Bundle BCU Performance, Finance & Information Governance Committee 24 February 2026

1 PRELIMINARY MATTERS

1.1 09:30 - PF26.01 Welcome & Apologies

1.2 09:31 - PF26,02 Declarations of Interest

1.3 09:32 - PF26.03 Minutes of the Previous Meeting 18 December 2025

PF26.03 Minutes of the Previous Meeting 18 December 2025

1.4 09:34 - PF26.04 Matters Arising & Action Log

PF26.04 Matters Arising & Action Log

2 MAJOR PROGRAMMES & LONG LASTING CHANGE

2.2 09:39 - PF26.05 Urgent & Emergency Care
Tehmeena Ajmal, Chief Operating Officer

PF26.05 Urgent & Emergency Care

2.3 09:54 - PF26.06 Planned Care
Tehmeena Ajmal, Chief Operating Officer
Russell Caldicott, Exec. Director of Finance & Performance

PF26.06 Planned Care

2.4 10:09 - PF26.07 Value & Sustainability
Russell Caldicott, Executive Director of Finance & Performance

PF26.07 Value & Sustainability

2.5 10:24 - PF26.08 Foundations of the Future - Presentation
Carol Shillabeer, Chief Executive

3 PLANNING, PERFORMANCE & STRATEGY

3.1 10:34 - PF26.09 Urgent Suspected Cancer Performance
Tehmeena Ajmal, Chief Operating Officer

PF26.09 Urgent Suspected Cancer Performance

3.2 10:44 - PF26.10 Annual Development Plan Q3
Paolo Tardivel, Exec. Director of Transformation & Strategic Planning

PF26.10 Annual Development Plan Q3

PF26.10a Annual Development Plan Q3

4 GOVERNANCE & RISK

4.1 10:54 - PF26.11 Finance Report
Russell Caldicott, Exec. Director of Finance & Performance

PF26.11 Finance Report

PF26.11a Finance Report

4.2 11:04 - PF26.12 Integrated Performance Report
Russell Caldicott, Exec. Director of Finance & Performance

PF26.12 Integrated Performance Report

PF26.12a Integrated Performance Report

4.3 11:14 - PF26.13 Information Governance KPI Report
Chief Digital & Information Officer/ Assistant Director Of Compliance And Business Management - Justine Parry

PF26.13 Information Governance KPI Report

PF26.13a Information Governance KPI Report Appendix 1 - Information Governance - Q1 KPI 2025-26

PF26.13b Information Governance KPI ReportAppendix 2 - Information Governance - Q2 KPI 2025-26

4.4 11:24 - PF26.14 IG Annual Report

Chief Digital & Information Officer/ Assistant Director Of Compliance And Business Management - Justine Parry

PF26.14 IG Annual Report

PF26.14a IG Annual ReportAppendix 1 Information Governance Annual Report Charts 2024-25

PF26.14b IG Annual ReportAppendix 2 Information Governance Annual Report 2024-25 Final Approved

4.5 11:29 - PF26.15 Corporate Governance Report

Director of Corporate Governance

PF26.15 Corporate Governance Report

PUBLIC Workplan for PFIG Committee (Live Version as at 19.01.26)

4.6 11:34 - PF26.16 Corporate Risk Register

DIrector of Corporate Governance

PF26.16 Corporate Risk Register

5 11:44 - CLOSING BUSINESS

5.1 PF26.17 Agree Items for Referral to Board / Other Committees

Chair

5.2 PF26.18 Review of meeting effectiveness

Chair

5.3 PF26.19 Date of the next meeting - 17 March 2026

Chair

5.4 PF26.20 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 18 December 2025
held in the Boardroom, Carlton Court, St Asaph and via teams

Committee Members Present	
Name	**Title**
Gareth Williams	Chair
Mike Larvin	Independent Member (via teams)
Tehmeena Ajmal	Via teams
Russell Caldicott	Executive Director of Finance
Nesta Collingridge	Head of Risk Management (part meeting)
Linda Dyson	Regional Risk Manager- Central
Nick Graham	Associate Director Workforce Optimisation
Dave Harris	Internal Audit
Emma Lea	Head of Business, Planning and Programmes
Justin Parry	Assistant Director of Compliance and Business Management
Pam Wenger	Director of Corporate Governance (via teams)
Ed Williams	Deputy Director Of Performance
In Attendance	
Philippa Peake-Jones	Head of Corporate Governance
Harriet Abbott	Minute Taker

PRELIMINARY MATTERS

PF25.110 Welcome and Apologies

Apologies were received for Rhian Watcyn-Jones, Jason Brannan, Dylan Roberts, Chris Lothian-Field, Clara Day, Paolo Tardivel, Stuart Keen.

PF25.111 Declarations of Interest

No declarations of interest were received.

PF25.112 Unconfirmed Minutes of the Meeting held on 22 October 2025

It was agreed that the minutes of the meeting held on 22 October 2025 were a true and accurate record.

PF25.113 Matters Arising & Action Log

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

- Action PF25.57: agreed to remain open to monitor.
- Action PF25.96.1: for action by the Executive Director of Finance.
- Action PF25.97.1: agreed to close as complete.

Unconfirmed

- Actions marked as “TBC” to be reviewed outside of meeting and updated as required.

It was resolved that the Committee:
- **AGREED** to close other actions that were proposed for closure.

ITEMS FOR ASSURANCE

PF25.114 Finance Report

The Director of Finance presented the item, and the following was highlighted.

- The Health Board is forecasting a year-to-date position of £17.3 million deficit.
- Cost pressures continue, including areas such as employee national insurance increases and out of area placements.
- Forecasting a breakeven position for end of year, with a £26 mil risk for delivery of breakeven position. £82 mil allocation is dependent on delivery of the financial plan.
- Looking to improve on 1% savings. Formed financial oversite group, requesting 1.5%. Risk is not yet mitigated entering Quarter 4. Further discussion required to bring in breakeven closing position. This equates to a saving of £20mil over the remaining months of 25/26. BCUHB currently monthly spend totals £210mil.
- BCUHB have been advised by Welsh Government that Welsh Risk Pool costs will be consumed, as well as the risk on staffing structured bow being sourced through Welsh Government for this financial year, which eliminates the risk of delivery.
- Discussion held in the last Board Development session, to identify and build savings for the next financial year. A joint PPHP and PFIG meeting is scheduled for January 2026 to discuss this further.
- £58.2mil allocated for BCU capital programme. Update on capital programmes to be received at the next meeting.

In discussing the item, the committee:
- Reviewed the trends and figures in relation to the main acute sites, the challenges faced, as well as proposed improvements that are being explored operationally.
- Were advised of the ongoing work of the Financial Oversight Group, and the current requirement of stricter financial controls. The Committee expressed some concern that this reinforces a disempowerment of organisational managers.
- Noted the cost pressures and risks to delivery of the financial plan. It was advised that there is an increased costs due to cross border charges. The relevant Health Board where a patient resides is charged directly by the Joint Care Commissioner (JCC) for any cross-border transfers of care. It was agreed for the total expenditure shares table for all Welsh Health Boards to be shared with Committee members.
- Highlighted the need for an Allied Health Professionals (AHP) bank, similarly to the Medical bank, especially in light of the hold on agency spending for the remainder of the financial year. It was clarified by Associate Director of Workforce Optimisation, that BCU currently has access to an AHP bank which is aligned with the medical bank. However, since the medical bank is now hosted “in house” within BCUHB, work is ongoing to establish an in house AHP bank, which will be progressed in 2026/27.

Unconfirmed

The following actions were agreed:

- **Action PF25.114.1**: total expenditure shares table for all Welsh Health Boards to be shared with Committee members.
- **Action PF25.114.2**: Update on the AHP bank to be received at the October 2026 meeting to review progress.

It was resolved that the Committee:

- **RECEIVED** the report.

PF25.115 Integrated Performance Report

The Director of Performance & Commissioning presented the report. Highlights included:

- Further improvement is required in regard to Planned Care. Referral to Treatment Times (RTT) has halved since August 2025, but further improvement is needed.
- Decrease seen in patients waiting 104 weeks.
- An increased is seen in relation the diagnostic wait times. Data currently available for November indicates as slight decrease in wait time.
- Concern regarding the number of 100% overdue follow up waiters. It was advised that a proportion of these are urgent ophthalmology referrals, which carries significant risk. This is to be raised with the Medical Director to ensure awareness. Validation work is ongoing in regarding to these waiting list to ensure accurate figures.

In discussing the item, the Committee:

- Clarified in regard to 100% overdue follow up waiters, that harm and risk is monitored through the committees. The Chair requested a paper is received at Quality, Safety and Experience Committee regarding this issue.
- Queried diagnostic rates, and discussed capacity across BCU specifically in relation to MRI waits. It was clarified that there are four main site MRI machines, two mobile, with potential use of an additional machine from Bangor University. This will be explored outside of the meeting.
- Advised that further improvement in performance is required.

The following actions were agreed:

- **Action PF25.115.1**: 100% overdue follow up waiting lists to be reviewed outside of meeting with Medical Director
- **Action PF25.115.2**: Paper on 100% overdue follow ups to be received at QSE Committee.
- **Action PF25.115.3**: 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.

It was resolved that the Committee:

- **NOTED** the current position.

[Emma Lea joined the meeting].

PF25.116 Information Governance KPI Report

Unconfirmed

The Assistant Director of Compliance and Business Management presented the item. Highlights included:

- Further review of Freedom of Information (FOI) statistics has taken place and found that those reported against Workforce and Organisation Development (WOD) were reported by the deadline, but elements from some other services were delayed.
- There has been a decrease in FOI compliance between Quarter 1 and Quarter 2 of 2025/26. Reminders and requested for further training have been received from leads, and compliance is hoped to improve in the next quarter.
- SARC compliance is satisfactory.
- Regarding incidents, there has been a decrease in breaches relating to external mail, however an increase regarding misfiling and prescription errors. Processes and improvement are being reviewed within effected services.
- One incident is outstanding from the Independent Commissioners Office.
- A section regarding lessons learnt will be included in future versions of the Information Governance KPI report starting from the next quarter.
- Continued improvement seen in Information Governance training compliance across the organisation – now 87% compliance.
- A reduction in NIAS notifications is noted.
- More information on use on the asset register system will be included in the next report.

It was resolved that the Committee:

- **NOTED** the current position.

PF25.117 Update on Integrated Medium Term Plan Process and Emerging Priorities

[Linda Dyson and Nesta Collingridge joined the meeting].

The Head of Business Planning & Programme for Central IHC presented the item, and the following was highlighted:

- The paper provides update on the current IMTP progress, which builds upon the existing IMTP 2025-28. It was noted that whilst this was approved by the Board, it was not approved by Welsh Government.
- Key themes highlighted the requirement of starting the process early with clear identification of priorities, with key focus areas including shifting of resources, addressing of access and inequality issues, a narrative drive plan and shifting of care to the community.
- There is a focus on a continuous planning cycle, with steps in place to meet the March deadline.
- A "bottom-up" approach is being adopted for service level planning, whilst also recognising the need for a top-down drive to meet strategic recommendations within the 10-year strategy and clinical service plan.
- The Integrated planning framework was signed off at the November Board meeting. Guidance is being developed to ensure consistency of planning across BCU.
- There is ongoing engagement with key groups and the Board. An update will be provided ahead of finalisation of the plan.

Unconfirmed

In discussing the item, the Committee:

- Were advised that whilst feedback from last year's submission was limited, there has been a continuation to build on best practice, aligning with strategic and Board priorities.
- Highlighted the importance of understanding how resource allocation will delivery the required performance metrics, with the aim of reporting against internal performance trajectories moving forward.
- Queried the shift from five strategic objectives to four strategic intents, and concerns these aren't underlined by the BAF.
- Requested that clear objectives are set out at the front of each section of the IMTP document for clarity.

It was resolved that the Committee:

- **NOTED** the report.

PF25.118 Progress against Planned Care – Verbal Update
Russell Caldicott, Executive Director of Finance

The Executive Director of Finance presented the item, and the following was highlighted:

- Significant improvement regarding outpatients' appointments
- As of December 2025, 286 patients are waiting 104 weeks. This figure was over 10,000 9-10 months ago.
- Work is ongoing with the improvement team.
- 19,000 patients currently waiting for an 8-week diagnostic. These referrals mainly relate to MRI, endoscopy and ultrasound. Target is to reduce to 4700 patients waiting but trying to reduce below this figure.
- Improvement required in regard to Cancer Services performance. Further work is ongoing to explore the areas and reasons for delay, and to give an accurate percentage split.
- Some additional resource has been committed by Welsh Government; however, this does not cover all preferred areas.
- A Grip and Control system is being adopted, with insourcing and outsourcing options being explored, with a focus on clinical leadership for decision making.

The following actions were agreed:

- **Action PF25.118.1**: Cancer Services performance to be reviewed for progress at the next Committee meeting.

It was resolved that the Committee:

- **NOTED** the current position.

PF25.119 Urgent and Emergency Care Programme Board

The Chief Operating Officer presented the item, and the following points were highlighted:

- Operationally, Health are linked with Local Authority colleagues to enable communication to aid processes for patients. A shared system between Health and Local Authorities has been developed to provide a live update on a patient and their

Unconfirmed

pathway. This allows Local Authorities to “drill down” into a specific pathway, to see what is outstanding and to explore the care that is in place.
- Considerable work is progressing across all acute sites. Directors are linking with sites to understand current processes, and to determine how things can be improved or work differently.
- Significant work ongoing regarding patient discharges, which is making a significant difference to patient flow through sites and departments. Further work is still required regarding weekend discharges, as this can be an area with increased pressure, with potential for greater build up in departments.
- Half of care delays are thought to be related to Health, with others relating to Local Authority delays. Discussion is ongoing with Local Authorities on how processes and delays can be improved.

In discussing the item, the Committee:

- Noted the improvement seen in relation to discharges across hospital sites, and referenced data recently shared from WAST that highlighted this.
- Were advised of the multiple previous site visits, and an upcoming informal visit to Ysbyty Glan Clwyd later this week by the Emergency Care Improvement Support Team (ECIST), which will explore the use of a diagnostic tool as well as an opportunity for shared learning. KPI metrics will be outlined within a report by the Director of Corporate Governance. This report will go to Renumeration Committee, to ensure accountability and progress reporting.
- Referenced the ongoing strike of Resident Doctors in England, and the potential impact this may have on patient numbers, specifically in Emergency Departments for areas near to the border.
- The Director of Corporate Governance requested that the progress actions are included within the report at the next update to Board in January to provide assurance and accountability.
- Requested that narrative regarding discharges and historical data is referenced within future reports provide assurance of improvement.
- Emphasised the importance of ensuring fundamental changes are imbedded with service areas to ensure continued progress and improvement.

[Tehmeena Ajmal left the meeting].

It was resolved that the Committee:
- **NOTED** the current position.

PF25.120 Q2 Annual Delivery Plan Report

The Head of Business Planning & Programme for Central IHC presented the item, and the following was highlighted:

- The report reflects the mid-year position, with a forward confidence rating in delivery for the end of financial year.
- Out of the five strategic objectives, objective four is seen as most challenging due to complexity of actions and the areas covered.

Unconfirmed

- Majority of areas have a high confidence in terms of delivery. Those with low confidence have support in place in order to deliver.

In discussing the item, the Committee:
- Queried the consequence for delivery being classed as "low". It was advised that this rating was introduced in Quarter 3 and links with the IMTP development, but that this will be incorporated going forward and fed back to the team.
- Requested clarity on issues regarding patient flow due to resource constraints. The Executive Director of Finance agreed to follow this up with the Executive Director of Transformation and Strategic Planning.
- Emphasised the importance of ensure clear depiction of actions within the reports, to ensure they are actions appropriate, and are tracked for assurance.

[Matthew Joyes joined the meeting].

- Requested that the Q3 report is submitted to Board in January 2026 at requested of the Chief Executive and asked this includes an update on progress.
- Clarified in relation to values and behaviours, that whilst actions may be complete, embedding and impact of these actions is ongoing.

The following actions were agreed:
- **Action PF25.120.1**: Resource constraints relating to patient flow to be reviewed to assure consistency.

It was resolved that the Committee:
- Received **ASSURANCE** on the progress made.

[Emma Lea left the meeting].

PF25.121 Legal Services
Pam Wenger, Director of Corporate Governance

The Deputy of Legal Services presented the item, and highlights included:

- A large number of changes were introduced in Quarter 3, due services now accessing legal advice through the BCU legal team only. This will therefore be covered in the next report covering Quarter 3 as the changes are embedded.
- A number of in-house lawyers will be joining the team in the new year, which will aid in reducing cost spend on external legal services.
- A new database is being created to hold all legal matters, which will enable identification of legal risk.
- A new process will be introduced in January 2026, LFERS, which currently sits around 15, which is significantly reduced on last year's position. Support will be offered to effected services to try and reduce numbers.
- An update regarding redress has been received since this report was generated. New rates will come into place from April 2026, with claim limit increasing from £25k to £50k. This is expected to create an increase in workload, and this cost is

Unconfirmed

- expected to be managed by BCU. National work is ongoing to explore the costing of redress and clinical negligence cases.
- There has been an increase is number of areas of procurement requiring legal supporting. This is thought to be due to the new procurement act and increased control measures that are in place. This is expected to continue to increase.

In discussing the item, the Committee:

- Were advised that the risk of increased need for LFERs has been escalated through Audit Committee.

