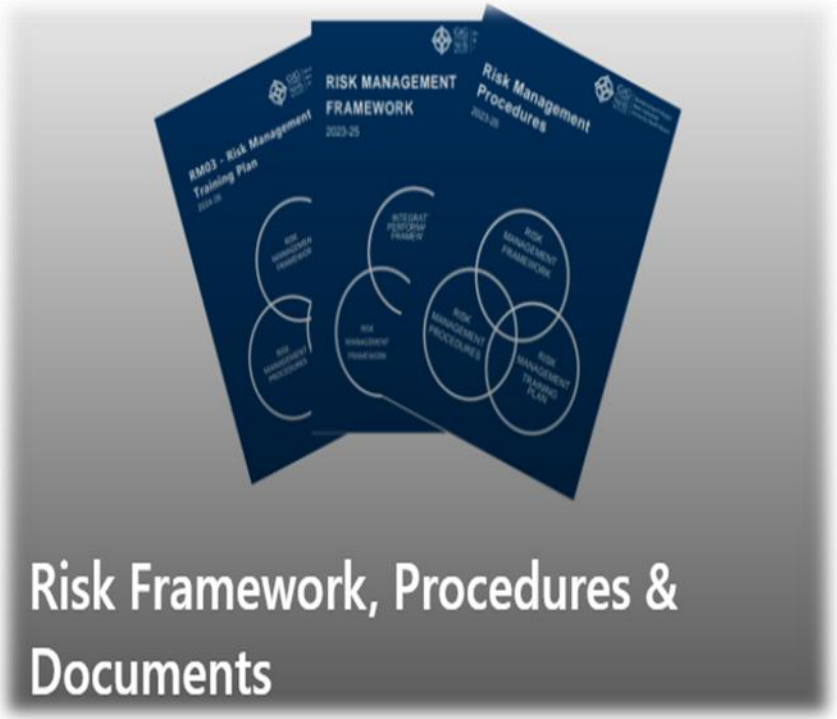
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Corporate Risk Register

This report provides the Performance and Finance Committee with an update on the Corporate Risk Register (CRR) risks within its remit, specifically:

- CRR25-06 – Value Delivery and Financial Sustainability
- CRR25-09 – Safe Environment
- CRR25-10 – Health and Safety

Each risk sets out the current position, including progress against the delivery of associated mitigating actions.



Appendix 1 - Dashboard

Lead	Ref	Risk Title	Current Score (Impact x Likelihood)	Risk Target Score	Appetite Main Risk Type / Appetite Level	Lead Board Committee	Action Progression			Risk Management Commentary
							Total	Completed	Delayed or Overdue	
EDoF	CRR25-06	Value Delivery and Financial Sustainability	5x4 20	12	Financial (<15) Above Tolerance	Performance and Finance Committee	10	0	0	10 actions identified, risk reviewed and updated by the service to current month 4 risk position.
DoE	CRR25-09	Safe Environment	4x5 20	12	Regulatory (<15) Above Tolerance	Performance and Finance Committee	8	0	0	8 actions identified, all 8 actions progressing and within date. Review of the risk undertaken by the service to align to operational aspects of the risk
DoE	CRR25-10	Health and Safety	4x4 16	8	Regulatory (<15) Above Tolerance	Performance and Finance Committee	8	0	0	8 actions identified, with all 8 progressing. Full review of the risk has been undertaken by the service to align to operational aspects of the risk.

Key:

Executive Lead	
Executive Director of Finance	EDoF
Director of Estates and Environment	DoE

Appendix 2 - Heatmap

Corporate Risk Register Heat Map – October '26

Impact			1	2	3	4	5
	Catastrophic	5				Extreme • Future Demand & Sustainable Workforce • Timely Patient Access to Safe and Effective Care • Modernising our Infrastructure • Value Delivery and Financial Sustainability • ICT Failure and Cyber	Extreme
	Major	4			• Strategic Change – Impacting Care and Staff Delivery • Non-Compliance with Regulatory and Legislative Requirements	• Population Needs • Leadership and Operating Model • Health and Safety	Extreme • Safe Environment
	Moderate	3				•	
	Minor	2					
	Negligible	1					
			Rare	Unlikely	Possible	Likely	Almost Certain

Appendix 3 - Corporate Risk Register Performance, Finance & Information Governance Committee – September 2026

CRR REF: CRR25-06 - Delivery of the 2026/27 Financial Plan and Financial Sustainability		
Director Lead: Executive Director of Finance		**Date Opened:** 01/04/2026
Assuring Committee: Performance and Finance Committee		**Date Last Committee Review:** 23/06/2026
Date Last Reviewed: 26/08/2026	**Link to BAF:** BAF26-01 / BAF26-02 / BAF26-03 / BAF26-04 / BAF26-05	**Target Risk Date:** 31/03/2027
There is a risk that the Health Board will be unable to deliver the 2026/27 financial plan and to demonstrate a credible route to longer-term financial sustainability. The plan is set within a zero-investment framework and includes a planned deficit of £43.0m, a recurrent savings requirement of £46.0m and significant reliance on delivery of savings, grip and control, and receipt/retention of anticipated Welsh Government allocations of £82m. In addition, Welsh Government has agreed to fund Welsh Risk Pool cost pressures of £26m if the organisation achieves an additional stretch savings of £17m which will facilitate achievement of financial balance in year. If the stretch target is not met there is a risk this additional funding will not be forthcoming. **This may be caused by** inflation and unavoidable cost pressures exceeding the 1.11% allocation uplift; recurrent impacts from 2025/26 cost pressures; growth and price pressures in commissioned services, prescribing, secondary care drugs and CHC; unfunded national pressures including Welsh Risk Pool, digital/Microsoft licensing and additional NWJCC contributions; pressures in Out of Area Mental Health placements and escalated capacity; and insufficiently mature savings and disinvestment plans. **This may lead to** failure to achieve the planned deficit trajectory and key financial duty, loss or non-retention of conditionally recurrent strategic funding, reduced ability to fund essential services and transformation priorities, further escalation and scrutiny, and increased risk to safe, timely and high-quality care.		

Mitigations/Controls in place	
• Monthly financial reporting to Welsh Government through the Monthly Monitoring Return and internal Health Board reporting, including forecast outturn, risks and opportunities. • Performance, Finance and Information Governance Committee oversight, with financial and performance information shared routinely. • Executive and divisional governance over targeted investment allocations, including Performance and Transformation, Planned Care, Value-Based Healthcare, Further Faster and other specific Welsh Government allocations. • Continuation of 2025/26 Grip and Control measures into 2026/27, including additional non-pay expenditure controls for non-clinical categories, scrutiny of Travel Bureau requests and Stores orders, procurement review of pending Oracle requisitions and cancellation where not critically urgent. • Pay controls and added oversight over non-clinical external recruitment and clinical posts prior to recruitment, with scrutiny of temporary workforce use through Clinical Executive leadership. • Value and Sustainability thematic savings model across Clinical Value, Workforce, Continuing Healthcare, Medicines Management and Non-Pay & Procurement. • Savings identification and monitoring through the Green/Amber/Red pipeline, with Welsh Government action point deadlines for schemes to meet required classification and conversion requirements by 30 September 2026. • Continued scrutiny of agency, locum and variable pay, including delivery against the Cabinet Secretary enabler target of a 30% agency cost reduction. • Ongoing review of reserves, central budgets, virements and forecast categorisation to improve transparency of cost pressures, mitigations and underlying deficit. • Core Savings targets for IHCs, Non-IHC Directorate and Corporate functions have been issued and performance to be challenged at Integrated Performance Executive Delivery Group – chaired by the Chief Executive. • Accountability Agreements issued to the budget managers for sign off in support of funding and deliverables required for each financial year. The signing off for these agreements monitored for review by Internal Audit and performance reported through Committees of the Health Board • Integrated Performance and Accountability Framework 2026-29 adopted by Board on 28 May 2026 • Escalation meetings took place with key budgets holders and Chief Executive for July 2026 for those services / divisions that had not underwritten their savings targets at the end of June 2026. •	

Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G1 The Month 4 position is adverse to plan, with an in-month deficit of £5.8m, £2.2m adverse to profile, a year-to-date deficit of £22.9m, £8.6m to profile.	Maintain enhanced monthly financial recovery and run-rate review through Executive, IP-EDG and PFIG Committee oversight. Financial recovery plan to be developed and presented to Board in September 26. **Outcome** In-month deficit and year-to-date adverse variance are contained and brought back towards the profiled planned deficit trajectory and achieve stretch savings of £63m. **Metric** In-month variance to plan; cumulative deficit to plan; run-rate movement by division. **Impact on Risk** Reduces likelihood of further deterioration and supports delivery of the £43.0m planned deficit and movement towards achieving key financial duty of breakeven.	Executive Director of Finance / Chief Executive Officer	Monthly to 31/03/2027	Progressing
G2 The plan relies on retention of conditionally recurrent strategic Welsh Government funding; loss of this funding is identified as an £82.0m risk and	Maintain evidence against conditions attached to strategic funding and ensure clear escalation where delivery or de-escalation requirements are at risk. **Outcome** Conditions for retention are explicitly tracked and risks escalated early. **Metric**	Executive Director of Finance / Executive Team	Monthly to 31/03/2027	Progressing

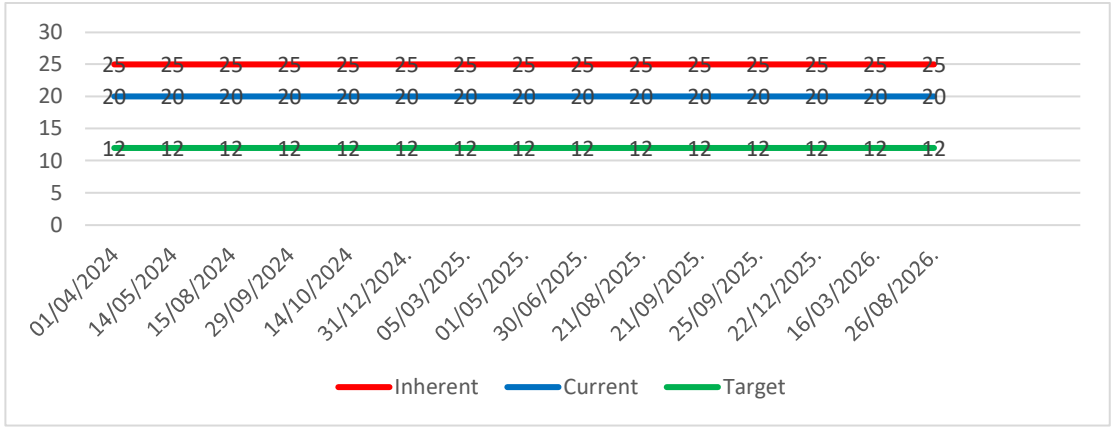
would materially worsen the underlying position.	Condition tracker RAG; evidence of delivery; value of funding at risk. **Impact on Risk** Protects critical income and reduces exposure to a significantly larger underlying deficit.			
Gaps in Controls	**Action**	**Action Owner**	**Due Date**	**Progression Analysis**
G3 £43.9m Green schemes are identified against the original £46.0m target, but only £22.9m is recurring; budget-releasing delivery is £10.1m, £5.2m below the year-to-date target, with £11.7m Red/pipeline opportunities and £18.0m Green-scheme delivery risk.	Accelerate conversion of pipeline and Red/Amber schemes to Green, with recurring/non-recurring split and delivery confidence reviewed monthly. **Outcome** The full £46.0m savings requirement becomes assured and deliverable and movement to the stretch savings target of £63m and recover year to date deficit against plan. **Metric** Green schemes £m and % of target; recurring savings £m; YTD delivery against profile; pipeline conversion rate. **Impact on Risk** Reduces risk of unachieved savings and reliance on non-recurrent mitigations.	Executive Director of Finance / Value & Sustainability Leads / Divisional CFOs	30/09/2026 and monthly thereafter	Progressing
G4 Unplanned cost pressures are being reported and offset by unplanned spend	Strengthen monitoring return reconciliation and recurrent/non-recurrent classification, with monthly CFO check-and-challenge on cost pressures, spend reductions and virements. **Outcome**	Executive Director of Finance / Central Finance /	Monthly to 31/03/2027	Progressing

reductions after virements, indicating volatility and complexity in interpreting run-rate, recurrent impact and genuine mitigations.	Improved clarity of the underlying position and fewer late adjustments. **Metric** Reconciliation issues resolved; value of items moved to correct category; forecast accuracy. **Impact on Risk** Improves financial grip and enables earlier corrective action.	Divisional CFOs		
G5 Inflationary and cost pressures exceed available allocation uplift, particularly CHC, Prescribing, Secondary Care Drugs, commissioned services, NWJCC/cross-border contracts, Welsh Risk Pool and digital pressures.	Maintain targeted pressure reviews and confirm mitigations/disinvestment proposals for high-risk categories, supported by benchmarking and contract scrutiny. **Outcome** Material pressures are quantified, mitigated and escalated through the financial governance route. **Metric** Pressure value by category; mitigation value identified; residual forecast variance. **Impact on Risk** Reduces likelihood that unavoidable pressures destabilise the plan.	Executive Director of Finance / Central Finance / Divisional CFOs	Monthly to 31/03/2027	Progressing
G6 Grip and Control measures may not deliver sufficient impact or may not be fully	Quantify the impact of continued Grip and Control measures across non-pay, procurement, pay and temporary workforce, and report delivery through monthly returns. **Outcome**	Executive Director of Finance / Executive Directors / Procurement	Monthly to 31/03/2027	Progressing

captured in the financial plan.	Savings and run-rate reductions attributable to Grip and Control are evidenced and sustained. **Metric** Value of requisitions cancelled/approved; non-pay reduction; recruitment controls impact; temporary workforce spend trend. **Impact on Risk** Supports run-rate containment and reduces reliance on unidentified mitigations.	and Workforce Leads		
G7 Agency and variable pay remain material risks, with Month 4 agency spend of £2.4m and variable pay of £8.6m, and 2026/27 variable pay forecast increasing to £101.7m.	Maintain executive scrutiny of agency, locum, bank and overtime, including action plans against the 30% agency reduction enabler and temporary workforce controls. **Outcome** Agency and variable pay are reduced where clinically safe and affordable. **Metric** Agency spend £m/% of pay; variable pay forecast; delivery against 30% reduction target. **Impact on Risk** Reduces pay overspend and supports workforce affordability.	Executive Director of Finance / Executive Director of Workforce / Clinical Executive Leads	Monthly to 31/03/2027	Progressing
Gaps in Controls	**Action**	**Action Owner**	**Due Date**	**Progression Analysis**
G8 Conditionally funded performance and	Track programme spend, benefits and recurrent consequences for Performance and Transformation,	Director of Transformation / Executive	Quarterly to 31/03/2027	Progressing

transformation schemes are forecast to spend £42.0m in full, creating a need for strong benefits tracking and clear disinvestment/alternative funding where relevant.	Planned Care, Value-Based Healthcare and Further Faster allocations. **Outcome** Strategic funding supports agreed priorities without creating unfunded recurrent commitments. **Metric** Spend vs forecast; benefits delivery; recurrent consequence assessment completed. **Impact on Risk** Protects affordability and value for money while supporting transformation.	Director of Finance / Programme SROs		
G9 Forecast assumptions depend on full receipt of anticipated income, including pay award funding and other RRL assumptions; misalignment with Welsh Government allocations would increase forecast risk.	Continue monthly confirmation of RRL assumptions and anticipated allocations with Welsh Government, including pay award estimates and working balances support. **Outcome** Income assumptions are validated, and any funding gaps are escalated early. **Metric** Confirmed vs anticipated Revenue Resource Limit (RRL); value of unconfirmed allocations; pay award estimate variance. **Impact on Risk** Reduces risk of unidentified income shortfalls affecting forecast outturn.	Executive Director of Finance / Deputy Director of Finance	Monthly to 31/03/2027	Progressing

