Bundle BCU Performance, Finance & Information Governance Committee 23 June 2026

1 PRELIMINARY MATTERS

1.1 13:30 - PF26.63 Welcome & Apologies
Gareth Williams, Chair

1.2 13:31 - PF26.64 Declarations of Interest
Gareth Williams, Chair

1.3 13:32 - PF26.65 Minutes of the Previous Meeting - 28 April 2026
Gareth Williams, Chair
1.3 28.04.26 Public Unconfirmed Minutes

1.4 13:34 - PF26.66 Matters Arising & Action Log
Gareth Williams, Chair
1.4 Action Log Public PFIG Committee

2 MAJOR PROGRAMMES, DEVELOPMENTS & EVERLASTING CHANGE

2.1 13:39 - PF26.67 Planned Care
Tehmeena Ajmal, Chief Operating Officer
2.1 Planned Care

2.2 13:54 - PF26.68 Urgent & Emergency Care
Tehmeena Ajmal, Chief Operating Officer
2.2 PFIG UEC paper

2.3 14:09 - PF26.69 Value & Sustainability
Russell Caldicott, Executive Director of Finance & Performance
2.3 V&S Paper

2.4 14:24 - PF26.70 Progress on Community by Design
Tehmeena Ajmal, Chief Operating Officer
2.4 PFIG Community by Design

3 14:39 - BREAK

4 GOVERNANCE, RISK & ASSURANCE

4.1 14:49 - PF26.71 Finance Report
Russell Caldicott, Executive Director of Finance & Performance
4.1.1 Finance Report Coversheet
4.1.2 Finance Report

4.2 15:04 - PF26.72 Integrated Performance Report
Russell Caldicott, Executive Director of Finance & Performance
4.2.1 IQPR PFIG Coversheet
4.2.2 IQPR

4.3 15:19 - PF26.73 Information Governance KPI Report Q4
Justine Parry, Acting Director of Digital, Data and Technology
4.3.1 IG KPI Q4 Report

4.3.2 Q4 KPI 2025-26 FINAL

4.4 15:29 - PF26.74 Information Governance Annual Report 2025-26
Justine Parry, Acting Director of Digital, Data and Technology
4.4.1 Information Governance Annual Report 2025-26
4.4.2 Appendix 2 Information Governance Annual Report Charts 2025-26

4.5 15:39 - PF26.75 Corporate Risk Register
Pam Wenger, Director of Corporate Governance
4.5.1 PFIG Corporate Risk Register Report
4.5.2 PFIG CRR - Appendix

4.6 15:49 - PF26.76 Corporate Governance Report
Pam Wenger, Director of Corporate Governance
4.6.1 Corporate Governance Report
4.6.2 DRAFT Cycle of Business for the PFIG Committee 2026-27

5 BUSINESS CASES

5.1 15:54 - PF26.77 Review of Business Cases in Development
Paolo Tardivel Interim Exec Director of Transformation & Strategic Planning
5.1.1 PFIG Business Cases Approach and Stocktake
5.1.2 Appendix 1 Health Board - Integrated Planning Framework

6 16:09 - CLOSING BUSINESS

6.1 PF26.78 Agree Items for Referral to Board / Other Committees
Gareth Williams, Chair

6.2 PF26.79 Review of Meeting Effectiveness
Gareth Williams, Chair

6.3 PF26.80 Date of the Next Meeting - 25 August 2026
Gareth Williams, Chair

6.4 PF26.81 Resolution to exclude the Press and Public
'Those representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960'

Betsi Cadwaladr University Health Board (BCUHB)
Unconfirmed Minutes of the Performance, Finance & Information Governance held in Public on 28 April 2026
held in the Boardroom, Carlton Court, St Asaph and via Teams

Committee Members Present	
Name	**Title**
Gareth Williams	Chair
Tehmeena Ajmal	Chief Operating Officer
Russell Caldicott	Executive Director of Finance & Performance
Dyfed Edwards	BCU Chairman
Jane Farrell	Improvement Advisor
Nick Graham	Associate Director Workforce Optimisation
Dave Harries	Head of Internal Audit (via Teams)
Carol Johnson	Head Of Information Governance (part meeting)
Matthew Joyes	Deputy Director of Legal Services
Stuart Keen	Director of Environment & Estates
Mike Larvin	Independent Member (via Teams)
Gillian Milne	Head Of Healthcare Contracting
Justine Parry	Acting Director of Digital, Data & Technology (via Teams)
Michelle Phoenix	Audit Wales
Tracy Pope	Head Of Healthcare Contracts
Rhian WatcynJones	Independent Member
In Attendance	
Philippa Peake-Jones	Head of Corporate Governance
Harriet Abbott	Secretariat

PRELIMINARY MATTERS

PF26.34 Welcome and Apologies

Apologies were noted from Debbie Eyitayo, Chris Lothian-Field, Pam Wenger and Ed Williams.

PF26.35 Declarations of Interest

No declarations of interest were received.

PF26.36 Unconfirmed Minutes of the Meeting held on 18 December 2025 & 24 February 2026

The minutes from December and February's meeting were reviewed. The following points were noted:

- **Minutes of the Meeting hold 18 December 2025**: Prior to the meeting the Chair had shared a further updated version with proposed amendments with the Committee Secretariat. It was agreed for this updated version to be shared outside

of the meeting for review and inclusion of any other amendments if still required, prior to circulating a final version to members.

- **Minutes of the Meeting held 24 February 2026**: it was requested that under item PF26.03, reference be made to the need of ensuring document accessibility for papers shared for Committee, and for this to be included as an action in the previous minutes.

The following actions were agreed:

- **Action PF26.36.1**: Minutes from December 2025 Committee to be updated following receipt of proposed amendments and circulated with members as final.

It was agreed that subject to the above amendments, the minutes of both meetings were a true and accurate record.

PF26.37 Matters Arising & Action Log

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

- **Action PF26.3.1** – The Executive Director of Finance & Performance updated regarding the action. Work is on track, with the new format of report to be presented at the next Committee meeting when the first data set from the new financial year 2026/27 is presented. The inclusion of clear language within reports was emphasised. It was agreed for the target date of the action to be amended to June 2026 in line with this.
- **Action PF25.115.3 –** It was advised that whilst this action was closed at the last meeting, as a matter of fact no discussion had taken place with the University regarding use of the scanner, and the issue is ongoing. It was advised that the team are now negotiating with a private company and were no longer exploring use of the University scanner. It was agreed for a new action to be opened and to be discussed outside of the meeting to identify the Executive Lead to explore this matter.

It was advised that at the last Board meeting in March 2026, it was agreed for the Integrated Performance and Accountability Framework to come back to PFIG Committee. It was agreed to reference this in the Committee update to the Board in May. It was suggested that there is difference between document contents and current practice. The work is being reported through the Financial Oversight Group (FOG), which is due to meet ahead of the next Board meeting. It was clarified that this work aligns with the All Wales Policy, which links with other Health Boards and the Ministerial Advisory Group (MAG) recommendations for policies around accountability and performance. It was requested for the document to be reviewed to ensure alignment between the framework and current practice, to allow assurance for sign off.

The following action was agreed:

- **Action PF26.37.1**: the Integrated Performance and Accountability Framework to be reviewed to ensure alignment with current practice, enabling assurance for sign off.

It was resolved that the Committee:

- **AGREED** to close the actions that were proposed for closure.

MAJOR PROGRAMMES & DEVELOPING STRATEGY & LONG-LASTING CHANGE

PF26.38 Planned Care

The item was presented by the Chief Operating Officer (COO), and the following points were highlighted:

- Hard work from the team was noted regarding work on insourcing, outsourcing, validation and outcomes. It was noted that this was due to significant additional funding received from the Welsh Government.
- The number of patients waiting over 52 weeks for their first outpatient appointment has reduced by 80%.
- Trajectories are in place for the end of Quarter 1. The COO has met with the three Integrated Health Centre (IHCs) regarding capacity planning, with support in place with the aim of meeting the trajectories.
- It was noted that the Cancer Services trajectory at the end of 2025/26 was 53%. There is need to increase this in order to meet deescalation criteria.
- It is believed to be feasible to have 0 patients waiting over 104 weeks by end of March 2027.

In discussing the item, the Committee:

- Noted the good progress made, however raised concern that the progress made was entirely down to additionality (insourcing and outsourcing) with no evidence of improved productivity in the delivery of in-house planned care.
- Sought reassurance that improvements were being delivered within existing resources and queried variability in productivity across specialties, particularly where comparable external providers were delivering higher throughput with similar capacity.
- Acknowledged that productivity challenges were multifactorial, with operational, cultural, and clinical factors, and emphasised the need to address barriers where there are limited reasonable productivity expectations. Members discussed the tension between managing the backlog and creating conditions for longer term service redesign, noting that sustained reliance on non-recurrent schemes risked inhibiting system stability.
- Were advised that weekly performance reviews were in place to monitor delivery and that, while some variance was anticipated, overall recovery remained achievable.
- Reflected on the broader organisational challenge of moving from short term operational control to a more improvement led approach, including the use of recognised improvement methodologies, clearer accountability, and clinically led service redesign.

It was resolved that the Committee:

- **NOTED** the report.

PF26.39 Urgent & Emergency Care

The item was presented by the Chief Operating Officer (COO), and the following points were highlighted:

- Variable performance has been seen across acute sites, with significant improvement noted in regards to Wrexham Maelor Hospital (WMH). Delayed discharges still remain as the primary constraint. Targeted support is in place, with urgent meetings scheduled to close any gaps in clinical leadership.
- Collaborative working is taking place with Local Authority partners with further system-wide engagement planned.
- Key focus areas include Single Point of Access (SPOA), Same Day Emergency Care (SDEC), management of discharge processes and ambulance handover performance.

In discussing the item, the Committee:

- Noted the ongoing work and progress, but sought further assurance regarding sustainability and impact of proposed changes, with reference to Community by Design. It was agreed for a report on implications and affordability of this to be received at the next Committee meeting.
- Highlighted the importance of understanding the financial and governance implications of a shift towards community-based models of care, including potential for use of pooled budgets, whilst recognising the governance, accountability and risk management requirements of this.
- Emphasised the importance of demonstrating improved patient experience, flow, and safety outcomes, alongside performance metrics, and requested future update on the impact of community resource utilisation.
- Queried arrangements in place regarding discharge to recover, including risk management, patient outcomes, and system learning, and requested information be received on this at a future meeting.
- Requested greater visibility of where improvement has been sustained, to provide assurance that changes were embedding effectively. It was confirmed that further evidence-based reporting is being developed to support oversight.

The following actions were agreed:

- **Action PF26.39.1**: a report on the financial implications and affordability of Community by Design to be received at the next meeting.
- **Action PF26.39.2**: Future UEC update to reference use of community resources and impact on patient experience and flow.
- **Action PF26.39.3**: Further information on discharge to recover arrangements, including risks and patient impact to be received at the next meeting for assurance.
- **Action PF26.39.4**: Future updates to include reference to sustained improvement for assurance of embedded changes

It was resolved that the Committee:

- **NOTED** the report.

PF26.40 Foundations for the Future – Verbal Update

The Executive Director of Finance & Performance gave a verbal update on the Foundations for the Future (FFTF) programme. The following points were highlighted:

- Further discussion is due at the upcoming Board Development session. The programme model proposes a reduction in the number of senior posts (Band 8c and above), which is subject to formal consultation.
- There are 207 posts within scope, with the new model identifying 198 posts in the future structure. This will result in an approximate £1.6 m, cost saving, with a more defined leadership structure. The structure elements of the programme are being picked up by the People & Culture Committee. It was noted that transition and implementation costs would require careful management.

In discussing the item, the Committee:

- Were advised that a fully costed business case will be presented at a future Committee meeting.
- Emphasised the importance of ensuring the programme is fully costed, including transition costs, workforce impacts and capacity to deliver the required change. Members noted that organisational experience indicated that such transformations often required upfront investment before savings are realised.
- Clarified that the model includes a number of vacancies, so does not necessarily involve redundancies, due to the use of vacancies and redeployment.
- Requested that a paper update regarding the financial aspects is received at a future Committee for the item for consideration to ensure appropriate governance.
- Emphasised the need for clear programme governance, dedicated project management capacity, and workforce support to mitigate organisational risk and maintain business continuity during implementation.
- Confirmed that the programme was progressing through appropriate internal governance routes, including People & Culture Committee oversight and internal audit review, with a paper scheduled at the next informal Board session.

The following actions were agreed:

- **Action PF26.40.1**: future updates on Foundations for the Future to focus on financial aspects to ensure appropriate governance.
- **Action PF26.40.2**: Ensure FFTF is considered at P&C Committee to ensure oversight.

It was resolved that the Committee:

- **NOTED** the report.

PLANNING, PERFORMANCE & STRATEGY

PF26.41 Finance Report

The Executive Director of Finance & Performance presented the item. The following points were highlighted:

- The Health Board forecasts a year-end deficit of £17.3m, subject to audit. This represents a 0.6.% deficit and is slightly below the revised end of year forecast provided to the Welsh Government, and is the second lowest deficit position of all Welsh Health Boards.
- All Health Boards in a deficit position are subject to a mandated “grip and control” checklist issued by the Welsh Government (WG). The Health Board response to this

will be brought through the next PFIG Committee and Financial Oversight Group (FOG).
- All Health Boards in a deficit position are required to resubmit financial plans by the end of May 2026. Those Health Boards who can submit a financially balanced plan will receive a further allocation to offset cost pressures from the Welsh Risk Pool (for BCUHB this is approximately £7m)

In discussing the item, the Committee:
- Explored key aspects of the financial position including workforce costs, non-pay expenditure and capacity pressures, noting increase in non-pay at the end of the previous financial year, and sought assurance regarding predictability and future mitigation.
- Raised concerns around bank and locum usage, as well as the apparent contradiction between the payroll headcount being significantly lower than the agreed establishment and the overspend overall on pay, with discussion centring on overtime, deployment, and efficiency.
- Expressed concern regarding operational and cultural impacts of prolonged centralised controls, noting potential inconsistencies with organisational values and the risk of driving higher-cost workarounds during vacancy periods.
- Had a lengthy discussion around control measures and earned autonomy, with members emphasising the need for proportionality and clear accountability and suggesting it would be better to empower front line managers to manage their budgets and establishments, while monitoring behaviours in order to re-introduce centralised controls for those parts of the Health Board which showed signs of failing to manage their budget appropriately.
- Noted internal audit observations regarding continued non-compliance with internal controls, including the absence of clear consequences. Members acknowledged the challenges and reiterated the need for collective ownership of financial decisions and strengthened accountability mechanisms

The following actions were agreed:
- **Action PF26.41.1**: Response to WG checklist following deficit position to be received at the next PFIG meeting prior to submission to WG.

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

PF26.42 Integrated Performance Report

The Executive Director of Finance & Performance presented the item. The item provided an overview of performance across areas such as Urgent & Emergency Care and Cancer Services, with underlying concepts around improvement.

In discussing the item, the Committee:
- Noted the focus on improvement and activity detailed, however, raised concerns around the clarity of narrative and data timeliness. Members were advised that data, prior to publishing, is validated, which can cause delay. Data can be shared earlier if agreed, however it must be noted that this is unvalidated.

- Requested consideration of data around theatre utilisation being escalated and covered in the exception report.

It was resolved that the Committee:

- **NOTED** the report.

[Gillian Milne and Tracy Pope joined the meeting].

PF26.43 Contracts & Commissioning

The item was introduced by the Executive Director of Finance & Performance. The following points were highlighted:

- The Commissioners Assurance Framework is designed to address points identified from Internal Audit and Ombudsman recommendations, with the aim of strengthening oversight of commissioned services.
- Two deadlines were previously missed for embedding the Commissioner Assurance Framework. It has been emphasised by the Ombudsman that the framework is to be embedded within the timeframe in place.
- Work is underway with the Director of Corporate Governance regarding the reporting line through relevant groups, Executives and Committees through to the Board.
- The document is currently in draft form, and is due to go to Executive Committee on 6 May, ahead of the Board at the end of May 2026, in order to meet the Ombudsman deadline.

In discussing the item, the Committee:

- Clarified that previously a draft version of the framework was shared with the private meeting on the day at the February Committee. It was agreed for the updated draft version to be circulated with Members outside of the meeting.
- Queried involvement from the quality lead. It was advised that the Executive Medical Director has been heavily involved and the item is due to be discussed at the upcoming Board Development session later this week.
- Sought assurance that appropriate oversight would be in place prior to Board consideration given the framework's significance, including ensuring awareness by Quality, Safety & Experience Committee.

The following actions were agreed:

- **Action PF26.43.1**: Commissioners Assurance Framework document to be circulated with Committee members.
- **Action PF26.43.2**: the Executive Director of Finance & Performance and Director of Corporate Governance to discuss further to ensure oversight ahead of the next Board meeting.
- **Action PF26.43.3**: Quality, Safety & Experience to consider the draft Commissioning Framework to ensure quality and safety are given sufficient weight in procurement activity.

It was resolved that the Committee:

- **NOTED** the report.

[Jody Evans joined the meeting, and Gillian Milne and Tracy Pope left the meeting].

GOVERNANCE, RISK & ASSURANCE

PF26.44 Information Governance KPI Report

[Carol Johnson joined the meeting].

The item was jointly presented by the Acting Director of Digital, Data & Technology and Head of Information Governance. The following points were highlighted:

- A previous issue raised relating to GP practice toolkit compliance has now been resolved, and all have now been submitted.
- It was advised that prior to the Committee being sighted on the report, it is received at Executive Committee. This step was put in during the last financial year. It will be queried at an upcoming Executive Committee meeting as to whether this step is still required.
- A slight reduction in Freedom of Information (FOI) compliance was noted at the end of Quarter 4 of 2025/26. Work in underway internally, and this is now at 86% after a recent review, with the aim of further improvement.
- Clarified that there were two incidents relating to Putting Things Right. One incident initially submitted was not considered to relate to information governance following review.
- 27 Information Governance Champions have been identified across the Health Board.
- Continued compliance with the Information Governance mandatory training target (85%) has been maintained across the Health Board for the past 12 months.

In discussing the item, the Committee:

- Reviewed the data and information relating to FOI requests, and emphasised the importance of ensuring as much information is published as possible for transparency, which could also prevent the need for some FOI requests.
- Noted the data regarding delays and breaches on FOI requests, and queried the potential reasons for this, which could include more information being required to allow sign off. It was advised that work is ongoing to identify any trends to allow learning.
- Emphasised the need for consistent communication, ensuring that individuals are directed to the appropriate resources.

The following actions were agreed:

- **Action PF26.44.1:** To be determined if the IG KPI report is still required to be received at Executive Committee prior to PFIG.
- **Action PF26.44.2:** PPHP to reconsider the current practice of staff advising journalists to source information through FOIs.

It was resolved that the Committee:

- **NOTED** the report.

[Carol Johnson left the meeting].

PF26.45 Board Assurance Framework

The Assistant Head of Risk Management presented the item. The following points were highlighted:

- A number of risks remain rated red or overdue. Work is underway to strengthen alignment between risks, strategic objectives and prioritised commitments.
- Risks are being actively mapped to associate activity to ensure oversight and assurance.

In discussing the item, the Committee:

- Noted the progress made in improving structure and management of the BAF.
- Requested against BAF 07, reference be made to productivity and inefficient working to recognise the significance to organisational sustainability and recovery.

The following action was agreed:

- **Action PF26.45.1**: Productivity and inefficient working to be referenced against BAF07

It was resolved that the Committee:

- **ENDORSED** the report.

[Jody Evans left the meeting].

PF26.46 Corporate Governance Report

The Head of Corporate Governance presented the report. It was advised that in coming months, the Committee assessment will be completed as part of the Annual Report. The Committee Cycle of Business is also being reviewed and is to be aligned with the Integrated Medium-Term Plan (IMTP) prior to being received for approval by the Committee.

In discussing the item, the Committee:

- Requested clarity on how private items are referenced to ensure consistency across Committees to maintain transparency while respecting confidentiality.
- Welcomed the continued emphasis on ensuring that matters considered in private were appropriately justified and that the default position remained transparent where possible.

It was resolved that the Committee:

- **NOTED** the report.

PF26.47 Corporate Services Financial Overview

Item deferred to the next meeting.

A paper update on this item will come to the next committee, once the required information is available.

CLOSING BUSINESS

PF26.48 Agree Items for Referral to Board / Other Committees

It was agreed that the following should be referred to the following Committees:

- People & Culture: Ensure assurance is sought on the availability and continuity of programme management support for the Foundations for the Future programme, to reduce the risk of disruption during implementation.

- Executive Committee: Ensure attention is drawn to the timing of Information Governance reporting, to ensure relevant information is seen by Executive Committee in good time to support oversight and decision-making

- Executive Committee is asked to escalate data on theatre productivity in performance reporting, as there is no evidence of positive change.

- Quality, Safety & Experience: To consider the draft Commissioning Framework to ensure quality and safety are given sufficient weight in procurement activity.

- Planning, Population Health & Partnership: The current practice of our staff advising journalists to source information through FOIs should be reconsidered.

PF26.49 Review of Meeting Effectiveness

It was agreed that:

- The overview of business cases was to come to the next Committee meeting as previously requested. This was initially due to be received in April's meeting.

PF26.50 Date of next meeting

23 June 2026

PF26.51 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'

Performance Finance & Information Governance Committee Action Log (Public)

Updated 16.06.2026

Open Actions						
Actions to remain open						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
1	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	Remain Open Added to forward workplan.
Proposed for Closure						
1	PF26.36.1	28.04.26	**Minutes of the Previous Meeting** Minutes from December 2025 Committee to be updated following receipt of proposed amendments and circulated with members as final	Harriet Abbott	April 2026	Proposed for closure 11.05.26 - Final version circulated to members
2	PF26.37.1	28.04.26	**Matters Arising** The Integrated Performance and Accountability Framework to be reviewed to ensure alignment with current practice, enabling assurance for sign off.	Russell Caldicott	June 2026	Proposed for closure 11.05.26 – noted on draft agenda for June 16.06.26 – action superseded. Framework was received and endorsed at Board in May 2026.
3	PF26.40.2	28.04.26	**Foundations for the Future** Ensure FFTF is considered at P&C Committee to ensure oversight.	Chair	June 2026	Proposed for closure 11.05.26 – action shared with P&C

4	PF26.43.3	28.04.26	**Contracts & Commissioning** Quality, Safety & Experience to consider the draft Commissioning Framework to ensure quality and safety are given sufficient weight in procurement activity	Philippa Peake-Jones / Harriet Abbott	July 2026	Proposed for closure 11.05.26 - Transferred to QSE Forward workplan
5	PF26.44.1	28.04.26	**Information Governance KPI Report** To be queried if the IG KPI report is still required to be received at Executive Committee prior to PFIG	Pam Wenger	June 2026	Proposed for closure 16.06.26 - The report will continue to be considered by Executive Committee first; and timelines will be managed to ensure no delay to PFIG reporting.
6	PF26.44.2	28.04.26	**Information Governance KPI Report** PPHP to reconsider the current practice of staff advising journalists to source information through FOIs.	Philippa Peake-Jones / Harriet Abbott	July 2026	Proposed for closure 12.05.26 – action shared with PPHP
7	PF26.3.1	24.02.26	**Integrated Performance Report** A new user-friendly integrated performance report to be developed, with aim to utilise from start if the next financial year.	~~Ed Williams~~ Russell Caldicott	~~April 2026~~ June 2026	Proposed for closure On track – a version to come to the IPR (or an update to be received at the April 2026 meeting) 28.4.26 – work on track, new format expected at June committee meeting when first data set from the new financial year (2026/27) is presented. Due date updated. 15.06.26 – new report included on June agenda

8	PF26.05.01	24.02.26	**Urgent Emergency Care (UEC)** Update on SPOA to be brought to June 2026 Committee meeting for update on progress from Q1	Tehmeena Ajmal	June 2026	Proposed for closure To be scheduled for June's meeting. 11.05.26 – added to draft agenda for June 26 15.06.26 – included within UEC update on June agenda
9	PF26.05.02	24.02.26	**Urgent Emergency Care (UEC)** Update on Acute Frailty Service (AFS) to be brought to Committee once timescales are agreed. Update expected through Q1.	Tehmeena Ajmal	June 2026	Proposed for closure To be scheduled for June's meeting. 11.05.26 – added to draft agenda for June 15.06.26 – included within UEC update on June agenda
10	PF26.3.2	24.02.26	**Matters Arising** Report authors to ensure accessibility of committee papers for items submitted	All	June 2026	Proposed for closure Added as amendment during April 2026 committee when reviewing previous minutes.
11	PF26.39.1	28.04.26	**Urgent & Emergency Care** A report on the financial implications and affordability of Community by Design to be received at the next meeting.	Tehmeena Ajmal	June 2026	Proposed for closure 11.05.26 – on June agenda
12	PF26.39.2	28.04.26	**Urgent & Emergency Care**	Tehmeena Ajmal	June 2026	Proposed for closure 11.05.26 – to be included in next update

			Future UEC update to reference use of community resources and impact on patient experience and flow.			
13	PF26.39.3	28.04.26	**Urgent & Emergency Care** Further information on discharge to recover arrangements, including risks and patient impact to be received at the next meeting for assurance.	Tehmeena Ajmal	June 2026	Proposed for closure 11.05.26 – to be covered in June update
14	PF26.39.4	28.04.26	**Urgent & Emergency Care** Future updates to include reference to sustained improvement for assurance of embedded changes	Tehmeena Ajmal	June 2026	Proposed for closure 11.05.26 – to be included in next updated
15	PF26.40.1	28.04.26	**Foundations for the Future** Future updates on Foundations for the Future to include a paper referencing financial aspects for consideration to ensure appropriate governance	Russell Caldicott	June 2026	Proposed for closure To include when next update due at committee
16	PF26.41.1	28.04.26	**Finance Report** Response to Welsh Government (WG) checklist following deficit position to be received at the next PFIG meeting prior to submission to WG.	Russell Caldicott	June 2026	Proposed for closure 11.05.26 – to be covered in June meeting
17	PF26.43.2	28.04.26	**Contracts & Commissioning** The Executive Director of Finance & Performance and Director of Corporate Governance to discuss further to ensure oversight ahead of the next Board meeting, regarding the Commissioners Assurance Framework.	Russell Caldicott / Pam Wenger	May 2026	Proposed for closure Item went to Board in May 2026
18	PF26.45.1	28.04.26	**Board Assurance Framework** Productivity and inefficient working to be referenced against BAF07	Pam Wenger / Jody Evans	June 2026	Proposed for closure 15.06.26 – action complete

19	PF26.43.1	28.04.26	**Contracts & Commissioning** Commissioners Assurance Framework document to be circulated with Committee members	Russell Caldicott	May 2026	Proposed for closure Item was received at Board in May 2026 and approved. Documentation was received with Board papers
Closed Actions (as agreed at meeting on 28.04.26)						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
1	PF25.115.3	18.12.25	**Integrated Performance Report** The use of additional MRI machines to be discussed outside of meeting. The Director of Finance to link in with the Programme Director of Planned Care for update.	Russell Caldicott	February 2026	Closed Discussions concluded with Operational teams and Executive (mobile units on site with software upgrades to existing machines) 28.04.26 – closed in Feb 26 meeting, however advised further in Apr 26 meeting that no discussion had taken place with the university regarding scanner use. Negotiations now ongoing with private company to resolve.
2	PF26.06.01	24.02.26	**Planned Care** Planned Care update to be standing item on every PFIG meeting going forward, incorporating timelines and outcome measures	Russell Caldicott / Tehmeena Ajmal	April 2026	Closed 18.03.26 – included on Committee cycle of business.
3	PF25.122.2	18.12.25	**Board Assurance Framework** Update on the six-facet survey to be received at future meeting.	Stuart Keen	April 2026	Closed Update to be provided by the Director of Estates and

						Environment at the April meeting. 18.03.26 – update added to draft agenda for April 24.03.26 - On Agenda – for update as part of BAF
4	PF26.09.01	24.02.26	**Urgent Suspected Cancer Performance** Relevant timeframes to be include in future updates	Tehmeena Ajmal	April 2026	Closed Paper went to Board March 2026
5	PF25.92.1	22.10.25	**Finance Report** Reprofile of capital expenditure plan to take place and update to be given at future PFIG meeting.	Russell Caldicott	February 2026	Closed To be added to Feb 26 agenda 19.01.26 – on Feb 26 agenda 24.02.26 – Remain open until update is received. Update to be requested. Update went direct to Board March 2026
6	PF26.05.03	24.02.26	**Urgent Emergency Care (UEC)** Update to be received at the next Committee meeting on UEC, including evidence, predicted actions and timescales to review progress	Tehmeena Ajmal	April 2026	Closed 18.03.26 – UEC now standing item on agenda and will be received as part of the Strategic Programmes cycle to PFIG.
7	PF26.06.02	24.02.26	**Planned Care** Trend analysis regarding Planned Care to be provided at a future PFIG meeting	Russell Caldicott / Tehmeena Ajmal	April 2026	Closed On April Agenda

8	PF26.08.01	24.02.26	**Foundations for the Future** Foundations for the Future update to be received at April 2026 PFIG meeting.	Russell Caldicott	April 2026	Closed On April Agenda
9	PF26.14.1	24.02.26	**Information Governance** Update to be received at the next PFIG Committee regarding delay in IG toolkit completion.	Justine Parry	April 2026	Closed On April Agenda

Performance Finance & Information Governance Committee

PLANNED CARE UPDATE

Dyddiad y Cyfarfod **Date of Meeting**	23 June 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
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol **Lead Executive Team Member name and title**	Tehmeena Ajmal Chief Operating Officer

Pwrpas yr Adroddiad **Report Purpose**	For Noting

Crynodeb Gweithredol
Executive Summary

The report provides an update on the current planned care position

- The Health Board has shown a significant reduction in patients waiting over 104w and 156w in the last half of 2025/26.
- A trajectory has been set for achieving 0 patients waiting over 104 weeks by the end of financial year 2026/27, although some specialties are less confident in achieving this
- In 2026/27 to date, the number of patients waiting in excess of 104 weeks has increased as opposed to following the trajectory for reduction.
- The current Q1 104 weeks cohort is 2,996 patients as at 16th June 2026 and the Q2 cohort is 7,908.
- The BCUHB >104 weeks currently account for 58% of Wales' 104 week waits.
- There are also ambitious targets for diagnostics and cancer.
- Specialty level Recovery Development sessions commenced in June to drive the consolidation and development of a single planned care recovery plan.
- A new planned care recovery governance and oversight structure has been developed to oversee the delivery and decision-making related to planned care recovery.

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**	
Not applicable for this report	

PLANNED CARE UPDATE

1. Y SEFYLLFA / SITUATION

1.1 The Health Board has shown a significant reduction in patients waiting over 104 and 156 weeks in the last half of 2025/26.

1.2 A trajectory had been set for achieving 0 patients waiting over 104 weeks by the end of 2026/27.

1.3 However, during 2026/27 so far, the number of patients waiting in excess of 104 weeks has increased as opposed to following the trajectory for reduction

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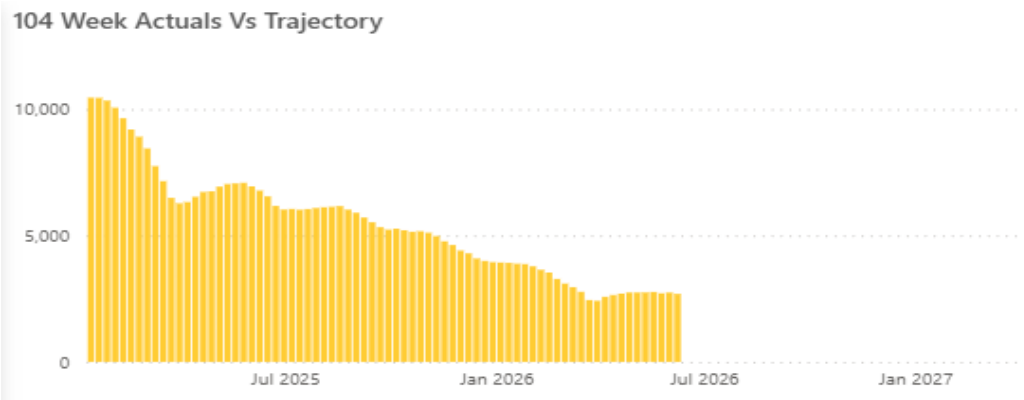
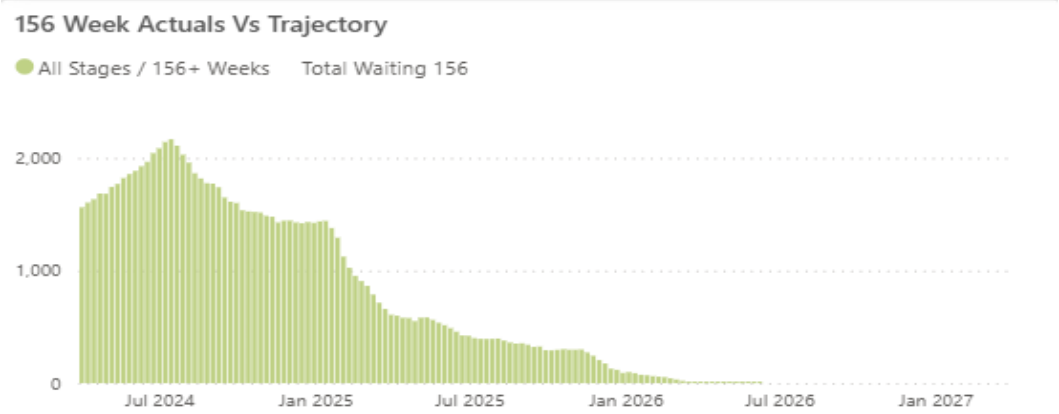


1.4 The current Q1 104 week cohort is 2,996 patients as at 16th June 2026 and the Q2 cohort is 7,908.

1.5 There are particularly large cohorts of 104 weeks patients in General Surgery, ENT, T&O, Oral Surgery, Gynaecology, Gastro, Urology and Pain.

1.6 In addition, the Q1 156 week cohort is 10 patients as at 16th June 2026 and the Q2 cohort is 138.



1.7 There are particularly large cohorts of 156-week patients in Pain, Gynaecology and Trauma & Orthopaedics.

2 Y CEFNDIR / BACKGROUND

2.1 The current position is being driven by a range of challenges including:

2.1.1 Capacity and demand issues within IHCs and within specialties.
2.1.2 Backlogs remain in patients
2.1.3 IHCs are working within silos to recover the position.
2.1.4 There are multiple plans, reports and governance structures.
2.1.5 There are multiple metrics being used, some referring to the same indicator but a different value.
2.1.6 Theatre inefficiencies include late starts, cancellations, and early finishes.
2.1.7 Productivity and efficiency is variable across services and IHCs.
2.1.8 Service models vary across IHCs for the same services.
2.1.9 Validation levels are extremely low and do not seem well managed.
2.1.10 New to Follow up ratios are variable across IHCs and specialties.

2.2 The BCUHB >104w weeks currently account for 58% of Wales' 104 week waits.

2.3 In terms of >156 week waits, BCUHB currently account for 62% of Wales' Q1 cohort.

2.4 Therefore, there is increased focus on BCUHB from Welsh Government and NHS Performance & Improvement teams.

2.5 It is unlikely that BCUHB will meet the Q1 2026/27 target of 1,597 patients waiting over 104 weeks.

2.6 Multiple specialties comment on not being part of establishing a trajectory to reach zero >104 weeks, 60% cancer performance or 80% of diagnostics <8 weeks by March 2027.

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

3.1 A new Recovery Director was appointed in May 2026.

3.2 A new Operational Huddle commenced on 15th June 2026 to recover operational uniformity and grip across specialties.

3.3 Recovery Development sessions are being arranged at specialty (not IHC) level throughout the latter half of June with specialty operational and clinical leadership representation. These sessions will drive the consolidation and development of a single planned care recovery plan.

3.4 A new planned care recovery governance and oversight structure has been developed to oversee the delivery and decision-making related to planned care recovery.

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

4.1 The previous report suggested:

4.1.1 Failure to meet IMTP targets.
4.1.2 Insufficient Internal capacity without outsourcing.
4.1.3 Theatre inefficiencies limiting productivity.
4.1.4 Financial risks due to outsourcing costs and recurrent pressures.
4.1.5 Cancer and diagnostic performance risks.
4.1.6 Reputational risks from long waits and performance issues

4.2 These will be explored and understood in more detail during the recovery development sessions.

5 ARGYMHELLION
RECOMMENDATIONS

5.1 Gofynnir i'r Pwyllgor/Cyfarfod/Grŵp / The Committee/Meeting/Group is asked to:

- **SUPPORT** the ongoing development of a planned care recovery plan and supporting governance. The resource implications of this are yet to be understood and will be an outcome of the recovery development sessions.

ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol **Link to Strategic Priorities**	     2. Enhance the Co-ordination of Care for People Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below: Improve Access, Outcomes and Experience
Yr Egwyddorion Dylunio **Design Principles**	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) CRR 25-01 BAF 24-07

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):** Public Sector Equality Duty [HTML] | GOV.WALES	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale: Not Applicable	
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: Not Applicable	

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: Not Applicable	
Human Rights Act *Have Human Right based concerns been addressed within WP8a*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome: Not applicable	
Compliance to the Welsh Language requirements? *Have you undertaken an Impact Assessment*	Os naddo, dylech gynnwys y rheswm: If no, please include rationale: Not Applicable	Naddo/No: ☒
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale: Not Applicable	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale: Not Applicable	
Compliance to giving 'Due Regard' to the principles of the Armed Forces Covenant *Have the principles of the Armed Forces Covenant*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	

been addressed within WP8a	Not Applicable	
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: Not Applicable	
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: Not Applicable	
	Do/Yes: ☐	Naddo/No: ☒

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*	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale: Not Applicable	
Cyfreithiol **Legal**	There are no specific legal implications related to the activity outlined in this report.	
	.	
Enw Da **Reputational**	Yes (Include further detail below)	
	The Health Board is already under close oversight due to performance challenges. Failure to deliver quarterly and year end trajectories would impact the reputation of the Health Board and may further increase oversight and intervention.	
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 & Information Governance Committee

URGENT & EMERGENCY CARE PROGRAMME UPDATE

Dyddiad y Cyfarfod Date of Meeting	23 June 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Liz Wedley, UEC Programme Director
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Tehmeena Ajmal, Chief Operating Officer

Pwrpas yr Adroddiad Report Purpose	For Assurance

**Crynodeb Gweithredol
Executive Summary**

This report provides the Performance, Finance and Information Governance Committee (PFIG) with an update on the Urgent and Emergency Care (UEC) Major Change Programme. It provides assurance that progress is being made against agreed performance trajectories related to the national transformation Programme, that a robust delivery and governance framework is in place, and that risks are actively managed through daily, weekly and monthly performance grip.

2. Executive Summary

Urgent and Emergency Care (UEC) services across Betsi Cadwaladr University Health Board (BCUHB) continue to experience significant and sustained operational pressure driven by high demand, constrained system flow, delayed discharge pathways and workforce fragility. These pressures present ongoing risks to patient safety and experience, quality of care, staff wellbeing and organisational reputation.

In response to Welsh Government (WG) Escalation Board recommendations and in alignment with the BCUHB Integrated Medium-Term Plan (IMTP) 2026–2029, the Health Board is developing 90-Day UEC Improvement Plans for each Integrated Health Community (IHC) to align with quarterly delivery pans.

The plan is focused on stabilisation, acceleration and sustainability of improvement across the highest-risk areas of concern within the UEC system:

- Ambulance handover delays – linked to a requirement to deliver the national Handover-45 target by September 2026
- Emergency Department (ED) exit block and 12-hour breaches
- Pathways of Care Delays (POCD) and improved discharge management
- Timeliness of senior clinical decision-making in the Emergency Department

There have been limited periods of improved operational grip, aligning to decreased demand, or attendances staggered more evenly through the day. However, performance remains outside national targets and risk remains high.

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
IMTP	Integrated Medium Term Plan
ED	Emergency Department
POCD	Pathways of Care Delays
WG	Welsh Government
EICOP	Executive Integrated Concerns Oversight Panel
YGC	Ysbyty Glan Clwyd
SOP	Standing Operating Procedure
GIRFT	Getting Things Right First Time
HALO	Hospital Ambulance Liaison Officer
IHC	Integrated Health Community
WAST	Welsh Ambulance Service (NHS) Trust
D2RA	Discharge to Recover then Assess
SDEC	Same Day Emergency Care
SPOA	Single Point of Access

URGENT & EMERGENCY (UEC) CARE UPDATE

1. Y SEFYLLFA / SITUATION

1.1. Urgent and Emergency Care services across BCUHB remain subject to significant operational risk, driven by sustained demand pressures, constrained system flow and delayed pathways of care. These risks are evidenced by continued breaches in ambulance handover times, prolonged ED waits, delayed senior clinical decision-making and high levels of inpatient delay. Collectively, these factors present ongoing risks to patient safety and experience, quality, workforce experience and organisational reputation.

1.2. Key access measures demonstrate ongoing variance against plan and against Welsh Government (WG) expectations.

1.3. Health Inspectorate Wales have recently inspected the ED in Ysbyty Glan Clwyd and are issuing a notice on 17 June escalating the department as a Service Requiring Significant Improvement.

2. Y CEFNDIR / BACKGROUND

2.1. UEC continues to operate under sustained demand pressure, with ED attendances remaining above planned levels and exceeding pre-pandemic baselines. Demand growth is driven by a combination of demographic pressures (including frailty), acuity, delayed discharges, and constrained flow across the wider system.

2.2. Key access measures, including performance against the four-hour access standard, time to initial clinical assessment, and ambulance handover delays, demonstrate ongoing variance against plan. While episodic periods of improvement have been observed, performance is volatile and remains outside the thresholds set as part of de-escalation criteria for the Health Board.

2.3. Trend analysis over time shows:

2.3.1. Persistent misalignment between demand and available ED capacity
2.3.2. Improvements achieved through escalation and temporary measures remain inconsistent
2.3.3. Flow constraints downstream of ED remain a critical constraint to recovery
2.3.4. Patient feedback reflects long waits with a deterioration in the level of satisfaction, however positive statements about the standard of care
2.3.5. Quality and safety concerns related to high demand and congestion, resulting in long waits for assessment and treatment

2.4. In the period since the last Board report, the Health Board has been supported by the Intensive Support Team to undertake a series of diagnostics focused on

Emergency Department processes and management, site management and flow, and discharge processes. Work continues to establish performance metrics and further required improvements.

2.5. Feedback and recommendations form the basis of site-specific 90-day recovery plans, supported by the UEC Major Change Programme "three pillars" of improvement. These plans aim to improve quality, safety, performance and experience.

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

3.1. Quality and Safety

3.1.1. A Rapid Quality Review addressing concerns in UEC was held in November 2025 to ensure clear identification of quality concerns, with defined governance routes for oversight and pathways for improvement.

3.1.2. Oversight of defined quality metrics is held fortnightly as part of the Executive Integrated Concerns Oversight Panel (EICOP). Each IHC reports in a structured manner outlining performance, incidents (including defined 'must report' incidents) and complaints. In addition, IHCs report daily forward waiting data, episodes of boarding in extremis, numbers receiving care in undesignated areas, and a now standardised audit of intentional rounding for those in undesignated areas.

3.1.3. Following an incident at YGC, a review of corridor care placement has been undertaken with a cap of 12 patients introduced. Areas defined as appropriate have been identified by local staff and agreed by the EMD and EDON.

3.1.4. Incidents within the UEC pathways meeting the criteria for review in EICOP continue to be reviewed at rapid review stage. Learning has included:

- 3.1.4.1. The need for review of falls assessments and management in emergency care
- 3.1.4.2. Prompt review and clarity of ownership by specialist teams
- 3.1.4.3. Provision of access to digital systems for all non-substantive staff
- 3.1.4.4. Learning around chest drain placement and care
- 3.1.4.5. Clear communication with forward waiting patients (patients moved to a ward area pending a planned discharge)

3.1.5. Work is also in place via the CEO-chaired weekly UEC oversight meeting to ensure review of all documentation associated with dynamic risk assessment within UEC pathways and learning from the first three months of implementation of the Forward Waiting SOP.

3.1.6. An ED business case is being reviewed pending agreement to ensure appropriate substantive nursing and medical staffing is in place in each of the three departments.

Patient Experience

3.1.7. Patient experience data is collected via Civica. Across 2025-26 there was a deterioration in the level of satisfaction between the first three quarters of the year and quarter 4 (which may in part be attributable to increased Winter pressures in the Emergency Departments).

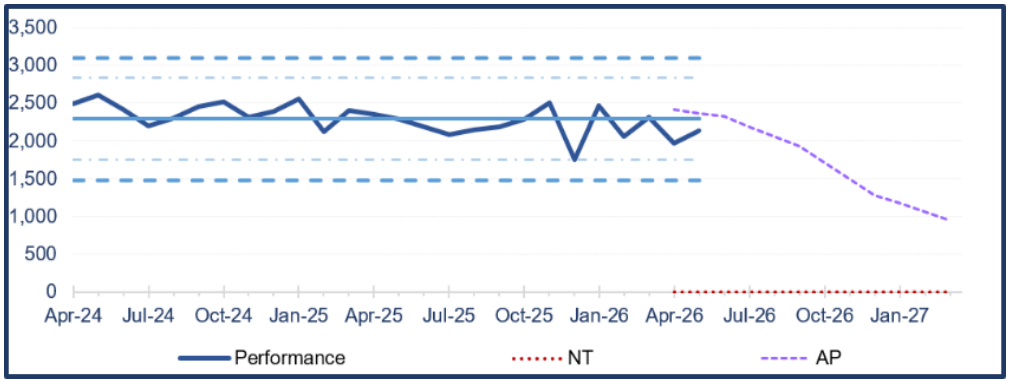
3.2. **Performance**

3.2.1. Performance against each measure remains outside national targets. While limited signs of operational grip are emerging, no measure has yet stabilised at an improved level.

3.3. Number of ambulance patient handovers over 45 minutes

3.3.1. Performance against this metric at the start of the emergency pathway are in line with previous months activity but fall short of national expectations. Performance relating to ambulance handovers exceeding 45 minutes has improved and is ahead of the health board's trajectory, which is positive but remains above the Welsh Government expectation of zero.

3.3.2. Focused improvement is needed over the next month to maintain alignment with the planned trajectory and support delivery within the performance framework. The Chief Operating Officer is working with partners to prepare for implementation of the 45-minute handover standard, with associated capacity risks under review. The revised Care in Undesignated Areas SOP is now in place, with monitoring to support patient safety improvements. Delivery remains dependent on improving ED flow and reducing delays for patients awaiting inpatient beds.



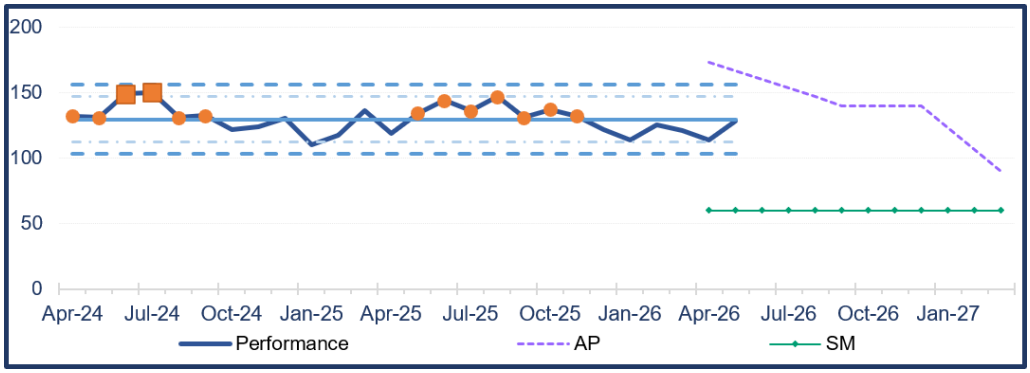
3.4. Median time to assessment by clinical decision maker in less than 60 minutes

3.4.1. An improved performance was noted between February to April 2026, with a reduction of 11 minutes in the median time to assessment. The reported position for May 2026 highlights a deterioration of 14 minutes. The median wait reported in May of 128 minutes is ahead of the health

board's trajectory of 160 minutes but is 54 minutes above the national 60-minute target.

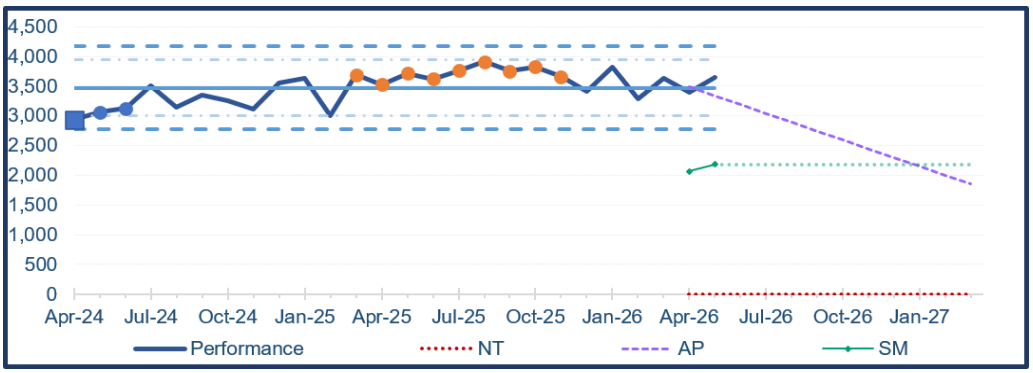
3.4.2. Development, approval and implementation of the emergency department business case. This relates to creating staffing rotas that meet the requirement of the Resident Doctors Contract that is being implemented, and a move to substantive staff in post, reducing the reliance on locum/agency staffing. The business case is in the final stages of development and is expected to be presented to the Executive Committee shortly.

3.4.3. Based on current trend, median time to clinical decision maker is meeting the health board's internal trajectory and should achieve the required level by March 2027.



3.5. Number of patients who spend 12 hours or more in ED

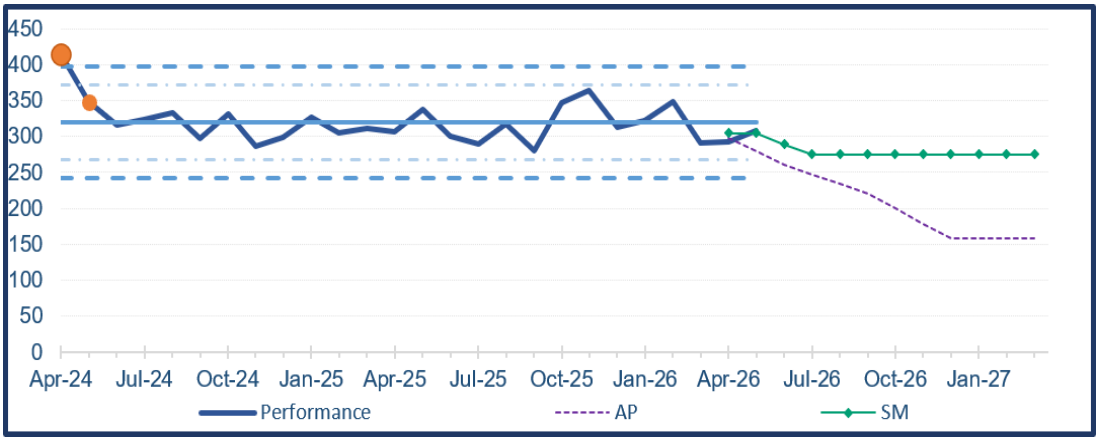
3.5.1. This metric assesses the flow through the emergency pathway and performance against the metrics is below the health board's trajectory and the national target. In May 2026,, there was an 8.7% increase in the number of patients waiting over four hours in the Emergency Department compared to the previous month. Twelve hour performance is 14.4% above the expected target for May, highlighting sustained operational pressure and a widening variance against plan.



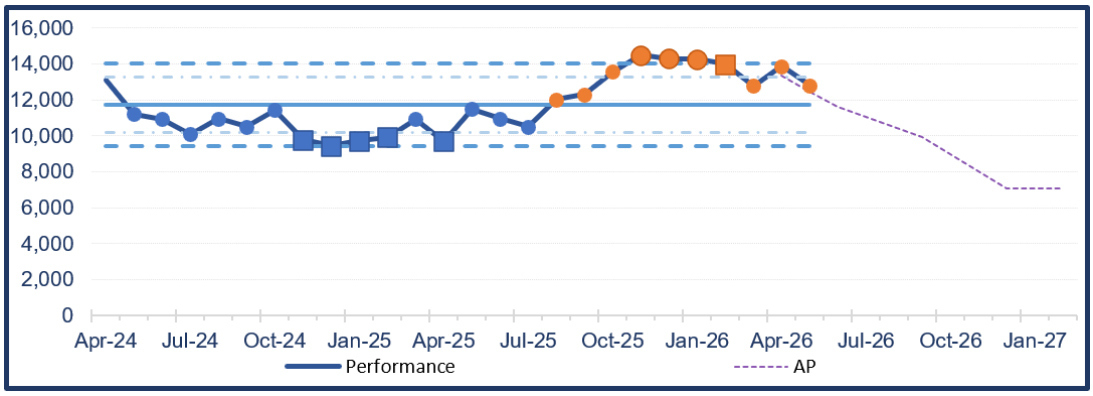
3.6. Pathway of Care Delays (PoCD)

3.6.1. PoCD patients has increased in May, the number of bed days lost due to PoCD is 10.1% above the quarter 1 profile, however the number of bed days has reduced by 1,070 days from the previous month. West IHC is an outlier in May accounting for 53% of all bed days lost across BCU, However, the number of patients on delayed pathways of care in May remains broadly comparable across IHCs (Central 97, East 105, West 106), indicating that while similar volumes of patients are delayed, the duration of delays is longer in West, driving the increased bed days lost.

Number of patients on delays pathways of care



Number of bed days lost to delayed pathways of care



3.7. **Corridor Care and 'Red Lines' (aligned to NHS Wales and GIRFT 2026 standards)**

3.7.1. In line with the NHS England GIRFT Corridor Care Improvement Guide (March 2026) and applicable NHS Wales principles, the following system red lines for UEC performance apply:

3.7.1.1. Ambulance handover – maximum 45 minutes (WAST): 68% of patients not handed over within 45 minutes (Mar 2026). Daily handover huddles, HALO/WAST liaison and IHC-level

accountability are in place. Improvement trajectory required by Q1 exit.

3.7.1.2. Zero tolerance for ED waits >12 hours: 3,756 patients waited >12 hours in Feb 2026. Senior clinical reviews and Executive walkthroughs are shaping rapid actions.

3.7.1.3. Corridor care – limits, escalation and reporting: BCUHB Full Capacity Protocols are being reviewed to include explicit corridor care limits aligned to safe staffing standards.

3.7.2. **Five Focus Areas for Reducing Corridor Care (BCUHB)**

3.7.3. Consistent with the GIRFT framework, the following five areas of focus are reflected within the BCUHB 90-Day Improvement Plan:

3.7.3.1. Ambulance: Daily handover huddles with WAST; consistent definition of 'handover complete'; IHC-led Fit to Sit standard operating procedures; ambulance receiving areas in ED, SDEC, frailty, SAU and AMU as a minimum

3.7.3.2. Emergency Department: SDEC and frailty pathways; Rapid Assessment and Treatment (RAT) model with senior clinical input; initial assessment within 15 minutes; time to treatment within 60 minutes; criteria-to-admit audits

3.7.3.3. Alternatives to Admission: SDEC First approach; frailty advisory service and AFS; SPoA; virtual ward/Hospital at Home expansion; hot clinics and urgent specialty opinion pathway

3.7.3.4. Inpatient Care: Daily consultant-led MDT ward and board rounds, 365 days per year; acute receiving area length of stay of 48–72 hours; criteria-led discharge and Home First; 21-day LOS reviews

3.7.3.5. Culture and Leadership: GIRFT Clinical Operational Standards (adoption target by July 2026); accountability for UEC performance; monthly staff engagement; daily OPEL-aligned site management

3.7.4. **Discharge to Recover and Assess (D2RA) and Home First**

3.7.4.1. Inconsistent application of D2RA and Home First principles is a primary driver of delayed discharge and ED exit block across BCUHB. The following improvement actions are in progress:

3.7.4.2. Executive-led validation and oversight of delayed patient lists, with weekly system-wide discharge reviews

3.7.4.3. Strengthening accountability for discharge ownership across IHCs and local authority partners and the development of a shared purpose and implementation plan between the Health Board and local authorities

3.7.4.4. Accelerating 21-day length of stay reviews and flow audit embedding as standard practice

3.7.4.5. New data dashboard to highlight POCD delays, driving joint work with local authorities, utilised as part of the reset fortnight
3.7.4.6. Implementation of criteria-led discharge pathways, including to virtual wards/Hospital at Home and hot clinics

3.7.5. **Same Day Emergency Care (SDEC) and Admission Avoidance**

3.7.5.1. SDEC and ambulatory pathways remain under-utilised across BCUHB. The following actions are being progressed:
3.7.5.2. Strengthening SDEC First streaming to reduce avoidable ED attendance and exit block
3.7.5.3. Expanding SDEC access to cover medicine, surgery, frailty and gynaecology as a minimum, available at least 12 hours per day, seven days per week
3.7.5.4. Developing the frailty service pathway, with a target of 80% of frailty patients remaining in hospital fewer than eight hours
3.7.5.5. Scaling virtual ward/Hospital at Home capacity to support both step-up and step-down pathways
3.7.5.6. Strengthening the Urgent Community Response service as an integral part of 'Call Before Convey' via Single Point of Access (SPoA)

3.8. **Staff Experience**

3.9. The 2025 staff survey reflected the differences between staff working in acute versus other Health Board settings, with staff morale and 'we nurture healthy working environments' being in particular significantly lower, patient safety scores also lower than other health care settings, and overall 44.4% agreeing that they would be happy with the standard of care provided if a friend or relative needed treatment (27.7% disagreed).

3.10. Although we are the lowest scoring Health Board in the 'We are compassionate and inclusive' survey theme at 67.6% – a drop of 1.47% from 2024 – we remain just 2% off the NHS Wales Health Board average

3.11. 82.9% of survey respondents agree we are compassionate towards patients/service users. This is a small reduction of 0.41% from 2024 and just beneath the NHS Wales Health Board average of 83.3%
3.12. We are the lowest scoring Health Board in the 'We are all able to speak up' theme at 63.9%. This is a reduction of 1.85% and below the NHS Wales Health Board average of 65.6%
3.13. Our score in the Staff Engagement theme has fallen by 2.88% to 55.9%, compared to an NHS Wales Health Board average of 57.7%
3.14. 2024 saw a 6.7% improvement in our Patient Safety theme score, and this has pretty much held in 2025, with a decline of just 0.47 % to 58.6%. This is just over 1% off the NHS Wales Health Board average. Some responses to questions within the survey connected to this are concerning, including a

drop of 2.51% on 2024 and 10.9% below the NHS Wales Health Board average of 55.3%

4. 90-Day Improvement Plans

4.1. ED recovery and system flow improvement are being progressed through a structured 90-day improvement cycle for each IHC, providing assurance that delivery is disciplined, time-limited and repeatable. This approach translates Escalation Board actions and agreed investment into specific, time-bound delivery actions with clear ownership, measurable outcomes and defined performance indicators.

4.2. The plans include a core set of actions relevant to all EDs alongside actions specific to individual sites. These plans are forward looking, setting trajectories for improvement in line with IMTP expectations, and ensuring actions are linked to quantifiable impact.

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

5.1. Urgent and Emergency Care (UEC) remains a high-risk operational domain for the Health Board, with sustained demand, constrained flow, workforce fragility and system dependencies creating ongoing exposure to patient safety, quality, workforce and reputational risk.

5.2. The risks below reflect both current system pressures and delivery risks associated with the UEC Programme, including the 90-Day Improvement Plan. These risks are actively monitored and managed through established governance arrangements, with clear escalation routes to Executive and Board level.

5.3. ED exit block remains a significant risk factor, driven by delays in transferring admitted patients into inpatient beds. This contributes to increased 12-hour breaches, corridor care, heightened clinical risk and adverse impacts on staff wellbeing. Mitigations include cohorting of admitted patients, standardised specialty response times, daily performance grip on ED exit metrics and direct Executive scrutiny of site-level flow constraints

5.4. Delayed pathways of care and discharge further exacerbate system congestion, with inconsistent application of Discharge to Recover and Assess (D2RA) and Home First principles resulting in unsafe bed occupancy levels. This risk is being addressed through Executive-led reviews of longest-stay patients, weekly system-wide discharge reviews, strengthened accountability for discharge ownership and targeted intervention work to improve D2RA compliance and data quality.

6. ARGYMHELLION / RECOMMENDATIONS

6.1. Gofynnir i'r Pwyllgor/Cyfarfod/Grŵp / The Committee is asked to:

6.1.1. **Note** progress and current risk position within the UEC 90-Day Improvement Planning
6.1.2. **Take assurance** that robust governance and mitigations are in place
6.1.3. **Support** continued delivery of the UEC Programme aligned to the IMTP 2026–2029
6.1.4. **Acknowledge** the critical role of workforce investment in sustaining improvement
6.1.5. **Endorse** ongoing monitoring and review through Board and Committee structure

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 Care 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	Choose an item.	
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 reputational risk to the Health Board of lengthy delays and potential harm	
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 & Information Governance Committee

VALUE & SUSTAINABILITY PROGRAMME

Date of Meeting	23 June 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	Russell Caldicott: Executive Director of Finance

Report Purpose	For Noting

Executive Summary

Purpose:

To provide assurance to the Performance, Finance and Information Governance Group (PFIG) on the alignment and delivery readiness of the Value & Sustainability (V&S) Programme at Month 2. The paper outlines the current savings position, highlights key risks to delivery and identifies actions undertaken and those further required to ensure the programme delivers sustainable financial balance alongside improved outcomes, quality and patient experience.

Headline Summary of Issues:

- £45.2m savings opportunities have been identified against a £46m target, however there is a material gap between identified opportunities and assured Green RAG savings.
- The programme is progressing from early-stage identification to more mature, quantified opportunity development, however Clinical Variation & Service Reconfiguration workstream remains a key focus and is an undeveloped opportunity.
- The approach to defining and reporting non-financial value (outcomes, quality and experience) is currently in development, with work underway through the Benefits Realisation Framework and Value Maturity Assessment Framework to strengthen consistency, improve measurement and provide clearer assurance that financial improvements are aligned with patient benefit.

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 2:

- £45.2m savings opportunities identified vs £46m target.
- Only £4.6m rated green (budget releasing), £8.7m green (non-budget releasing) and £1m red, with £30.9m in pipeline.

Savings Plan by V&S Workstream

Workstreams	Green * (Budget Releasing)	Green * (Non Budget Releasing)	Red	Pipeline	TOTAL
1. Workforce	1,591,620	6,621,517	172,633	9,731,049	18,116,819
2. Medicines Management				12,828,000	12,828,00
3. Non-Pay & Procurement	956,317	34,913	18,520	3,538,000	4,547,750
4. Continuing Health Care (CHC)	2,000,000	124,950	0	3,500,000	5,624,950
5. Clinical Value & Service Reconfiguration		1,926,367	0	1,000,000	2,926,367
Other	85,600		798,978	320,000	1,204,578
TOTAL	**4,633,537**	**8,707,747**	**990,130**	**30,917,049**	**45,248,464**

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

This profile is not unexpected at this early stage of the financial year, but highlights the need for strong delivery grip, timely validation and clear accountability to convert opportunities and Red RAG schemes into assured value.

High-value opportunity areas have been identified but require further quantification, including within the Clinical Variation workstream:

- Theatre productivity
- Outpatient productivity
- Demand management
- Patient flow and length of stay

The programme is transitioning from high-level opportunity identification to detailed, quantified delivery planning, supported by executive-led deep dives in priority areas (e.g. Workforce, Medicines Management, Non-Pay & Procurement and Continuing Health Care (CHC).

Work is underway to strengthen benefits realisation and value measurement, including new frameworks to capture both financial and non-financial benefits.

Risks & Implications:

- **Financial risk:** Failure to close the savings gap risks not achieving statutory financial balance, increasing reliance on non-recurrent measures and undermining financial recovery.

- **Delivery risk:** Heavy reliance on unvalidated pipeline schemes creates uncertainty and reduces confidence in in-year delivery.
- **Strategic risk:** Immaturity of the Clinical Variation workstream could result in missed system-level productivity gains and continued unwarranted variation.

Actions Undertaken or In Progress:

- **Executive-led deep dives across key workstreams** (Workforce, Medicines Management, Non-Pay & Procurement, CHC) to identify and accelerate opportunities.
- **Development and implementation of a Benefits Realisation Framework** (May 2026) to ensure consistent tracking of financial and non-financial value.
- **Introduction of a Value Maturity Assessment Framework (VFMA)** to embed value as a strategic intent of the organisation.
- **Planned alignment of value metrics with Major Change Programmes** to ensure transformation delivers measurable outcomes and productivity improvements.
- **Strengthening focus on quantifying high-impact opportunities** (e.g. theatres, outpatients, flow, demand management).
- **Establishing a rolling pipeline of opportunities** to improve financial resilience and reduce reliance on short-term measures.

Ask of the Group:

The Committee is asked to:

- **Note** the current savings gap and reliance on early-stage pipeline and Red RAG opportunities.
- **Support** strengthened delivery grip, including validation, accountability and pace of implementation.
- **Support** prioritisation of the Clinical Variation workstream, particularly the rapid quantification of high-impact productivity opportunities.
- **Endorse** continued development of value-based approaches, ensuring alignment between financial delivery and improvements in outcomes, quality and experience.

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.

PFIG	Performance, Finance & Information Governance
V&S	Value & Sustainability
NHS	National Health Service
BCUHB	Betsi Cadwaladr University Health Board
RAG	Red, Amber, Green
CHC	Continuing Health Care
UEC	Urgent Emergency Care
VFMA	Value Framework Maturity Assessment
BAF	Board Assurance Framework

Value & Sustainability Programme

1. SITUATION

1.1 This paper provides assurance to the Performance, Finance and Information Governance Group (PFIG) on the alignment, governance and delivery readiness of the Value & Sustainability Programme. It summarises the current position at Month 2, identifies key risks and actions required to ensure the programme delivers assured value in line with national expectations.

2. BACKGROUND

2.1 The Value & Sustainability (V&S) Programme is the Health Board's primary mechanism for responding to the dual challenge set out in the NHS Wales Planning Framework: to achieve financial balance while continuing to improve outcomes, quality and experience for patients. The programme has been deliberately designed to reflect national policy direction, recognising that long-term financial sustainability cannot be achieved through cost control alone, but must be delivered through improving value in how care is designed, delivered and resourced.

2.2 Consistent with the principles of Prudent Healthcare, A Healthier Wales and the national Value in Health agenda, the programme defines value as the relationship between the outcomes that matter to patients and populations and the resources used to achieve them. This approach places emphasis on reducing unwarranted variation, improving productivity and patient flow, optimising the use of workforce and medicines, removing waste and low-value activity and redesigning pathways where this leads to better outcomes and more sustainable services. The programme therefore brings together financial, clinical and operational perspectives into a single, integrated framework, rather than treating savings as a purely financial exercise.

2.3 Therefore, our V&S Programme has been established (and is in a state of maturity) to translate national strategy for value and sustainability in NHS Wales into practical, local delivery across BCUHB.