It was resolved that the Committee:

- **NOTED** the current position.

[Matthew Joyes left the meeting].

ROUTINE REPORTING

PF25.122 Board Assurance Framework
Nesta Collingridge, Head of Risk Management

The Head of Risk Management presented the item. Highlights included:

- The Business Assurance Framework (BAF) remain aligned with the IMTP, but there are some delays with moving to the portal.
- The BAG will be linked to the strategic objectives within the long-term plan.
- Majority of risks have a March 2026 deadline.
- Discussion has been held with the Executive team to review and subsequent close of some low-level risks, following agreement at Audit Committee in December 2025.
- At the recent Executive Committee, it was requested that several risks are to be scored higher than initially updated. This will be amended and reviewed.
- Whilst the six-facet survey was not part of the budget for this financial year, it was in line with Health Board savings. It will need to be reviewed if included for 2026/27.

In discussing the item, the Committee:

- Congratulated the Risk Team on their recent award.
- Queried BAF 24.07 and its accuracy. This will be reviewed by the risk team and amended as required.
- Requested a formal update at the next Committee meeting regarding the six-facet survey, with an additional update provided ahead of submission of the BAF to the Board in January 2026.

The following actions were agreed:

- **Action PF25.122.1**: BAF 24.07 to be reviewed for accuracy and amended as required.
- **Action PF25.122.2**: Update on the six-facet survey to be received at the next meeting.

It was resolved that the Committee:

- **NOTED** the current position.

FOR INFORMATION

Unconfirmed

PF25.123 Corporate Governance Report
Pam Wenger, Director of Corporate Governance

The Head of Corporate Governance presented the report.

It was resolved that the Committee:
- **NOTED** the current position.

[Nesta Collingridge and Linda Dyson left the meeting].

CLOSING BUSINESS

PF25.124 Summary of Business to be reported from Private

The following items were discussed in private at the previous Committee meeting:

- Contract briefing paper on Community Equipment with FCC and DCC.
- Business Case regarding Penrhos Care Home

PF25.125 Agree Items for Referral to Board / Other Committees

It was agreed that the following should be referred to the Committee / Board:
- Quality, Safety and Experience Committee to look at evidence of harm as a result of delays to follow up appointments.
- People and Culture Committee to consider how the establishment control process can be simplified given evidence that inability to recruit to posts within establishment in a timely manner is negatively impacting performance.

PF25.126 Agree Items for Chairs Assurance Report

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

1. There is a deficit of £17.3 million on the year to date and a financial risk of £26.0 million to achieving the plan to break-even: The Financial Oversight Group has agreed to a number of additional centralised control measures although it is recognised this reinforces some negative behaviours on the part of managers who have become unused to prioritising within their budgets.
2. There is little sign of any improvement in performance indicators relating to theatre utilisation which are key measures of our efficiency and productivity.
3. We have not succeeded in meeting our trajectory towards eliminating 104 plus waits for planned care which is a key target for the Welsh Government, while performance on cancer and breaches in respect of the eight-week target for diagnostics remain concerning.

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

1. It received the Information Governance KPI Reports for the first and second quarters of the year, and performance continues to be good.

Unconfirmed

2. There now appears to be a clear prioritised approach to improving Urgent and Emergency Care performance with some initial indications of real improvement.

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

1. There was evidence of some improvement with regard to Planned Care, particularly in respect of reducing the number of patients experiencing long waits for their initial consultant appointment, and in terms of therapies.
2. The Committee noted the report on implementation of the Annual Plan to 30 September but raised concerns around the number of red deliverables and asked for clarification in future papers as to include a narrative on any harm to patients due to these not being delivered on time.

PF25.127 Review of Meeting Effectiveness

It was agreed that:
- The Committee meeting ran well.

PF25.128 Date of next meeting

24 February 2026.

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'

Unconfirmed

Performance Finance & Information Governance Committee Action Log (Public)

Updated 18.02.26

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.
2	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	Remain Open Update to be provided by the Director of Estates and Environment at the meeting.
Proposed for Closure						
1	PF25.96.1	22.10.25	**Shared Services Update** Future reports to include percentage savings of total spend on services by BCUHB through NWSSP.	Russell Caldicott	October 2026	Proposed for closure NWSSP in future reporting to include analysis of % of total spend on services by BCUHB
2	PF25.114.1	18.12.25	**Finance Report** Total expenditure shares table for all Welsh Health Boards to be shared with Committee members.	Russell Caldicott	February 2026	Proposed for closure All Wales performance shared with members by email.
3	PF25.115.1	18.12.25	**Integrated Performance Report**	Russell Caldicott	February 2026	Proposed for closure

			100% overdue follow up waiting lists to be reviewed outside of meeting with Medical Director			Discissions have concluded and plans under development
4	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	Proposed for closure Discussions concluded with Operational teams and Executive (mobile units on site with software upgrades to existing machines)
5	PF25.120.1	18.12.25	**Q2 Annual Delivery Plan Report** Resource constraints relating to patient flow to be reviewed to assure consistency	Russell Caldicott	February 2026	Proposed for closure Plans developed to maintain flow within the Operational teams
6	PF25.122.1	18.12.25	**Board Assurance Framework** BAF 24.07 to be reviewed for accuracy and amended as required.	Nesta Collingridge	February 2026	Proposed for closure The Board Assurance Framework was updated before reporting to the Board in January 2026.
7	PF25.67.1	26.08.25	**Integrated Performance Report** Comments to be fed back to Ed Williams	Gareth Williams/Rhian Watcyn Jones/Russell Caldicott	February 2026	Proposed for closure Gareth Williams and Rhian Watcyn Jones have met Ed Williams and work on a simpler summary report is ongoing. 19.01.26 – on Feb 26 agenda
8	PF25.92.1	22.10.25	**Finance Report**	Russell Caldicott	February 2026	Proposed for closure To be added to Feb 26 agenda

			Reprofile of capital expenditure plan to take place and update to be given at future PFIG meeting.			19.01.26 – on Feb 26 agenda
9	PF25.92.2	22.10.25	**Finance Report** The Chief Pharmacist to be invited to attend when Value & Sustainability is next on the agenda to ensure Medicines Management representation.	Chair	February 2026	Proposed for closure 19.01.26 – on Feb agenda. Chief Pharmacist invited to meeting.
10	PF25.115.2	18.12.25	**Integrated Performance Report** Paper on 100% overdue follow ups to be received at QSE Committee		March 2026	Proposed for closure 19.01.26 – transferred to QSE for March agenda.
11	PF25.118.1	18.12.25	**Progress against Planned Care** Cancer Services performance to be reviewed for progress at the next Committee meeting.	Russell Caldicott/Ed Williams	February 2026	Proposed for closure 19.01.26 – on Feb agenda
Closed Actions (as agreed at meeting on 18.12.25)						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
	PF25.64.2	26.08.25	**Matters Arising and Action Log** RC and PW to meet and agree how to factor issues about the corporate centre into the workplan	Russell Caldicott/Pam Wenger	October 2025	Closed PW and RC meeting on 17.10.25 update to be shared. 12.11.25 Agreed to report biannually – action to be closed.
	PF25.65.1	26.08.25	**Finance Report** Clarity of MMR definition to be added to Finance Report.	Russell Caldicott	~~October 2025~~ March 2026	Closed Scheduled on agenda for October meeting 22.10.25 – scoping exercise exploring budget baseline to be

						conducted ahead of next financial year. 12.11.25 – definition of MMR ‘Monthly Monitoring Report’. Updated in finance report. Agreed close
	PF25.68.2	26.08.25	**Progress Against Planned Care Performance Targets** Update to be requested on Endoscopy Business Case	Tehmeena Ajmal	October 2025	Closed 09.12.25 – item went to Board in May 2025.
	PF25.69.2	26.08.25	**Urgent and Emergency Care Programme Board** Further information on role of the facilitators to be updated at next committee meeting.	~~Victoria Peach~~ Tehmeena Ajmal	October 2025	Closed Paper received at board in September 2025 and update included within UEC update on October 2025 PFIG agenda. Discussed in October’s meeting.
	PF25.70.1	26.08.25	**Legal Services** Future Legal Services Report to contain detailed breakdown on personal injury and clinical negligence claims.	Matthew Joyes	~~October 2025~~ December 2025	Closed 13.10.25 Update – information to be included in future reports, with compliance to data protection and legal privilege requirements.

						22.10.2025 – rescheduled meeting has meant insufficient time to complete action. Deferred to December’s meeting On December agenda.
	PF25.70.2	26.08.25	**Legal Services** Legal Services Update to be included as standard agenda item going forward.	Gareth Williams	~~October 2025~~ December 2025	Closed 25.09.25 – item added to agenda as standard during agenda setting 22.10.2025 – rescheduled meeting has meant insufficient time to complete action. Deferred to December’s meeting On December agenda.
	PF25.90.1	22.10.25	**Unconfirmed Minutes held on 26.08.25** Summary of items not included on standard agenda to be reviewed and added to the cycle of business if required. List of items referenced in public minutes of 26.08.25.	Gareth Williams	December 2025	Closed 14.11.25 – summary list shared with attendees along with minutes for the last meeting.
	PF25.96.2	22.10.25	**Shared Services Update** Next NWSSP to be added to March 2026 PFIG committee agenda.	Gareth Williams	March 2026	Closed Added to forward workplan

	PF25.97.1	22.10.25	**Corporate Risk Register (CRR)** Finance risk 25-06 to be reviewed to clarify actions to be taken to bring into tolerance range, and to link in with Director of Environment and Estates ahead of the next Board meeting.	Nesta Collingridge	November 2025	Closed 09.12.25 - Actions for Finance risk has been updated by Executive Director of Finance, can be closed once CRR is reviewed by the committee, to Committee satisfaction. Director of Environment and Estates deep dive on risks completed, follow up meeting on Estates risk to be scheduled end of Dec. 18.12.25 – agreed closed. Action complete
	PF25.97.2	22.10.25	**Corporate Risk Register** Actions in report for November to be reviewed and update ahead of submission to November's board meeting.	Nesta Collingridge	November 2025	Closed 09.12.25 – action complete
	PF25.98.1	22.10.25	**Corporate Governance Report** Meeting to be scheduled to review the committee forward workplan and business cycle.	Harriet Abbott	December 2025	Closed Meeting to be arranged and cycle of business included in corporate governance report. Once arranged, can close. 09.12.25 – action complete

Performance Finance & Information Governance Committee

Urgent & Emergency Care (UEC) Programme

Dyddiad y Cyfarfod **Date of Meeting**	24 February 2026
Statws Cyhoeddi **Publication Status**	Open / Public
	Business Sensitive
Enw a theitl Awdur(on) yr Adroddiad **Report Author name and title**	Liz Wedley Programme Director, Urgent & Emergency Care (UEC)
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol **Lead Executive Team Member name and title**	Tehmeena Ajmal Chief Operating Officer

Pwrpas yr Adroddiad **Report Purpose**	For Noting

Crynodeb Gweithredol
Executive Summary

This report provides an updated overview of progress across the UEC Programme, aligned to the Six Goals for Urgent and Emergency Care and Ministerial priorities for 2026–27. A strengthened governance structure is now in place, with the Chief Operating Officer as SRO, interim programme leadership, and a newly appointed UEC / Six Goals Clinical Lead.

A clinically led UEC Task Force has been established to accelerate improvements in demand reduction, patient flow and discharge optimisation. Key progress includes national funding for Community-Based Falls Response, training and equipment deployment across Care Homes, and implementation of Optimal Hospital Flow with over 600 staff trained. Work continues on the Acute Frailty Service (AFS) with baseline assessments complete and workforce/financial modelling underway.

Development of a Single Point of Access (SPoA) is a key priority for the UEC programme 2026/27, this will act as a key enabler to move on both Ambulance 45 and falls workstreams.

Key areas

Community-Based Falls Response
The Community Based Falls Response programme continues to progress at pace across BCUHB, underpinning the organisation's wider ambitions to reduce avoidable

conveyance, improve community based management of demand, and strengthen resilience across urgent and emergency care pathways.
Non-recurrent Welsh Government funding to March 2026 has enabled a significant expansion of falls related training and equipment provision across the region. This includes the delivery of Level 1 falls training to 70 Care Homes, supporting care home staff to safely assess and respond to non-injurious falls and reduce the reliance on emergency ambulance conveyance. In addition, 30 Care Homes are being provided with lifting equipment, helping to ensure residents can be assisted safely, reducing risk of harm and improving overall response capability within the care home sector.

Baseline assessments have now been completed across participating homes, giving BCUHB a clearer understanding of current practice, equipment availability, staff confidence levels, and areas of variation across the sector. This intelligence is informing targeted support, training, and future investment decisions. A Community Resource Team (CRT) options appraisal has also been submitted nationally, outlining potential models for enhanced, multidisciplinary community based response to falls.-based response to falls.

The workstream is closely aligned with several key organisational and national priorities:

- **Ambulance 45 (MAG45):** Community-based falls response is a critical enabler for reducing low-acuity demand on WAST, decreasing handover pressures in Emergency Departments, and supporting alternative care pathways.

- **Single Point of Access (SPoA):** Development of SPoA will significantly strengthen coordination of community response, ensuring falls-related calls are appropriately triaged and directed to the right service at the right time.

- **BCUHB's Community Strategy and Whole System Flow Objectives:** Improved falls response contributes directly to reducing avoidable admissions, supporting timely discharge, and managing demand at the "front door" of acute hospitals.

As the programme moves forward, the focus will be on consolidating training and equipment use, improving data capture and shared reporting with Care Homes, and ensuring stronger integration between care-home response, CRTs, WAST, district nursing, and urgent community response models. Work will continue with localities, commissioners, and national partners to ensure sustainable models are developed beyond March 2026.

This programme is expected to have measurable impact on non-injurious falls management, avoidable conveyance rates, and overall patient experience, while strengthening the capability of the care home sector across North Wales.

Optimal Hospital Flow Framework (OHFF)
OHFF Facilitators spend 4–6 weeks embedded on each ward to support the implementation of core patient-flow principles. This includes establishing twice-daily board rounds, promoting consistent utilisation of STREAM (electronic patient data whiteboard), and strengthening processes that support effective, timely discharge planning.

Since taking up post in January 2025, the facilitators have trained 616 staff across 15 wards, as well as staff within therapy and pharmacy teams. Increased and consistent use of STREAM is helping to embed Red to Green patient flow principles, ensuring patients receive timely, value-adding care throughout their stay. Live, real-time data from STREAM

also feeds into the Right Person, Right Place (RPRP) data dashboard, supporting site management teams to review ward-level pressures and optimise patient flow across the organisation.

Ambulance Handover (MAG45)

BCUHB continues engagement with national H45 taskforce aligning ED improvements, GIRFT and pressures planning. The 6 Goals Plan for 2026/27 has some key interdependencies for MAG45.

Remote Clinical Assessment / SPoA

Development is underway in alignment with the national framework, with a focus on triage models and strengthening integration between community services and WAST response. Work undertaken during Q4 2025/26 will establish the foundations required for implementation. Q1 2026/27 will prioritise testing and validating Priority 1 data collection, in line with the SPoA data set specification, to ensure a consistent and robust approach to monitoring outcomes and activity.

Acute Frailty Service (AFS)

Progress on the Acute Frailty Service continues with baseline assessments completed across all acute sites. These assessments have provided a clear understanding of current service models, workforce capacity, patient pathways, and key operational constraints affecting frailty care within BCUHB.

Workforce modelling is now underway to inform the optimal skill mix required to deliver a consistent and sustainable frailty model across the Health Board. This includes developing proposals for advanced clinical practice roles, dedicated frailty practitioners, and improved multidisciplinary team (MDT) coverage to ensure earlier identification and intervention for frail patients.

The programme will move into a phased implementation during 2026–27, aligned with national Six Goals priorities and BCUHB's wider unscheduled care improvement aims. The phased approach will:

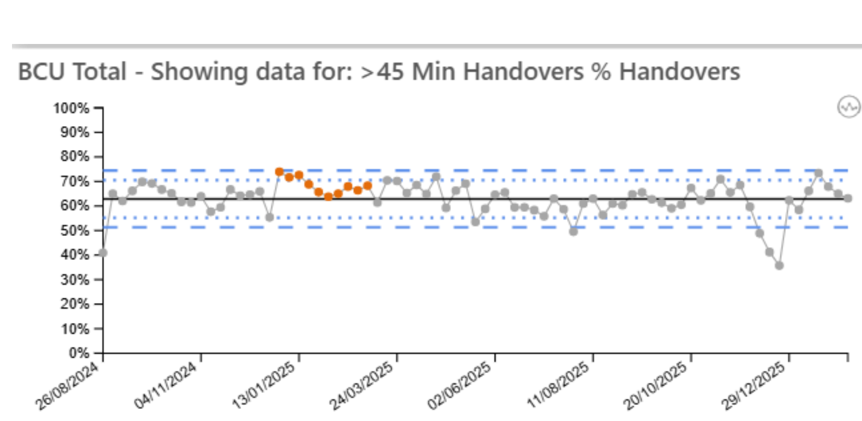
- Establish a consistent frailty assessment and intervention model across acute sites
- Strengthen links with community-based frailty pathways to reduce avoidable admissions
- Improve same-day emergency care (SDEC) access for frail patients
- Enhance discharge planning to support safe transitions of care
- Improve data capture and visibility of frailty patient outcomes
- Explore a community option

The AFS is expected to contribute to reducing length of stay, improving patient experience, and minimising deconditioning risk through earlier, targeted intervention for older people living with frailty. Work will continue with clinical and operational teams to ensure alignment with existing programmes, including Optimal Hospital Flow, the proposed SPoA development, and community response models.