G11 Risks and opportunities identified / total quantified risks and no / low quantified opportunities	Maintain monthly risk and opportunity review to ensure risks are reflected in forecast where clear and evidenced. **Outcome** The forecast position remains aligned to the risk register and MMR Table A2. **Metric** Quantified risks/opportunities £m; movements since prior month; forecast inclusion status. **Impact on Risk** Improves transparency and supports early mitigation or escalation.	Executive Director of Finance / Central Finance	Monthly to 31/03/2027	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score	4	3	12
Risk Appetite	Financial/VfM <15		Not in Tolerance

Position & Intended Outcome for Risk
At Month 4 financial sustainability risk remains material and outside appetite. The Health Board reports a £22.9m year-to-date deficit, £8.6m adverse to plan, and a July deficit of £5.8m, £2.2m adverse to profile. Although £43.9m Green schemes have been identified, budget-releasing delivery is £5.2m below the year-to-date target and the route to break-even depends on delivery of £63.0m savings, including a further £17.0m stretch target, together with £26.0m Welsh Risk Pool mitigation. The intended outcome is an approved Financial Recovery Plan for the September Board, supported by quantified and owned divisional actions, improved run-rate, stronger recurring and budget-releasing savings, robust forecast classifications, secured conditional funding and delivery of the statutory break-even duty. The current score remains 20 pending evidence that the Month 4 adverse variance is recovering and the stretch savings and Welsh Risk Pool conditions are sufficiently assured.

CRR REF: 25-09: Safe Environment		
Director Lead: Director of Environment and Estates		**Date Opened:** 04/01/2024
Assuring Committee: Performance and Finance Committee		**Date Last Committee Review:** 23/06/2026
Date Last Reviewed: 21/08/2026	**Link to BAF**: BAF26-04	**Target Risk Date:** 31/03/2030

Risk Detail:

There is a risk that patients may be exposed to unsafe, uncomfortable, or unsuitable care environments if the organisation's estates and infrastructure are not maintained to appropriate standards.

This may be caused by ageing estate, backlog maintenance, and gaps in fire safety, health and safety compliance, and alignment with the estate's strategy.
This may lead to safety incidents, non-compliance with statutory duties, and barriers to service modernisation.

Mitigations/Controls in place

1. Estates Strategy developed and approved by the Health Board in January 2023.
2. Internal Governance for capital allocation in place within the Health Board.
3. Business Cases to Welsh Government to resolve major infrastructure issues in line with the Estates Strategy
4. Priority bids against Welsh Government Estates Funding Advisory Board (EFAB) for the allocation and prioritisation of funding in relation to infrastructure funding, decarbonisation, fire and Mental Health and Learning Disability.
5. Discretionary Capital Allocation of £17m for 25/26 approved by Welsh Government with an allocation of approximately £3.45m aligned to improvements within the Estates. Prioritisation is based on Operational Estates Risk Register
6. Regular Welsh Government /Health Board Capital Meetings – which provides a direct link with Welsh Government to raise concerns regarding the funding available to effectively manage the condition of the estate and ensure safety of patients and staff.

7. Operational Estates Safety Groups in place to provide assurance, the safety groups are as detailed below and oversee risks relevant to the groups:
    a. Fire Management
    b. Asbestos Management
    c. Water Safety,
    d. Ventilation Safety
    e. Electrical Safety
8. Welsh Government Capital Resource Meetings in place to provide route for escalation.
9. Estates and Facilities Performance Management System (EFPMS) reporting template and recording of backlog maintenance
10. Capital Allocation from Welsh Government – additional capital funding of allocated to the Health Board to focus on Backlog Maintenance
11. The Health Board submitted the Major Capital prioritisation plan to Welsh Government (WG) to identify required investment. The end date is dependant of how much capital investment is provided to the Health Board from WG. The 10 year capital investment requests align with the capital prioritisation form that we will submit to Welsh Government.
12. Updated agreed protocol for use of Annual Discretionary Slippage in place for developing Business Justification Cases (BJC) for essential estates works and discretionary capital schemes that could be aligned with in-year additional Capital Funding provided by WG.
13. Review of Reinforced Autoclaved Aerated Concrete (RAAC) completed by the Health Board's approved structural engineers – Curtins and a report will be presented at the Strategic Occupational Health and Safety Group
14. Targeted Estates Funding (TEF) approved by Welsh Government and allocation of £15.390m awarded over a 2-year period (2025-2026 / 2026/2027) to progress the national programme of capital schemes for Fire, Infrastructure, Decarbonisation, Mental Health, Infection Prevention Control and Decontamination

Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G1 6-facet surveys to be undertaken to obtain an updated report of the condition of the Estate' this will inform the risk	**Facet Survey** Undertake actions to deliver a facet survey across the Health Board over the next 2 years. Due to financial constraints within the Health Board a review of the facet survey programme is being undertaken to confirm which facets are a priority for the Health Board.	Head Of Operational Estates	31/03/2028 (Subject to funding)	Progressing Due date extended from 31/03/2027 to 31/03/2028

status by site, which will be assessed against the controls currently in place. Additional mitigation or strengthening of controls will also be considered.	**Facet 1** - Physical Condition Survey (Fabric and M&E) **Facet 2** - Statutory Requirements (Risk Based Methodology for Establishing and Managing Backlog) **Facet 3** – Space Utilisation (Scope to be finalised) **Outcome** Deliver a phased, prioritised partial Facet Survey Programme across the Health Board over the next 2 years, ensuring a comprehensive understanding of estate condition, statutory compliance, space utilisation and backlog risk. Due to financial constraints, conduct a review to determine which facets are critical to informing investment decisions, focusing initially on Facet 1 (Physical Condition: Fabric & M&E) and Facet 2 (Statutory Requirements / Risk-Based Backlog). The outcome is to produce accurate, site-wide data that underpins capital planning, operational risk management, and strategic estate development. **Metric** **Programme Scope & Completion -** Completion of Facet 1 and Facet 2 surveys for all major acute, community, and mental health sites within 3 years. **Data Quality & Integration -** Survey data validated and uploaded into estates asset management systems (e.g., MICAD and future CAFM plans). Buildings or			