2.4 National policy, including the NHS Wales Planning Framework, the Cabinet Secretary's enabling actions, A Healthier Wales, and the Value in Health agenda, consistently emphasise that:

- Financial sustainability depends on improving value, not simply reducing spend
- Unwarranted variation in clinical practice is a major driver of inefficiency and poorer outcomes

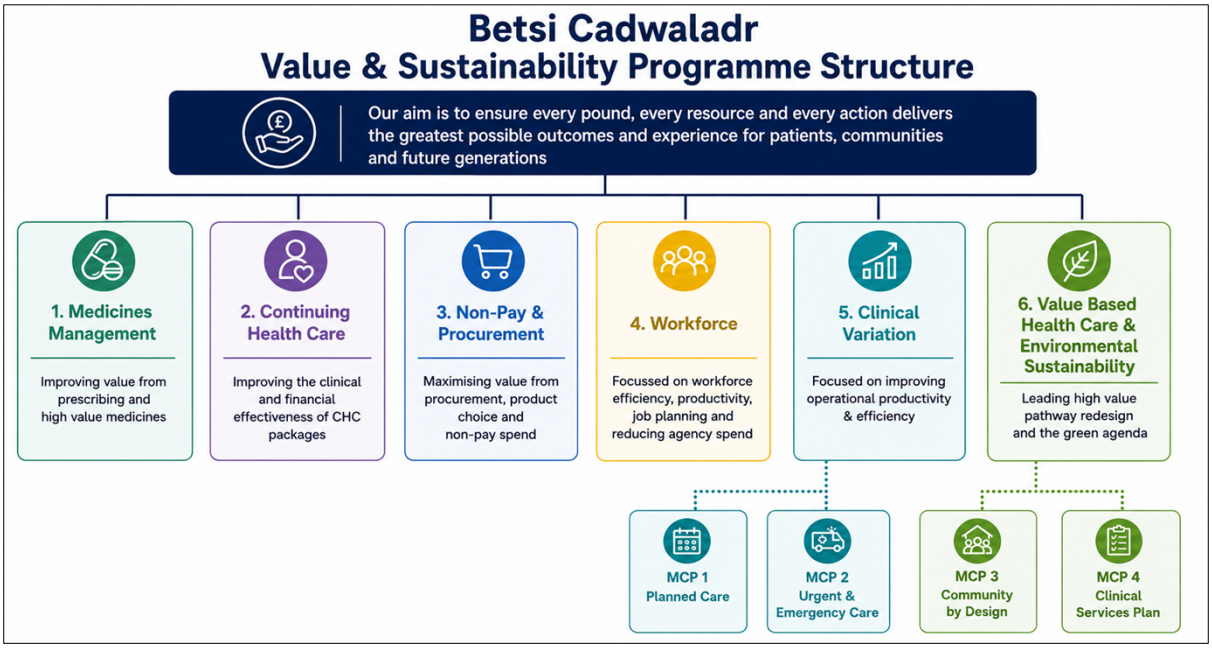
- Productivity, patient flow and demand management are critical to system sustainability
- Workforce and service sustainability must be considered alongside cost
- Capacity and investment should be redirected towards activities that deliver the greatest benefit for patients and populations

2.5 The BCUHB V&S Programme deliberately replicates this national steer, moving away from a traditional, siloed cost improvement model and instead providing an integrated value framework that considers:

- Financial sustainability (cost, efficiency and productivity)
- Clinical outcomes
- Patient/staff experience
- Operational performance (flow, length of stay and access)
- Workforce & environmental sustainability

2.6 Delivery is structured across six workstreams that reflect the nationally recognised drivers of value (see Fig. 1), with the work explicitly aligned to, and supporting delivery of, the Health Board's Major Change Programmes by translating strategic transformation into measurable financial, clinical and operational value at a service and pathway level.

Fig 1 – V&S Workstream Structure



2.7 The Programme is therefore positioned as a delivery vehicle for national strategy, bridging policy intent and service-level change and supporting the Health Board to deliver financial recovery in a way that is clinically credible, operationally sustainable and focused on improving outcomes for patients.

3. SPECIFIC MATTERS FOR CONSIDERATION

3.1 Overall Programme Position

At Month 2 of 2026/27, the programme has identified (see Fig. 2) a total savings opportunity of £45.2m, against a target of £46m comprising of:

- £4.6m Green (Budget Releasing) RAG schemes
- £8.7m Green (Non-Budget Releasing) RAG schemes
- £1m Red RAG schemes
- £30.9m Pipeline schemes

This profile is not unexpected at this early stage of the financial year, but highlights the need for strong delivery grip, timely validation and clear accountability to convert opportunity into assured value.

Fig 2 – M2 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	1,591,620	6,621,517	172,633	9,731,049	18,116,819
2. Medicines Management				12,828,000	12,828,00
3. Non-Pay & Procurement	956,317	34,913	18,520	3,538,000	4,547,750
4. Continuing Health Care (CHC)	2,000,000	124,950	0	3,500,000	5,624,950
5. Clinical Value & Service Reconfiguration		1,926,367	0	1,000,000	2,926,367
Other	85,600		798,978	320,000	1,204,578
TOTAL	**4,633,537**	**8,707,747**	**990,130**	**30,917,049**	**45,248,464**

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

To close the financial savings gap, the Executive Medical Director and Programme Director have facilitated 'Deep Dives' with workstream leads for; Workforce; Medicines Management; Non-Pay & Procurement and Continuing Health Care (CHC), with further opportunities being scoped around clinical procurement standardisation, corporate non-pay, estates rationalisation, further medicines management opportunities (blue-tech 'high cost drugs, oral nutritional supplements) and further CHC opportunities (acquired brain injury).

Whilst the Clinical Variation & Service Reconfiguration workstream is strategically critical to the delivery of sustainable value and is central to national priorities on Prudent Healthcare, productivity improvement and Value-Based Healthcare, at present this workstream remains at an early stage of maturity, with identified opportunities largely held at a high level and limited quantification of the potential value available.

To strengthen assurance and support delivery planning, there is a clear need to move from thematic identification to robust opportunity quantification, particularly in the following areas:

- **Theatre productivity**, including utilisation, session productivity, start and finish times, cancellation rates and case mix.
- **Outpatient productivity**, including follow-up ratios, new-to-follow-up balance, clinic utilisation and alternative models of care.
- **Demand management**, including referral management, pathway thresholds and unwarranted variation in access and intervention rates.
- **Patient flow and length of stay**, including discharge processes, internal flow constraints and variation in clinical decision-making.

These areas represent some of the largest system-level opportunities for improving outcomes and productivity and are directly aligned to the objectives of the Planned Care and UEC Major Change Programmes.

As the programme matures in-year, a core objective is to maintain a **rolling pipeline of value opportunities**, strengthening financial resilience by enabling forward planning, sustained delivery of value and reduced reliance on reactive, short-term measures.

By Q4, we also seek to embed a **value-based approach to decision-making**, ensuring that investment and disinvestment decisions are consistently informed by their impact on outcomes, quality, productivity and sustainability, in line with national Value in Health and Prudent Healthcare principles.

3.2 Non-Financial Metrics of Value

While the Value & Sustainability Programme has an established approach to identifying and tracking financial benefits, the consistent definition, measurement and reporting of non-financial metrics of value remains an area for development (as identified in our Internal Audit Report Jan-26).

At present, non-financial benefits are variably articulated across schemes and workstreams, with greater maturity in areas such Value-Based Health Care (linked to the projects funded via the ring-fenced £3.1m value fund) and less consistent in areas such as Clinical Variation (linked to the Major Change Programmes). This limits the ability to provide full assurance that financial improvements are being delivered alongside and not at the expense of, quality and outcomes. The Programme is therefore taking steps to strengthen this aspect of delivery, including:

- Development of a **Benefits Realisation Framework** that explicitly requires schemes to identify and track non-financial benefits alongside financial impact (completed May-26).

- Introduction of a **Value Maturity Assessment Framework (VFMA)** to support services in embedding value-based decision-making into routine practice (completed May-26).
- Alignment of value metrics with **Major Change Programmes**, ensuring that transformation activity delivers measurable improvement in outcomes, productivity and sustainability (to be undertaken June-26)

To provide robust assurance, future reporting will need to demonstrate clearer and more consistent linkage between financial delivery and non-financial value, particularly in relation to outcomes, productivity and patient experience. This will be essential to evidencing alignment with national expectations and supporting confident decision-making.

4. KEY RISKS / MATTERS FOR ESCALATION

4.1 Savings Gap & Pipeline Maturity

Identified savings (£45.2m) remain slighlty below the £46m target, however the majority (£31.9m) held in early-stage pipeline schemes and Red RAG rated limited assured delivery.

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 scale of the delivery gap and reliance on pipeline
- **Support** strengthened delivery grip, validation and accountability

4.2 Clinical Variation Workstream Maturity

The Clinical Variation & Service Reconfiguration workstream remains at an early stage, with high-level opportunities and limited quantified benefit, despite being critical to sustainable value delivery.

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

Potential Impact
- Failure to realise largest system productivity and value opportunities
- Ongoing unwarranted variation and inefficiency

Board / Committee ask:

- Note the immaturity and associated delivery risk
- Support prioritisation of quantified opportunity development (e.g. theatres, outpatient productivity, flow, demand management)

5. RECOMMENDATIONS

a. 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	

Performance Finance & Information Governance Committee

PROGRESS ON COMMUNITY BY DESIGN

Dyddiad y Cyfarfod Date of Meeting	23 June 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Tehmeena Ajmal – Chief Operating Officer
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Tehmeena Ajmal – Chief Operating Officer

Pwrpas yr Adroddiad Report Purpose	For Discussion

Crynodeb Gweithredol / Executive Summary

Community by Design (CbD) is a nationally initiated programme aligned to a long-standing Welsh Government policy direction towards integrated, preventative and community-based care.

In December 2025 a national strategy event reinforced that CbD should be understood not as an additional programme, but as a core operating framework for the health and care system, positioning primary and community services as the coordinating hub of care.

Within Betsi Cadwaladr, there is a strong and consistent message that delivering this ambition requires:

- A fundamental shift from reactive, service-led models to proactive, population-health approaches
- Designing care around people and place, with neighbourhood-level multidisciplinary teams
- Addressing system fragmentation, siloed working and unwarranted variation

This paper discusses the development of metrics which might be developed to track whether services are being transferred into a community setting and to measure impact and effectiveness of any change.

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**
Executive Committee	13/05/2026	Discussion on core elements of Community by Design, next steps for discovery and design phases
PPHP	15/05/2026	Discussion on core elements of Community by Design, and the implications for the priorities and strategic direction of the Health Board
Health Board	28/05/2026	Discussion on core elements of Community by Design, and the implications for the priorities and strategic direction of the Health Board

Acronymau / Rhestr Termau **Acronyms / Glossary of Terms**	
CbD	Community by Design

PROGRESS ON COMMUNITY BY DESIGN

1. Y SEFYLLFA / SITUATION

1.1. Policy and strategic direction in Wales towards community-led provision have been strong and consistent for more than fifteen years, with a view that implementation will lead to improved health outcomes. Although there has been extensive activity, innovation, and examples of excellent work, the transformation remains incomplete with hospital-centric models still prevailing across Wales.

1.2. To drive forward action to achieve this shift in focus and activity a national Community by Design Transformation Programme has been established to accelerate progress and to ensure that:

1.2.1. People and staff can navigate care pathways easily
1.2.2. Appointments are timely and appropriate to need, in the right setting
1.2.3. Staff well-being is enhanced
1.2.4. Population health management and prevention are systematically embedded into every contact.

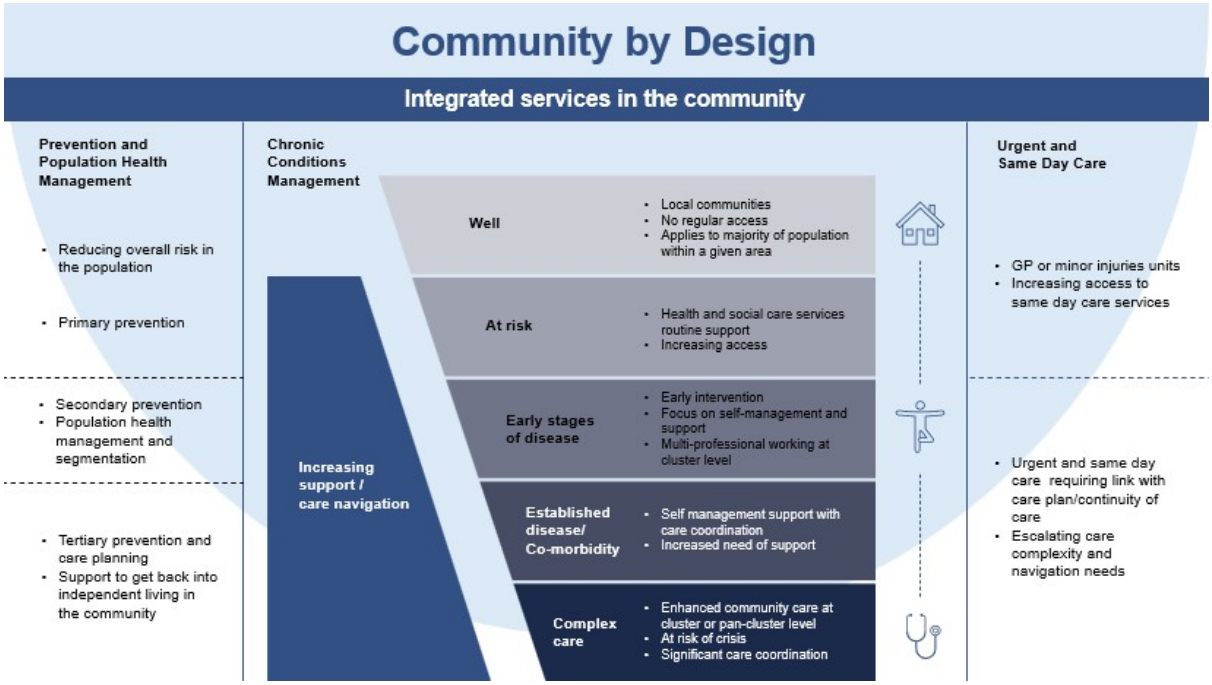
1.3. Underlying principles include designing services with communities, working in partnership, including with local communities, ensuring actions are clinically driven, and moving beyond primary care to focus on the whole system, where activity is based in the community by default and in an acute setting by exception.

1.4. Both the national programme and local delivery are at the very early stages of development, providing the opportunity to discuss internally and with wider partners what this programme should deliver for the population of North Wales.

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

2.1. The national programme has developed three key pillars for the CbD programme:

2.1.1. prevention and population health management; urgent and same day care, and chronic conditions management, to deliver the following outcomes:
2.1.2. Improved population health and reduced inequalities
2.1.3. Reduction in prevalence and complications of chronic disease
2.1.4. Improved quality of life, particularly for frailty and end-of-life care
2.1.5. Improved access, experience and care coordination
2.1.6. Increased citizen activation and shared decision-making
2.1.7. A measurable shift in resource and cost towards community-based care



2.2. The purpose of this paper is to define appropriate measures and metrics to track transition of services into community settings, and to measure the impact and effectiveness of the change.

2.2.1. Improved population health and reduced inequalities
2.2.2. Reduction in prevalence and complications of chronic disease
2.2.3. Improved quality of life, particularly for frailty and end-of-life care
2.2.4. Improved access, experience and care coordination
2.2.5. Increased citizen activation and shared decision-making
2.2.6. A measurable shift in resource and cost towards community-based care

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

3.1. There are a number of risks associated with establishing measures for change of this nature. These include lack of digital infrastructure and interoperability; timelines for visibility of impact; gathering reliable data on experience and outcomes; measurement of impact where there are one or more long-term conditions present; and the likelihood that community-based intervention will not be cash releasing (although there may be indirect impact on costs). Mitigations will include:

3.1.1. Agreement of the core measures and metrics against expected outcomes across clinical, performance and quality domains
3.1.2. Ability to measure change across three-five years
3.1.3. Investment in digital systems which can track patients across primary, community and secondary care services
3.1.4. Review of measures developed elsewhere in the UK (for example associated with Ageing Well and the development of Urgent Care Response services in England)

4. ARGYMHELLION / RECOMMENDATIONS

4.1. Gofynnir i'r Pwyllgor/Cyfarfod/Grŵp / The Committee is asked to

4.1.1. Agree approach to development of metrics and measures
4.1.2. Endorse a focus across performance, quality and experience/outcomes domains
4.1.3. Endorse an approach which allows for measurement of impact across a three-five year period
4.1.4. Agree population health measures as a core component of evaluation

ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol **Link to Strategic Intent**	3. Improve Access, 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**	Choose an item. 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):** Public Sector Equality Duty [HTML] | GOV.WALES	Do/Yes: ☒	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Equality Act 2010 - Socio-economic Duty	Do/Yes: ☒	Naddo/No: ☐
	Canlyniad/Outcome:	

Has BCUHB provided evidence of 'Due Regard' to compliance of ther Socio-economic Duty when making strategic decisions?	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 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:	
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**	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.	

Performance Finance & Information Governance Committee

2026-27 BCU Finance Report – Month 2 (May)

Date of Meeting	23 June 2026
Publication Status	Open/ Public
	Not Applicable
Report Author name and title	Michelle Jones, Head of Financial Reporting Daniel Eyre, Head of Capital Development (Capital)
Lead Executive Team Member name and title	Russell Caldicott, Executive Director of Finance.

Report Purpose	For Noting

Executive Summary

This report provides a briefing on the on the financial position of the Health Board as at the end of Month 2 (May 2026) and includes an update on delivery of the approved Capital Programme and Savings delivery against target.

Finance Report

The Health Board submitted a deficit plan totalling £43m for the 2026/27 financial year, including the conditionally recurrent funding totalling £82m. If this funding is not secured from Welsh Government into 2026/27 the deficit increase to £125m. The deficit plan of £43m does not attain the key duty to break-even and the Health Board is required to develop a Financial Recovery Plan for Welsh Government to improve the outturn for 2026/27.

As at the end of Month 2 (May 2026) the Health Board is reporting an in-month deficit of £5.6m, which is £2.0m adverse compared to the Month 2 profiled financial plan deficit of £3.6m.

The Year-to-date position is reporting a deficit of £10.9m, £3.8m adverse to the planned year to date £7.2m deficit. The cumulative shortfall on savings delivery is £5m, with additional grip and control not yet fully captured in the savings plan contributing towards the overall position.

The below table summarises the monthly actual and forecast variance for 2026/27:

	2026/27 Monthly Variance													
	Actual		Forecast											
	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Year to Date Position	Full Year Forecast Outturn Position
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Total Monthly Surplus/ (Deficit)	(5.4)	(5.6)	(4.5)	(3.5)	(3.0)	(3.0)	(3.0)	(3.0)	(3.0)	(3.0)	(3.0)	(3.0)	(11.0)	(43.0)

The focus remains on conversion of identified opportunities contained within the Value and Sustainability Programme, including improvements in securing efficiencies and productivity across the five themes of (a) Medicines Management (b) Workforce (c) non-pay (d) Continuing Healthcare and (e) Clinical Value, productivity and efficiency.

In the period these schemes are developed and importantly implemented, the Health Board continues to seek to mitigate shortfalls in savings attainment through containing cost overruns through application of Welsh Government Grip and Control measures, additional actions implemented during 2025-26 continuing into 2026-27, to include:

- **Non-Pay Expenditure Controls** where this doesn't impact direct clinical care
- **Procurement –** Enhanced approvals for requisitions
- **Pay –** Oversight and controls placed upon external recruitment
- **Temporary Workforce –** Clinical Executive leadership oversight

Cash

Closing cash balance for May was £7.2m, including £3.6m cash held for revenue expenditure and £3.6m for capital projects. The Health Board is currently forecasting a closing cash balance for 2026-27 of (£35.1m) made up of (£40.5m) revenue cash and £5.5m capital cash.

Savings

The Health Board's financial plan requires a savings target of £46.0m to be delivered in 2026/27. The savings target is set at 2.4% based on recurrent budgets that exclude funds that are ringfenced. The Value and Sustainability approach is focused on delivering improvements within the core domains of Clinical Value, Workforce, Continuing Healthcare, Medicines Management and Non-Pay & Procurement.

As at the end of May (Month 2), the Health Board has identified £13.3m Green saving schemes. Of these savings £5.1m have been identified as recurring, with a full year effect of £7.6m and £8.2m are non-recurring savings. £13.2 is cash releasing with £0.1m made up of income generation and cost avoidance schemes.

Year to Date Savings delivery is £2.7m, of which £0.2m is recurring.

This is substantially behind the required £46m for the year and £3.8m requirement per month needed to attain the financial plan. Welsh Government are seeking for the Health Board to deliver the key duty and submit a balanced plan, which would require enhanced savings delivery.

The full year plan value of Red Schemes and pipeline opportunities totals £31.9m. It is now vitally important that the savings opportunities are increased and the identified opportunities convert to green schemes at pace, so as not to result in adverse performance in the early part of 2026/27, and avoid the necessity of additional recovery actions in future months.

Capital Programme

The approved Capital Resource Limit (CRL) for 2026/27 is £61.0m. Year to Date expenditure is £1.7m. The forecast outturn of £58.6m and subsequent variance relating to Royal Alex Hospital – Phase 1 and Electrical Infrastructure upgrade – Ysbyty Glan Clwyd, reflects a revised CRL agreed with Welsh Government. Once a revised CRL has been received, the Health Board will be forecasting spend in full against the revised CRL.

The Health Board is currently reviewing the overall estates strategy.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome, Evidence and Data**

Acronyms / Glossary of Terms	
IMTP	Integrated Medium Term Plan
CRL	Capital Resource Limit

BCU 2026-27 M2 Finance Report

***Please see Appendix A* - BCU 2026/27 M02 Finance Report – May 2026**

ASSESSMENT	
Link to Strategic Priorities	 1. Building an effective organisation If more than one applies, please list below: This paper aligns to the strategic goal of attaining financial balance and supports a number of organisational priorities.
Design Principles	Wise Spending
Corporate Risks and Board Assurance Framework	Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR) **Appendix A** **BAF risks** BAF SP14 – Estates & Capital *(There is a risk of failing to deliver and provide a safe and compliant built environment, equipment and digital landscape due to limitations in capital funding, adversely impacting on the Health Board's ability to implement safe and sustainable services through an appropriate refresh programme, could result in avoidable harm to patients, staff, public, reputational damage and litigation.)* BAF24-03 – Value Delivery & Financial Sustainability *(There is a risk that the Health Board will be unable to secure current non-recurrent (one-off) allocations in future financial years, as these allocations are conditional on meeting agreed financial plans. Failure to secure this resource will require services to operate within a significantly reduced financial envelope.* *The objective is to achieve long-term financial sustainability or maximise value from its spending).* **Link to Corporate Risk Register:** CRR24-06 Suitability and Safety of Sites CRR25-06 Delivery of the 2025/26 Financial Plan
Wellbeing of Future Generations Act – Wellbeing Goals	A Resilient Wales If more than one applies, please list below:

IMPACT ASSESSMENTS		
Equality	Yes: ☐	No: ☒

Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)	Outcome:	Not applicable
	If no, please include rationale:	
Socio-Economic Impact Assessment *Have you undertaken a Socio-Economic Impact Assessment*	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	The health board continues to assess the requirement for carrying out Equality Impact Assessments and Social-Economic impact assessments on a capital project by project basis.
Quality *Have you undertaken a Quality Impact Assessment Screening?*	**Enablers of Quality** Data to Knowledge	**Domains of Quality** Effective
	If more than one applies, please list below:	If more than one applies, please list below:
Wellbeing of Future Generations Act – Wellbeing Goals	A Resilient Wales	

Environmental /Sustainability Impact (5Rs)	If more than one applies, please list below:	
	No - Not Applicable	
	If more than one applies, please list:	
Armed Forces Covenant Due Regard Duty Have you considered the Armed Forces Covenant Due Regard Duty?	Yes: ☐	No: ☒
	Outcome:	No - Not Applicable
	If no, please include rationale:	
Data Protection Impact Assessment *Have you undertaken a Data Protection Impact Assessment Screening?*	Yes: ☒	No: ☐
	Outcome:	No personal data included in the report.
	If no, please include rationale:	
Counter Fraud Impact Assessment *Have you considered the counter fraud impacts*	Yes: ☒	No: ☐
	Outcome:	
	If no, please include rationale:	
Legal	There are no specific legal implications related to the activity outlined in this report.	
Reputational	Yes (Include further detail below)	
	Implications of deterioration of forecast to reputation.	
Resource Impact *(People / Financial)*	Yes (Include further detail below)	
	The Health Board is in receipt of £82m of conditionally recurrent funding from Welsh Government that requires attainment of the 2025/26 plan (a) delivery of financial balance £40m and (b) de-escalation from Special Measures £42m for these funds to be received recurrently (available for future financial years). If the plan is not improved upon and delivered the funding of £82m will be at risk of clawback from Welsh Government and this places risk on the sustainability of existing service models.	

Trugaredd
Compassion

Agored
Openness

Parch
Respect

Finance Report – Health Board May - Month 2 2026/27

Russell Caldicott
Executive Director of Finance

Executive Summary

Situation		• To provide assurance on financial performance and delivery against Health Board financial plans and objectives; and give early warning on potential performance issues. To make recommendations for action to continuously improve the financial position of the organisation, focusing on specific issues where financial performance is showing deterioration or there are areas of concern.
Statutory Financial Duties	**Revenue**	• The Health Board is reporting a £5.6m deficit for May, which is £2.0m worse than the planned deficit of £3.6m. This reflects a £1.3m shortfall in delivering planned savings during the month. • For the year to date, the deficit is £10.9m, which is £3.8m higher than the planned position of £7.2m. There is a cumulative £5m shortfall in savings delivery, further work underway to fully assess the impact of on-going enhanced grip and controls. • The forecast for 2026/27 remains a planned deficit of £43m, in line with the approved financial plan for the year.
	Cash	• Closing cash balance for May was £7.2m, including £3.6m cash held for revenue expenditure and £3.6m for capital projects. The Health Board is currently forecasting a closing cash balance for 2026-27 of (£35.1m) made up of (£40.5m) revenue cash and £5.5m capital cash.
	Savings	• The financial plan has set a savings target of £46.0m to be delivered in 2026/27 profiled equally across the financial year. • Full year forecast value of deliverable (Green) schemes total £13.3m, resulting in £32.7m still to be identified. • Year to Date Savings delivery is £2.7m. • Red schemes and pipeline opportunities total £31.9m, work is progressing to convert to deliverable schemes.
	Capital	• Approved Capital Resource Limit (CRL) for 2026/27 is £61.0m. Year to date expenditure is £1.7m.
	PSPP	• PSPP performance to be reported from end of Quarter 1.
Key Risks & Matters for Escalation		➢ The Health Board has submitted a deficit plan of £43m for the 2026/27 financial year, including £82m conditionally recurrent funding. ➢ Welsh Government requiring formation of a Financial Recovery Plan and improved outturn for the year. ➢ Focus will remain on converting opportunities to implementation of savings scheme to ensure delivery of the plan, in the interim continuing to apply enhanced grip and control actions, controls put in place 2025-26 continuing into 2026-27. ➢ Identification and delivery of green savings need to be progressed at pace, so as not to result in adverse performance in the early part of 2026/27 that will require recovery during the financial period. ➢ It is of note that the 2026/27 £43.0m planned deficit does not attain the key duty of the Health Board to achieve a balanced position, which would result in the £82m conditionally recurrent allocation being at risk. The Health Board asked to include this as a risk in year.

Key Performance Indicators

Month 2 Position

In Month: £202.9m against plan of £200.9m
£2.0m adverse position

YTD: £405.3m against plan of £401.5m
£3.8m adverse position

Forecast

Projection held at planned deficit but this is subject to inflationary risk.

£43.0m deficit

Month 2 Divisional Variance

West IHC	£1.9m adverse
Central IHC	£3.2m adverse
East IHC	£3.3m adverse
Womens	£0.6m adverse
MH & LD	£0.7m adverse
Commissioning Contracts	£2.9m adverse
ICD Primary Care	£0.4m favourable
ICD Regional Services	£2.3m adverse
Support Functions	£0.8m adverse
Other Budgets	£11.5m favourable

Savings

In Month: £2.5m against target of £3.8m
£1.3m adverse

Full Year Savings Delivery

£13.3m forecast against target of £46.0m
£32.7 adverse

(Red and pipeline opportunities totalling £31.9m are being developed)

Year to Date Income

£30.1m against budget of £28.6m

£1.5m favourable

Year to Date Pay

£203.9m against budget of £202.5m

£1.5m adverse

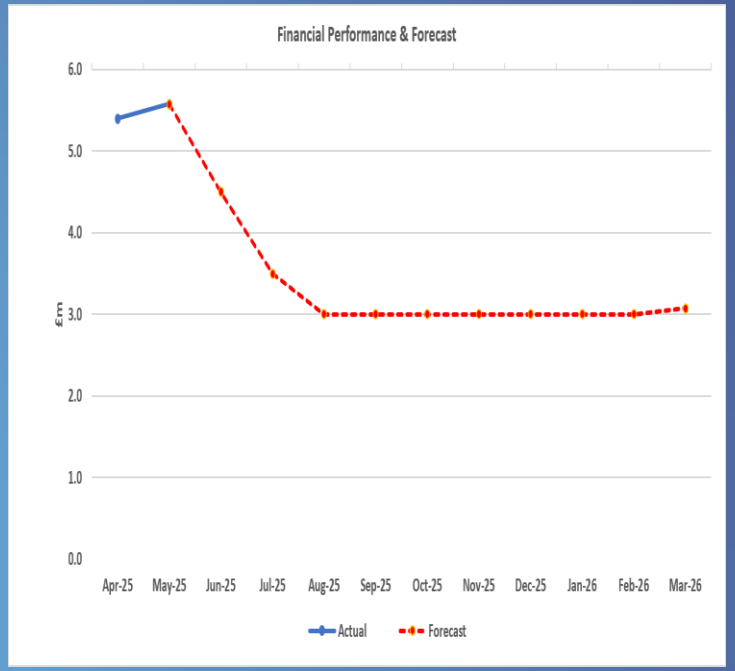
Year to Date Non-Pay

£231.4m against budget of £227.6m

£3.8m Adverse

Revenue Position

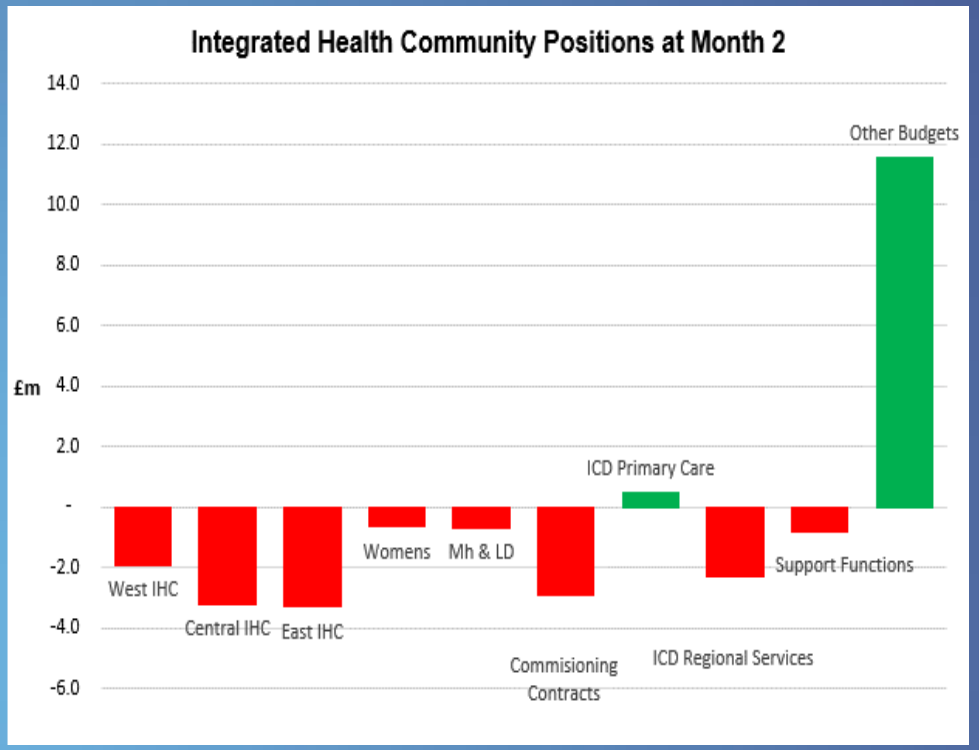
	Actual		Forecast										2026/27 Cumulative against Plan			
	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	Budget	Actual	Variance	Variance
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	%
Revenue Resource Limit	(197.0)	(197.3)	(196.2)	(197.8)	(195.8)	(197.3)	(196.7)	(196.0)	(197.6)	(196.7)	(194.7)	(198.5)	(394.3)	(394.3)	**0.0**	0.0%
Miscellaneous Income	(14.7)	(15.4)	(14.7)	(14.6)	(14.7)	(14.7)	(14.7)	(14.6)	(14.6)	(14.6)	(14.6)	(14.6)	(28.6)	(30.1)	**(1.5)**	5.2%
Health Board Pay Expenditure	101.6	102.4	101.5	101.4	101.6	101.7	101.5	101.5	101.5	101.9	101.7	101.5	202.5	203.9	**1.5**	0.7%
Non-Pay Expenditure	115.5	115.9	113.8	114.5	111.9	113.3	112.9	112.1	113.7	112.4	110.6	114.7	220.4	231.4	**11.0**	5.0%
Total Deficit / (Surplus)	**5.4**	**5.6**	**4.5**	**3.5**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.1**	**0.0**	**10.9**	**10.9**	
Planned Deficit	**3.6**	**3.6**	**3.6**	**3.6**	**3.6**	**3.6**	**3.6**	**3.6**	**3.6**	**3.6**	**3.6**	**3.6**	**7.2**	**0.0**	**7.2**	**100.00%**
Total Deficit / (Surplus) above Plan	**1.8**	**2.0**	**0.9**	**(0.1)**	**(0.6)**	**(0.6)**	**(0.6)**	**(0.7)**	**(0.6)**	**(0.6)**	**(0.6)**	**(0.5)**	**7.2**	**10.9**	**3.8**	



- The Health Board's in-month position is reporting a deficit of £5.6m and is £2.0m adverse to the Month 2 profiled financial plan deficit of £3.6m. The position reflects a £1.3m shortfall in savings delivery for the month.
- Year-to-date position is reporting a deficit of £10.9m, £3.8m adverse to the planned year to date £7.2m deficit. The cumulative shortfall on savings delivery is £5m, with additional grip and control not yet fully assessed in the plan contributing towards the overall position
- 2026/27 forecast position is to deliver the planned deficit of £43m, which is in line with the financial plan for the year.
- The focus will remain on containing cost overruns and recovering the in-month deficit. Enhanced Grip and Control actions implemented during 2025-26 will continue in 2026-27 as necessary.
  - **Non-Pay Expenditure Controls –** Additional controls will be widened to all non-pay categories which do not directly impact clinical care or are covered by reasonable adjustments" under H&S legislation. Controls are also extended to include Travel Bureau requests and orders which are processed directly to Stores.
  - **Procurement –** Review all pending requisitions in Oracle, cancelling any that are not critically urgent.
  - **Pay –** With immediate effect, a freeze on all non-clinical external recruitment and further oversight for any clinical posts prior to recruitment.
  - **Temporary Workforce –** Additional oversight and scrutiny for use of temporary workforce through the relevant Clinical Executive leadership.

Divisional Positions

	In Month				Cumulative				Forecast Year End Variance against the Planned Deficit
	Budget	Actual	Variance to Plan	Variance to Plan	Budget	Actual	Variance to Plan	Variance to Plan	
	£m	£m	£m	%	£m	£m	£m	%	£m
WG RESOURCE ALLOCATION	(197.3)	(197.3)	0.0	0%	(394.3)	(394.3)	0.0	0%	0.0
WEST INTEGRATED HEALTH COMMUNITY									
Management	0.1	0.1	0.0		0.2	0.2	0.0		0.1
West Area	18.5	18.5	0.0		36.6	37.0	(0.4)		(4.1)
Ysbyty Gwynedd	12.5	13.2	(0.6)		24.9	26.3	(1.4)		(6.5)
Facilities	1.2	1.3	(0.1)		2.5	2.6	(0.1)		(0.8)
Total West	32.4	33.1	(0.7)	-2%	64.2	66.1	(1.9)	-3%	(11.3)
CENTRAL INTEGRATED HEALTH COMMUNITY									
Management	0.1	0.1	(0.0)		0.3	0.3	(0.0)		(0.1)
Central Area	23.8	24.2	(0.3)		47.3	48.4	(1.1)		(9.6)
Ysbyty Glan Clwyd	15.5	16.2	(0.7)		30.3	32.4	(2.1)		(15.0)
Facilities	1.5	1.6	(0.0)		3.1	3.1	(0.0)		(0.3)
Total Central	41.0	42.1	(1.1)	-3%	81.0	84.2	(3.2)	-4%	(25.0)
EAST INTEGRATED HEALTH COMMUNITY									
Management	0.1	0.1	0.0		0.2	0.2	0.0		0.1
East Area	26.9	27.5	(0.5)		53.3	55.0	(1.6)		(12.9)
Ysbyty Wrexham Maelor	13.5	13.9	(0.4)		26.2	27.8	(1.6)		(11.4)
Facilities	1.4	1.4	(0.0)		2.8	2.8	(0.1)		(0.3)
Total East	41.9	42.9	(1.0)	-2%	82.5	85.8	(3.3)	-4%	(24.6)
Total Midwifery and Women's Services	4.5	4.7	(0.2)	-5%	8.7	9.4	(0.6)	-7%	(2.7)
Total Mental Health and LDS	18.2	17.4	0.8	5%	33.7	34.4	(0.7)	-2%	(7.8)
Total Commisioning Contracts	26.9	28.4	(1.6)	-6%	53.5	56.4	(2.9)	-5%	(13.3)
INTEGRATED CLINICAL DELIVERY PRIMARY CARE									
Covid Programmes	(0.0)	0.0	(0.0)		(0.0)	0.0	(0.0)		0.0
Dental North Wales	3.1	3.0	0.1		6.2	5.8	0.4		1.0
Community Dental Services	0.6	0.6	0.1		1.3	1.2	0.1		0.3
Other Primary Care	(0.1)	(0.0)	(0.0)		0.2	0.3	(0.1)		(0.3)
Total Integrated Clinical Delivery Primary care	3.7	3.5	0.1	3%	7.7	7.3	0.4	6%	1.0
INTEGRATED CLINICAL DELIVERY REGIONAL SERVICES									
Provider Income	(1.9)	(2.7)	0.8		(3.8)	(4.8)	1.0		2.1
Diagnostic and Specialist Clinical Support	7.2	8.4	(1.2)		14.3	16.8	(2.5)		(14.4)
Cancer Services	6.5	6.6	(0.1)		12.6	13.4	(0.8)		(6.3)
Total Integrated Clinical Delivery	11.7	12.2	(0.5)	-5%	23.1	25.4	(2.3)	-10%	(18.6)
Total Service Support Functions	15.0	15.6	(0.6)	-4%	30.2	31.0	(0.8)	-3%	(6.8)
Total Other Budgets	5.7	2.9	2.7	48%	16.9	5.4	11.5	68%	109.0
Total Health Board Position	**3.6**	**5.6**	**(2.0)**		**7.2**	**10.9**	**(3.8)**		**(0.0)**



- In-Month Position is reporting a deficit of £5.6m, which is £2.0m higher than the profiled Financial Plan deficit of £3.6m.
- The forecast position is to deliver a deficit of £43.0m, which is in line with the financial plan for the year.
- Further detail on Pay and Non-Pay spend is reported in Slide 6 and 11.
- £32m of reserves has been allocated to IHCs in Month to fund existing pressures.

Expenditure – Pay & Non-Pay

Pay Costs	2026-27 Actual		2026-27 Forecast										Cumulative			Full Year 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	14.7	14.6	14.7	14.7	14.7	14.7	14.7	14.7	14.7	14.7	33.0	27.9	5.1	187.1
Medical & Dental	23.3	23.5	22.6	22.6	22.7	22.7	22.6	22.6	22.6	22.7	22.7	22.6	43.0	46.8	(3.7)	288.9
Nursing & Midwifery Registered	31.2	31.5	31.4	31.3	31.4	31.4	31.4	31.4	31.4	31.5	31.4	31.4	61.5	62.7	(1.2)	400.3
Additional Clinical Services	15.3	15.6	15.5	15.5	15.5	15.6	15.5	15.5	15.5	15.6	15.6	15.5	29.3	30.9	(1.5)	198.2
Add Prof Scientific & Technical	4.4	4.4	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	9.1	8.8	0.3	50.6
Allied Health Professionals	6.8	6.8	6.7	6.7	6.7	6.7	6.7	6.7	6.7	6.8	6.7	6.7	13.2	13.6	(0.5)	85.9
Healthcare Scientists	1.9	1.9	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	3.8	3.8	0.0	21.5
Estates & Ancillary	4.6	4.7	4.8	4.8	4.8	4.9	4.8	4.8	4.8	4.9	4.9	4.8	9.4	9.3	0.1	61.8
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	0.2	0.2	(0.0)	1.2
Health Board Total	**101.6**	**102.4**	**101.5**	**101.4**	**101.6**	**101.7**	**101.5**	**101.5**	**101.5**	**101.9**	**101.7**	**101.5**	**202.5**	**203.9**	**(1.5)**	**1295.5**
Other Services (Incl. Primary Care)	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	5.4	6.3	1.0	38.1
Total Pay	**104.7**	**105.6**	**104.7**	**104.6**	**104.8**	**104.9**	**104.7**	**104.7**	**104.7**	**105.1**	**104.9**	**104.6**	**207.9**	**210.3**	**(2.4)**	**1333.6**

Non-Pay Costs as per Monitoring Return Table	2026-27 Actual		2026-27 Forecast										Cumulative			Full Year 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	22.4	22.4	22.4	22.5	22.6	22.7	22.7	22.7	22.7	22.7	45.5	44.6	1.0	270.3
Primary Care - Drugs & Appliances	11.1	10.6	12.0	12.5	11.1	12.2	12.0	11.4	12.5	11.4	10.9	11.7	22.6	21.7	0.9	139.4
Provider Services - Non Pay (excluding drugs & depreciation)	20.1	19.6	16.5	16.5	16.3	16.7	16.8	16.9	16.9	17.0	16.8	17.1	24.4	39.7	(15.3)	207.3
Secondary Care - Drugs	9.2	9.1	9.4	9.6	9.2	9.6	9.5	9.3	9.6	9.3	9.1	9.4	20.1	18.3	1.8	112.2
Healthcare Services Provided by Other NHS Bodies	33.4	33.9	33.6	33.6	33.6	33.5	33.6	33.5	33.6	33.5	33.5	35.4	67.4	67.3	0.1	404.7
Continuing Care and Funded Nursing Care	11.9	12.4	12.5	12.8	12.3	12.0	12.3	12.0	12.3	12.3	11.4	12.3	24.3	24.3	(0.0)	146.7
Other Private & Voluntary Sector	3.5	3.5	3.0	2.8	2.6	2.5	2.0	2.0	1.9	1.9	1.9	1.9	8.1	7.0	1.0	29.6
Joint Financing and Other	0.5	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.5	0.9	(0.3)	4.6
Losses, Special Payments and Irrecoverable Debts	0.3	0.3	0.5	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.5	0.7	(0.2)	4.5
Non-pay costs	**112.3**	**112.1**	**110.3**	**111.0**	**108.3**	**109.8**	**109.4**	**108.5**	**110.2**	**108.9**	**107.1**	**111.2**	**213.4**	**224.4**	**(10.9)**	**1319.2**
AME/DEL Depreciation	3.2	3.9	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5	7.0	7.0	0.0	42.1
Total non-pay	**115.5**	**115.9**	**113.8**	**114.5**	**111.9**	**113.3**	**112.9**	**112.1**	**113.7**	**112.4**	**110.6**	**114.7**	**220.4**	**231.4**	**(10.9)**	**1361.4**

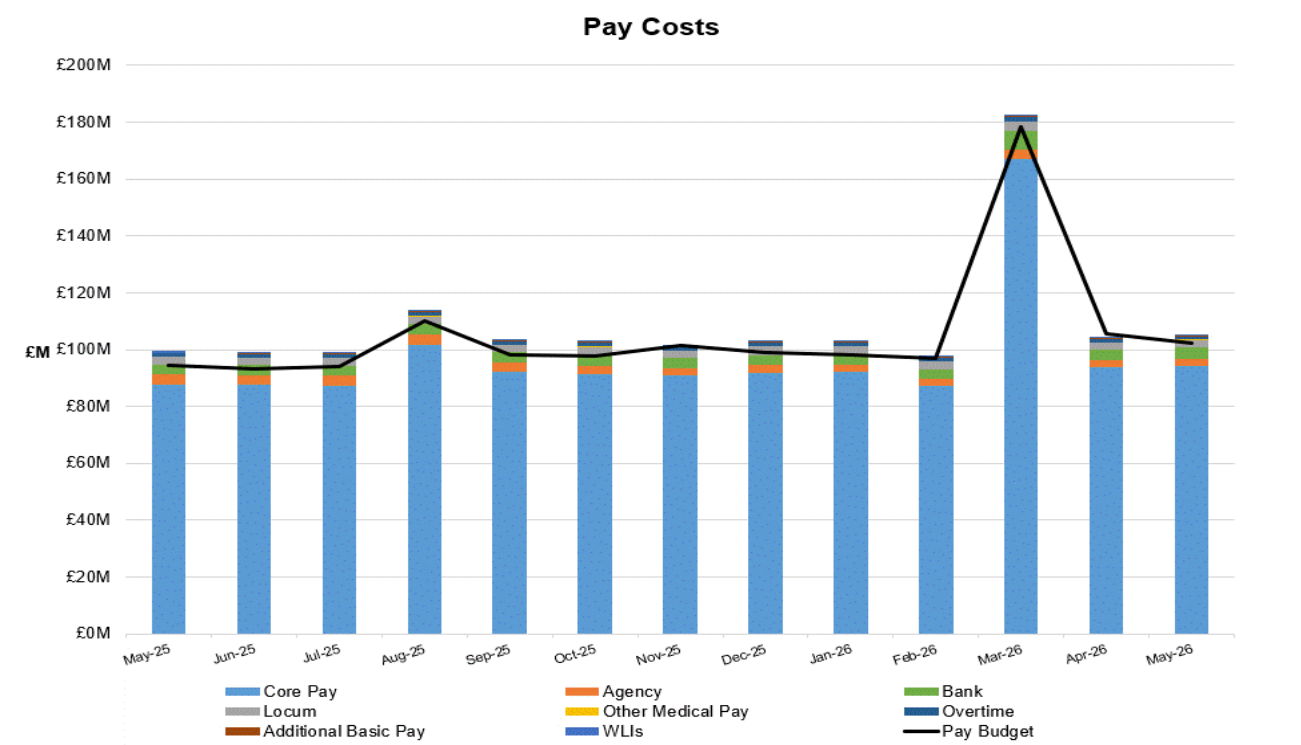
Health Board Pay:

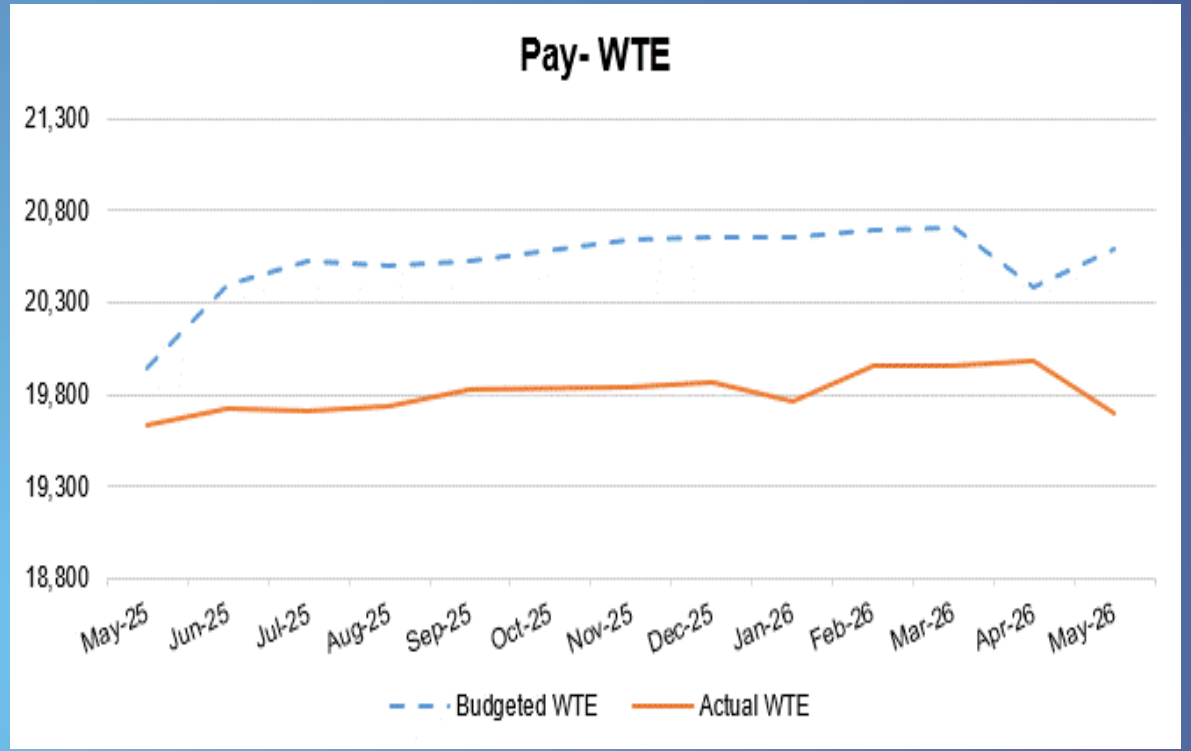
- Month 2 Provider Services Pay increased by £0.8m (0.8%) from previous month total pay.
- Variable Pay totals £11.3m for May, an increase of £0.2m from previous month driven by increases of £0.4m in Bank and £0.1m in Locum this is offset by reductions in other areas, partly impacted by the additional bank holidays in May.
- Further 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) reduced by £0.2m from previous month.
- Further detail on Non-Pay expenditure movements is reported in Slide 11.

Expenditure – Pay





Variable Pay	2025-26 M9 £m	M10 £m	M11 £m	M12 £m	2026-27 M1 £m	M2 £m	Total £m
Agency	2.9	2.6	2.3	3.1	2.5	2.5	5.0
Overtime	1.1	1.3	1.4	1.6	1.2	1.2	2.3
Locum	3.0	2.7	2.5	3.3	2.7	2.8	5.5
WLIs	0.5	0.5	0.4	0.4	0.4	0.4	0.9
Bank	3.6	3.8	3.7	6.5	3.7	4.0	7.7
Other Non Core	0.1	0.1	0.1	0.1	0.0	0.1	0.1
Additional Hours	0.4	0.4	0.4	0.4	0.5	0.4	0.9
Total	**11.6**	**11.2**	**10.8**	**15.3**	**11.1**	**11.3**	**22.4**

- May budgeted WTE increased by 209 WTE from April. See Slide 8 for further detail.
- Variable Pay totals £11.3m for May, an increase of £0.2m from previous month driven by an increase of £0.3m Bank and £0.1m reduction in additional hours.

Pay - WTE

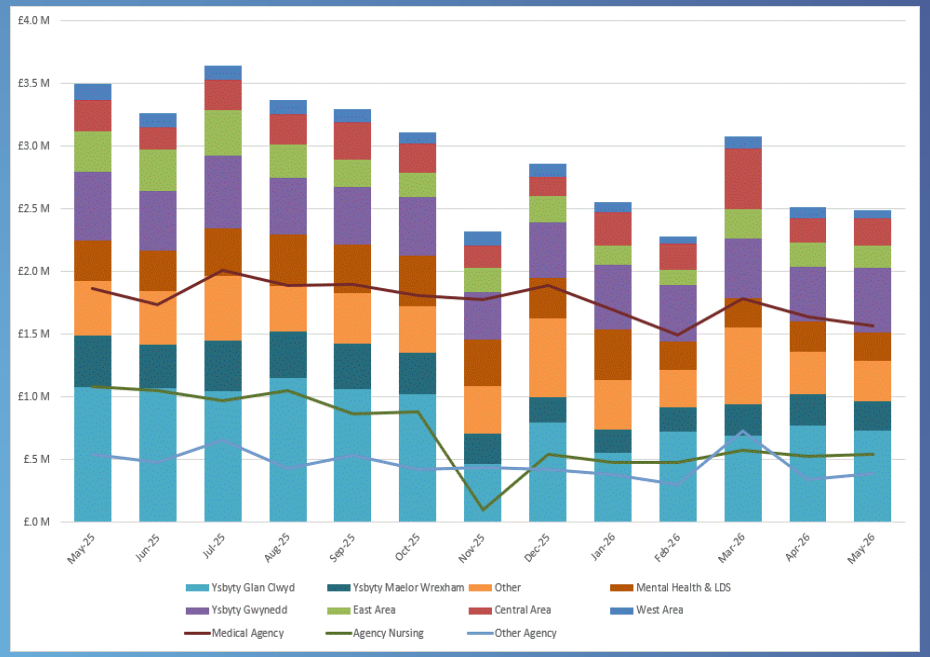
	2025/26						2026/27		
	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Movement M01 V M12
Budgeted WTE	20,575	20,637	20,649	20,656	20,693	20,705	20,384	20,593	209
Actual WTE	19,907	19,844	19,869	19,767	19,952	19,951	19,978	19,691	-287

- Budgeted WTE increased by 209 WTE in April from previous month, with the below table providing further detail on Budgeted WTE movements.
- Actual worked in May is 19,691, a reduction of 287 WTE from April.

	2025/26 WTE Budget						2026/27 WTE Budget			
	M07 Oct	M08 Nov	M09 Dec	M10 Jan	M11 Feb	M12 Mar	M01 Apr	M02 May	In Month Movement	Explanation of in-month movements (>5WTE)
West IHC - Management	8	8	8	8	8	8	8	8	0	
West IHC - West Area	1,575	1,572	1,572	1,572	1,573	1,573	1,567	1,585	18	Reserve allocation for cost pressures - Escalation areas 9.8wte, Contract Income (LA) 6.5wte, Skill Mix 0.13wte, HEIW income 1.48wte
West IHC - Ysbyty Gwynedd	1,839	1,838	1,840	1,841	1,846	1,855	1,836	1,885	50	Non-Rec Reserves allocation for cost pressures: Escalation areas 44.74WTE, ED British Red Cross new starters 1.48wte. Correction to reflect NSA funding allocated in 25/6 Dulas Ward increase by 2.84wte, Correction of RIGA WTE to reflect post now funded internally (1.00WTE), Increase in actual insourcing/1st outpatient Admin 0.33WTE and Orthopaedic PA funded from vacant Consultant sessions 1.00WTE
West IHC - Facilities	382	382	382	382	382	382	382	382	0	
Centre IHC - Management	8	8	8	8	14	14	15	15	0	
Centre IHC - Central Area	2,312	2,310	2,309	2,303	2,307	2,307	2,263	2,296	34	6.00wte Progress Chasers transfer from YGC, 9.50wte Office of Police and Crime Commissioner for SARC service, 3.83wte Childrens CHC packages, 7.59wte Cluster schemes for 26/27, 3.15wte Regional CAMHS A2A/NWJCC/Bids non recurrent posts, 1.45wte Managed Practices (RIGA), 0.20wte RIF additional funding, 1.72wte HEIW income, 0.59wte skill mix for recruitment
Centre IHC - Ysbyty Glan Clwyd	2,241	2,243	2,245	2,245	2,248	2,250	2,243	2,256	13	Ward 10, Heart Failure Business Case, EPU non recurrent students
Centre IHC - Facilities	422	422	421	421	419	419	420	420	0	
East IHC - Management	10	10	10	10	10	10	10	10	0	
East IHC - East Area	2,476	2,483	2,485	2,481	2,485	2,484	2,470	2,479	9	
East IHC - Ysbyty Wrexham Maelor	1,906	1,954	1,962	1,970	1,971	1,972	1,908	1,963	56	ED Nursing 20.5wte, Endoscopy sustainability 12.5wte, ED Progress Chasers 4.1wte, Cancer Specialist Nurses 3.91wte, Welshpool Dialysis 2.98wte, Intensivists 2wte, Community Heart Failure 2.00wte, ECG 2wte, General Medicine Secretaries 1.6wte, Rapid Diagnostics Clinics 1.39wte
East IHC - Facilities	365	365	365	365	365	366	365	365	0	
Midwifery & Womens Services	694	695	696	696	696	695	684	687	3	+0.64wte Bank (Escalation Reserves funding); +2.00wte Badgernet Development funded posts; -0.08wte B2 conversion to B3 Housekeeper to address historical cost pressure; -0.05wte Cons Income Budget Tidy Up Contra;
Mental Health & LDS	2,319	2,327	2,327	2,326	2,327	2,331	2,299	2,324	25	Setting 4.3wte budget for RIGA funded Stroke Services posts, 8.4wte Transformation fund OPMH Crisis Care OT, 12.4wte Transformation Fund ICAN Primary Care
COVID Programmes	0	0	0	0	0	0	0	0	0	
Dental GDS	14	14	14	14	14	14	14	14	0	
Dental CDS	168	168	167	165	165	165	166	166	0	
Other Primary Care	15	15	15	15	15	15	15	15	0	
Diagnostics & SCS	1,024	1,028	1,028	1,029	1,031	1,030	1,023	1,023	0	
Cancer Services	423	423	423	424	423	423	423	425	2	
Corporate	2,251	2,249	2,249	2,255	2,269	2,265	2,147	2,146	-1	
Med ED/R&D	123	124	125	125	125	127	126	126	0	
Health Board Total	**20,575**	**20,637**	**20,650**	**20,656**	**20,693**	**20,705**	**20,384**	**20,593**	**209**	

Pay Costs – Agency

	2026-27 Agency Spend £m												YTD Expenditure £m	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	0.2	0.8
Central Area	0.2	0.2	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.4	1.5
East Area	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.4	2.2
Ysbyty Gwynedd	0.4	0.5	0.5	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.9	5.1
Ysbyty Glan Clwyd	0.8	0.7	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	1.5	9.7
Ysbyty Maelor Wrexham	0.3	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.5	2.7
Mental Health & LDS	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.5	2.8
Womens	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	1.5
Other incl pan BCU Cancer Servcies and Corporate	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.4	2.2
Total Agency	**2.5**	**2.5**	**2.6**	**2.4**	**2.4**	**2.4**	**2.3**	**2.3**	**2.3**	**2.3**	**2.3**	**2.3**	**5.0**	**28.7**



- Agency expenditure for May (Month 2) is £2.5m representing 2.4% of total pay, the same as previous month. Monthly average spend in 2025/26 was £3.1m. 2026/27 Full year Agency forecast outturn is £28.7m (2.3% of total pay), a decrease of £7.9m compared to the £36.6m 2025/26 full year actual agency spend.

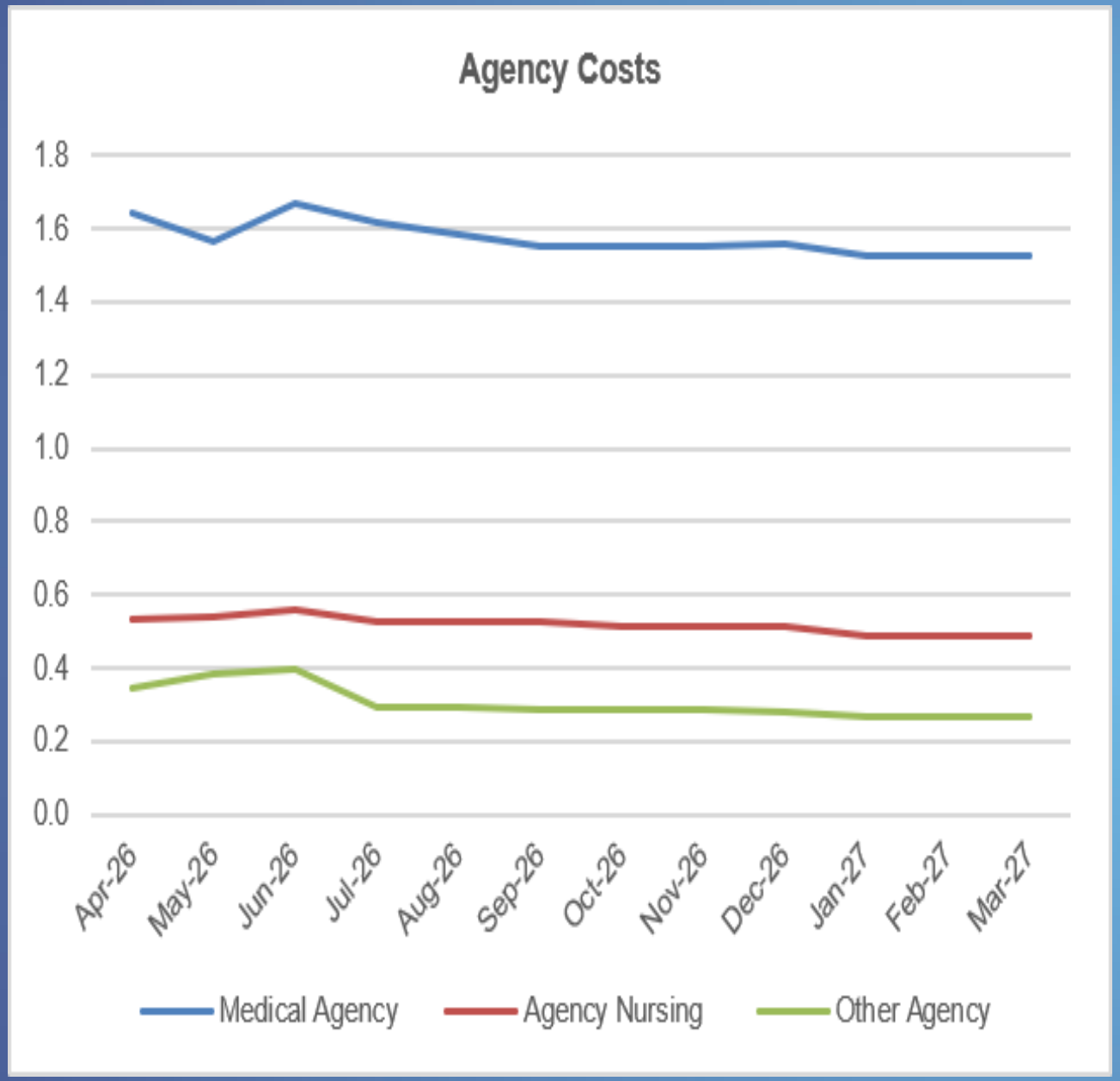
- Month 2 Medical Agency expenditure is £1.6m, the same as April. The monthly average medical agency expenditure for 2025/26 was £1.8m. In-month Medical Agency spend is predominantly within Ysbyty Glan Clwyd (£0.5m), Ysbyty Gwynedd (£0.4m), Ysbyty Wrexham Maelor (£0.1m), Women's (£0.1m) and Mental Health (£0.2m), covering medical vacancies and sickness.

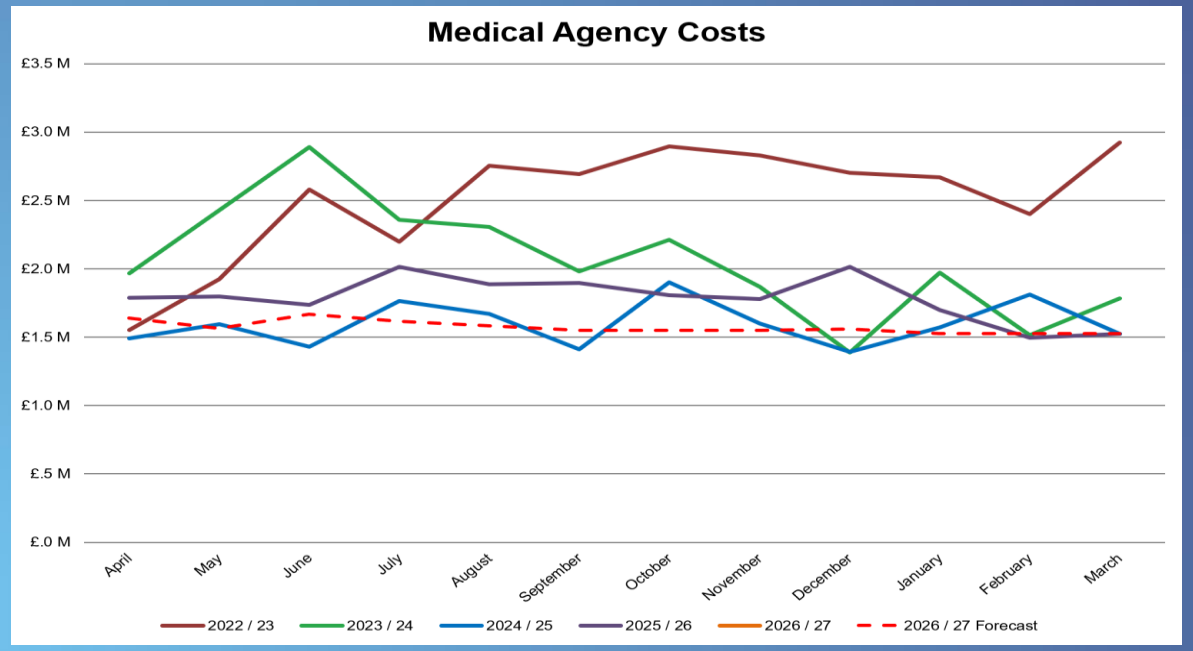
- Registered Nurse agency costs totalled £0.5m for the month and is the same as last month's spend. Agency Nurses are being used to staff unfunded escalated beds, low numbers of registered nurses available through the Nurse Bank and cover for ward vacancies to ensure Nurse Staffing Act ward staffing levels are maintained. In-month Nurse Agency spend is predominantly within Ysbyty Glan Clwyd (£0.2m), Ysbyty Maelor Wrexham (£0.1m), and Gwynedd (£0.1m).

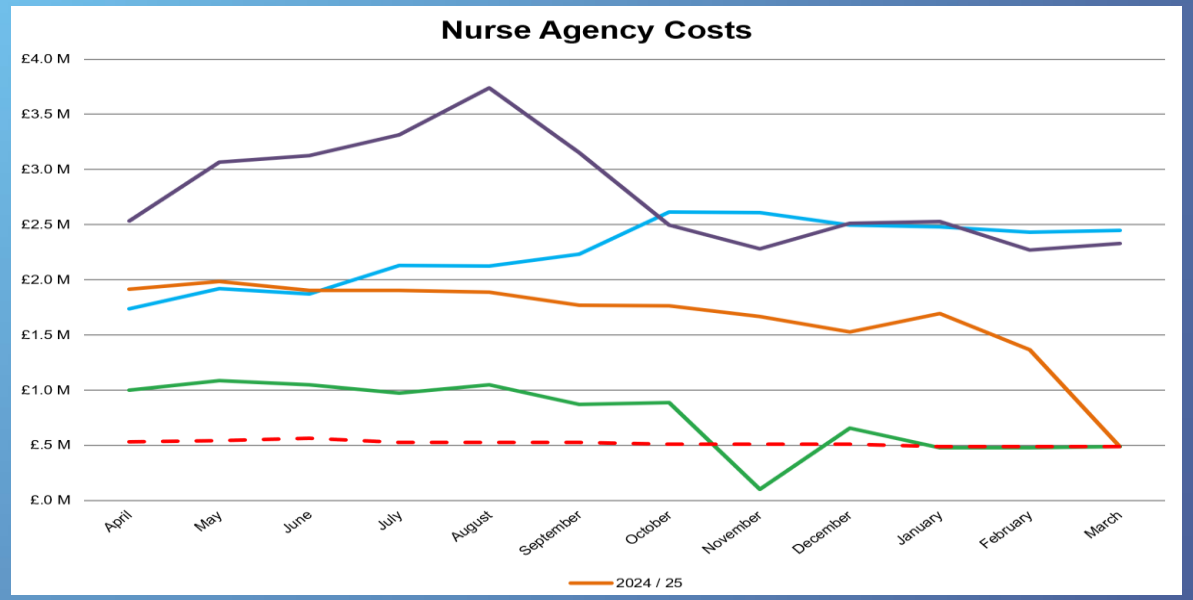
- Other agency costs totalled £0.4m in May, an increase of £0.1m from previous month spend and is £0.1m less than the 25/26 monthly average. Other Agency costs mainly consist of Allied Health Professionals spend of £0.4m in May.

- Work continues to support the Cabinet Secretary workforce enabling actions within the required areas.