Performance Data relating to Major Change Programme

<u>45-minute handover</u>

- Whilst there have been some improvements noted on individual sites, this has not been sustained
- 6-week harm reduction plans initiated from 30 November, supported by reset fortnight actions targeted at all stages of the pathway



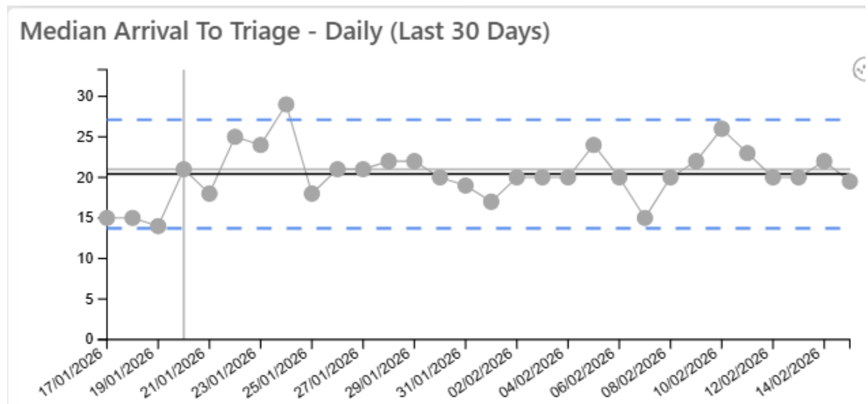
- Across BCU, 68% of patients were not handed over within the 45 minutes target for January 2026. This is a decrease of 5% from the previous month.
- A clinically-led Urgent and Emergency Care Task Team has been established to lead on taking decisive steps with senior clinical leaders and operational teams to support system-wide improvement and improve outcomes and experience for patients. The focus is on three key areas:
  1) Reducing avoidable admissions and ambulance conveyances to EDs
  2) Improving flow through the hospital including establishing an acuity-led discharge process and improved weekend flow
  3) Working with clinical and operational teams to strengthen system working.

<u>ED 12-hour breaches</u>

- Twelve hour waits in EDs fell 4% percent in December 2025, with 3,656 patients waiting over twelve hours.
- Senior clinical reviews and executive walkthroughs are shaping rapid actions to improve quality and safety across ED pathways., with specific focus on non-admitted breaches
- Discharge practice and system flow are being strengthened, supported by a new data dashboard that highlights delays and drives joint work with local authorities, which is being utilised as part of the reset fortnight.

<u>Median time to clinician</u>

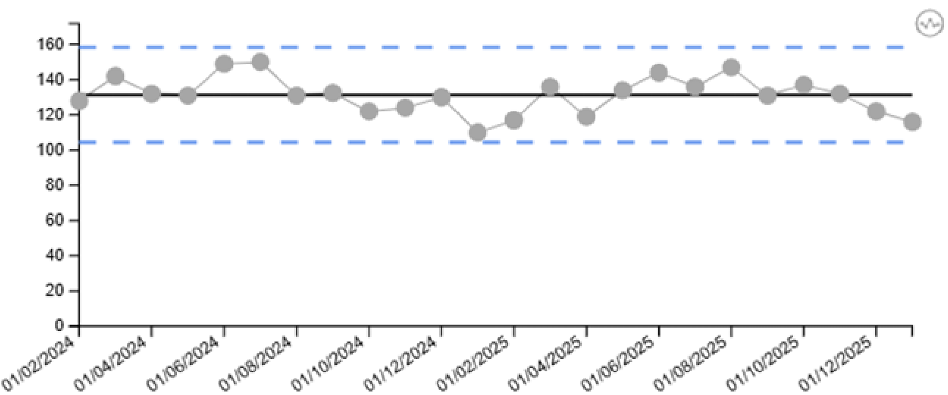
- Latest locally reported time of 20 minutes for February 2026 to date, this shows an increase in performance from December 2025



- Latest nationally reported position 20 minutes for median time to clinician for September 2025. This is a slight improvement of 1 minute from October 2025. The current National target is 15 minutes.

Time to triage

- Latest locally reported position 116 minutes for median time to triage for January 2026. This is a slight increase in performance of 8 minutes from November 2025. The current national target is 60 minutes



- Latest nationally reported position 132 minutes for median time to triage for November 2025.This is a slight improvement of 6 minutes from October 2025. The current National target is 60 minutes.

Pathway of care delays

- Winter Sprint 2 was delivered between 21 January and 4 February 2026 as a continuation of the December 2025 Winter Sprint Fortnight.
- Developed collaboratively by BCUHB, Local Authorities, and Regional Partnership Board partners, the sprint sought to maintain the strengthened collaborative behaviours and system grip established during Sprint 1. The workstream continued to prioritise Pathway of Care Delays (PoCD), which remain a significant constraint on system flow and patient experience.
- In contrast to Sprint 1, Winter Sprint 2 was not intended to act as a performance reset. Instead, its primary purpose was to assess whether the effective ways of working developed during Sprint 1 could be maintained during a sustained period of winter pressure, without requiring additional escalation measures.
- The sprint focused on:
  - Maintaining clear visibility of delayed patients and associated lost bed days
  - Embedding forward-looking, patient-centred behaviours across operational teams
  - Strengthening the use of shared system data, including the Right Patient Right Place (RPRP) dashboard
  - Building and sustaining local ownership of flow and discharge activity within a consistent regional framework
  -
- Analysis of performance data shows that the reductions achieved during Sprint 1 were not fully maintained through January. However, despite increased demand and significant capacity pressures across the system, the number of delayed patients did

not return to December baseline levels. This performance pattern reflects the operational realities of winter rather than a failure of the sprint methodology.

- Winter Sprint 2 demonstrated that performance data can be used effectively to support shared situational awareness, collaborative planning, and joint decision-making. Operational teams reported improved confidence in the use of common data sets, with a noticeable shift from attribution and escalation towards collective problem-solving and system accountability. The sprint reaffirmed the value of a regional approach that enables local action while maintaining system oversight.
- Winter Sprint 2 also provided assurance that the collaborative behaviours and system grip developed during Sprint 1 can be sustained during periods of prolonged operational pressure. While performance gains were not fully retained, the system avoided a full regression to pre-sprint levels, demonstrating increased resilience. The sprint further strengthened shared operational understanding, use of data, and joint responsibility for addressing PoCD, creating a foundation for continued improvement during the remainder of the winter period and into 2026/27.

Multi Agency Discharge Event (MADE) event feedback
During the January 2026 MADE events across BCUHB, several system constraints were identified:

- Inconsistent Home First practices across hospital sites
- Variability in Integrated Discharge Teams (IDT) configuration and escalation routes
- Delayed discharge planning and extensive non-value inpatient assessments
- Insufficient Pathway 1 (home support) and Pathways 2–3 (short-term and complex recovery beds) capacity
- Limited use of Trusted Assessors, contributing to workflow bottlenecks
- Lack of standardisation in discharge processes across counties

These findings show clear misalignment with Welsh Government's Hospital Discharge Guidance, which emphasises multidisciplinary co-ordination, IDT leadership, trusted assessor deployment, and clear pathways.

Agreed Actions going forward

1) Implement a System-Wide D2RA Model
Adopt and embed all four D2RA pathways as defined in national guidance to ensure appropriate allocation of support, reablement, and assessment at home or in community settings.

2) Embed Home First as the Default Approach
Make Home First the operational expectation. Staff should discharge patients as soon as acute medical treatment is complete, with all remaining assessments undertaken at home or equivalent community setting.

3) Establish Integrated Discharge Teams (IDTs) with Clear Accountability
Create standardised multi-agency IDTs across all acute hospitals, aligned to WG requirements for unified discharge coordination.

4) Commence Discharge Planning on Day One
Ensure that discharge planning starts at admission, consistent with WG expectations for early planning to reduce length of stay and prevent deconditioning.

5) <u>Remove Non-value Adding Inpatient Assessments</u>
Streamline internal workflows and eliminate serial assessments not required by national minimum standards for discharge. Welsh guidance stresses proportional, timely decision-making.
6) <u>Introduce and Expand Trusted Assessor Models</u>
Deploy Trusted Assessors across all sites to reduce assessment-related delays and prevent unnecessary admission to long-term care. Trusted Assessors are specifically endorsed in WG discharge guidance.

7) <u>Strengthen Community Capacity Across Pathways 1–3</u>
Enhance community therapy, reablement, EMI provision, D2RA bedded capacity, and third-sector support consistent with D2RA Pathways 1–3.

8) <u>Standardise Discharge Processes Across Counties</u>
Create a single regional discharge policy for acute hospitals and local authorities to ensure consistent application of pathways, information flows, documentation, and daily operational routines.

9) <u>Improve Daily Medically Led Board Rounds & Specialty Ownership</u>
Ensure consistent, timely, medically-led board rounds with clear senior accountability for progression of care and discharge barriers, reflecting minimum discharge standards.

10) <u>Expected Outcomes</u>
- Reduced length of stay, earlier discharge, and reduced deconditioning
- Improved whole-system flow and reduction of pathways of care delays
- Greater patient independence and improved experience
- More efficient use of acute hospital capacity
- Consistent practice across the Health Board and partner local authorities

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 and Emergency Care
WAST	Welsh Ambulance Service Trust
POCD	Pathways of Care Delays
IRD	Immediate Release Directions
SDEC	Same Day Emergency Care
SPOA	Single Point of Access
SICAT	Single Integrated Clinical Assessment & Triage

ED	Emergency Department
D2RA	Discharge to Recover then Assess

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: Consistency with organisation values
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd **Corporate Risks and Board Assurance Framework**	CRR25-01 Timely Patient Access to Safe and Effective Care BAF24-07

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: ☐ Canlyniad/Outcome: Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Naddo/No: ☒
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: ☐ Canlyniad/Outcome: Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Naddo/No: ☒
Ansawdd	**Galluogwyr Ansawdd Enablers of Quality**	**Meysydd Ansawdd Domains of Quality** Safe

<table>
<tr><td rowspan="3">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?</td><td>Whole-systems Perspective</td><td></td></tr>
<tr><td>Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:
If more than one applies, please list below:</td><td>Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:
If more than one applies, please list below:</td></tr>
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<tr><td>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant
Wellbeing of Future Generations Act – Wellbeing Goals</td><td colspan="2">A Healthier Wales</td></tr>
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<tr><td rowspan="3">Effaith Amgylcheddol / Cynaliadwyedd (5Rs)
Environmental /Sustainability Impact (5Rs)</td><td colspan="2">Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:
If more than one applies, please list below:</td></tr>
<tr><td colspan="2">No - Not Applicable</td></tr>
<tr><td>Os oes mwy nag un yn berthnasol, rhestrwch hynny:
If more than one applies, please list:</td><td></td></tr>
<tr><td rowspan="3">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?</td><td>Do/Yes: ☐</td><td>Naddo/No: ☒</td></tr>
<tr><td>Canlyniad/Outcome:</td><td></td></tr>
<tr><td>Os naddo, dylech gynnwys y rheswm:
If no, please include rationale:</td><td></td></tr>
<tr><td rowspan="3">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?</td><td>Do/Yes: ☐</td><td>Naddo/No: ☒</td></tr>
<tr><td>Canlyniad/Outcome:</td><td></td></tr>
<tr><td>Os naddo, dylech gynnwys y rheswm:
If no, please include rationale:</td><td></td></tr>
</table>

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**	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 the impact and outcomes for patients as a result of long delays across the whole urgent & emergency care system.	
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.	

Produced by the **Performance Directorate**

Tuesday 10th February 2026

Performance Finance and Information Governance Committee – Planned Care 24 February 2026

Planned care programme

Performance: Planned Care programme

Produced by the **Performance Directorate**

Validation RTT waiting list – Technical and Clerical

In response to the Welsh Government (WG) ask in December 2025, to validate all Referral to Treatment (RTT) pathways waiting over 36 weeks:

- £150,000 WG funding is available to support this activity up to the end of March 2026
- Activity has been set up under the Core Validation Team Manager with a focus on; Total Pathways Validated since 16/12/2025, Duplicate, and Stage 3 pathways; exploring additional reporting to target validation of Stage 2
- Due to many competing admin resources within the IHCs, this has been accelerated through a call to overtime of skilled WPAS pathway trackers/validators, which commenced 21/01/2025
- Progress and performance is reported weekly to; Nick Wood (Welsh Government) via their allocated NHS P&I lead, BCU CEO's *Planned Care Performance Weekly Check-ins,* and BCU *'Must Attend'* meetings

There is good progress across this bespoke activity and within IHCs, with the following validation headlines for reporting Week 3:

- This reporting week has seen #2556 pathways validated, and a minimum of #467 pathway closures (circa 18%)
- An accumulative total of #1394 over 104 (tip in) pathway closures since the activity started before Christmas
- As at 27/01, #708 over 104 pathways left to validate (without a validation marker)
- Overtime activity has been stepped up with over #900 pathways validated in one week through this additionality, showing improvements in the 'duplicates' and 'stage 3' pathway validation cohorts

Lessons learnt from the activity so far are:

- Historic missing clinical conditions make validation more difficult – this is being addressed in the longer-term via the WAP Full (e-referrals) roll-out pan-BCU
- Using unskilled staff to work in WPAS contributes to poor data quality and unclean waiting lists – this latest overtime initiative is only using skilled staff
- Nationally there needs to be an agreement on the reporting of closed pathways – we have developed a local methodology, but this will need resolving nationally before the new enabling action for 2026/27
- This level of activity and focus is not sustainable – BCU will need investment in the Core Validation Team if it is to continue at the same pace past the end of March 2026

Total Pathways Validated since 16/12/2025

	Totals: Week 1 - 11	
	>104	**36**
Cental	2119	176
East	1603	511
West	2109	128
Open Pathways	6646	
Removed Pathways	2164	
Total by RTT Band	**7225**	**1585**
Total Validated	**8810**	

Total Pathway Closures by Site & RTT Band

	Totals: Week 1 - 11	
Total Searches 1-4 (all RTT Bands)	4587	
	>104	**36**
Cental	455	297
East	367	252
West	572	221
Total	1394	770
	30%	17%
	2164	

Presented by: Tehmeena Ajmal

Performance: Planned Care programme

Validation RTT waiting list – Patient & Clinical

Patient Validation

- EBO Chat-bot Validation:
  - Successfully rolled out to *Gastro* before Christmas
  - This joins *Trauma & Orthopaedics* to provide continuous validation (every 3-months) of all S1 patients waiting over 52 weeks, replacing the phone call with a virtual conversation where patients have 'opted in' to receive SMS, and calling those that have 'opted out'
  - Work has commenced to onboard *Gynae*, with the ambition to roll out to all specialities by end Q2 2026/27 – challenges are with BCU integration capacity resulting in delays
  - Exploring with the company an opportunity to upload bespoke cohorts of patients through the same technology, without integration but including the benefits of the patient optimisation signposting
- Other Patient Validation – the Core Validation Team continue to support clinical validation with patient calls to ensure we are working from clean lists – currently supporting a review of Gynae >104 Stage 4 patients

Clinical Validation

- Clinical Validation Policy and Procedure has been published, with an online 'Validation Resource Hub' created as an accessible resource
- The 'Planned Care Clinical Group' has been established under the Executive Medical Director, with the inaugural meeting held 9th January 2026
- 'Clinical Validation Workshops' have been set up on each site in February 2026 (attended by NHS Exec Clinical Leads), to support take-up of clinical validation
- Requested retrospective update to pathway notes (#CV) for validations already undertaken is being carried out
- PTL reporting has been improved to include the reporting of clinical validation activity
- An approach has been set-up to ensure good governance of letters to patients and referrers, during and following clinical validation activities
- Targeted clinical validation cohorts have been prepared for review by clinical and operational teams for 'frailty' and 'EBIWs' (previously INNUs)
- Stage 1 Opportunity Review - 50 - T&O, ENT, Urology, Gynaecology; 75- Gen Surgery (NHS Exec P&I Clinical Leads) – in progress

Presented by: Tehmeena Ajmal

Planned care

Performance: Planned Care – 1st New Outpatients

Produced by the **Performance Directorate**

Current position, quarter four outlook, expectations, risks and mitigations

Stage 1 52 Week Actuals Vs Trajectory

Actual · Total S1 2526

30,000 · 20,000 · 10,000 · 0

Mar 2025 · May 2025 · Jul 2025 · Sep 2025 · Nov 2025 · Jan 2026 · Mar 2026

Specialty	Total
130 - Ophthalmology	2,101
502 - Gynaecology	1,151
100 - General Surgery	935
191 - Pain Management	838
120 - ENT	810
330 - Dermatology	667
302 - Endocrinology	567
101 - Urology	240
410 - Rheumatology	202
320 - Cardiology	191
107 - Vascular Surgery	185
110 - Trauma & Orthopaedics	122
140 - Oral Surgery	105
143 - Orthodontics	102
361 - Nephrology	71
301 - Gastroenterology	70
103 - Breast Surgery	42
160 - Plastic Surgery	32
141 - Restorative Dentistry	17
340 - Respiratory Medicine	15
341 - Respiratory Physiology	14
420 - Paediatrics	4
430 - Geriatric Medicine	1
Grand Total	**8,482**