	zones with complete, up-to-date backlog and condition profiles **Backlog & Statutory Risk Assessment -** Reduction in “unknown” condition/risk items within asset registers (target: elimination). Development of a risk-based statutory compliance backlog for Facet 2. **Alignment With Capital Plans -** Capital bids or business cases supported by validated facet data. Use of Facet 1 and 2 outputs to prioritise high-risk backlog items in annual capital allocation. **Alignment with developing clinical service plans** – to ensure optimum utilisation of the retained Estate and disposal opportunities for lease hold properties and redundant or obsolete Estate **Impact on Risk** Delivering this programme will: **Reduce strategic and financial risk** by ensuring investment decisions are based on validated, prioritised, and risk-driven estate data rather than assumptions or incomplete surveys. **Mitigate statutory non-compliance** through a clear understanding of high-risk areas within Facet 2,			

	enabling timely intervention and reducing exposure to regulatory enforcement. **Lower operational risk** by identifying critical M&E, structural, and fabric issues early, preventing service disruption, safety incidents, or unplanned ward/department closures. **Improve organisational assurance**, giving the Board confidence that estate condition, backlog maintenance, and statutory risks are transparently understood and being managed in a structured, evidence-based manner. **Strengthen long-term planning**, ensuring the estate strategy, clinical strategies, and capital programme are all informed by a consistent, Health Board-wide dataset. **Reduce reputational risk**, demonstrating responsible stewardship of the estate and a proactive approach to addressing backlog and compliance issues before they compromise patient care.			
Gaps in Controls	**Action**	**Action Owner**	**Due Date**	**Progression Analysis**
G2 Standardised approach by the Health Board in relation to management of	**Develop ToR** Develop a standardised Terms of Reference to be considered and endorsed by Capital Investment Group	Director of Environm	31/09/2026	Progressing Due date extended from 31/03/2026 to 30/09/2026 to reflect

Estates and Capital between the Integrated Health Community IHC's) and other services and the Estates/Capital teams – linked to the changes to the Operating Model.	**Outcome** A standardised, comprehensive, and governance-compliant Terms of Reference (ToR) is developed and endorsed by the Capital Investment Group. This ensures consistent governance, clarity of responsibilities, improved decision-making, and strengthened assurance for capital planning, prioritisation, and delivery across the Health Board. **Metric** **Development & Approval** • Revised ToR to be drafted and aligned with SFI and SoRD • ToR reviewed by required stakeholders (Capital Planning, Finance, Clinical, Estates). • ToR formally endorsed by the Capital Investment Group. **Quality & Governance Compliance** • Alignment with HB governance framework and Welsh Government capital governance. • Evidence of clear roles, responsibilities, delegated authority, and reporting lines within the ToR. **Implementation**	ent and Estates		Foundations for the future structure, and review of capital processes.

	• ToR published and communicated to all relevant stakeholders within agreed timescale. **Impact on Risk** **Governance Risk Reduction** • Reduces ambiguity around decision-making, leading to robust capital approval process • Ensures consistent application of governance standards across capital schemes. • Strengthens audit trail and assurance for internal/external scrutiny (WG, Audit Wales). **Strategic & Operational Risk Reduction** • Ensures that roles, responsibilities, and authority for capital decisions are clearly defined, minimising project delays or misaligned decisions. • Enhances reliability of capital programme delivery through improved oversight. **Compliance & Regulatory Risk Reduction** • Reduces likelihood of non-compliance with Welsh Government capital governance requirements.			

	• Supports consistent, well-governed business case progression.			
Gaps in Controls	**Action**	**Action Owner**	**Due Date**	**Progression Analysis**
G3 Ensure that the Health Board has an Estates rationalisation programme in place that will support the capital prioritisation programme and reduce backlog maintenance.	**Estates Rationalisation Programme** Undertake action to deliver a Health Board Estates Rationalisation Programme. Estates Rationalisation Programme being developed and in draft format. The Draft will be submitted to a multi-disciplinary group for initial comment, with a final version to be ratified by Capital Investment Group. Health Board Rationalisation Programme to be presented to CIG on 12th September 2024. Estate's rationalisation plan is being reviewed and updated taking into account disposal that have been approved in 2024-2025 and opportunity for disposals in 2025-2026 as part of rationalisation of our estates that supports the Caledfryn Project. **Outcome** Deliver a comprehensive Health Board–wide Estates Rationalisation Programme that identifies, prioritises, and progresses opportunities for estate disposal, consolidation, and optimisation, utilising information received from the HB Clinical Plans and Estates Condition Survey. This includes producing a fully developed Estates Rationalisation Plan—currently in	Head Of Operational Estates	30/03/2028	Progressing Due date extended from 31/03/2026 to 30/03/2028. Aligned with Facet Survey Programme

	draft—to be reviewed by a multidisciplinary group and ratified by the Capital Investment Group (CIG), with formal presentation scheduled for September 2026. The programme will be updated to incorporate approved disposals within financial year. **Metric:** **Programme Development & Governance -** Draft Rationalisation Programme completed and submitted to the multidisciplinary review group. Final Estates Rationalisation Plan to be approved by the Board. **Delivery of Approved Disposals** - Number and value (£) of estate disposals completed. Progress planned disposal opportunities for 2026–2030. **Estate Consolidation & Space Efficiency** - Total reduction in estate footprint through rationalisation. Under-utilised space to be identified and addressed through disposal, consolidation, or repurposing. **Financial Impact** - Revenue savings delivered through reduction of lease, utility, security, and maintenance costs (year-on-year increase). Capital receipts generated from disposal of surplus estate (reported annually). **Impact on Risk**			

	Delivering the Estates Rationalisation Programme will: **Reduce financial risk** - Lowering the cost of maintaining under-utilised, poor-condition, or non-compliant estate assets, and by generating capital receipts that can be reinvested in priority clinical infrastructure. **Mitigate operational risk**, ensuring that estate resources are focused on the most functional, safe, and strategically aligned sites, reducing exposure to failures in aged or inefficient buildings. **Lower compliance and statutory risk** by enabling the Health Board to phase out high-risk assets where the investment required to achieve compliance is disproportionate to clinical benefit. **Improve organisational assurance**, Demonstrating to CIG, the Board, and regulators that the estate is being actively and responsibly managed through structured, risk-based rationalisation. **Reduce reputational risk**, as proactive rationalisation demonstrates efficiency, and commitment to improving the quality and sustainability of the estate.			
Gaps in Controls	**Action**	**Action Owner**	**Due Date**	**Progression Analysis**

G4 Internal Audit review of Fire Safety – Agreed Management Action Plan being implemented and being managed through the Fire Safety Management Group	**Non-Compliance with Fire Safety** Ensure the HB is fully compliant with Fire Safety Infrastructure on all sites (acute and Community) YG - Health Board submitted a PBC to address the Fire Safety and Infrastructure compliance issues on the Ysbyty Gwynedd site through the Welsh Government Infrastructure Board. In response to Programme Business Case Welsh Government have asked the Health Board to identify within the Programme Business Case those elements that relate to Fire safety only. Wrexham Maelor - Health Board submitted a PBC to address the infrastructure compliance issues on the Ysbyty Maelor site (Wrexham Resilience Programme) through the Welsh Government Infrastructure Board. In response to Programme Business Case, Welsh Government have asked the Health Board to identify high risk priority improvement projects **Outcome** Achieve full statutory compliance with fire safety legislation across the Health Board estate by implementing all required actions identified in the Fire Safety Audit/Firecode compliance assessment. This includes ensuring fire precautions, compartmentation, detection and alarm systems, evacuation procedures, maintenance regimes, training, and governance arrangements fully meet regulatory and NHS Firecode	Head Of Operational Estates	31/03/2030	Progressing