Pay Costs – Agency

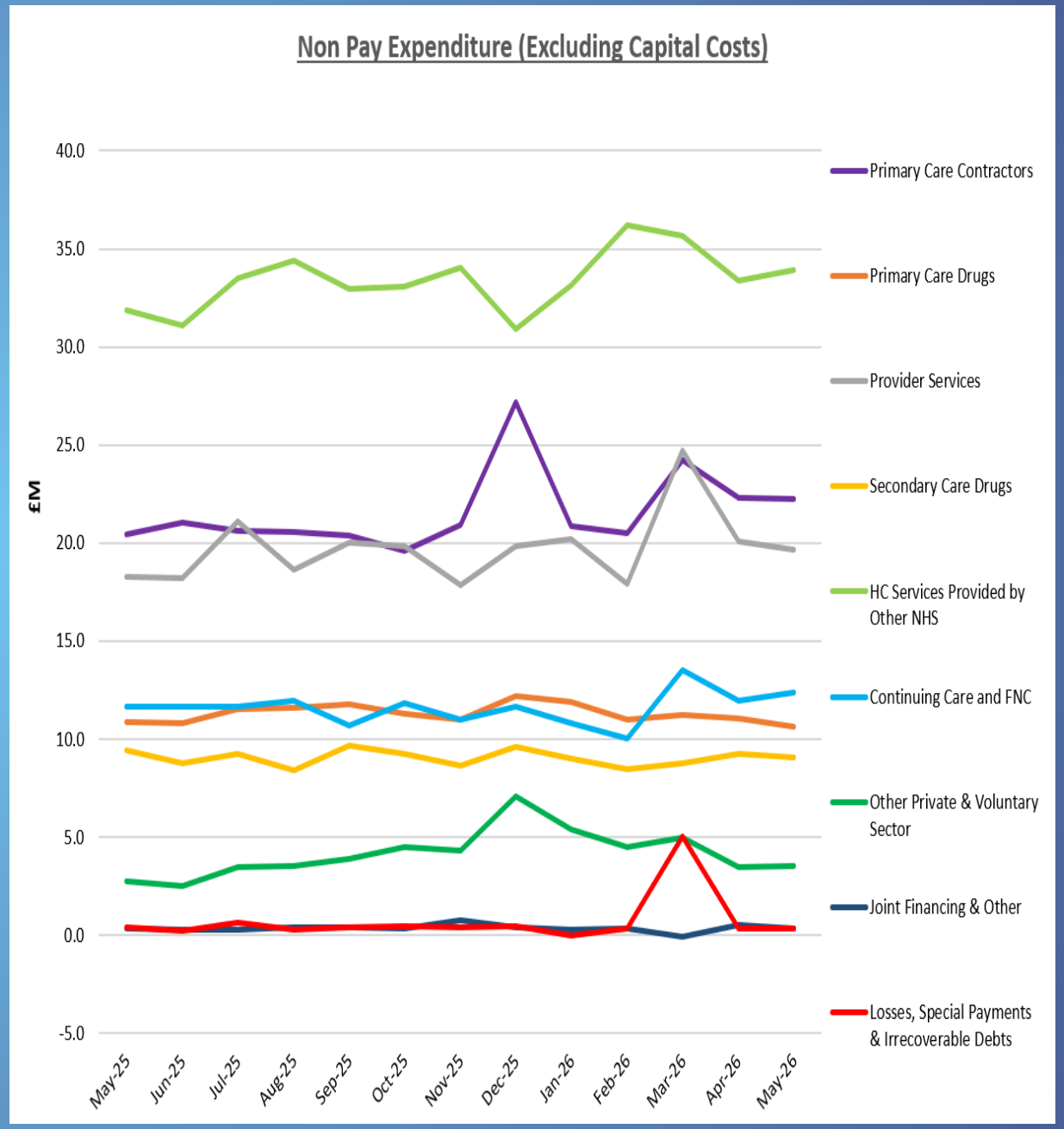






Expenditure - Non-Pay

- **Primary Care Contractor:** May in-month expenditure decreased by £0.1m (0.3%) from April spend.
- **Primary Care Drugs:** Expenditure is £0.5m (4.4%) less than April spend due to the overall number of Items Prescribed per Prescribing Day decreasing by 1.2%; March had 69,140 items prescribed per Prescribing Day compared to the average of 69,933 items per Prescribing Day in 2025/26
- **Provider Services Non-Pay:** Expenditure is £0.4m (2.0%) less than April spend, due to a reduction in Clinical Services & Supplies including M&S and implants. May expenditure is £3.5m higher than forecast, reflecting an in-month £1.3m shortfall in savings delivery, which has been partially offset by lower expenditure driven by the continued application of grip and control measures.
- **Secondary Care Drugs:** Expenditure decreased by £0.2m from previous month, with the in-month reduction being predominantly in Cancer Services Haemophilia drugs costs.
- **Healthcare Services provided by Other NHS Bodies**: Expenditure is £0.5m (1.5%) higher than previous month and forecast for the month due to increased costs reported against commissioning contracts including CoCH Obstetrics, Liverpool Heart & Chest and Christies plus increased spend associated with in-year funding for the 111 digital platform.
- **Continuing Health Care (CHC) and Funded Nursing Care (FNC):**Expenditure increased by £0.4m (3.6%) from previous month and is £0.3m higher than forecast for the month, of which £0.2m increase relates to MHLD CHC packages and an increase in adult care packages numbers and high cost 1:1 patients.
- **Other Private & Voluntary Sector:** In-month expenditure increased by £0.1m (1.9%) from previous month and is £0.3m higher than forecast for the month due to an increase in patient numbers and cost of private rehabilitation within Commissioning.



Allocations

	£m
Total Allocations Received	2,342.0
Total Allocations Anticipated	19.7
Total Welsh Government Income	**2,361.7**

- The Health Board is funded in the main from the Welsh Government allocation via the Revenue Resource Limit (RRL). Total Revenue Resource Limit (RRL) for the year is 2,361.7m.
- Confirmed allocations to date are £2,342.0m.
- Further anticipated allocations in year total £19.7m as detailed in the table.

Description	£m
Allocations Received	2,342.0
Total Allocations Received	**2,342.0**

Description	£m
Allocations anticipated	
Donated Asset Depreciation	1.5
Removal of IFRS-16 Leases (Revenue)	-3.9
WRP Forecast Contribution	-34.0
Substance Misuse	6.4
IM&T Refresh Programme	2.6
Prevention and Early Years fund allocation 2026/27	1.2
A4C Payaward funding	33.7
All Ages Mental Health Digital Solution 26/27	2.4
ESR charges 2026-27 "Future Workforce Solution - WG Support"	2.3
ESMCP Resources / CRS / MDVS / ARRP	0.7
GMS Disp Doctors / PADMS & List Size funding	1.2
Integration and Rebalancing Capital Fund (IRCF)	0.5
Neurodivergence Improvement Programme	2.0
Other	3.0
Total Allocations Anticipated	**19.7**

Risks (not included in financial position)

- 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.

	Risks	£m	Level
1	Risk of conditionally recurrent funding removed	£82.0m	Medium
2	Risk that Prescribing costs may rise by up to 4% when growth of certain items is included	£2.0m	Medium
3	Risk of unachieved savings	£20.0m	Low
4	Risk of final actual Band 2/3 costs being higher than the provision	TBC	Medium
5	Resident Doctors New contract impact	TBC	Medium
6	Impact of new contracts for Dental, GMS and Community Pharmacy	TBC	Medium
	Total Quantifiable Risks	**£104.0m**	

Balance Sheet & Cash

- Balance Sheet Position to be reported from Month 3, in line with Monthly Monitoring Return (MMR) Requirements.
- Closing cash balance as at 31st May 2026 was £7.182m, which included £3.572m cash held for revenue expenditure and £3.610m for capital projects.
- The Health Board is currently forecasting a closing cash balance for 2026-27 of (£35.061m) made up of (£40.517m) revenue cash and £5.456m capital cash.
- The forecast closing cash balance assumes working balance support of £3.875m for capital payments relating to Right of Use Assets and £8.658m for movements in revenue balances.

Capital

BUDGET 2025/26					
Capital Resource Limit 2025/26	**£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	46.9				
CRL	**61.0**				

CAPITAL PROGRAMME 2025/26	Initial Programme (£m)	Year to Date (£m)	Forecast Outturn (£m)	Current Over/Under Commitment (£m)	Comments
Divisions	4.5	0.2	4.5	0.0	Programmed planned works progressing supported by tenders/purchase orders.
Operational Estates	1.6	0.1	1.6	0.0	Programmed planned works progressing supported by tenders/purchase orders.
Medical Devices	5.0	0.1	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**	**0.4**	**14.1**	**0.0**	**Under Commitment**

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	24.6	0.0	20.1	(4.5)	The principle contractor is MTX. The demolition contractor has been appointed. Works on site is due to start in July 2027.
Replacement Diagnostic and Treatment Equipment	1.6	0.5	1.6	0.0	The first Linac has been installed with the second Linac due for installation in quarter 2.
Electrical Infrastructure upgrade - Ysbyty Glan Clwyd	2.4	0.2	4.5	2.0	Construction has progressed well to both substations and they are on programme.
TEF - Fire	2.4	0.0	2.4	0.0	TEF funding is across a number of projects and being delivered on over a 2 year programme.
TEF - Infrastructure	5.0	0.0	5.0	0.0	TEF funding is across a number of project sand being delivered on over a 2 year programme.
TEF - Decarbonisation	2.5	0.0	2.5	0.0	TEF funding is across a number of projects and being delivered on over a 2 year programme.
TEF - Mental Health	2.1	0.0	2.1	0.0	TEF funding is across a number of projects and being delivered on over a 2 year programme.
TEF - Infection Prevention Control	0.6	0.0	0.6	0.0	TEF funding is across a number of projects and being delivered on over a 2 year programme.
TEF - Decontamination	0.8	0.0	0.8	0.0	TEF funding is across a number of projects and being delivered on over a 2 year programme.
Redevelopment the Hospital Helipad at Ysbyty Gwynedd	1.0	0.1	1.0	0.0	The contractor has started on site and is on programme to complete quarter 3 of this financial year.
Diagnostic Equipment 2026-27	2.5	0.0	2.5	0.0	Design is complete and have commenced procurement preparations.
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	In detailed design stage, all works to be complete by March 2027.
North Wales Medical School Fees	0.4	0.0	0.4	0.0	Works to prepare business case is ongoing. Targeting business case submission to be quarter 4.
All Wales Capital	**46.9**	**1.3**	**44.5**	**-2.4**	

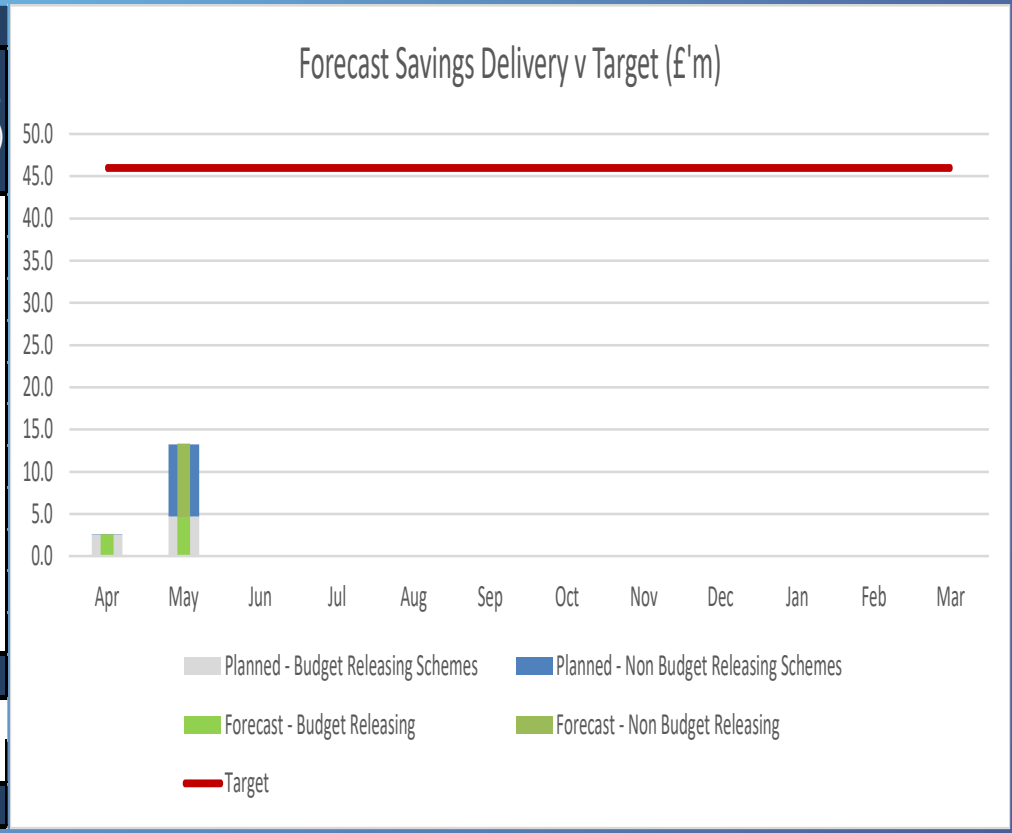
Total	**61.0**	**1.7**	**58.6**	**-2.4**	

- Approved Capital Resource Limit (CRL) for 2026/27 is £61m.
- The forecast outturn and subsequent va riance relating to Royal Alexandra Hospital – Phase 1 and Electrical Infra structure upgrade – Ysbyty Glan Clwyd, reflects a revised CRL agreed with Welsh Government. Once a revised CRL has been received the above variances will clear and the Health Board will forecast spending the CRL in full.

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 totals £13.3m, of which £5.1m is recurring, with a full year effect of £7.6m. £13.2m is cash releasing and £0.1m is income generation and cost avoidance schemes. Of the full year value only £4.6m of these savings have been identified as budget releasing.
- Year-to-date Savings delivery is £2.7m, against the target of £7.7m, resulting in a £5.0m shortfall, which is impacting on the revenue position..
- In-month delivery is £2.5m, against the £3.8m target.
- Red schemes and pipeline opportunities total £31.9m, 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	0.1	1.1	7.1	0.4	6.6	0.4	1.2	0.0	1.1
Central Integrated Health Community	0.0	0.4	9.6	0.4	9.2	0.4	1.6	0.0	1.5
East Integrated Health Community	0.2	1.1	9.1	1.1	8.0	0.4	1.5	0.2	1.3
MHLD	0.2	4.1	4.3	2.2	2.2	2.0	0.7	0.2	0.5
Commissioning Contracts	0.0	0.0	1.1	0.0	1.1	0.0	0.2	0.0	0.2
Womens Services	0.0	0.0	7.0	0.0	7.0	0.0	1.2	0.0	1.2
Diagnostic and Specialist Clinical Support	0.0	0.2	1.9	0.1	1.8	0.1	0.3	0.0	0.3
Cancer Services	0.0	0.0	1.8	0.0	1.8	0.0	0.3	0.0	0.3
Dental Services	0.0	0.0	0.2	0.0	0.1	0.0	0.0	0.0	0.0
Service Support Functions & Other Budgets	0.0	0.3	3.9	0.3	3.6	0.1	0.6	0.0	0.6
Grip and Control Savings	2.1	6.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Saving Total	**2.7**	**13.3**	**46.0**	**4.6**	**41.4**	**3.5**	**7.7**	**0.6**	**7.1**
Non Budget Releasing Savings				8.7	-8.7	4.1		2.1	-2.1
Accountancy Gains	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	**2.7**	**13.3**	**46.0**	**13.3**	**32.7**	**7.6**	**7.7**	**2.7**	**5.0**



Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Performance Finance and Information Governance Committee

INTEGRATED QUALITY AND PERFORMANCE REPORT (IQPR)

Dyddiad y Cyfarfod **Date of Meeting**	25 June 2026
Statws Cyhoeddi **Publication Status**	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad **Report Author name and title**	Ed Williams Dirprwy Cyfarwyddwr Perfformiad Deputy Director for Performance Olivia Shorrocks Cyfarwyddwr Perfformiad Director of Performance
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol **Lead Executive Team Member name and title**	Russell Caldicott Cyfarwyddwr Gweithredol Cyllid Executive Director of Finance

Pwrpas yr Adroddiad **Report Purpose**	For Noting

Crynodeb Gweithredol
Executive Summary

This report summarises the health board's current position regarding key performance metrics and identifies key actions required to strengthen outcomes and achieve sustained improvement.

This report provides the Committee with an objective assessment, underpinned by analysis, on significant performance issues alongside longer-term data and information on the improvements underway.

Members are asked to note the current position and assurance levels against key 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 health board approved its Integrated Performance and Accountability Framework 2026-29 in May 2026 and sets out within this the framework for integrated performance and accountability and processes to provide assurance on the comprehensive implementation of its Board Plan (Annual Plan/Integrated Medium-Term Plan). An effective framework for assessment and management of performance and accountability supporting a culture and practice of improvement is key to the ongoing development of an effective organisation delivering for the people it serves

1.2 The implementation of the framework will identify key performance metrics within specific domains with frequency of reporting articulated. It allows for clear differentiation from those services/directorates performing well with appropriate recognition, and areas that require support and escalation to improve. The framework indicates the response to be undertaken where performance does not improve in regards to a team or individual basis.

2.0 Y CEFNDIR / BACKGROUND

2.1 The Integrated Quality and Performance Report underpins the Performance and Accountability Framework and seeks to integrate key performance indicators (KPIs) taken from:

1. Key deliverables from the Annual and Integrated Medium-Term Plan (IMTP)
2. Special Measures de-escalation criteria
3. NHS Wales Performance Framework Measures
4. Key deliverables in response to Welsh Government (WG), Health Education and Improvement Wales (HIEW) and other formal recommendations

The integrated quality and performance report provides a clear 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

The health board has been on an improving trajectory, with reductions in waiting times reported until the end of March 2026, with performance exceeding the forecasted position. The new financial year has seen an increase in 2-year breaches with a small number of 3-year breaches noted.

The health board has formed 90-day operational improvement plans to support further improvement, though Cancer performance remains the worst in Wales as we seek to remove the backlog of treatments. There is a continued focus on operational delivery, productivity, validation, and targeted commissioning. A Recovery Director (interim) started mid-May with a focus on implementing planned care recovery plans from the start of quarter 2 (from July 2026).

Urgent Emergency Care (UEC) remains the highest safety and operational risk and priority for the Health Board, with support and focus from a dedicated intervention team supporting improvement. The Health Inspectorate Wales (HIW) Inspection of Ysbyty Glan Clwyd Emergency Department triggered a number of immediate assurances and prompted HIW to designate the service as one of significant concern.

3.2 Quality, safety and patient experience

Two never events were reported to May 2026 (totalling nine recorded in the last 12 months). There has also been an Increase in **n**ational reportable incidents with Median completion time remaining the best in Wales (75 days), though the proportion open over 90 days has increased.

Patient safety incident backlog remains high (4,976 open; 58.9% overdue) and refreshed recovery trajectories are being agreed with IHC's/Divisions. Progress noted against national Patient Safety Alerts (PSA)

There is a UK wide profemur hip recall affecting 821 patients in BCUHB with management plan and executive sponsorship in place. Complaints volume now totalling 311 (up from 291) and overdue cases are now 69 (up from 49) though

overall performance is 77.8% (and whilst down from 83.2%) this remains among the best in Wales.

3.3 Finance and sustainability

The financial plan highlights an £89m shortfall to deliver break-even, after a targeted £46m savings, this results in a planned 43m deficit which does not attain the key financial duty.

The year-to-date position (end of May 2026) is reporting a deficit of £10.9m, (£3.8m adverse to the planned year to date £7.2m deficit). The adverse performance driven largely through a cumulative shortfall on savings delivery of £5m. Whilst grip and control isn't fully captured in the savings delivery it continues to provide mitigation within the overall financial position.

The health board has an initial ask in the plan to deliver £46m of savings, with a stretch ask of a further £17m to result in £63m (2.4% of turnover). This would result in the securing of a further central mitigation for the Welsh Risk Pool impact of £26m and enable the delivery of the key first duty to break-even. However, further work is needed at pace to identify green schemes that total initially the £46m and then further the £17m to attain the stretch target.

3.4 People and places

Short-term sickness remains at 2.4% for May 2026, whilst long-term sickness was stable at 3.7%.

Nursing and midwifery agency usage continues to decrease since May 2025 (3.7%) to May 2026 where it stands at 1.7%. In May 2026 89.7 whole time equivalent (WTE), whereas in May 2025 it was 205.6 whole time equivalent (WTE). The rolling 12-month nursing staff turnover percentage has reduced to 4.7% as of May 2026.

4.0 ASSESSMENT

4.1 The health board is not meeting the majority of the national targets or all of the levels required for special measures de-escalation. There has been a deterioration across a range of measures during April 2026. Internal escalation is focused upon the suspected cancer pathway and urgent and emergency care, with improvements noted across adult mental health and diagnostics.

90-day recovery plans are in development for quarter 2 in order to support delivery priorities to substantially improve elective wait times, outpatients (new & follow up) cancer, 8-week diagnostic performance and urgent and emergency care.

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

5.0 ARGYMHELLION / RECOMMENDATIONS

5.1 The Committee is asked to note the current position and to discuss the corrective actions in place. All exceptions noted in this paper are being monitored and are under considerable scrutiny, despite this there is considerable risk that the Health Board's trajectories will not be met this quarter.

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	

MMR	Mental Health and Learning Disabilities 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** **Enablers of Quality**	**Meysydd Ansawdd** **Domains of Quality** All Apply

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?*	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** *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 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.	

Tuesday, 23 June 2026

Trugaredd
Compassion

Agored
Openness

Parch
Respect

Performance, Finance and Information Governance Committee

Integrated Quality and Performance Report

Produced on behalf of the Performance, Finance and Information Governance Committee by the Performance Directorate and partners

Table of Contents

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.

In addition, due to the health board being in special measures, the health board has introduced an additional element to complement the 3As approach;

- **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.

Performance is challenged across many of the metrics, and we have enhanced the 3 As assessment to incorporate an escalation status. This status is used to highlight those metrics where additional executive or board assessment and action is needed.

What is our data telling us?

Performance and access

The health board has been on an improving trajectory, with reductions in waiting times reported until the end of March 2026, with performance exceeding the forecasted position. The new financial year has seen an increase in 2-year breaches with a small number of 3-year breaches noted, in response 90-day operational improvement plans are in place to support further improvement. Cancer performance remains the worst in Wales. There is a continued focus on operational delivery, productivity, validation, and targeted commissioning. A Recovery Director (interim) started mid-May with a focus on implementing planned care recovery plans from the start of quarter 2.

Urgent Emergency Care (UEC) remains the highest safety and operational risk and priority for the health board, with support and focus from a dedicated intervention team in HB supporting improvement. The Health Inspectorate Wales (HIW) Inspection of Ysbyty Glan Clwyd Emergency Department triggered a number of immediate assurances and prompted HIW to designate the service as one of significant concern.

Quality, safety and patient experience

Two never events were reported this period; nine recorded in the last 12 months. There has been an Increase in **n**ational reportable incidents this period (20 vs 14). Median completion time remains the best in Wales (75 days), though the proportion open over 90 days has increased. Patient safety incident backlog remains high (4,976 open; 58.9% overdue). Reduction target not achieved; refreshed recovery trajectories being agreed with IHCs and Divisions. Progress noted against national patient safety alerts (PSA); some compliance timelines extended. There is a UK wide profemur hip recall affecting 821 patients in BCUHB with management plan and executive sponsorship in place. Complaints volume 311 (up from 291) and overdue cases, 69 (up from 49) have increased, though overall performance at 77.8% (down from 83.2%) remains among the best in Wales. Legislative transition to *Listening to People* successfully implemented.

Finance and sustainability

The financial plan highlights an £89m shortfall to deliver break-even, after a targeted £46m savings, this results in a planned 43m deficit which does not attain the key financial duty. The year-to-date position (end of May 2026) is reporting a deficit of £10.9m, £3.8m adverse to the planned year to date £7.2m deficit. The cumulative shortfall on savings delivery is £5m, with additional grip and control not yet fully captured in the savings plan contributing towards the overall position. Further work is needed at pace to convert the red schemes and identified opportunities of £31.9m to green deliverable schemes.

People and places

Short-term sickness remained at 2.4% for May 26 whilst long-term sickness for May 26 was stable at 3.7%. Nursing and midwifery agency usage continues to decrease since May 25 (3.7%) to May 26 where it stands at 1.7%. In May 26 it was 89.7 whole time equivalent (WTE), whereas in May 25 it was 205.6 whole time equivalent (WTE). Rolling 12-month nursing staff turnover percentage has reduced to 4.7% as of May 26.

Executive Summary: Performance and access

Planned care - since July 2024 there has been a 79% reduction in waits over 2 years from 10,400 to under 2,200 – the lowest position since March 2021. The overall waiting list has fallen for seven consecutive months to 176,000, its lowest position since February 2024. These improvements have been made through increased outpatient activity, resulting in an 80% reduction in the number of patients waiting for their first outpatient appointment. Increased commissioning has reduced waiting times for ophthalmology, general surgery, ENT, urology and orthopaedics. The position for the end of April does however indicate a worsening position with increases noted in the overall waiting list and the number of 2-year waits. Work will focus both on backlog reduction and pathway management and management of referrals.

Waiting times for **diagnostic** procedures within 8 weeks improved by 36% falling from 22,000 in January 2026 to below 14,000 at the end of March, this improvement has continued into April and May.

Cancer performance remains disappointing, with an overall deterioration from over 60% at the end of March 2025 to 54% at the end of March 2026 against a standard target of 80%. Recovery focus is on skin, colorectal, urology and breast.

Urgent and emergency care services across the health board continue to operate under sustained pressure, driven by high demand, constrained patient flow, delayed discharge pathways and workforce challenges. These factors continue to present risks to patient safety and experience, quality of care, staff wellbeing and organisational reputation. Ambulance conveyances are static (3,587), with 35% of handovers achieved within the 45-minute target. Emergency department 12-hour performance has improved by 4% over the past four months but 24% of patients continue to wait over 12 hours. Time to triage is above target (median 20 minutes against the 15-minute target), while median time to clinician stands at 121 minutes (61 minutes over the National target).

Adult mental health performance is compliant across the health board in several areas; the April performance highlights that compliance with Part 1a is above target at 84.35% and Part 1b at 85.52%. However, there is variation across the sites and within some pathways. Part 2 Valid Care and Treatment Plan compliance is below target at 86.2%**.**

Psychological therapy waits under 26 weeks are below target at 50.62% across the health board.

Children and adolescent mental health performance remain compliant across the health board for April for Part 1a at 92.94% and Part 2 at 91.5%**.** Part 1b first intervention is under the 80% target with compliance at 78.14% in April although this is an improvement from April 2025 when performance was 42%.

Neurodevelopment assessments are below expectation with those waiting less than 26 weeks to start an ADHD or ASD assessment at 12.3%, no health board is currently achieving target of 80% with latest all-Wales performance at 24.1%

Executive Summary: Quality, safety and patient experience

Key Performance Matters In this reporting period, 20 Nationally Reportable Incidents (NRIs) have occurred (up from 14 in the last period), including two “never events,” are under full investigation with clear actions in place to reduce recurrence. Investigation timeliness has improved to above the national average. Backlogs remain (4,976 open; 58.9% overdue) but are being actively reduced. Patient Safety Alerts (PSAs) and recalls are being managed effectively. Complaints have increased slightly with 311 open (up from 291). Although response times remains strong at 77.8% (down from 83.2%), 69 remain overdue (up from 49). Quality assurance processes continue to be strengthened.

Key Risks relate to investigation delays, repeat incidents and diagnostic waiting times. Increased complaints highlight issues with delays and communication. Mitigation plans are in place. Focus is on the spread of learning and sustainability of improvement.

Patient Safety and Safeguarding Patient safety **i**ncident management remains a key challenge due to the backlog (4,976 open; 58.9% overdue). Training and early action are being strengthened to improve this. Safeguarding training has reached many staff, with strong positive feedback and plans to expand further.

Infection Prevention and Control Performance is mixed. Targeted actions are in place to address variation and manage seasonal pressures impacting capacity. Whilst cases of E.coli (-3) and MRSA (-3) remain below trajectory, cases of C.difficile (+7), Klebsiella (+7) , Pseudomonas (+6) and MSSA (+37) are above trajectory.

Patient Experience Patient feedback remains positive overall. Complaints have increased at 311, (up from 291), mainly relating to delays or lack of treatment or assessment (85), incorrect or insufficient treatment or assessment (66) and delay or lack of diagnosis (17). Communication is the next highest ranking complaint issue. A new system improving learning and responsiveness has been embedded. Whilst the number of overdue complaints is up at 69 (from 49), on average, the health board resolves complaints within 21 working days and with a closure within 30 days rate of 77.8% (down from 83.2%) remains one of the best performing in Wales.

Clinical Effectiveness Most clinical audits meet national standards. Actions are in place to address diagnostic delays, data quality and consistency.

Quality Assurance and Oversight Regulatory progress is evident with strengthened oversight and clear processes. Digital tools are supporting learning and improvement.

Legal and Governance Matters Legal processes and complaint management have improved, with stronger oversight and organisational learning.

Executive Summary: Finance and sustainability

Financial Plan

The health board submitted a deficit plan totalling £43m for the 2026/27 financial year, including the conditionally recurrent funding totalling £82m, and incorporating a £46m savings target. If the £82m conditionally recurrent funding is not secured from Welsh Government into 2026/27 the deficit increases to £125m. The deficit plan of £43m does not attain the key duty to break-even and the health board is required to develop a Financial Recovery Plan for Welsh Government to improve the outturn for 2026/27.

Financial Position

The health board reported an in-month deficit of £5.6m at the end of May, £2.0m adverse to the profiled planned deficit of £3.6m. The year-to-date position (end May) is a deficit of £10.9m, £3.8m adverse to the planned year to date £7.2m deficit. The cumulative shortfall on savings delivery is £5m, with additional grip and control not yet fully captured in the savings plan contributing towards the overall position.

	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)	(4.5)	(3.5)	(3.0)	(3.0)	(3.0)	(3.0)	(3.0)	(3.0)	(3.0)	(3.0)	(11.0)	(43.0)

Savings and mitigations

- At the end of May, the health board has identified a forecast £13.3m of green schemes against the target of £46.0m.
- Year to date savings delivery is £2.7m, of which £0.2m is recurring.
- Substantially behind the annual target and the £3.8m requirement per month needed to attain the financial plan.
- Red Schemes and pipeline opportunities are estimated at £31.9m and urgently need converting to green schemes to avoid continued adverse performance in the early part of 2026/27 and avoid the necessity of additional recovery actions in future months.
- Welsh Government Grip and Control measures remain whilst the savings schemes are being fully developed.

Capital programme

The approved Capital Resource Limit (CRL) for 2026/27 is £61.0m. Year to Date expenditure is £1.7m.

Executive Summary: People and places

- The vacancy rate is 8%, with no change against the position during the same period last year. Clinical staff groups including Registered Nursing, AHPs, and Add Professional Scientific and Technical are seeing positive reductions in vacancy WTE. Recruitment challenges, control delays, and hard-to-fill roles continue to impact the organisation's ability to reduce vacancies, however, progress is being made through strengthened workforce planning and targeted recruitment, improved filtering of applications, and focused support for priority areas. Working alongside Finance colleagues there is a plan to review the recruitment approval and establishment control process to streamline to the process and remove any unnecessary bureaucracy.
- Workforce planning from 26/27 requires a review of workforce establishment against affordability and longer-term clinical/service plans. It is anticipated that there will be a reduction in the workforce utilised, this includes temporary workforce usage (agency, bank, overtime) as well as substantive, (WTE) of circa 1.5 to 2.5% over the period of 26/27. This will be supported through the V&S Workforce programme where work is being taken forward to undertake a corporate administrative review and a back-office review across the organisation. Other workforce efficiency work is being undertaken across medical staffing in the areas of job planning, deployment (rota management), productivity and agency spend reduction. This programme of work has already commenced and will run through 26/27 and beyond.
- Turnover is 7.1% down 0.8% on the position in May 2025. Registered Nursing staff group reporting the lowest turnover rate at 4.7%, whilst Estates and Ancillary see the highest rates of 11.6%. The organisation has a number of retention initiatives ongoing led by a dedicated Staff Retention Lead.
- The rolling sickness absence rate has increased slightly, up 0.1% over 12 months to 6.14% in May 2026. Long-term rolling absence stands at 3.7% compared to 2.4% short-term. The in-month rate for May 2026 is 6.01%, unusually high for this time of year, with May rates over the previous five years all below 5.7%. The in-month long term sickness rate is up 0.3% on the previous year to 3.7% and the short term in month rate is also up 0.3% to 2.3%. The organisation-wide Sickness Reduction work is underway with hotspots areas identified for targeted intervention to support staff in attending work and to achieve a measurable decrease in our absence levels.
- Agency usage continues to improve, falling from 3.7% in May 2025 to 2.4% in May 2026, equating to £1m lower in-month spend than the previous year and 192 fewer equivalent FTEs utilised. Registered Nursing agency usage was 2% lower in May 2026 compared to the previous year, utilising 116 fewer equivalent FTEs with spend reduced by £546k. Progress against the Enabling Actions over the April and May 2026 is positive with a 27% reduction in agency usage on the position last year.
- PADR compliance currently stands at 80%, a 0.7% decline on the same period in the previous year. Priority areas for targeted support include Facilities West and Cancer Admin.
- Level 1 mandatory training compliance remains above the target of 85% at 90.6%. There is a focus on compliance for bank staff, medics and targeted intervention in departments that are failing to achieve the 85% target.

Executive Summary: Population health and prevention

Health Protection Considerable work has been undertaken to ensure the Health Board is prepared and able to manage safely and effectively High Consequence Infectious Diseases (HCID) which present to services and pose significant risk to patients, our staff and our communities. HCIDs require rapid identification and disease specific infection control measures and may result in enhanced public health responses beyond standard hospital procedures.

Health Improvement Offer A framework approach to health improvement that can be delivered across all health and care settings is being reviewed alongside input from stakeholders including GPs and primary care. This will contribute to the prevention elements which will be a core component of the Clinical Services Plan.

Co-Producing an Anchor Charter for North Wales 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. The Charter incorporates seven Missions that enable North Wales to deliver on Marmot principles that tackle inequalities, deliver on the Ways of Working and Wellbeing Goals within the Wellbeing of Future Generations Act and take action to address the wider determinants of health, including housing, food, lifelong learning, and active & creative lifestyles.

Population Health Management A population health management approach is being established within the health board, using data and insight to identify population health needs, target at-risk groups, and coordinate proactive interventions to improve outcomes, reduce inequalities, and use resources more effectively. Through the Warm Homes proof-of-concept project, the health board is working with RPB partners, Local Authorities, and the third sector to identify vulnerable patients living in cold or damp homes and offer support via the Nest Scheme to enable property improvements that may help reduce the exacerbation of health condition

Diabetes - Working with primary care to identify unwarranted variation and improve the offer for patients with diabetes focusing on the 8 Care Processes. Developing the holistic patient centred model for diabetes care across North Wales including a diabetes care pathway and the transformation of prevention and management of diabetes in primary care

Readiness for New Homelessness Legislation BCUHB has received Welsh Government recognition for the work undertaken to prepare for the forthcoming duties outlined in the Homelessness and Social Housing Allocation (Wales) Act. Through the Homelessness Reduction Implementation Group, the Health Board undertook comprehensive insight work across health, partners and people with lived experience to understand readiness for the new “Ask, Act and Cooperate” duties. This programme demonstrates commitment to improving quality, safety and is informing a broader Inclusion Health offer for the Health Board

Vaccination and immunisation Review of the staff immunisation offer which considers delivery and access, in order to improve uptake of the staff flu vaccination programme in 26/27.

Section 1
Performance and access

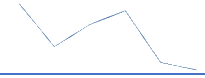
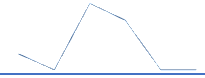
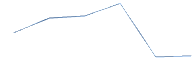
Scorecard : Performance and access (1 of 3)

REF	Measure Description	Target Suite			Wales Benchmark	Actual Performance				Delivery Assurance	Action
		NT	SM	AP		Mar-26	Apr-26	May-26	6 Month Trend		
LMU01	Total number of ambulance coveyances to acute emergency departments	N/A	N/A	TBC	N/A	3,587	3,236	3,580		Limited Assurance	Advise
3A P02	Percentage of ambulance patient handovers within 15 minutes	80%	N/A	TBC	6th from 6	11.90%	10.60%	11.62%		No Assurance	Alert
3A P01	Number of ambulance patient handovers over 45 minutes	0	0	TBC	N/A	2,316	1,960	2,142		No Assurance	Escalate
LMU02	Number of ambulance patient handovers over 1 hour	0	0	TBC	6th from 6	2,059	1,697	1,818		No Assurance	Alert
LMU03	Number of ambulance patient handovers over 4 hours	0	0	TBC	N/A	798	569	581		Limited Assurance	Advise
LMS 01	Percentage patients received CT scan within 20 minutes of clock start	40%	N/A	N/A	N/A	28.70%	30.10%	21.40%		No Assurance	Alert
LMS 02	Percentage eligible patients thombolysed	100%	100%	100%	N/A	100%	100%	100%		No Assurance	Alert
LMS 03	Percentage of all stroke patients thrombolysed (higher is better)	20%	N/A	N/A	N/A	12.7%	17.0%	23.2%		No Assurance	Alert
LMS 04	Percentage patients underwent thrombectomy	10%	N/A	N/A	N/A	4.00%	5.40%	2.70%		No Assurance	Alert
LMS 05	Percentage of those thrombolysed: door to needle in less than 30 minutes	N/A	N/A	N/A	N/A	7.70%	0.00%	0.00%		No Assurance	Alert
LMS 06	Percentage direct admission to ASU within 4 hours	50%	N/A	N/A	N/A	24.20%	29.40%	37.50%		No Assurance	Alert
LMU03	Total number of attendances to Minor Injury Units (MIUs)	N/A	N/A	N/A	N/A	5,467	5,548	6,093		Reasonable Assurance	Assure
LMU04	Toal number of attendances to acute emergency departments	N/A	N/A	N/A	N/A	15,704	15,070	15,724		Limited Assurance	Assure
LMU05	Median time to initial triage less than 15 minutes	15	N/A	20	4th from 6	20	19	19		No Assurance	Escalate
3A P04	Median time to triage by clinical decision maker in less than 60 minutes	60	N/A	120	5th from 6	121	114	128		No Assurance	Escalate
NPF25	Percentage of patients who spend less than 4 hours in all major and minor emergency care facilities from arrival until admission, transfer or discharge	95%	N/A	N/A	7th from 7	59.05%	60.99%	60.27%		No Assurance	Escalate
3A P03	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	0	-	7th from 7	3,631	3,400	3,645		No Assurance	Escalate
LMU07	Total number of patients spent over 24 hours in ED (Reduce)	N/A	N/A	N/A	N/A	1,849	1,707	1,783		No Assurance	Alert
LMU08	Total number of patients spent over 48 hours in ED (Reduce)	N/A	N/A	N/A	N/A	607	464	463		Limited Assurance	Alert
LMU09	Number of patients left the ED, did not wait to be seen (Reduce)	N/A	N/A	N/A	N/A	1,632	1,408	1,725		No Assurance	Alert
TPG-29	Percentage rate of all discharges, discharged before midday (Increase)	N/A	N/A	33%	N/A	18%	17.95%	17.25%		No Assurance	Escalate
3A P05	Number of patients on delayed pathways of care (Reduce)	0	<5%	<15%	8th from 8	291	293	308		No Assurance	Escalate
3A P06	Number of bed days lost to delayed pathways of care (Reduce)	0	N/A	<20%	N/A	12,771	13,847	12,784		No Assurance	Escalate
LMU11	Total number of unplanned returns to ED within 48 hours with the same complaint (Reduce)	N/A	N/A	N/A	N/A	338	319	323		No Assurance	Alert

Scorecard : Performance and access (2 of 3)

REF	Measure Description	Target Suite			Wales Benchmark	Actual Performance				Delivery Assurance	Action
		NT	SM	AP		Mar-26	Apr-26	May-26	Trend to Date		
3BP03	Number of patients waiting more than 26 weeks for a new outpatient appointment	0	N/A	TBC	N/A	15,694	16,575	16,955		No Assurance	Alert
3BP02	Number of patients waiting more than 52 weeks for a new outpatient appointment	0	0	6,785	8th from 8	5,858	5,922	5,385		Limited Assurance	Advise
3BP01	Number of patients waiting more than 104 weeks for referral to treatment	0	0	1,895	N/A	2,161	2,436	2,528		Limited Assurance	Alert
3BP14	Percentage of patients starting their first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)	75%	55%	55%	6th from 6	53.8%	52.6%	RIA		No Assurance	Escalate
3BP15	Reduction in number of patients on an active suspected cancer pathway after day 62	N/A	N/A	TBC	N/A	209	192	RIA		No Assurance	Escalate
3BP16	Number of patients (all ages) waiting more than 8 weeks for a specified diagnostic	0	N/A	TBC	7th from 7	13,778	12,386	10,461		Limited Assurance	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%	N/A	Improvement	5th from 8	56.10%	55.30%	54.90%		No Assurance	Alert
3BP04	Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%	92,455	N/A	TBC	7th from 7	123,259	128,079	131,031		No Assurance	Alert
3EP01	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 people aged under 18 years	80%	N/A	80%	5th from 7	88.90%	92.90%	RIA		Reasonable Assurance	Assure
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	80%	N/A	80%	5th from 7	85.40%	78.10%	RIA		Reasonable Assurance	Advise
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 and over	80%	N/A	80%	5th from 7	87.18%	84.35%	RIA		Reasonable Assurance	Assure
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 and over	80%	N/A	80%	5th from 7	91.55%	85.52%	RIA		Reasonable Assurance	Assure
3DP06	Material reduction in the number of adult mental health out of area placements	N/A	N/A	TBC	N/A	33	27	16		Limited Assurance	Alert
NPF18	Percentage of children and young people waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment	80%	N/A	12%	7th from 7	12.30%	12.20%	RIA		No Assurance	Alert
NPF19	Percentage of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health	80%	N/A	80%	3rd from 7	54.76%	50.62%	RIA		No Assurance	Alert
3BP05	Number of patients (all ages) waiting more than 14 weeks for a specified therapy	0	N/A	0	6th from 7	1,339	1,423	1,631		No Assurance	Alert
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	N/A	0	2nd from 7	13	20	31		Reasonable Assurance	Advise
NPF31	Number of children waiting more than 6 weeks for all audiology pathways (to include new assessment and intervention pathways)	0	N/A	0	6th from 7	594	678	695		Reasonable Assurance	Advise

Scorecard : Performance and access (3 of 3)

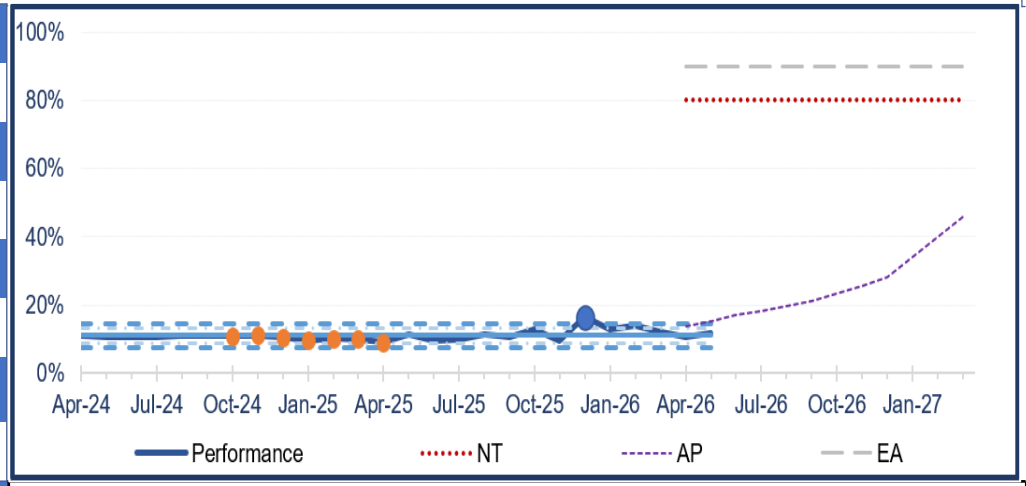
REF	Measure Description	Target Suite			Wales Benchmark	Actual Performance				Delivery Assurance	Action
		NT	SMDT	CMT		Mar-26	Apr-26	May-26	Trend to Date		
1BP02	Percentage of patients offered an index colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioner assessment appointment	90%	N/A	TBC	4th from 7	13%	RIA	RIA		No Assurance	Alert
3BP11	Theatre session utilisation is improved to achieve GIRFT standard late starts (>15 mins) *	N/A	N/A	44%	N/A	43.80%	41.40%	40.10%		No Assurance	Alert
3BP12	Theatre session utilisation is improved to achieve GIRFT standard of early finishes (>60 minutes) *	N/A	N/A	25%	N/A	27.90%	23.20%	23%		No Assurance	Alert
LMP01	Average number of cases per theatre list (session)	N/A	N/A	2.5	N/A	2.4	2.1	2.1		No Assurance	Alert
LMP02	Percentage procedures cancelled the day before or on the day	5%	N/A	<5%	N/A	14%	11.10%	11.20%		No Assurance	Alert
LMP03	Percentage Treat in Turn Rate (Stage 4)	N/A	N/A	TBC	N/A	19%	20%	25%		No Assurance	Alert
LMP08	Percentage of new first orthoptic appointments offered within 6 weeks: Strabismus	95%	N/A	95%	N/A	100%	100%	RIA		Substantial Assurance	Assure
LMP09	Percentage of new first orthoptic appointments attended within 6 weeks: Strabismus	95%	N/A	95%	N/A	100%	RIA	RIA		Substantial Assurance	Assure
LMP10	Percentage of new first orthoptic appointments offered within 6 weeks: Reduced Vision	95%	N/A	95%	N/A	100%	100%	RIA		Substantial Assurance	Assure
LMP11	Percentage of new first orthoptic appointments attended within 6 weeks: Reduced Vision	95%	N/A	95%	N/A	100%	RIA	RIA		Substantial Assurance	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	970 (1 hr handover)	Zero	2,318	1,923	1,282	950

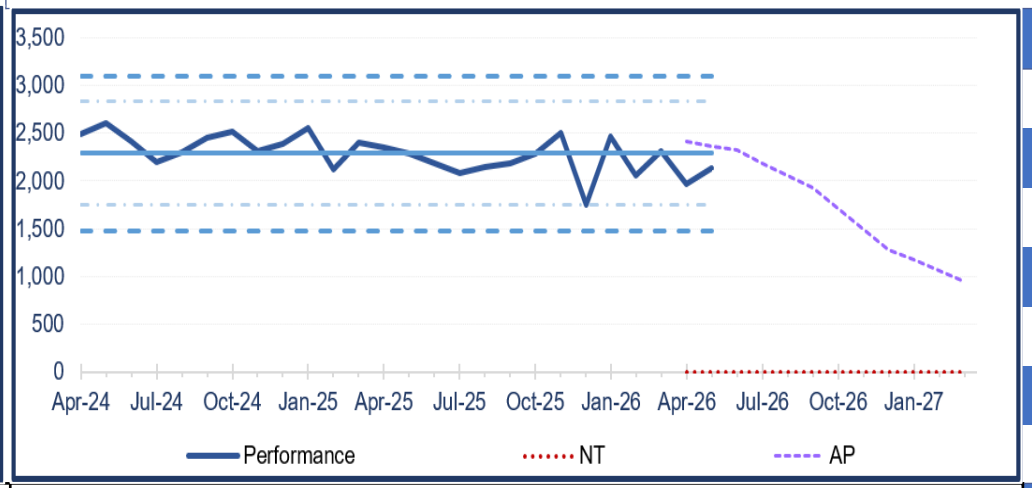
Percentage of ambulance patient handovers within 15 minutes

Latest Month	Profile	Actual	Status	Benchmark
May 2026	17%	11.6%	Escalate	BCU ranked as 6 of 6.



Number of ambulance patient handovers over 45 minutes

Latest Month	Profile	Actual	Status	Benchmark
May 2026	2,318	2129	Escalate	BCU ranked 6 of 6.



What does the data tell us? – Performance against these two metrics at the start of the emergency pathway are in line with previous months activity but fall short of national expectations. Handover within 15 minutes at under 12% is adrift from the national target of 90% target and is a deterioration over the last 12 months. Performance relating to ambulance handovers exceeding 45 minutes has improved and is ahead of the health board's trajectory, which is positive but remains above the Welsh Government expectation of zero.

Actions being taken to improve – Focused improvement is needed over the next month to maintain alignment with the planned trajectory and support delivery within the performance framework. The Chief Operating Officer is working with partners to prepare for implementation of the 45-minute handover standard, with associated capacity risks under review. The revised Care in Undesignated Areas SOP is now in place, with monitoring to support patient safety improvements. Delivery remains dependent on improving ED flow and reducing delays for patients awaiting inpatient beds.

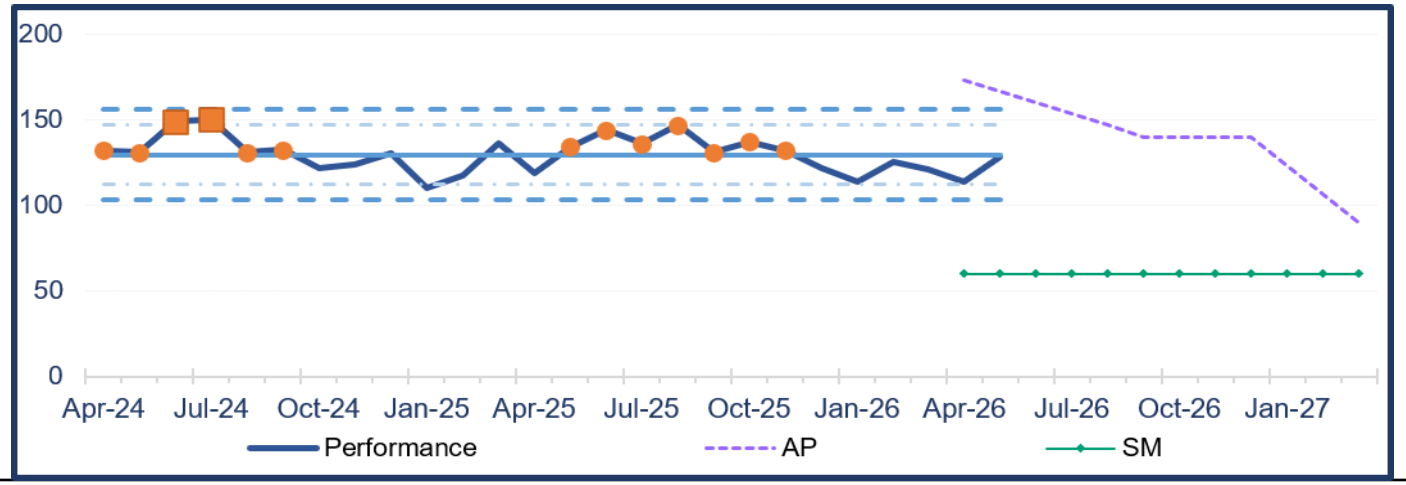
Expected impact upon forecasted performance –Performance against 15-minute handovers is not expected to meet the quarter 1 target and presents a significant delivery risk for Quarter 4. While performance for handovers exceeding 45 minutes is currently aligned with the quarter 1 trajectory, substantial 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
May 2026
Profile
160
Actual
128
Status
Advise



Benchmark	BCU ranked 5 of 6.

What does the data tell us? An improved performance was noted between February to April 2026, with a reduction of 11 minutes in the median time to assessment. The reported position for May 2026 highlights a deterioration of 14 minutes. The median wait reported in May of 128 minutes is ahead of the health board's trajectory of 160 minutes but is 54 minutes above the national 60-minute target.

Actions being taken to improve – Development, approval and implementation of the emergency department business case. This relates to creating staffing rotas that meet the requirement of the Resident Doctors Contract that is being implemented, and a move to substantive staff in post, reducing the reliance on locum/agency staffing. The business case is in the final stages of development and is expected to be presented to the Executive Committee shortly.

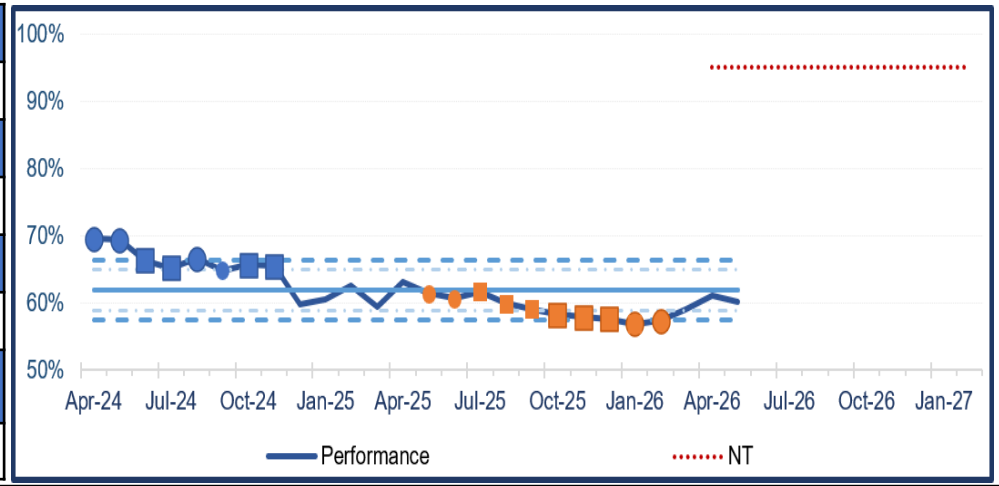
Expected impact upon forecasted performance – Based on current trend, median time to clinical decision maker is meeting the health board's internal trajectory and should achieve the required level by March 2027.

UEC: Number of patients who spend 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 4 hours or more in ED	N/A	95%	95%	95%	95%	95%
	3AP03	Number of patients who spend 12 hours or more in ED	<10%	Zero	3,189 (35%)	2,743 (30%)	2,297 (25%)	1,850 (20%)

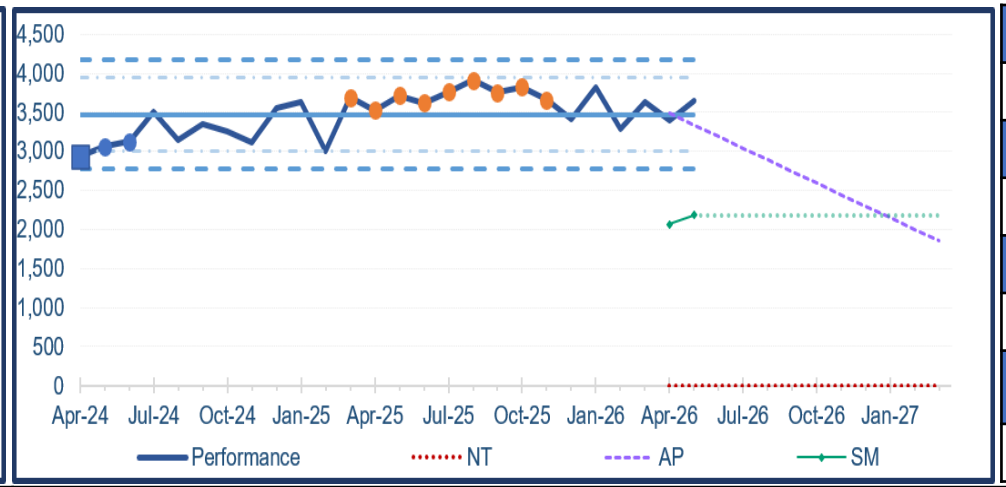
Number of patients who spend 4 hours or more in ED

Latest Month
May 26
Profile
95%
Actual
60.2%
Status
Escalation



Benchmark BCU ranked as 7 of 7.

Number of patients who spend 12 hours or more in ED



Latest Month
May 26
Profile
3,189
Actual
3,648
Status
Escalation

BCU ranked as 7 of 7. **Benchmark**

What does the data tell us? These metrics assess the flow through the emergency pathway and performance against both metrics is below the health board's trajectory and the national target. In May 2026,, there was an 8.7% increase in the number of patients waiting over four hours in the Emergency Department compared to the previous month. Twelve hour performance is 14.4% above the expected target for May, highlighting sustained operational pressure and a widening variance against plan.

Actions being taken to improve – The revised Forward Waiting SOP will be implemented in June following positive outcomes at Wrexham Maelor Hospital, with evaluation in place to assess its impact as part of wider regional adoption. Care in Undesignated Areas remains a key risk, with increased and flexible staffing being deployed in line with GIRFT guidance to support the elimination of corridor care. A further review of Professional Standards is underway to strengthen specialty response times in ED, supported by improved visibility to identify and address delays.

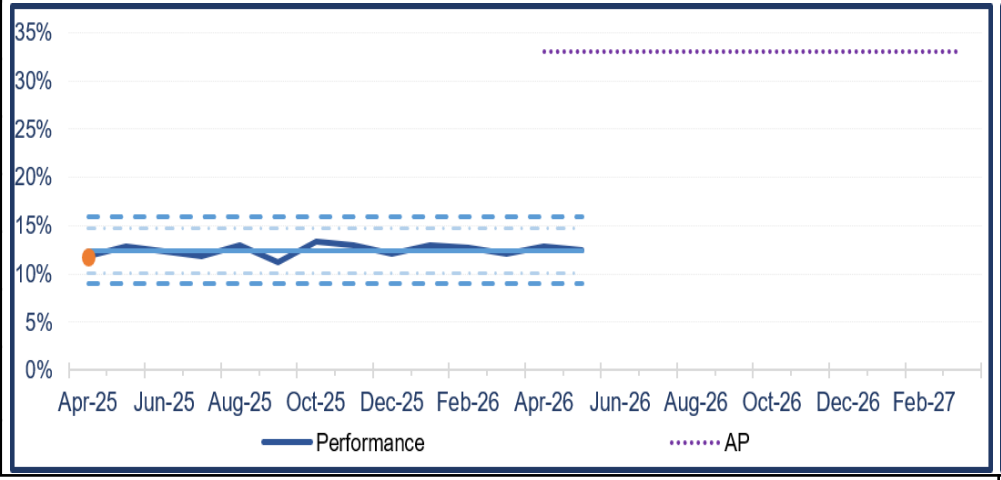
Expected impact upon forecasted performance – Based on current trend, both metrics will not meet the Q1 target. Further sustained improvements will be required as part of ongoing improvement plans

UEC: Discharges before midday

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

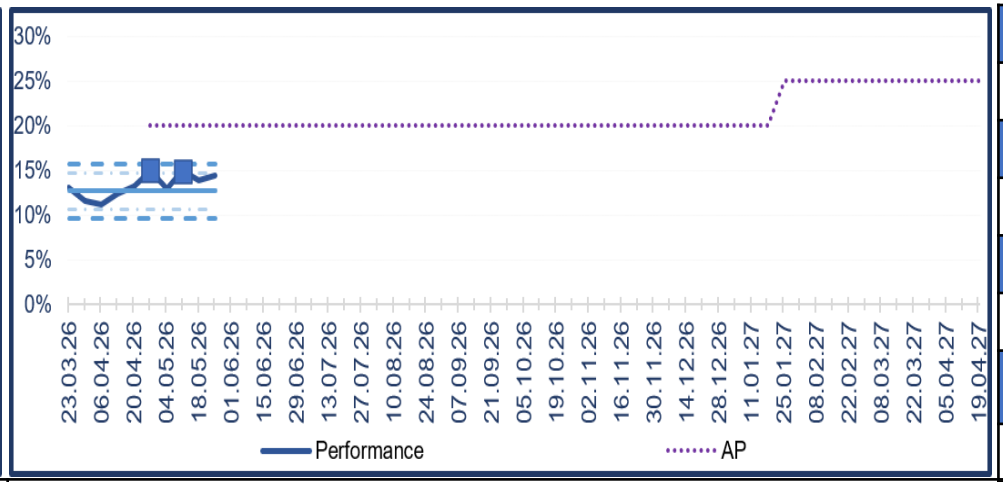
Discharges before midday - Weekday

Latest Month	Profile	Actual	Status
May 2026	33%	12.5%	Alert



Benchmark N/A

Discharges before midday - Weekend



Latest Month	Profile	Actual	Status
May 2026	15%	14.4%	Alert

Benchmark N/A

What does the data tell us? – Both metrics remain below the agreed trajectory. Weekend discharges before midday have shown slight improvement, increasing by 1% from April to May 2026 and only 0.6% under the Q1 profile . However, weekday performance remains unchanged, reflecting ongoing operational pressure, a widening gap against plan, and a continued adverse impact on patient flow, including afternoon bottlenecks.

Actions being taken to improve – The revised Forward Waiting SOP will be implemented in June following positive outcomes at Wrexham Maelor Hospital, with evaluation in place to assess its impact as part of wider regional adoption. Established ward processes support timely discharges, including sustained focus on early transfer to discharge lounges, enabling patients in the Emergency Department to be moved to inpatient wards as capacity becomes available. Further improvement actions include daily senior clinical review of clinically optimised patients and a strengthened focus on increasing weekend discharge performance.

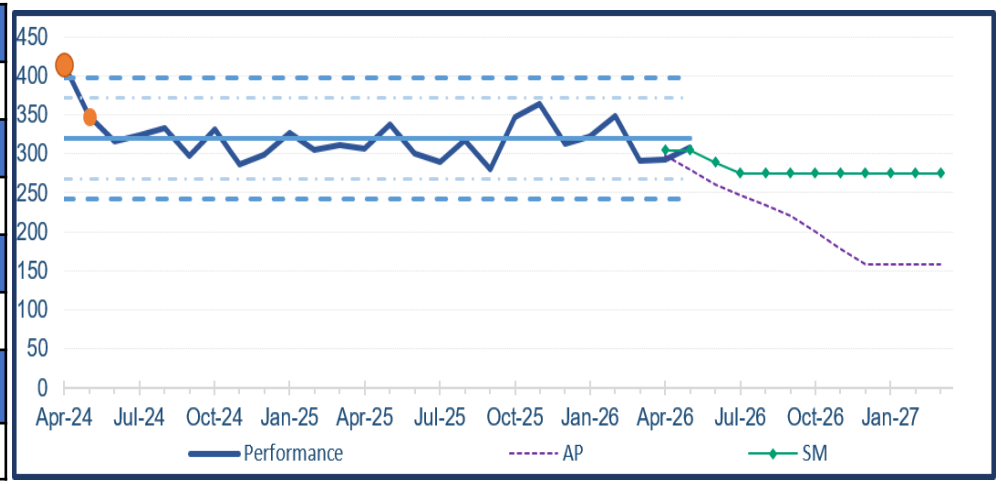
Expected impact upon forecasted performance – Based on current trend, overall discharges before midday is not expected to deliver the step up required during Q1.

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

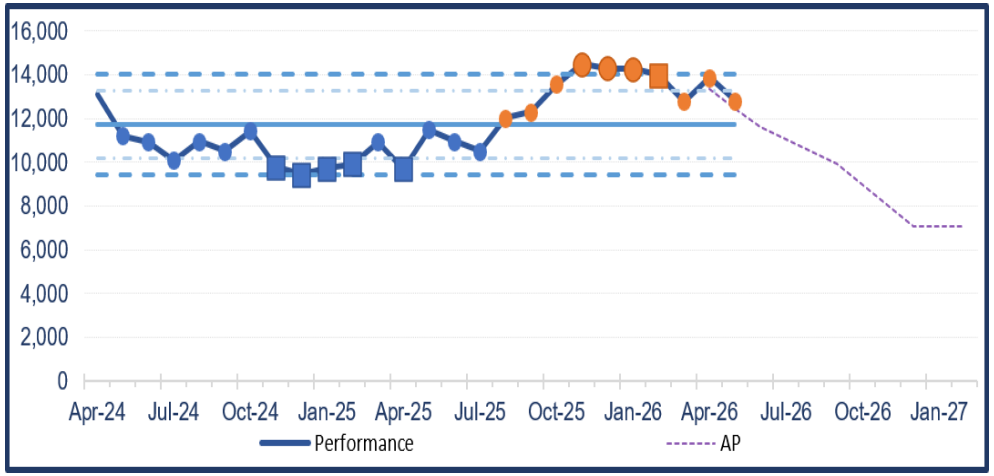
Number of patients on delayed pathways of care

Latest Month
May 2026
Profile
260
Actual
308
Status
Alert



Benchmark 8 of 8.

Number of bed days lost to delayed pathways of care



Latest Month
May 2026
Profile
11,628
Actual
12,804
Status
Escalate

Benchmark N/A

What does the data tell us? PoCD patients has increased in May, the number of bed days lost due to PoCD is 10.1% above the quarter 1 profile, however the number of bed days has reduced by 1,070 days from the previous month. West IHC is an outlier in May accounting for 53% of all bed days lost across BCU, However, the number of patients on delayed pathways of care in May remains broadly comparable across IHCs (Central 97, East 105, West 106), indicating that while similar volumes of patients are delayed, the duration of delays is longer in West, driving the increased bed days lost.

Actions being taken to improve – Three Shared Purpose events have either taken place or are scheduled across May, June, and July. Masterclasses are being delivered in June to support the rollout of the Shared Purpose programme and Integrated Discharge Hubs, with support from the Regional Partnership Board (RPB). A clinical engagement event focused on patient flow is taking place to strengthen system-wide understanding and collaboration. Optimal Flow Trainers have been appointed across the BCU to support the implementation and sustainability of flow improvement initiatives.

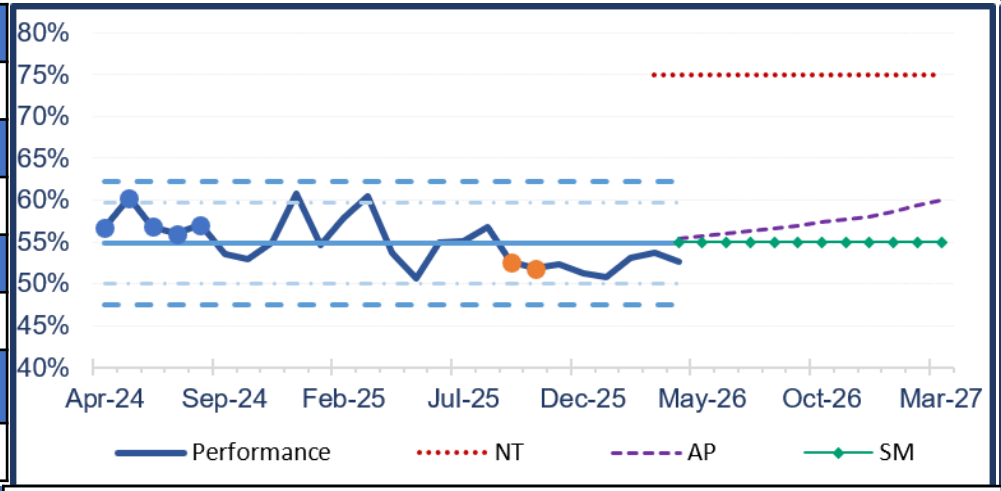
Expected impact upon forecasted performance –Significant improvement will need to be made over the next month to meet ongoing targets. Continual improvement in reducing the number of delays is predicted but reducing the days delays will require focused actions

Planned Care: Suspected Cancer Pathway Metric

	ID	Metric	SM De-escalation	Planning / Performance Framework	Q1	Q2	Q3	Q4
Metric Overview	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

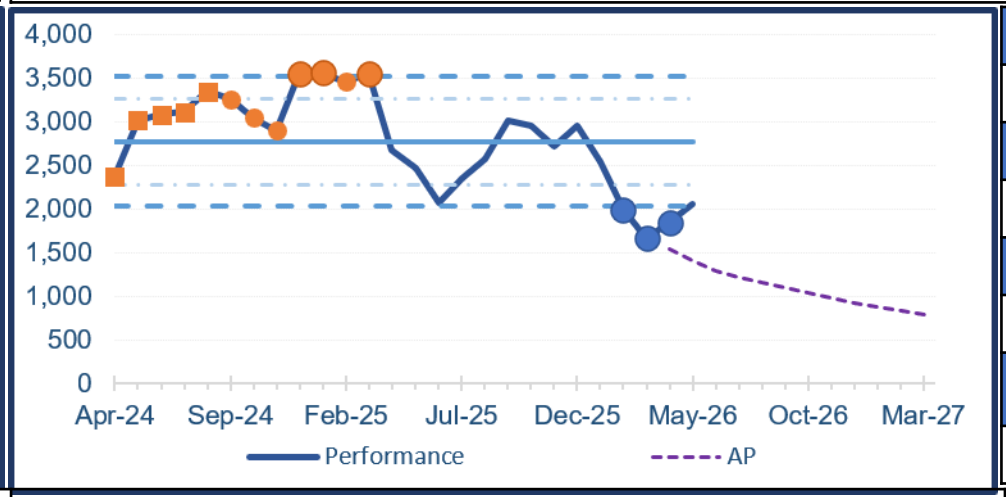
Latest Month
Apr-2026
Profile
55%
Actual
52.6%
Status
Escalate



Benchmark

6th of 6 (March 2026)

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



Latest Month
May-2026
Profile
1,539
Actual
2,058
Status
Escalate

Benchmark

All health boards have seen increase in numbers waiting over 62 days since end of last quarter, however the increase in BCU is greater than others.

What does the data tell us? - Cancer performance is still the worst in Wales and has shown no sustainable improvement since January 2025, the number of patients waiting over 62 days for their cancer diagnosis or treatment has increased over the last 3 months following a period of improvement. Both metrics are considerably adverse to the agreed trajectory. Between January and March 2026, 12,883 patients were told that they did not have cancer

Actions being taken to improve – Focus is on four key areas of skin (review of additional capacity for first appointment and minor ops, utilisation of insourced capacity and clinical model) , colorectal (straight to test and endoscopy capacity), urology (prostate biopsy capacity) and breast (reducing wait times to first appointment) .