Improved Access for Patients

- Benchmarking graph illustrates impact from delivering an additional c2,000 a week via the national outpatient programme since August 2025 and reduction in profile compared to other Health boards
- Latest national figures indicate BCU Position reduced from 30,409 in August 2025 to 9,733 at 31st December 2025 a 68% reduction. The latest position being 8,842 as analysed in the table.
- Latest internal position indicates further reduction in waiting list from end of December – six specialties account for 76% of the over 52 week wait

Total Waiting Chart

Health Board · ABUHB · BCUHB · CTMUHB · CVUHB · HDUHB · PTHB · SBUHB

30,000 · 20,000 · 10,000 · 0

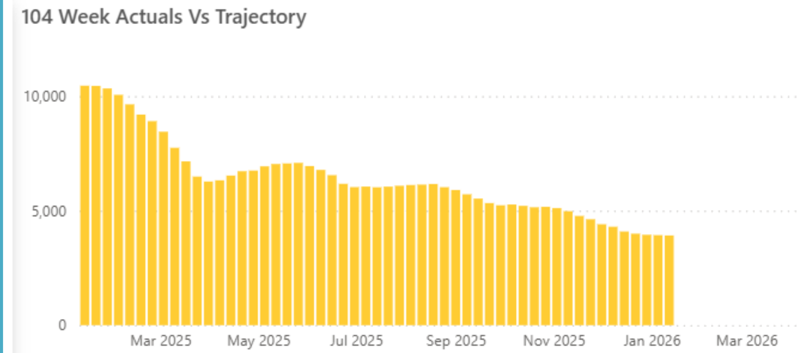
2020 · 2021 · 2022 · 2023 · 2024 · 2025

Presented by: Tehmeena Ajmal

Performance: Planned Care – 104 weeks all stages

Produced by the **Performance Directorate**

Current position, quarter four outlook, expectations, risks and mitigations



Forecast patients waiting over 104 weeks by 31st March 2026

Specialty	Current Modelling
100 - General Surgery	1,073
101 - Urology	405
107 - Vascular Surgery	122
110 - Trauma & Orthopaedics	380
120 - ENT	684
130 - Ophthalmology	129
140 - Oral Surgery	395
301 - Gastroenterology	250
502 - Gynaecology	344
Grand Total	**3,782**

- End of December position saw performance of 3,668 patients waiting in excess of 104 weeks against a 3,889 submitted plan
- Refreshed plan developed in Quarter 2 and submitted to Welsh Government indicates 3,782 patients waiting beyond 104 weeks at the end of Q4.
- Quarter 4 modelling indicates a substantial increase in cohort (those breaching 104 weeks in month) an increase from 2,000 to 3,000 per month
- Key areas of focus to improve on forecast performance centre upon;
    - General Surgery, Urology, Trauma & Orthopaedics, ENT, Oral Surgery, Gastroenterology, Gynaecology
- NHS P&I support has commenced since Q3 and this is being further reviewed as part of the additional support arrangement where focus is being provided on;
    - reducing long waits for treatment
    - ensuring waiting list information is effectively validated
    - supporting the management of outsourced activity
    - optimising capacity and the use of theatres
    - establishing robust reporting of activity

Presented by: Tehmeena Ajmal

Performance Finance & Information Governance Committee

MEWNOSODWCH DEITL YR ADRODDIAD
VALUE & SUSTAINABILITY – MEDICINES MANAGEMENT

Dyddiad y Cyfarfod **Date of Meeting**	24 February 2026
Statws Cyhoeddi **Publication Status**	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad **Report Author name and title**	Neil Windsor – Programme Director: Value & Sustainability
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol **Lead Executive Team Member name and title**	Russell Caldicott, Executive Director of Finance

Pwrpas yr Adroddiad **Report Purpose**	For Noting

Crynodeb Gweithredol
Executive Summary

The purpose of this report is to outline the progress to date at M10 in delivering against the core thematics identified within the National Medicines Management Value & Sustainability (V&S) Board, including recommendations to; -

1. Maximise Use of Biosimilars;
2. Switch to Generics;
3. Preferential Use of Medicines in Primary Care;
4. Restrict Low Value Prescribing.

Accordingly, Medicines Management is one of six core workstreams under BCUHB's local Value & Sustainability framework, with improvement work led by the Chief Pharmacist and sponsored by the Executive Medical Director.

As per our Month 10 financial monitoring return, the workstream is forecasting the delivery of £10.4m of Green RAG rated savings at year end (this is an over delivery of £1.7m against our original plan).

In addition, there remains circa £1.2m of further pipeline opportunities identified, which are not yet in delivery phase. However, following recent discussions with the

workstream lead, the remaining pipeline will be rolled over to 26/27, as they constitute schemes which require further invest to save funding to support delivery and will therefore not be realised in-year.

At M10, the workstream has delivered £8.5m of the anticipated savings.

To support the planning for 26/27, seven priority areas of focus have been identified through the Directors of Pharmacy's Medicines Value and Sustainability Delivery Assurance Group and have been endorsed by the NHS Value and Sustainability Board. These nationally agreed priority areas are: -

- Maximise biosimilar use, including preferential use of the best value biologic medicines;
- Maximise compliance with "on-contract" generic medicine use in secondary care;
- Increase the use of generic apixaban and rivaroxaban as a proportion of all direct oral anticoagulants (DOACs);
- Reduce the prescribing of bath and shower emollients;
- Increase the use of blood glucose testing strips with a unit price under £10 per box as a proportion of all blood glucose testing strips;
- Increase the use of generic dapagliflozin as a proportion of all Sodium-Glucose Co-Transporter-2s (SGLT2s); and
- Optimise the prescribing of oral nutritional supplements.

Early analysis from within the Medicines Management Workstream has identified circa £4m of local savings opportunities for 26/27, though this is an early estimate and requires further work-up and validation.

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**	
V&S	Value & Sustainability
CHC	Continuing Health Care
PFIG	Performance, Finance & Information Governance Group
IPEDG	Integrated Performance Executive Delivery Group
RAG	Red, Amber, Green

WG	Welsh Government
DOAC	Direct Oral Anticoagulants
SGLT2s	Sodium-Glucose Co-Transporter-2s

MEWNOSODWCH DEITL YR ADRODDIAD
VALUE & SUSTAINABILITY – MEDICINES MANAGEMENT

1. Y SEFYLLFA SITUATION

1.1 The Value & Sustainability Programme is a nationally co-ordinated, systematic approach to improving financial performance, reducing unwarranted variation and developing the long-term sustainability of services across NHS Wales.

1.2 Replicating the national structure, our local programme organises improvement effort around six core areas of spend and opportunity, including; Medicines Management, Workforce, Continuing Health Care (CHC), Non-Pay & Procurement; Clinical Variation and Value-Based Health Care.

1.3 The purpose of this report is therefore to provide the committee with the latest overview of progress at an individual workstream level, with the focus of this month's report exclusive to Medicines Management. The report builds upon updates previously provided to PFIG in August 2025 and Board in November 2025 and outlines progress to date, next steps and key challenges.

1.4 More detailed workstream and wider programme level updates continue to be provided to the Value & Sustainability Programme Board and both the Integrated Performance Executive Delivery Group (IPEDG) and Executive Committee (as a designated Major Change Programme), for executive oversight.

2 Y CEFNDIR BACKGROUND

2.1 Medicines Management is one of six core workstreams under the Value & Sustainability framework, with improvement work led locally by the Chief Pharmacist and sponsored by the Executive Medical Director.

2.2 As medicines are the second-largest area of NHS Wales spend after pay, the workstream is a critical enabler of financial recovery and longer-term sustainability, through the identification of opportunities to optimise

prescribing, reduce unwarranted variation and deliver system-wide efficiencies without compromising quality of care.

2.3 Consequently, its mission statement is to "Improve the quality, safety, consistency, and cost-effectiveness of medicines use across NHS Wales, reducing unwarranted variation and supporting significant, sustainable financial savings while ensuring high-quality patient care".

2.4 As part of the national strategic priority for "Maximising Value for Money", full implementation of the Medicines Management Value & Sustainability Board recommendations is a key Cabinet Secretary enabling action within the national planning framework for both 25/26 and 26/7. This is split into four key thematics;

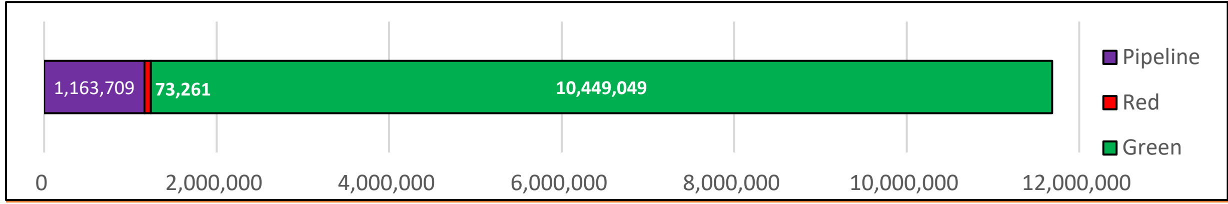
- Maximise Use of Biosimilars;
- Switch to Generics;
- Preferential Use of Medicines in Primary Care;
- Restrict Low Value Prescribing.

3 MATERION PENODOL I'W HYSTYRIED SPECIFIC MATTERS FOR CONSIDERATION

3.1 As per our Month 10 financial monitoring return, the workstream is forecasting the delivery of £10.4m of Green RAG rated savings at year end (see fig 1 below), which represents 22% of the total savings plan.

3.2 In addition, there remains circa £1.2m of further pipeline opportunities identified, which are not yet in delivery phase. However, following discussions with the workstream lead, the remaining pipeline will be rolled over to 26/27 for the M11 returns (as they constitute schemes which require further invest to save funding to support delivery), which will not be realised in-year.

Fig 1 – Medicines Management Savings Categorisation at M10



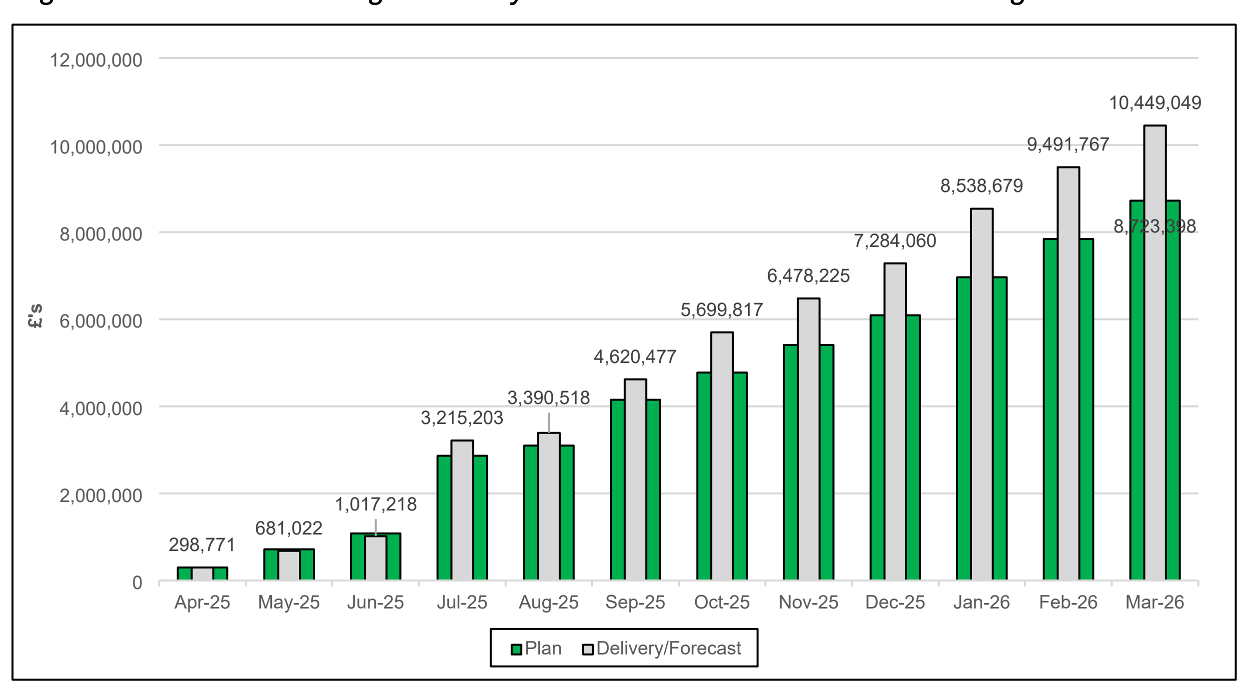
3.3 The high-level workstream schemes and associated values can be broken down as follows:- (see fig 2)

Fig 2 – Medicines Management Schemes (filtered by WG Reporting Subjective)

BCUHB Initiative (filtered by WG Reporting Subjective)	RAG (£)		
Admin & Management Efficiencies (incl outsourcing savings, procurement savings)	320,000		686,428
Digital driven efficiencies such as prescribing software usage			2,051,039
Optimising medicine prescribing within clinical pathways	0	29,997	1,290,358
Procurement efficiencies including maximising drugs rebates and loss of exclusivity	132,500	43,264	3,471,500
Product switching to cheaper alternatives and biosimilars	711,209		1,293,485
Reduced non-necessary usage			113,357
Other Medicines (incl accountancy gains)			1,542,882
TOTAL	**1,163,709**	**73,261**	**10,449,049**

3.4 At M10, the workstream has delivered £8.5m of savings with a year-end forecast of £10.4m. This is a forecast over-delivery of £1.7m against the original plan (see fig 30.

Fig 3 – Cumulative Savings Delivery/Forecast 25/26 - Medicines Management



3.5 To support the planning for 26/27, seven priority areas of focus have been identified through the Directors of Pharmacy's Medicines Value and Sustainability Delivery Assurance Group and have been endorsed by the NHS Value and Sustainability Board. The nationally agreed priority areas are: -

- Maximise biosimilar use, including preferential use of the best value biologic medicines;
- Maximise compliance with “on-contract” generic medicine use in secondary care;
- Increase the use of generic apixaban and rivaroxaban as a proportion of all direct oral anticoagulants (DOACs);
- Reduce the prescribing of bath and shower emollients;
- Increase the use of blood glucose testing strips with a unit price under £10 per box as a proportion of all blood glucose testing strips;
- Increase the use of generic dapagliflozin as a proportion of all Sodium-Glucose Co-Transporter-2s (SGLT2s); and
- Optimise the prescribing of oral nutritional supplements.

3.6 Against these priority areas, early analysis from within the Medicines Management Workstream has identified circa £4m of local savings opportunities for 26/27, though this is an early estimate and requires further work-up and validation.

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

Workforce capacity may be insufficient to deliver the requisite change. Limited pharmacy workforce capacity would affect our ability to complete the switching programme at scale (eg. Biosimilars, branded to generic).

Rising medicines costs and high expenditure on medicines management. Even with our savings programme, medicines costs remain high and difficult to contain.

Increasing demand driven by our ageing population and complex conditions. These demographic pressures drive: -

- Higher prescribing volumes;
- Increased use of expensive long-term medications
- Greater use of polypharmacy

5 ARGYMHELLION
RECOMMENDATIONS

5.1 The Committee/Meeting/Group is asked to:

NOTE and **COMMENT** on the report.

ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol Link to Strategic Priorities	2. Developing strategy and long-lasting change 4. Improving Quality, Outcomes & Experience
Yr Egwyddorion Dylunio Design Principles	Wise Spending Simplify, Standardise & Adopt Best Practices
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd 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

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:	This report is purely administrative in nature and submitted for information only.
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:	This report is purely administrative in nature and submitted for information only.
Ansawdd *A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?* **Quality**	**Galluogwyr Ansawdd Enablers of Quality** All Apply	**Meysydd Ansawdd Domains of Quality** All Apply

<table>
<tr><td rowspan="2">Have you undertaken a Quality Impact Assessment Screening?</td><td>Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:
If more than one applies, please list below:</td><td>Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:
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Wellbeing of Future Generations Act – Wellbeing Goals</td><td colspan="2">A Healthier Wales</td></tr>
</table>

<table>
<tr><td rowspan="3">Effaith Amgylcheddol / Cynaliadwyedd (5Rs)
Environmental /Sustainability Impact (5Rs)</td><td colspan="2">Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:
If more than one applies, please list below:</td></tr>
<tr><td colspan="2">Yes - Reduce</td></tr>
<tr><td>Os oes mwy nag un yn berthnasol, rhestrwch hynny:
If more than one applies, please list:</td><td></td></tr>
<tr><td rowspan="3">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?</td><td>Do/Yes: ☐</td><td>Naddo/No: ☒</td></tr>
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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?</td><td>Do/Yes: ☐</td><td>Naddo/No: ☒</td></tr>
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Counter Fraud Impact Assessment
Have you considered the counter fraud impacts</td><td>Canlyniad/Outcome:</td><td></td></tr>
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If no, please include rationale:</td><td>This report is purely administrative in nature and submitted for information only.</td></tr>
<tr><td rowspan="2">Cyfreithiol
Legal</td><td colspan="2">There are no specific legal implications related to the activity outlined in this report.</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td rowspan="2">Enw Da
Reputational</td><td colspan="2">There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td rowspan="2">Effaith ar Adnoddau
(Pobl / Ariannol)
Resource Impact
(People / Financial)</td><td colspan="2">Yes (Include further detail below)</td></tr>
<tr><td colspan="2">To deliver the scale of opportunity identified in the pipeline schemes for 26/27, further invest to save funding may be required.</td></tr>
</table>

Performance Finance & Information Governance Committee

SUSPECTED CANCER PERFORMANCE REPORT

Dyddiad y Cyfarfod **Date of Meeting**	24 February 2026
Statws Cyhoeddi **Publication Status**	Closed / Private Business Sensitive
Enw a theitl Awdur(on) yr Adroddiad **Report Author name and title**	Caroline Williams Network Manager – Cancer Services
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol **Lead Executive Team Member name and title**	Tehmeena Ajmal Chief Operating Officer

Pwrpas yr Adroddiad **Report Purpose**	For Noting

Crynodeb Gweithredol
Executive Summary

This paper outlines NHS Wales' Cancer Waiting Times Target (the Suspected Cancer Pathway) and BCUHB's declining compliance with the target.