	standards to protect life, property, and continuity of clinical services. **Metric** **Fire Audit Action Completion Rate -** Fire safety audit actions completed within agreed timescales **WHTM 05 Compliance Level -** Measured compliance against HTM 05-01/02/03 requirements, including structural fire precautions, fire alarm and suppression systems, and management arrangements (target: full compliance or approved derogations). **Fire Safety Training Compliance -** staff completing mandatory fire safety training and evacuation drills. **Number of Fire Incidents & Unwanted Fire Signals (UWFS) -** Reduction in fire incidents and UWFS across the estate (target: continual reduction and compliance with national UWFS targets). **Impact on Risk** **Significantly reduce risk to life** - by ensuring effective fire detection, containment, and evacuation arrangements for patients, staff, and visitors. **Mitigate legal and regulatory risk**, - ensuring compliance with the Regulatory Reform (Fire Safety) Order 2005 and NHS Firecode, preventing			

	enforcement notices, prosecutions, or reputational harm. **Improve estate resilience**, - reducing the likelihood of fire-related service disruption, ward closures, or damage to critical clinical infrastructure. **Strengthen organisational assurance**, - providing the Board with confidence that fire safety across the estate is being effectively managed, monitored, and continuously improved.			
Gaps in Controls	**Action**	**Action Owner**	**Due Date**	**Progression Analysis**
G5 Timely progression of major Capital Schemes which address Estates Safety such as Wrexham Maelor Continuity Plan – Phase and Ysbyty Gwynedd PBC	**PBC Developments** Ensure the HB has a strategic plan of major Capital Schemes which address Estates Safety such as Wrexham Maelor Continuity Plan – Phase and Ysbyty Gwynedd PBC **Outcome** A comprehensive, Board-approved strategic pipeline of major capital schemes is produced, ensuring that critical Estates Safety, infrastructure resilience, and service continuity risks across Wrexham Maelor and Ysbyty Gwynedd are clearly defined, prioritised, and supported by robust, compliant PBCs. This enables the HB to progress to SOC and subsequent business case	Director of Environment and Estates	30/09/2026	Progressing Due date extended from 31/03/2026 to 30/09/2026 to reflect Foundations for the future structure

	stages with confidence, in alignment with WG capital requirements and timelines. **Metric** **PBC Development & Approval** • Review of Wrexham Maelor Continuity Plan PBC within agreed timeline. • Review of Ysbyty Gwynedd PBC within agreed timeline. **Strategic Alignment & Quality** • Compliance with WG Capital Guidance and Five-Case Model requirements. • Number of key risks and constraints captured and mitigations identified in PBCs. **Impact on Risk** **Estates Safety Risk Reduction** • High-risk backlog maintenance reduced through planned major capital interventions. • Clear identification and prioritisation of statutory and infrastructure compliance issues (e.g. fire safety, electrical resilience, water systems).			

	• Enables proactive replacement of life-expired critical infrastructure (HV/LV, ventilation, medical gases, roofs, drainage etc.). **Service Continuity & Resilience** • Reduced risk of unplanned service outages at Wrexham Maelor and Ysbyty Gwynedd. • Improved resilience for essential acute and emergency services. • Lower likelihood of business continuity incidents due to infrastructure failure. **Strategic & Financial Risk Reduction** • Reduces risk of WG capital bids failing due to incomplete or misaligned business cases. **Governance & Assurance** • Improved transparency and auditability through structured PBC documentation. • Ensures HB meets statutory obligations for safe, sustainable estate provision.			
Gaps in Controls	**Action**	**Action Owner**	**Due Date**	**Progression Analysis**
G6	**BCUHB Estates Strategy**	Director of	30/09/2026	Progressing

Assurance around the progress made with the BCUHB Estates Strategy and the lack of clarity around the BCUHB Clinical Strategy.	Progress with delivering an updated Estates Strategy by engagement with stakeholders across BCUHB and identifying a number of common themes around strategic ambitions for the estate that aligns with the Health Board's Clinical Strategy. **Outcome** Deliver meaningful progress on the Health Board's Estates Strategy by actively engaging with key stakeholders across BCUHB to identify shared priorities, establish common themes, and ensure that estates planning aligns directly with the Health Board's Clinical Strategy. This includes producing a clear, evidence-based strategic direction for the estate that supports clinical service transformation, improves functionality and resilience, and informs future investment decisions. **Metric** **Stakeholder Engagement Completion -**Divisions, Clinical Boards, and Corporate Departments engaged as part of the Estates Strategy programme **Themes & Strategic Priorities Identified -** Number of common themes captured and validated across stakeholder groups (e.g., capacity, clinical adjacencies, digital enablement, estate condition, sustainability).	Environment and Estates		Revised date from 31/03/2026

	Alignment with Clinical Strategy - Evidence of mapped alignment between Estates Strategy themes and the Health Board's Clinical Strategy goals (target: full alignment across all major programmes). **Strategic Output Deliver -** Completion of key strategy documents (e.g., Strategic Outline Programme, Estate Development Priorities Schedule, site-specific masterplans) within agreed timescales **Incorporation Into Planning & Capital Process -** strategic priorities formally integrated into capital plans, business cases, or service transformation programmes. **Impact on Risk** **Reduce strategic misalignment risk**, ensuring estate development directly supports the Clinical Strategy rather than evolving in isolation. **Mitigate investment and Financial risk (Capital and Revenue)** by providing a clear, prioritised plan that supports informed capital decision-making and reduces the likelihood of unsuccessful business cases or inefficient expenditure. **Lower operational and service delivery risk** by identifying estate constraints early and planning			

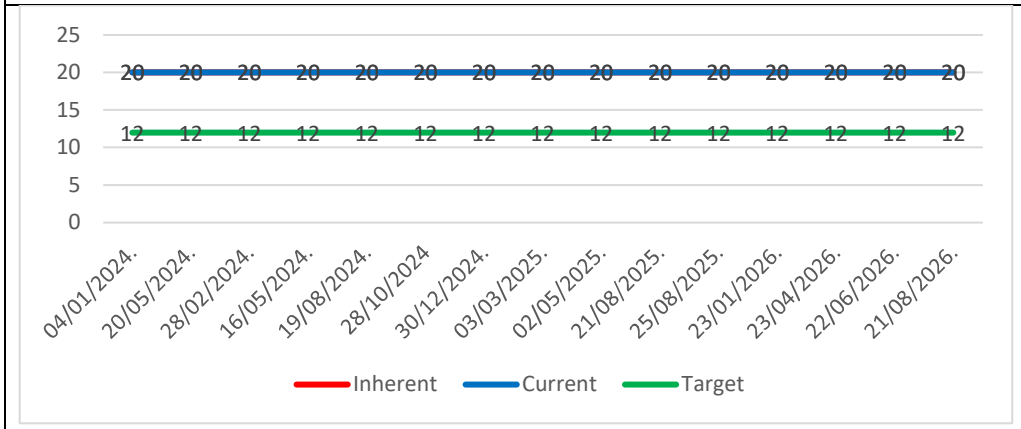
	improvements that enhance flow, capacity, and resilience across clinical environments. **Improve organisational assurance**, demonstrating that the Estates Directorate is actively engaging service leaders and shaping a modern, fit-for-purpose estate that supports safe, effective care. **Reduce reputational and regulatory risk**, ensuring that estate challenges—condition, compliance, functional suitability, sustainability—are addressed through a transparent and collaboratively developed long-term plan. **Strengthen future readiness**, ensuring the estate is aligned to changing service models, population health needs, digital transformation, and sustainability commitments.			
Gaps in Controls	**Action**	**Action Owner**	**Due Date**	**Progression Analysis**
G8 NWSSP Authorising Engineer – Water – Audit on water safety undertaken and agreed action developed to improve compliance which	**Legionella Management and Control** Ensure the Health Board is compliant with its statutory duty to manage water systems across the estate by addressing all fundings reported as part of the AE audit of water systems and operational management **Outcome**	Head Of Operational Estates	30/09/2026	Progressing Revised date from 31/03/2026