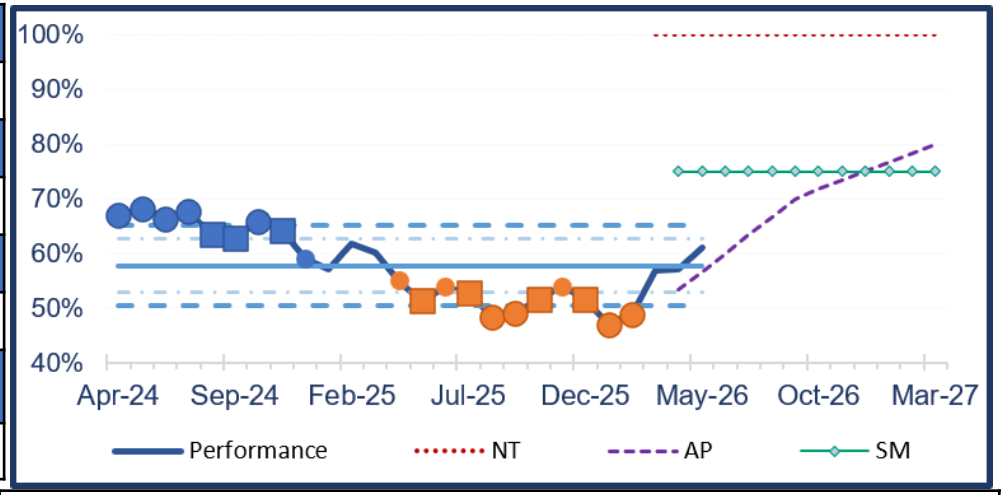
Expected impact upon forecasted performance – Timely mobilisation of actions is key to delivery recovery. The increase in number of patients on an active pathways after day 62 placing risk on delivery of targets at the end of quarter 1. Escalation required to address the issues.

Planned Care: 8-weeks Diagnostic Waits

Metric Overview	ID	Metric	SM De-escalation	Planning / Performance Framework	Q1	Q2	Q3	Q4
	3BP16	8 weeks diagnostic waits	75%	100%	60%	70%	75%	80%
	3BP16	No. of patients waiting in excess of 8 weeks for diagnostic test	N/A	Zero	12,000	8,995	6,000	3,000

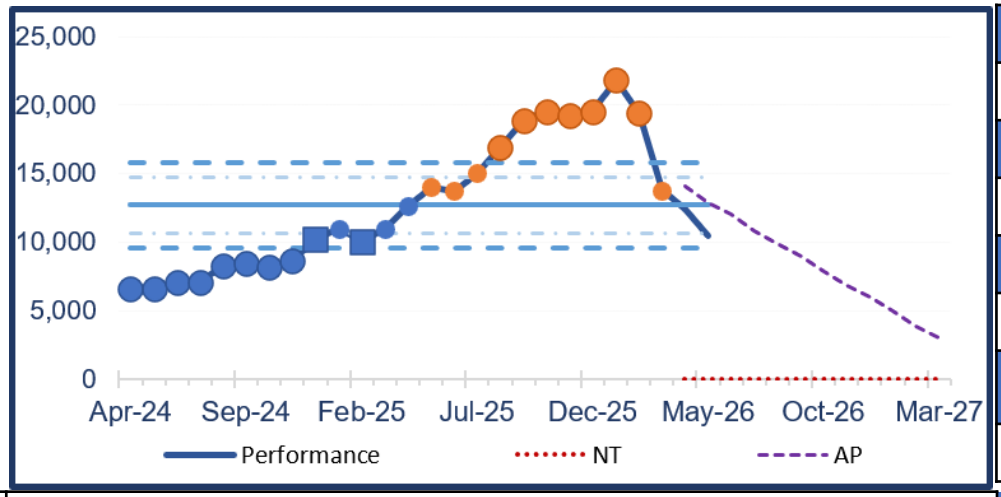
8 weeks diagnostic waits

Latest Month
May-2026
Profile
56.7%
Actual
62.6%
Status
Alert



Benchmark BCU ranked 7th of 7.

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



Latest Month
May-2026
Profile
12,905
Actual
10,645
Status
Alert

Benchmark BCU ranked 6th of 7 and accounts for 55% of all Wales backlog

What does the data tell us? – Waiting times for **diagnostic** procedures within 8 weeks improved by 36% from January 2026 falling to below 14,000 at the end of March, this improvement has continued into April and May. Despite this improvement over 12,000 are waiting over 8 weeks for a diagnostic procedure against a national target of zero. Challenges remain around modalities of Endoscopy, Imaging and Pathology.

Actions being taken to improve – Insourcing activity has been secured within radiology and endoscopy for the first half of the financial year. Improvement work is being undertaken supported by NHS Performance and Improvement to review performance improvement opportunities in-house and review any assess any further capacity requirements for deployment from Q2 onwards.

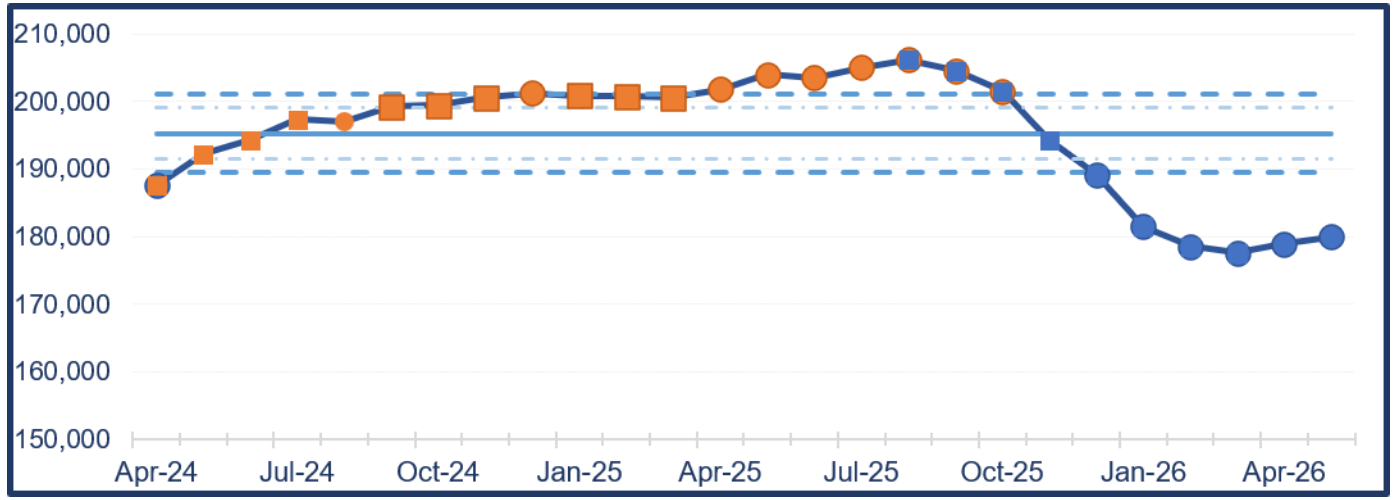
Expected impact upon forecasted performance – Current performance indicates that Q1 trajectory will be delivered for both metrics. Finalisation of plans beyond the end of the first quarter is key for continuation of improvement trajectory Q2 onwards. Sustainability remains a challenge.

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

Total RTT Pathways

Latest Month
May-2026
Profile
Reduction
Actual
179,966
Status
Alert



Benchmark	Increase in overall waiting time numbers across all health boards from March to April 2026 but remain below January 2026 levels

What does the data tell us? - over the last 12 month the overall waiting list has fallen by 11% from over 201k in April 2025 to under 179k in April 2026. This reduction is linked to the increased volume of activity undertaken between August 2025 and February 2026 where additional new outpatient appointments were delivered via the national programme. The overall waiting list position has shown a slight tendency to increase during the last two months.

Actions being taken to improve – Operational Improvement plans are being progressed supported by the Intensive Support Team (sponsored by the partnership of the health board, Welsh Government and NHS Performance and Improvement). In addition, the Planned Care Major Change Programme provides the framework to integrate pathway redesign, national best practice, GIRFT recommendations and value-based healthcare principles. One on the focuses of this programme is to improve referral management with a focus on best practice, community health pathways and advice and guidance.

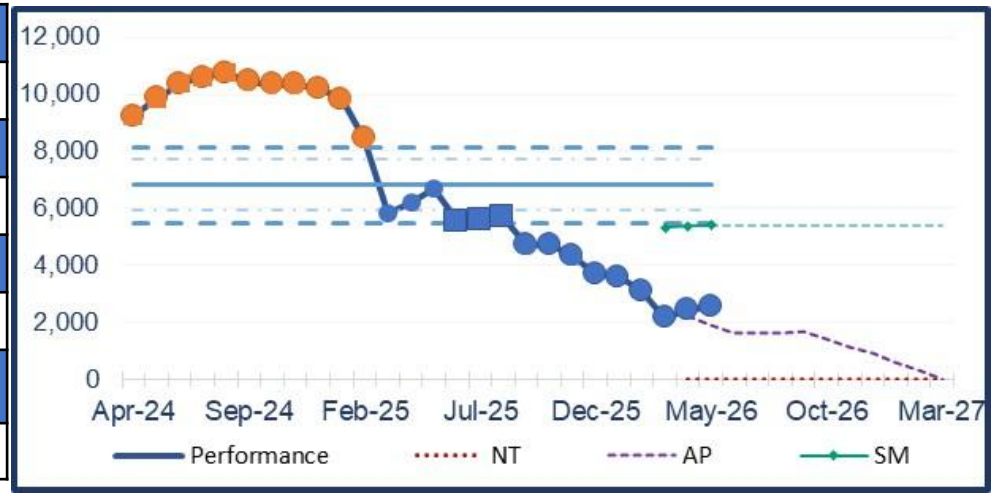
Expected impact upon forecasted performance – The overall waiting list should continue to fall as workstreams are mobilised as part of the operational improvement plans and the major change programme

Planned Care : Referral to Treatment Metrics

Metric Overview	ID	Metric	SM De-escalation	Planning / Performance Framework	Q1	Q2	Q3	Q4
	3BP01	104 weeks for referral to treatment	3% of open pathways	Zero	1,597	1,668	894	0
	3BP02	Open outpatient pathways waiting < 52 weeks	98%	100%	90%	91%	93%	93%

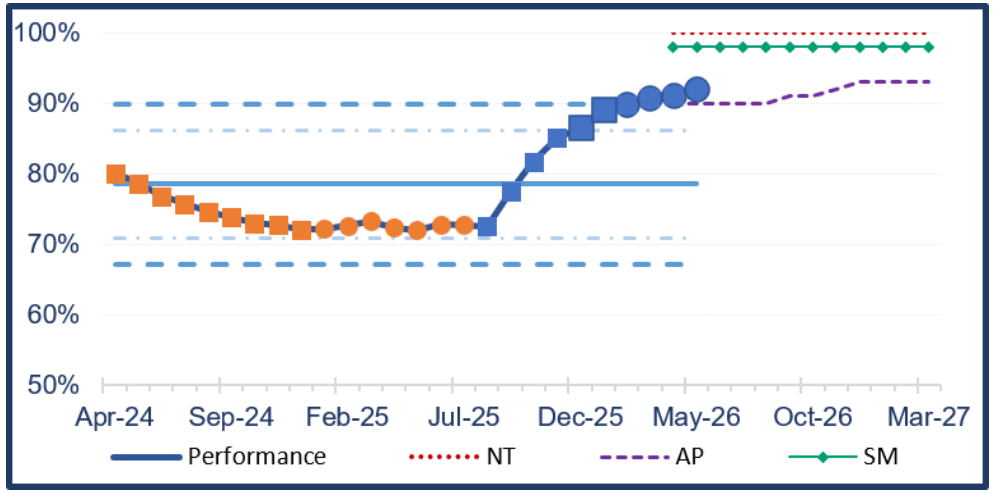
104 weeks for referral to treatment

Latest Month
May-2026
Profile
1,895
Actual
2,528
Status
Alert



Benchmark 8 of 8 at March 2026

Open outpatient pathways waiting < 52 weeks



Latest Month
May-2026
Profile
90%
Actual
92.1%
Status
Advise

8 of 8 at March 2026 – based on volume waiting in excess of 52 weeks **Benchmark**

What does the data tell us? – There has been a reduction in overall number of patients waiting for treatment over 2-years from 10,400 in July 2024 to under 2,200 at end of March 2026. The position has deteriorated during quarter 1 and is adverse to profile. The health board is currently meeting the Q1 trajectory for % of open outpatient pathways within 52 weeks (91% at latest month against trajectory of 90%). The number of patients waiting over 52 weeks for a first new outpatient appointment has reduced from 31,000 in August 2025 to <6,000 by end of March 2026 (80% improvement) but remains below national target.

Actions being taken to improve – Quarter 1 focus for new outpatients is on reducing patients waiting in excess of 78 weeks for a new appointment. 90 day improvement plans are being consolidated with specialty level focus on internal productivity and continuation of outsourcing for General Surgery, ENT, Urology and Gynaecology during quarter 1. Focused support continues to be provided by the national Intervention Support team with the recent appointment of a recovery Director working to the Chief Operating Officer to strengthen delivery grip, coordination and pace of improvement

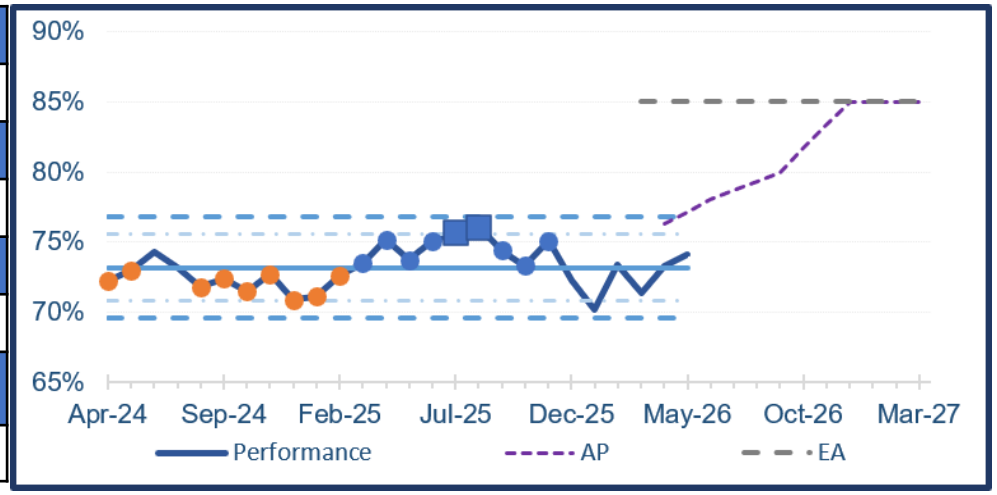
Expected impact upon forecasted performance – Forecast data indicates that the 104 weeks metric will not meet Q1 profile with current data indicating waits of c2,500 at quarter end.

Planned Care : Productivity / Utilisation

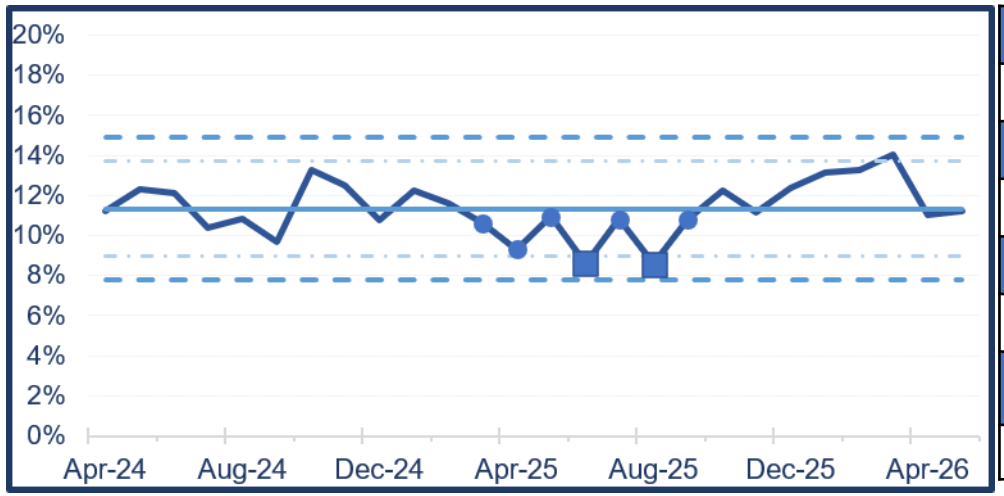
Metric Overview	ID	Metric	SM De-escalation	Planning / Performance Framework	Q1	Q2	Q3	Q4
	3BP13	Theatre session overall utilisation is reported as a key KPI to underpin the GIRFT standard	N/A	85%	78%	80%	85%	85%
	Local	Theatre Short Notice Cancellations	N/A					

Theatre Session Overall Utilisation

Latest Month
May-2026
Profile
76.3%
Actual
74.1%
Status
Alert



Theatre Utilisation – Short Notice Cancellations



Latest Month
May-2026
Profile
N/A
Actual
11.2%
Status
Alert

What does the data tell us? – Performance against the overall utilisation metric has fluctuated between 70% and 76% over the last thirteen months. Whilst this remains within normal variation the position is adverse to the end of quarter 1 target at latest reporting position. Cases per session (CPS) needs to monitored alongside overall utilisation. Latest twelve months data indicates that performance varies from 2.0 top 2.3 cases per session. At local level, the performance has been below 70% in West IHC (Oct-25, Mar-26) and East IHC (Jan-26) during the last twelve calendar months. Short notice cancellation data indicates a rate of c13% during the last two months which is in line with normal variation.

Actions being taken to improve – Self assessment submitted nationally and meetings taking place to identify opportunities / gaps and risks to help inform planned care improvement plans. Actions include establishment of clinically led local improvement group within West IHC area and re-introduction of standby process for elective on the day cancellation mitigation. Sustained reduction in day of surgery admission outliers to protect planned care will remain a key focus area.

Expected impact upon forecasted performance – Based on current trend, overall theatre utilisation performance is not expected to deliver the step up required during Q1. With stepped improvement expected in trajectories during the year, further detail on local and pan BCU actions to deliver sustained improvements will be required as part of ongoing improvement plans. These plans are expected to include measures to increase utilisation and deliver additional cases within existing establishment.

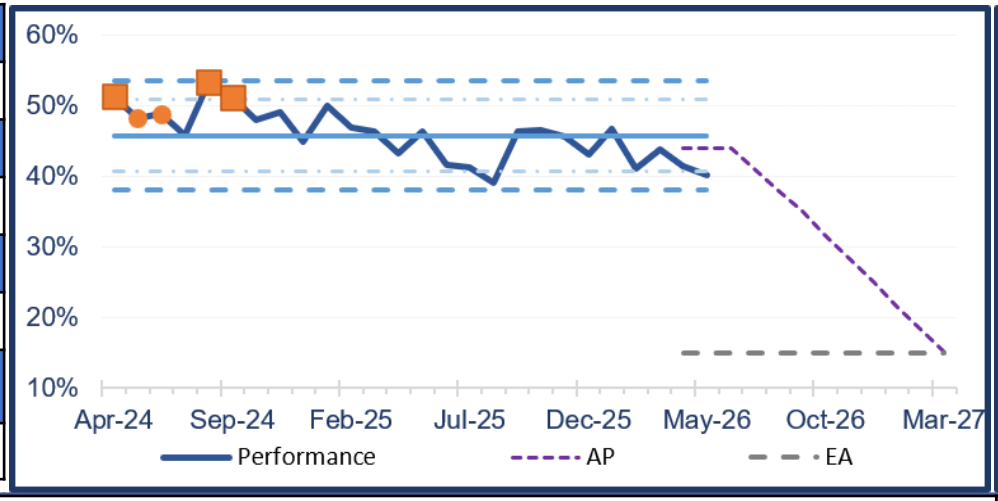
Area	CPS
West	2.0
Central	2.0
East	2.3
BCU	2.1

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%

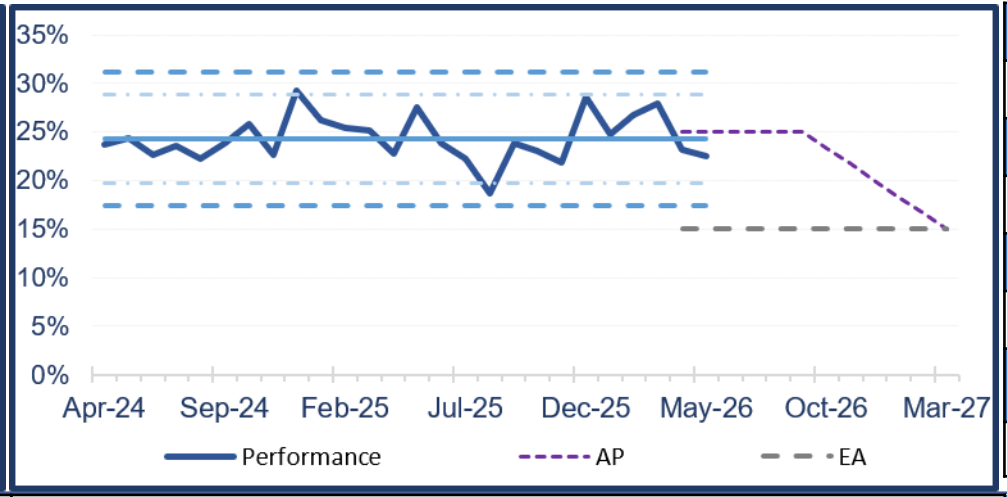
Theatre Utilisation – Late Start

Latest Month	Profile	Actual	Status	Benchmark
May-2026	44.0%	40.1%	Alert	N/A



Theatre Utilisation – Early Finish

Latest Month	Profile	Actual	Status	Benchmark
May-2026	25.0%	22.5%	Alert	N/A



What does the data tell us? – Data on late start in excess of fifteen minutes indicate that site pressures were the main contributor over the last three months with ward escalation and ward delay accounting for highest recorded late start reasons. During April and May, the performance has been below the 44% target at 41% and 40% respectively. Overall performance over the last twelve months indicate that 24% of lists have early finish with completion of planned cases and cancellation of patients being the main reasons noted for theatre session early finish. Trauma and Orthopaedics and Ophthalmology are the specialties with main volume of early finish during the period.

Actions being taken to improve – A review of both late start and early finish as an aggregate is required to provider a detailed review of overall opportunity at specialty level to identify level of opportunity.

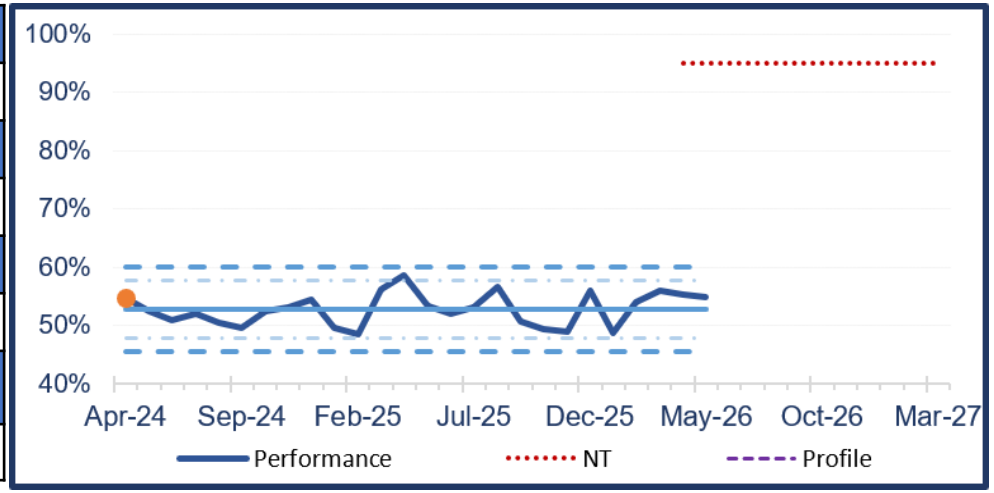
Expected impact upon forecasted performance – Levels of opportunity to increase theatre utilisation differ at specialty level dependent on procedure time.

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%)

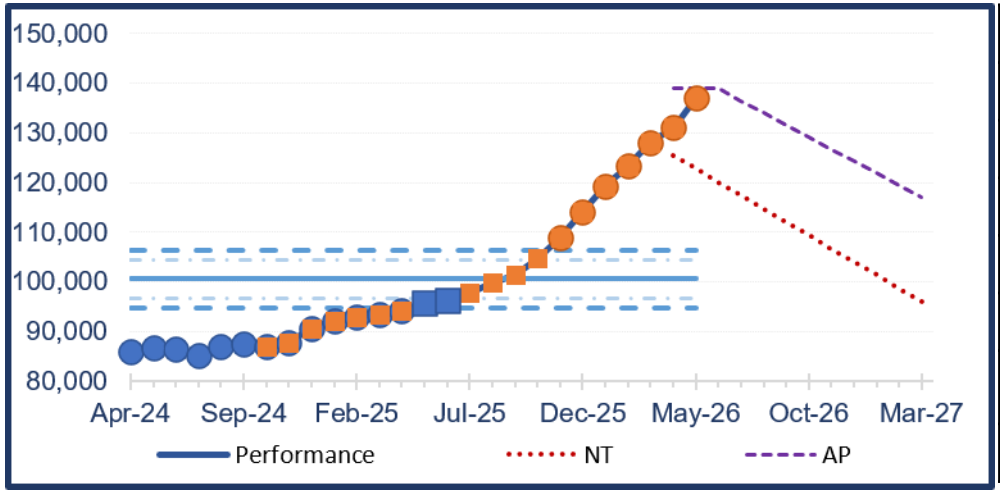
% R1 patient pathways waiting within or within 25% beyond clinical target date

Latest Month
May-2026
Profile
Improvement
Actual
54.9%
Status
Alert



Benchmark 5 of 8 at March 2026

Follow Up Delayed by over 100%



Latest Month
May-2026
Profile
138,903
Actual
137,003
Status
Alert

7 of 7 at March 2026 **Benchmark**

What does the data tell us? – Over the last 12 months there has been a deterioration in the number of high-risk patients waiting within or beyond 25% of their clinical review date.

Actions being taken to improve – Multi-professional case note review team onboarding to redress coding nulls. This will support streaming onto appropriate pathways including to WGOS optometry monitoring in community settings.

Expected impact upon forecasted performance – Coding on track in Q1 2026-27 for ongoing identification of patients suitable for discharge to Primary Care WGOS. Staged profile of delivery improvement

What does the data tell us? – Number of patients overdue by 100% has been increasing month on month and 39% higher than same reporting point in 2025.The health board accounts for 43% of the all Wales total

Actions being taken to improve - Re-launch of See on Symptoms (SOS) and Patient Initiated Follow Up (PIFU) pathways. Gynaecology services to cleanse of the follow up waiting list in line with national Clinical Information Network pathways and discharge protocol.

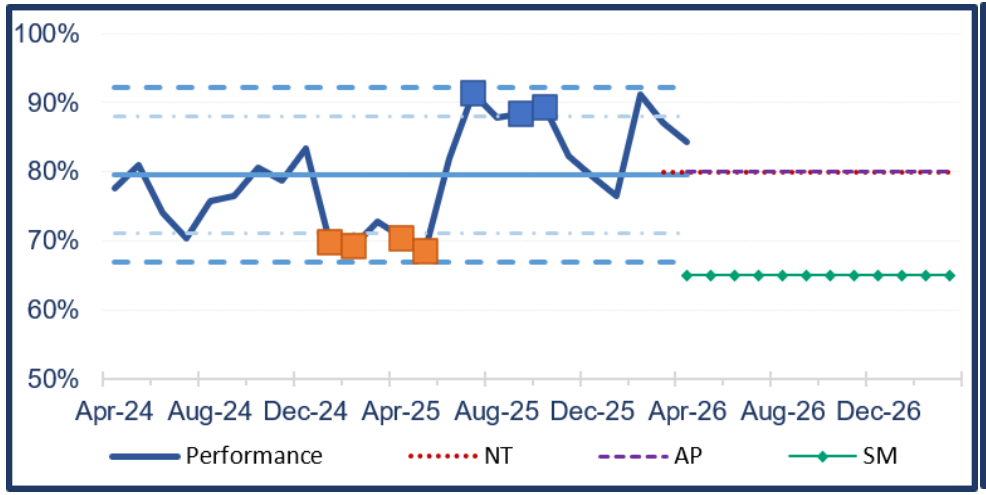
Expected impact upon forecasted performance – Actions are expected to significantly address follow up backlog volumes which will enable a re-balance of new to follow up ratio / clinical validation activity.

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%

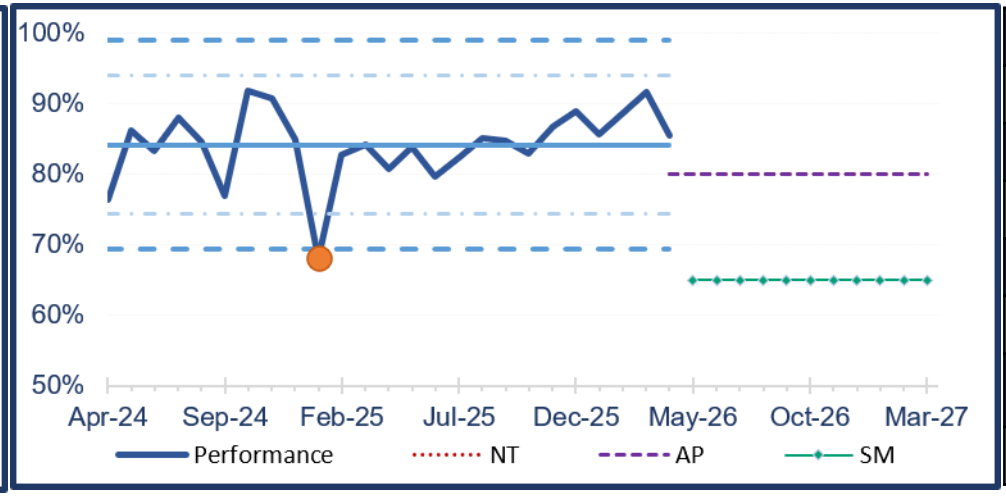
Mental Health Measure Part 1a - Assessments

Latest Month
Apr-2026
Profile
80%
Actual
84.4%
Status
Assure



Benchmark	5 of 7 at March 2026

Mental Health Measure Part 1b - 1st Intervention



Latest Month
Apr-2026
Profile
80%
Actual
85.5%
Status
Assure

5 of 7 at March 2026	Benchmark

What does the data tell us? Health board is compliant for both Mental Health Measure access standards., **84.4%** of adult assessments were undertaken within 28 days of referral, and **85.5%** of therapeutic interventions were started within 28 days following assessment. Both measures are against a target of 80%. There is significant locality variation and sustained long-wait cohorts within Anglesey and Gwynedd, particularly for those waiting beyond 28 days for first intervention.

Actions being taken to improve? . Improvement work is focused on waiting-list validation, recovery trajectories, capacity for assessment and intervention, and oversight of patients waiting beyond the 28-day standard.

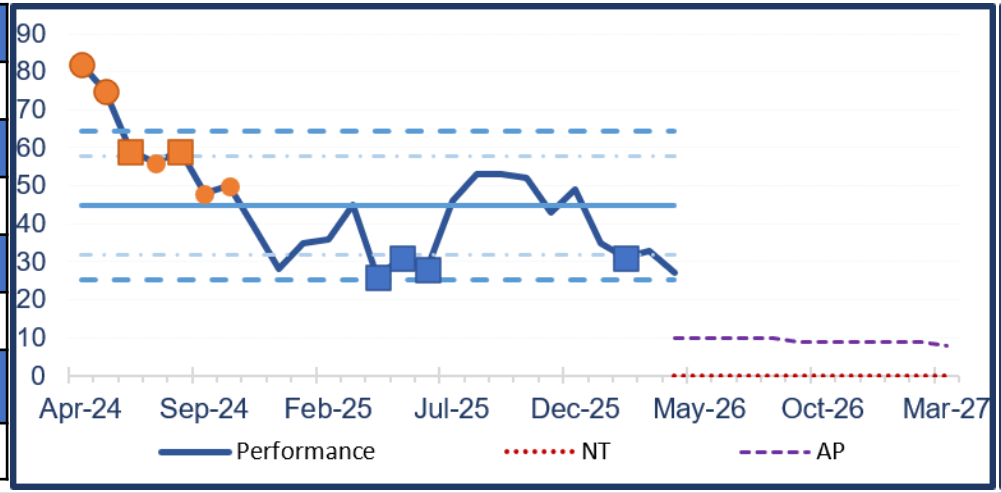
Expected impact upon forecasted performance Based on the current position, the health board is expected to remain above the 80% target in the short term if current delivery is maintained. However, sustained improvement over the next 6–12 months will depend on reducing long-wait cohorts, improving waiting-list grip and narrowing variation between localities. Key risks include demand pressure, capacity constraints, workforce availability, data quality, and the potential for aggregate compliance to mask inequitable access within specific 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		10	9	9	8
	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%

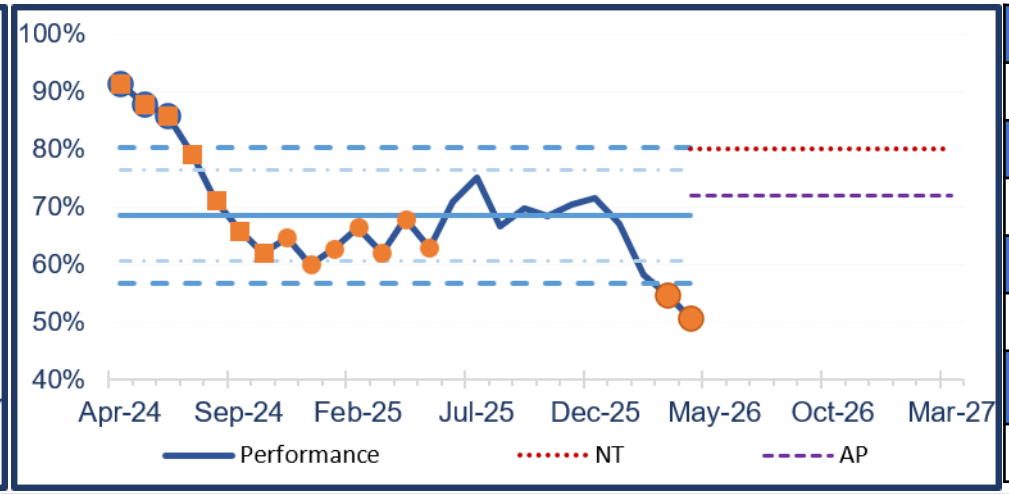
Out of Area Placements

Latest Month
Apr-2026
Profile
10
Actual
27
Status
Alert



Benchmark N/A

Psychological Therapies



Latest Month
Apr-2026
Profile
80%
Actual
50.6%
Status
Alert

3 of 7 at March 2026 **Benchmark**

What does the data tell us? Psychological therapy access remains significantly below target. In April 2026, 50.62% of patients were waiting less than 26 weeks to start psychological therapy in specialist Adult Mental Health against the 80% target, with 81 patients waiting in total. In relation to out-of-area placements, April showed improvement compared with March. There were 27 placements and 359 placement days in April, compared with 33 placements and 424 placement days in March. Reported out-of-area placement expenditure reduced from approximately £685k in March to approximately £339k in April.

Actions being taken to improve For psychological therapies, the focus is on recruitment, retention and embedded psychological services within Community Mental Health Teams. And ensuring availability of suitable clinical rooms. For out-of-area placements, improvement is linked to reducing delayed pathways of care, improving inpatient flow, strengthening local alternatives and working across commissioning, social care, placement providers and community pathways.

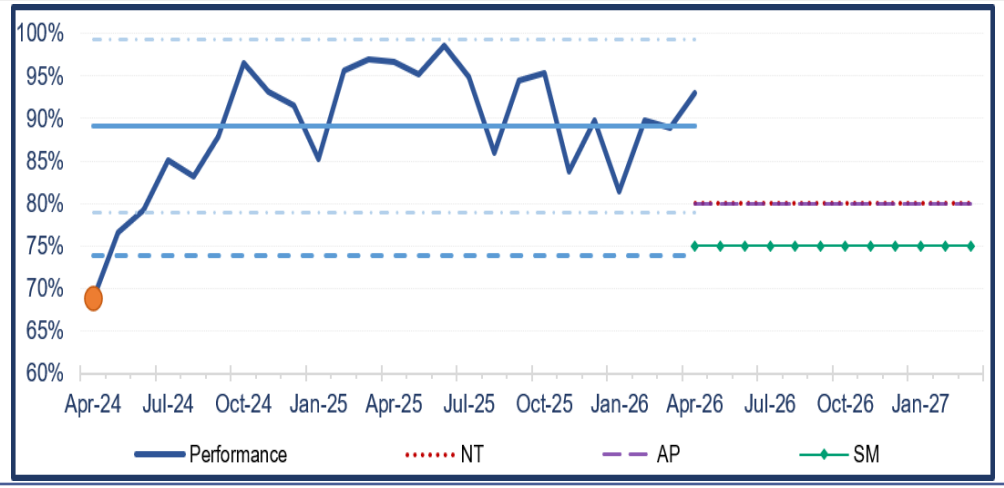
Expected impact upon forecasted performance Psychological therapy performance improvement relies upon the resolution of capacity, workforce and estates constraints. For out-of-area placements, if the April improvement is sustained, the health board should see continued reduction in placement days and associated expenditure over coming months. Key risks include patient complexity, placement capacity, delayed discharge pathways, workforce constraints and limited availability of appropriate local alternatives.

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%

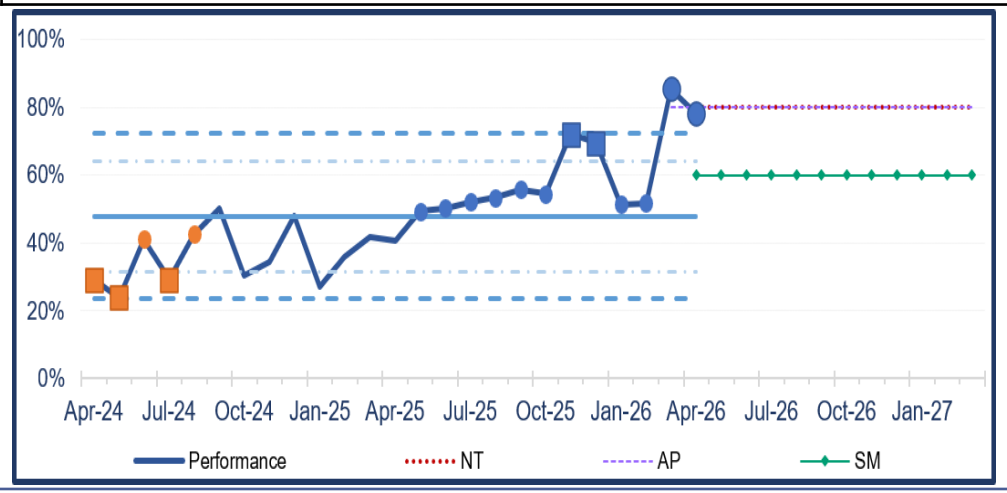
Measure – Part 1A (Assessments) – people aged under 18 years

Latest Month
Apr-2026
Profile
80%
Actual
92.9%
Status
Assure



Benchmark 5 of 7 at March 2026

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



Latest Month
Apr-2026
Profile
80%
Actual
78.1%
Status
Advise

Benchmark 5 of 7 at March 2026

What does the data tell us? – Performance has been above the framework target of 80% for the **assessment** metric since July 2024 with latest submitted data indicating performance in excess of 90% with management data showing that the standard will be maintained during May. For the **interventions** metric, 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%. Whilst performance dipped below the framework target of 80% in April, the special measures threshold of 75% was sustained with a performance of 78%.

Actions being taken to improve – Weekly monitoring in place to ensure pathways remain appropriate. Agency staffing secured during quarter 1 to support activity delivery with discussion regarding provision beyond this point ongoing as part of delivery planning. Reporting alignment taking place for getting started groups across IHCs

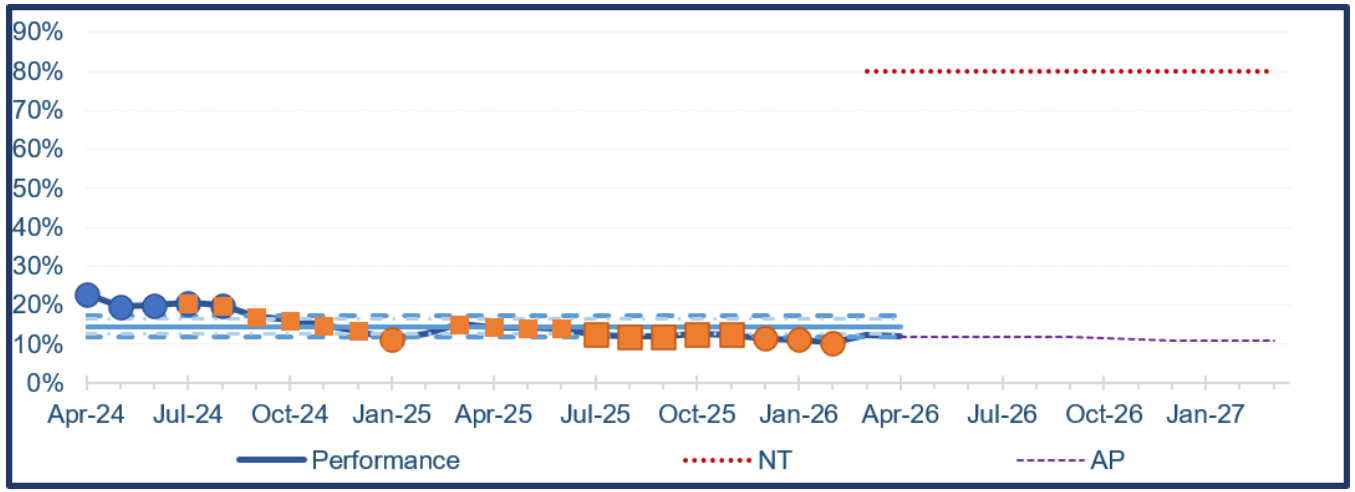
Expected impact upon forecasted performance – Performance against the assessment metric is expected to be maintained at or above the 80% framework threshold. For the interventions metric, the performance is expected to flux at or around the 78% - 80% rate during the next quarter as further work takes place to reduce longer waits. Exit strategies relating to use of temporary workforce will be key in sustaining delivery.

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
Apr-2026
Profile
12%
Actual
12.2%
Status
Alert



Benchmark	BCU 7th of 7 (March 2026)

What does the data tell us? – Performance is considerably below expectation with those waiting less than 26 weeks to start an ADHD or ASD assessment at 12.3%. No health board is currently achieving target of 80% with latest all-Wales performance at 24.1%

Actions being taken to improve – Additional commissioning taking place during early part of 2026/27 with focus on extreme waits above four years. Ongoing support being provided by NHS Performance and Improvement colleagues

Expected impact upon forecasted performance – Contract meetings continuing with provider and further clarity expected on timescales and activity to strengthen forecast impact.

Section 2
Quality, safety and patient experience

Scorecard: Quality, safety and patient experience

Quality, Safety and Experience

RIA = Reported in Arrears

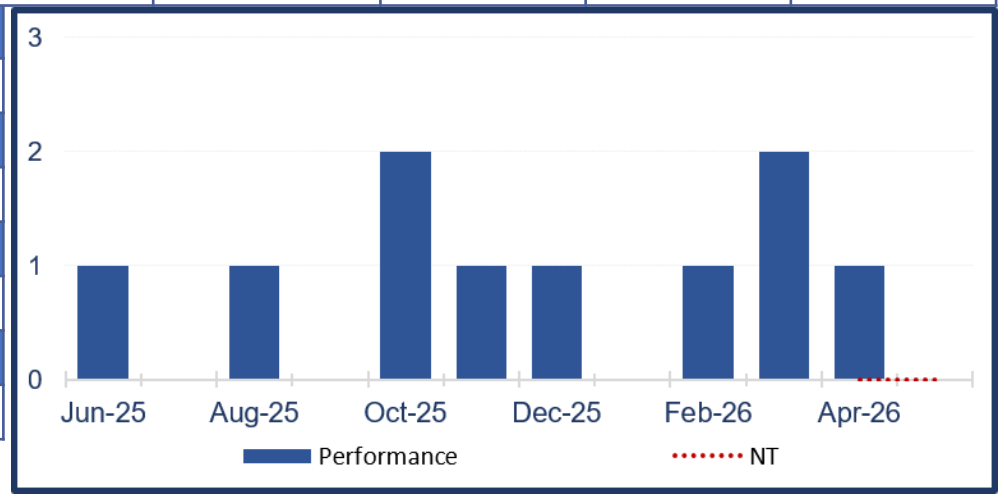
REF	Measure Description	Target Suite			Wales Benchmark	Actual Performance				Delivery Assurance	Action
		NT	SM	AP		Mar-26	Apr-26	May-26	Trend to Date		
NPF39	Percentage of episodes clinically coded within one reporting month post episode discharge end date	95%	N/A	95%	4th from 8	95.56%	RIA	RIA		Reasonable Assurance	Assure
3HP02	Gabapentin and pregabalin DDDs per 1,000 patients (10% reduction)	<10%	N/A	TBC	N/A	1592.4	RIA	RIA		Reasonable Assurance	Assure
3HP03	Average quantity per item prescribed from start period for the reference basket of medicines (Prescribing interval of 35 days or more in March 2026, an increase of at least 10% on March 2026 baseline)	<10%	N/A	TBC	2nd from 7 (at Mar 26)	32.22	RIA	RIA		Reasonable Assurance	Assure
NPF49	Number of new never events	0	0	0	RIA	2	1	0		No Assurance	Alert
NPF40	Nationally reportable incidents open over 12 months	0	N/A	0	0	0	0	0		Reasonable Assurance	Assure
4HP02	12 month rolling average crude mortality rate	N/A	N/A	N/A	N/A	1.33	RIA	RIA		Reasonable Assurance	Assure
NPF41	Cumulative number of hospital onset *Klebsiella spp* BSI cases (10% reduction on 24/25)	103	N/A	TBC	5th from 6	136	13	21		Limited Assurance	Advise
NPF42	Cumulative number of hospital onset *Pseudomonas aeruginosa* BSI cases (10% reduction on 24/25)	27	N/A	TBC	5th from 6	39	4	5		Limited Assurance	Advise
NPF43	Cumulative rate of hospital onset *E.coli* BSI cases (10% reduction on 24/25)	67.00	N/A	TBC	4th from 6	70.67	82.03	72.1		Limited Assurance	Assure
NPF44	Cumulative rate of hospital onset MSSA BSI cases (20% reduction on 24/25)	20	N/A	TBC	3rd from 6	28.47	43.63	39.48		Limited Assurance	Alert
NPF45	Cumulative rate of *C.difficile* infection cases (25% reduction on 24/25)	25	N/A	TBC	5th from 6	47.4	47.12	37.77		Limited Assurance	Alert
LMQ01	Number of New falls with harm	N/A	N/A	Reduce	N/A	376	336	385		Limited Assurance	Advise
LMQ02	Number of new falls with harm	N/A	N/A	Reduce	N/A	44	31	23		Reasonable Assurance	Assure
LMQ03	Number of new hospital acquired pressure ulcers	N/A	N/A	Reduce	N/A	488	457	467		Limited Assurance	Assure
NPF50	HB overall patient experience score (out of 10)	8.5	N/A	Increase	N/A	8.5	8.59	8.6		Limited Assurance	Assure
LMQ03	% complaints closed within 30 days of date received	N/A	N/A	N/A	N/A	RIA	RIA	RIA		Substantial Assurance	Assure
LMQ05	Number of complaints closed within 30 days of date received	N/A	N/A	N/A	N/A	RIA	RIA	RIA		Substantial Assurance	Assure

Quality: Never Events and National Reportable Incidents (NRIs)

Number of Never Events

SM De-Escalation	N/A	Framework	0	Latest Benchmark	TBC

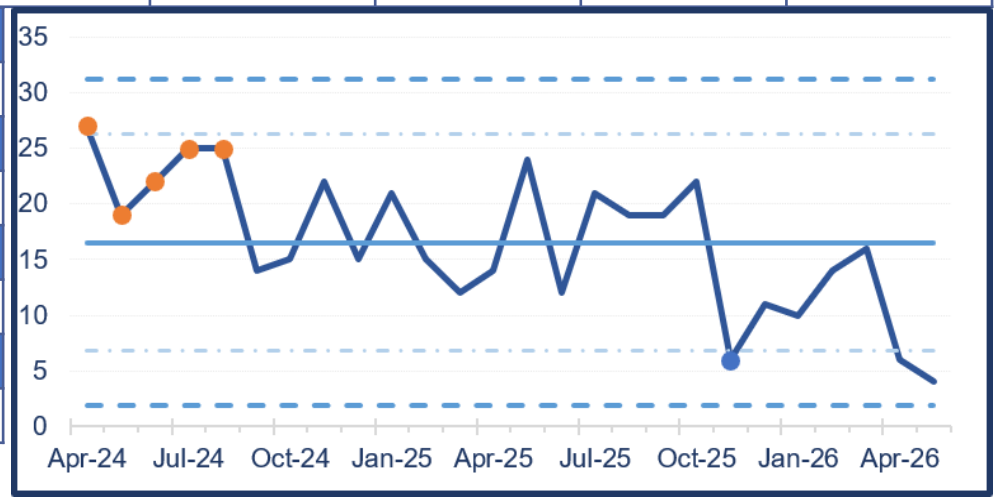
Latest Month	Profile	Actual	Status
May-26	0	0	Alert



New National Reportable Incidents (NRI) by incident date (snapshot in time and data likely to fluctuate)

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

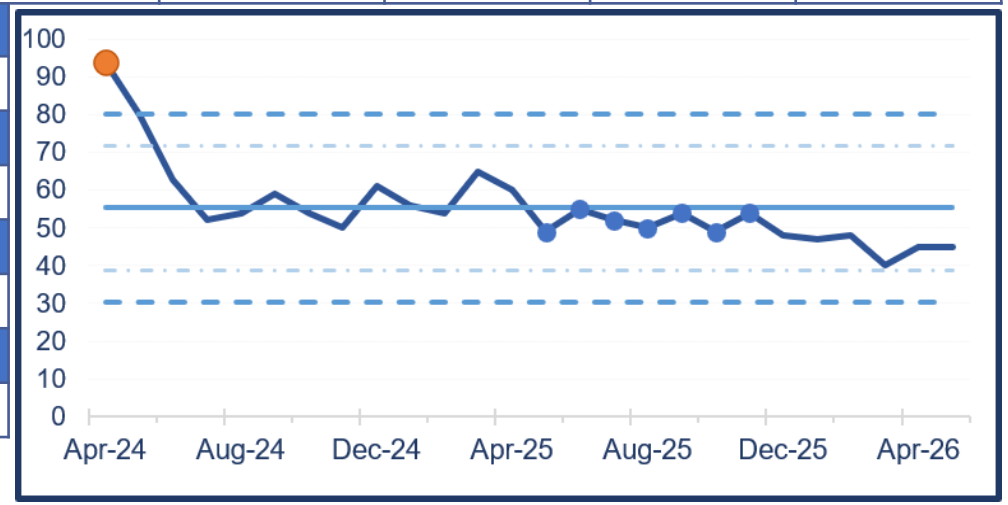
Latest Month	Profile	Actual	Status
May-26	N/A	4	Advise



All open NRIs

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

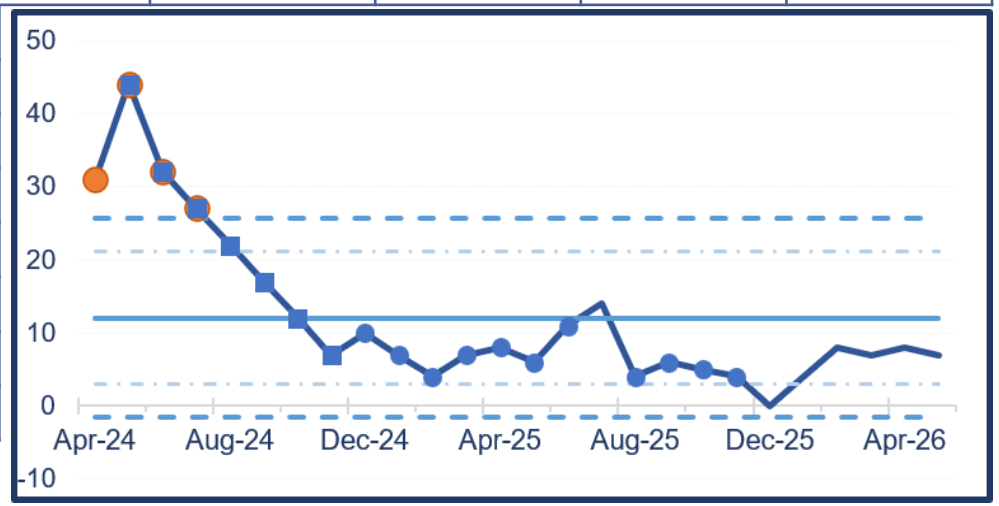
Latest Month	Profile	Actual	Status
May-26	N/A	45	Advise



All overdue NRIs

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

Latest Month	Profile	Actual	Status
May-26	N/A	7	Advise

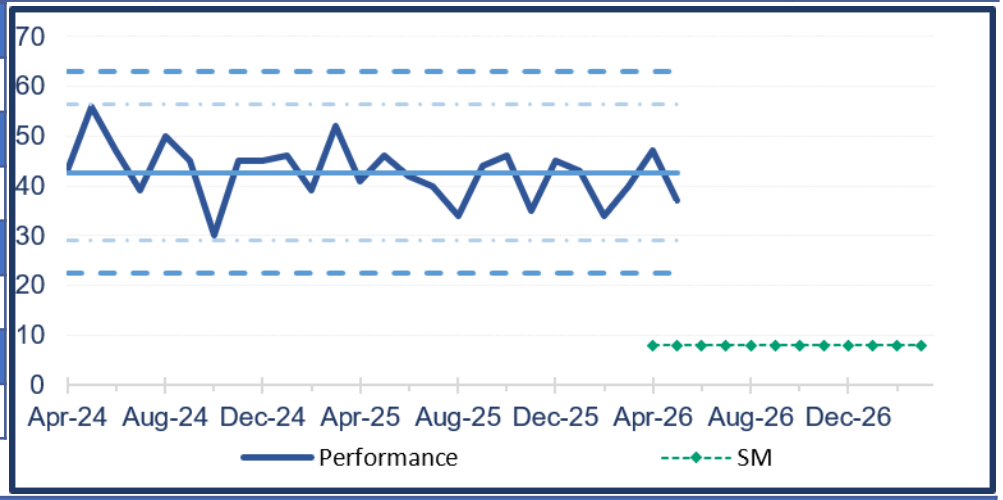


Quality: Infections

Number of hospital onset E-coli infections

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

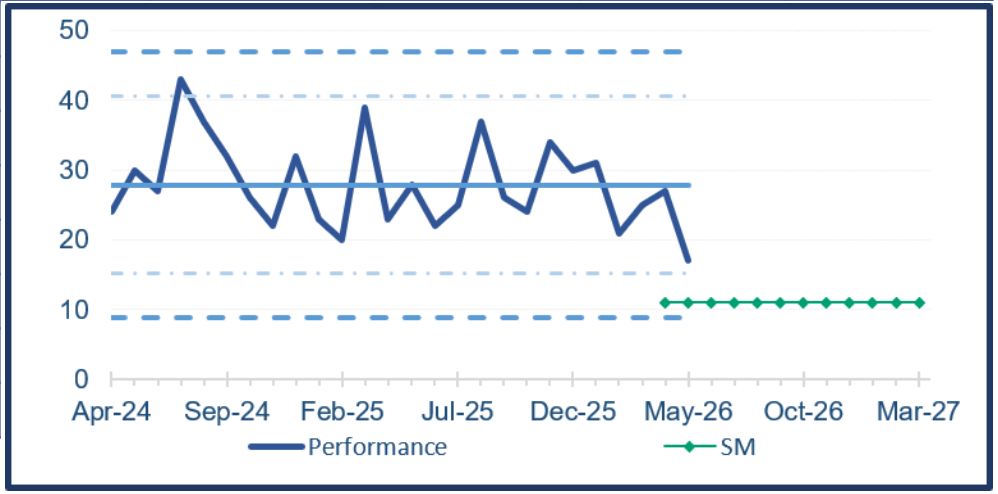
Latest Month	May-26
Profile	N/A
Actual	37
Status	Advise



Number of hospital onset C-Ddiff infections

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

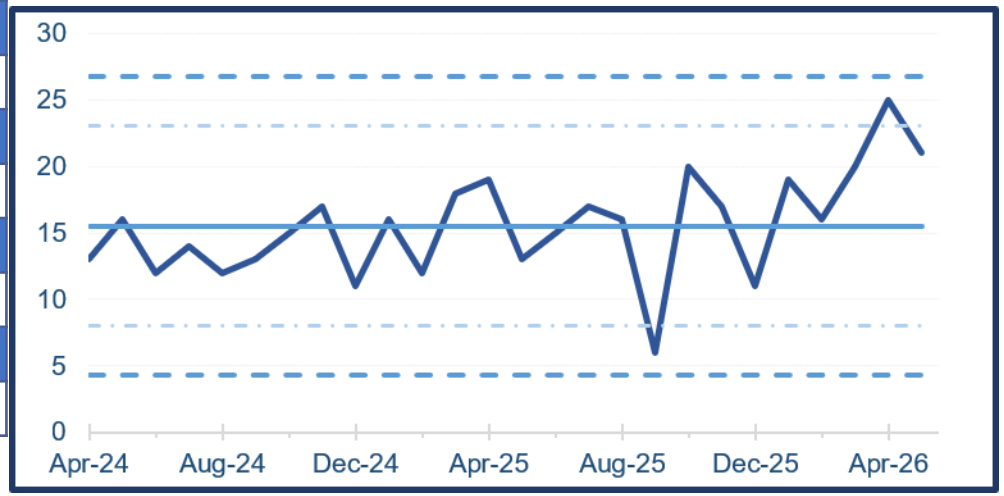
Latest Month	May-26
Profile	N/A
Actual	17
Status	Advise



Number of hospital onset MSSA infections

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

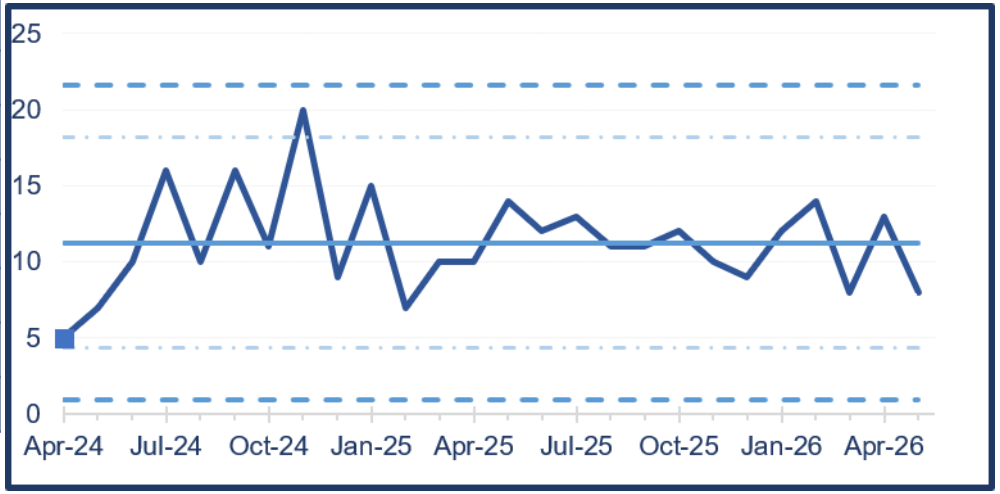
Latest Month	Mar-26
Profile	N/A
Actual	21
Status	Advise



Number of hospital onset Klebsiella infections

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

Latest Month	May-26
Profile	N/A
Actual	8
Status	Advise

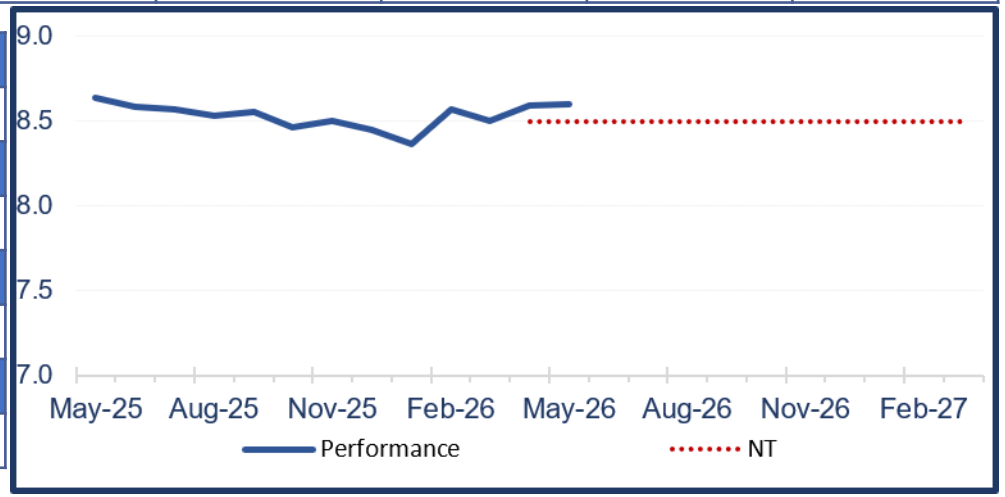


Quality: Patient Experience and Regulation 28 notices

Overall health board patient experience score

SM De-Escalation	N/A	Framework	8.5	Latest Benchmark	TBC

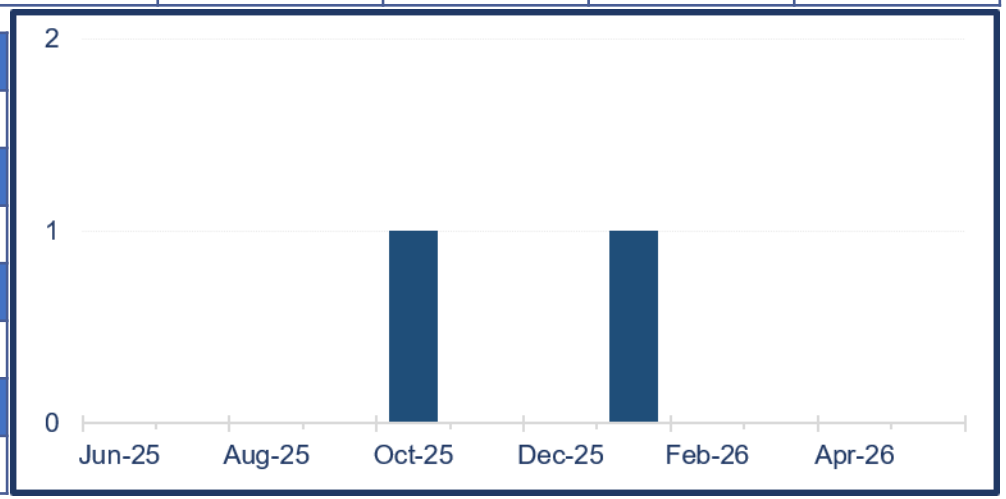
Latest Month
May-26
Profile
Actual
8.6
Status
Advise



Regulation 28 notices (Prevention of Future Deaths reports)

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

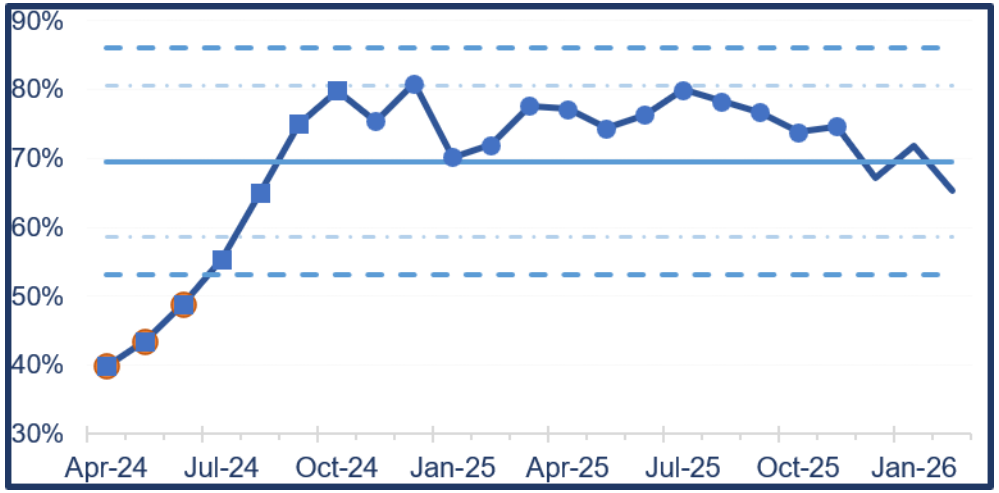
Latest Month
May-26
Profile
Actual
0
Status
Advise



Percentage of complaints closed within 30 days of date received

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

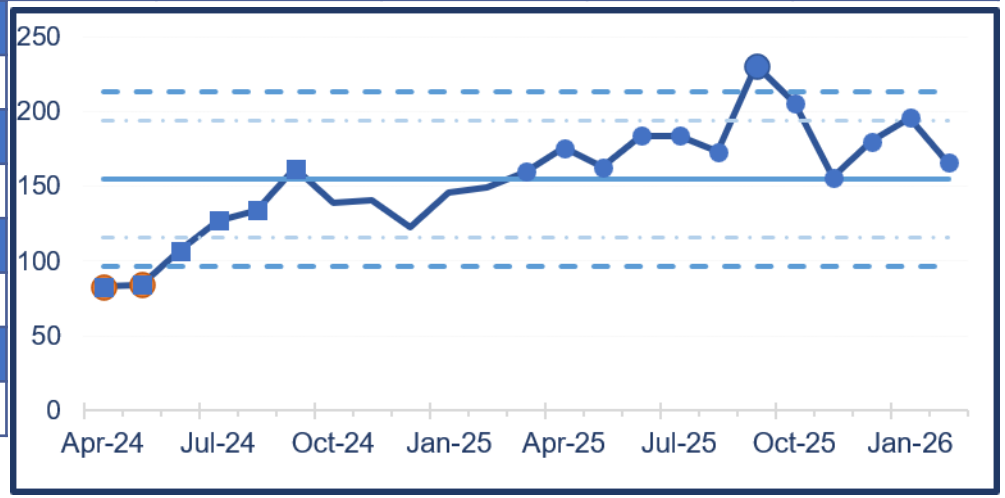
Latest Month
Feb-26
Profile
N/A
Actual
65.4%
Status
Assure



Number of complaints closed within 30 days of date received

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

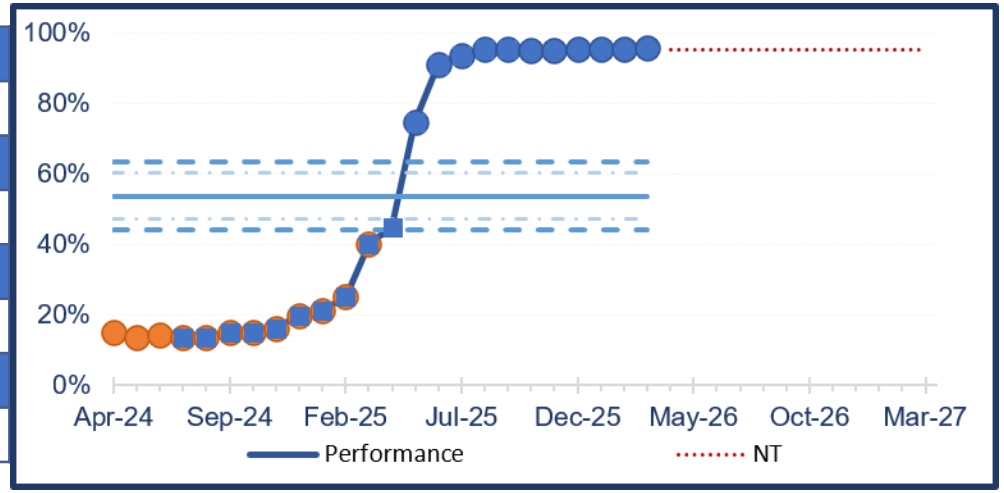
Latest Month
Feb-26
Profile
N/A
Actual
166
Status
Assure



Quality: Clinical Coding

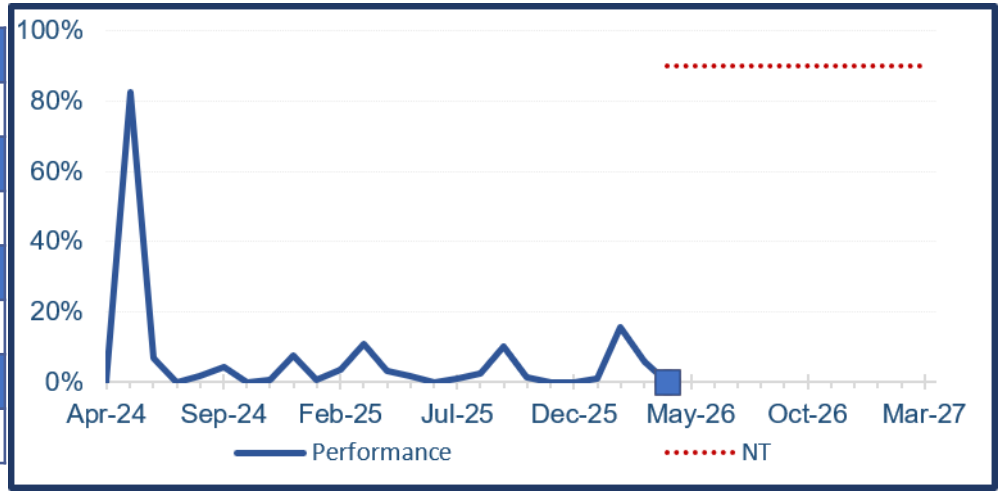
% of episodes clinically coded within one reporting month post episode discharge end date					
SM De-Escalation	N/A	Framework	95%	Latest Benchmark	4 of 8