It analyses the priority actions set out nationally and sets out the agreed local actions to improve performance.

The paper notes the most significant risks to delivery:

- Dermatology - failure to extend the dermatology insourcing contract beyond March 31st 2026 will mean there is no dermatology service in West and will increase waiting times for all
- Endoscopy – waiting times for cancer patients remain too long, leading to poor performance on the colorectal pathway
- Urology – the lack of a robotic assisted surgery strategy for north Wales will delay the potential repatriation of major urology cancer surgery, leading to a continuation of extended urology cancer pathways.

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**
n/a		

Acronymau / Rhestr Termau Acronyms / Glossary of Terms	
USC	Urgent Suspected Cancer
SCP	Suspected Cancer Pathway
NOP	National Optimal Pathway
WCCG	Welsh Clinical Communications Gateway
WPRS	Welsh Patient Referral Service
GI	Gastro Intestinal
CT	Computed Tomography (scan)
MDT	Multi Disciplinary Team
PMB	Post Menopausal Bleeding
FIT	Faecal Immunochemical Test
PIFU	Patient Initiated Follow up
ENT	Ear, Nose & Throat

ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol **Link to Strategic Priorities**	4. Improving quality, outcomes and experience
Yr Egwyddorion Dylunio **Design Principles**	Equity and Accessibility
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd **Corporate Risks and Board Assurance Framework**	Failure to deliver the Suspected Cancer Pathway target is on the Health Board risk register

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: ☒
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	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** Data to Knowledge	**Meysydd Ansawdd** **Domains of Quality** Timely
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:

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Efficient
Safe</td></tr>
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Reputational</td><td colspan="2">Yes (Include further detail below)</td></tr>
<tr><td colspan="2">There is a reputational risk in relation to patients not being seen timely and any subsequent harm</td></tr>
<tr><td rowspan="2">Effaith ar Adnoddau
(Pobl / Ariannol)
Resource Impact
(People / Financial)</td><td colspan="2">Yes (Include further detail below)</td></tr>
<tr><td colspan="2">The report highlights areas where future investment is required</td></tr>
</table>

Suspected Cancer Performance Report

1. Y SEFYLLFA/SITUATION

1.1. This paper outlines NHS Wales' Cancer Waiting Times Target (the Suspected Cancer Pathway) and BCUHB's current compliance with the target.

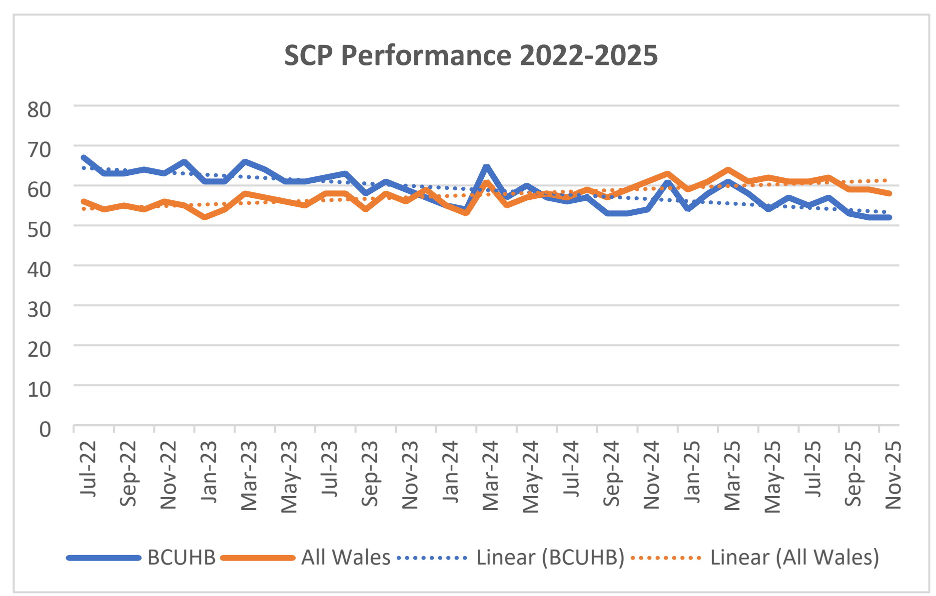
1.2. It highlights the priority actions set out nationally and agreed local actions to improve performance.

2. Y CEFNDIR/BACKGROUND

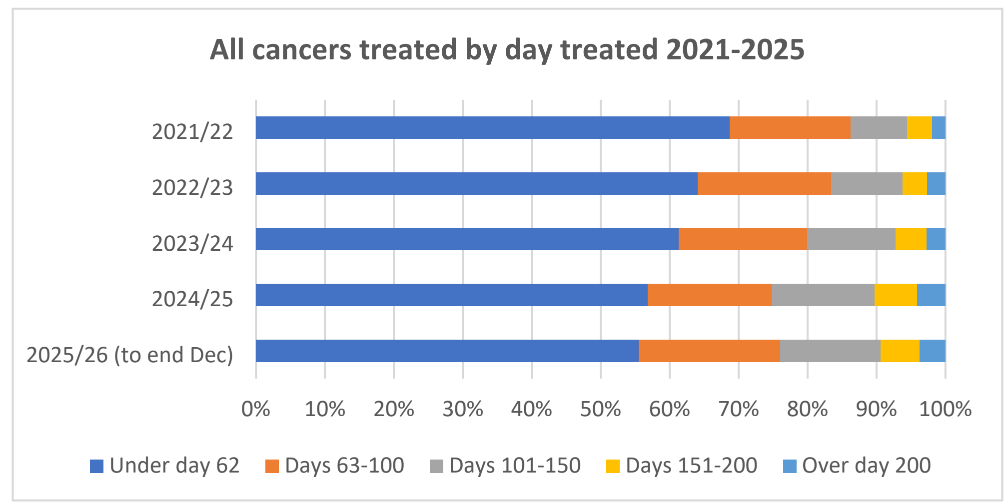
2.1. NHS Wales introduced the Suspected Cancer Pathway (SCP) measure in 2020. It requires at least 75% of patients to be treated within 62 days of suspicion of cancer:

- Suspicion can be at the point of GP referral, outpatient upgrade, incidental finding on a diagnostic test, screening assessment or emergency admission
- No adjustments are made for patient unavailability, unless the patient is unavailable for 2 months or more at which point the clock is reset
- The target only applies to new diagnoses of cancer (not recurrences).
- The clock stops at first treatment; the target does not apply to subsequent treatments

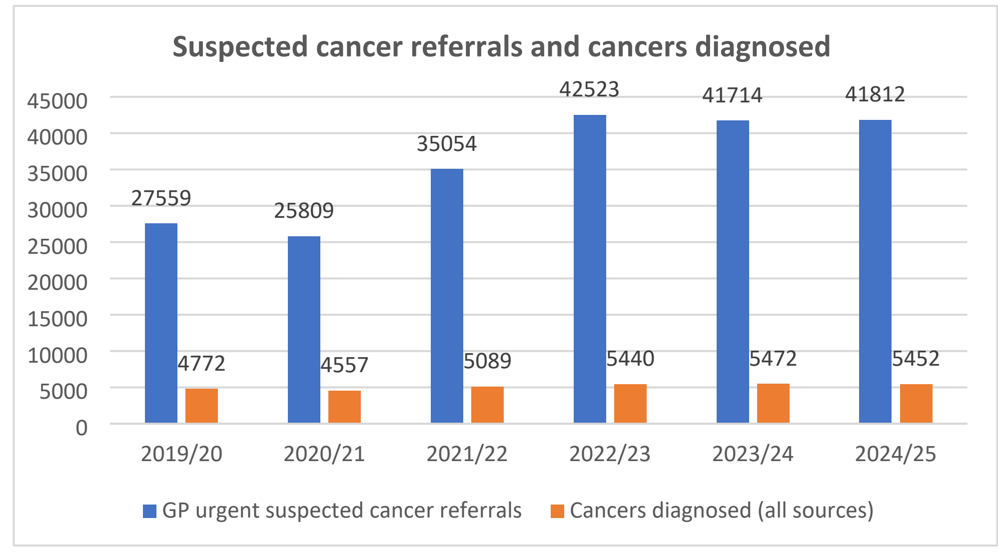
2.2. NHS Wales and BCUHB have not achieved the target since its introduction. BCUHB initially performed above the all Wales average but performance has since declined:



2.3. Of further concern is the fact that the length of time people are waiting for treatment has grown since 2021/22:



2.4. Demand on services has increased with GP USC (urgent suspected cancer) referrals growing significantly post the COVID-19 pandemic, then stabilising more recently. Cancer diagnoses have also increased but at a slower rate:



2.5. Improving cancer outcomes relies on early diagnosis. It is therefore important to ensure an emphasis on high quality comprehensive referrals with appropriate diagnostic pathways in place, rather than focussing on simply reducing referrals.

2.6. The Wales Cancer Network has produced 26 National Optimal Pathways (NOPs) which set out the diagnostic and treatment steps and timelines for each tumour site from suspicion to treatment. The NOPs vary by tumour site but are based on principles as analysed below:

Principle	**BCUHB position**

1	All referrals should be received and triaged electronically: • by day 1 for USC referrals • by day 3 for routine referrals (as may be upgraded to USC)	• GP referrals received electronically (WCCG) but not internal referrals • WPRS (e-triage) programme commenced 2024 and is prioritising specialties that receive USC referrals – 5 specialties completed to date; roll out continues • Vetting timescales formally monitored for WPRS specialties – do not fully comply with 1-3 day standard
2	Patient pathways should be streamlined to include as first step: • straight to test (diagnostic prior to outpatient review) or • one stop clinics (assessment and diagnostics in one clinic)	• Straight to test pathways in place for eg GI specialties (endoscopy), prostate (mpMRI) • One stop clinics in place for breast, neck lump, haematuria. Work ongoing to establish post menopausal bleeding clinics • Mixed access to direct imaging for primary care
3	Each step on the pathway should be delivered in a timely manner in line with relevant NOP eg: • CT within 3 days of suspicious chest Xray on lung pathway • Endoscopy within 5-7 days • Rapid access breast cancer clinic (RABC) within 10 days	• Target timescales not met as at Feb 26 eg: – CT after chest xray =4-9 days – USC endoscopy = 509 colorectal patients waiting over day 21 – RABC = 143 patients waiting over day 10
4	Where further diagnostic tests are required these should be: • direct booked or • follow accelerated imaging pathway (ie same day)	• Direct booking of diagnostic tests generally not in place • Accelerated imaging pathways in place for some pathways eg following endoscopy but uptake varies by site
5	Outpatient appointments should follow MDT meetings on same day or next day to allow early discussion with patient re treatment options	• Varies by MDT • Clinic capacity does not always align with MDT dates

2.7. In April 2025 the Ministerial Advisory Group (MAG) on the effectiveness of current arrangements in NHS Wales concluded that cancer performance challenges '*are not attributable to a lack of clarity regarding the headline standard, nor a lack of analytical insight about where the problems lie, nor the absence of knowledge about what needs to be done. Instead, there is a chronic, and in some cases growing, inability to translate ideas into meaningful change'* and recommended an immediate focus on implementing a narrow set of deliverables drawn from existing policy proposals. The table below analyses the tumour site priorities identified in the MAG report:

MAG priority	BCUHB current position

Breast – develop breast pain pathway to reduce pressure on rapid access clinics	National cancer team invited proposals for funding in Oct 25 - proposal submitted, underwritten by CEO. National funding decision awaited as at February 2026
Colorectal – maximise consistent use of FIT (blood in stool test) as triage tool	FIT in use in symptomatic service since 2021. 92% tests requested by primary care in line with guidance; 20% reduction in GP USC referrals since 22/23; 0.1% conversion to cancer in FIT negative patients.
Gynae – provision of post menopausal bleeding clinics	Two stop PMB model agreed locally. Work ongoing to realign existing clinic and ultrasound capacity
Skin – provision of teledermatology in primary care	Teledermoscopy in place on all 3 sites – capacity for 75 patients per week; planning to increase in 26/27

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

3.1. The number of cancers treated varies significantly between tumour sites as does the percentage compliance with the SCP target due to the different complexity of each pathway – see table below for 2024/25 volumes, compliance and reasons for non-compliance.

	Total	Breaches	% in target	Top breach reasons
Urology	1146	708	38%	Prostate biopsy, surgery, 1st appointment
Skin	1204	348	71%	1st appointment, excision, biopsy
Colorectal	541	337	38%	Endoscopy, surgery
Breast	740	304	59%	Screening, 1st appointment, surgery
Lung	545	210	61%	Radiology, oncology appt, complex pathways
Gynae	256	147	43%	Biopsy, surgery
Head & Neck	215	146	32%	Oncology, surgery, biopsy
Upper GI	406	132	67%	Tertiary provider, oncology, endoscopy
Haem	297	53	82%	Diagnostic bx delay prior to referral to haem
Other	102	7	93%	Complex
Total	**5452**	**2392**	**56%**	

3.2. Given that some pathways are more complex than others it seems reasonable to expect higher levels of performance in some tumour sites than others. Skin pathways for example are relatively straightforward (clinical assessment +/-biopsy, excision) whereas others are more complex eg head and neck (often multiple biopsies and scans to establish primary site and complex treatment planning). Internal tumour site targets have therefore been set but are not yet being achieved:

	Local target	Impact on overall performance from 24/25 baseline	Resulting cumulative improvement in overall performance	Actual performance by tumour site Q1-Q3 25/26	Variance from local target
Urology	70%	+7%	63%	40%	-30
Skin	90%	+4%	67%	72%	-18
Colorectal	60%	+2%	69%	38%	-22
Breast	90%	+4%	73%	53%	-37
Lung	65%	+0%	74%	61%	-4
Gynae	60%	+1%	75%	37%	-23
Head & Neck	60%	+1%	76%	30%	-30
Upper GI	70%	+0%	76%	71%	+1
Haem	90%	+0%	76%	73%	-17
Other	90%	+0%	76%	90%	-
Total	**75%**			**56%**	**-19**

3.3. Based on the review of the NOP guiding principles, national reports, and the analysis of BCUHB 2024/25 performance, the Health Baord agreed the priority areas for SCP improvement in 2025. The full list is attached as Appendix 1.

3.4. Since agreement of the action plan in September 2025, the following improvements have been achieved

1	Sustained focus on 4 key measures to improve performance of the 4 largest tumour sites: • **Breast** – patients waiting over 21 days for rapid access breast clinic appointment reduced from 242 to 36 (85% improvement) • **Skin** – patients waiting over 21 days for first dermatology appointment reduced from 2093 to 804 (62% improvement), primarily delivered through insourced capacity including the expansion of teledermoscopy • **Colorectal** – commencement of nurse led triage on all 3 sites in order to increase straight to test uptake and reduce time to endoscopy; numbers awaiting endoscopy remain high – see actions required below • **Urology** – additional insourced capacity for prostate biopsies to reduce time to diagnosis commenced first weekend in February
2	Refreshed 80th percentile urgent suspected cancer demand calculations included within the Health Board's capacity and demand modelling for 2026/27
3	Roll out of e-vetting of GP referrals to breast services; preparatory work underway with respiratory and GI services
4	Launch of MDT reform programme with dedicated project lead to streamline current MDT processes, commencing with urology and skin; focussed workshops in April

5	Preparation complete to commence PIFU (patient initiated follow-up) for some skin cancers to release capacity in outpatient clinics – pending national sign off of process
6	Agreement of a new pathway for patients presenting with lymphadenopathy; to be piloted from April with aim of reducing time to diagnosis
7	Recruitment of 2 additional ENT consultants to reduce waits for specialist head and neck cancer surgery and stabilise service provision

3.5. As a result of the above, the number of patients still active on a suspected cancer pathway over day 62 has reduced from 2,930 in September to 2,397 in February (18% reduction). The largest reduction has been seen on the skin pathway. It should be noted the reducing this backlog initially leads to a reduction in SCP target compliance as patients are treated after their breach date; the target will only be achieved once the backlog is largely eliminated.