are reported at the Water Safety Group	Achieve full statutory compliance in the management and control of Legionella across the Health Board estate by implementing all required actions identified in the Authorising Engineer (Water) audit. This includes ensuring safe operation, monitoring, testing, maintenance, and governance of water systems to minimise the risk of Legionella proliferation and protect patients, staff, and visitors. **Metric:** **AE (Water) Audit Action Completion Rate -** Audit actions completed within the agreed timeframe (target: 100%). **Compliance score against ACoP L8**, - WHTM 04-01 Part B, and internal Water Safety Plan standards (target: full compliance or approved derogations in place). **Legionella and Pseudomonas Sampling Compliance -** Routine water sampling and microbiological monitoring completed on schedule. **Impact on Risk** **Reduce the risk of Legionella growth**, lowering the likelihood of Legionnaires' disease outbreaks, safeguarding vulnerable patient groups and clinical operations.			

	Mitigate statutory non-compliance, reducing exposure to enforcement action from regulators (HSE), legal claims, and reputational damage. **Improve system reliability**, ensuring cold and hot water systems remain within safe operating parameters. **Strengthen organisational assurance** through robust water safety governance, clear maintenance regimes, and evidence-based compliance reporting. **Reduce operational disruptions**, preventing ward closures, service interruptions, and emergency remedial works due to water safety failures.			
Gaps in Controls	**Action**	**Action Owner**	**Due Date**	**Progression Analysis**
G9 NWSSP Authorising Engineer – Electrical– Audit on Electrical Systems undertaken and agreed action developed to improve compliance which are reported at the Electrical Safety Group	**Electrical and Mechanical Infrastructure on the Wrexham Maelor Hospital Site** Ensure the Health Board is compliant with its statutory duty to manage electrical systems across the estate by addressing all fundings reported as part of the AE audit of electrical systems and operational management **Outcome** Achieve full statutory compliance for electrical systems across the Wrexham Maelor Hospital site by implementing all required actions arising from the	Head Of Operational Estates	31/03/2028	Progressing

	Authorising Engineer (AE) electrical audit. This includes ensuring safe operation, maintenance, resilience, and governance of electrical infrastructure, thereby supporting continuity of clinical services and reducing risk to patients, staff, and the organisation. **Metric** **Statutory Compliance -** Measured improvement against HTM 06-01 / BS 7671 compliance requirements (target: full compliance or approved derogations in place). **Risk Reduction Achievement -** Reduction in high- and medium-risk items recorded on the electrical risk register (target: 0 high risks, 50% reduction in medium risks within 12 months). **Unplanned Outage Incidents -** Year-on-year reduction in electrical infrastructure failures or unplanned interruptions impacting clinical services (target: continual reduction). **Impact on Risk** **Significantly reduce risks associated with electrical system failure**, including power loss to critical clinical areas, unsafe equipment operation, or potential electrical fires.			

	Mitigate organisational statutory non-compliance risk, preventing enforcement action, regulatory escalation, or reputational harm. **Improve resilience of electrical infrastructure**, reducing vulnerability during peak clinical load, emergency events, or equipment failure. **Lower health and safety risks** to patients, staff, and contractors through improved control of isolation, testing, and operational procedures. **Strengthen assurance to the Board**, demonstrating that the Estates function is effectively managing safety-critical infrastructure in line with HTMs, legislation, and AE recommendations.			



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	3	4	12
Risk Appetite	Regulatory/Compliance <15	Not in Tolerance	

Position & Intended Outcome for Risk
Current Risk score of 20 aims to be reduced to a 12 by April 2035 as a part of a wider Estates strategy. Backlog maintenance is the cost to bring estate assets that are below acceptable standards (either physical condition or compliance with mandatory fire safety requirements and statutory safety legislation) up to an acceptable condition. Total 2021/22 backlog costs for all BCUHB properties were £348.4m. Cost to achieve physical condition B is c. £213m. Cost to achieve condition B for fire and safety statutory compliance is c. £136m. Total risk adjusted backlog is c. £240m. The majority (73%) of backlog relates to the 3 acute hospitals. Backlog for MH&LD, Community and Local Hospitals, and Community Facilities each comprise c.10% of total backlog. The estate is facing significant risks and challenges and severe limitations on expected future funding. The current estate is not sustainable or viable in the long term and will not support the implementation of key BCUHB strategies and is a significant risk to the Board. To aid with supporting a Capital Programme the Health Board will commence with a programme to deliver a partial facet survey for the Estates, these surveys will commence in 2026 focussing on Acute sites and then community hospitals with a target to complete within 2 years. This will be a significant part of the estate's portfolio and backlog maintenance cost. As sites are completed the cost associated with backlog maintenance will be identified and capital funding requested. The end date is dependant of how much capital investment is provided to the Health Board from Welsh Government. The 10-year capital investment requests align with the capital prioritisation form that we will submit to Welsh Government. In addition, significant works have been undertaken on the fire project at Ysbyty Gwynedd which will result in approx £2M being invested and works completed by March 2026. Wrexham Resilience Programme has undertaken a risk-based approach to address key findings of the original Business Case. The Health Board has disposed of 2 sites (Ala Road and Cilan) this financial year which were vacated as 'not being fit for purpose', approval has also been received to dispose of Rossett HC and Ruthin HC which have been vacated due to condition of the Estate and these are expected to progress to auction in early 2025. Both sites are currently being disposed of with Ruthin HC awaiting completion of contract.

Internal Audit review of Asbestos Management has been completed which reported Substantial Assurance, due to this outcome action G7 ‘Internal Audit review of Asbestos Management – Agreed Management Action Plan developed and managed through the Asbestos Management Group’ has been completed.

Estates Rationalisation programme being reviewed to identify any quick wins that can deliver financial savings quicker.

Audit Wales conducted a review of the Estates within BCUHB – ‘Are NHS estates fit for purpose’. The findings of the review which includes recommendations has been submitted to the Health Board in draft format.

CRR REF: 25-10 Risk Title: Health and Safety		
Director Lead: Director of Environment and Estates (DoE&E)		**Date Opened:** 21/08/2025
Assuring Committee: Performance and Finance Committee		**Date Last Committee Review:** 23/06/2026
Date Last Reviewed: 21/08/2026	**Link to BAF**: BAF26-04	**Target Risk Date:** 31/03/2027

Risk Detail:

There is a risk that the organisation may fail to maintain a safe environment for staff, patients, service users and visitors in line with health and safety legislation.

This may be caused by

- Inadequate governance, leadership oversight or assurance of health and safety arrangements.
- Insufficient resources (financial, staffing or time) allocated to health and safety management.
- Poor compliance with statutory inspections, maintenance schedules or risk assessments.
- Lack of staff competence, training or awareness of health and safety responsibilities.
- Failure to learn from incidents, near misses or external safety alerts.
- Ageing estate, infrastructure failures or unsafe plant and equipment.
- Inconsistent application of policies and procedures across sites or services.

This may lead to

- Injury, ill-health or fatalities involving staff, patients or visitors.
- Increased incidents, near misses and reportable accidents (RIDDOR).
- Regulatory enforcement action (e.g. HSE or CQC notices, prosecutions or fines).
- Civil claims, increased insurance costs and reputational damage.
- Reduced staff morale, increased sickness absence and staff turnover.