Latest Month
Mar-26
Profile
95%
Actual
95.6%
Status
Assure



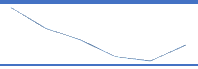
% of all classifications' coding errors corrected by the next monthly reporting submission following identification					
SM De-Escalation	N/A	Framework	90%	Latest Benchmark	8 of 8

Latest Month
Mar-26
Profile
90%
Actual
5.7%
Status
Alert



Section 3
People and places

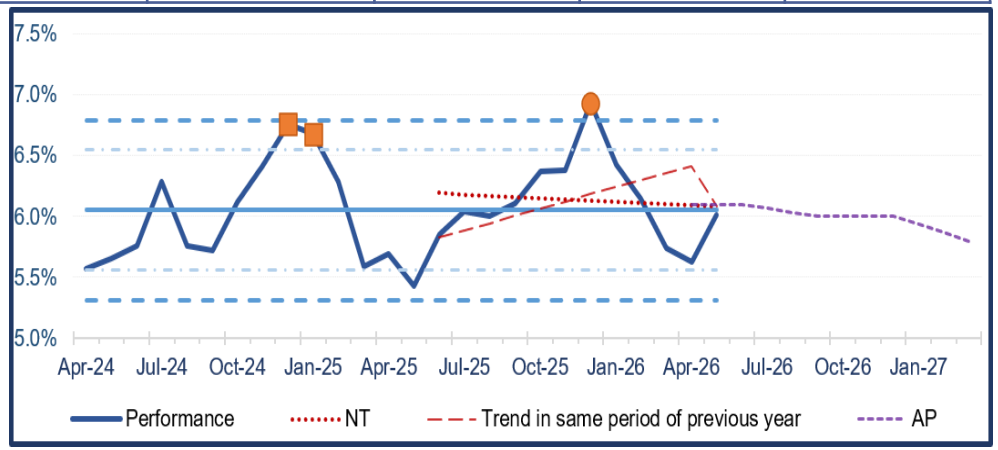
Scorecard: People and places

REF	Measure Description	Target Suite			Wales Benchmark	Actual Performance				Delivery Assurance	Action
		NT	SM	AP		Mar-26	Apr-26	May-26	Trend to Date		
NPF36	Percentage of sickness absence rate of staff (month by month)	N/A	N/A	N/A	N/A	5.74%	5.63%	6.01%		Reasonable Assurance	Assure
LMW05	Percentage Performance Appraisal Development Review (PADR)	N/A	N/A	N/A	N/A	80.7%	80.8%	80.0%		Reasonable Assurance	Assure
LMW06	Percentage staff completed Level 1 Mandatory Training	85%	N/A	90%	N/A	90.6%	90.8%	90.6%		Reasonable Assurance	Assure
LMW07 (NPF37*)	Turnover rate for nurse, midwifery, medical and dental registered staff leaving BCUHB	N/A	N/A	N/A	5th from 11	7.02%	7.02%	7.08%		Substantial Assurance	Assure

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

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

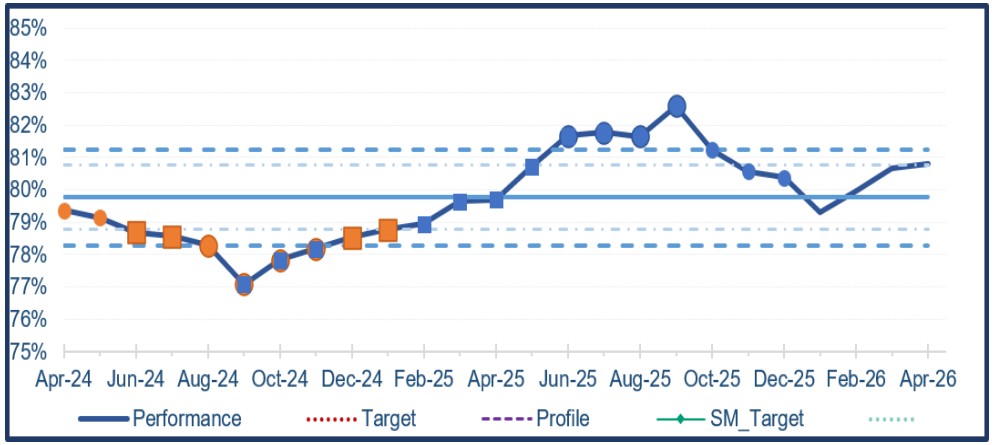
Latest Month	May-26
Profile	6.1%
Actual	6.0%
Status	Alert



Percentage of Performance Appraisal Development Reviews (PADRs) undertaken

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

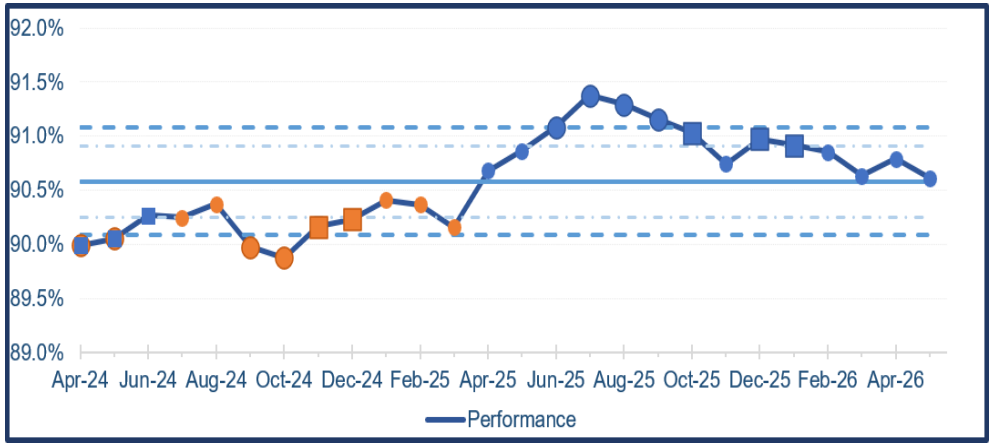
Latest Month	May-26
Profile	N/A
Actual	80.0%
Status	Advise



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

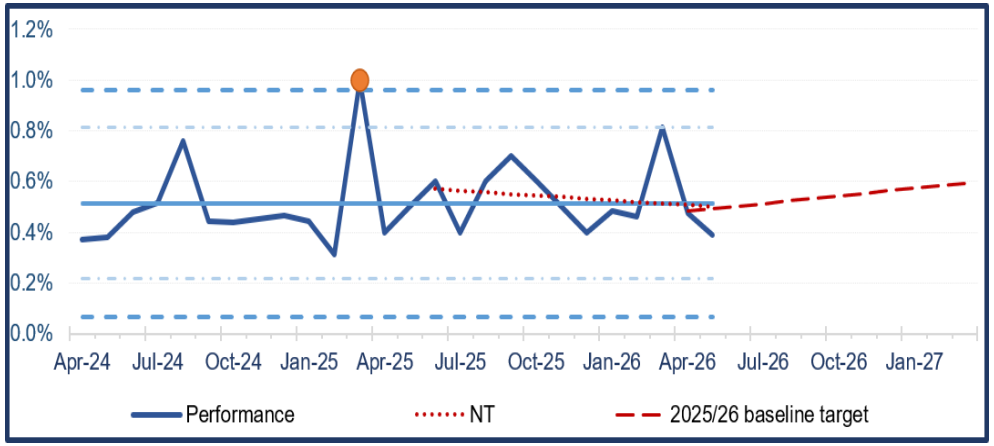
Latest Month	May-26
Profile	N/A
Actual	0.39%
Status	Advise



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	May-26
Profile	N/A
Actual	0.39%
Status	Advise

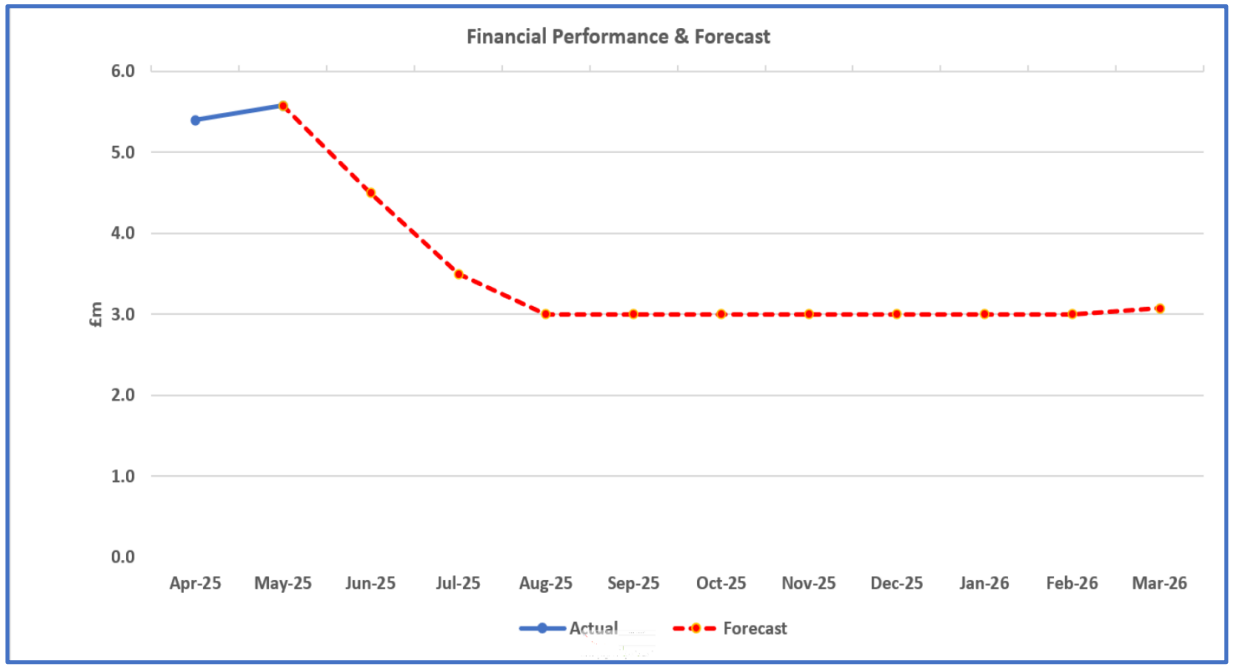


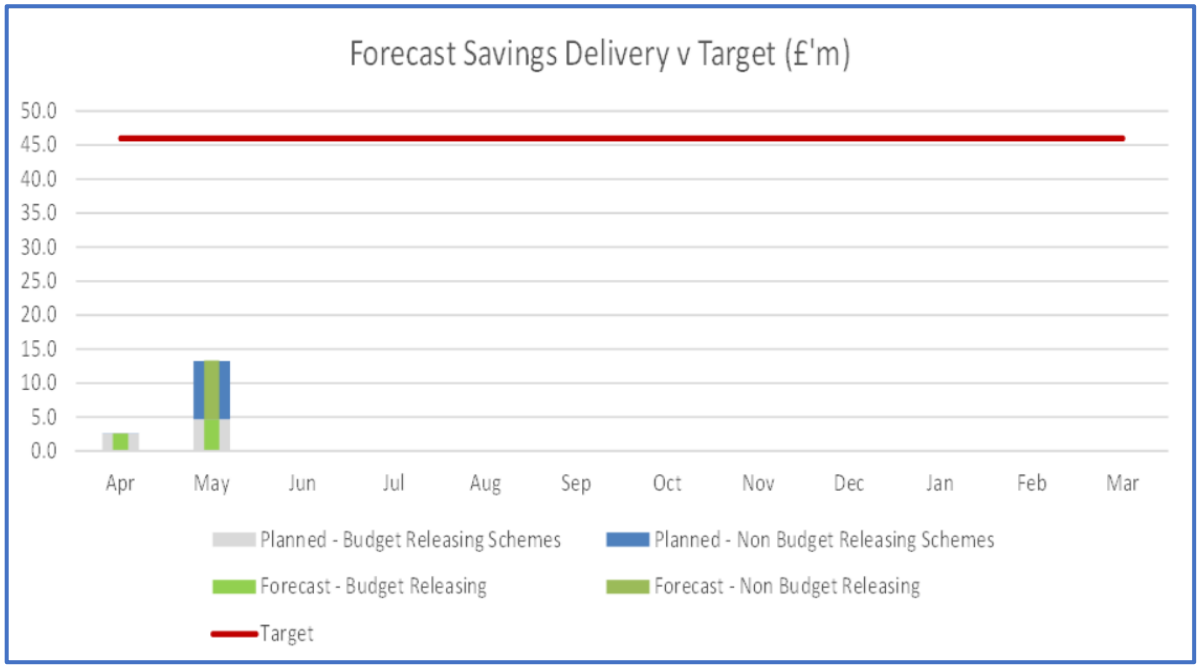
Section 4
Finance and sustainability

Scorecard: Finance and sustainability

REF	Measure Description	Target Suite			Wales Benchmark	Actual Performance			Delivery Assurance	Action
		NT	SMDT	AP		Mar-26	Apr-26	May-26		
NPF38	30% reduction on Agency spend (based upon positon 31.03.26) - forecast	30%	N/A	N/A	N/A		19%	22%	Reasonable Assurance	Assure
LMF01	Revenue Position - Expenditure over profile deficit position per month	£43m	N/A	N/A	N/A		£1.8m	£2.0m	Limited Assurance	Advise
LMF02	Value and Sustainablity Opportunities forecast	£46m	N/A	N/A	N/A		£34.4m	£45.2m	Limited Assurance	Advise
4GP01	Cash releasing savings forecast (including productivity and efficiency and length of stay reductions)	£46m	N/A	N/A	N/A		£0.2m	£13.3m	Limited Assurance	Advise
LMF03	Capital Spend	£61m	N/A	N/A	N/A		N/A	£1.7m	Reasonable Assurance	Assure

Scorecard: Finance and sustainability





Scorecard: Finance and sustainability

	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)	(196.2)	(197.8)	(195.8)	(197.3)	(196.7)	(196.0)	(197.6)	(196.7)	(194.7)	(198.5)	(394.3)	(394.3)	**0.0**	0.0%
Miscellaneous Income	(14.7)	(15.4)	(14.7)	(14.6)	(14.7)	(14.7)	(14.7)	(14.6)	(14.6)	(14.6)	(14.6)	(14.6)	(28.6)	(30.1)	**(1.5)**	5.2%
Health Board Pay Expenditure	101.6	102.4	101.5	101.4	101.6	101.7	101.5	101.5	101.5	101.9	101.7	101.5	202.5	203.9	**1.5**	0.7%
Non-Pay Expenditure	115.5	115.9	113.8	114.5	111.9	113.3	112.9	112.1	113.7	112.4	110.6	114.7	220.4	231.4	**11.0**	5.0%
Total Deficit / (Surplus)	**5.4**	**5.6**	**4.5**	**3.5**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.1**	**0.0**	**10.9**	**10.9**	
Planned Deficit	**3.6**	**3.6**	**3.6**	**3.6**	**3.6**	**3.6**	**3.6**	**3.6**	**3.6**	**3.6**	**3.6**	**3.6**	**7.2**	**0.0**	**7.2**	**100.00%**
Total Deficit / (Surplus) above Plan	**1.8**	**2.0**	**0.9**	**(0.1)**	**(0.6)**	**(0.6)**	**(0.6)**	**(0.7)**	**(0.6)**	**(0.6)**	**(0.6)**	**(0.5)**	**7.2**	**10.9**	**3.8**	

Section 5
Population health and prevention

Scorecard: Population health and prevention

Population Health

RIA = Reported in Arrears

REF	Measure Description	Target Suite			Wales Benchmark	Actual Performance				Delivery Assurance	Action
		NT	SM	AP		Q2 25/26	Q3 25/26	Q4 25/26	Notes		
1AP01	Percentage of adult smokers who make a quit attempt via smoking cessation services	8%	N/A	1.5%	2nd from 7 (at Q3 25/26)	4.19%	6.02%	8.05%	Annual Target	Reasonable Assurance	Assure
1AP02	Percentage of adult smokers who make a quit attempt via smoking cessation services who are co-validated as quit at 4 weeks	40%	N/A	40%	4th from 7 (at Q3 25/26)	25.0%	24.1%	23.7%		Limited Assurance	Advise
3DP05	Percentage of people who have been referred to health board services who have completed treatment for substance misuse (drugs or alcohol)	80%	N/A	80%	1st from 7 (at Q3 25/26)	95.9%	100.0%	96.2%		Substantial Assuranc	Assure
1DP01	Percentage of children who are up to date with all routine scheduled vaccinations by age 5	95%	N/A	95%	3rd from 7 (at Q3 25/26)	90.5%	89.7%	87.6%		Limited Assurance	Advise
1DP02	Percentage of children receiving the Human Papillomavirus (HPV) vaccination by the age of 15	90%	N/A	90%	5th from 7 (at Q3 25/26)	72.3%	70.3%	70.8%	School year based programme	Limited Assurance	Advise
2AP01	Percentage of population (adult) receiving NHS dental care over a 24-month period - General Dental Services (GDS)	Inc	N/A	N/A	6th from 7 (at Q3 25/26)	31.9%	31.5%	RIA		Limited Assurance	Advise
2AP02	Percentage of population (child) receiving NHS dental care over a 12-month period - General Dental Services (GDS)	Inc	N/A	N/A	6th from 7 (at Q3 25/26)	40.7%	40.3%	RIA		Limited Assurance	Advise
3HP01	Percentage of community pharmacies providing Pharmacist Independent Prescribing service (PIPS)	70%	N/A	44%	6th from 7	43.4%	43.4%	42.7%		Limited Assurance	Advise
3HP04	Number of low Global Warming Potential (GWP) inhalers as a percentage of all inhalers prescribed	80%	N/A	N/A	7th from 7	40.8%	42.1%	44.5%		Limited Assurance	Advise

REF	Measure Description	Target Suite			Wales Benchmark	Actual Performance				Delivery Assurance	Action
		NT	SM	AP		Mar-26	Apr-26	May-26	Notes		
1CP01	Percentage uptake of the influenza vaccination amongst adults aged 65 years and over	75%	N/A	S	N/A	N/A	N/A	N/A	Seasonal programme		
1DP04	Percentage uptake of the Respiratory Syncytial Virus (RSV) for those turning 75 years old	70%	N/A	70%	5th from 7	New Metric	51.4%	RIA	Routine cohort only	Limited Assurance	Advise
1AP07	Percentage of patients (aged 12 years and over) with diabetes who have had foot surveillance recorded within last 15 months	80%	N/A	80%	5th from 7	68.0%	67.4%	66.3%		Limited Assurance	Advise
1AP08	Percentage of patients (aged 12 years and over) with diabetes who have had their urine albumin recorded within last 15 months	80%	N/A	80%	6th from 7	65.0%	65.3%	64.8%		Limited Assurance	Advise

Appendices

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

Interpreting Statistical Process Control (SPC) Charts

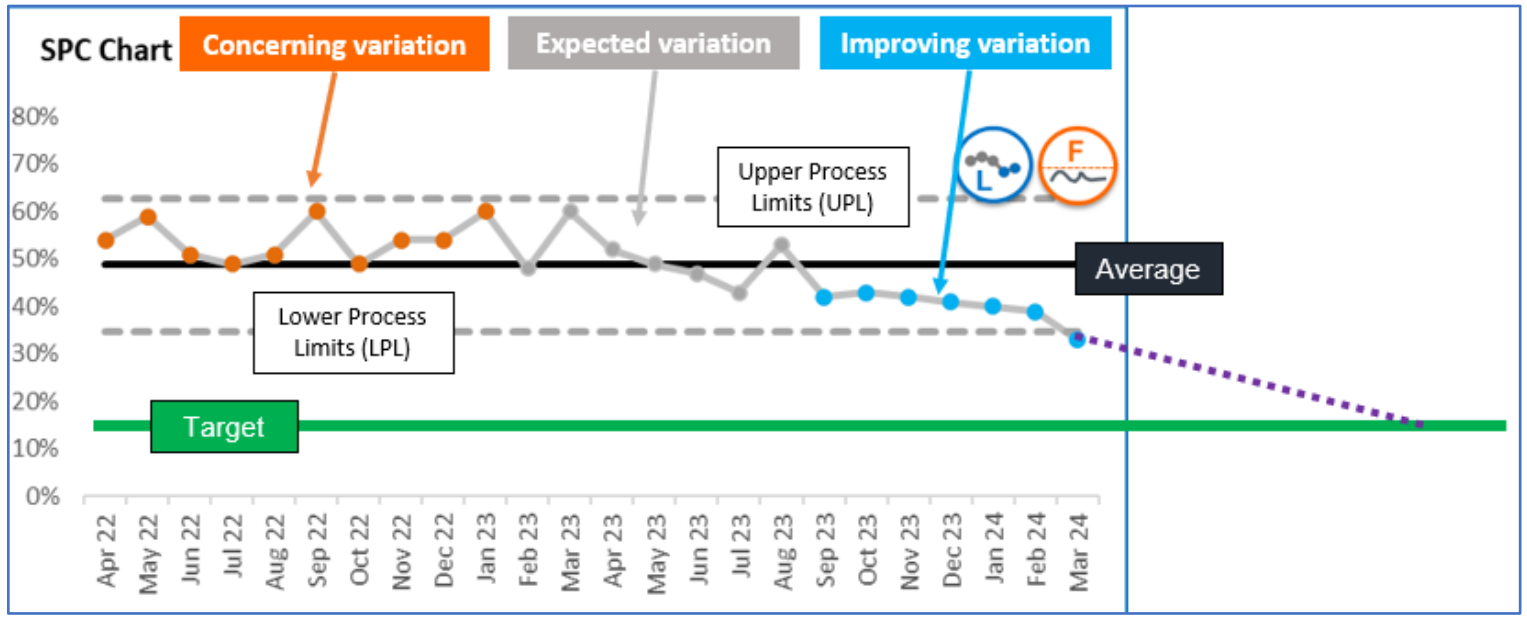
A statistical process control (SPC) chart is a useful tool to help distinguish between signals (which should be reacted to) and noise (which should not as it is occurring randomly).

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 (the **green** line) 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	**Improving**	Where performance has improved month on month, but may not have statistically improved beyond process limits
	No Change	Where performance has neither improved or deteriorated
	Worse	Where performance has deteriorated month on month, but may not have statistically deteriorated outside of process limits

Action	**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.

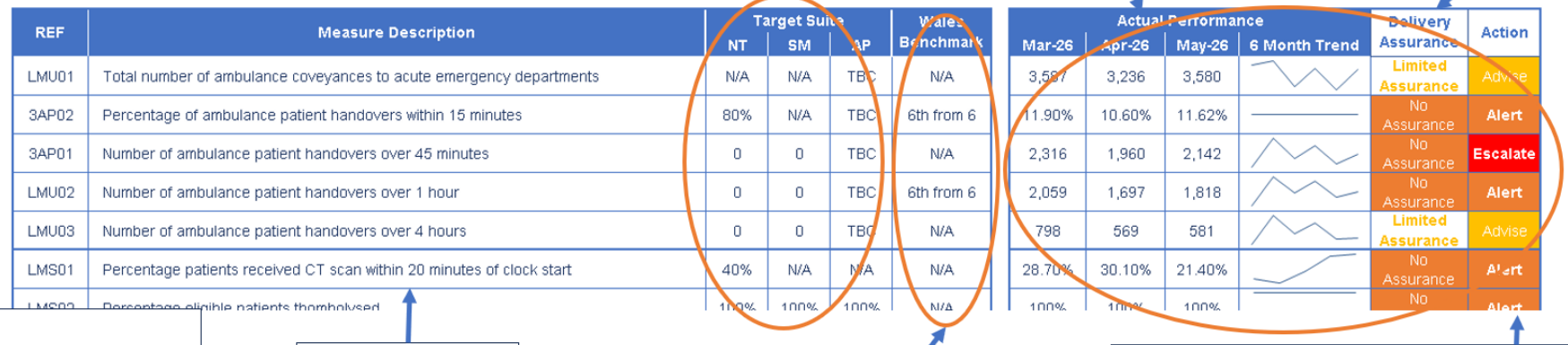
How to interpret the Integrated Performance Scorecard

Diagram and description of Scorecard elements

Target Suite:
NT = Natiuonally Mandated Target
SMDT = Special Measures De-escaltion Target
CMT = 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 NT	SM	AP	Wales Benchmark	Actual Performance Mar-26	Apr-26	May-26	6 Month Trend	Delivery Assurance	Action
LMU01	Total number of ambulance coveyances to acute emergency departments	N/A	N/A	TBC	N/A	3,587	3,236	3,580		Limited Assurance	Advise
3AP02	Percentage of ambulance patient handovers within 15 minutes	80%	N/A	TBC	6th from 6	11.90%	10.60%	11.62%		No Assurance	Alert
3AP01	Number of ambulance patient handovers over 45 minutes	0	0	TBC	N/A	2,316	1,960	2,142		No Assurance	Escalate
LMU02	Number of ambulance patient handovers over 1 hour	0	0	TBC	6th from 6	2,059	1,697	1,818		No Assurance	Alert
LMU03	Number of ambulance patient handovers over 4 hours	0	0	TBC	N/A	798	569	581		Limited Assurance	Advise
LMS01	Percentage patients received CT scan within 20 minutes of clock start	40%	N/A	N/A	N/A	28.70%	30.10%	21.40%		No Assurance	Alert
LMS02	Percentage eligible patients thrombolysed	100%	100%	100%	N/A	100%	100%	100%		No	Alert

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

Action:
Based on all the information displayed, the performance function prescribe the following action

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.

Assure: For information only. No actions expected to be undertaken by the Committee / Health Board

Advise: or information only. No actions expected to be undertaken. However committee/ Health Board members may wish to explore further for assurance on delivery confidences

Alert: Members are advised to to explore further for evidence of mitigations and /or more substantial assurances on delivery confidences

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

Abbreviations

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

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

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

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Performance Finance & Information Governance Committee

ADRODDIAD DANGOSYDDION PERFFORMIAD ALLWEDDOL. CHWARTER 4 2025/26

INFORMATION GOVERNANCE QUARTER 4 2025/26 KEY PERFORMANCE INDICATORS REPORT

Dyddiad y Cyfarfod **Date of Meeting**	23 June 2026
Statws Cyhoeddi **Publication Status**	Open/ Public Not Applicable
Enw a theitl Awdur(on) yr Adroddiad **Report Author name and title**	**Information Governance Q4 KPI 2025-2026 Report** Carol Johnson Pennaeth Llywodraethu Gwybodaeth Head of Information Governance
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol **Lead Executive Team Member name and title**	Justine Parry Cyfarwyddwr Thechnoleg Ddigidol a Data Dros Dro Acting Director of Digital, Data and Technology

Pwrpas yr Adroddiad **Report Purpose**	For Noting

Crynodeb Gweithredol
Executive Summary

Information Governance Q4 KPI 2025-2026 Report

BCUHB has a responsibility to ensure robust information governance systems and processes are in place to protect patient, personal and corporate information. This report is to provide assurance across the key areas of information governance including, but not limited to, confidentiality, data protection, and requests for information, information security and training. The report identifies areas of weaknesses, further actions and recommendations required to address the weaknesses, lessons learnt and good practice.

Due to statutory timelines for processing Freedom of Information (FOI) and Subject Access Requests (SARs), KPI reports can only be produced one month after the end of each quarter and cannot be reported any sooner. Also, the figures for FOI and SAR delays and divisional compliance represent the position as at 1st May 2026. A number of cases have closed since then, and those updates will appear in the Quarter 1 2026/27 KPI report.

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**
Information Governance Group	19/05/2026	Presented to group, chaired by Dr James Risley. Included in minutes and Chairs Assurance Report.
Senior Leadership Team	26/05/2026	Chairs Assurance Report presented and agreed by group.
Executive Committee	03/06/2026	Presented and approved at meeting on 3rd June 2026.

Appendices / Atodiadau	
Appendix 1	Information Governance – Q4 KPI 2025-26

1. **Y SEFYLLFA**
SITUATION

1.1 The reports provide the board with an overview of current performance across key statutory and operational information governance functions, including compliance with data protection obligations, response timeliness, and governance activities. The report highlights areas of assurance as well as emerging risks where performance has fallen below expected standards. These trends have the potential to impact organisational compliance, resource demand, and the health board's overall assurance position. Board oversight is required to note the performance position and consider any actions needed to support improvement.

2 **Y CEFNDIR**
BACKGROUND

2.1 The framework is designed to provide the Board with clear and timely assurance on the Health Board's performance against key statutory, regulatory, and internal IG requirements. Regular monitoring and reporting of IG KPIs support effective oversight of compliance, highlight areas of emerging risk, and enable early identification of any themes or pressures that may impact organisational assurance. The report forms an essential part of the Board's governance arrangements, ensuring transparency in how the Health Board manages personal data, responds to information requests, and maintains robust information governance standards.

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

3.1 **Patient record storage risk:** Significant and recurring organisational risk relating to capacity, security, and inappropriate storage practices, requiring continued Executive oversight and escalation.

3.2 **Information Asset Register (IAR):** Progress made, but incomplete coverage remains a key dependency for risk management, cyber response, and DPIA activity; further engagement and population required.

3.3 **FOI demand and performance:** Record high volumes with improved compliance (66%), but sustained pressure on resources and response times.

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

4.1 The issues highlighted in Section 3.1 require escalation to the Executive Committee.

5 **ARGYMHELLION**
RECOMMENDATIONS

5.1 Gofynnir i'r Pwyllgor/Cyfarfod/Grŵp:
The Committee/Meeting/Group is asked to:

- **NOTE** – The updates outlined in the Executive Summary and also the matter requiring escalation.

ASESIAD / ASSESSMENT	

Cyswllt â'r Blaenoriaethau Strategol
Link to Strategic Priorities
	
	1. Building an effective organisation
	The supporting information governance objectives will be achieved by ensuring there is an effective Information Governance framework in place by:
	• Ensuring that BCUHB meets its legal and statutory obligations as defined in the Data Protection Act 2018, UK GDPR and European GDPR 2016 and the Freedom of Information Act 2000 (FOI Act):
	  • Continue to develop and improve systems for Records of Processing Activity (ROPA);
	  • Ensure privacy by design and default is considered at all stages of service design, system procurement and partnership working;
	• Ensure IG Strategies, policies, procedures and training plans are all updated to reflect best practice and changes in legislation including social media and Artificial Intelligence (AI).
	• Develop and implement a system and process for the regular review of information sharing agreements / protocols both nationally and locally.
	• Continually look at ways to improve, monitor for assurance and report on the Systems and Records Assets held within the Information Asset Register
	• Continue to meet the Information Governance training national target of 85% to help improve staff understanding and continuous awareness.
	• Strengthen relationships with IHC clusters to improve Information Governance compliance with Primary Care Contractors.
	• Increase service user and Regulator confidence in the Health Board and its staff with increased visibility and working relationships, including a refresh of the IG

<table>
<tr><td></td><td>Webpages and the exploration of introducing IG Champions.
• Encourage and support the professional development of team members by providing opportunities for training, skill enhancement, and knowledge acquisition in relevant areas and to include the development of training programmes.</td></tr>
<tr><td></td><td>Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:
If more than one applies, please list below:</td></tr>
<tr><td>Yr Egwyddorion Dylunio Design Principles</td><td>Simplify, Standardise, and Adopt Best Practices
Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:
If more than one applies, please list below:</td></tr>
<tr><td>Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd
Corporate Risks and Board Assurance Framework</td><td>Non-compliance with the legislation can lead to penalties imposed by the Information Commissioner and loss of confidence by the public in the Health Board’s ability to protect the privacy of their information.

<table>
<tr><td colspan="5">Risk Register - Tier 2</td></tr>
<tr><td>ID4306 – Data Flow Mapping and Records of Processing Activity (ROPA)</td><td>9</td><td>9</td><td>6</td><td>Unchanged</td></tr>
<tr><td>ID5238 - Development and ongoing management of Corporate Records Management function</td><td>15</td><td>12</td><td>6</td><td>Unchanged</td></tr>
<tr><td>ID5239 - BCU site wide audit to identify health and corporate records store</td><td>15</td><td>12</td><td>4</td><td>Unchanged</td></tr>
</table>
</td></tr>
</table>

	in vulnerable locations				
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals	Not Applicable				
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:				

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Cydraddoldeb *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 *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	Not Applicable	

Wellbeing of Future Generations Act – Wellbeing Goals	

Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
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** *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 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)	
	Ensuring that BCUHB meets its legal and statutory obligations as defined in the Data Protection Act	

	2018, UK GDPR and European GDPR 2016 and the Freedom of Information Act 2000 (FOI Act): • Continue to develop and improve systems for Records of Processing Activity (ROPA); • Ensure privacy by design and default is considered at all stages of service design, system procurement and partnership working;
Enw Da **Reputational**	Yes (Include further detail below) Underperformance against these KPIs may present a reputational risk to BCUHB by reducing confidence in the Health Board's information governance practices. Conversely, strong performance supports organisational assurance and reinforces public and stakeholder trust in our management of personal information.
Effaith ar Adnoddau *(Pobl / Ariannol)* **Resource Impact** *(People / Financial)*	Yes (Include further detail below) Non-compliance with the legislation can lead to significant fines imposed by the Information Commissioners office.

Trugaredd
Compassion

Agored
Openness

Parch
Respect

Atodiad 1 - Dangosyddion Perfformiad Allweddol

Chwarter 4 – Ionawr i Mawrth 2026

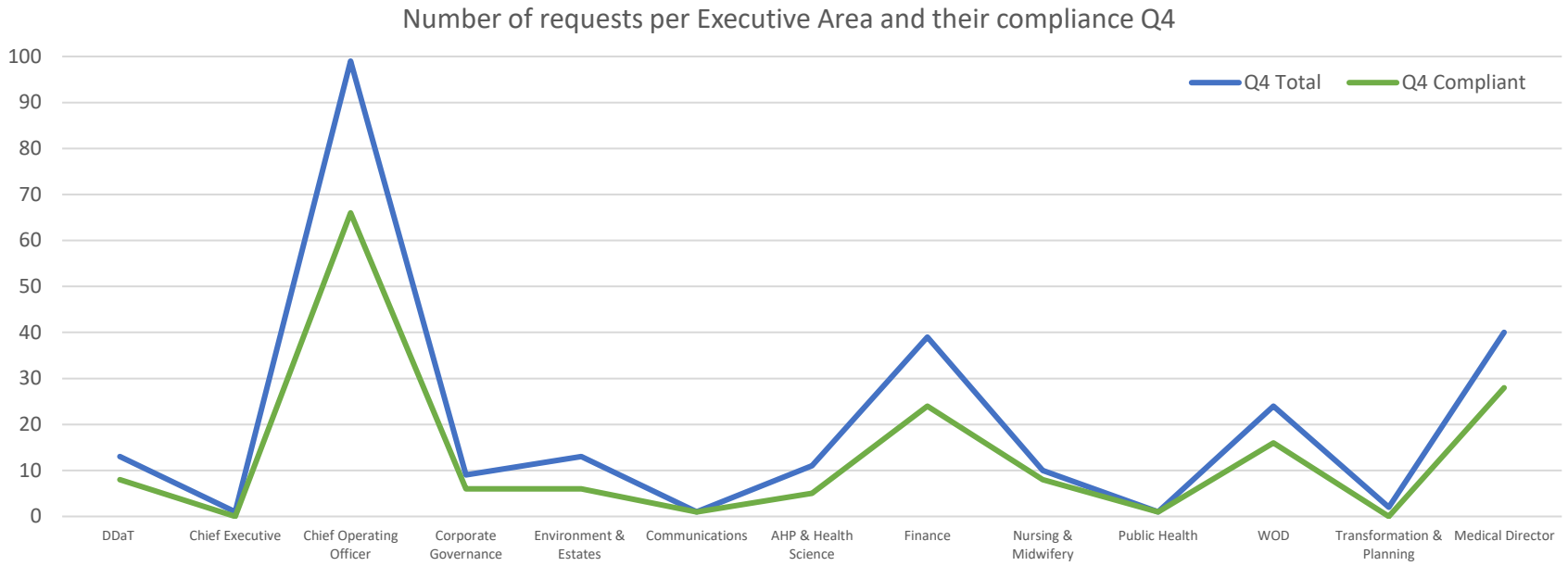
Appendix 1 - Key Performance Indicators

Quarter 4 – January to March 2026

Appendix 1 - Key Performance Indicators: Quarter 4 – January to March 2026.

Freedom of Information (FOI) Compliance

In Quarter 4 2025/26, the Information Governance (IG) Team handled 263 Freedom of Information requests, representing a 36% increase compared to Quarter 3 (193) . Despite this increased demand, compliance improved from 57% to 66% following the reallocation of resources within the IG Team, demonstrating improved capacity and resilience. A total of 1,380 hours was spent processing FOI requests during the quarter, equating to an estimated cost of £34,500 under the Freedom of Information Act. This represents an increase of approximately 91% compared to Quarter 3 and reflects the significant rise in request volumes. A detailed breakdown of the reasons for delay, together with divisional compliance percentages, is provided later in the report



FOI Exemption and internal reviews - Please note due to the timeframe permitted under the Act for applicants to request an internal review, some reviews may not be captured in time for this report, however they will be captured within the Information Governance Annual Report.

Exemption	Exemption Category	Total	Internal Review	Upheld/ Overturned
Section 12 – Cost Limit Exceeded	Absolute – No Public Interest Test Required	29	1	Ongoing
Section 21 - reasonably accessible to an applicant by other means.	Absolute – No Public Interest Test Required	13	1	Ongoing
Section 31 – Law Enforcement	Public Interest Test applied	1	-	-
Section 40 - Personal Information	Absolute – No Public Interest Test Required	4	-	-
Section 42 – Legal Professional Privilege	Public Interest Test applied	1	-	-
Section 43 – Commercially Sensitive	Public Interest Test applied	2	-	-
No Exemption applied	N/A	213	5	Ongoing (1) Partially Overturned (2) Upheld (2)
Total		263	7	

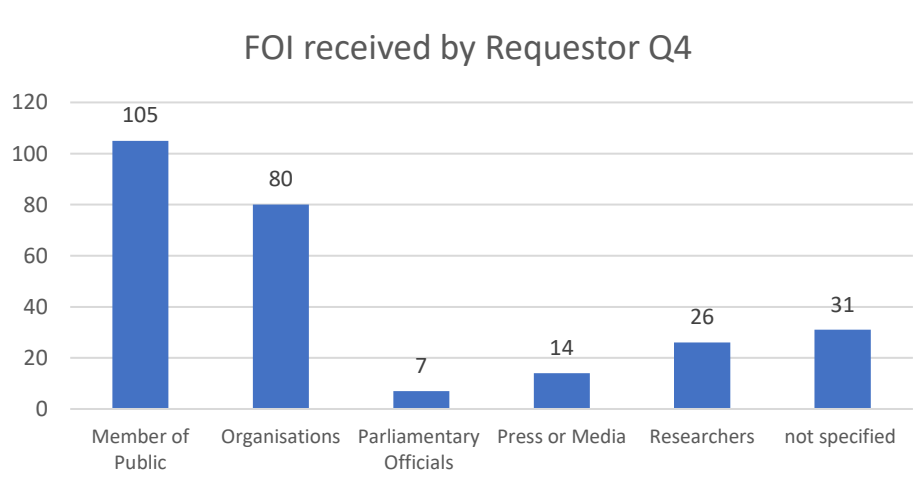
Highest reported reasons for delays/breaches for non compliant cases:	The Divisions with the lowest percentage of compliance
• 25 delays reported due to receiving the information from Divisional Leads. • 23 delays due to Executive approval. • 11 delays due to formulation of response from IG Team. • 9 delays due to unable to identify correct lead. • 3 delays due to the need to consider an exemption to the response.	• Chief Executive– 1 out of 1 (100%) non-compliant. • AHP & Health Science – 6 out of 11 (54.6%) non-compliant. • Environment & Estates – 7 out of 13 (53.8%) non-compliant. • Transformation & Planning – 1 out of 2 (50%) non-compliant. • DDaT– 5 out of 13 (38.5%) non-compliant. • Finance – 15 out of 39 (38.5%) non-compliant.

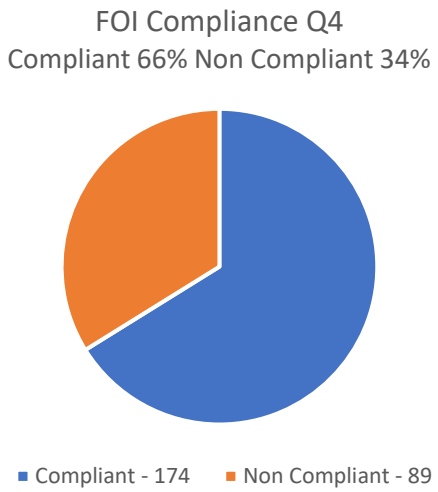
Trends in Freedom of Information Subject - The themes remain largely consistent with Q3.

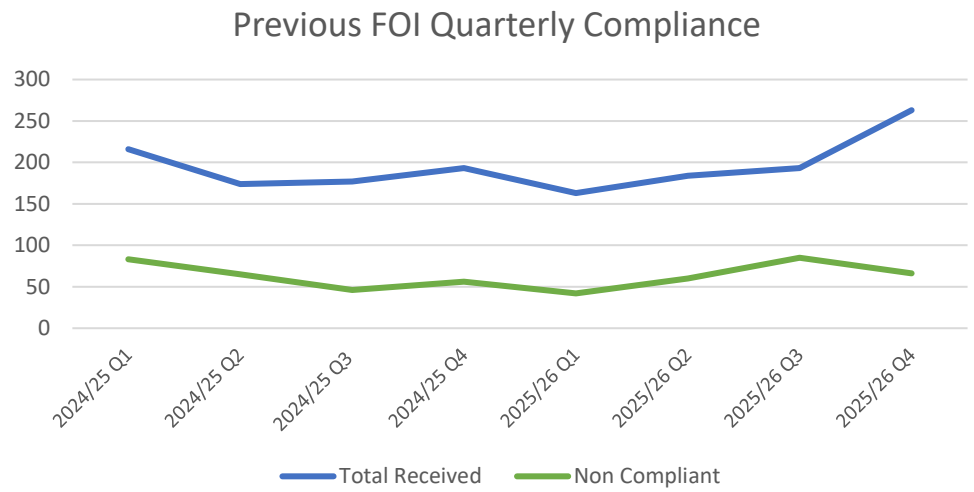
- **Clinical treatment and medication (41)** is the largest category, spanning a number of specialities, with detailed requests on patient numbers and regimens.
- **Workforce and temporary staffing spend (36)** with extensive breakdown requests for agency, locum, and bank staff across nursing, medical, AHP, and non-clinical roles.
- **Access and waiting times (27)** are a recurring theme, particularly for ADHD/autism, mental health services, dentistry, elective surgery, diagnostics, and community pathways.
- **Outsourcing, insourcing, and commissioning (22)** including private provider use for elective backlogs, diagnostics, complex care, and consultancy services.
- **Governance, policy, and assurance (23)** sustained scrutiny of Health Board accountability, covering policies, audits, reviews, committee papers, incidents, and complaints.
- **Digital and IT systems (19)** focusing on EPR/PAS/PACS systems, interoperability, digital strategy, IT spend, cyber assurance, and system migrations.

Improvement Actions

The Information Governance team will sustain data quality improvements through ongoing monitoring of case classification and closure processes. Data accuracy controls remain embedded in routine practice. Work will also continue with colleagues to proactively publish information on common FOI themes, improving transparency, supporting public access, and reducing repeat requests. These actions will support continued compliance and strengthen assurance over FOI reporting.







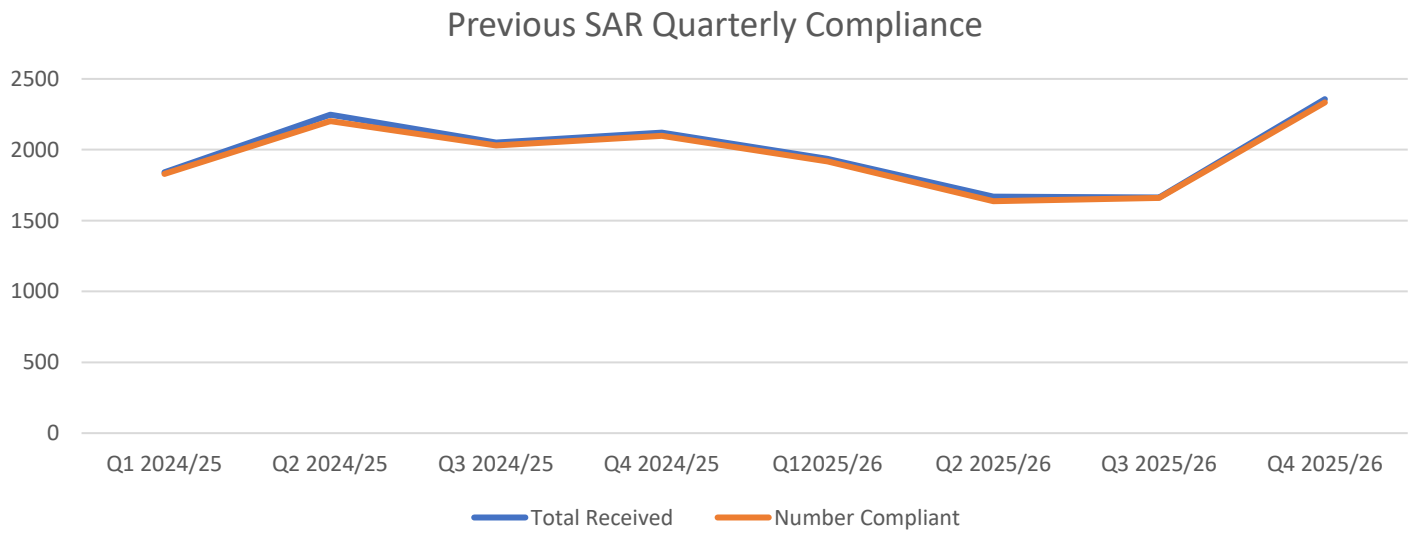
Subject Access Request Compliance

Overall Subject Access Request compliance increased to 99%, with non-clinical requests maintaining 100% compliance. This improvement was achieved alongside a 45.6% increase in request volumes.

During Quarter 4, the Information Governance Team noted a continued increase in the use of AI tools by requestors to draft and refine Subject Access Requests, including clarifying initial submissions and generating follow-up queries. To support clarity and manage expectations, a SAR information leaflet was developed, providing clear guidance on what can be requested and what requestors can expect from the process. The leaflet is currently in the final stages of translation and is scheduled for publication in the next quarter.

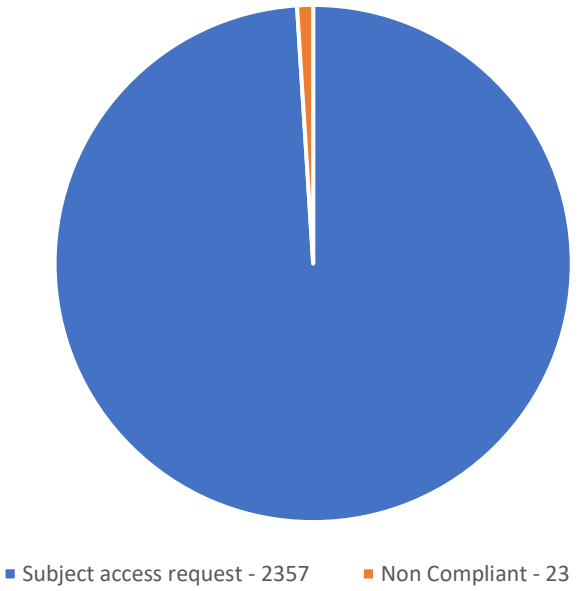
2025/26 Improvement Actions

The Information Governance and Access to Health Records Teams will continue to strengthen joint working on complex requests, with a particular focus on enhancing communication with requestors. This includes providing clearer explanations of processes, expected timelines and the scope of information we can provide, supporting greater transparency and helping to manage expectations more effectively. We also plan to further develop collaborative working with the Health Board's Complaints Team to streamline cases where complaints transition into information requests, ensuring a consistent and coordinated response. These improvements are intended to deliver a more efficient, user-focused service while maintaining compliance with statutory requirements.

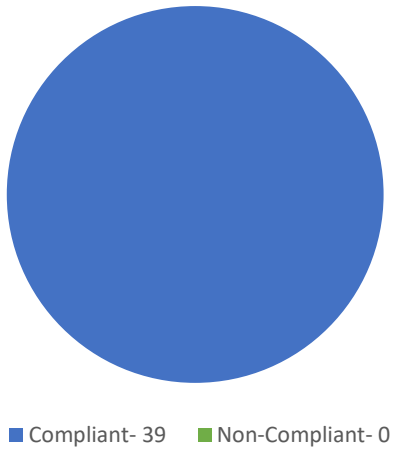


Data Protection Subject Access Requests (SAR) for all requests clinical and non-clinical Q4

Compliant: 99% Non Compliant: 1%



Data Protection Subject Access Requests (SAR) for non-clinical information Q4



Information Governance Incidents and Complaints Information Quarter 4 – January to March 2026.				
Incident Category	**Sub Category**	**Number of incidents**	**Self-Reported to Information Commissioners Office (ICO) / Welsh Government (WG)**	**Number of complaints**
Confidentiality Breach (External)	E-mail	12	-	-
	External Mail	27	-	-
	Records	4	-	4
	Prescription/Form/Letter Error	10	-	-
Confidentiality Breach (Internal)	PPI in public place	7	-	-
	E-mail	6	-	-
	Internal Mail	2	-	-
Information Management & Technical Security	BCU Device Loss	1	-	-
	ID Badge Loss	5	-	-
Non Compliance	IG08 – E-mail Procedure	2	-	-
	IG13 – Confidentiality Code of Conduct	21	-	1
	IG14 - IM&T Security Procedure	6	-	-
	IG15 - Safe Storage & Transport of Personal Data	12	-	-
	IG16 – Disclosing Personal Data Procedure	2	-	-
	IG17 – Photography, Video & Audio Recording Procedure for a Non-Clinical Purpose	2	-	-
Total		**119**	**0**	**5**

During this reporting period, 119 information governance incidents were recorded and managed in accordance with organisational policy, representing a further decrease from the 135 incidents reported in Quarter 3. This continued reduction reflects improving compliance, increased staff awareness, and the effectiveness of existing risk controls. The majority of incidents were low risk and resolved within required timescales, with no incidents meeting the threshold for self-reporting to the Information Commissioner's Office or Welsh Government. Ongoing root cause analysis and targeted actions, including staff training and process improvements, continue to support the reduction of repeat incidents and strengthen overall compliance.

Outcomes

- Ensured prompt management of lost or misplaced ID badges through reinforced reporting processes and timely badge deactivation to mitigate unauthorised access risks.
- Strengthened records management controls by reviewing local filing practices and reinforcing correct procedures to support accurate storage and retrieval of patient information.
- Improved compliance with secure information handling by reinforcing clear-desk standards and secure storage requirements following incidents of unattended documentation.

Allegations	**Legal Claims**
In Quarter 4, 1 new allegation was recorded, relating to inappropriate access to information and sharing with another party. This represents an improvement compared to Quarter 3, during which 3 allegations were reported.	In Quarter 4, 1 legal claim was received in January 2026. The claim relates to an incident in which sensitive results were sent to an incorrect email address by a GP practice.

Complaints

In Quarter 4, 5 Information Governance–related complaints were recorded, representing an increase compared to Quarter 3, during which 2 complaints were reported.

Complaints Received

- Concern that solicitors held a patient's full medical records. No IG action pending investigation; complaint later withdrawn.
- Another child's notes placed in a paediatric patient's file and acted upon. Support provided to the investigating team.
- Memory box SD card contained images of other babies. Post-incident review completed and SOP development initiated.
- Patient misidentification within cardiology outpatient services. Case reviewed and closed by the complaints team.
- Incorrect blood results added to a patient's record. Investigator supported while breach status was clarified.

Lessons Learnt

- Robust patient identification and verification is critical to prevent misidentification and record co-mingling.
- Consistent adherence to confidentiality and records-handling procedures remains essential to reduce the risk of inappropriate disclosure.

Information Commissioners Office (ICO) Complaints

Self-reported incidents to the Information Commissioners Office Quarter 4

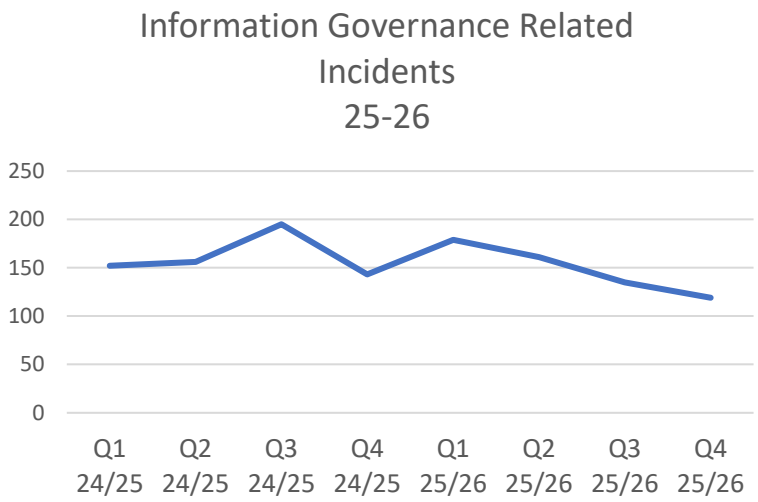
In Quarter 4, no self-reported incidents were submitted to the Information Commissioner's Office (ICO). This represents a further improvement in comparison to Quarter 3, during which 1 incident was reported. The incident reported in Quarter 3 related to patient information being found by a landlord in a recycling bin. This case has since been reviewed by the ICO and was closed in January 2026 with confirmation that no further action was required.

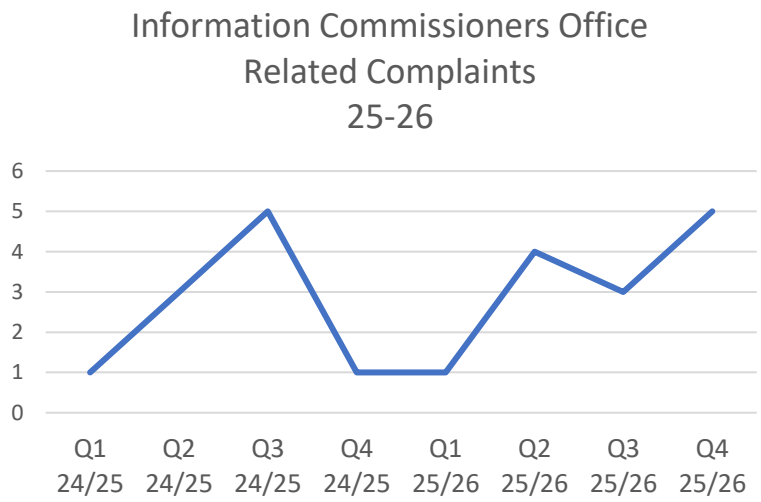
*** For noting – 4 self reported incidents were not captured Q1-Q3. Total incidents for 2025/26 = 5, with 1 remaining open with the ICO. All incidents will be reflected in the IG Annual Report.**

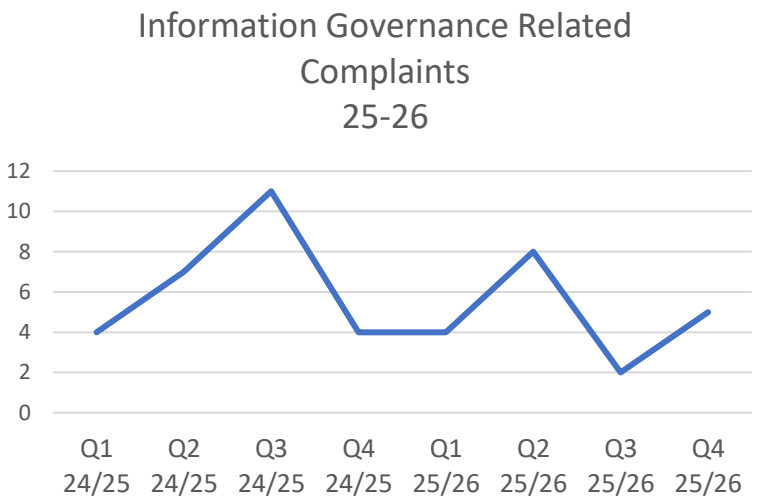
Complaints received from the Information Commissioners Office Quarter 4

In Quarter 4, 5 FOI-related complaint notifications were received. Complaints primarily related to FOI handling, including response timeliness, application of redactions, and correspondence errors. 1 complaint regarding a late FOI response was closed immediately, as the response had already been issued prior to notification. At the end of Quarter 4, 4 complaints remain open, all of which are awaiting further guidance from the Information Commissioner's Office (ICO). Updates will be provided in future KPI reports as the cases progress.

During Quarter 4 of 2025/26, the Health Board continued to receive engagement from the ICO in relation to a complaint originally received in 2024/25 concerning an alleged inappropriate sharing of personal information without consent. The ICO upheld the complaint, identifying concerns regarding transparency around the recording of a private element of a Board meeting, including whether attendees were clearly informed that recording would take place and that it could be shared with third parties. The ICO noted that the Health Board has since strengthened policies and procedures governing the collection, use, storage, and retention of recordings, and highlighted the importance of ongoing clarity and vigilance in recording practices. The ICO also recommended improvements to the timeliness of responses to data protection rights queries. The matter has been recorded by the ICO for monitoring purposes, and no further regulatory action has been taken at this stage.







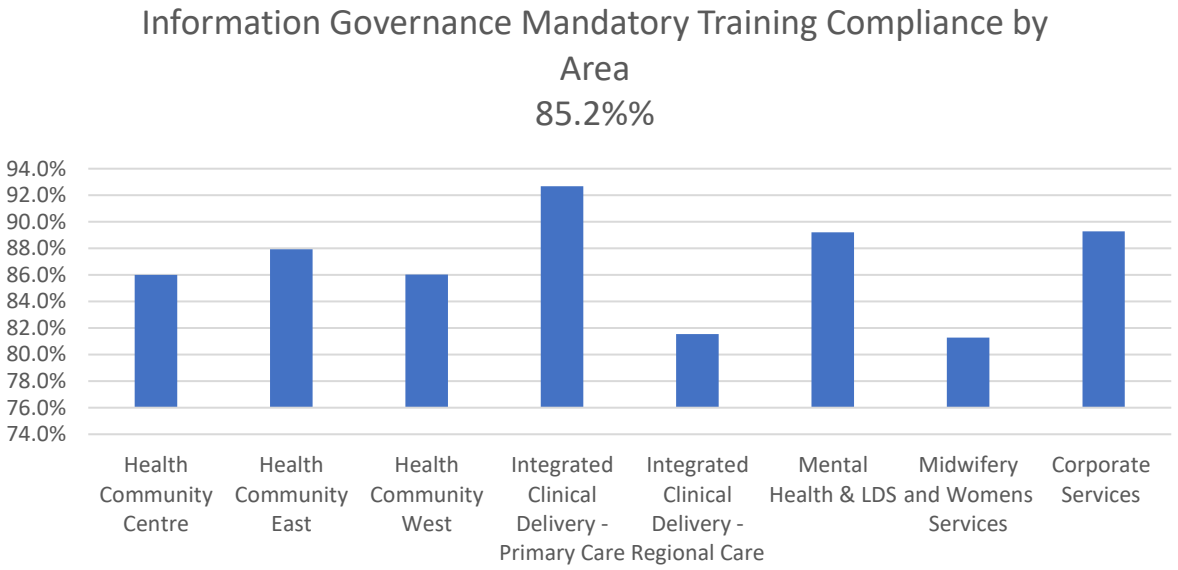
Information Governance Training and Budget Information Quarter 4 – January to March 2026.

Information Governance Budget (including Cost Improvements)	Annual Budget (pay and non-pay)	Year To Date actual spend (pay and non-pay) as at end of June 2025	Year To Date Variance
T410	838,873	654,928	183,945 underspend (not a true reflection, please see below comments)

Please note that the reason for the underspend this quarter is due to:

1. Delays in invoicing for confidential waste expenditure;
2. Continued agile / home working thus reducing travel costs;
3. Flexible Working arrangements;
4. Service reduced run rate to support overall Health Board Financial Position with scrutiny of spend.

The underspend reflects reduced expenditure due to restricted budget usage, agile working arrangements, delayed invoicing, and a vacant post, despite a £33k budget reduction.



Information Governance Mandatory Training

Mandatory training sessions have continued during Quarter 4, with 2 sessions delivered and a total of 24 staff attending. An additional session was scheduled but was cancelled due to no enrolments. In addition, a dedicated training session was delivered via Microsoft Teams for a GP cluster, with 111 attendees. As of the end of Quarter 4, there are 30 staff members nominated as Information Governance Champions, an increase from the previous quarter. Of these, 19 have received specialist training, further strengthening local expertise and support for Information Governance compliance across services.

In addition, 3127 staff members have completed their Information Governance training online during this quarter.

The overall compliance for mandatory Information Governance training across the Health Board has remained above the National target at **85.2%.**

National Intelligent Integrated Auditing Solution (NIIAS), Service Desk and IG10 Information Quarter 4 – January to March 2026.

IG10

A total of **13** IG10 requests were submitted in Quarter 4, 9 of which were approved. This is a decrease from the 20 reported in Q3. The IG10's approved in this quarter were from a number of different areas and no trends were identified.

The breakdown of request types is as follows:

- Video Surveillance – 8
- System Activity – 3
- Attendance Data – 1
- Telephone Call Log – 1

Service Desk – Information Governance Portal

The total number of Halo queries increased slightly to 62 in Quarter 4, compared to 60 in Quarter 3. Whilst the number of queries has raised it is still relatively low compared to figures that have been previously reported. This may be attributed to the Information Governance Team's more frequent circulation of circulating guidance and communications to staff members.

Some key trends identified during the quarter were:

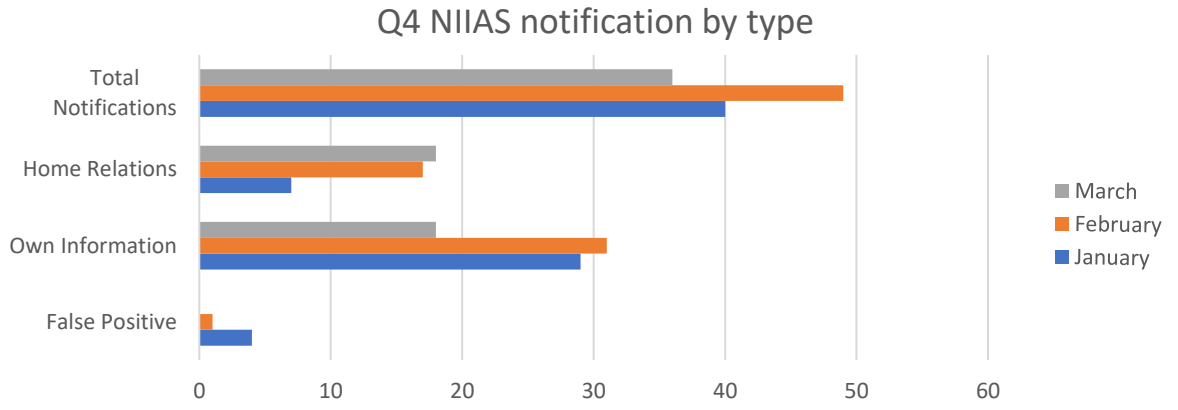
- Sharing information with other Health Boards
- Datix queries
- Local & National Research Projects
- Policies & Procedures

NIIAS (National Intelligent Integrated Auditing Solution)

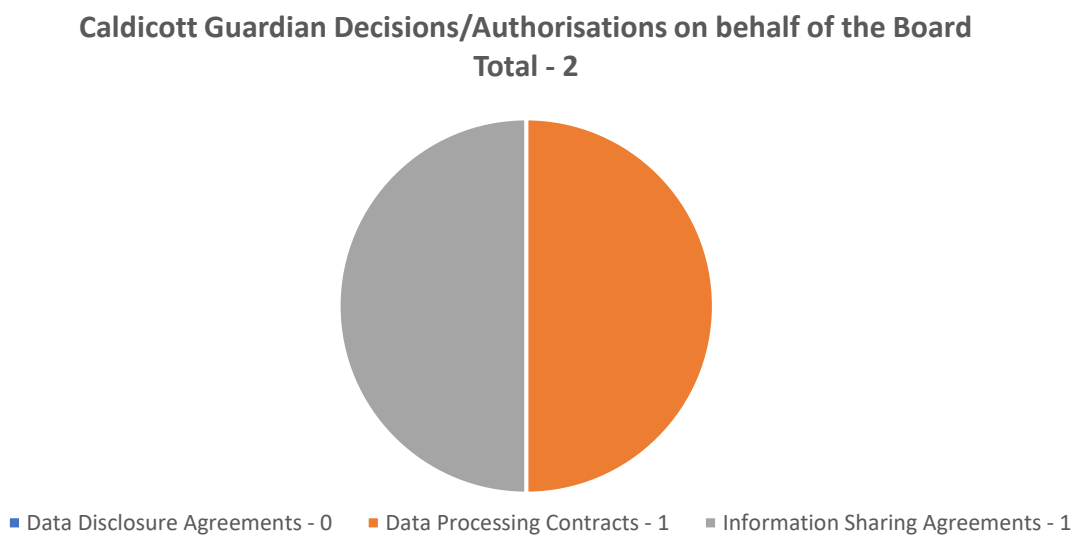
During Quarter 4 there were 125 NIIAS notifications received for staff inappropriately accessing records on Health Board. This is a slight increase from the 102 reported in Quarter 3. Of the 125, 52 have been confirmed as first notifications and 5 found to be false positives the remaining are being investigated.

Cases involving People Services.

Area	Case not proven	Informal Action	No Case to Answer	Referred to Hearing	To be confirmed
West	0	8	3	0	0
Central	0	2	0	0	3
East	0	0	0	0	3
Pan BCU	0	0	0	0	3



Caldicott Guardian Decisions, Data Protection Impact Assessments, Compliance Audits & Asset Register Quarter 4 – January to March 2026.



Compliance Audits

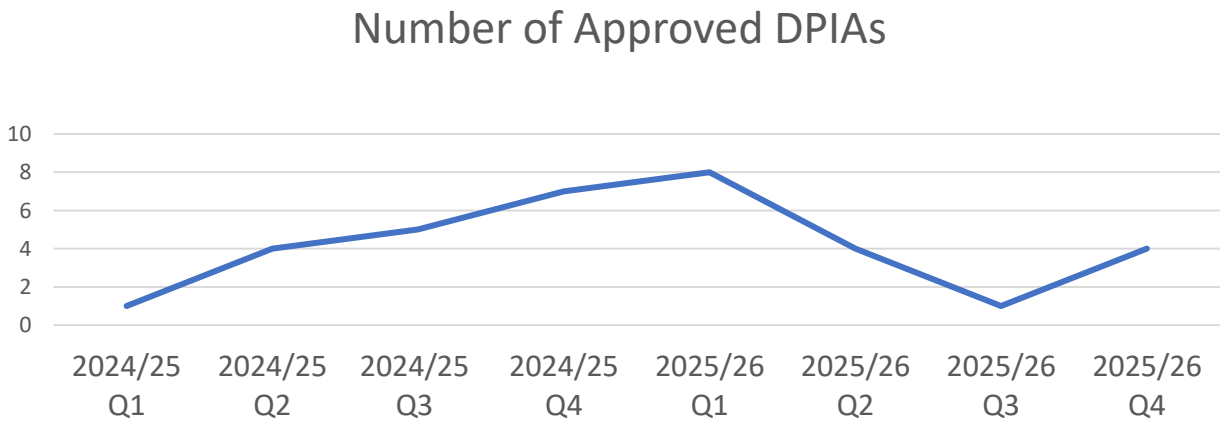
During Quarter 4, no face-to-face compliance audits were carried out across BCUHB sites. However, 4 remote audit pre-assessments were completed. Feedback from departments that participated in the pre-assessments has been positive, with recommendations well received. The pre-assessment audits identified a good overall level of compliance, with strong staff awareness, full Information Governance training compliance, and effective arrangements for the secure handling and sharing of information. Minor areas for improvement were noted, including the visibility of privacy information within services and completion of the Information Asset Register. Addressing these actions will further strengthen assurance and transparency. In parallel, site-wide audits following the previously identified significant risks in physical records management are now underway. These audits are being conducted collaboratively by the Information Governance Team and the Patient Records Team, with a focus on improving secure storage, clarifying ownership, and strengthening controls around the management of physical records across BCUHB

Asset Register

Work is ongoing to improve the completion and quality of the Information Asset Register (IAR). Engagement is continuing with Information Asset Owners (IAOs) and Information Asset Administrators (IAAs) to support the identification and recording of information assets. Drop-in engagement sessions have been delivered, supplemented by targeted, hands-on support for IAOs and IAAs where required. Risk assessment of information assets is also progressing.