3.6. Actions underway or still required to eliminate the backlog and improve target compliance are:

1	There is an urgent need to extend the current dermatology insourcing contract, from 1st April 2026, in order to maintain reduced waiting times; without this contract there is no dermatology service in the West IHC. This extension is required whilst the Dermatology Delivery Group progresses the work to agree the future model for dermatology services in north Wales
2	Additional minor operating capacity for skin lesions in Connah's Quay Medical Centre to commence February 23rd 2026. This service is funded for 12 months; funding will need to be extended to maintain and further reduce waiting times
3	Expansion of teledermoscopy services to further reduce waiting times through a realignment of consultant dermatologist job plans
4	Continued focus on reducing waiting times to endoscopy. The nurse led triage service commenced in December 2025; the impact will be evaluated in the next quarter, together with an audit to understand variation in cancer demand between sites
5	Potential extension of the prostate biopsy insourcing contract whilst in-house training and service planning continues to increase internal capacity
6	Agreement of a robotic assisted surgery strategy for the Health Board is required; this will involve colorectal and gynaecology who currently use the robotic platform in West but is also essential for urology where over 80% of major cancer surgery is outsourced to England (London and the Wirral) due to the lack of an appropriate robotic platform. This outsourcing extends patient pathways, reduces patient satisfaction and comes at significant financial cost.

7	Finalising the oncology strategy for north Wales, taking into account the rapid and continuing clinical advancements in this area
8	Realignment of ultrasound capacity to support the development of one stop post-menopausal bleeding clinics in gynaecology
9	Review of CT biopsy capacity in order to support the current lung service and begin to plan for the anticipated launch of lung cancer screening in 2027
10	Work with the breast screening service (Breast Test Wales) to reduce waits to assessment for women with an abnormal mammogram

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

4.1. The most significant risks to delivery are:

- Dermatology - failure to extend the dermatology insourcing contract beyond March 31st 2026 will mean there is no dermatology service in West and will increase waiting times for all
- Endoscopy – waiting times for cancer patients remain too long, leading to poor performance on the colorectal pathway
- Urology – the lack of a robotic assisted surgery strategy for north Wales will delay the potential repatriation of major urology cancer surgery, leading to a continuation of extended urology cancer pathways.

5. ARGYMHELLION/RECOMMENDATIONS

5.1. The Committee is asked to:

1) Note the actions and improvements delivered to date
2) Support the proposed next actions to improve performance further
3) Review the three key risks identified

APPENDIX 1

SCP DELIVERY ACTIONS (SEPT 2025)

Generic (applicable to all tumour sites)

Action	First task	Lead
Confirm Executive level focus on delivery of SCP measure	Confirm Executive Lead for Cancer	Executive
Standardise USC target times in line with NOP principles	Agree generic 7-10 day target for all USC pathway steps with some specific local variation as required	Planned Care Programme Board
Ensure USC 1st appointment capacity is in line with 80th percentile demand	Agree principle of amending clinic templates to meet 80th percentile USC demand	Planned Care Programme Board
Establish capacity required in radiology to meet target waiting times (inc CT, MRI, ultrasound and PET)	Complete capacity and demand analysis in radiology	Radiology
Establish capacity required in pathology to meet target waiting times	Complete capacity and demand analysis in pathology	Pathology
Establish capacity required in oncology to meet target waiting times	Complete capacity and demand analysis in oncology	Oncology
Roll out of WPRS to all specialties that receive GP USC referrals	WPRS Programme to provide roll-out timescales for review	Planned Care Programme
All referrals to be vetted within 1 day (USC) or 3 days (routine)	Speciality managers to ensure processes in place to achieve vetting standard and monitor compliance via IRIS WPRS dashboard (when live)	IHC and Division specialty managers
Establish consistent direct access to imaging for primary care across Health Board	Review current practice v NOPs and Community Health Pathways requirements	Radiology
Introduce e-referral for consultant to consultant referrals	Review with Planned Care Digital Programme lead	Planned Care Programme

Introduce direct booking for diagnostic tests requested in clinic	Review with Planned Care Digital Programme Lead	Planned Care Programme
Ensure MDTs operate in an efficient manner to avoid pathway delays	Launch MDT reform programme	Cancer Services
Ensure processes in place to review patients within one day of MDT	Review current clinic set up	IHCs and Division specialty managers
Consider alternative follow-up models in order to reduce pressure on outpatient clinics	Scope potential for roll-out of My Medical Record software (used for prostate cancer follow-up) to other tumour sites	Planned Care Programme and Cancer Network Manager

Individual tumour sites

Breast		
Ensure sufficient RABC capacity weekly to meet demand	Review current capacity v demand and propose revised configuration (day of week to avoid bank holidays etc) to meet demand every week	IHCs and Network Manager, Cancer
Establish breast pain pathway to reduce pressure on RABCs	Develop local proposed model in line with national programme	IHCs and Network Manager, Cancer
Colorectal		
Increase straight to test uptake	Implement nurse led triage on all 3 sites – business case approved	IHCs
Reduce waiting times for USC endoscopy	Endoscopy business case	Endoscopy ROG
Implement accelerated imaging pathway post endoscopy	Roll out pathway in Central and West	Endoscopy ROG
Ensure sufficient surgical capacity to meet increased demand inc from screening programme expansion	Ensure current robotic capacity maximised and expand provision of robotic assisted surgery at YG to meet future demand	West IHC lead
Gynaecology		
Implement agreed post menopausal bleeding clinic model	Identify ultrasound requirements to support model	Women's Division and Radiology

Haematology		
Establish referral route for patients with lymphadenopathy	Agree pathways with relevant specialties and referral guidance for GPs	Cancer Division
Head and Neck		
Maximise effectiveness of one stop neck lump clinic	Expand capacity and streamline referral process inc from East and West	IHCs
Establish sufficient surgical capacity	Increase ENT consultant establishment – awaiting business case approval	IHCs
Lung		
Maximise effectiveness of reflex CT pathway	Agree implementation of 3 day target for CT after chest xray	Radiology
Reduce waiting times to CT guided biopsy	Review current capacity across north Wales	Radiology
Skin		
Maximise potential of teledermoscopy	Complete roll out of teledermoscopy across BCUHB; consider potential for AI	IHCs and Skin Network Manager
Increase MOPs capacity to meet demand	Open additional capacity in Connah's Quay	IHCs
Upper GI		
Reduce times to USC endoscopy		Endoscopy ROG
Urology		
Increase straight to test uptake on prostate pathway	Expand nurse led triage to Central IHC	IHCs
Ensure sufficient prostate biopsy capacity in place to meet demand	Consider WLIs and/or insourcing to meet demand	IHCs and Urology Network Manager
Develop longer term plan to repatriate major urology cancer surgery to north Wales to reduce surgical delays	Initial meetings with Arrowe Park to progress plan	IHCs and Urology and Cancer Network Managers

Performance Finance & Information Governance Committee

ANNUAL DELIVERY PLAN 2025/2026
QUARTER 3 PROGRESS REPORT

Dyddiad y Cyfarfod Date of Meeting	24 February 2025
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Fi Mash, Head of Organisational Portfolio Management Office
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Paolo Tardivel, Executive Director of Transformation and Planning (Interim)

Pwrpas yr Adroddiad Report Purpose	Endorse for Board Approval

Crynodeb Gweithredol Executive Summary
This report provides an overview of progress against the Annual Delivery Plan (2025/26) as at Quarter 3, and the delivery confidence for the remainder of the financial year. The report sets out current progress and highlights where focused improvement activity is required to optimise performance and ensure meaningful impact. The paper was reviewed at the Strategic Planning and Service Change group on the 16th February, where particular attention was draw to the 10 sub objectives currently rated Red. The CEO requested that these be escalated to the responsible executives so that appropriate remedial actions can be put in place to recover the position and reduce risks to delivery. An updated position be provided to March Board, which will include an executive insert to describe the actions undertaken.

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**
Strategic Planning and Service Change	16th February 2026	Approved for onward submission to PFIG

Acronymau / Rhestr Termau Acronyms / Glossary of Terms	

Annual Delivery Plan 2025/2026
Quarter 3 Progress Report

1. SITUATION

1.1 The report provides a Q3 review against the organisations 2025/26 commitments set out in the 2025-2028 Integrated Medium-Term Plan and detailed in the 2025-26 Annual Delivery Plan (ADP)

1.2 The ADP has been developed to ensure full alignment with the organisation's five 'Key Strategic Objectives'. Each action, initiative and performance measure within the plan directly supports the delivery of these priorities, ensuring that resources, efforts and outcomes are strategically focused to achieve the desired impact.

1.3 The ADP Report is structured to provide a clear overview of delivery against each of the 35 sub-objectives within the context of the five Strategic Objectives.

1.4 While its primary focus is the delivery position at Quarter 3, the report also outlines confidence in achieving each sub-objective by the end of Quarter 4, highlighting areas on or off track, reasons for variance, and mitigating actions.

2 BACKGROUND

2.1 Over 70% of the sub-objectives are progressing well and remain on track for Q4 delivery, with high delivery confidence in a number of the foundational and supporting areas as well as a few of the clinical service areas.

2.2 Areas identified with medium delivery confidence are largely due to resourcing issues, mixed performance of items within the sub-objective or challenging targets that remain achievable but require additional focus.

3 SPECIFIC MATTERS FOR CONSIDERATION

3.1 The overall delivery confidence assessments indicate an average confidence level that sits slightly above ‘medium’, reflecting positive progress while highlighting a need for continued focus in some areas.

3.2 A summary by Strategic Objective and Sub-Objective is provided below:

Strategic Objective - Sub-Objective	Summary and delivery confidence
Objective 1: Building an Effective Organisation	
Effective Governance (1A)	**High** Governance Hub and Toolkit embedded with strong organisational uptake. Some elements still require Q4 completion (decision-making, training modules). Final Board effectiveness review and framework completion due in Q4
Foundations for the Future (1B)	**Medium** Structures workstream progressed: proposed structures developed, portfolios refreshed, consultation preparation complete. Implementation planning underway across all workstreams; consultation to commence Q4.
Legislative Compliance (1C)	**Medium** Improvements made to inquiry response processes and H&S alignment. • Legislative tracking and oversight system still under-developed. Further compliance work and interim solutions due in Q4.
Quality Management System (1D)	**High** QMS maturity tool rolled out to challenged services strong recognition from national bodies. Communication and briefing programme completed; improved organisational understanding of QMS. Alignment with organisational restructure remains a dependency. Continued rollout and integration into planning processes in Q4.
Objective 2: Developing Strategy and Long-Lasting Change	
Health Board Strategy & CSP (2A)	**High** Strategic Intent approved and informing strategy and CSP development. CSP Phase 1 partially delivered; some pathways require further development. Q4 focus on engagement and diagnosis phase completion.
Planning & Commissioning (2B)	**Medium** Commissioning work slower due to leadership shifts and capacity. Planning capacity strengthened; Integrated Planning Framework approved and embedded into current cycle. Q4 focus on National Maturity Matrix outputs and commissioning reviews.

Estates & Facilities (2C)	**Medium** Major capital schemes progressing, including medical school and hubs. Challenges remain around Ablett redevelopment, climate risks and estate rationalisation.
Digital & Data (2D)	**Low** ePMA rollout continues; National EHR paused impacting timelines and creating risks. 80% devices upgraded to Windows 11. Q4 focus on MH-EHR procurement and WPAS Phase 5 delivery.
Value & Sustainability (2E)	**High** Savings delivery ahead of plan with strengthened programme structure £40m savings target exceeded with £44.9m forecast; Value principles being embedded in organisational frameworks through Foundations for the Future. Value-funded projects delivering recognised clinical improvements.
Workforce Planning (2F)	**Medium** Strategic Workforce Planning Framework drafted. Agency usage reduced 19%; job planning guidance in development; sickness reduction plan approved. • Q4 will embed job planning guidance and sickness actions.
Objective 3: Compassionate Culture, Leadership and Engagement	
Culture Development (3A)	**High** Culture & Leadership Synthesis Report completed with improvement plan; CCL network expanded. Staff Survey shows improvement across several metrics and increased engagement. • Q4 will develop co-designed workstreams based on the Synthesis Report.
Leadership Development (3B)	**High** Leadership pathways well attended with strong early impact. Coaching review and competency framework alignment underway. Q4 focus on middle manager pathways and evaluation improvements.
Citizen Engagement (3C)	**High** Targeted digital engagement increased reach. Betsi Way Engagement Framework progressing through governance. Youth Voice, councillor pilots and Anchor Institution Charter development progressing. Q4 focus on Youth Voice event and framework implementation.
Welsh Language (3D)	**High** Operational delivery of Welsh Language Standards underway; training programme in development. Q4 focus on Active Offer tools and strengthened assessments.
Objective 4: Improving Quality, Outcomes and Experience	
Prevention and Early Intervention (4A)	**High** Grant-funded healthy weight/smoking/arts programmes delivered. Social prescribing model codesigned; Wellbeing & Prevention Anchor Framework developed. Q4 focus on targeted improvement actions to increase vaccination uptake.

Primary Care (4B)	**Low** PCMW and Community by Design groundwork progressed with improved strategic coordination. Cluster footprint review delayed and federated models still in development. Q4 priorities include developing the transformation plan and defining federation footprints.
Community Care (4C)	**Low** Enhanced Community Care (ECC) referrals increased in Conwy; DN and palliative weekend capacity strengthened. Business cases for expanded services progressing slower due to resource constraints. Q4 will focus on DN establishment review and expanding ECC participation
Planned Care / Cancer / Diagnostics (4D)	**Low** **Planned Care -** Validation, referral optimisation and POA workstreams progressed with early performance benefits. Full recovery limited by workforce, national programme delays and cost constraints. Demand/capacity modelling and integrated planning elements re-phased to 2026/27. **Cancer Care** - Additional endoscopy/dermatology capacity; nurse-led colorectal triage; teledermoscopy expansion. 25% reduction in >62-day waits; Maggie's Centre opened; repatriation of radiotherapy services. Q4 focus on improving waits for breast, skin and endoscopy pathways **Diagnostics** - RISP implemented. Estates limitations and national delays affecting pathology and endoscopy plans. Q4 focus on 8-week target delivery and operationalising key improvement projects.
UEC (4E)	**Medium** Hospital flow improvements achieved through early Optimal Flow actions. Falls Response and Frailty models progressing but not yet implemented. Q4 preparation for 45-minute handover protocol and acute frailty implementation.
Adult Mental Health and Learning Disability (4F)	**High** Improved access and quality; progress on RCPsych recommendations. MH EHR procurement advanced. Perinatal and eating disorder services strengthened. 80% seen within 28 days for primary care mental health.
CAMHS (4G)	**Medium** Workforce and training plans progressing; recovery plan implemented for East team. Getting Started groups launched; weekly tracking and early-warning systems in place. Q4 priorities include daily monitoring and sustaining Part 1b recovery.
Neurodevelopmental (4H)	**High** ND training expanded; early help hubs reducing demand on specialist pathways. Needs-led model and early help approaches progressing with RPB partners. High demand persists despite

	pathway redesign and prudent assessment changes. Q4 focus on monitoring impact and embedding new practices regionally.
Dementia (4I)	**Low** ED improvement actions begun. Training, prevention resources and Memory Support Pathway strengthened; multiple pilots underway. Q4 will enhance delivery monitoring and patient/carer experience actions.
Challenged Services (4J)	**Medium** the overall delivery confidence for the Challenged Services reflects an overall position, indicating steady progress with some areas requiring additional attention to strengthen delivery. Oncology and are on track for delivery in Q4 and under consideration for de-escalation from Special Measures. Orthodontics, Diabetes, Research & Innovation and Palliative Care, End of Life & Bereavement Care remain the highest risk for delivery. With Vascular, Ophthalmology, Dermatology, Urology, Plastics, Dental and Academy Careers rated as medium risk; reinforcing the need for escalation and focus to support.
A. Urology	**Medium** Interim out-of-hours IR cover; vasectomy commissioning approved; LATP biopsy rollout progressing; MyMR integration advancing. Q4 focus on completing IR SLA and finalising MyMR rollout.
B. Vascular	**Medium** Workforce training plan agreed; nurse-led urgent clinics; AAA surgeries commissioned out; audits informing improvement plan. Q4 priorities include audit group implementation and SOP rollout.
C. Dermatology	**Medium** Workforce pressures persist; teledermoscopy expanded; referral streamlining progressing; Connah's Quay capacity awaited.
D. Plastics	**Medium** Waiting times reduced; minor ops capacity increased; Connah's Quay development progressing; MWL waitlist handover planned. Q4 priorities include applying new PIFU guidance.
E. Oncology	**High** SABR Phase 1 live, improving access to advanced radiotherapy locally. Consultant recruitment remains challenging due to national shortages. Q4 focus on completing Oncology Strategy and progressing SABR Phase 2.
F. Ophthalmology	**Medium** HVLC model embedded in Centre; POAC rollout progressing; community optometry capacity significantly increased. West implementation paused, limiting consistent adoption across BCU. Q4 priorities include resuming West rollout and strengthening data quality.
G. Orthodontics	**Low** • GIRFT workshop clarifying priorities and informing future workforce planning. Capacity pressures remain due to limited

	consultant availability and rising demand. Q4 focus on sustainable service model design and waiting list validation.
H. Trauma & Orthopaedics	**High** SOS rollout commenced; showing strong impact on reducing unnecessary follow-ups. Q4 priorities include expanding SOS and standardising implant pathways.
Womens (4K)	**High** Women's Health Hub design complete with site/funding secured; digital maternity go-live 10 March 2026. Strong progress on MatNeo quality actions; workforce and KPI mapping advancing. Q4 focus on Hub implementation, digital maternity go-live and perinatal dashboard development.
Children and Young People (4L)	**High** Children's Charter implemented; Corporate Parenting Charter signed; Youth Voice Board development begun. Q4 focus on evidence consolidation, immunisation improvement and transition planning.
Pharmaceutical Services (4M)	**High** MPharm first cohort launched; hypertension community pharmacy pilot completed; pharmacy review actions still in early implementation.
Palliative Care, End of Life & Bereavement Care (4N)	**Low** Strategic PEoLC plan drafted; SWAN model pilot wards identified; SPC workforce review underway. Weekend SPC cover expanded; quality-improvement planning strengthened.
Dental (4O)	**Medium** Demand/capacity review in CDS progressing following contract award; CDS waits remain pressured due to demand and operational constraints. Q4 focus on domiciliary pathway design and CDS workflow improvements.
Diabetes (4P)	**Low** Baseline for 8 Care Processes established with early improvement. Q4 focus on reducing variation in primary care and strengthening MDT capacity.
Objective 5: Effective Environment for Learning and Skills Development	
University Partnerships (5A)	**High** MOUs progressing; preparatory work aligned with CSP development; strong partner collaboration.
Research & Innovation (5B)	**Low** Governance strengthened; programme focus on increased research activity and academic partnerships.
Academic Careers (5C)	**Medium** Community of Interest Group established to support academic career routes. Progress dependent on alignment with university partners and workforce plans. Q4 focus on progressing MoUs and strengthening career development pathways.
Intelligence-Led (5D)	**High** IRIS dashboard live with predictive analytics and RPA proposals advancing. Q4 focus on expanding analytics capability and progressing automation projects.