- Service disruption, ward closures or loss of public confidence.
- Failure to meet statutory duties and corporate objectives.

Mitigations/Controls in place	

Governance and Leadership (Links to ACR1)

- HS01 Health and Safety Policy approved and reviewed at Board level
- Director of Environment and Estates Designated Executive Lead for Health and Safety
- Health and Safety Committee (Strategic Occupational Safety and Health Group) with staff side representation, which escalates up to People and Culture Committee.

Health and Safety Risk Management (Links to ACR2)

- Annual gap analysis using the NHS Employer Health and Safety Standards used to assess compliance against current health and safety legislation and standards
- HS03 General Risk Assessment Procedure
- Local Health and Safety File
- Routine workplace risk assessments (e.g. slips and trips, manual handling, COSHH, etc.)
- Incident reporting systems and investigation processes

Training and Competence (Links to ACR3)

- Mandatory health and safety training for all staff
- Accredited Health and Safety Training courses (e.g. NEBOSH)
- In-house taught Health and Safety Training courses (e.g. Risk Assessment, COSHH, RIDDOR)
- Health and Safety webpages on BetsiNet

Monitoring and Assurance (Links to ACR4&5)

- Proactive: Scheduled health and safety reviews/audits that incorporate workplace inspection
- Reactive: Ad hoc visits in response to incidents

Additional Controls Required	Action	Action Owner	Due Date	Progression Analysis
ACR1: Governance and Leadership (PLAN)				
ACR1a A review of resources required following the internal audit	A review of resources within the Health, Safety and Security Service is required following the internal audit findings. Produce a documented resource review paper and proposed structure for Leadership consideration. Complete a business case if necessary ready for approval. Initial structure review and remodelling completed; progress dependent on the outcome of the Foundations for the Future program, which will inform final decisions. Addresses audit recommendations to ensure adequate resourcing and supports delivery of Health and Safety objectives across BCUHB. Complete the resource review and business case by September 2026, following confirmation of Foundations for the Future outcomes. **Outcome** An appropriately resourced Health, Safety and Security Service that meets internal audit recommendations and supports statutory compliance across BCUHB. **Metric** • Resource review paper and proposed structure completed by September 2026.	DoE&E	31/03/27	Progressing

	• Business case (if required) completed and submitted for approval by November 2026. • Final structure aligned with outcomes of the Foundations for the Future programme. **Impact on Risk** Completing the review and securing the required resources will reduce the likelihood of non-compliance, improve assurance, and strengthen organisational safety governance.			
ACR1b A review of the Terms of Reference, Cycle of Business and Escalation and De-escalation Routes	Undertake a comprehensive review and update of the Terms of Reference, Cycle of Business, and escalation and de-escalation routes to ensure clarity of roles, responsibilities, decision-making authority and timely escalation of health and safety risks. **Outcome** Clear, consistent and well-understood governance arrangements that support effective oversight, assurance and timely management of health and safety risks at all levels of the organisation. **Metric** • Revised Terms of Reference, Cycle of Business and escalation framework formally approved • Evidence of dissemination and staff awareness • Auditable compliance with escalation timescales and reporting routes	DoE&E	31/03/27	Progressing

	• Reduction in delayed or inappropriate escalations identified through reviews or audits **Impact on Risk** Improves governance and assurance, reducing the likelihood of unmanaged or unrecognised health and safety risks, and lowering the overall risk of failing to maintain a safe environment for staff and patients.			
ACR2: Health and Safety Risk Management (DO)				
Gaps in Controls	**Action**	**Action Owner**	**Due Date**	**Progression Analysis**
ACR2a Review of HS03 General Risk Assessment Procedure	Undertake a review and update of the HS03 General Risk Assessment Procedure to ensure it remains current, legally compliant, clearly articulated and consistently applied across all services and sites. **Outcome** A robust, clear and standardised risk assessment procedure that supports effective identification, evaluation and control of health and safety risks and promotes consistent practice across the organisation. **Metric** • HS03 procedure formally reviewed, updated and approved	Head of Health, Safety and Security	31/03/27	Progressing

	• Evidence of implementation and dissemination to managers and staff • Increased compliance identified through audits and assurance reports • Improved quality and consistency of risk assessments reviewed **Impact on Risk** Reduces the likelihood of poorly identified or inadequately controlled hazards, strengthening organisational compliance with health and safety legislation and lowering the overall risk of harm to staff and patients.			
ACR2b Implement an Electronic Document Management System (EDMS) across BCUHB to centralise health and safety compliance reporting and house risk management documentation, to support a health and safety management framework	Source or develop and implement a digital technology solution to support the health and safety risk management framework, enabling consistent recording, monitoring, escalation and assurance of risks, actions and controls across the organisation. **Outcome** A single, reliable and transparent system that improves the visibility, consistency and timeliness of health and safety risk management, supporting informed decision-making and effective organisational assurance. **Metric** • Technology solution procured/developed and fully implemented	Head of Health, Safety and Security	31/03/27	Progressing

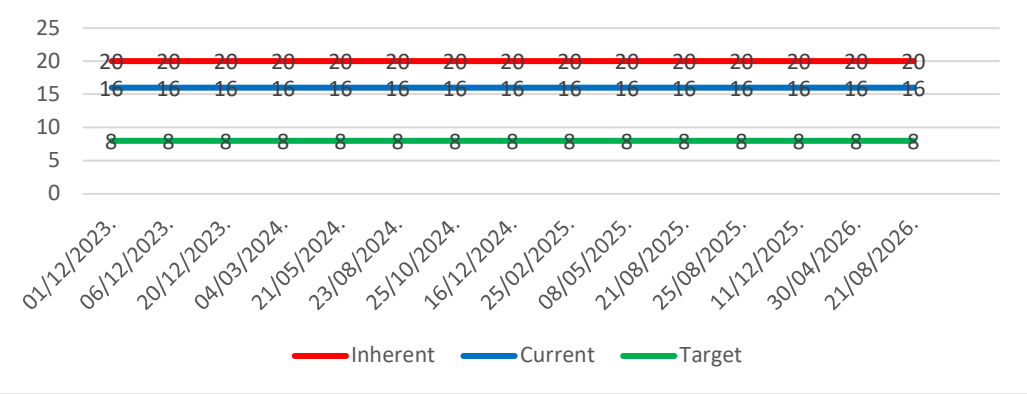
	• Percentage of services using the system for health and safety risk management • Improved completeness, timeliness and quality of risk and action data • Reduction in manual processes and duplicated reporting **Impact on Risk** Strengthens risk identification, monitoring and escalation, reducing the likelihood of unmanaged or poorly controlled health and safety risks and improving the organisation's ability to maintain a safe environment for staff and patients.			
Gaps in Controls	**Action**	**Action Owner**	**Due Date**	**Progression Analysis**
ACR2c Reviewing and updating the Health and Safety Risk Assessment Training Course	Review, update and re-launch the Health and Safety Risk Assessment Training Course to ensure it reflects current legislation, organisational procedures and best practice, and is accessible to all staff with health and safety responsibilities. **Outcome** Improved staff knowledge, competence and confidence in completing suitable and sufficient health and safety risk assessments, leading to more consistent and effective risk control across the organisation. **Metric**	Head of Health, Safety and Security	31/03/27	Progressing