Data Protection Impact Assessments (DPIAs)

As at 9 April 2026, 4 Data Protection Impact Assessments (DPIAs) were approved during Quarter 4. Activity levels remain high, with 13 new DPIAs received during the period and a total of 54 currently in progress. Of these, 28 are under active review by the Information Governance Team or project leads, 6 require further information to enable progression, and 20 remain with project teams pending initial submission. 7 of the DPIAs still in progress relate to national projects, reflecting the continued strategic and cross organisational nature of the workload.



Information Governance Toolkit Submission 2025 -2026

The 2025/26 Information Governance (IG) Toolkit self-assessment was successfully completed within the given timescales and submitted on the 31st March 2026.

Requirement owners across relevant departments were provided with a detailed list of their individual requirements/ evidence required in July 2026, in readiness for the recommencement of the IG Toolkit Subgroup meetings in September 2026.

Monthly IG Toolkit Subgroup meetings then recommenced as planned, with continued engagement and support from Health Records, IT, Mental Health and Learning Disabilities, Community Services, Procurement, Health & Safety/Security, Contracting Services (Finance), and Workforce. This enabled the timely provision of compliance evidence and supported a smooth submission for the 2025/26 IG Toolkit.

The IG Toolkit comprises 12 overarching requirements, which are broken down into 152 individual questions. Of these, 119 relate to minimum expectations. Where minimum expectations are not met, a nil score is automatically applied to the Exceeds element, as the Toolkit does not permit progression beyond this stage.

Following improvements to reporting arrangements by Digital Health and Care Wales (DHCW), a dashboard has now been developed which enables the Health Board to monitor submissions and progress for all GP practices across North Wales. As a result, comprehensive data for all 96 GP practices within the Health Board is now available and presented below.

Non-Submitters: 0
Minimum Expectations Met: 10
Minimum Expectations Not Met: 0
Expectations Exceeded: 55
Total Practices: 96

Level
Expectations Not Met
Expectations Partially Met
Expectations Met

Requirement	Minimum Expectations	Expectations Exceeded
Leadership & Oversight	100%	100%
Policies & Procedures	100%	100%
Training & Awareness	100%	80%
Individual Rights	100%	100%
Record of Processing and Lawful Basis	100%	0%
Contracts and Information Sharing	100%	71%
Risks and Data Protection Impact Assessments (DPIAs)	100%	100%
Breach Response and Monitoring	100%	100%
Freedom of Information (FOI) and Environmental Information (EIR)	100%	100%
Information Security	96%	0%
Video Surveillance	78%	0%
Business Continuity	100%	100%

Performance, Finance & Information Governance Committee (Private Closed Session)

INFORMATION GOVERNANCE ANNUAL REPORT 2025-26 ADRODDIAD BLYNYDDOL LLYWODRAETHU GWYBODAETH 2025-26	
Dyddiad y Cyfarfod **Date of Meeting**	23 June 2026
Statws Cyhoeddi **Publication Status**	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad **Report Author name and title**	Carol Johnson Pennaeth Llywodraethu Gwybodaeth Head of Information Governance
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol **Lead Executive Team Member name and title**	Justine Parry Cyfarwyddwr Thechnoleg Ddigidol a Data Dros Dro/ Acting Director of Digital, Data and Technology

Pwrpas yr Adroddiad **Report Purpose**	For Noting

Crynodeb Gweithredol **Executive Summary**
BCUHB has a responsibility to ensure robust information governance systems and processes are in place to protect patient, personal and corporate information. This report is to provide assurance across the key areas of information governance including, but not limited to, confidentiality, data protection, and requests for information, information security and training. The report identifies areas of weaknesses, any further actions/recommendations required, lessons learnt and areas of good practice and overall achievements. • Delivered objectives set in the BCUHB Information Governance Framework (formerly known as the Strategy).

- Achieved national target of 85% mandatory Information Governance training compliance, supported by sustained face-to-face delivery and targeted engagement with services reporting low-compliance.
- Maintained compliance with Data Protection legislation and the Freedom of Information Act 2000, providing ongoing assurance on statutory obligations.
- Improved Subject Access Request compliance to 99%, demonstrating enhanced responsiveness and operational performance.
- Successful completion of the All-Wales Information Governance Toolkit, meeting 10 of 12 minimum requirements and exceeding expectations in 7 areas.
- Worked closely with Digital, Data and Technology (DDaT) teams to embed Information Governance requirements into new and existing projects from the outset.
- Sustained effective engagement with national teams, supporting the successful local delivery of national programmes in line with national direction.
- Deployed and enhanced the replacement Information Asset Register, strengthening accuracy, oversight, and organisational assurance.
- Introduced face-to-face Information Asset Register support sessions, providing targeted guidance to Information Asset Owners and Administrators.
- Reviewed and implemented the Information Governance Business Continuity Plan, ensuring continuity of critical IG functions during disruption.
- Established a network of Information Governance Champions.
- Completed site-wide audits across the West, with findings escalated and reported through established governance mechanisms.
- Introduced pre-assessment audits, enabling earlier risk identification and strengthening proactive assurance.
- Collaborated with Welsh Government, Digital Health and Care Wales (DHCW), and national partners to progress safe Data Sharing Agreements and Joint Controller Arrangements for the National Data Resource (NDR).
- Achieved national recognition for Information Governance leadership, with the Senior Information Governance Manager receiving the Unsung Hero Award for contributions to WASPI data sharing across Wales.

The main emphasis for 2026/27 will be to ensure there is continued improvements made throughout the Health Board and appropriate support is provided to all areas. Key areas for improvement will be:

- Ensuring the effective implementation of the BCUHB Information Governance Framework, with strong assurance mechanisms and sound governance in place.
- Maintain compliance with all legal and statutory requirements, including Data Protection legislation, the Freedom of Information Act 2000, and new requirements arising from the Data (Access and Use) Bill.
- Embed privacy by design and by default across service design, system procurement, and partnership working.

- Deliver priorities within the 2026/27 Information Governance Toolkit, working with leads to improve standards and organisational maturity.
- Fully embed the Information Asset Register, supported by training, ongoing engagement with Information Asset Owners and Administrators, and consistent risk assessment of assets.
- Maintain mandatory Information Governance training compliance above 85%.
- Support the professional development of the Information Governance team through access to training and structured learning opportunities.
- Increase service user, partner, and regulator confidence through improved visibility, transparency, and strengthened relationships.
- Expand and enhance the publication scheme, proactively increasing the volume of information published.
- Work collaboratively with specialist teams to support the appropriate and ethical introduction of Artificial Intelligence, ensuring legal compliance, privacy safeguards, transparency, and bias considerations are fully addressed.

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**
Justine Parry – Acting Director of Digital, Data and Technology	08/05/2026	Reviewed and feedback provided.
Information Governance Group	19/05/26	Circulated prior to meeting on 19th May 2026 and presented during meeting by Lisa Parry, Senior Information Governance Manager.
Executive Committee Group	03/06/26	Presented and approved during meeting on 3rd June 2026.
Performance, Finance & Information Governance (PFIG) Group	23/06/26	To be added to PFIG Agenda.

Appendices / Atodiadau	
Appendix 1	Information Governance Annual Report 2025-26 Final Approved
Appendix 2	Information Governance Annual Report Charts 2025-26

INFORMATION GOVERNANCE ANNUAL REPORT 2025-26
ADRODDIAD BLYNYDDOL LLYWORDAETH GWYBODAETH 2025-26

1 Y SEFYLLFA
SITUATION

BCUHB has a responsibility to ensure robust information governance systems and processes are in place to protect personal and corporate information.
The purpose of this report is to: -

Provide the Information Governance Group (IGG), the Executive Committee and the Performance, Finance and Information Governance (PFIG) Committee with assurance on the progress and developments made within Information Governance throughout the Health Board in 2025/26. This report aims to clearly describe the Health Board's current position, the work undertaken along with the aims, objectives and the challenges ahead for the forthcoming year.

This report aims to provide assurance across the key areas of information governance including, but not limited to: -

- Confidentiality,
- Data Protection,
- Freedom of Information,
- Subject Access Requests,
- Individual Rights,
- Information Security.

The Information Governance Teams overarching aims with this report is to: -

- Provide assurance to key stakeholders that information governance systems and processes are appropriate and effective.
- Inform BCUHB and key stakeholders in relation to BCUHB compliance rates with legislation and standards.
- Describe the achievements relating to information governance within BCUHB during the previous 12 months.
- Give an overview of our priorities and the plans being put in place to improve compliance for the next 12 months.

2. Y CEFNDIR
BACKGROUND

2.1 Information Governance (IG) describes the framework through which Betsi Cadwaladr University Health Board (BCUHB) manages information to ensure it is handled lawfully, securely, efficiently, effectively and in a manner that maintains public trust.

IG ensures an appropriate balance between protecting patient confidentiality and enabling lawful information sharing, both of which are fundamental to the delivery of safe and effective healthcare. It provides the safeguards necessary to protect personal confidential data while

supporting staff in making informed decisions about when information should and should not be shared.

The Health Board operates within a complex and comprehensive legislative and regulatory environment and is required to demonstrate compliance with, but not limited to, the following:

- Data Protection Act 2018
- Data Use Access Act 2025
- EU General Data Protection Regulation (GDPR) 2016
- UK General Data Protection Regulation 2021
- Freedom of Information Act 2000
- Environmental Information Regulations 2004
- Public Records Act 1958
- Access to Health Records Act 1990
- Computer Misuse Act 1990
- Common Law Duty of Confidentiality
- Caldicott Principles in Practice (C-PIP)
- Wales Accord to Share Personal Information (WASPI)
- Welsh Information Governance Toolkit
- NHS Records Management Code of Practice
- Information Commissioner's Office (ICO) Codes of Practice
- Information Security: ISO/IEC 27001:2013
- Network and Information Systems (NIS) Regulations
- Data Quality standards

A robust Information Governance Framework is in place to provide assurance against these requirements. This framework is monitored and supported by the Information Governance Team in collaboration with the wider Digital, Data and Technology Directorate.

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

3.1. To note the overall achievements and the plans in place to continually make improvements for 2026/2027.

To note there will be challenges in meeting all the All-Wales IG toolkit requirements for 2026/27 in respect of the CCTV and Information Security gaps until further improvements are implemented across the Health Board.

To note the continued effort to improve FOI compliance rates throughout 2025/26 which was difficult due to complexity of some of the requests.

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

4.1. None at present

5. ARGYMHELLION
RECOMMENDATIONS

5.1. Gofynnir i'r Pwyllgor/Cyfarfod/Grŵp:

The Committee/Meeting/Group is asked to:

- **NOTE** – Note the report and receive assurance on compliance with Data Protection and Freedom of Information Legislation.

ASESIAD / ASSESSMENT	

Cyswllt â'r Blaenoriaethau Strategol
Link to Strategic Priorities
	
	1. Building an effective organisation
	The supporting information governance objectives will be achieved by ensuring there is an effective Information Governance framework in place by:
	• Ensuring that BCUHB meets its legal and statutory obligations as defined in the Data Protection Act 2018, UK GDPR and European GDPR 2016 and the Freedom of Information Act 2000 (FOI Act):
	  • Continue to develop and improve systems for Records of Processing Activity (ROPA);
	  • Ensure privacy by design and default is considered at all stages of service design, system procurement and partnership working;
	• Ensure IG Strategies, policies, procedures and training plans are all updated to reflect best practice and changes in legislation including social media and Artificial Intelligence (AI).
	• Develop and implement a system and process for the regular review of information sharing agreements / protocols both nationally and locally.
	• Continually look at ways to improve, monitor for assurance and report on the Systems and Records Assets held within the Information Asset Register
	• Continue to meet the Information Governance training national target of 85% to help improve staff understanding and continuous awareness.
	• Strengthen relationships with IHC clusters to improve Information Governance compliance with Primary Care Contractors.
	• Increase service user and Regulator confidence in the Health Board and its staff with increased visibility and working relationships, including updated IG

<table>
<tr><td></td><td>Webpages and continued promotion and use of IG Champions.
• Encourage and support the professional development of team members by providing opportunities for training, skill enhancement, and knowledge acquisition in relevant areas and to include the development of training programmes.</td></tr>
<tr><td></td><td>Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:
If more than one applies, please list below:</td></tr>
<tr><td>Yr Egwyddorion Dylunio Design Principles</td><td>Simplify, Standardise, and Adopt Best Practices
Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:
If more than one applies, please list below:</td></tr>
<tr><td>Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd
Corporate Risks and Board Assurance Framework</td><td>Non-compliance with the legislation can lead to penalties imposed by the Information Commissioner and loss of confidence by the public in the Health Board’s ability to protect the privacy of their information.

<table>
<tr><td colspan="5">Risk Register - Tier 2</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>ID4306 – Data Flow Mapping and Records of Processing Activity (ROPA)</td><td>9</td><td>9</td><td>6</td><td>Unchanged</td></tr>
<tr><td>ID5238 - Development and ongoing management of Corporate Records Management function</td><td>15</td><td>12</td><td>6</td><td>Unchanged</td></tr>
<tr><td>ID5239 - BCU site wide audit to identify health and corporate records store in vulnerable locations</td><td>15</td><td>12</td><td>4</td><td>Unchanged</td></tr>
</table></td></tr>
</table>

	Three Tier 3 risks were successfully closed following completion of agreed actions IN 2025/26. These related to MS Office 365 records management, compliance with Data Protection and Freedom of Information legislation, and improvements to the Information Asset Register.
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals	Not Applicable
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Cydraddoldeb *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 *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 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** *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 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)	
	Ensuring that BCUHB meets its legal and statutory obligations as defined in the Data Protection Act	

	2018, UK GDPR and European GDPR 2016 and the Freedom of Information Act 2000 (FOI Act): • Continue to develop and improve systems for Records of Processing Activity (ROPA); Ensure privacy by design and default is considered at all stages of service design, system procurement and partnership working;
Enw Da **Reputational**	Yes (Include further detail below)
	Any underperformance within these areas may present a reputational risk to BCUHB by undermining confidence in the Health Board's Information Governance framework. Strong and consistent performance, however, provides organisational assurance and helps maintain public, patient, and stakeholder trust in our stewardship of personal and sensitive information.
Effaith ar Adnoddau *(Pobl / Ariannol)* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)
	Non-compliance with the legislation can lead to significant fines imposed by the Information Commissioners office.

Appendix 1

Information Governance Annual Report 2025/26

Contents

Background
Information Governance (IG) describes the framework through which Betsi Cadwaladr University Health Board (BCUHB) manages information to ensure it is handled lawfully, securely, efficiently, effectively and in a manner that maintains public trust.

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The Health Board operates within a complex and comprehensive legislative and regulatory environment and is required to demonstrate compliance with, but not limited to, the following:

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- Welsh Information Governance Toolkit
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- Information Commissioner's Office (ICO) Codes of Practice
- Information Security: ISO/IEC 27001:2013
- Network and Information Systems (NIS) Regulations
- Data Quality standards

A robust Information Governance Framework is in place to provide assurance against these requirements. This framework is monitored and supported by the Information Governance Team in collaboration with the wider Digital, Data and Technology Directorate.

1.0 Purpose

BCUHB has a statutory and corporate responsibility to ensure robust information governance arrangements are in place to safeguard both personal and corporate information.

The purpose of this report is to:

- Provide the Information Governance Group (IGG), Executive Committee and the Performance, Finance and Information Governance (PFIG) Committee with assurance on progress and developments in Information Governance during 2025/26.

- Set out the Health Board's current position, summarising work undertaken, achievements, risks, and challenges.
- Outline key priorities, objectives and areas for development for the forthcoming year.

The report provides assurance across the following key areas:

- Confidentiality
- Data Protection
- Individual Rights
- Subject Access Requests
- Freedom of Information
- Information Security

The overarching aims of this report are to:

- Provide assurance to key stakeholders that IG systems and processes remain effective and appropriate.
- Inform the organisation of compliance levels against relevant legislation and national standards.
- Highlight achievements and improvements made during the previous 12 months.
- Present future priorities and improvement plan for the next reporting period.

2.0 Accountability and Responsibilities

2.1 Chief Executive

The Chief Executive has overall accountability for the Health Board's information governance performance and must ensure that:

- The Health Board demonstrates accountability under the Data Protection Act and UK GDPR
- Decision-making aligns with IG policies, procedures and statutory requirements
- Information risks are identified, assessed and mitigated to an acceptable level
- IG performance is continuously reviewed and improved
- Mandatory IG training is provided to all staff at a level appropriate to their role

To satisfy the above this responsibility is formally delegated to the Chief Digital and Information Officer (CDIO).

2.2 Chief Digital and Information Officer (CDIO)

The CDIO is responsible for ensuring that the Health Board:

- Meets its corporate legal obligations relating to information governance
- Adopts and embeds internal and external IG requirements
- Receives expert advice on IG effectiveness and organisational compliance
- Maintains secure, resilient and high-quality information systems and infrastructure

The CDIO acts as the organisational conscience for information governance.

2.3 Caldicott Guardian

The Executive Medical Director is the Board's Caldicott Guardian and is responsible for:

- Protecting the confidentiality of patient identifiable information
- Ensuring that information sharing is lawful, ethical, proportionate and secure
- Representing the patient perspective in information-sharing decisions

The Caldicott Guardian chairs the Information Governance Group (IGG).

2.4 Executive Medical Director

The Executive Medical Director has overall responsibility for the management of all patient record types across the Health Board.

2.5 Executive Lead for Corporate Records

The CDIO acts as the Executive Lead for Corporate Records and is responsible for:

- The overall management and performance of corporate records management arrangements
- Ensuring organisational compliance with records management standards

2.6 Senior Information Risk Owner (SIRO)

The CDIO was the Health Board's **Senior Information Risk Owner (SIRO)** and has ownership of all information risks. The SIRO:

- Provides strategic oversight of information risk management
- Ensures information risk is embedded into the organisation's culture and decision-making
- Receives assurance from Information Asset Owners
- Has completed role-specific SIRO training

The Executive Director of Public Health became the interim SIRO in February 2026.

2.7 Data Protection Officer (DPO)

The Assistant Director of Compliance and Business Management undertakes the statutory role of Data Protection Officer. The DPO:

- Provides independent, risk-based advice on the processing of personal and special category data
- Advises staff, patients and the Board on data protection compliance
- Monitors compliance with UK GDPR and Data Protection legislation

The Information Governance function sits within this portfolio.

2.8 Information Governance Team

The Head of Information Governance is responsible for:

- Developing, implementing and monitoring IG policies, procedures and action plans
- Supporting organisational compliance with best practice and statutory requirements

The role reports to the Assistant Director of Compliance and Business Management and is supported by the Information Governance Team, who work collaboratively with IG Leads and Information Asset Owners.

2.9 Chief Technology Officer (CTO)

The Chief Technology Officer:

- Leads on ICT infrastructure security and regulatory compliance
- Provides strategic direction on compliance with the NHS Wales Code of Connection and NIS Regulations

2.10 Cyber Security and Compliance Manager

The Cyber Security and Compliance Manager:

- Leads on cyber security protection, detection, response and recovery
- Oversees compliance with NIS Regulations and Cyber Essentials certification

- Provides expert advice on cyber threat management and mitigation

2.11 Assistant Director of Patient Records Management
Responsible for:
- The management and performance of the Health Records Service
- Providing assurance against records management standards for all patient records (paper and digital)
- Ensuring organisation-wide access to health records is appropriately managed

2.12 Executive Directors, Directors and Integrated Health Community (IHC) Directors
Each Director is accountable for information governance within their area and must ensure compliance with all relevant IG requirements.

2.13 Information Governance Leads/ Champions
IG Leads support local compliance with corporate IG policies and standards. These roles will be reviewed during 2026/27 to ensure:
- Appropriate representation across services
- Clear understanding of expectations and responsibilities

Information Governance Champions are trained volunteers who support early identification, mitigation and reporting of data protection incidents, helping to minimise risk and prevent recurrence in partnership with the IG team.

2.14 Information Asset Owners (IAOs)
IAOs are senior responsible individuals who:
- Understand the information assets within their remit
- Ensure risks are identified, managed and reported to the SIRO
- Maintain asset records, access controls, supplier assurance, and business continuity arrangements

2.15 Information Asset Administrators (IAAs)
- Support IAOs by maintaining accurate information asset records
- Identify and escalate information security incidents and risks
- Ensure day-to-day compliance with access and system controls

2.16 All Staff
All employees, contractors, volunteers and students are responsible for:
- The records and data they create or use
- Compliance with IG policies, procedures and standards in their employment contracts and the Staff Code of Conduct

2.17 Third-Party Contractors
Appropriate contractual, confidentiality and assurance arrangements must be in place where third parties may access Health Board information assets.

3.0 Information Governance Operational Plan

The Health Board remains committed to delivering the objectives set out in the Information Governance Operational Plan and the Information Governance Framework 2026/27.
The operational plan is managed via Microsoft Planner, enabling:

- Real-time tracking of progress
- Clear ownership of actions
- Improved reporting and assurance

The plan incorporates:

- High-level IG objectives
- Outstanding actions from the 2025/26 plan
- ICO recommendations
- Internal and external audit actions
- Priorities arising from the Welsh IG Toolkit 2025/26 submission
- National programmes of work
- Local transformation and improvement initiatives, including progress towards the Electronic Health Record

4.0 Information Governance Toolkit

The 2025/26 Information Governance (IG) Toolkit self-assessment was successfully completed within the given timescales and submitted on the 31st March 2026.

Requirement owners across relevant departments were provided with a detailed list of their individual requirements/ evidence required in July 2026, in readiness for the recommencement of the IG Toolkit Subgroup meetings in September 2026.

Monthly IG Toolkit Subgroup meetings then recommenced as planned, with continued engagement and support from Health Records, IT, Mental Health and Learning Disabilities, Community Services, Procurement, Health & Safety/Security, Contracting Services (Finance), and Workforce. This enabled the timely provision of compliance evidence and supported a smooth submission for the 2025/26 IG Toolkit.

The IG Toolkit comprises 12 overarching requirements, which are broken down into 152 individual questions. Of these, 119 relate to minimum expectations. Where minimum expectations are not met, a nil score is automatically applied to the Exceeds element, as the Toolkit does not permit progression beyond this stage.

Please find below the final submission levels:

Level
Expectations Not Met
Expectation Partially Met
Expectations Met

Requirement	Minimum Expectations	Expectations Exceeded
Leadership & Oversight	100%	100%
Policies & Procedures	100%	100%
Training & Awareness	100%	80%

Individual Rights	**100%**	**100%**
Record of Processing and Lawful Basis	**100%**	**0%**
Contracts and Information Sharing	**100%**	**71%**
Risks and Data Protection Impact Assessments (DPIAs)	**100%**	**100%**
Breach Response and Monitoring	**100%**	**100%**
Freedom of Information (FOI) and Environmental Information (EIR)	**100%**	**100%**
Information Security	**96%**	**0%**
Video Surveillance	**78%**	**0%**
Business Continuity	**100%**	**100%**

During 2025/26, the minimum standard requirements were not fully met for this year's submission.

Of the 152 individual question sets assessed, the Health Board was unable to provide assurance against 5 requirements. As a result, 2 of the 12 overarching requirement areas were not fully achieved.

The unmet minimum expectations relate to Information Security and Video Surveillance. These gaps are primarily associated with legacy ICT infrastructure and inconsistencies in the deployment of video surveillance signage across the estate. Further detail and contextual explanations are contained below:

- Information Security – 2 of the 20 minimum requirements not met.

  Supported Systems and Software
  The requirement could not be met as not all IT systems and software in use are fully supported by manufacturers with the latest updates installed. While the majority of the Health Board's infrastructure is supported, legacy systems remain due to historical under-investment and unfunded ICT pressures. Updated national guidance clarified that full compliance is required across *all* systems for this requirement to be met.

  Encryption of Devices and Removable Media
  Although laptops and mobile devices are encrypted as standard, the requirement was not fully met due to exceptions where encryption is not technically feasible, such as certain medical devices and removable media required for clinical use. These exceptions are risk-managed; however, they prevent full assurance against the minimum expectation.

- Video Surveillance – 3 of the 12 minimum requirements not met.

  Surveillance Signage

The requirements were not fully met due to inconsistent deployment of video surveillance signage across the Health Board's estate. While CCTV and body-worn surveillance systems are in operation and governed by existing policies and procedures, signage does not consistently inform individuals that surveillance is in use, explain the purpose of surveillance, or provide clear contact details for further information. Assurance arrangements are in place for the secure operation, storage, retention, and disclosure of recorded footage, and a Data Protection Impact Assessment covering video and audio surveillance has been developed. However, the lack of consistent, standardised signage prevents full compliance with the minimum expectations for this requirement set.

The issues identified during the 2025/26 Information Governance Toolkit submission were escalated to the Digital, Data and Technology Senior Leadership Team (SLT) and the Executive Committee during the year. Relevant leads have committed to taking these actions forward, with work planned during 2026/27 to address the gaps identified and strengthen overall compliance.

Please find details below of the priorities identified which form part of the 2026/27 Information Governance Toolkit Action Plan and are incorporated into the IG Operational Work Plan along with IG Toolkit Leads operational plans where required:

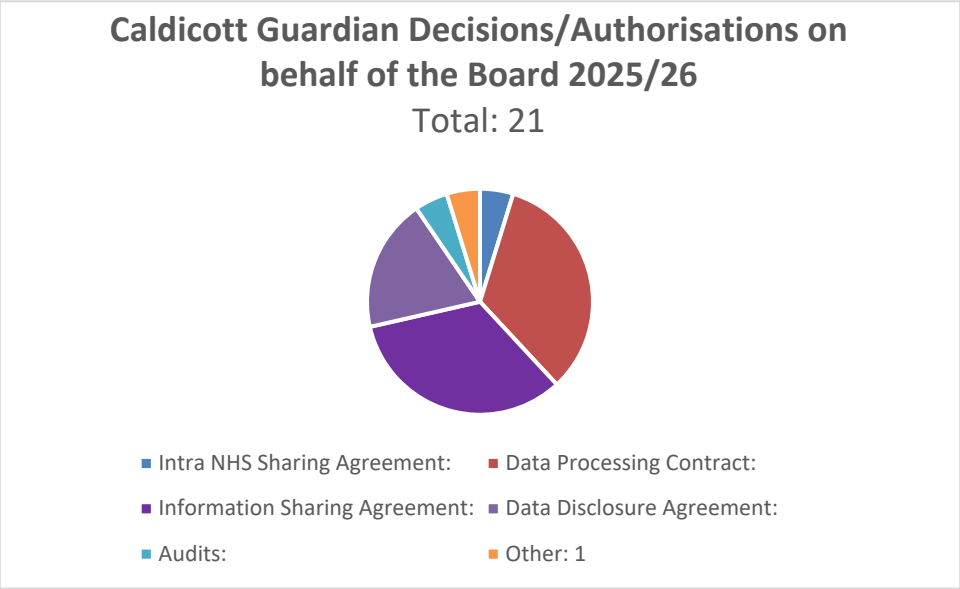
Requirement	Priorities for 2026/27
Leadership & Oversight	1. Continue to escalate matters via Chairs report and SLT, Executive Committee, PFIG Reporting routes.
Policies & Procedures	1. Ensure Data Quality policy/ standard operating procedures (SOPs) are embedded into the organisation. 2. Data Quality Policy to be implemented 2026/27. This will be in line with the on the ongoing standardisation work within the DDaT Roadmap and Health Board objectives.
Training & Awareness	1. Continue to target lower areas of compliance with escalation to Executives where appropriate. 2. Continue to meet the 85% national target with a view to work towards the national exceeded target currently set at 95%.
Individual Rights	No priorities required/identified/added
Record of Processing and Lawful Basis (ROPA)	1. Evidence ROPA requirements within the Information Asset Register. 2. Create process to proactively review records of previously gathered consent to confirm and refresh the consent as required.
Contracts and Information Sharing	1. Ensure process in place to ensure contracts and formal Information sharing agreements, confidentiality agreements etc are in place for commissioned reviews and external investigations. 2. Embed a review process for all Contracts and agreements in place within BCUHB and pro-actively monitor those coming to an end.

	3. Ensure that all information sharing agreements / protocols and the Information Sharing Register is maintained in accordance with any changes/updates.
Risks and Data Protection Impact Assessments (DPIAs)	No priorities required/identified/added
Breach Response and Monitoring	No priorities required/identified/added
Freedom of Information (FOI) and Environmental Information (EIR)	1. Continue to support / encourage and promote services to publish information on the Health Boards publication scheme. 2. Improve FOI compliance and continue to build relationships with the FOI leads.
Information Security	1. Ensure recently updated National Policies are published and made available to all staff. 2. Ensure all systems and devices are maintained on supported versions and create a forward plan for timely upgrades. 3. Ensure all new mobile devices and removable media can be encrypted. 4. Continue to risk assess information/ record assets submitted onto the Health Boards Information Asset Register. 5. Improve procurement and contract management processes.
Video Surveillance	1. BCUHB to agree ownership and accountable lead to ensure the safe management and oversight of CCTV equipment in line with Data Protection Regulations. 2. Improve CCTV signage around BCUHB sites. 3. Approve draft DPIA for BCUHB CCTV. Acknowledge current position and gaps within overall CCTV process. 4. Ensure risks identified within CCTV DPIA have been mitigated and managed regularly.
Business Continuity	No priorities required/identified/added

4.1 Caldicott Guardian Authorisations

As part of the role of the Caldicott Guardian (CG) there is a requirement for operational decisions or, as the delegated officer, to authorise information sharing on behalf of the Board where services or systems involve patient information.

In 2025/26 the following information sharing was authorised by the Caldicott Guardian.



5.0 Senior Information Risk Owner

5.1 Information Security

The Health Board continued to operate at a heightened cyber threat level due to the risk posed by ongoing global tensions and the increasing sophistication, and availability of the tools and methods used by Cyber Criminals.

In response to the increasing threat, several staff awareness sessions have been held, a monthly awareness newsletter has been implemented and the team continued to publish ad-hoc awareness campaigns. Staff feedback on awareness activities has been consistently positive, with staff feeling much more confident, and aware in their ability to identify malicious attempts.

High profile Cyber-attacks on healthcare organisations and critical suppliers continued throughout the year, with several impacting critical services, and leading to the unauthorised disclosure of sensitive patient information. In response to the ongoing threat to the NHS, BCUHB have continued to strengthen supplier security assessments, supply chain management and monitoring in line with legal obligations.

Ransomware “double extortion” continues to be the single biggest Cyber threat facing the organisation. During such an attack, the criminals will gain access to the ICT network, slowly stealing confidential data over a period of time. Once they have stolen significant volumes of data, the attacker will trigger Ransomware software which encrypts ICT systems across the victim organisation rendering them useless. The organisation is then asked to pay a ransom payment for the release of their systems. Should the organisation refuse to pay the ransom, the Cyber criminals will share the stolen sensitive data on the Internet. The proliferation of Ransomware has increased as “Ransomware as a Service” offers organised criminals a lucrative income stream with minimal risk of being brought to justice and requires minimal technical knowledge.

In response to the growing threat of ransomware, and to reduce the success of these attacks, the UK Government is developing new legislation which aims to deter cyber criminals from attacking UK organisations by preventing payments to criminals, increasing

intelligence and enhancing the Government's understanding of the threats in this area to inform future interventions, including through cooperation at international level. The Information Commissioner's Office (ICO) maintains a report of data security breaches, including ransomware incidents experienced by the type of organisation. Data published for 2025, indicates there were 617 ransomware attacks reported to the ICO at a National level in 2025.

In compliance with the Network and Information System Regulations 2018 (NIS-R), the Health Board has taken a continuous improvement approach to its Cyber Security posture and has agreed several Key Performance Indicators. Progress continues with aligning several key processes and procedures with the ISO27001 standard for best practice and several national exercises have been held to test major incident recovery plans with close partners. The Cyber Security and Compliance Team have also worked in collaboration with Emergency Preparedness, Resilience and Response (EPRR) colleagues to deliver targeted training and awareness to senior on-call staff, and ensure business continuity plans for critical systems are updated.

5.2 Information Governance Incidents

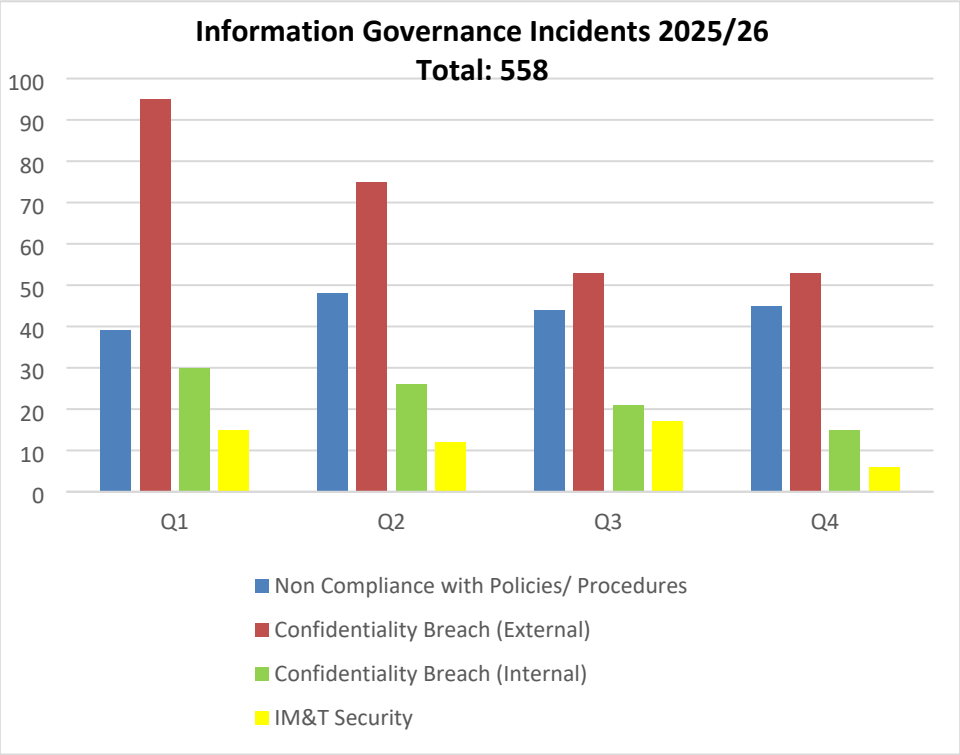
During 2025/26, a total of 558 information governance incidents were reported and managed in line with organisational policy, representing a decrease of 107 incidents (16.1%) compared to the previous year. The majority of incidents were low risk and resolved within required timescales. Root cause analysis, targeted actions, staff training, and process improvements have supported improved compliance and a reduction in incidents across the year.

The Health Board has guidance in place for the notification and management of information security breaches, aligned with the Department of Health's checklist for reporting, managing, and investigating information governance serious incidents. This guidance supports appropriate categorisation and assessment of incidents based on severity and potential impact on individuals' rights and freedoms. All incidents scored as 2 or above are notified to the Information Commissioner's Office within 72 hours, in line with data protection requirements.

The number of incidents categorised 0 to 1 or 2 are broken down below:

Category 0 or 1	Category 2 or above – reportable to the ICO
558	5

These incidents are reported to the Information Governance Group, Executive Committee and the Performance, Finance and Information Governance Committee on a quarterly basis and are broken down into categories:



During 2025/26, there was an overall decrease in the number of information governance incidents reported. Reductions were seen in several key breach categories, including internal confidentiality breaches and IM&T security incidents. External confidentiality breaches, including incidents involving incorrectly addressed correspondence, also demonstrated a downward trend over the course of the year.

Improvements were supported by increased staff awareness, targeted training, and ongoing monitoring of incident themes. A detailed breakdown of incident types and trends is provided later in this report.

Any lessons learned are disseminated throughout the Health Board and published in the Information Governance bulletin. The following topics have been covered in the bulletins circulated to all staff during 2025/26:

- Recording of meetings within MS Teams.
- Advice when taking photos within the workplace.
- Secure Printing.
- Inappropriate Access to Personal Data.

5.3 Serious Information Governance Incidents

The Health Board self-reported 5 data security breaches that triggered referral to the Information Commissioners Office and Welsh Government. These were in relation to:

Confidentiality Breach-External	5
Total	**5**

4 self-reported incidents have now been closed by the Information Commissioner's Office with no further action required, reflecting the immediate actions and improvements

implemented by the Health Board. 1 self-reported incident remains open, and the Health Board is awaiting the final outcome from the Information Commissioner's Office.

Any recommendations made have been, or will be, implemented by the Health Board and continue to be monitored by the Information Governance Team.

5.4 Identified Incident Improvement Actions

Below are just some of the improvements that have or will be made as a result of incident investigations:

1. Staff have been reminded of the requirement to handle patient information securely at all times, including using secure record bags when transporting diaries and limiting the amount of patient-identifiable information recorded in them.
2. Additional assurance has been provided to administrative teams to strengthen checks when printing patient appointment letters in bulk, ensuring documents are verified before being placed into envelopes.
3. Clear guidance has been reinforced that photographing patient records or handwritten notes using personal devices is prohibited, unless explicitly authorised within an approved clinical system.
4. Expectations have been reiterated that patient records and notes must not be removed from secure work environments, including taking paperwork home or storing it in unsecured locations such as vehicles or personal accommodation.

5.5 Personal Injury claims

During 2025/26, two personal injury claims relating to data breaches were identified. One claim involved unauthorised access to a patient's medical records; this claim was later withdrawn. A second claim was received in January 2026, relating to sensitive results being sent to an incorrect email address.

The total amount paid in 2025/26 was £1,394.95 in claimant costs and damages. The Information Governance Team will continue to raise awareness through training and Health Board communications to reduce the risk of recurrence.

5.6 Information Governance Risk Register

The Health Board has a robust Incident Reporting system (Datix) and Policy in place. There is an established Information Governance risk register within Datix which the Head of Information Governance monitors and is reported through the Information Governance Group (IGG).

During 2025/26, 6 Information Governance risks were monitored on the risk register.

3 Tier 3 risks were successfully mitigated and formally closed following completion of agreed actions. These related to MS Office 365 records management, compliance with Data Protection and Freedom of Information legislation, and improvements to the Information Asset Register.

The remaining 3 risks, all assessed as Tier 2, remain open and continue to be actively managed. These relate to data flow mapping, the development and ongoing management of the Corporate Records Management function, and the completion of a BCU-wide audit to identify health and corporate records stored in vulnerable locations.

6.0 Complaints/Concerns & Outcomes

During 2025/26 BCUHB received 25 complaints, which has decreased by 11% (28) from 2024/25, involving:

Breaches in confidentiality such as:
- Inappropriate access to information.
- Disclosure of information to a third party.
- Correspondence sent to incorrect address or recipient.
- Data Loss.
- Delay in a Subject Access Request response.

As part of the investigation process for each complaint, an action plan is implemented along with lessons learnt which are monitored by the Information Governance Team and operationally within each service.

6.1 Complaints to the Information Commissioners Office (ICO)

In addition to the complaints reported locally to the Health Board, there was a total of **10** complaints received from the ICO during 2025/26 which is a decrease from 2024/25 (14).

These cases continue to be linked to the increase in the number of complex cases received and dealt with between Information Governance, Access to Health Records and the Complaints Team.

5 of the complaints investigated have been closed with the remaining 5 awaiting a final outcome.

Please find below a breakdown of these complaints:

Subject Access Requests (SARs)

There were 3 complaint notifications received from the ICO, all relating to SARs. These concerned delays in responses, correspondence being issued to incorrect recipients, and the application of redactions within SAR disclosures. 2 complaints have been closed with no further action required. The remaining complaint remains under consideration by the ICO, and the Information Governance team is awaiting further guidance before any additional action can be taken.

Freedom of Information Requests

4 complaints were received from the ICO relating to dissatisfaction with the handling of information requests. 1 complaint related specifically to a delay in response; however, no further action was required as the request was completed prior to notification of the complaint being received. The remaining 3 complaints relate to Freedom of Information requests and remain open at this time, with the Information Governance team awaiting further correspondence from the ICO.

Ad-Hoc

The remaining **3** complaints relate to incidents of inappropriate sharing of personal information. Of these 3 complaints, 2 have been closed with 1 awaiting an update from the ICO regarding any further action required.

As part of the investigation process for each ICO complaint, an action plan is implemented along with lessons learnt which are monitored by the Information Governance Team and operationally within the service. Any trends are monitored by the Information Governance Team and are highlighted to Health Board staff, further raising awareness and to avoid incidents from occurring in the future.

An ICO complaint received in 2024/25 concerning the inappropriate sharing of personal information was upheld following investigation in 2025/26. The ICO identified issues with transparency around the recording of a meeting, including whether attendees were adequately informed. The Health Board has since strengthened its recording policies. The ICO also highlighted the need for timelier responses to data protection requests.

7.0 Compliance Audits/Assurance/Reporting

Compliance is measured in a number of ways as follows:

7.1 Compliance Audit

To support the Health Board's statutory obligations and provide assurance against legislative, national and local Information Governance (IG) standards, compliance audit activity continued throughout 2025/26. Audits are used to confirm that information is appropriately safeguarded, to highlight good practice, and to identify areas for improvement supported by agreed action plans. Activity was targeted in response to identified risks, incidents and emerging themes, particularly in relation to physical records management.

The IG compliance audit process continued to include a remote pre assessment conducted via Microsoft Teams. This approach supported services in preparing for audit, enabled early identification of issues, and ensured face to face visits were focused and proportionate. Feedback from services undertaking pre assessments remained positive, with recommendations well received.

During the year, 7 face to face compliance audits were undertaken by the IG team across the following sites:

- Ivor Lewis Building, Glan Clwyd Hospital
- Bethesda Health Centre – District Nursing (West)
- Intec Parc Menai – District Nursing (West)
- Trauma & Orthopaedics, Wrexham Maelor Hospital
- Nefyn District Nursing Team
- Dwyfor Ganol, Pwllheli – District Nursing (West)
- Special Care Baby Unit, Ysbyty Gwynedd

In addition, 76 remote audit pre assessments were undertaken across a range of services. These provided assurance in relation to staff awareness, IG training compliance, secure handling and sharing of information, and Information Asset Register arrangements. Guidance was also provided on secure storage, information sharing, out of hours access and transportation of records.

Audit findings during the year identified significant risks relating to physical records management, including insecure storage, records held beyond retention periods and unclear ownership. In response, the IG Team worked with local services and the Patient

Records Team to support improvements, including strengthened storage arrangements, confirmation of ownership and enhanced retention and labelling controls.

As a result of collective working between the Health Records Team and Information Governance department, site wide audits were undertaken in the West area with all findings reported to the IHCs. Site wide audits will continue in Central and East throughout 2026/27.

Targeted and ad hoc audits will continue where risks or incidents are identified, with assurance reported through the IG Quarterly Key Performance Indicator report to the Information Governance Group and onward to the Performance, Finance and Information Governance Committee.

7.2 Internal Audit/ External Audit

No specific internal audit reviews on information governance compliance audits were carried out during 2025/26, although wider Digital, Data and Technology audits have been undertaken which the IG Team have contributed to.

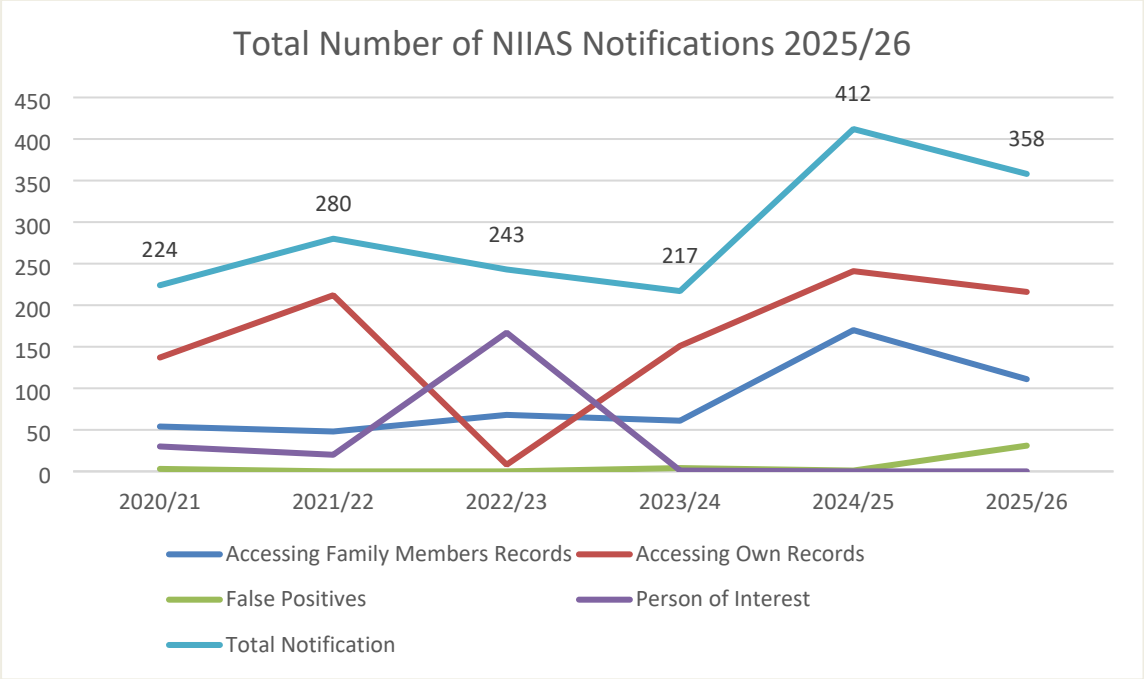
At the 31st March 2026, 43 of the 48 actions from the Information Governance Rapid Review were complete with the remaining 5 actions being partially completed and continually monitored until they can be closed.

1. Health Board to consider funding to develop progress Corporate Records Management function. This has not progressed due to lack of funding.
2. That the Health Board consider developing a records classification scheme, a method used to categorise, mark, and organise records to aid compliance with legal and security requirements.
3. Review where more information can be published on the Publication Scheme.
4. Establish a Community of Interest where IAO's can share/ask questions, guidance etc.
5. Consider if a list of known Information Asset Owners needs to be published on the intranet.

7.3 Auditing of systems

During 2025/26, the National Intelligent Integrated Auditing System (NIIAS) generated 358 notifications of alleged inappropriate access to records, representing a reduction of 54 notifications compared to the previous year. Notifications were routinely monitored to identify any emerging trends and were reported through quarterly Key Performance Indicator reports to the Information Governance Group.

During the year, 183 cases were referred to Workforce & Organisational Development and progressed through workforce processes; all cases have now been closed. Escalation arrangements remain in place with senior clinical and professional leads should any increase in notifications be identified.



7.4 Governance Reports

There is a robust reporting framework in place which ensures there is accountability across the Health Board for accurate reporting and to ensure that compliance is being reviewed and met in every area.

The Information Governance and Patient Record Team continued to meet throughout the year, with the Access to Health Records Team reporting routinely through the Information Governance Group (IGG).

The Information Communication Technology (ICT) Governance and Security Group also remained active, escalating issues of significance to the IGG.

The Information Governance Toolkit Subgroup reports issues of significance into the Information Governance Group (IGG).

The Information Governance Group (IGG) meets on a quarterly basis. The IGG is chaired by the Health Board's Caldicott Guardian and is attended by the Data Protection Officer, Senior Information Risk Owner and representatives from Information Governance, ICT, Health Records and other Clinical and Corporate services across the Health Board.

The IGG provides onward assurance and reporting to the Executive Team and the Performance, Finance and Information Governance Committee.

The Information Governance Department is represented across both governance forums, supporting effective oversight, joined-up assurance, and clear escalation routes.

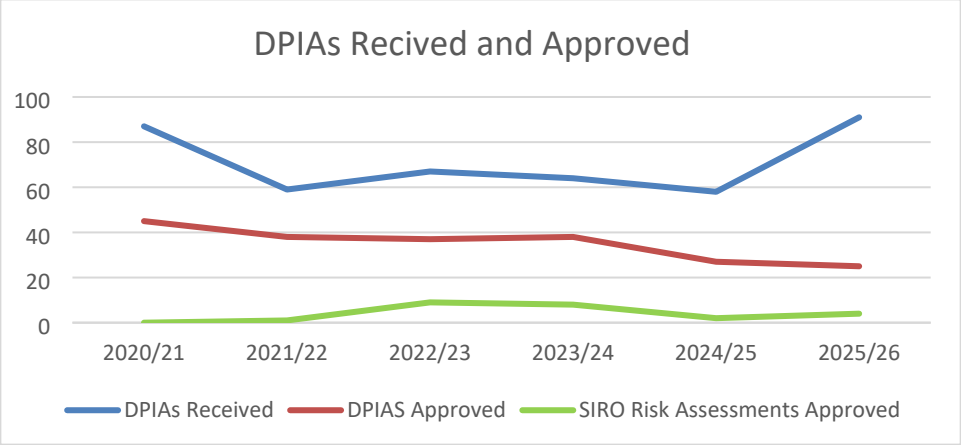
The Caldicott Guardian, Date Protection Officer and Senior Information Risk Owner (CDS) group was formed in August 2025 to enable the Caldicott Guardian, the DPO and the SIRO

to come together to discuss, review and make informed decisions which may require escalation in line with the responsibilities in their specific roles and areas of expertise.

In addition, there is representation from BCUHB at the Information Governance Management Advisory Group (IGMAG) which is a national forum for all NHS organisations is Wales.

8.0 Data Protection Impact Assessments DPIA Assurance

8.1 Data Protection Impact Assessment (DPIA)



During 2025/26, there was a large increase in DPIA requests received. A total of 91 DPIA requests were logged. An additional 8 DPIA's were carried over approved from 2024/25 which is included in the table below. This was made up of both local and national programmes of work.

25 DPIA's were formally approved. In addition, 4 SIRO risk assessments were submitted during the year, all of which were approved.

SIRO risk assessments are required where a supplier does not fully meet the Cyber Security and Information Governance requirements set out in Welsh Health Circular WHC/2017/025. As this guidance predates the introduction of UK GDPR and the Network and Information Systems (NIS) Regulations, the assessment process provides assurance by documenting alternative risk mitigations and controls implemented by suppliers. Approval decisions are made by the Senior Information Risk Owner (SIRO) following joint consideration with the Cyber, IT and Information Governance teams. Welsh Government has acknowledged the related concerns raised at a national level.

21 requests were either withdrawn or deemed to not be required, with a further 24 requests not having received a DPIA to progress.

DPIA Status Overview for 2025/26

Status	Total
No Longer Required	21
Awaiting DPIA	24
Declined	1

Approved in 2025/26	25
In Progress	28

9.0 Data Quality

The Data, Intelligence and Insight function are responsible for data quality of information held in systems including; Welsh Patient Administration System (WPAS) and the Welsh Immunisation system, they are led by the Assistant Director - Data, Intelligence & Insight. The team works to ensure compliance with national standards and engages with colleagues across the organisation to improve quality and timeliness of data collection across a range of systems and datasets.

A Data Quality Forum within the Data, Intelligence and Insight service identifies and prioritises areas for action and improvement. Focussed workstreams and task and finish groups are in place to take necessary remedial actions including making best use of systems, training and advising system users implementing changes to ways of working and monitoring their impacts.

Operational data quality groups are in place within each of the three area Integrated Health Communities (IHCs). The focus of these groups is predominantly around planned care and high-quality waiting list data to support service planning and management to reduce waiting times and improve patient experiences and outcomes. The groups work to identify areas for prioritised action and focus on education and guidance as well as error correction.

A data quality kite mark is bring rolled out across a number of key datasets. This focusses around six domains; validity, completeness, consistency, duplication, timeliness and correct loading (into the data warehouse and reports). Presented together, these elements give users of information products an indication of how robust the underpinning data is.

As we move into the next year and based on learning from the external review of Referral to Treatment (RTT) reporting undertaken in 2025, we will be implementing a programme of data audits. These will be a focussed deep dive on specific datasets and seek to provide assurance around data standards compliance and accuracy of reporting processes.

10.0 Policies and Procedures

During 2025/26 the following Information Governance policies and procedures were reviewed and approved in line with legislation:

- IG13 – Confidentiality Code of Conduct
- IG14 – ICT Security Procedure
- IG15 – Procedure for the Safe Transport and Storage of Personal Data
- IG16 – Disclosing Personal Data Procedure
- IG17 – Photo Video Audio Procedure
- IG20 Information Governance Framework
- IG23 - Procedure for the Auditing and Escalation of Staff Access to Patient Information Systems
- IG24 - Reporting Information Security Breaches Procedure
- IG28 – Bring your own device Procedure
- IG30 - Information Asset Register Procedure

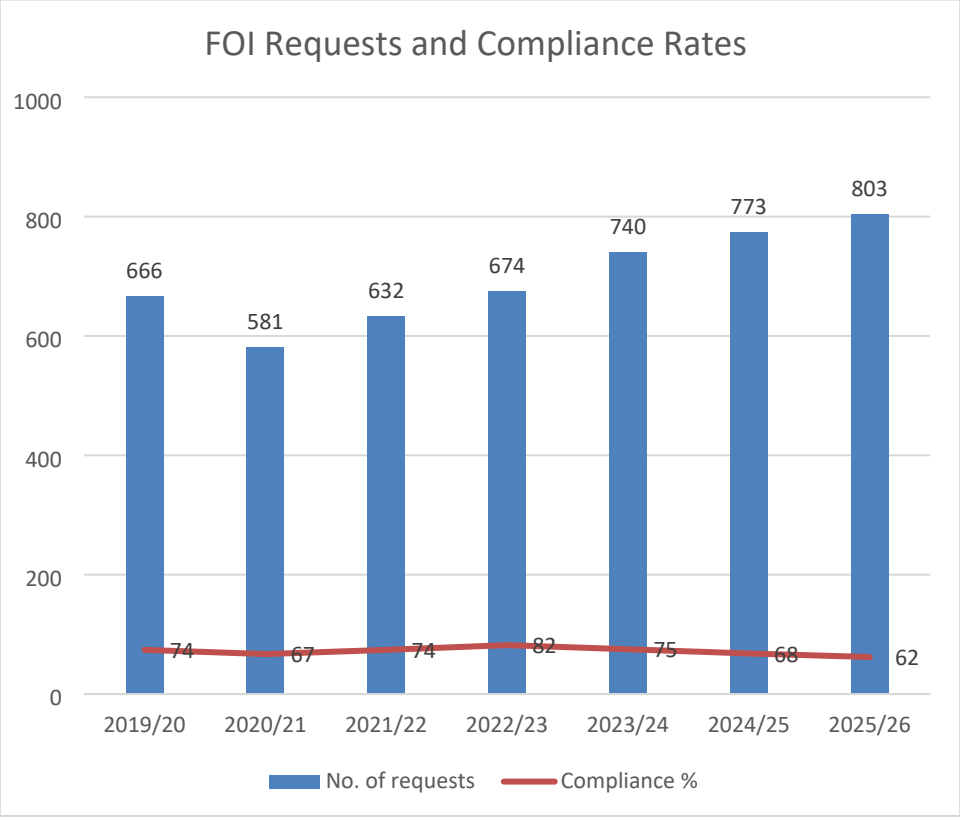
Policies and procedures will continue to be developed or updated during 2026/27 to further support the Information Governance Framework.

11.0 Requests for Information

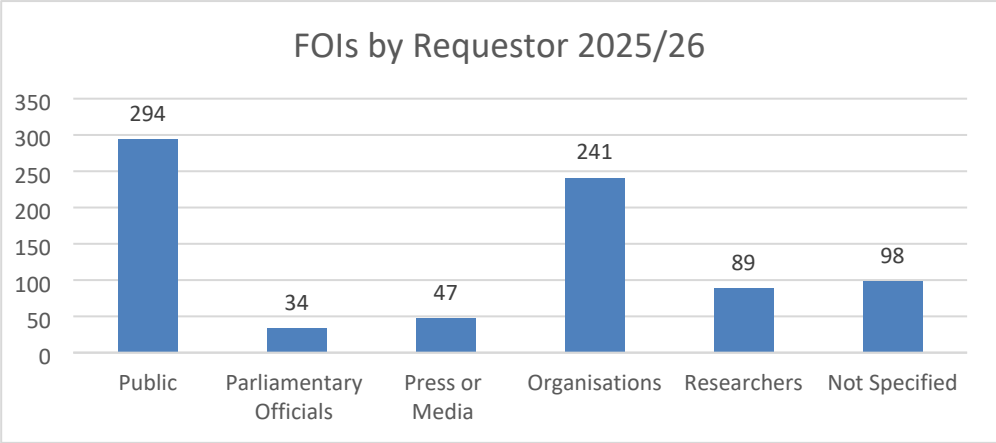
The BCUHB Access to Information Policy incorporates requests for information under the Freedom of Information Act, Environmental Information Regulations, Data Protection Act and Access to Health Records Act.

11.1 Freedom of Information Act 2000 / Environmental Information Regulations 2004 Requests

During 2025/26 BCUHB received and processed **803** Freedom of Information (FOI) requests, an increase of 3.9% from the previous year (773), with compliance decreasing from 68% to **62%.** This was due to the increase in the total number of requests being the most received to date and also a high number of these being complex cases spanning across multiple services.



The total number of hours spent processing these requests totalled 448 days . This number is made up from the resources spent by both the Information Governance Team, the FOI leads and Executive Team approvals.



In the spirit of openness and transparency and where appropriate, all finalised responses are published anonymously on the BCUHB Internet site under the FOI Disclosure log.

11.2 Requests for Internal Reviews

There were 27 requests in total for an internal review during 2025/26, an increase compared to the 12 received in 2024/25. It should be noted a number of the internal reviews received are linked to complex cases.

FOIs received, Internal Reviews and exemptions applied 2025/26

Exemption	Exemption Category	Total	Internal Review	Upheld/ Overturned	ICO	Upheld/ Overturned
Section 10 – Marketing Purposes	Absolute – No Public Interest Test required	5	-	-	-	-
Section 17 – Refusal Notice	Section 12 – fee limit.	42	1	1 x ongoing		-
Section 21 - Information accessible by other means	Absolute – No Public Interest Test required	36	5	4 x upheld 1 x overturned	2	2 x Ongoing
Section 36 - Qualified Person Statement	Class Based, so Public Interest Test assessed	1	1	1 x ongoing		-
Section 31 – Law Enforcement	Class Based, so Public Interest Test assessed	4	2	2 x partially overturned		-
Section 40 - Personal Information	Absolute – No Public Interest Test required	23	1	1 x upheld	1	1 x Ongoing
Section 42 – Legal Professional Privilege	Class Based, so Public Interest Test assessed	1	-			
Section 43 - Commercial interests	Class based, so Public Interest Test assessed	8	2	2 x overturned		
No Exemptions Used		683	15	1 x Overturned 3 x partially overturned 11 x Upheld	1	1 x Overturned
Total		**803**	**27**	**-**	**4**	**-**

11.3 Data Protection Act Subject Access Requests (DPA SAR)

During 2025/26, **7653** requests were received into the Health Board a decrease from 8260 in 2024/25, with the average overall compliance increasing to **99%.** The Information Governance Team have continued to receive a high number of complex requests which are requests for emails or all the information held about an individual as a Health Board, this can sometimes result in thousands of emails/documents having to be manually reviewed and redacted.

11.4 Third Party Requests for Personal Information

The Information Governance Team have received **93** requests for information from North Wales Police during 2025/26. Some examples of requests are Medical Records, Personnel Records, CCTV, Witness Statements and Telephone Records, these were all processed in a timely manner.

11.5 National Inquiries

Infected Blood Compensation Authority (IBCA)

In response to the ongoing Infected Blood Inquiry and the establishment of the Infected Blood Compensation Authority (IBCA), the organisation will ensure full compliance with national guidance and statutory obligations relating to the retention, preservation, and provision of records.

The IBCA compensation scheme will remain open until 2031, and claims may require a wide range of supporting evidence, including clinical records, administrative data, and personal information such as historical addresses and familial relationships. In recognition of this, and in line with direction from the Welsh Government and IBCA, the organisation will implement an “evidence hold” on all records that may be of potential relevance to infected blood cases. In accordance with duties under the National Health Service (Wales) Act 2006, the organisation will fully cooperate with IBCA in all matters relating to compensation claims. This includes ensuring that no original documentation relating to infected blood is destroyed unless appropriate digital copies are in place and retention aligns with national policies.

Given that IBCA has advised that it is not currently possible to define precisely which records will be required, the organisation will adopt a precautionary approach. All records associated with infected blood treatment, whether clinical or administrative, will be retained where there is any potential relevance to current or future claims, including those from individuals not previously registered on support schemes or claims made on behalf of estates.

The organisation will continue to review guidance issued by IBCA and Welsh Government and will update local policies, retention schedules, and staff guidance accordingly. Compliance will be supported through ongoing engagement with the Health Records Management Assurance Group and internal governance structures to ensure that records are appropriately safeguarded and accessible for the duration of the scheme.

12.0 Training

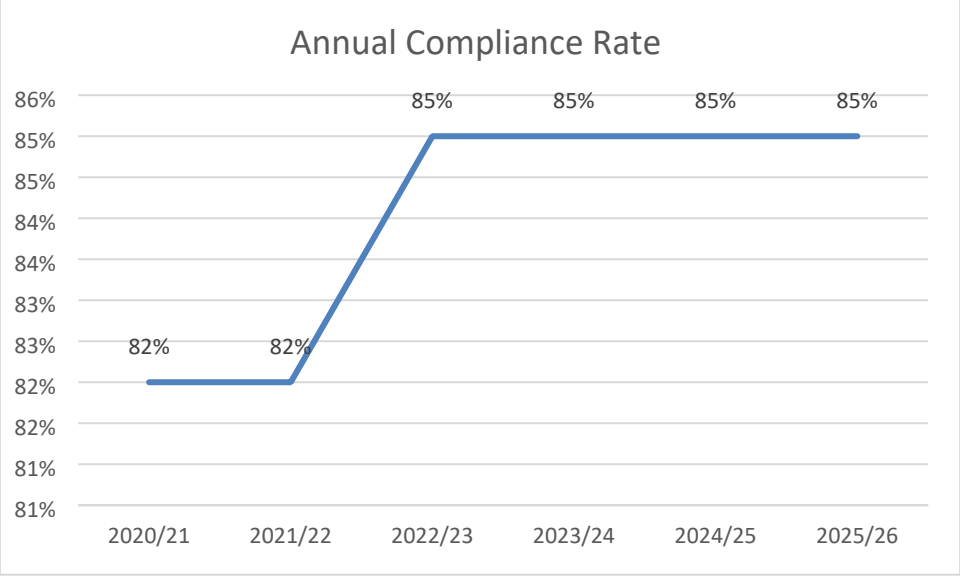
During 2025/26 we have continued trying to improve our mandatory training compliance, specifically targeting lower areas of compliance, this has resulted in maintaining the minimum national target of **85%.**

The following training is offered in the Health Board for all staff:

- IG training (as part of the UK Core Skills for Health) is mandatory for all staff every 2 years and is embedded into the Workforce & Organisational Development & Clinical mandatory training days.
- Staff have access to the All-Wales e-learning package.
- Formal training sessions for all staff across the organisation via Microsoft Teams.
- Ad-hoc sessions to individual departments/ teams to coincide with their training days / staff meetings etc. at a time and place convenient to them.
- Workbook available for facilities staff without supervisory responsibilities, who are unable to access IT facilities.
- Regular awareness raising and sharing lessons learnt via corporate bulletin and BetsiNet.
- Regular distribution of guidance and updated policies and procedures.

During 2025/26, Information Governance training continued to be delivered through a combination of team-based sessions and face-to-face training. A total of 24 training sessions were held, with 251 staff members attending. In addition, specialist training was delivered to targeted areas, including GP clusters and Learning Disabilities services, with approximately 150 staff attending these bespoke sessions. This continued programme of training supports improved awareness and compliance with Information Governance requirements across the organisation.

Mandatory IG training compliance in all divisions is monitored by the Information Governance Group and if needed targeted reminders are issued to encourage completion of the mandatory training via E-Learning.



13.0 Information Governance within Primary Care

Following improvements to reporting arrangements by Digital Health and Care Wales (DHCW), a dashboard has now been developed which enables the Health Board to monitor submissions and progress for all GP practices across North Wales. As a result, comprehensive data for all 96 GP practices within the Health Board is now available and presented below.

Non-Submitters: 0
Minimum Expectations Met: **10**
Minimum Expectations Not Met: **0**
Expectations Exceeded: 55
Total Practices: **96**

During 2026/27 the Information Governance Team will continue to work closely with the managed practices in order to support and advise on how they can increase their compliance for submissions. DHCW will continue to focus on the non-managed practices to ensure compliance is monitored and to provide assistance where required. During 2026/27 we will gain further assurance that non-managed practices are meeting the IG toolkit requirements and provide support where needed to these practices in order for them to submit their toolkits.

14.0 Achievements

In 2025/26 there has been a number of significant achievements across the Health Board which include:

- Continued to deliver against the objectives set out in the BCUHB Information Governance Framework demonstrating sustained compliance and alignment with organisational governance expectations.
- Mandatory Information Governance training compliance met the national target of 85%, reflecting sustained delivery of in-person training and focused engagement with services demonstrating lower compliance rates.
- Ongoing compliance with Data Protection legislation and the Freedom of Information Act 2000 was maintained, providing assurance that statutory obligations continue to be met.
- Compliance with Data Protection Subject Access Requests improved to 99%, demonstrating enhanced performance and responsiveness.
- Successful submission of the All-Wales Information Governance Toolkit, with 10 of the 12 minimum requirements met and performance exceeding expectations in 7 areas, evidencing strong overall compliance and organisational maturity.
- Effective collaboration with Digital, Data and Technology (DDaT) teams supported the successful roll-out of new projects and local initiatives, ensuring Information Governance requirements were embedded from inception.
- Sustained engagement with national teams supported the effective delivery of national programmes, ensuring local implementation aligns with national direction and expectations.
- Deployment and continued enhancement of the replacement Information Asset Register, strengthening oversight, accuracy, and assurance of information assets across the organisation.
- Introduction of face-to-face Information Asset Register support sessions, providing targeted guidance and support to Information Asset Owners and Administrators.
- Full review and implementation of the Information Governance Business Continuity Plan, providing assurance that critical IG functions can be maintained during periods of disruption.
- Successful establishment of an Information Governance Champions network, strengthening governance, awareness, and local ownership of Information Governance responsibilities across the organisation.
- Completion of site-wide audits across the West, with findings appropriately escalated and reported through established governance structures.

- Roll-out of pre-assessment audits, enabling earlier identification of risks and strengthening proactive assurance ahead of formal reviews.
- Successful collaboration with Welsh Government, Digital Health and Care Wales (DHCW), and partner organisations across Wales to progress the safe Data Sharing Agreement (DSA) and Joint Controller Arrangement (JCA) for the National Data Resource (NDR).
- National recognition of Information Governance expertise and leadership, with the Senior Information Governance Manager receiving the Unsung Hero Award for her contribution to WASPI data sharing across Wales.

15.0 Conclusion

Throughout the reporting period, the Information Governance function has continued to operate effectively within a challenging and high-demand environment. Despite sustained increases in workload, capacity pressures, and the growing complexity of national and local requirements, the Health Board has remained compliant with its statutory and legal obligations, supported by the continued commitment and professionalism of the Information Governance Team.

A consistent and structured approach to governance, assurance, and improvement has been maintained, including the successful submission of the All-Wales Information Governance Toolkit for the seventh consecutive year. Strong ownership and accountability across the organisation have ensured that requirements are met or appropriately mitigated through agreed and monitored action plans. Early preparation for the 2026/27 Toolkit submission, including new assurance requirements relating to Artificial Intelligence, is already underway.

Mandatory Information Governance training compliance has been sustained above the national target, complex incidents and complaints have been effectively managed, and enhanced systems—such as the improved Information Asset Register—are beginning to provide increased assurance around the management and lifecycle of information assets.

Overall, the year demonstrates continuous improvement, organisational resilience, and a clear commitment to strengthening Information Governance arrangements. While further development remains necessary, the Health Board is well-positioned to respond to future Information Governance challenges.

16.0 Looking forward

The primary focus for 2026/27 is to build on sustained improvement across the Health Board, strengthening assurance, supporting services, and responding to evolving legislative, technological, and national requirements. The Information Governance (IG) Operational Work Plan for 2026/27 sets out the following high-level objectives.