Learning Organisation (5E)	**High** Integrated Concerns & Complaints Policy embedding; Learning Forum and Repository maturing; thematic review processes strengthened. Q4 priorities include strengthening learning governance.

4 KEY RISKS / MATTERS FOR ESCALATION

4.1 There are areas of risk identified where confidence of delivery remains low, the majority of which sit within Strategic Objective 4. This area will require significant focus during the remainder of the year to ensure delivery expectations are met and clinical services are strengthened.

5 RECOMMENDATIONS

5.1 The Group is asked to:

RECEIVE ASSURANCE on the progress made during Quarter 3 and note the delivery confidence for the remainder of the financial year and endorse for onward review at PFIG and Board.

ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol Link to Strategic Priorities	Choose an item.
	All
	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: All
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)

Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals	Choose an item.
	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:	*N/A*
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:	*N/A*
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** Choose an item.	**Meysydd Ansawdd** **Domains of Quality** Choose an item.
	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	Choose an item.	

[Wellbeing of Future Generations Act – Wellbeing Goals]()	

Effaith Amgylcheddol / Cynaliadwyedd (5Rs) **Environmental /Sustainability Impact (5Rs)**	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
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:	N/A
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:	N/A
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:	N/A
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.

APPENDIX 1

Quarter 3- 2025/26 ADP Monitoring Report

January 2026

Annual Delivery Plan Quarter 3 - Overview by Sub-Objective

KEY:	High Delivery Confidence	Medium Delivery Confidence	Low Delivery Confidence	Complete

*Not delivered in expected quarter

Sub-Objective	Executive Lead	Overall Assurance of Delivery
1A Effective Systems of Governance	Director of Corporate Governance	Delivery Confidence

Action	Quarter
1A.9. Deliver a recovery plan to eliminate the backlog of overdue Learning from Events Report (LFERs, which are part of the claims and redress process with the Welsh Risk Pool), and embed a new process to ensure future timely submission and also a reduction in the number case LFERs that are 'red deferred' (which necessitate significant review and resubmission)	Q1
1A.4. Improve governance arrangements so they align to and support delivery of the organisation's strategic objectives and enable whole system quality-based decision making	Q2
1A.3. Develop a Governance Hub, Governance Toolkit and handbook and ensure that training and support is available for managers to understand the governance arrangements across the Health Board	Q3
1A.5. Conduct risk maturity audits to measure and strengthen risk management and risk governance to ensure consistency in risk management practices across the Health Board	Q3 *
1A.6. Complete the roll out of the three levels of the agreed risk management training	Q3 *
1A.7. Deliver the training and support to managers in application of the SOs, SFIs and SoRD, with specific focus on procurement in securing value for money and engagement with the wider market in placement of orders for goods and services	Q3 *
1A.8. Enhance the Accountability Agreements Framework with all staff who have responsibility for managing expenditure within the budget issued, for the purposes for which it was provided and adherence to the Health Boards approved SOs, SFIs and SoRD, specifically in regard to recruitment and commissioning of goods and services	Q3
1A.1. Develop and progress a Governance Improvement Plan to continuously improve governance arrangements, embedding recommendations from the 2024/25 Structured Assessment. The plan will include measurable actions to improve governance arrangements, ensuring that Board and Committee effectiveness is reviewed on an ongoing basis and improved accordingly	Q4
1A.2. Undertake an annual formal board effectiveness self-assessment in accordance with good practice	Q4

Overview

- The Effective System of Governance sub objective is based around nine core priorities delivering measurable improvements to existing governance arrangements through the creation of a Governance Improvement Plan, improved governance arrangements with additional training and support, together with strengthening risk management practices and governance across the organisation.
- Outputs from this work are expected to result in improved governance arrangements, whole system quality-based decision making, improved recruitment and commissioning of goods and services and eliminate the backlog of overdue Learning from Events Reports (LFER).

Current Position

- A Governance Improvement Plan to continuously improve governance arrangements has been established and is in place (1A.1)

- A Governance Hub, Governance Toolkit and handbook is now live and available on Betsi-Net, complemented by "Corporate Governance Masterclasses" led by the Director of Corporate Governance *(1A.3)*
- Governance arrangements have been strengthened throughout the year. This includes work with Health Board finance colleagues to clarify the Schedule of Reservation and Delegation and the Standing Financial Instructions *(1A.8)*
- The Executive Team received specific procurement training in November 2025, with further Tier 2 training planned for February 2026. In November 2025, the Board approved the Accountability Agreements Framework *(1A.7)*
- A decision-making framework, has been developed and further work to finalise it will be completed in Q4 *(1A.4)*
- Progress on risk maturity audits to measure and strengthen risk management and risk governance have progressed in accordance with the plan *(1A.5)*
- Delivery of the three levels of risk management training, and the establishment of a recovery plan for overdue Learning from Events Reports (LFERs) (1A.9) all underpin the Governance Improvement Plan.

Collectively, these activities demonstrate meaningful progress toward establishing a highly reliable governance environment, characterised by stronger controls, clearer accountability, and more consistent organisational practice.

Remainder of the financial year

- The annual formal Board effectiveness self-assessment will take place in Q4 *(1A.2)*
- Continued refinement and expansion of the Governance Hub and Toolkit, including additional training resources *(1A.3)*
- Once the 10-year strategy has been finalised, the Board Assurance Framework (BAF) will be refreshed and realigned to reflect the longer-term strategic direction. The corporate risk register will continue to be reviewed to ensure that correct actions are being taken to reduce risks
- All three levels of Risk Management Training will continue to be promoted *(1A.5-1A.6)*
- The draft decision-making framework will be completed following consultation *(1A.4)*

Impact

- Improved internal and external confidence in governance arrangements, supported by Audit Wales' Structured Assessment 2025, which confirms that a Governance Improvement Plan is now established, reflecting *tangible progress in strengthening core governance processes*
- Strengthened organisational governance environment, with delivery of 1A.1 supporting more effective corporate functions and contributing to improved assurance and confidence in governance among internal and external stakeholders
- Enhanced organisational understanding and consistency of governance practice, demonstrated by strong engagement with the Governance Hub, toolkit and handbook on BetsiNet, and by attendance of over 150 colleagues at each Corporate Governance Masterclass
- Closer alignment between strategic priorities and risk oversight, with the Board Assurance Framework (BAF) scheduled for refresh and realignment once the 10-year strategy is finalised.
- Improved quality and effectiveness of risk management, with ongoing review of the Corporate Risk Register (CRR); the January 2026 CRR will incorporate strengthened action clarity to support *actual reduction in risk scores*
- Increased organisational capability and confidence in risk governance, reflected in high compliance with all three levels of risk management training, including more than 700 staff completing Level 1 and Level 2 compliance progressing toward the 85% tolerance target
- More consistent, transparent and accountable learning governance, supported by strengthened oversight, centralised tracking, and proactive monitoring of Learning from Events Reports (LFERs), which collectively enhance the organisation's approach to learning from legal concerns

1B Establishing Foundations for the Future	Chief Executive	Delivery Confidence
1B.1. Conclude the Design Phase, having been through a process of co-design, testing and consultation, gaining formal approval to proceed to the delivery phase and implementation via the necessary governance		Q2 *
1B.2. Implement the first phase of the new operating model, completing the 2025/26 work plan across structures, strategy, people, processes and culture		Q3 *
1B.3. Develop the operating model work plan for 2026/27, including implementing the second and third phases and mechanisms to continue to monitor how it is being embedded and sustained across all aspects of structures, strategy, people, culture and processes		Q4

Overview

- The Establishment of the Foundations of the Future sub objective is about building an effective and sustainable organisation for the long term by ensuring the approach to five interlinked workstreams: Strategy, Culture, People, Process and Structures, are all aligned in the development of a new organisational operating model.
- The focus of the programme within this financial year consists of three priorities focusing on the final design, implementation and future development of the organisation.
- The programme is focused on making sure the Health Board has the most effective operating model to enable the best possible care for the people of North Wales with a shared ambition to work together to deliver the organisation's core purpose and strategic objectives with the right support and tools in place, to achieve this.

Current Position

- During 2025/26, the programme has focused on completing the Discovery and Design phases of the Foundations for the Future Programme, establishing the core organisational components required for a more effective operating model *(1B.1)*
- Discovery Report has been published, design principles formally approved by the Board, and 87 co-design/engagement events delivered across the organisation *(1B.1)*
- All five workstreams: Strategy, Culture, People, Processes and Structures have developed and implemented detailed plans. They are covered in other areas of this reporting e.g., Strategy under 2A and this section therefore focuses on the structures workstream. *(1B.1)*
- Examples of delivery in these workstreams include rollout of the Values and Behaviours Framework, culture diagnostics, leadership frameworks, co-creation of Strategic Intentions and approval of a revised Integrated Planning Framework *(1B.2)*
- The Structures workstream has: Finalised proposed corporate and service structures, refreshed executive portfolios, progressed costings, legal advice and supporting documentation, prepared Board and consultation materials, paper submitted and approved at formal Board in January 2026 with structured consultation to follow *(1B.1)*
- While structural change has not yet been implemented, the programme has delivered the required governance, design coherence and organisational readiness to move into delivery *(1B.2)*

Remainder of the financial year

- Finalising Board papers and completing financial and legal assurance *(1B.1)*
- Commencing formal consultation under the Organisational Change Policy *(1B.1)*
- Advancing implementation planning across all workstreams, supported by Programme Board oversight
- Executive Director cascade conversations continuing *(1B.2)* following the early socialisation of the proposed structures and subsequently supported by Executive Directors meeting with direct line reports to recap the case for change, discuss the proposed structures, identification of staff pools and potential JD's, and anticipated timelines.
- Progressing early adopter activity, career conversations, job family standardisation and culture-focused actions to support a safe transition
- Further iterations of communications and engagement plan being developed and embedded, including providing information and encouraging staff engagement through a dedicated FFTF Hub on the intranet
- Strengthened governance and programme planning through on-going review and updates
- Continuing to ensure products are defined and implemented through programme assurance documentation such as product descriptions and delivery plans management
- Continue structured implementation planning

Impact

Once implemented the programme seeks to have the following direct / indirect impact

- Improvement in the culture of the organisation
- Increased patient outcomes and experience through improved regional working
- Increased staff morale
- Create an effective organisation that delivers value through positive patient outcomes and financial stability

1C Responding to Legislative Requirements	Director of Corporate Governance	Delivery Confidence
1C.3. Improve processes to prepare for, respond to and embed learnings from any requests made by national Inquiries		Q2
1C.5. Develop options for the introduction of an organisational wide system for monitoring audit recommendations		Q2
1C.6. As an Operator of Essential Services, implement any actions required resulting from the forthcoming Cyber Security and Resilience Bill		Q2 *
1C.1. Complete a review of the current arrangements in relation to Regulatory Assurance to ensure the governance arrangements are robust and demonstrate improvements in compliance		Q3 *
1C.2. Re-establish the legislation library, processes to capture new legislation, the dissemination of that legislation to the relevant areas of the Health Board and the development of plans to deliver any necessary changes		Q3 *
1C.7. Develop a Health and Safety Improvement Plan ensuring improvements are made to the Health Board's current Health and Safety Policy, guidance and practices		Q3
1C.4. Implement the Health Board's Three-Year Plan based upon the Health and Safety Executive (HSE) HSG65 Plan, Do, Check, Act process methodology		Q4
1C.8. Develop a robust system of audit and action which informs the Health board's readiness and implementation of the latest Medical Devices and Procurement Regulations		Q4

Overview

- The Responding to Legislative Requirements sub objective is based around eight core priorities delivering measurable improvements to regulatory assurance through the extensive review of current arrangements, improved processes for the preparation, response and implementation of requests from inquiries or new legislation.
- Outcomes from this work are expected to result demonstrate legislative compliance, and drive improvements to the Health Boards current policies, guidance and practices.

Current Position

- Improvements have been made in processes to prepare for, respond to, and embed learning from national inquiries, including the establishment of a Discovery and Learning Group, with Terms of Reference approved in August 2025, and an approved referral process and effectiveness review (1C.3)
- Options have been developed for a Health Board-wide system for monitoring audit actions, ensuring improved tracking and oversight of compliance-related activity (1C.5)
- Progress continues in implementing the Health Board's Three-Year Plan aligned to the HSE HSG65 Plan and associated development of Health and Safety policy, guidance and practices (1C.4, 1C.7) work may carry over into Q1.

Remainder of the financial year

- Legislative compliance is critically important to ensure the Health Board operates legally, ethically and in a way that prioritises patient well-being.
- A review of current arrangements relating to Regulatory Assurance has commenced to strengthen governance and demonstrate improvements in compliance. This includes a review by the Director of Corporate Governance of the Terms of Reference for the Regulatory Assurance Group (1C.1)
- Re-establishing the Legislation Library, introducing processes to capture new legislation, disseminating it across the organisation and developing plans to implement any required changes (1C.2). Further work is required to determine the most appropriate system for capturing and managing legislative requirements; this may continue into Q1 2026/27, and a short-term interim solution may be needed (1C.2). An extended period is required to source and procure a value for money compliance management system that meets a number of Health Board requirements.

- A compliance management system is necessary to meet a number of requirements such as legislative and regulatory compliance, audit, risk and policy management. Welsh Health Board approaches to compliance management systems are being considered in Q4, with a range of options under consideration (1C.8). Updates will continue to be provided during Quarter 4 by Health and Safety colleagues to ensure continued progress and compliance with legislation (1C.4, 1C.7)

Impact
- Improved response to legislative requirements strengthens organisational effectiveness and helps enable services to improve the health and well-being of the population of North Wales
- Stakeholder and public confidence is expected to increase as governance arrangements become more robust and compliance becomes more visible
- Enhanced readiness to respond to new legislation and learn from national inquiries ensures the organisation can apply learning to improve care and outcomes
- Continued strengthening of Health and Safety arrangements supports safer environments for patients, visitors and staff

1D Implementing the Quality Management System	Executive Director of Nursing and Midwifery	Delivery Confidence
1D.2. Complete a series of communication exercises and briefing sessions to keep BCUHB workforce informed about QMS utilising an educational and myth busting approach designed to strengthen knowledge and understanding of QMS ** This objective has already been completed		Q1
1D.1. Ratify a standardised QMS Maturity Assessment for Health Board services and development of a governance framework to enable operationalisation and agree an associated rollout plan		Q2
1D.4. Evaluate the Heath Board's design and implementation of the QMS		Q2
1D.3. Integrate a QMS approach into the approach to Clinical Services Planning and early identification of challenged services		Q3 *
1D.5. Improve the quality of estates infrastructure and buildings through (*Linked to 2C.5*)		Q4

Overview
- The implementation of the Quality Management System (QMS) sub-objective consists of five priorities delivering standardised QMS maturity assessments across the Health Board, development of governance frameworks, mobilisation and implementation planning across the health board, integration of QMS into Clinical Service Planning and Challenged Services and evaluation of the Health Boards design and implementation of the QMS.
- Outputs from this work are expected to result in strengthened knowledge and understanding of the QMS across the BCUHB workforce.