	• Updated training course approved and implemented • Percentage of relevant staff completing the updated training • Improved quality of risk assessments identified through audit and review • Reduction in errors, omissions or repeat findings linked to risk assessments **Impact on Risk** Reduces the likelihood of hazards being poorly identified or inadequately controlled by improving workforce competence, thereby lowering the overall risk of harm to staff and patients and improving compliance with health and safety legislation.			
ACR3: Training and Competence (DO)				
G3a A pan BCUHB Health, Safety and Security Training Needs Analysis is required.	Health, Safety and Security Training Needs Analysis under development. **Outcome** A comprehensive, pan-BCUHB Health, Safety and Security Training Needs Analysis that clearly identifies statutory, mandatory, role-specific and risk-based training requirements across the organisation. The completed TNA will provide a clear framework for training provision, resource planning and compliance monitoring, ensuring consistent and appropriate training delivery across all services.	Head of Health, Safety and Security	31/12/26	Progressing

	Metric • Approval of the TNA by relevant governance groups (e.g., SOSHG and Executive Committee). • Identification of training gaps and development of an implementation or delivery plan. • Measurable improvements in training compliance rates across Health, Safety and Security subjects. • Reduction in variation of training requirements or delivery between Divisions. **Impact on Risk** A robust, organisation-wide TNA reduces the risk of non-compliance with statutory and mandatory training requirements, improves clarity for managers and staff, and supports safer practice across the organisation.			
Gaps in Controls	**Action**	**Action Owner**	**Due Date**	**Progression Analysis**
G3b BCUHB Executive Team and Board of Directors to complete health and safety training.	NEBOSH HSE Certificate in Health and Safety Leadership Excellence 1-day accredited course. **Outcome** Executive Team and Board members will have the required level of Health and Safety knowledge and assurance to fulfil their statutory duties, demonstrate effective organisational oversight, and meet internal audit expectations.	Director of Environment & Estates	31/03/27	Progressing

	Metric • Agreement of the proposal by the Director of Estates and Director of Governance. • Approval and scheduling of the training programme. • 100% completion of the required Health and Safety training by Executive Team and Board members within the agreed timeframe. **Impact on Risk** Completing Health and Safety training for Executive and Board members will enhance understanding at senior levels reduces risks relating to poor decision-making, inadequate oversight, regulatory non-compliance, and potential enforcement action.			
G3c Intranet pages for Health, Safety and Security Services require development.	**Outcome** A comprehensive, accessible and up-to-date Health, Safety and Security intranet site aligned to the NHS Employer Health and Safety Standards that provides staff with clear guidance, policies, procedures, training information and support resources. The developed intranet pages will improve organisational visibility, enhance staff access to essential information, and support consistent practice across BCUHB. **Metrics**	Head of Health, Safety and Security	31/03/27	Progressing

	• Increased staff access and usage (measured via intranet analytics, where available). • Reduction in staff queries related to information that is now accessible online. **Impact of Risk** Improved access to accurate and current Health, Safety and Security information reduces the likelihood of procedural errors, non-compliance, and inconsistent practice. Clear guidance supports safer working environments, reduces the risk of incidents, strengthens organisational assurance, and improves staff confidence in accessing essential safety information.			



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	Regulatory/Compliance <15		Not in Tolerance

Position & Intended Outcome for Risk

There is an inherent risk that the failure of health and safety management systems could lead to RIDDOR Reportable. Specified Injuries to Workers. Patient mismanagement, long-term effects. Death or significant irreversible harm which will result in prosecution by the Health and Safety Executive consequently leading to loss of reputation and financial penalties. The risk is extenuated by Non-compliance with national standards with significant risk to patients/public. An unacceptable level or quality of treatment/service. Gross failure of patient safety leading. Inquests and Coroners reports. Low staffing level that reduces the service quality. Low staff morale. Poor staff attendance for mandatory/key professional training. Uncertain delivery of key objective/ service due to lack/loss of staff within the Health and Safety team. Structural changes implemented on 31/03/2025, with Health and Safety moving from Workforce Directorate to a new role of Director of Environment, reporting directly to CEO (Chief Executive Officer).

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Performance & Finance Committee

CORPORATE GOVERNANCE REPORT

Dyddiad y Cyfarfod Date of Meeting	27 October 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Philippa Peake-Jones, Head of Corporate Governance
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Pam Wenger, Director of Corporate Governance

Pwrpas yr Adroddiad Report Purpose	For Noting

Crynodeb Gweithredol Executive Summary
This report presents routine corporate governance matters for the Committee's consideration. These documents support good governance, accountability, continuous improvement and assurance to the Board regarding the effectiveness of the Committee's operation and oversight arrangements. Members are asked to: • **NOTE** the summary of business considered in private session to be reported in public.

Ymgysylltu (mewnol/allanol) yr ymgymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp) Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	**Dyddiad Date**	**Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data**
Not applicable for this report		

Acronymau / Rhestr Termau
Acronyms / Glossary of Terms

CORPORATE GOVERNANCE REPORT

1. Y SEFYLLFA / SITUATION

1 The Health Board is required to act according to its Standing Orders. This report contains information to allow the Health Board to conform to this.

2 It is essential that the Board has robust arrangements in place for Corporate Governance and failure to do so could have legal implications for the Health Board.

3 Y CEFNDIR / BACKGROUND

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

4 MATERION PENODOL I'W HYSTYRIED / SPECIFIC MATTERS FOR CONSIDERATION

4.1 Summary of Business Considered in Private

4.1.1 Standing Order 6.5.3 requires the Board to formally report any decisions taken in private session to the next meeting of the Board in public session. This principle is also applied to Committee meetings.

4.1.2 The below item was considered in private at the meeting held on 25 August 2026:

Agenda Item	Subject (including narrative)	Committee Resolution	Rationale for item in Private
PF26.117	Legal Services Update	It was resolved that the Committee: • **NOTED** the report.	Legally Privileged

5 RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO

KEY RISKS / MATTERS FOR ESCALATION

5.1 There are no matters for escalation.

6 ARGYMHELLION RECOMMENDATIONS

6.1 Gofynnir i'r Pwyllgor/Cyfarfod/Grŵp:
The Committee/Meeting/Group is asked to:

- NOTE the matters considered in Private at the 25 August 2026. Items included:
  - PF26.117: Legal Services Update

ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol **Link to Strategic Priorities**	 1. Building an effective organisation
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Yr Egwyddorion Dylunio **Design Principles**	Simplify, Standardise, and Adopt Best Practices Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd **Corporate Risks and Board Assurance Framework**	BAF24-01 Building an Effective and Accountable Organisation CRR-16 – Leadership/Special Measures

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Cydraddoldeb *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)* **Equality** *Have you undertaken an Equality Impact Assessment Screening (which includes the*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report

requirements of the Welsh Language Standards)		
Asesiad o'r Effaith Economaidd-gymdeithasol *A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?* **Socio-Economic Impact Assessment** *Have you undertaken a Socio-Economic Impact Assessment*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report
Ansawdd *A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	**Galluogwyr Ansawdd Enablers of Quality** All Apply	**Meysydd Ansawdd Domains of Quality** All Apply
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals	Not Applicable	

Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	

A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog: **Armed Forces Covenant Due Regard Duty** Have you considered the Armed Forces Covenant Due Regard Duty?	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report
Asesiad o Effaith ar Ddiogelu Data *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?* **Data Protection Impact Assessment** *Have you undertaken a Data Protection Impact Assessment Screening?*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report
Asesiad o Effaith ar Atal Twyll *A ydych chi wedi ystyried yr effeithiau ar atal twyll?* **Counter Fraud Impact Assessment** *Have you considered the counter fraud impacts*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report
Cyfreithiol **Legal**	There are no specific legal implications related to the activity outlined in this report.	
Enw Da **Reputational**	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith ar Adnoddau *(Pobl / Ariannol)* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	