Strategic and Compliance Objectives

- Deliver the objectives of the BCUHB Information Governance Framework for 2026/27, ensuring sustained compliance and effective governance arrangements.
- Maintain compliance with all legal and statutory obligations, including the Data Protection Act 2018, UK GDPR, retained EU GDPR (2016), the Data (Access and Use) Bill (post-Royal Assent), and the Freedom of Information Act 2000.
- Ensure ‘privacy by design and by default’ is embedded at all stages of service design, system procurement, and partnership working.

- Prepare for and deliver priorities identified within the 2026/27 Information Governance Toolkit, working closely with Toolkit leads to improve standards and organisational maturity.

Systems, Records, and Asset Management

- Continue to develop and enhance Records of Processing Activity (ROPA) to strengthen transparency, assurance, and regulatory compliance.
- Fully embed the updated Information Asset Register across the organisation, providing training, ongoing support to Information Asset Owners and Administrators, and risk-assessing all information assets.
- Improve monitoring, assurance, and reporting of systems and record assets held within the Information Asset Register.
- Develop and implement a formal process for the regular review of information sharing agreements and protocols, both locally and nationally.

Records Management and Corporate Accountability

- Update IG strategies, policies, procedures, and training plans to reflect best practice and legislative change, including developments relating to social media and Artificial Intelligence (AI).
- Provide interim support and guidance to staff on records management responsibilities pending the establishment of a formal Corporate Records Management function. Corporate Records Management continues to represent a key organisational risk and should be recognised as a core corporate function requiring clear accountability and appropriate resourcing.

Workforce and Culture

- Maintain mandatory Information Governance training compliance above the national minimum target of 85%, with an aspirational target of 95% to strengthen awareness and organisational culture.
- Encourage and support professional development within the Information Governance team, including access to training, skill development, and structured learning opportunities.
- Strengthen engagement with IHC clusters to improve Information Governance compliance and assurance across Primary Care contractors.

Assurance, Transparency, and Engagement

- Increase service user and regulator confidence through improved visibility, transparent working practices, and strengthened internal and external relationships.
- Continue to expand and improve the Health Board's publication scheme, proactively increasing the amount of information published.
- Enhance governance and reporting arrangements, including:

    - Improvements to IHC reporting
    - Confidential waste re-tender
    - CCTV governance and assurance improvements
    - Support for internal audit activity in relation to non-DDaT systems

Digital Innovation and Artificial Intelligence

- Work collaboratively with specialist teams to support the appropriate introduction of Artificial Intelligence, where permitted, ensuring ethical use, legal compliance, privacy safeguards, and bias considerations are fully assessed.

**** Further details and a breakdown of the Information Governance work plan can be requested from the Head of Information Governance***

Atodiad 2 – Siartiau Adroddiad Blynyddol Llywodraethu Gwybodaeth

2025/26

Appendix 2 – Information Governance Annual Report Charts

2025/26

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Information Governance Toolkit

The 2025/26 Information Governance (IG) toolkit self-assessment was successfully completed within the given timescales and submitted on the 31st March 2025.

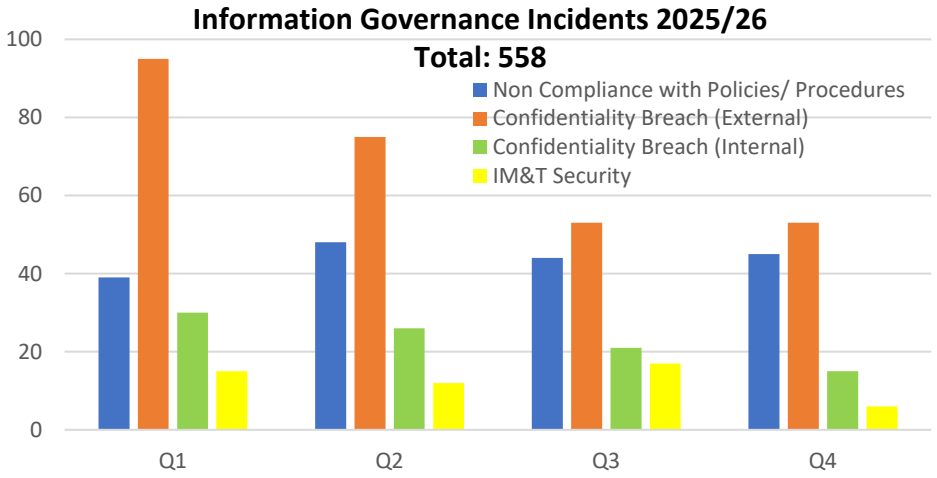
Level
Expectations Not Met
Expectations Partially Met
Expectations Met

Requirement	Minimum Expectations	Expectations Exceeded
Leadership & Oversight	100%	100%
Policies & Procedures	100%	100%
Training & Awareness	100%	80%
Individual Rights	100%	100%
Record of Processing and Lawful Basis	100%	0%
Contracts and Information Sharing	100%	71%
Risks and Data Protection Impact Assessments (DPIAs)	100%	100%
Breach Response and Monitoring	100%	100%
Freedom of Information (FOI) and Environmental Information (EIR)	100%	100%
Information Security	96%	0%
Video Surveillance	78%	0%
Business Continuity	100%	100%

Requirement	Priorities for 2026/27
Leadership & Oversight	1. Continue to escalate matters via Chairs report and SLT, Executive Committee, PFIG Reporting routes.
Policies & Procedures	1. Ensure Data Quality policy/ standard operating procedures (SOPs) are embedded into the organisation. 2. Data Quality Policy to be implemented 2026/27. This will be in line with the on the ongoing standardisation work within the DDaT Roadmap and Health Board objectives.
Training & Awareness	1. Continue to target lower areas of compliance with escalation to Executives where appropriate. 2. Continue to meet the 85% national target with a view to work towards the national exceeded target currently set at 95%.
Individual Rights	No priorities required/identified/added
Record of Processing and Lawful Basis (ROPA)	1. Evidence ROPA requirements within the Information Asset Register. 2. Create process to proactively review records of previously gathered consent to confirm and refresh the consent as required.
Contracts and Information Sharing	1. Ensure process in place to ensure contracts and formal Information sharing agreements, confidentiality agreements etc are in place for commissioned reviews and external investigations. 2. Embed a review process for all Contracts and agreements in place within BCUHB and pro-actively monitor those coming to an end. 3. Ensure that all information sharing agreements / protocols and the Information Sharing Register is maintained in accordance with any changes/updates.
Risks and Data Protection Impact Assessments (DPIAs)	No priorities required/identified/added
Breach Response and Monitoring	No priorities required/identified/added
Freedom of Information (FOI) and Environmental Information (EIR)	1. Continue to support / encourage and promote services to publish information on the Health Boards publication scheme. 2. Improve FOI compliance and continue to build relationships with the FOI leads.
Information Security	1. Ensure recently updated National Policies are published and made available to all staff. 2. Ensure all systems and devices are maintained on supported versions and create a forward plan for timely upgrades. 3. Ensure all new mobile devices and removable media can be encrypted. 4. Continue to risk assess information/ record assets submitted onto the Health Boards Information Asset Register. 5. Improve procurement and contract management processes.
Video Surveillance	1. BCUHB to agree ownership and accountable lead to ensure the safe management and oversight of CCTV equipment in line with Data Protection Regulations. 2. Improve CCTV signage around BCUHB sites. 3. Approve draft DPIA for BCUHB CCTV. Acknowledge current position and gaps within overall CCTV process. 4. Ensure risks identified within CCTV DPIA have been mitigated and managed regularly.
Business Continuity	No priorities required/identified/added

Incidents & Complaints

Category 0 or 1	Category 2 or above – reportable to the ICO
558	5



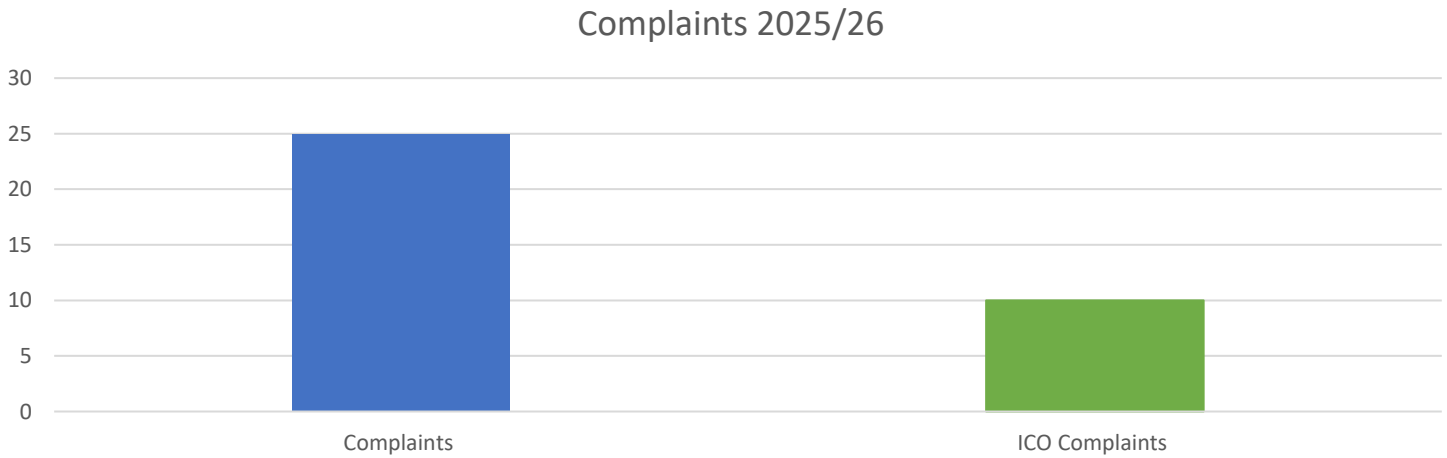
The Health Board self-reported 5 data security breaches that triggered referral to the Information Commissioner's Office and Welsh Government. This was in relation to external confidentiality breaches.

4 self-reported incidents have now been closed by the Information Commissioner's Office with no further action required, reflecting the immediate actions and improvements implemented by the Health Board. 1 self-reported incident remains open, and the Health Board is awaiting the final outcome from the Information Commissioner's Office. Any recommendations made have been, or will be, implemented by the Health Board and continue to be monitored by the Information Governance Team.

During 2025/26, there was an overall decrease in the number of information governance incidents reported. Reductions were seen in several key breach categories, including internal confidentiality breaches and IM&T security incidents. External confidentiality breaches, including incidents involving incorrectly addressed correspondence, also demonstrated a downward trend over the course of the year.

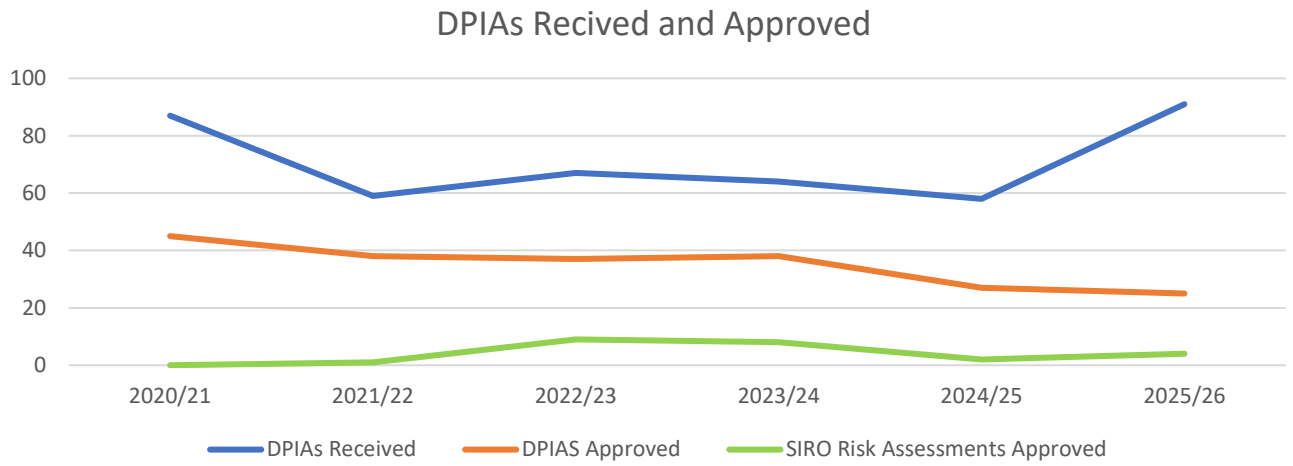
Improvements were supported by increased staff awareness, targeted training, and ongoing monitoring of incident themes. A detailed breakdown of incident types and trends is provided later in this report. Any lessons learned are disseminated throughout the Health Board and published in the Information Governance bulletin. The following topics have been covered in the bulletins circulated to all staff during 2025/26:

- Recording of meetings within MS Teams.
- Advice when taking photos within the workplace.
- Secure Printing.
- Inappropriate Access to Personal Data.



During 2025/26, 2 personal injury claims relating to data breaches were identified. One claim involved unauthorised access to a patient's medical records; this claim was later withdrawn. A second claim was received in January 2026, relating to sensitive results being sent to an incorrect email address. The total amount paid in 2025/26 was £1,394.95 in claimant costs and damages. The Information Governance Team will continue to raise awareness through training and Health Board communications to reduce the risk of recurrence.

Data Protection Impact Assessments, Caldicott Authorisations and Compliance Audits



There were **91** requirements for a DPIA logged during 2025/26. 25 DPIA's were formally approved. In addition, 4 SIRO risk assessments were submitted during the year, all of which were approved.

Status	Total
No Longer Required	21
Awaiting DPIA	24
Declined	1
Approved in 2025/26	25
In Progress	28

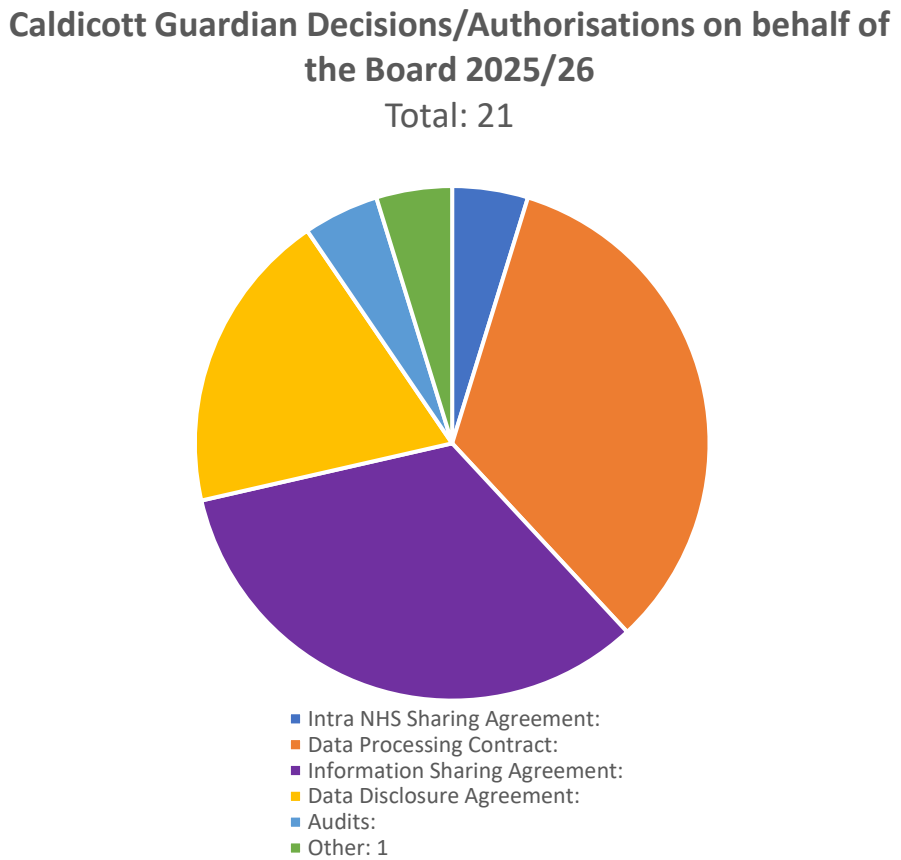
Information Governance Compliance checks

During the year, 7 face to face compliance audits were undertaken by the IG team across the following sites:

- Ivor Lewis Building, Glan Clwyd Hospital
- Bethesda Health Centre – District Nursing (West)
- Intec Parc Menai – District Nursing (West)
- Trauma & Orthopaedics, Wrexham Maelor Hospital
- Nefyn District Nursing Team
- Dwyfor Ganol, Pwllheli – District Nursing (West)
- Special Care Baby Unit, Ysbyty Gwynedd

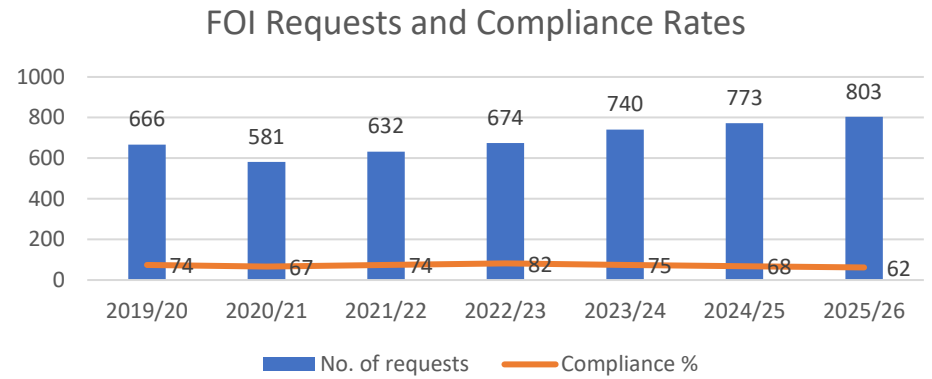
In addition, 76 remote audit pre assessments were undertaken across a range of services. Audit findings during the year identified significant risks relating to physical records management, including insecure storage, records held beyond retention periods and unclear ownership. In response, the IG Team worked with local services and the Patient Records Team to support improvements, including strengthened storage arrangements, confirmation of ownership and enhanced retention and labelling controls.

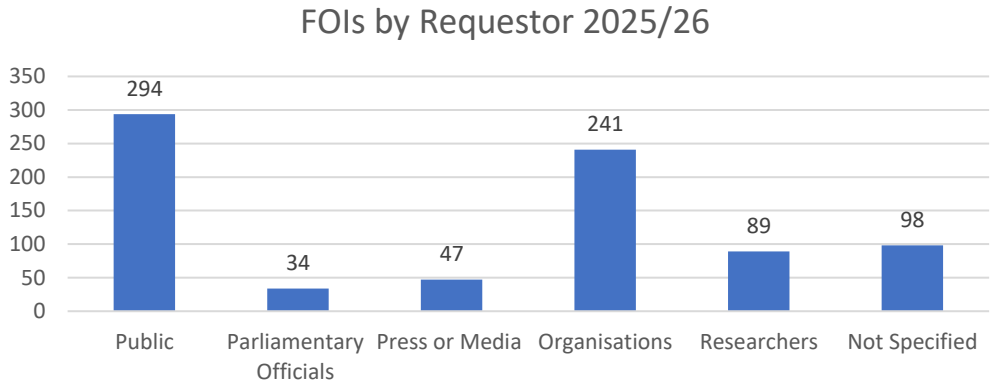
As a result of collective working between the Health Records Team and Information Governance department, site wide audits were undertaken in the West area with all findings reported to the IHCs. Site wide audits will continue in Central and East throughout 2026/27.



Freedom of Information Requests

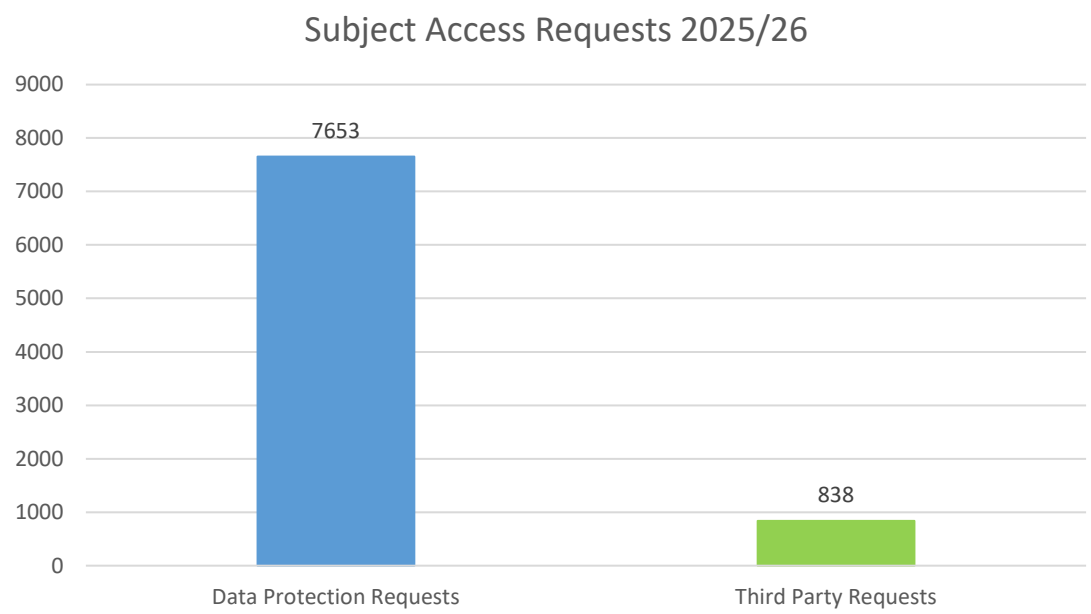
During 2025/26 BCUHB received and processed **803** Freedom of Information (FOI) requests, an increase of 3.9% from the previous year (773), with compliance decreasing from 68% to **62%.** This was due to the increase in the total number of requests being the most received to date and also a high number of these being complex cases spanning across multiple services. The total number of hours spent processing these requests totalled 448 days . This number is made up from the resources spent by both the Information Governance Team, the FOI leads and Executive Team approvals.





Exemption	Exemption Category	Total	Internal Review	Upheld/ Overturned	ICO	Upheld/ Overturned
Section 10 – Marketing Purposes	Absolute – No Public Interest Test required	5	-	-	-	-
Section 17 – Refusal Notice	Section 12 – fee limit.	42	1	1 x ongoing		-
Section 21 - Information accessible by other means	Absolute – No Public Interest Test required	36	5	4 x upheld 1 x overturned	2	2 x Ongoing
Section 36 - Qualified Person Statement	Class Based, so Public Interest Test assessed	1	1	1 x ongoing		-
Section 31 – Law Enforcement	Class Based, so Public Interest Test assessed	4	2	2 x partially overturned		-
Section 40 - Personal Information	Absolute – No Public Interest Test required	23	1	1 x upheld	1	1 x Ongoing
Section 42 – Legal Professional Privilege	Class Based, so Public Interest Test assessed	1	-			
Section 43 - Commercial interests	Class based, so Public Interest Test assessed	8	2	2 x overturned		
No Exemptions Used		683	15	1 x Overturned 3 x partially overturned 11 x Upheld	1	1 x Overturned
Total		**803**	**27**	**-**	**4**	**-**

Subject Access Requests & National Intelligent Integrated Auditing System (NIIAS) Notifications

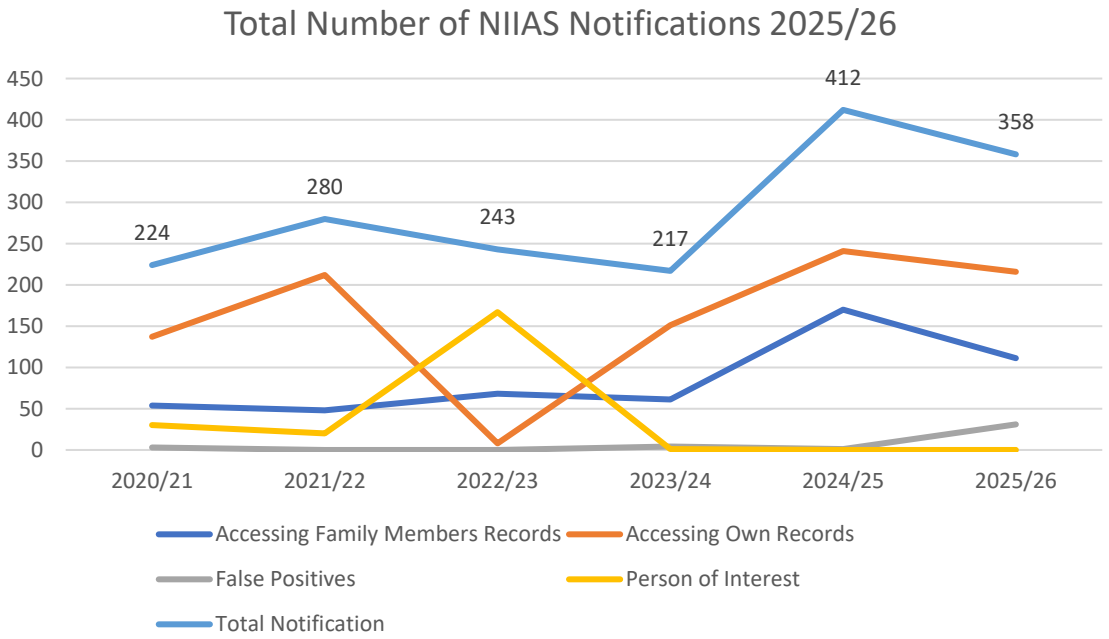


Data Protection Act Subject Access Requests (DPA SAR)

During 2025/26, **7653** requests were received into the Health Board a decrease from 8260 in 2024/25, with the average overall compliance increasing to **99%.** The Information Governance Team have continued to receive a high number of complex requests which are requests for emails or all the information held about an individual as a Health Board, this can sometimes result in thousands of emails/documents having to be manually reviewed and redacted.

Third Party Requests for Personal Information

The Information Governance Team have received **93** requests for information from North Wales Police during 2025/26. Some examples of requests are Medical Records, Personnel Records, CCTV, Witness Statements and Telephone Records, these were all processed in a timely manner.

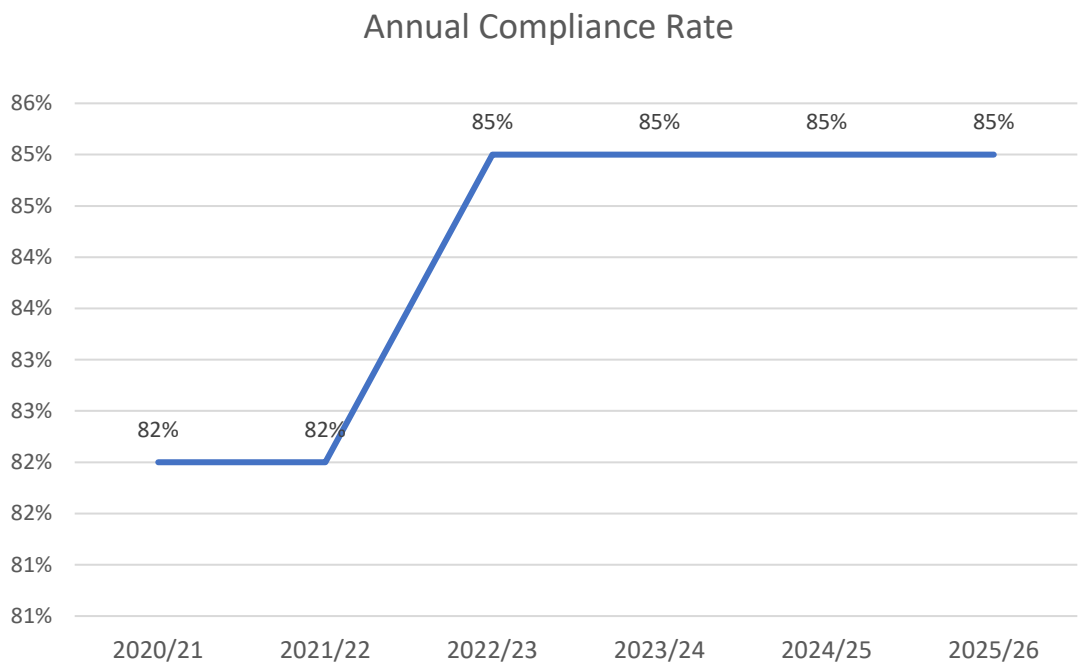


National Intelligent Integrated Auditing System (NIIAS)

During 2025/26, the National Intelligent Integrated Auditing System (NIIAS) generated 358 notifications of alleged inappropriate access to records, representing a reduction of 54 notifications compared to the previous year. Notifications were routinely monitored to identify any emerging trends and were reported through quarterly Key Performance Indicator reports to the Information Governance Group.

During the year, 183 cases were referred to Workforce & Organisational Development and progressed through workforce processes; all cases have now been closed. Escalation arrangements remain in place with senior clinical and professional leads should any increase in notifications be identified.

Information Governance Training, Risks and Policies & Procedures



Information Governance Mandatory Training

During 2025/26 we have continued trying to improve our mandatory training compliance, specifically targeting lower areas of compliance, this has resulted in maintaining the minimum national target of 85%.

During 2025/26, Information Governance training continued to be delivered through a combination of team-based sessions and face-to-face training. A total of 24 training sessions were held, with 251 staff members attending. In addition, specialist training was delivered to targeted areas, including GP clusters and Learning Disabilities services, with approximately 150 staff attending these bespoke sessions. This continued programme of training supports improved awareness and compliance with Information Governance requirements across the organisation.

Information Governance Risk Register

During 2025/26, 6 Information Governance risks were monitored on the risk register.

3 Tier 3 risks were successfully mitigated and formally closed following completion of agreed actions. These related to MS Office 365 records management, compliance with Data Protection and Freedom of Information legislation, and improvements to the Information Asset Register.

The remaining 3 risks, all assessed as Tier 2, remain open and continue to be actively managed. These relate to data flow mapping, the development and ongoing management of the Corporate Records Management function, and the completion of a BCU-wide audit to identify health and corporate records stored in vulnerable locations.

Policies and Procedures

During 2025/26 the following Information Governance policies and procedures were reviewed and approved in line with legislation:

- IG13 – Confidentiality Code of Conduct
- IG14 – ICT Security Procedure
- IG15 – Procedure for the Safe Transport and Storage of Personal Data
- IG16 – Disclosing Personal Data Procedure
- IG17 – Photo Video Audio Procedure
- IG20 Information Governance Framework
- IG23 - Procedure for the Auditing and Escalation of Staff Access to Patient Information Systems
- IG24 - Reporting Information Security Breaches Procedure
- IG28 – Bring your own device Procedure
- IG30 - Information Asset Register Procedure

Policies and procedures will continue to be developed or updated during 2026/27 to further support the Information Governance Framework.

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Performance Finance & Information Governance Committee

CORPORATE RISK REGISTER

Dyddiad y Cyfarfod **Date of Meeting**	23 June 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

There are no proposed changes to risk scores, and all three risks remain above the Health Board's risk appetite.

Significant updates have been made to CRR25-10 – Health and Safety to reflect the current position, as outlined in the Full Corporate Risk Register. This includes actions proposed for closure and the transfer of appropriate actions to operational risk registers, to strengthen clarity of ownership and accountability.

CRR25-06 – Financial Sustainability has not yet been fully updated for this reporting cycle. An Executive Committee deep dive has been undertaken, and further refinement of the risk narrative and associated actions is in progress. This will be completed ahead of Board consideration.

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**
Executive Committee (EC)	20/05/2026	Full CRR presented to the Executive Committee.
Risk Scrutiny Group (RSG)	12/05/2026	Following review by the Risk Scrutiny Group (RSG) on the 12th May 2026, minor further amendments to the template were agreed, alongside the need to present action details in a more succinct and consistent manner in future iterations of the cycle.
Deep Dive – CRR25-06 – Value Delivery and Financial Sustainability	01/04/2026	Deep Dive undertaken at Informal Executives Meeting.

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:

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

Overdue/Delayed Actions

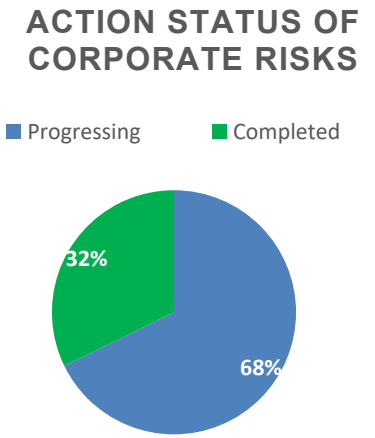
None

Risks above Health Board 24/25 appetite

All three risks reported to committee score outside the tolerance range set in the 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, 31 actions have been developed to mitigate the risks, with 21 open actions progressing and on track. 10 actions have been completed

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

- All risks have been reviewed and updated by the relevant service, with no proposed changes in risk scoring. The risks have current risk scores which sits outside the risk tolerance level set within the risk appetite.
- Significant updates have been made to CRR25-10 – Health and Safety to reflect current position, as set out in the Full Corporate Risk Register. The risk includes actions proposed for closure, and actions proposed for migration to operational-level risk management to improve clarity of ownership and accountability.

- One Corporate Risk has not yet been fully updated for this reporting cycle: CRR25-06 – Financial Sustainability. An Informal Executive Committee deep dive has taken place; however, further refinement of the risk narrative and actions has been requested and will be completed prior to Board Committee consideration

5. ARGYMHELLION RECOMMENDATIONS

5.1 Gofynnir i'r Pwyllgor/Cyfarfod/Grŵp:
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.
- **To note** CRR25-10 and CRR25-09 are to undergo deep dives in June 2026.

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	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	

A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data? **Data Protection Impact Assessment** *Have you undertaken a Data Protection Impact Assessment Screening?*	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	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.	

Corporate Risk Register

Performance, Finance and Information Governance Committee – 23rd June 2026

GIG CYMRU NHS WALES

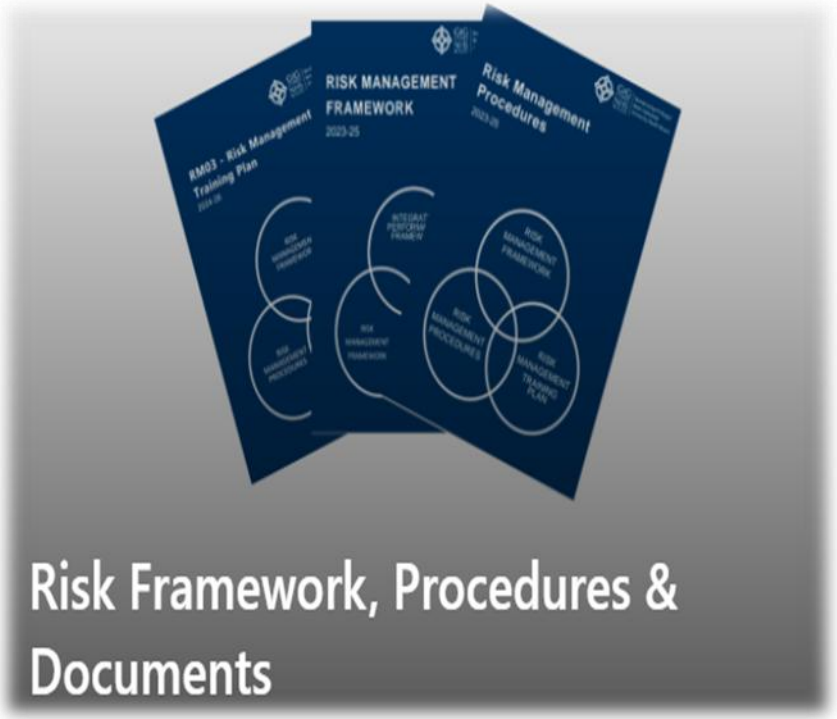
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Corporate Risk Register

This report provides the Performance Finance and Information Governance (PFIG) 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.

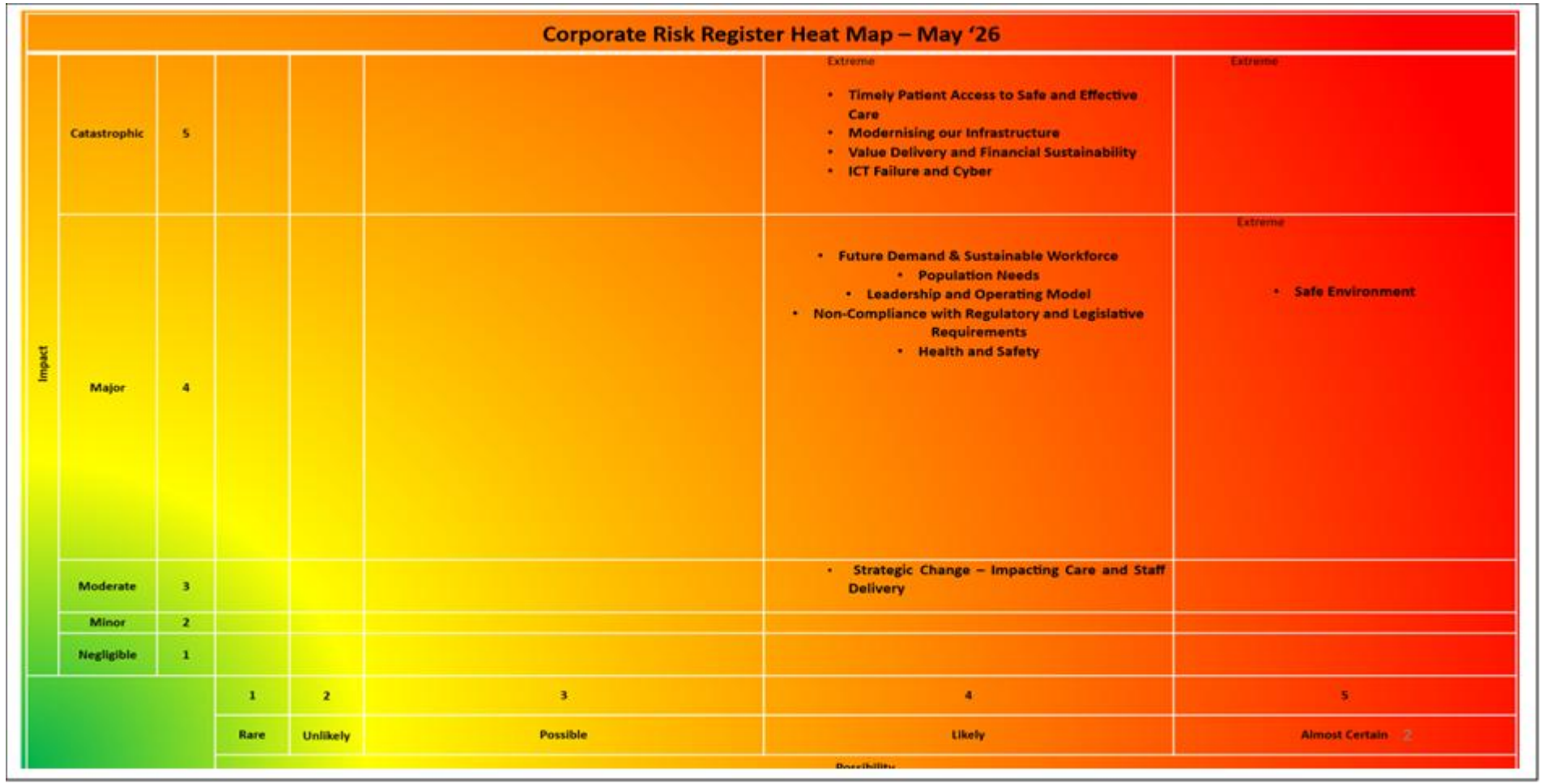


Appendix 1 - Dashboard

Appendix 1 - Corporate Risk Register Dashboard – Performance, Finance and Information Governance (PFIGC) – May 2026

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, Finance and Information Governance Committee	11	6	0	11 actions identified, with 6 closed actions and 5 actions progressing and ongoing Deep Dive undertaken in April 2026
DoE	CRR25-09	Safe Environment	4x5 20	12	Regulatory (<15) Above Tolerance	Performance, Finance and Information Governance Committee	9	1	0	Review of the risk undertaken by the service to align to operational aspects of the risk Deep Dive to be undertaken in June 2026
DoE	CRR25-10	Health and Safety	4x4 16	8	Regulatory (<15) Above Tolerance	Performance, Finance and Information Governance Committee	11	3	0	Full review of the risk has been undertaken by the service to align to operational aspects of the risk, with proposal to move some actions to current operational risks. Deep Dive to be undertaken in June 2026

Appendix 2 - Heatmap



Appendix 3 – Corporate Risks aligned to Committee

CRR REF: 25-06 Risk Title: Value Delivery and Financial Sustainability		
Director Lead: Executive Director of Finance		**Date Opened:** 21/08/2025
Assuring Committee: Performance, Finance and Information Governance Committee		**Date Last Committee Review:** 24/02/2026
Date Last Reviewed: 16/03/2026	**Link to BAF**: BAF24-03	**Target Risk Date:** 31/03/2026

There is a risk that the Health Board will be unable to secure current nonrecurrent (on-e off) allocations in future financial years, as these allocations are conditional on meeting agreed financial plans. Failure to secure this resource will require services to operate- within a significantly reduced financial envelope.

The objective is to achieve long-term financial sustainability or maximise value from its spending.

This may be caused by cost overruns from mental health out of- area referrals, additional costs linked to patient- flow pressures and emergency care capacity, and non- delivery- of required savings and transformation plans.

This may lead to reduced access to safe, timely and high quality care, increased risk of patient harm, and an inability to achieve long- term -financial sustainability.

Mitigations/Controls in place

1) 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.
2) Value and Sustainability programme approach to 2025/26 savings has been endorsed by the Executive and Board. Executive Leads have been assigned and a flow chart issued setting out the governance process for sharing of costed savings opportunities and Divisional delivery.
3) Accountability Agreements to be 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

4) Continuation of the Enhanced Establishment Control Group (executive approval before advertising) to review all requests for A&C posts and all Band 7+ posts, moratorium on requests for Permanent recruitment to Band 8B and above where potentially affected by Foundations for the Future but excluding any clinical posts and minimising interim staff appointments.
5) Expansion of EEC (Enhanced Establishment Control) to be utilised for acting up and any increase in hours to be managed through the Enhanced Establishment Control process.
6) Cease use of agency in line with Ministerial Actions by end of September 2025 with the exceptionality of sign off by Executive Director of Nursing for all Agency nursing requests which are deemed clinically necessary beyond 31 October. This exceptionality for nursing requests is for all areas from December 2025.
7) Non-Pay – all discretionary, non-clinical expenditure directed to the office of the Executive Director of Finance for scrutiny prior to approval
8) Internal scrutiny by central finance teams, of the Divisional financial assumptions, overspends and forecasts.
9) Financial reporting throughout the Health Board and to Welsh Government monthly via the Monthly Monitoring Return.
10) Early identification of emerging issues through horizon scanning and trends in run rate and alerting Operational Management to changes to regularity requirements.
11) Monitoring the adequacy and effectiveness of internal control, accuracy and completeness of financial reporting and forecast, compliance with laws and timely remediation of deficiencies through conformance reporting to Audit Committee and reporting through local finance reports to services
12) Review of Scheme of Reservation and Delegation (SORD) September 2025 to provide clarity with aim of authority moving towards earned autonomy
13) Health Board receiving a report on need for additional financial oversight, delegating Executive to develop a recovery plan building on the measures deployed and key asks of officers from the Integrated performance executive Delivery Group. A representation of the Health Board to support development of the recovery plan and Performance, Finance and Information Governance Committee to provide Health Board oversight
14) Chief Executive Officer (CEO) wrote to all Executive colleagues on 12 January 2026 imposing Immediate implementation of strengthened organisation-wide expenditure controls across all Directorates—covering non-pay, procurement and pay—including enhanced oversight of non-clinical spend, stricter purchasing controls, mandatory compliance with “No PO, No Pay”, criticality checks on all pending orders, and a freeze on all non-clinical vacant posts

Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G1 Financial performance has materially deteriorated, indicating insufficient controls. Additional actions, endorsed by the Integrated Performance – Executive Delivery Group, are required to stabilise the run rate and reduce the deficit.	**Additional financial recovery measures to be implemented to control the run rate and reduce the deficit, as endorsed by the Integrated Performance – Executive Delivery Group.** **Outcome** The Health Board is unable to stabilise financial performance, with the run rate deteriorating and the deficit not reducing towards a balanced position despite agreed actions. **Metric** In-year Run-Rate Variance (£m per month) compared to the planned trajectory to break even. • *Monthly overspend vs plan* • Secondary metric: *Cumulative deficit position vs plan* **Impact on Risk** • Increased risk of failing to achieve financial balance, escalating regulatory scrutiny. • Reduced ability to fund essential services and transformation activity. • Heightened risk of service instability and negative impact on quality, access and patient outcomes.	Executive Director of Finance (EDOF)	31/03/2026	Complete

Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G2 Health Board delegation to Executive to produce a recovery plan, Health Board working group formed to provide Board oversight with Performance, Finance and Information Governance Committee to mitigate against the year-to-date deficit and risk to attainment of target break even whilst assessing impact on patient safety and quality	A representation of the Health Board to support development of the recovery plan and Performance, Finance and Information Governance Committee to provide Health Board oversight **Outcome** Health Board receiving a report on need for additional financial oversight, delegating Executive to develop a recovery plan building on the measures deployed and key asks of officers from the Integrated performance executive Delivery Group. **Metric** Completion and approval of the financial recovery plan (Yes/No) **Impact on Risk** Strengthened oversight and actions reduce the risk to delivery of the financial plan	Chief Executive Officer (CEO) / Executive Director of Finance (EDOF)	30/11/2025	Complete

Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G3 Performance is reported and scrutinised through the IP-EDG monthly meetings where officers are held to account for delivery. A 1.5% cost benefit and savings ask delivery is required as a minimum	Reporting of Performance for accountability **Outcome** Continued oversight and holding to account via the Integrated Performance Executive Delivery Group, and holding to account against expenditure reductions identified for the remainder of the financial year. **Metric** • Delivery of monthly expenditure reduction target (£) vs plan. • Run rate improvement attributable to monitored actions (£m). **Impact on Risk** Reduces risk that the that the Health Board fails to control in year spend, worsening financial deterioration.	Chief Executive Officer (CEO) / Executive Director of Finance (EDOF)	Monthly 31/03/2026	Progressing
Gaps in Controls	**Action**	**Action Owner**	**Due Date**	**Progression Analysis**
G4 Insufficient robust and consistent scrutiny of divisional forecasts and financial risks, resulting in inaccurate forecasts, delayed escalation, and weak accountability for overspends.	Enhanced 'Check and Challenge' discussions with Chief Finance Officers, on a monthly basis **Outcome**	Executive Director of	Monthly 31/03/2026	Complete

	• Improve forecast accuracy, reducing the chance of unforeseen overspends. • Strengthen early identification and escalation of financial risks. • Increase accountability for divisional financial performance. • Provide a structured mechanism to challenge assumptions and ensure corrective action is taken promptly. **Metric** Meetings taking place on a monthly basis (Y/N) **Impact on Risk** The enhanced oversight arrangements strengthen financial grip, reducing the likelihood of further deterioration and thereby lowering the overall financial risk.	Finance (EDOF)		
Gaps in Controls	**Action**	**Action Owner**	**Due Date**	**Progression Analysis**
G5 Gaps in delivery of savings targets mandated to be met on a recurrent basis	To task IHCs and Divisions to ensure recurrent savings plans are delivered in full and on time **Outcome** Strengthening the Health Board's underlying financial position and reducing reliance on non-recurrent measures	Executive Director of Finance (EDOF)	31/03/2026	Progressing

	Metric Recurrent savings delivered vs plan (£ and %). **Impact on Risk** will reduce the likelihood of financial deterioration, improve the underlying deficit position, lessen reliance on non-recurrent measures, and lower the overall financial sustainability risk			
G6 Divisional performance issues are not being resolved through routine oversight processes, requiring CEO-level escalation to address persistent non-delivery and ensure timely implementation of corrective actions.	Escalation meetings where improvements are not realised will continue to be held with leadership teams by the Chief Executive. **Outcome** In these forums support is offered to improve performance and trajectories supported for improvement **Metric** Reduction in repeated escalations for the same issue or division. **Impact on Risk** strengthens accountability and accelerates corrective action, reducing the likelihood of continued under-performance	CEO / Exec Director of Finance	31/03/2026	Ongoing /Progressing

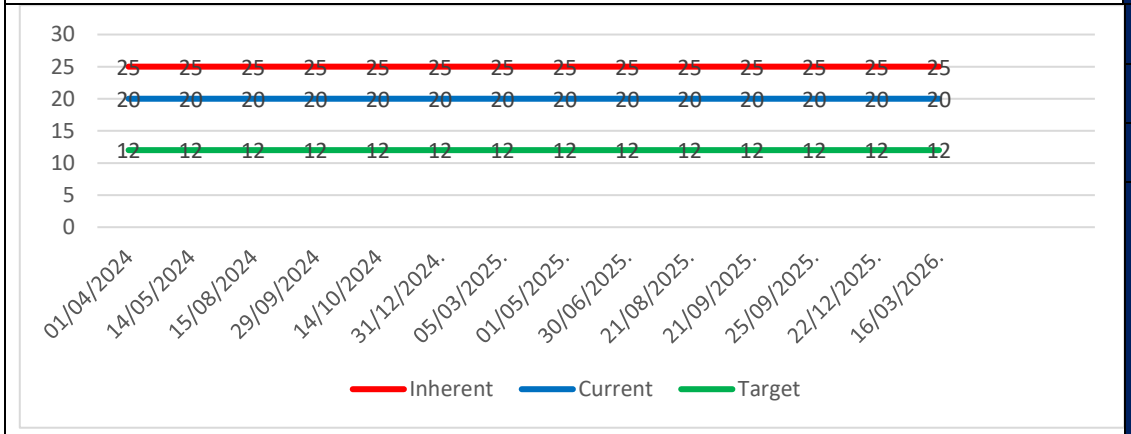
Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G7 Transformation funding schemes risked progressing without clear disinvestment or long-term funding, creating exposure to future recurrent financial pressures.	Exercise to be undertaken to agree the prioritisation of the utilisation of the £42m transformation funding **Outcome** Prioritisation exercise involving £42m transformation funding received on a conditionally recurrently basis to the end of 2025/26 completed for clinical schemes, with requirement to disinvest / identify alternative funding streams prior to new developments being funded. **Metric** Prioritisation exercise completed with the requirement for disinvestment before new schemes are approved (Y/N). **Impact on Risk** Effective prioritisation reduces the likelihood of creating new unfunded recurrent pressures, strengthens financial sustainability, ensures investment aligns with clinical priorities, and lowers the overall risk associated with financial deterioration or inability to deliver long-term transformation	31/12/2025	Director of Transformation	Complete
Gaps in Controls	**Action**	**Action Owner**	**Due Date**	**Progression Analysis**
G8	To confirm additional controls to be implemented to contain further deterioration in financial position	CEO	31/01/2026	Complete

There is a financial gap to plan because earlier-year cost pressures were not contained, recovery actions from IHCs were insufficient, and enhanced financial controls were implemented but were late to prevent deterioration, resulting in forecast volatility and a £17m deficit at Month 8. .	**Outcome** On 12 January 2026, Chief Executive confirmed: Immediate implementation of strengthened organisation-wide expenditure controls across all Directorates—covering non-pay, procurement and pay—including enhanced oversight of non-clinical spend, stricter purchasing controls, mandatory compliance with “No PO, No Pay”, criticality checks on all pending orders, and a freeze on all non-clinical vacant posts **Metric** • Monthly spend reduction achieved vs £6m target. • Number/value of pending orders approved or stopped following criticality review. • Reduction in non-clinical pay costs (vacancy freeze impact). • Total in-year deficit movement from Month 10 onwards. **Impact on Risk** If effective, these controls will reduce the likelihood of further financial deterioration, enable delivery of the in-year plan, and secure £82m of critical Welsh Government income, thereby significantly lowering the financial sustainability risk and strengthening future funding allocations			

Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G9 Medical devices replacement plans lacked full alignment and consistent governance, creating a risk of delays in prioritising and replacing essential equipment.	Directorate teams to review medical devices capital replacement plans. **Outcome** The medical devices capital programme has been agreed for 2026-27 via the Medical Devices Capital Group. Refinements to the process will be made in line with progress with Foundations for the Future, which will determine the appropriate governance processes. Proposal to close the action	Assistant Director of Ahps and Health Science, Therapies & Health Science	31/03/2026	Complete
G10 The Health Board currently lacks a comprehensive, system-wide understanding of how money is spent, how IHC areas perform, and how cost, activity and outcomes align, limiting its ability to make Value-Based, allocatively efficient financial decisions.	Programme of work initiated to review how the Health Board spends its money, visibility of IHC performance and national benchmarks to ensure value outcomes (Patient Related) **Outcome** The Value & Sustainability (V&S) Programme controls are partially effective. Early modelling has identified £23.7m of opportunities for 2026/27, and several workstreams have progressed enabling actions, internal benchmarking and national alignment. However, the majority of opportunities remain in the pipeline and have not yet converted to 'Green RAG' deliverables, and the overall forecast requires further schemes to bridge the target. This indicates that while controls are generating insight and potential schemes, delivery maturity is limited, benefits are not yet realised, and	Executive Director of Finance	31/03/2026 and ongoing	Progressing

	the controls are not yet sufficient to reduce the financial risk position. **Metric** Outcome Measures are developed to support Allocative Efficiency moving forwards (cost / activity / outcomes) **Impact on Risk** Better visibility of spend, performance, and outcomes reduces the likelihood of inefficient allocation of resources, supports more informed financial decisions, strengthens value for money, and lowers the overall risk of financial deterioration or poor service sustainability			
Gaps in Controls	**Action**	**Action Owner**	**Due Date**	**Progression Analysis**
G11 The Health Board currently does not have sufficient insight into clinical variation, limiting its ability to benchmark performance, identify inefficiencies and target improvement actions that support financial sustainability. There is a gap because the majority of Value & Sustainability opportunities	A programme of work to examine, explain and benchmark clinical variation across services, identifying unwarranted variation and opportunities to improve quality, efficiency and financial sustainability. **Outcome** Examine and explain clinical variation with a view to benchmarking opportunities internally initially with a view to ensuring financial sustainability **Metric**	Executive Director of Finance	31/03/2026 and ongoing	Progressing

have not yet been developed into fully-defined, deliverable schemes, meaning they remain high-level pipeline ideas rather than assured savings capable of reducing the financial risk	• Identification and monitoring of unwarranted variation (RAG). • Cost / activity / outcome improvements achieved following variation reduction. • Adoption of best-practice pathways (compliance %) **Impact on Risk** control will reduce the likelihood of inefficient clinical practices, support more consistent and cost-effective models of care, improve resource utilisation, and strengthen financial sustainability by addressing unwarranted clinical variation.			



	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

The Health Board has a substantial risk to deliver improvement in this rating, with a proposed deficit (subject to endorsement by Health Board) for 2026/27 and substantial allocations dependent upon delivery of conditions that include de-escalation from special measures (one criteria being to attain the key financial duty).

In response to the current challenges, the Health Board has mirrored the national vehicle for improvement through Value & Sustainability, targeting areas of development (to include medicines Management, Clinical Variation, Workforce, Continuing Healthcare and Non-pay). This approach to improvement supports delivery of improved quality, access and outcomes for the local population.

Welsh Government has indicated significant financial challenge to be evident within the financial modelling of NHS Wales, seeking organisations to develop plans to meet Ministerial expectations within available funds. As such there is a requirement for the Executive to develop plans to attain the key financial duty to break-even over a three-year period whilst delivering performance and qualitative criteria.

The Executive (reporting to Performance, Finance and Information Governance Committee) are to develop a list of opportunities to include repatriation of services, cessation of services, and benefits from improved productivity and efficiency to deliver sustainable services for the local population. On implementation of the above measures and profiling of how these improve financial standing over a three year period, the Health Board can attain the conditions associated with release of the conditionally recurrent funds and deliver a break-even outturn, attain the financial key duty and reduce the risk to delivery of high quality, timely services that deliver improved outcomes.

CRR REF: 25-09: Safe Environment

Director Lead: Director of Environment and Estates		**Date Opened:** 04/01/2024
Assuring Committee: Performance, Finance and Information Governance Committee		**Date Last Committee Review:** 24/02/2026
Date Last Reviewed: 23/04/2026	**Link to BAF**: BAF24-03	**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 status by site, which will be assessed against the controls currently in place. Additional mitigation or strengthening of controls will also be considered.	**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. **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**	Head Of Operational Estates	31/03/2028 (Subject to funding)	Progressing Due date extended from 31/03/2027 to 31/03/2028

	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 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.	**Develop ToR** Develop a standardised Terms of Reference to be considered and endorsed by Capital Investment Group **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).	Director of Environment and Estates	31/09/2026	Progressing Due date extended from 31/03/2026 to 30/09/2026 to reflect Foundations for the future structure

	• 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** • 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	**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	Head Of Operational Estates	30/03/2028	Progressing Due date extended from 31/03/2026 to 30/03/2028. Aligned with Facet Survey Programme

reduce backlog maintenance.	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 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	**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	Head Of Operational Estates	31/03/2030	Progressing

managed through the Fire Safety Management Group	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 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 stages with confidence, in alignment with WG capital requirements and timelines. **Metric** **PBC Development & Approval**	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

	• 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 Assurance around the progress made with the BCUHB Estates Strategy and	**BCUHB Estates 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	Director of Environment and Estates	30/09/2026	Progressing Revised date from 31/03/2026

the lack of clarity around the BCUHB Clinical Strategy.	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). **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**
G7 Internal Audit review of Asbestos Management – Agreed Management Action Plan developed and managed through the Asbestos Management Group	**Pan BCUHB Asbestos Management and Control** Ensure the Health Board is fully compliant with its duty to manage asbestos by addressing all findings listed within the internal audit review **Outcome** Ensure full statutory compliance with asbestos legislation across the Health Board estate by completing all actions arising from the Authorising Engineer (Asbestos) audit and the Internal Audit review of Asbestos Management. This	Head Of Operational Estates	30/06/2026	Completed Revised date from 31/03/2026

	includes strengthening governance, improving accuracy and completeness of the Asbestos Register, ensuring safe management of asbestos-containing materials (ACMs), enhancing training and control measures, and embedding robust operational procedures to protect patients, staff, contractors, and visitors **Metric** **Internal Audit Recommendation Completion Rate -** % of Internal Audit recommendations for Asbestos Management completed (target: 100%). Improvement in Internal Audit assurance rating (target: move to “Reasonable Assurance” or higher). **Asbestos Register Accuracy & Completeness** % of buildings surveyed or re-surveyed within required timeframes (target: 100%). - % of ACM data updated following works or inspections (target: 100%). **Asbestos Management Plan (AMP) Compliance -** Completion rate of actions within the AMP, including monitoring of ACMs **Training & Competency Compliance** % of identified staff and contractors completing mandatory asbestos awareness or duty to manage training			

	Reduce the risk of asbestos exposure, protecting patients, staff, visitors, and contractors from significant health hazards associated with disturbed ACMs. **Strengthen statutory compliance**, ensuring alignment with the Control of Asbestos Regulations 2012 and reducing the risk of enforcement action or prosecution. **Enhance organisational assurance**, particularly through improved Internal Audit ratings, demonstrating that asbestos risks are effectively identified, monitored, and controlled. **Minimise operational and clinical disruption**, reducing the likelihood of ward closures, emergency remediation, or service interruptions caused by uncontrolled asbestos findings. **Improve data accuracy and decision-making**, through a reliable asbestos register, robust survey regime, and embedded compliance processes. **Impact on Risk** **Reduce the risk of asbestos exposure**, protecting patients, staff, visitors, and contractors from significant health hazards associated with disturbed ACMs.			

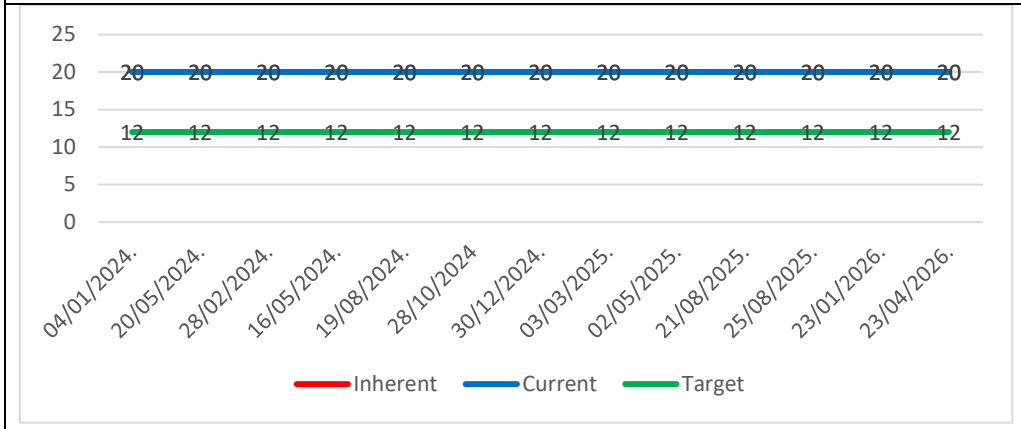
	Strengthen statutory compliance, ensuring alignment with the Control of Asbestos Regulations 2012 and reducing the risk of enforcement action or prosecution. **Enhance organisational assurance**, particularly through improved Internal Audit ratings, demonstrating that asbestos risks are effectively identified, monitored, and controlled. **Reduce financial risk**, preventing costly reactive works, claims, or regulatory penalties associated with poor asbestos management. This action is completed following the presentation of the internal audit review of Asbestos Management to audit committee which reported substantial assurance.			
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 are reported at the Water Safety Group	**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

	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**	Head Of Operational Estates	31/03/2028	Progressing

	Achieve full statutory compliance for electrical systems across the Wrexham Maelor Hospital site by implementing all required actions arising from the 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.

CRR REF: 25-10: Health and Safety		
Director Lead: Director of Environment and Estates (DoE&E)		**Date Opened:** 21/08/2025
Assuring Committee: Performance, Finance and Information Governance Committee		**Date Last Committee Review:** 24/02/2026
Date Last Reviewed: 30/04/2026	**Link to BAF**: BAF24-03	**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

Gaps in Controls	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. • Business case (if required) completed and submitted for approval by November 2026. • Final structure aligned with outcomes of the Foundations for the Future programme.	DoE&E	31/03/2027	Progressing

	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.			
Gaps in Controls	**Action**	**Action Owner**	**Due Date**	**Progression Analysis**
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 • Reduction in delayed or inappropriate escalations identified through reviews or audits **Impact on Risk**	DoE&E	31/03/2027	Progressing

	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)				
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 • 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.	Head of Health, Safety and Security	31/03/2027	To commence

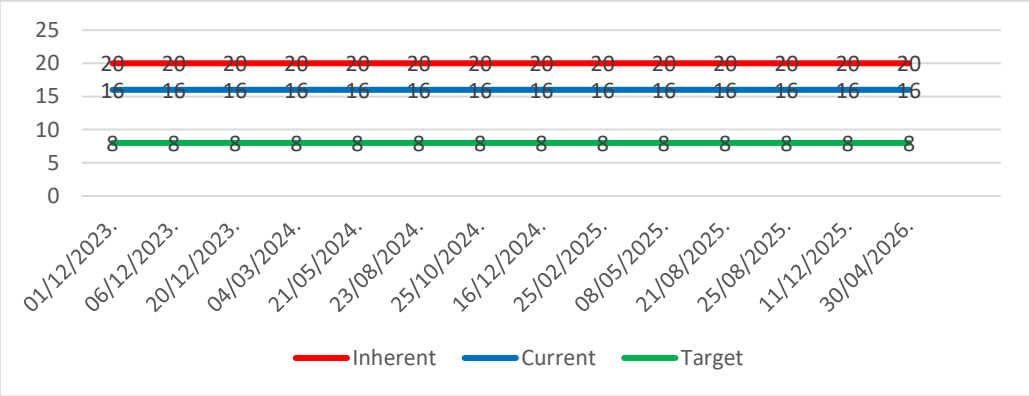
Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
ACR2b Implement an Electronic Document Management System (EDMS) across BCUHB to centralise health and safety compliance reporting and house risk management documentation, to support a health and safety management framework	Source or develop 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 • 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.	Head of Health, Safety and Security	31/03/2027	To commence

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** • 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.	Head of Health, Safety and Security	31/03/2027	To commence

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. **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.	Head of Health, Safety and Security	31/12/2026	Progressing

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. **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.	DoE&E	31/03/2027	Progressing

Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
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** • 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.	Head of Health, Safety and Security	31/03/27	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	Regulatory/ 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).

COMPLETED ACTIONS (AUDIT TRAIL)				
Additional Controls required	Action	Action Owner	Due Date	Progression Analysis
ACR1: Governance and Leadership (PLAN)				
ACR1c Determine the Organisations H&S policy/Plan for implementation: Review of health and safety policies within the next 12-24 months.	Policy tracker presented to SOSHG quarterly and updates specific to Policies provided to Executive Policy Oversight Group, with further oversight by Policy and Compliance Team. **Outcome** A fully reviewed, up-to-date, and compliant suite of Health and Safety policies that reflect current legislation, national guidance, internal audit expectations, and organisational requirements. The policy tracker provides structured oversight and assurance to SOSHG, ensuring visibility of progress and governance throughout the review cycle. **Metric** • Regular updates of the policy tracker and presentation to SOSHG. • Reduction in overdue policies or those requiring exception reporting. **Impact on Risk** Timely review and updating of health and safety policies reduces the likelihood of non-compliance with statutory requirements, inconsistent practice across the organisation, and potential legal or regulatory challenge. Up-to-date policies strengthen governance, provide clarity for staff, and ensure that safe systems of work are based on current, accurate guidance.	DoE&E	28/04/27	Complete

ACR2: Health and Safety Risk Management (DO)				
ACR2a A Health and Safety Management Framework needs developing.	Develop a Health Board Health and Safety Management Framework. The introduction of the NHS Employer's Health and Safety Standards will provide an indication of Health & Safety performance and be a mechanism to monitor the Health Board Health & Safety management framework and will be used to formulate strategy moving forwards. Key service objectives will be monitored going forward. Standards and guidance are available; resources and stakeholder engagement will be secured through the Health & Safety governance structure. Supports compliance, improves governance, and provides a structured mechanism for monitoring and continuous improvement of health and safety performance. Framework to be developed, approved, and implemented by April 2025 with first performance report issued by June 2025.This is complete. The standards are in use and the Health and Safety Team are completing the second Cohort of the self-assessment exercise that this action is built around. Paper went to Executive Committee 12/11/2025 and People and Culture Committee 04/12/2025.	Head of Health, Safety & Security	31/12/25	Complete
ACR4&5: Governance and Leadership (PLAN)				
ARCR4&5 A Health and Safety Management Framework needs developing.	A process to monitor and review department self-assessments is under development and will be issued in readiness for the April Self-Assessment Cycle. Complete see action point 1 above and the paper that went to EC (Executive Committee) and P&CC (People & Culture Committee)	Director of Estates	31/12/25	Complete

ACTIONS DELETED FROM THIS RISK FOLLOWING REVIEW UNDERTAKEN 30/04/2026 – SECTION TO BE REMOVED FOLLOWING EXEC. COMMITTEE REVIEW OF RISK IN MAY 2026 – RECORDED FOR AUDIT TRAIL OF CHANGES ONLY.				
Additional Controls required	Action	Action Owner	Due Date	Progression Analysis
~~**G3**~~ ~~The business model aligned to the NHS Manual Handling Passport Scheme to be reviewed~~	ACTION DELETED AS NOT RELEVANT TO THIS RISK. TO BE INCORPORATED INTO MANUAL HANDLING RISK. ~~The BCUHB business model aligned to the All-Wales NHS Manual Handling Passport Scheme 2020 to be reviewed. Following meeting with DDoNs (Deputy Director of Nursing) and Service Leads, further meetings scheduled to discuss bespoke service requirements.~~ ~~Complete a gap analysis and produce a revised business model document that addresses bespoke service requirements, with sign-off from all relevant stakeholders. Initial meetings with DDoNs and Service Leads have taken place; further meetings are scheduled to gather detailed requirements and ensure feasibility.~~ ~~Supports compliance with national standards and improves consistency in manual handling training and practice across BCUHB. Finalise and approve the revised business model by August 2026, following stakeholder engagement and review.~~ ~~**Outcome**~~ ~~A revised and fully compliant Manual Handling business model that aligns with the All-Wales NHS Manual Handling Passport Scheme (2020) and reflects bespoke service requirements across BCUHB.~~ ~~**Metric**~~	~~Director of Estates~~	~~31/08/26~~	

	• ~~Completion of a full gap analysis comparing current BCUHB practice with the All-Wales Scheme by August 2026.~~ • ~~Production and stakeholder sign-off of the revised business model document by August 2026.~~ **~~Impact on Risk~~** ~~Updating the business model will reduce the likelihood of non-compliance with national standards and mitigate risks associated with inconsistent manual handling practice, including patient harm, staff injury, litigation, and enforcement action.~~			
Gaps in Controls	**Action**	**Action Owner**	**Due Date**	**Progression Analysis**
~~G4~~ ~~Investment in training venues is required for manual handling training delivery.~~	ACTION DELETED AS NOT RELEVANT TO THIS RISK. TO BE INCORPORATED INTO MANUAL HANDLING RISK. **~~Outcome~~** ~~BCUHB has access to suitable, safe, and fully equipped training venues that meet the requirements of the All-Wales NHS Manual Handling Passport Scheme.~~ ~~Investment in appropriate facilities enables consistent, high-quality manual handling training, supports staff competency, and ensures training can be delivered reliably without disruption.~~ **~~Metric~~** • ~~Completion of an assessment of current training venue suitability and resource gaps.~~ • ~~Identification of required investment (e.g., equipment, space, layout, dedicated training areas).~~			

	• ~~Approval of funding or capital allocation for venue improvements.~~ • ~~Readiness of upgraded venues or establishment of new venues within agreed timescales.~~ • ~~Improved training compliance and reduced course cancellations or relocations due to unsuitable facilities.~~ **~~Impact on Risk~~** ~~Investing in appropriate training venues reduces the risk of inconsistent or inadequate manual handling training, which can lead to increased staff injury, patient harm, litigation, and non-compliance with national standards.~~			
Gaps in Controls	**Action**	**Action Owner**	**Due Date**	**Progression Analysis**
~~G5~~ ~~Senior Leaders to nominate staff to support with Divisional delivery of manual handling refresher training.~~	ACTION DELETED AS NOT RELEVANT TO THIS RISK. TO BE INCORPORATED INTO MANUAL HANDLING RISK **~~Outcome~~** **~~Metric~~** **~~Impact on Risk~~**			
G9 ~~Utilise the Violence Prevention and Reduction Standards to provide a framework for a safer environment.~~	ACTION DELETED AS NOT RELEVANT TO THIS RISK. TO BE INCORPORATED INTO SECURITY, VIOLENCE AND AGGRESSION RISK **~~Outcome~~** ~~A consistent, organisation-wide framework for preventing and reducing violence across BCUHB, fully aligned with the Violence Prevention and Reduction Standards (VPRS).~~ ~~Implementation of the standards will strengthen governance, improve safety~~			

	~~for staff, patients and visitors, and ensure a structured approach to managing violence and aggression risks across all services.~~ ~~**Metric**~~ • ~~Completion of a gap analysis against the Violence Prevention and Reduction Standards.~~ • ~~Development and implementation of an action plan to address identified gaps.~~ • ~~Evidence of compliance monitoring and regular reporting to relevant governance groups.~~ • ~~Measurable reduction in reported incidents of violence and aggression.~~ • ~~Increased completion of relevant training (e.g., VPR training modules).~~ • ~~Audit outcomes demonstrating improved alignment with VPRS requirements.~~ ~~**Impact on Risk**~~ ~~Using the VPRS as the organisational framework reduces the likelihood and severity of violence-related incidents, protecting staff and patients and improving the overall safety environment.~~ ~~Compliance with national standards mitigates legal, regulatory, and reputational risks while strengthening assurance and improving the organisation's ability to prevent, respond to, and manage violence and aggression effectively.~~			
	ACTION DELETED AS NOT RELEVANT TO THIS RISK. TO BE INCORPORATED INTO SECURITY, VIOLENCE AND AGGRESSION RISK ~~In-house security service model not being pursued. 22/01/2025: Extension of current Security SLA (Service level agreement) and Technical specification awaiting sign off.~~	~~Director of Estates~~	~~01/10/26~~	

	~~Extension to due date requested. Tender delayed due to governance timetable and hampered by Christmas break, and legal obligations under TUPE, which means 4-week consultation and 12-week notice period cannot commence until after 26/03/2025.Secure sign-off for SLA extension, publish tender documentation, complete TUPE consultation (4 weeks) and notice period (12 weeks), and award the new contract. Dependencies include governance approval and TUPE legal obligations; timelines adjusted to accommodate these requirements. Ensures continuity of security services and compliance with legal and governance obligations while transitioning to a new provider. Obtain SLA extension sign-off by 14/01/2026, award new contract by 01/10/2026.~~			

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Performance Finance & Information Governance Committee

CORPORATE GOVERNANCE REPORT

Dyddiad y Cyfarfod Date of Meeting	23 June 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Philippa Peake-Jones, Head of Corporate Governance
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Pam Wenger, Director of Corporate Governance

Pwrpas yr Adroddiad Report Purpose	For Noting

Crynodeb Gweithredol Executive Summary
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 28 April 2026:

Agenda Item	Subject (including narrative)	Committee Resolution	Rationale for item in Private
PF26.56	Security Service Tender Process	It was resolved that the Committee: • **Endorsed** the content of the report.	Commercially Sensitive
PF26.57	Llandudno Orthopaedic Hub	it was resolved that the Committee: • **Noted** the verbal update	Commercially Sensitive
PF26.58	Royal Mail Framework	It was resolved that the Committee:	Commercially Sensitive

Agenda Item	Subject (including narrative)	Committee Resolution	Rationale for item in Private
		• **Endorsed** the content of the report.	
PF26.59	Procurement of Dental Services	It was resolved that the Committee: • **Approved** the report.	Commercially Sensitive
PF26.60	Community Equipment Maintenance and Loan Tender	It was resolved that the Committee: • **Endorsed** the report for Board Approval	Commercially Sensitive
PF26.61	IMCA Contract Re-Tender	It was resolved that the Committee: • **Approved** the report.	Commercially Sensitive
PF26.62	Radiology Mobile PETCT Contract Tender for Approval	It was resolved that the Committee: • **Approved** the report.	Commercially Sensitive

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 28 April 2026. Items included:

- PF26.56 Security Service Tender Process
- PF26.57 Llandudno Orthopaedic Hub
- PF26.58 Royal Mail Framework
- PF26.59 Procurement of Dental Services
- PF26.60 Community Equipment Maintenance and Loan Tender
- PF26.61 IMCA Contract Re-Tender
- PF26.62 Radiology Mobile PETCT Contract Tender for Approval

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 requirements of the Welsh Language Standards)*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report
Asesiad o'r Effaith Economaidd-gymdeithasol *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:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:

	If more than one applies, please list below:	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 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:	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?*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	

Counter Fraud Impact Assessment *Have you considered the counter fraud impacts*	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.	

DRAFT

Betsi Cadwaladr University Health Board

Performance, Finance and Information Governance Committee

Cycle of Business

(1 April 2026 – 31 March 2027)

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

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

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

The role of the Performance, Finance and Information Governance Committee is set out in the Terms of Reference which is available here:

Committee Chair Gareth Williams **Committee Vice Chair**	**Independent Members** Mike Larvin Christopher Lothian Field Rhian Watcyn Jones	**Executive Members** Russell Caldicott (Executive Director of Finance & Performance) Tehmeena Ajmal (Chief Operating Officer) Dylan Roberts (Chief Digital and Information Officer)	**In Attendance** Pam Wenger (Director Corporate Governance) Stuart Keen (Director of Environment & Estates)

PERFORMANCE, FINANCE AND INFORMATION GOVERNANCE COMMITTEE CYCLE OF BUSINESS 2026-27

Item of Business	Executive Lead	Reporting Period	Q1			Q2			Q3			Q4			2027-28	
			April 2026	May 2026	June 2026	July 2026	Aug 2026	Sep 2026	Oct 2026	Nov 2026	Dec 2026	Jan 2027	Feb 2027	Mar 2027	April 2027	May 2027
PRELIMINARY MATTERS																
Minutes of the Previous Meeting	Director of Corporate Governance	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑		⚑	
Matters Arising and Action Log	Director of Corporate Governance	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑		⚑	
STRATEGIC ITEMS																
Major Change Programmes																
Planned Care	Chief Operating Officer	Every meeting	⚑		⚑		⚑		⚑		⚑		⚑		⚑	
Urgent and Emergency Care	Chief Operating Officer	Every meeting	⚑		⚑		⚑		⚑		⚑		⚑		⚑	
Clinical Services Plan	Executive Medical Director	TBC														
Value and Sustainability	Executive Director of Finance	Every meeting	⚑		⚑		⚑		⚑		⚑		⚑		⚑	
Key Programmes																
Health and Wellbeing Hubs	Chief Operating Officer	Bi-Annually														
Foundations for the Future	Chief Executive	To be agreed at agenda setting														
Cancer Services	Chief Operating Officer	As Required			⚑											
STRATEGIC PLANNING																
Performance and Financial Aspects of the Integrated Medium Term Plan	Executive Director of Transformation & Strategic Planning	Annually / As Required														
Integrated Medium Term Plan Progress Report	Executive Director of Transformation & Strategic Planning	End of year regular update							⚑		⚑		⚑			
Royal Alexandra Hospital	Director of Environment & Estates	As Required														
Ablett Mental Health Unit	Director of Environment & Estates	As Required														
Mental Health Electronic Health Records (EHR)	Chief Digital & Information Officer	As Required														
Electronic Healthcare Record (EHR)	Chief Digital & Information Officer	As Required														
Estates Plan 2025/2028	Director of Environment & Estates	Annually											⚑			
Procurement of Dental Services	Chief Operating Officer	To be agreed at agenda setting														
Business Cases related to Key Programmes for Approval	Executive Director of Finance	To be agreed at agenda setting														

Item of Business	Executive Lead	Reporting Period	Q1			Q2			Q3			Q4			2027-28	
			April 2026	May 2026	June 2026	July 2026	Aug 2026	Sep 2026	Oct 2026	Nov 2026	Dec 2026	Jan 2027	Feb 2027	Mar 2027	April 2027	May 2027
Evaluation of Business Cases implemented	To be agreed at agenda setting	To be agreed at agenda setting														
INTEGRATED PERFORMANCE																
Integrated Performance Report	Executive Director of Finance	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑		⚑	
Integrated Performance and Accountability Framework	Executive Director of Finance	Annually	⚑													
Finance Report	Executive Director of Finance and Performance	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑		⚑	
Contracts and Commissioning	Executive Director of Finance	As Required														
Commissioning Assurance Framework	Executive Director of Finance	Annually	⚑													
Information Governance Strategy	Chief Digital & Information Officer	Annually							⚑							
Information Governance KPI Report	Chief Digital & Information Officer	Quarterly	⚑		⚑				⚑		⚑		⚑			
Information Governance Annual Report	Chief Digital & Information Officer	Bi-Annually			⚑								⚑			
GOVERNANCE, RISK & ASSURANCE																
Corporate Governance Report *(Including summary of business to be reported from private and forward workplan)*	Director of Corporate Governance	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑		⚑	
Committee Cycle of Business	Director of Corporate Governance	Annually	⚑													
Committee Terms of Reference	Director of Corporate Governance	Annually	⚑													
Committee Self-Assessment	Director of Corporate Governance	Annually	⚑													
Committee Annual Report	Director of Corporate Governance	Annually	⚑													
Corporate Risk Register Report	Director of Corporate Governance	Quarterly			⚑				⚑				⚑			
Board Assurance Framework Report	Director of Corporate Governance	Quarterly			⚑		⚑				⚑					
Legal Services	Director of Corporate Governance	Quarterly	⚑				⚑				⚑		⚑			
CLOSING BUSINESS																
Agree Items for Referral to Board / Other Committees	Chair	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑		⚑	
Review of Meeting Effectiveness	Chair	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑		⚑	
Date of Next Meeting	Chair	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑		⚑	

Item of Business	Executive Lead	Reporting Period	Q1			Q2			Q3			Q4			2027-28	
			April 2026	May 2026	June 2026	July 2026	Aug 2026	Sep 2026	Oct 2026	Nov 2026	Dec 2026	Jan 2027	Feb 2027	Mar 2027	April 2027	May 2027
Resolution to Exclude the Press and Public	Chair	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑		⚑	
PRIVATE AGENDA																

Performance Finance & Information Governance Committee

BUSINESS CASES APPROACH AND STOCKTAKE

Date of Meeting	23 June 2026
Publication Status	Open/ Public
	Not Applicable
Report Author name and title	Paolo Tardivel, Executive Director of Transformation & Strategic Planning (Interim)
Lead Executive Team Member name and title	Paolo Tardivel, Executive Director of Transformation & Strategic Planning (Interim)

Report Purpose	For Noting

Executive Summary

The purpose of this report is to provide PFIG committee members with an overview of the organisational approach to managing business cases, along with a stock take of all current live cases.

The paper explores the background to the different elements of work that fed into the recent work in this area, the existing detail outlined in the Integrated Planning Framework and latest improvements in approach.

It also provides a work in progress response to the ask from the PFIG Committee in relation to a business case stock take of all live cases.

Members are asked to resolve:

- To **note** the overview and future work in this area.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome, Evidence and Data**
Executive Committee	03/06/2026	Discussion paper

Acronyms / Glossary of Terms	
PPHP	Planning, Population Health & Partnerships Committee
PFIG	Performance, Finance and Information Governance
IMTP	Integrated Medium-Term Plan

BUSINESS CASE APPROACH AND STOCKTAKE

1. SITUATION

1.1 The purpose of this report is to provide PFIG committee members with an overview of the organisational approach to managing business cases, along with a stock take of all current live cases.

2 BACKGROUND

2.1 The organisational approach to business cases within the health board is widely recognised as an area that could be improved upon. Business cases are used too frequently for a broad range of topics, many of which relate to service planning and configuration and are often not of the right quality to support swift yet well informed decision making.

2.2 At present business cases work their way through the tiers of service governance and then come through Executive Committee in an ad hoc manner throughout the year, with some going onward to Committees, Board and Welsh Government. Given the high volume and variable quality of the cases, this occupies a relatively significant portion of Executive Committee and the wider organisation's time and is inefficient.

2.3 The Integrated Planning Framework, approved by Board in November 2025, contains a section outlining an improved approach to managing business cases in line with an annual planning cycle. This however was reliant on a new governance structure to support the work required. The work undertaken on the Executive Committee sub-groups by the Corporate Governance team now provides a platform to further develop the approach outlined within the Integrated Planning Framework.

2.4 This work also falls within the Processes workstream of the Foundations for the Future (FFTF) operating model programme. The organisational approach to business cases and associated processes and decision-making is referenced within the FFTF Discovery report as an issue that needs to be addressed.

2.5 The Performance Finance and Information Governance (PFIG) Committee has requested a stock take of current live business cases. A tracker has been socialised for each Executive Director to populate for their portfolio in order to

support this ask. This is something that will be maintained and managed as part of the improved governance and reporting arrangements outlined in this paper.

3 SPECIFIC MATTERS FOR CONSIDERATION

3.1 INTEGRATED PLANNING FRAMEWORK

3.2 The Integrated Planning Framework (IPR – attached as an appendix to this paper for ease of reference) contains a section on business cases that outlines what they are, why they are important and when they are required.

3.3 It talks through the Five Case Model (strategic case, economic case, commercial case, financial case and management case) along with the both single stage business cases (for low to medium value and risk cases) and the three-stage business case process (Strategic Outline Case - SOC, Outline Business Case - OBC and Full Business case – FBC) for those that are higher value (over £2 million) and risk.

3.4 The IPR covers how the annual planning cycle defines a number of discrete funding streams (e.g. Planned Care, 6-Goals, Further Faster, etc) and associated requirements for their use. These funding streams could be recurrent or non-recurrent in nature, with the latter requiring clear exit strategies from the outset. It refers to the importance for a funding stream to be identified and confirmed as appropriate prior to a business case being written. If an appropriate funding stream is not avaliable then a service must be supported to identify what it is proposing should be de-prioritised in order to fund the scheme.

3.5 The IPR goes on to outline an approach to funding envelopes and prioritisation being part of the annual planning cycle and there being a window for business cases that meet the criteria for each envelope to be submitted to bid against the available funding. Once the window closes those successful cases would be included in the Integrated Medium-Term Plan (IMTP) with any unallocated funding from each of the envelopes being bid against through the year and the IMTP being updated accordingly via change control. Any prioritisation / de-prioritisation during the window or through the year would be undertaken in line with the organisation's Decision Making and Prioritisation Framework (which is in the process of being finalised before taken through governance for sign off).

3.6 The IPR outlines the importance of business cases covering the whole service change, not only enabling works and that this features as part of a robust evaluation and benefits realisation approach.

3.7 It does also reference a group reporting into the Executive Committee with the remit of considering business cases and ensuring they meet the required standard, with the Executive Committee and onward governance retaining the decision making and approval authority in line with the Scheme of Delegation.

3.8 It is proposed that the agreed way forward on the organisational approach to business cases is formally documented in the next iteration of the IPR. This is planned for Q2 once the annual planning cycle learning and reflection exercise and planning maturity matrix self-assessment have completed.

3.9 ADDITIONS TO THE ORGANISATIONAL APPROACH

3.10 Following informal discussions with a number of stakeholders over recent months, most recently with the Executive Director of Finance and Director of Corporate Governance as part of the FFTF Business Processes workstream work, there are a number of planned developments to the organisational approach to business cases outlined in the IPR.

3.11 First is to formally incorporate an envelope setting stage as part of the annual planning cycle to be concluded by the end of Q2, supporting a business case submission and review window across September and October. Business as usual Budget setting and Establishment confirmation to also be added as part of the annual planning cycle, to be concluded during Q3 and then adjusted with any implications from the NHS Wales Planning Framework and Financial Settlement as and when it arrives (last two years has been around Christmas).

3.12 Bring both Capital and Revenue business case approaches into alignment, acknowledging that many cases have implications across both and therefore and approach and governance needs to have a clear linkage to manage interdependencies.

3.13 Be more specific around service planning and reconfiguration issues that currently often manifest themselves in ad hoc business cases. Historic or new 'cost pressures' should first be addressed through service planning and exploration of what can be done within existing resources allocated to the service or area. A new group with a working title of the Service Reconfiguration Oversight Group will be set up to oversee these scenarios both for visibility of service reconfigurations that require no additional resource or approval as well as assessing those that suggest they do.

3.14 Introduce a new group with a working title of the Revenue Investment Scrutiny Group that reviews, tests and supports refinements to revenue business cases to ensure they meet the required standards. The scope of the revenue business cases coming through this group would only be those that are bidding against the defined envelopes of funding available for defined purposes and outcomes (e.g. Planned Care, 6 Goals, Further Faster etc). This group will meet through the year but is the mechanism that supports the annual planning cycle business case window during Q3.

3.15 Align the existing Capital Investment Group (CIG) to this new governance structure, ensuring that processes are put in place to monitor and manage linkages between cases that have both capital and revenue implications.

3.16 There has been some discussion as to whether each of the groups above should report into the Strategic Planning and Service Change (SP&SC) sub-group of the Executive Committee or direct to the Executive Committee. It is proposed that given the Executive decision-making authority sits at the Executive Committee and currently the decision making is not delegated that as part of the review of the executive delivery group arrangements (including that of the Capital Governance) then the principles of the reporting structures and groups require further consideration in terms of scope and delegation.

3.17 The proposal will consider the most streamlined way to enable decision making, this will mean that the intention is to remove an additional unnecessary governance step and associated delay. It is proposed that these sub-groups would provide their assessments on the cases and recommendations to the Executive Committee, with the Executive Committee making the final decision.

3.18 The groups and business case authors will need to be supported by the corporate teams in relation to best practice. It is proposed that the Transformation and Strategic Planning Directorate act as a single point of contact for this, drawing in expertise from other departments where appropriate.

3.19 BUSINESS CASE STOCK TAKE

3.20 The Performance Finance and Information Governance (PFIG) Committee has requested a stock take of current live business cases across both capital and revenue to be presented to the committee at the 23rd June.

3.21 Whilst the IMTP has reference to key business cases within it, there is not currently a single repository or tracker for this information in the Health Board. This is something that will be addressed as part of the new governance and reporting arrangements under the improved approach outlined above.

3.22 A tracker was developed to capture headline information relating to all live business cases. A work in progress tracker can be found in the supporting papers, with further work required to refine it but provides a high-level overview of the current business case landscape.

3.23 The work in progress tracker represents each executive portfolio's view of the live business cases in their area, at any stage of development. As such some are at the very early stages and have not been fully developed nor been through divisional governance. It is intended that this forms a pipeline view of all live business cases and be managed under the new governance and reporting arrangements outlined in this paper.

4 KEY RISKS / MATTERS FOR ESCALATION

4.1 The main risk associated with not appropriately managing business cases is that key issues may be delayed in being addressed, resources may not be used optimally and efforts may be wasted on unviable business cases.

5 RECOMMENDATIONS

5.1 The Committee is asked to:

- **Note** the overview and future work in this area.

ASSESSMENT	
Link to Strategic Priorities	
	2. Developing strategy and long-lasting change
	If more than one applies, please list below:
Design Principles	Simplify, Standardise, and Adopt Best Practices If more than one applies, please list below:
Corporate Risks and Board Assurance Framework	▪ BAF24-01 - Not Fully Building an Effective and Accountable Organisation ▪ BAF24-02 - Not Delivering Strategic Development and Digital Transformation ▪ BAF24-03 - Not Achieving Long Term Financial Sustainability ▪ BAF24-04 - Not Establishing a Compassionate Culture, Leadership, Engagement and workforce capacity and capability ▪ BAF24-05 - Not Engaging with Citizens, Partners and Communities ▪ BAF24-06 - Not Delivering the Required Improvements to Transform Care and Enhance Outcomes ▪ BAF24-07 - Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk ▪ BAF24-08 - Not Implementing Evidenced Based Improvement and Innovation
Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales
	If more than one applies, please list below:

IMPACT ASSESSMENTS		
Equality *Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)*	Yes: ☒	No: ☐
	Outcome:	Pass
	If no, please include rationale:	

Socio-Economic Impact Assessment *Have you undertaken a Socio-Economic Impact Assessment*	Yes: ☒	No: ☐
	Outcome:	Pass
	If no, please include rationale:	
Quality *Have you undertaken a Quality Impact Assessment Screening?*	**Enablers of Quality** All Apply	**Domains of Quality** All Apply
	If more than one applies, please list below:	If more than one applies, please list below:
Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales	

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

Teitl adroddiad: ***Report title:***	Integrated Planning Framework 2025			
Adrodd i: ***Report to:***	Health Board			
Dyddiad y Cyfarfod: ***Date of Meeting:***	27th November 2025			
Crynodeb Gweithredol: ***Executive Summary:***	The Integrated Planning Framework (IPF) sets out the Board's commitment to joined-up, integrated and transparent planning across the organisation and with partners. It ensures that: ▪ Planning becomes a core organisational discipline that drives delivery, accountability and improvement. ▪ Aligns with strategic objectives, supports accountability, and strengthens governance. ▪ Is one of three linked frameworks that together enhance assurance arrangements across Planning, Risk and Performance.			
Argymhellion: ***Recommendations:***	The Board is asked to: ▪ **APPROVE** the report on the Integrated Planning Framework.			
Arweinydd Gweithredol: ***Executive Lead:***	Paolo Tardivel, Interim Executive Director of Transformation & Strategic Planning.			
Awdur yr Adroddiad: ***Report Author:***	Paolo Tardivel, Interim Executive Director of Transformation & Strategic Planning.			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☒	Am sicrwydd *For Assurance* ☐	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence /*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

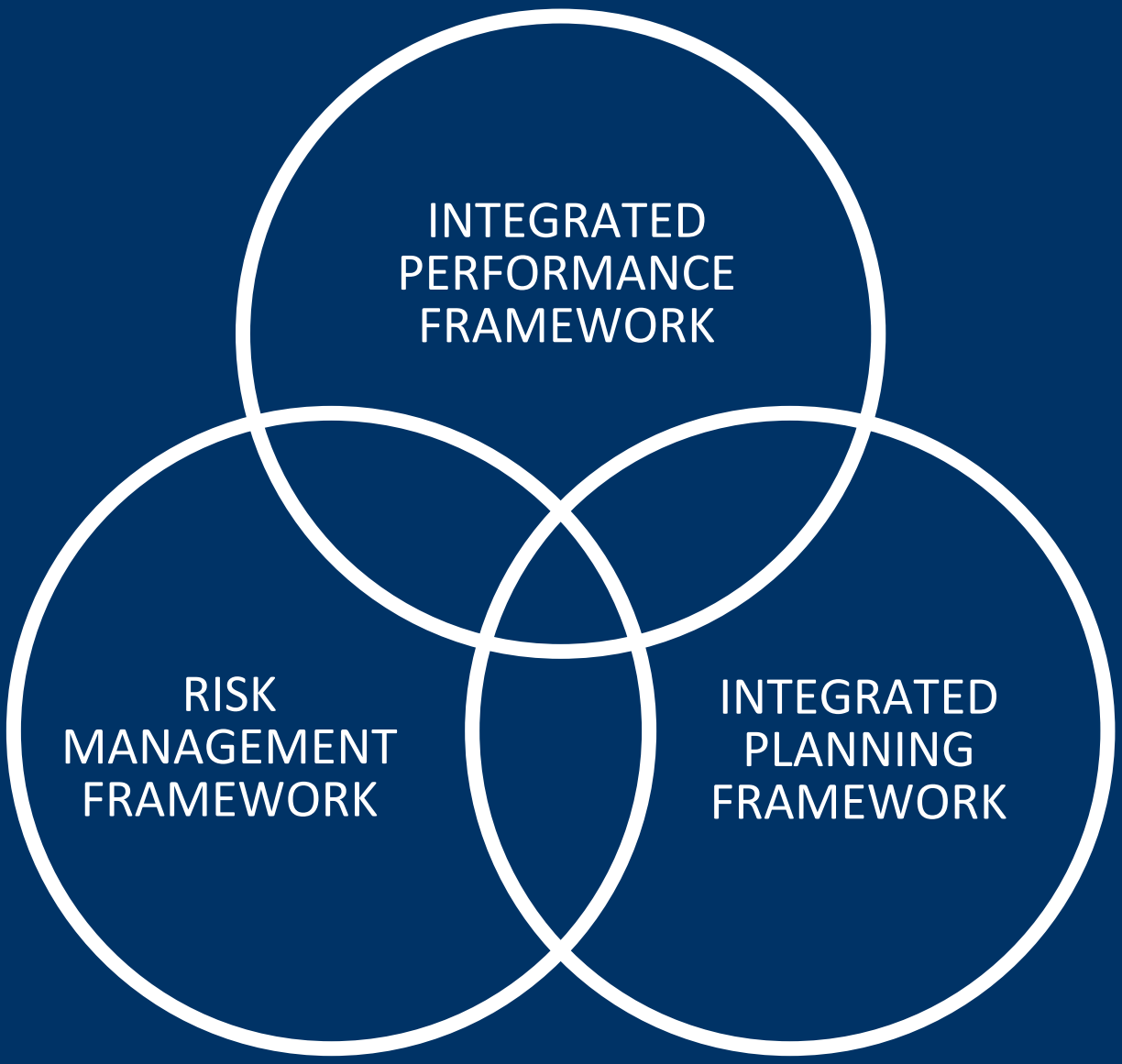
	existing mechanisms/objectives	*evidence in delivery of existing mechanisms / objectives*	*existing mechanisms / objectives*	

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Good strategic planning facilitates delivery of the Health Board's strategic objectives. The Framework sets out the expected approach to ensure this is clear and consistent in all plans.
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	The legislative requirements in relation to planning are set out within the framework.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	The EqIA will be refreshed in line with approval of the Framework.
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	As above
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)***	Failure to meet Special Measures Framework requirements could result in undeliverable plans, inefficient use of resources, and limited impact on health outcomes and inequalities (BAF Risk 2.4).
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The Framework has no direct financial impact. It ensures that service, workforce, and financial planning are integrated, supporting plans that are realistic and affordable within the Board's overall financial position.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	There are no direct workforce implications arising from the Framework. It ensures workforce planning is fully integrated with service and financial planning, supporting the

	optimisation of workforce resources through innovation and continuous improvement.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Not applicable
Cysylltiadau â risgiau BAF: **(neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)** ***Links to BAF risks:*** ***(or links to the Corporate Risk Register)***	Failure to deliver an approved integrated medium-term plan covering service, workforce, financial balance and key performance targets to Welsh Government could lead to a regulatory audit opinion.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Camau Nesaf/Next Steps ▪ Publish the Integrated Planning Framework 2025. ▪ Share it across management and planning networks.	
Rhestr o Atodiadau: ***List of Appendices:*** N/A	

INTEGRATED PLANNING FRAMEWORK

2025



GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Contents

Introduction

Overview

The Integrated Planning Framework (IPF) sets out the Health Board's long-term commitment to developing planning as a core discipline that drives delivery, accountability and improvement across the organisation and with partners, ensuring Health Board plans are aligned, sustainable, and capable of meeting the changing needs of the population.

Over the next two years, this framework will guide how the Health Board strengthens planning capability and embeds evidence-based approaches into everyday practice. Effective planning is not simply about meeting annual requirements; it is central to shaping strategic direction, commissioning and delivering high-quality services, and improving outcomes for the communities in North Wales.

This will be particularly important to support the changes to the operating model under the Foundations for the Future programme, where the organisation moves towards pan-North Wales services. Planning will be a core part of the role for those leading these services and this framework and its underpinning collateral will seek to support consistent application of best practice across the organisation.

The IPF defines the principles and standards that will underpin planning, sets the context within national policy and legislation, and provides a structured foundation for continuous improvement. By embedding planning as a discipline, the Health Board will enhance resource stewardship, strengthen partnership working, and ensure the organisation is equipped to deliver sustainable, person-centred healthcare and well-being services well into the future.

Supporting the IPF are more detailed guidance that focus on specific aspects of planning. There is the annual Planning Guidance associated with three year Integrated Medium-Term Planning (IMTP) that provides a timeline and detailed process, the most up to date planning assumptions and requirements and templates to complete to support the process. There is also in development a set of planning toolkits to support the generation of each different type of plan outlined in this framework, providing more detail on approaches, processes and templates. More information on these supporting materials can be found on the Corporate Planning BetsiNet site.

The organisation has been on a journey to build the right foundations in effective planning. The Special Measures Independent Review of Planning produced in March 2024 (which can be found here) highlighted the need to create a fit for purpose planning system, to develop an organisational strategic route map and to create a baseline plan to fully understand the Health Board's commitments around change. There have been a lot of improvements over the last year and a half in terms of stakeholder engagement, more focused priorities and moving from 'crowdsourcing' the plan to commissioning defined programmes of work to meet strategic priorities. This culminated in the production of the organisation's first ever financially balanced IMTP submitted in March 2025. There is still some distance to travel, particularly in development of organisation-wide planning capability, which can be evidenced in the Planning Maturity Matrix self-assessment conducted in November 2025, which showed mostly level 2 (early progress) and level 3 (initial achievements)

maturity-out of the possible five levels. The resultant action plan has been aligned to this framework in support of future improvements to organisation-wide planning maturity. Planning therefore remains on a journey to deliver effective, consistent and high standard planning across the Health Board and this framework will be part of that drive for improvement over the next two years.

Other frameworks

This framework is designed to work in conjunction with and to complement other organisational frameworks:

1) **Risk Management Framework** – Important for plans to support mitigation of organisational risks and for the risks to delivery of the plans themselves to be appropriately identified and managed.
2) **Integrated Performance Framework** – Crucial to ensure that every plan identifies and tracks the intended impact and value in relation to outcomes, experience and cost.

There are a number of other frameworks in development that are also important to ensure they are aligned e.g. Decision Making and Prioritisation, Workforce Planning and the Organisational Approach to Change.

Legislative requirements

There are a number of legislative requirements that need to be taken into consideration when planning. Some relate to specific planning activity, such as the development of an Integrated Medium-Term Plan (IMTP), whereas others are more generally applicable to all planning activity. The main relevant legislation is listed below, further information can be found on the Welsh Government web site.

- Welsh Language Act 1993 and Welsh Language Standards, Section 26 of the Welsh Language (Wales) Measure 2011 – Statutory duty to deliver services to the public in both Welsh and English.
- NHS (Wales) Act 2006 – Contains the primary statutory duty to prepare an integrated plan for improving the health as well as the provision of health care to the population.
- Equality Act 2010 – Health Boards must involve people whom it considers representative of those with different protected characteristics and those who have an interest in how it carries out its functions.
- NHS Finance (Wales) Act 2014 - annual statutory requirement for expenditure not to exceed resource limits over a 3-year period.
- Social Services and Well-being (Wales) Act 2014 - Requires health boards to co-operate with Partners in the formation of a Regional Partnership Board (RPB) to prepare and publish a 5-Year Area Plan.

- Well-being of Future Generations (Wales) Act 2015 - Relates to improving the social, economic, environmental and cultural well-being of Wales. Requires health boards to: 1) consider the long-term impact of decisions, 2) to achieve the seven Well-being Goals, applying the '5 Ways of Working' to do so, 3) to set out well-being objectives and to work in partnership through Public Service Boards to develop a local Well-being Plan.
- Health and Social Care (Quality and Engagement) (Wales) Act 2020 – Relates to the Duty of Quality - ensuring health boards improve the quality of services, and the Duty of Candour – requiring health boards to be open and honest with people receiving care and treatment.

Broader strategic context

When planning it is important to take into consideration the broader strategic context. This can take many forms, but some of the main elements to consider can be found below.

National

1) **A Healthier Wales (link)** – Published in 2018 and refreshed in 2024, this is Welsh Government's 10-Year strategy to create a whole system approach to health and social care, that focuses on health and well-being and the prevention of illness and the shift of services out of hospitals to communities.
2) **National Clinical Framework (link)** – Published in 2021, this sets a coherent vision for the strategic and local development of NHS clinical services.
3) **Chief Scientific Advisor for Health report – NHS in 10+ years (link)** – Published in September 2023, the report outlines the changes in population demographics and health care needs expected over the next decade.
4) **Ministerial Priorities** – Each year the Cabinet Secretary for Health and Social Care publishes their priorities focusing on the following financial year.
5) **NHS Wales Escalation Status (link)** – Covering the requirements associated with the 5 levels of escalation a Health Board could be in, from Level 1 (Routine Arrangements) to Level 5 (Special Measures).
6) **NHS Wales Planning Framework** – Alongside the annual publication of the Cabinet Secretary's priorities, NHS Wales produce a technical planning framework that details the activity required to satisfy the conditions of producing an approvable 3-Year Integrated Medium-Term Plan (IMTP).
7) **NHS Wales Performance Framework** – This accompanies the NHS Wales Planning Framework and sets out the measures and targets expected to be achieved for the following financial year.
8) **Quality Statements (link)** – Set out the Welsh Government's policy and commissioning expectations for health boards to plan towards. Demonstrating delivery of services in line with

the quality statements through Health Boards' IMTPs evidences delivery against the Duty of Quality.

9) **Horizon Scanning** – Involves identifying emerging medical innovations, technologies and trends to inform future planning, including technology appraisal, budget planning and workforce planning.

Regional

It is important to take into consideration the strategic landscape across North Wales and adjacent areas. This includes:

1) **Joint population needs assessment (link)** - Produced with partners via the Regional Partnership Board (RPB).
2) **Partner strategies and long-term plans** – Taking into consideration public sector, third sector and voluntary sector strategies and long-term plans – including but not limited to Regional Partnership Board (RPB) and Public Service Boards (PSBs).

Local

Any plans developed need to fit with and further the Health Board's long-term local strategy and plans:

1) **Strategic Intent co-developed with Partners (in development) –** Outlining a joint purpose and vision with partners, detailing a number of strategic intent statements.
2) **Health Board 10-Year Strategy (in development) –** Covering a 10-Year period, this document sets out the agreed choices and principles which will help the Health Board realise its strategic intent and fulfil its other obligations. It will be delivered through a number of underpinning plans e.g. Clinical Services Plan.
3) **Health Board Clinical Services Plan (in development) -** Set over three years and regularly refreshed, the CSP details how, aligned with the Health Board's strategy, clinical services will be configured to maximise quality and performance.
4) **Health Board Integrated Medium-Term Plan (IMTP) -** A three-year plan outlining how the Health Board will use its resources to deliver healthcare services that fulfil its strategic objectives and other obligations.
5) **Organisational Design Principles** - These design principles serve as a common and consistent set of considerations to be applied during planning and service development.

Principle	Overview	Considerations
1) People centred	Prioritise a people centred approach to support better health and well-being outcomes.	▪ Am I improving outcomes for people? ▪ Whose life am I making better? ▪ The Health Board's Wellbeing Objectives
2) Inclusive	Bring together the right people to collaborate and co-design services.	▪ Have key stakeholders' been involved? For example, service users, carers, families, staff, other partners and those with relevant technical expertise.
3) Wise spending	Best value (outcomes, experience, cost)	▪ Will this decision improve value in terms of outcomes, wise spending, and cost
4) Simplify, standardise and adopt best practice	Recognise complexity, streamline and reduce inappropriate variation.	▪ Learn from others and apply best practice ▪ Is there a recognised standard, process or policy to benchmark against? ▪ Have the different aspects/consequences of change been considered? ▪ Keep it simple for the public
5) 'Digital first'	Adopt and promote new ways of working, harnessing the potential of digital innovation.	▪ Seek advice and guidance from the Health Board's Digital, Data and Technology Team.
6) Equity and accessibility	Equitable and accessible services which take account of the diverse needs of the communities we serve.	▪ Does this decision promote fairness and equality of access? ▪ Seek advice and guidance from the Health Board's Equalities Team ▪ Consider the requirements of the Welsh Language Standards
7) Consistent with the Health Board's Values	The Health Board values, guide behaviours and decision making.	▪ Does this decision align with the organisation's values?

Table 1: Organisational Design Principles

Quality Management System

The Duty of Quality Act applies to all NHS bodies in Wales, with two overarching aims:

- To improve the quality of healthcare services.
- To improve outcomes for people in Wales.

The guidance sets out a definition of quality and describes the need for NHS bodies to strengthen their Quality Management Systems (QMS) to achieve these aims.

A QMS enables an organisation to maintain a consistent and coordinated approach to meet the needs and expectations of the local communities. This will be achieved through joined up structures, systems and processes that allow for quality to be built into all activities with people and patients at the heart of all decision making and planning.

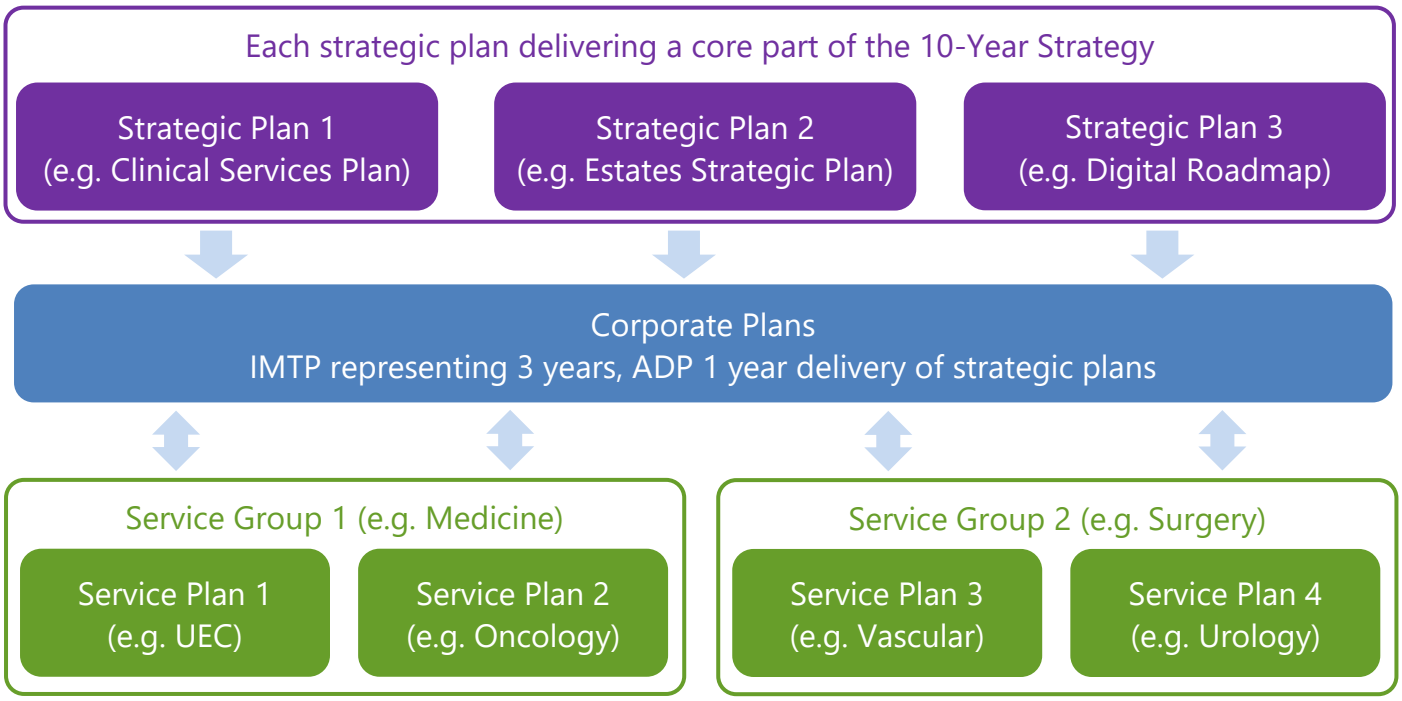
As can be seen in the graphic above, there are four elements to a QMS: Quality Planning, Quality Improvement, Quality Control and Quality Assurance. This framework focuses on ensuring effective Quality Planning but also touches on other areas in less detail.

Quality Planning is all about understanding needs and can be summarised into:

- Understand the standards and models that provide the best outcomes and experience.
- Evaluate current services with the input of those who provide and use them.
- Assess the gap between current and potential quality.
- Design services to meet the needs and provide the best outcomes and experience, as well as sustainability for the longer term.
- Identify the culture, systems, processes and structures needed to deliver the best quality model.

Types of plans

Given the broad applications of planning as a discipline, there are many different forms of plans. This section seeks to articulate the main types of plans in relation to those most commonly used within the Health Board in delivery of the Health Board's long-term strategic objectives.

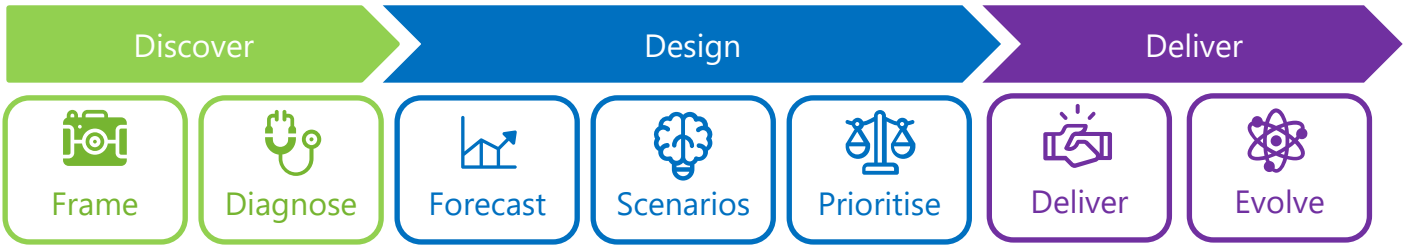


- **Strategic plans** - These represent the longest time horizon plans that span multiple years to support delivery of the Health Board's 10-Year Strategy. There will be a small number of strategically important plans that align with and deliver the organisation's strategic objectives, such as the Clinical Services Plan, Estates Strategic Plan, Digital Strategic Plan.
- **Corporate plans** – These plans are the primary delivery vehicle for the strategic plans, translating them into short to medium-term priorities and actions for delivery. The 3-Year Integrated Medium-Term Plan (IMTP) and the 1-Year Annual Delivery Plan (ADP) are examples of these.
- **Operational service plans** – These are more detailed Service Group (e.g. Medicine / Surgery etc) and individual Service (e.g. UEC / Oncology / Vascular / Urology etc) plans. They have a reciprocal relationship with the more strategically focused Corporate Plans in that they both inform and support delivery of the higher-level priorities. Modelling is an important part of this activity, to ensure there is a collective endeavour to produce connected activity, performance, workforce and finance projections for the service. These are multi-faceted plans that describe the approach for effective management of a service or department, covering safety, service, finance and people.
- **Supporting plans** – There are many other types of specific plans that support delivery, such as workforce plans, business plans, engagement plans and project-based plans. The guidance and

toolkits that support this framework will provide more detail and guidance relating to these plans.

Lifecycle of a plan

The organisation has regularly used the Discover > Design > Deliver phased approach to planning and delivery. This section explores in a bit more detail the component steps within each phase.



Discover

Frame

- Plans should clearly outline the strategic context and statutory requirements they address, while demonstrating alignment with the Health Board's strategic objectives. They must also define their scope from the outset, highlighting key objectives and the services, staff, and patients affected. Any areas explicitly excluded should also be noted.
- Organisational risk is often a key driver for the creation of plans and whether it is the primary driver or not, impact on the most important risks is something that should be explicitly identified.
- When considering the scope, the Tushman and O'Reilly model of considering: Strategy, People, Process, Culture and Structures is a useful model.
- Engagement in plans from the outset is pivotal to their success. Whether that be staff, patients, families, carers, communities, partners or stakeholders, everyone will have something to contribute to planning from the very beginning of and throughout the process. An important part of this, across discover, design and deliver phases is ensuring that everyone can engage in the process through the medium of Welsh. This ensures the widest possible involvement and that issues, solutions and learning are well understood by all.
- Clinical leadership should be embedded within planning from the outset, ensuring plans are clinically credible and patient-centred, and owned by the services themselves.
- Examples of external requirements for consideration in plans are: Welsh Government requirements (set out in the section above), or those of a body like Health Inspectorate Wales (HIW) or National Institute for Health and Care Excellence (NICE), whose requirements must be met in the design and delivery of the plan.

Diagnose

- This phase is all about gathering together and triangulating across as broad a range of insights as possible in order to develop the most holistic plan possible.
- Plans should be informed by current and projected population health needs, using evidence such as Population Needs Assessment and Well-being Assessment to identify priorities and reduce health inequalities. They must also include an assessment of current service provision, highlighting risks, sustainability challenges, and any gaps that could impact performance or outcomes.
- As referenced in the section on QMS, quality, safety and experience are of paramount importance to every level of plan. Insights can be drawn from multiple sources to inform intelligence on current quality delivery and identify any gaps to an appropriate quality standard.
- The current performance of an area, across the broadest set of metrics possible, is important insight to be analysed and triangulated in order to ensure plans to improve performance are robust.
- Using internal and external benchmarking provides important insights to inform plans. This helps identify potential areas of unwarranted variation and opportunity for improvement.

Design

Forecast

- Plans should include horizon scanning to take a forward-looking assessment of internal and external factors to anticipate challenges, identify opportunities, and adapt accordingly.
- They must also integrate long-term financial, workforce, digital, and change management considerations, assess current performance using benchmarking where appropriate, and focus on achieving better outcomes and value for money.
- Every plan should clearly outline its financial requirements and impact of the plan, including identifying appropriate sources of funding (both revenue and capital). A common issue is not identifying exit strategies in relation to non-recurrent sources of funding.
- Where plans have a workforce requirement or impact, this needs to be considered carefully.
- Recruitment challenges are common, requiring innovative modern workforce models and skill-mix solutions.
- Ensuring that an appropriate and unified modelling exercise is conducted that takes in a wide range of factors for the type of plan in question. For a service plan for example this would cover well informed demand projections, productivity utilisation and efficiency assumptions, modern workforce models, that then generate connected activity, performance, workforce and finance projections.

Generate scenarios

- Plans should always start by considering the possibility of prevention of ill-health and improving well-being, rather than treatment alone. This is the only way the health service will be able to cope with the long-term future demand of an aging and increasingly ill population.
- Plans must also be grounded in evidence and co-design with service users, carers, staff and key stakeholders, drawing on lived experience, professional standards, and input from statutory and non-statutory groups.
- Plans should use both internal and external sources of best practice to inform plans is important to benefit from the learning of others on what does and does not work. Whether that be across North Wales, Wales, UK or the World. Useful sources of best practice include: Getting It Right First Time (GIRFT), Royal Colleges, National Institute for Health and Care Excellence (NICE) Guidelines, National Programmes, Clinical Implementation Networks.
- It is important to ensure that every aspect of delivery of a plan is considered and making sure that enabling infrastructure such as digital or estates work is included. This will ensure plans are well-rounded and appropriately balanced in their composition.
- Consider opportunities to work regionally, both internal to the organisation but also with partners. This involves co-producing shared plans and working together to create innovative integrated service models.
- Plans should make a determination as to whether there is sufficient demand and or in house capacity or capability to provide a service internally ('make') or whether the population would be better served by another provider commissioned by the Health Board ('buy').
- Plans should take a logic model approach to be clear on both process (inputs, activities, outputs) and outcomes (short-medium, and long-term) to ensure that they really focus on driving the right outcomes and to support effective evaluation of the plan.
- Ensure that all objectives within the plans are SMART (Specific, Measurable, Achievable, Relevant and Timebound).

Prioritise

- Prioritisation and de-prioritisation are essential to managing the complex challenges facing the Health Board. The Decision Making and Prioritisation Framework mentioned earlier in this document will bring a clarity and consistency in approach.
- Prioritising in a system where the need is great but resources are constrained means difficult decisions need to be taken. Attempting too much with limited resources undermines delivery. Applying a consistent set of criteria, focused on delivery of strategic priorities, is key to a successful organisation.
- It is important that all plans ensure good value in relation to use of taxpayers' money. Value in this context refers to the right balance between outcomes, experience and cost. Value in its broadest sense should inform a broad ranging benefits case for each plan.

- Qualitative as well as quantitative benefits should be taken into account when prioritising to ensure that all aspects that will make a difference to the population are taken into consideration, whether they are easy to quantify or not.
- Understanding and taking into consideration the potential risks to delivery during the design phase is important to ensure decisions to proceed are made with all relevant factors. This also enables early planning of mitigating actions to reduce the risk to the delivery phase.

Deliver

Deliver

- Having engaged with those impacted by plans from the outset, using their experiences to inform the discovery phase, then co-designing ideas and solutions in the design phase, it is equally as important to continue this engagement and involvement through co-production in the delivery phase.
- Ensuring all aspects of delivery are aligned is vital for successful change. Whether plans span different geographical or organisational boundaries, or different aspects such as service, people and infrastructure, ensuring the plan is considered as a whole and is delivered as such is important.
- Continuing to monitor risks and their controls identified during the design phase, and identifying any emerging risks and mitigating actions as soon as possible, is crucial in successful delivery.
- Clinical leadership during the delivery phase ensures that the plans are delivered and owned within the services themselves and not 'done on to' from outside the team. This is the only way to make truly sustainable change.

Evolve

- Initiatives should be monitored after they have been deployed to measure and assess their impact, taking any learning in order to adapt the current implementation or inform future ones. This is important for effective benefits realisation.
- Ensuring the 'value' in its broadest sense is taken into consideration, both qualitatively and quantitatively, with a keen focus on real changes to outcomes is key.
- Some plans, especially where they are targeting long-term improvements in health and well-being through preventative interventions addressing wider determinants of health, require the use of leading indicators to monitor future impacts. It is important to note however that not all preventative interventions have long lead times in term of their impact.

Business cases

Why are business cases important?

Strategies and plans will only achieve their spending objectives and deliver benefits if they have been scoped robustly and planned realistically from the outset and the associated risks taken into account. The business case, both as a product and a process, provides decision-makers, stakeholders, and the public with a management tool for evidence-based, transparent decision-making and a framework for the delivery, management and performance monitoring of the resultant scheme.

The organisation has a history of creating a large number of business cases throughout the year, for a variety of reasons and not always aligned with the annual planning cycle. It is important that everyone across the Health Board is clear on the organisational approach and process associated with business cases, to ensure consistency of approach, clarity of expectations and that effort is not wasted developing cases that cannot be supported. It is important to note, however, that investment is not always necessary in order to make improvements.

A business case is required where funding is required in addition to a service's delegated budget, with all approval routes in accordance with the Scheme of Reservation and Delegation (here – see Table 5b). The Corporate Planning team should be contacted before developing a business case to confirm whether a business case is the appropriate route for the change.

The Five Case Model

The Five Case Model is HM Treasury's approved standard for the production of public sector business cases, under the wider Green Book guidance on how to appraise policies, programmes and projects, (more information can be found here). The Better Business Case approach uses the Five Case Model to provide a structured approach by evaluating projects across five interconnected dimensions: Strategic, Economic, Commercial, Financial, and Management. The framework ensures that proposed projects align with strategic objectives, provide value for money, are financially affordable, and can be realistically delivered.

Strategic case	That the intervention is supported by a compelling case for change that provides holistic fit with other parts of the organisation and public sector.
Economic case	That the intervention represents best public value.
Commercial case	That the proposed Deal is attractive to the market place, can be procured and is commercially viable.
Financial case	That the proposed spend is affordable – both capital and revenue.
Management case	That what is required from all parties is achievable.

Table 2: The Five Case Model overview from Green Book 2022

The Business Case Development Stages

Single stage business cases are appropriate for low to medium value and risk initiatives, however where there are high value (over £2 million) and risk, the three-stage business case process should be applied:

- **Strategic Outline Case (SOC)** - The 'early' business case and first stage in the development of a business case for a significant project, which sets out the case for change and appraises available options**.**
- **Outline Business Case (OBC)** - The 'intermediate' business case and second stage in the development of a business case for a significant project, which identifies the option offering the best public-value, confirms the Deal and affordability, and puts in place the arrangements for successful delivery.
- **Full Business Case (FBC)** - The completed business case and third stage in the development of a business case for a significant project / programme, which confirms the most economically advantageous offer after procurement, confirms affordability and puts in place the detailed arrangements for successful delivery.

Further detail on the process and relevant templates can be found in the supporting guidance and toolkits.

Funding streams

The annual planning cycle will define a number of discrete funding streams and associated requirements for their use. It is important to confirm whether funding is recurrent or non-recurrent; for non-recurrent funding, an appropriate exit strategy must be defined from the outset. Prior to a business case being written it is important to identify and confirm that the case will be eligible for one of the defined funding streams. If it is not then the service must be clear on what it is proposing to de-prioritise in order to fund the scheme.

Envelopes and prioritisation

Each funding stream will set an envelope of funding that is available to be drawn down through the year by individual qualifying business cases. Those business cases that are eligible for a particular funding stream and meet the required standard during the IMTP development window will be prioritised against available funding. For cases that arise in-year, they will be prioritised against any unallocated funding and in exceptional circumstances prioritised against any schemes committed during the IMTP window that are able to be de-committed. The organisation's Decision Making and Prioritisation Framework will be used to make consistent and effective prioritisation decisions, ensuring that a view of the whole service is provided, not just the additionality requested. It is important that all prioritisation exercises are channelled through a single organisational approach, in particular in relation to the development of an IMTP. Areas that contain enabling works, such as digital or estates, which are often vital in the delivery of broader clinical service change, need to be viewed in the context of the complete service change and be prioritised through the IMTP process.

Governance

The Executive Committee will establish a group that will have the remit of considering business cases and decisions will be made in accordance with the Scheme of Delegation. This group will review qualifying business cases, in order to ensure they are supported to achieve the required standard. The Executive Committee, Performance, Finance and Information Governance (PFIG) Committee, Health Board and Welsh Government will then be used as appropriate to sign off qualifying business cases, dependent on their value.

Evaluation and Benefits Realisation

Gateway reviews will be conducted at appropriate stages within the lifecycle of each business case, including the final Post Implementation Review in order to understand the impact of delivery and any future learning. The Welsh Government Infrastructure Investment Guidance (here) provides some more detailed guidance in this regard.

Impact assessments

There are a number of important impact assessments that need to be considered when planning. These impact assessments should be completed early in the planning process to proactively inform the plans.

- **Equality Impact Assessment (EQIA) -** Ensures that plans consider and address the needs of diverse population groups, promoting fairness and eliminating discrimination in access, experience, and outcomes.
- **Quality Impact Assessment (QIA) -** Evaluates how proposed plans may affect the safety, effectiveness, and patient experience of care, helping to safeguard and improve service quality.
- **Socio-economic Impact Assessment (SEIA) -** Assesses how plans may affect individuals and communities experiencing socio-economic disadvantage, supporting efforts to reduce health inequalities and improve equity.
- **Environmental Impact Assessment (EIA) -** Considers the environmental consequences of plans, including carbon emissions, resource use, and sustainability, aligning with NHS Wales' decarbonisation and climate goals.
- **Data Protection Impact Assessment (DPIA) –** General Data Protection Regulation (GDPR) stipulates that organisations must complete a DPIA when data processing is likely to result to result in a high risk to the rights and freedoms of individuals.

It is worth noting that Health Impact Assessments (HIA) will become a statutory requirement from April 2027. HIAs act as an assessment of the likely effect, both in the short-term and in the long-term, of a proposed action or decision on the physical and mental health of the people of Wales or of some of the people of Wales.

Roles and responsibilities

Whilst this framework applies to all Health Board staff, this section outlines the roles and responsibilities of some key groups.

Unitary Board

Collectively responsible for the leadership, governance, and strategic direction of the Health Board's strategic plans.

- Sets strategic priorities aligned with national policy.
- Approves the 3-Year Integrated Medium-Term Plan (IMTP) and ensures it reflects population needs, financial sustainability, and service transformation.
- Provides oversight and assurance on delivery, risk management, and performance.
- Ensures public accountability and transparency in decision-making.
- Promotes a culture of quality, safety, and continuous improvement.

Independent Members

Bring independent scrutiny, community insight, and governance expertise to the development and delivery of key strategic plans.

- Challenge and support the Executive Team in developing and delivering key strategic plans.
- Ensure plans are evidence-based, equitable, and patient-centred.
- Represent the public interest, advocating for transparency and inclusion.
- Chair and participate in Board Committees to monitor strategic plan delivery, progress and risks.
- Promote collaboration with external partners and community stakeholders.

Executive Team

Leads delivery of key strategic plans to achieve the Health Board's objectives.

- Develops key strategic plans, ensuring alignment with national, regional and local priorities.
- Leads service transformation, workforce planning, and financial strategy.
- Oversees performance, quality, and risk management.
- Engages with stakeholders to ensure plans are co-produced and inclusive.
- Drives innovation, digital transformation, and value-based healthcare.

External Partners

Support collaboration and alignment between the Health Board and external partners, such as local authorities, voluntary organisations, social care providers, and community stakeholders.

- Co-produce integrated plans that reflect local population needs and priorities.

- Collaborate on joint commissioning, service delivery, and workforce development.
- Provide community intelligence and lived experience to shape services.
- Support prevention, early intervention, and place-based integrated care models.
- Help ensure plans are inclusive, equitable, and locally relevant.

Management Teams

Management Teams translate strategic objectives into operational delivery plans and oversee performance across divisions, departments, or service areas.

- Translate strategic plans and objectives into operational delivery plans.
- Manage budgets, workforce, and service performance.
- Lead change management and service redesign initiatives.
- Monitor KPIs, risks, and improvement actions.
- Ensure staff engagement and alignment with organisational priorities.

Corporate Teams

Teams supporting the planning, monitoring, and reporting processes across the organisation.

- Provide technical expertise and infrastructure to support integrated planning across areas such as: Planning, Performance, Finance, Workforce, Digital, Governance and Risk, Estates, Quality, Commissioning.
- Ensure compliance with national frameworks, reporting, and assurance processes.
- Support data analysis, modelling, and forecasting.
- Facilitate internal and external engagement and communications.
- Enable digital transformation, workforce sustainability, and financial governance.

Clinical and Operational Teams

Clinical and operational team engagement is crucial to ensure that their expertise, patient experience, and frontline insights shape planning and performance monitoring.

- Deliver safe, effective, and person-centred care.
- Provide clinical leadership in service design and pathway development.
- Identify service pressures, risks, and improvement opportunities.
- Engage in multi-profession planning and delivery.
- Champion quality improvement, patient safety, and value-based care.

By clarifying these roles, the framework ensures:

- A common baseline for how planning and performance management should be conducted.
- Consistency and integration of plans across all levels of the organisation.
- A shared planning approach for delivering safe, high-quality, patient-centred services that are aligned with strategic objectives.

Organisational capability

Organisational capability in planning within the Health Board is critical for delivering high-quality, efficient, sustainable and patient-centred care. The Health Board is committed to strengthening the organisational capability in planning across the whole organisation, so every service is capable of planning for the future and delivering against those plans. By focusing on developing consistent planning approaches, embedding best practice, and building confidence and expertise across teams, the Health Board can foster a culture of proactive and effective planning that supports short, medium, and long-term priorities.

The efforts to improve the organisational capability in planning are focused in the areas outlined below.

Strategy development

A crucial part of effective planning is ensuring that plans align and contribute to delivery of the organisation's overarching strategy. At the time of writing in October 2025, the organisation is in transition between the previous strategy Living Healthier Staying Well published in 2018 and development of a new strategy.

This strategy development work introduces three interlinked strategic products, which will in turn provide a framework for the development of the Health Board's Integrated Medium-Term Plan (IMTP) and Annual Delivery Plan (ADP).

1) **Strategic Intent:** The 'big things' (strategic aims) the Health Board will seek to deliver over the next 5 to 10 years; a cornerstone of the Strategy. A 'Strategic Intent for health and wellbeing for the population of North Wales co-created with partners.
2) **10 Year Strategy:** The choices and principles that will enable the Health Board to realise its Strategic Intent and fulfil its other obligations.
3) **Clinical Services Plan (CSP):** One of the Health Board's strategic plans which details how clinical services will be configured to maximise quality, performance and value.

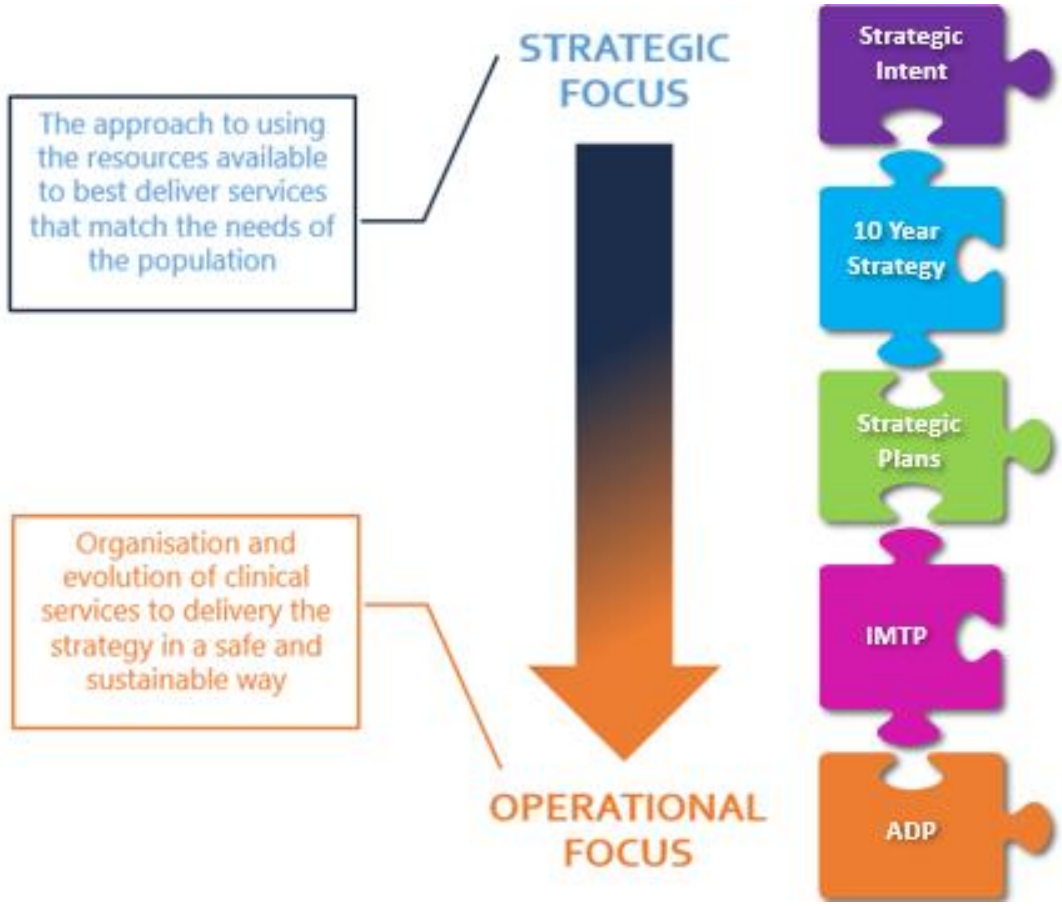


Figure 1 – Strategy Programme

This strategy work will act as a 'North Star' for all the other plans across the organisation to align to.

Embedding Planning in the Annual Performance Cycle

To ensure planning becomes part of everyday business across the organisation, there are a number of structural and cyclical processes that help with embedding planning practices. The first of these is bottom-up engagement in the Integrated Medium-Term Plan (IMTP) process to ensure that services are fully represented in the process and subsequent delivery plans. The Annual Delivery Plan (ADP) that covers the first year of the IMTP needs effective cascade at the start of the new financial year, so that everyone across the organisation is clear on their objectives for the coming year and how they contribute to delivery of the organisation's strategic goals. With the ADP disseminated through everyone's annual objectives, this provides a platform for teams to discuss during team meetings and managers to review progress at monthly one-to-ones. Executing this annual cascade effectively is vital in ensuring that the whole organisation moves in lock step and is focused on delivering the strategic priorities throughout the year.

Investing in Staff Skills and Training

It is important to ensure that all managers across the organisation have the necessary skills, tools, guidance and support to enable them to develop and deliver the various types of plans outlined in this framework. This is one of the core management competencies that will be supported through

a rolling training programme that covers the whole organisation. Relevant planning tools and resources will be available to support managers, along with access to further advice and guidance from the Corporate Planning team when necessary.

It is envisaged that there will be three tiers of planning training available in order to cater for the different requirements as well as existing knowledge and experience across the organisation.

- Level 1 – **Planning Bitesize**: A two-hour virtual course introducing the main concepts, principles and processes in planning as a discipline.
- Level 2 – **Planning Basics**: A series of half day virtual / face to face sessions building upon the Bitesize course with some practical application of planning in action, using the tools and templates.
- Level 3 – **Diploma in Healthcare Planning**: Cardiff Business School have developed and are managing the level 7 Diploma, which runs as an 18-month programme, accredited through Cardiff University. More details on the Diploma and the broader All Wales Planning Programme for Learning (PP4L) can be found here.

Numerate Plans

Whilst it is important to have appropriate narrative within plans, it is equally if not more important for plans to be numerate. This means that appropriate modelling has taken place on things like forecast demand, planned productivity and service model to generate activity profiles, performance trajectories and workforce and finance forecasts. This unified modelling approach gives complete line of sight from key assumptions, planned improvements and intended impact. This will require specialist support from Corporate Teams in order to make the data, tools and processes available to teams to work with. This will be a key part of the investment in skills and training.

Planning Maturity Matrix

The Welsh Government Planning Maturity Matrix self-assessment tool provides a useful barometer of where the organisation is and where it needs to be in regards to Planning, across the six domains in the table below. The self-assessment process is conducted once a year and submitted to Welsh Government, with an accompanying action plan of improvements to be made over the subsequent year.

Domain	Description
A) Strategy Development/Clarity of Purpose, Vision and Strategy	▪ Evidence of a clear purpose, vision and strategy for the organisation. ▪ Responds to national, regional, local and partnership priorities, and the wider determinants of health. ▪ Translates national policies into local strategy, planning, and delivery.
B) Strategy Alignment and Development of an IMTP	▪ Evidence of alignment of strategy with components of the plan.
C) Dynamic and Engaged Planning	▪ Reflecting a dynamic, engaged and ongoing approach to planning. Process is positively influencing outcomes. ▪ Organisation identifies fragile services and has plans in place to address / mitigate risks and proposals in place for more robust service models e.g. via regional solutions, consolidation of services etc.
D) Operational Planning	▪ Evidence of demand and capacity planning, linking to triangulation of operational plans, workforce and finance. ▪ Embedding a culture of reducing unwarranted variation, improved performance and outcomes end evaluation of improvements
E) Best Practice Approach to Improvement	▪ Ambition to deliver best practice levels of equity, efficiency, effectiveness, quality and safety.
F) Realistic and Deliverable:	▪ Sensitivity analyses, risk assessment of deliverability, reference to track record of delivery. Sustainable and affordable.

Table 3: Welsh Government Planning Maturity Matrix six domains and descriptors

Implementation and review

Implementation

The Framework will be disseminated through the Health Board management structures and the planning leads' networks. The implementation of the framework will commence through the annual planning cycle for development of corporate plans and also through the actions required to grow organisational capability in planning outlined above. It is recognised that it will take time to implement fully all the requirements of the framework and it is intended to support incremental improvement.

This framework concentrates on the Quality Planning phase of the Quality Management System (QMS). Other frameworks focus on the other phases of the QMS, for example the Organisational Approach to Change framework that is in development and associated with the Quality Improvement phase of the QMS.

Review

The framework will be reviewed every year as part of the annual planning cycle reflection and learning phase. This will give insight to help assess how this framework is being embedded and to refine the content and approach. The Planning Maturity Matrix self-assessment tool and associated action plan will also be a key part of the annual reflection and learning and it is important that this framework remains aligned to them. Any changes to the framework will be brought through the appropriate Board and committee governance routes.