Current Position
- Digital QMS maturity assessment tool developed, iterated, and internally tested since December 2024 (1D.1)
- Rolled out to Challenged Services and is being extended to Clinical Services, supported by a transition from SharePoint lists to a more robust platform to support future growth (Dataverse) improving scalability (1D.1)
- The tool has helped services establish baselines and plan improvement activity and has positioned BCUHB as a leading implementer of QMS across NHS Wales, with recognition from QSE, senior nursing leadership, the Chief Nursing Officer, NHS Improvement and Performance, Audit Wales and Internal Audit (1D.1, 1D.4)
- A full programme of communication exercises and briefing sessions has been completed, successfully informing the BCUHB workforce about QMS through an educational and myth-busting approach designed to enhance knowledge and understanding (1D.2)

Remainder of the financial year
- Work will continue to focus on ensuring alignment with the organisational restructure and supporting services to engage at pace, with coordinated activity between the QMS Project Group and the Foundations for the Future Project Group *(1D.3–1D.4)*
- Early adopters have begun their QMS journey, enabling data collection to begin across parts of the organisation *(1D.1–1D.3)*
- The programme remains well positioned to maintain momentum through year-end, with risks actively managed and organisational alignment strengthened *(1D.1–1D.5)*

Impact

- QMS maturity assessment tool has helped services establish baselines and improvement priorities, with widespread recognition strengthening organisational credibility and influence in quality management
- Improved patient safety and outcomes through systematic design, monitoring and improvement of care processes
- Increased consistency and standardisation, reducing variability and duplication and supporting predictable care delivery
- Stronger governance and accountability, with clearer roles and escalations aligned with statutory duties such as the Duty of Quality (Wales)
- More proactive risk management, enabling early identification of risks and regulatory compliance
- Enhanced staff engagement and culture, with increased empowerment and shared responsibility for improvement
- Increased financial and operational efficiency through reduced waste, duplication and rework

Annual Delivery Plan Quarter 3 - Overview by Sub-Objective

KEY:	High Delivery Confidence	Medium Delivery Confidence	Low Delivery Confidence	Complete

*Not delivered in expected quarter

2A Developing and delivering a Health Board Strategy and Clinical Services Plan (CSP)		Executive Director of Transformation and Strategic Planning	Delivery Confidence
2A.5	Complete phase 1 of the CSP focusing on services that are currently assessed as most challenged. This will develop well rounded plans based on a Quality Management System (QMS) approach, prioritising service improvements that can be made in the short to medium term in order to stabilise these services		Q3 *
2A.1	Work with partners to develop a high-level Strategic Intent for North Wales that will provide an outline of the joint priorities and areas of collaboration for the next 10-Years		Q4
2A.2	Complete the diagnosis phase of the 10-Year Strategy development including agreement on the scope and development of a baseline assessment setting out a summary of the population health needs; performance; drivers for change; outcomes and quality standards		Q4
2A.3	As part of the broader engagement on strategy development, review the Health Board Well-being objectives, ensuring continued alignment with the requirements of the Well-being of Future Generations (Wales) Act 2015 and Social Partnership and Public Procurement (Wales) Act 2023		Q4
2A.4	Maintain regular dialogue with partners and stakeholders to inform strategy development via partnership boards and stakeholder groups		Q4

NOTE: 2A.6 Develop a Digital and Data Roadmap is reporting through 2D – Enhancing digital, data and technology approaches

Overview

- This priority area is about developing the organisation's strategy and clinical services plan. It focuses on the three main strategy development products of 1) Co-creating a Strategic Intent with partners for the population of North Wales, 2) The Health Board's 10-Year Strategy, 3) Strategic Plans to deliver the 10-Year Strategy e.g. CSP.
- As part of the strategy development approach, it also covers a review of the Health Board's Well-being objectives and ensuring that partners and stakeholders are involved throughout the strategy development process.
- This work is vital in ensuring the organisation, it's staff and partners have a clear strategic vision for the Health board and supporting plans to achieve it over the next 10 years.

Current Position

- Work this year has focused on establishing the strategic foundations required ahead of the development of the full 10-year strategy and the CSP. A Draft Strategic Vision and 4 Strategic Intentions have been co-designed with partners *(2A.4)* and were approved by at Board in January as planned (2A.1). The intentions will replace the existing 5 strategic objectives, which were derived from the earlier Special Measures response plan and no longer reflect current organisational priorities or the realities of service delivery.
- Work has commenced on the 10-Year Strategy diagnosis phase, drawing on engagement findings, population health insight and system conditions identified through recent strategic discussions (e.g 8th October Strategy event co-hosted with the Bevan Commission) *(2A.2)*
- The refresh of the organisation's Well-being objectives was completed earlier this year, with a focus on the changes related to 'fair work'. A fuller review will be completed in 2026/27 as part of the 10-year Strategy development work *(2A.3)*
- Improvement plans have been developed and are in delivery relating to the Challenged Services under CSP Phase 1, with good progress made across a number of areas and two of the services (Oncology and Plastics) being considered for de-escalation *(2A.5)*
- Preparatory work for the CSP Phase 2 is also underway, including early scoping of priority pathways, identification of enabling requirements, and alignment with planning cycles.

Remainder of the financial year

- Continue to support improvements in the Challenged Services that form part of the CSP phase 1 and plan for their transition into the broader CSP work under phase 2 *(2A.5)*
- Focus will be on completing the diagnosis phase of the 10-Year Strategy and preparatory work for phase 2 of the CSP, in readiness for entering design phase in 2026/27 *(2A.2)*
- Continue to engage with partners and stakeholders, as well as staff and communities in all of the strategy development programme *(2A.4)*

Impact

- Collectively, these activities ensure that the organisation is progressing in line with the overarching aim of establishing a coherent, evidence-based strategic direction that can guide service redesign and investment as the detailed strategy and CSP are produced
- Work undertaken to develop BCUHB's draft vision, Strategic Intentions and initial mobilisation of the Clinical Services Plan (CSP) has produced some early benefits, mainly in strengthening shared understanding, improving alignment, and preparing the system for more detailed planning through integrating the SIs into the forthcoming IMTP
- From a quantitative perspective, measurable population-level outcomes are not expected at this stage. However, the process has engaged a broad range of clinical, operational and strategic stakeholders, helped identify service areas with potential for community-based delivery, and provided a structured foundation for the next phase of pathway redesign through the CSP

2B Strengthening Planning and Commissioning	Executive Director of Transformation and Strategic Planning / Director of Performance and Commissioning	Delivery Confidence
2B.6. A review of insourcing/outsourcing contracting will be undertaken leading to a plan for improvement and development		Q1 *
2B.1. Develop proposals to enhance capacity and capability for organisational wide planning, building upon the action plan produced following the Independent Review of Planning in 2024/25.		Q2 *
2B.4. Undertake a review of current and future commissioning commitments, drawing out the capacity required. This will form a baseline from which feasibility, risk and inter-dependencies can be assessed.		Q3 *
2B.2. Conduct a review of learning with stakeholders of the most recent planning cycle, updating the Integrated Planning Framework with any associated improvements and implementing them in the next planning cycle.		Q4
2B.3. Complete the National Planning Maturity matrix assessment and incorporate the outputs into the plans to improve the organisation wide planning system and capability		Q4
2B.5. Conduct a Third Sector review, undertaking a review of unit price and contract currencies within contracts and complete an exercise to ensure that the standard and consistency of commissioned documents and processes meets expected standards.		Q4

Overview

- The Strengthening Planning and Commissioning sub-objective is about ensuring the organisation has effective planning and commissioning at the heart of service design and delivery, to provide more effective and sustainable services for the population of North Wales.
- There are several different aspects to the work with the overarching aim of improving the organisational capability in this space.
- There are two elements to this; one on Planning, informed by the Special Measures independent review of planning, and the other on Commissioning, with some specific reviews of commitments, Third Sector and insourcing / outsourcing contracting.

Current Position

- The organisation continues to strengthen its planning capability, building on the improvements made over the last year and aligning planning and commissioning commitments to support more effective and sustainable services for the population of North Wales *(2B.1)*
- Further progress has been made to enhance organisational planning capacity and capability, informed by recommendations from the Independent Review of Planning. Work to develop core planning competencies for key roles is underway and continues to mature *(2B.1)*
- Approval of the Integrated Planning Framework (IPF) by the Board in November 2025 represents a key organisational achievement, demonstrating commitment to embedding learning and structured improvement from previous planning cycles *(2B.2)*
- The IPF has now been incorporated into the current planning cycle, supported by learning from Board Development Sessions, CEO–Executive 1:1s, and broad engagement with internal and external stakeholders *(2B.2)*
- The National Planning Maturity Matrix self-assessment has informed an organisational action plan that is now embedded within forward planning processes and is supporting improvements in planning maturity across the system *(2B.3)*

- Commissioning activity has been central to the delivery of in-year planned care long-wait reductions, with further essential components of the commissioning portfolio scheduled for progression across Q3 and Q4 *(2B.4)*
- Leadership of the Commissioning portfolio has now transferred to the Executive Director of Finance, providing strengthened strategic oversight and clearer accountability for advancing commissioning workstreams *(2B.4 / 2B.5 / 2B.6)*

Remainder of the financial year

- Ongoing work will focus on developing and strengthening planning capacity and capability across the organisation, ensuring alignment with the Foundations for the Future programme, as this defines future operating models and requirements (2B.1 / 2B.2 / 2B.3)

Impact

- Collective work to build planning capability has now been incorporated into organisational approach to planning, supporting a strengthened culture of planning throughout the organisation
- Adoption of the IPF and development of service-level plans aligned to the IMTP have contributed to a more consistent, structured and collaborative approach to planning across services
- Early impacts are evident in the development of the current IMTP, where engagement and shared ownership across clinical and operational teams have improved the quality and integration of planning outputs
- While there remains work to complete, the shift toward more cohesive organisational planning is progressing and is beginning to influence how services plan, prioritise and collaborate

2C Improving the Environment, Estate and Facilities	Director of Environment and Estates	Delivery Confidence
2C.1. Review the schedule of prioritised business cases in light of the outcome of the all-Wales capital prioritisation exercise		Q1
2C.3. Align ambitions relating to Health and Wellbeing Hubs to available capital funding. These play an important role in the Health Board's plans relating to primary care, the medical school, partnership working and shift left.		Q2
2C.8. Provide leadership in the identification, prioritisation and delivery of schemes through the Integration and Rebalancing Capital Fund (IRCF), including participation in the Regional Partnership Board (RPB).		Q2
2C.7. Work with the Bangor University to support the development and growth of the North Wales Medical School.		Q3
2C.9. Undertake a comprehensive assessment of facilities standards and performance, informing at improvement and development plan.		Q3
2C.2. Progress work in relation to major capital schemes including prioritisation of: Orthopaedics Hub in Llandudno, Electrical Infrastructure at Glan Clwyd Hospital, Royal Alexandra Hospital in Rhyl, Ablett Mental Health unit in Glan Clwyd Hospital, Nuclear Medicine consolidation, Health and Well-being hubs, decarbonisation and anti-ligature work.		Q4
2C.4. Develop and commence implementation of a fit for purpose estates strategy to include estate rationalisation, decarbonisation and climate resilience, as well as maximising the potential and use of existing estate and opportunities with partners. Acknowledging that the estates strategy will be led by and informed by the Health Board's 10-Year Strategy and Clinical Services Plan.		Q4
2C.5. Maximise the potential of strategic disposals, partnership work and resultant capital receipts to reinvest in a modern and fit for purpose estate and infrastructure.		Q4
2C.6. Support organisational business continuity through the capital process, including the Wrexham Maelor and Ysbyty Gwynedd business continuity cases.		Q4
2C.10. Complete the Welsh Government Adaptation Climate Change Risk Assessment, develop an action plan to address the risks identified, utilising the adaptation toolkit and liaising with PSB and other key partners.		Q4
2C.11. Build strategic relationships with partners including Local Authorities and Third Sector organisations to understand the opportunities to collaborate and implementation routes.		Q4
2C.12. Install onsite renewable energy generation facilities where viable to do so		Q4

Overview

- The Improving the Environment, Estate and Facilities sub- objective consists of 12 priorities based around multiple areas to; identify, prioritise and deliver schemes through the Integration and Rebalancing Capital Fund (IRCF), review current standards and performance of existing estate, inform future developments whilst maximising potentials from strategic disposals, enhancing efficiencies and opportunities especially around business continuity, whilst minimising contributions too and impacts from climate change.

Current Position

- A business case has been developed for the North Wales Medical School and the approach has been agreed with the WG Capital Team and a Programme Business Case approved by the Health Board. This continues to be progressed *(2C.7)*.
- The major capital schemes continue to be progressed but are subject to various challenges, which are being addressed on a project specific basis. Positive progress has been made on Orthopaedics Hub in Llandudno, Electrical Infrastructure at Glan Clwyd Hospital, Royal Alexandra Hospital in Rhyl, Nuclear Medicine consolidation, Health and Well-being hubs, decarbonisation and anti-ligature work. Challenges relating to the Ablett Mental Health unit in Glan Clwyd Hospital remain to be addressed *(2C.2)*
- The Health Board continues to explore estate rationalisation opportunities, though there are challenges relating to understanding current space utilisation and the opportunities to release space. The future development of clinical strategies and integrated approaches, such as, Health and Well-being hubs will support this further *(2C.4)*
- The business continuity works at YG and WMH continue to be progressed; however, these are phased multi-year schemes *(2C.6)*
- Onsite renewable energy projects are being integrated into schemes wherever possible, including the Royal Alexandra development and the Orthopaedic Hub in Llandudno. Stand-alone photovoltaic schemes are also being explored *(2C.12)*
- • The Health Board has continued to develop strategic relationships, though this remains ongoing. Examples include partnerships with RSLs, contractors and local authorities *(2C.11)*
- • Work continues on the delivery of the Climate Change Risk Assessment, but progress is affected by internal resource levels and internal skill sets *(2C.10)*
- • A review of capital prioritisation has been completed, reflecting the outcomes of the All-Wales capital prioritisation exercise (2C.1)
- • Progress on the review of facilities will be limited, as the delivery of facilities services currently remains within IHCs directly. However, work is underway to coordinate a wider review of car parking delivery and to advocate for improved IPC equipment *(2C.9)*
- • Work has commenced to begin the process for capital prioritisation for the next financial year *(2C.1)*

Remainder of the financial year

- Progress to improve the environment, estate and facilities will continue, alongside the proactive delivery of developments within major change programmes. This will include using audit findings and feedback to support continuous improvement
- Activity in several areas, particularly at locality level, will remain dependent on the outcomes of the Foundations for the Future work
- Continued progress will depend on the availability of specific resources and on developments in clinical strategies and the data relating to the current estate

Impact

- Demonstrable progress has been made across major capital schemes and Health and Well-being Hubs, with these programmes now embedded within the organisation's key programmes.
- These programmes are subject to formal scrutiny through SPSCG and the Mental Health Oversight Board
- Work is underway to develop and initiate a fit-for-purpose Estates Strategy covering estate rationalisation, decarbonisation, climate resilience and strategic disposals, aligned to agreed programme timescales. This work will continue into future years

2D Enhancing digital, data and technology approaches	Chief Digital and Information Officer	Delivery Confidence
2D.2. Develop a Digital and Data Roadmap to underpin the Health Board's clinical and organisational transformation		Q2
2D.12. Support the implementation and roll-out of the NHS Wales App for maximum impact and benefit to include the uptake of its use for repeat prescriptions		Q2
2D.14. Develop a clear cyber response plan for the organisation		Q2 *
2D.1. Secure a multimillion-pound investment from Welsh Government for the EHR Transformation Programme which will reduce paper records and be a key enabler for service transformation.		Q3 *

2D.3 Delivery of a digital maternity EHR and patient facing app, which will eliminate paper records.	Q4
2D.4. Completion of the implementation of the replacement diagnostics systems, RISP and LIMS.	Q4
2D.5. Procurement and delivery of Phase 1 of the Mental Health EHR programme informing the wider EHR transformation agenda.	Q4
2D.6. Complete the Therapies Manager System developments and increase the user satisfaction rating through Floorwalking and Engagement Teams.	Q4
2D.7. Complete the minimum viable recruitment of expertise to deliver basic 2020s DDaT services, appointing to all key funded posts within 25/26	Q4
2D.8. Effectively deliver, through strict prioritisation and effective resource management, the DDaT enabled portfolio of projects and programmes, with particular focus on benefits realisation. This exercise will include pausing or deferring some projects where necessary due to financial pressures.	Q4
2D.9. Complete delivery of phase 5 Welsh Patient Administration System (WPAS) including treatment function codes, cancer tracker, copy correspondence and patient numbering.	Q4
2D.10. Implement electronic Prescribing and Medicines Administration (ePMA) across acute sites	Q4
2D.11. Develop a proposal for Digital Academy training programme and launch a communications campaign so that staff feel empowered to use technologies.	Q4
2D.13. Eradicate unsupported systems and devices in line with available resources.	Q4

Overview

- The Enhancing Digital, Data and Technology approaches sub objective is based around 14 priorities each delivering several technological improvements or advancements into the organisation, the benefits of which will enable service transformation, improve patient safety, and reduce reliance on paper-based processes.
- The programme includes major projects such as Electronic Health Records (EHR), Mental Health EHR, electronic prescribing (ePMA), maternity systems, and diagnostics platforms, all of which are critical enablers for future integrated care.

Current Position

- The Outline Business Case for the Electronic Health Record (EHR) has been completed and secured local approval; however, the programme is paused pending the updated national roadmap due in 2027 *(2D.1)*
- Rollout of Electronic Prescribing and Medicines Administration (ePMA) has advanced, with the East Mental Health early adopter going live in December and providing learning ahead of the acute rollout from January–March 2026 *(2D.10)*
- Phase 1 of the Learning Management System (LMS**)** was delivered, and the training booking platform is ready for launch
- Diagnostics modernisation progressed, with RISP going live and entering stable operations, while LIMS continues to progress but has been affected by national build delays *(2D.4)*
- Digital resilience has improved through moving 80% of devices to Windows 11, identifying 3,500 replacements, and completing a Gartner TIME (Tolerate, Invest, Migrate, Eliminate) assessment of more than 380 systems, highlighting approx. 120 for safe retirement *(2D.13)*
- Supported delivery of WPAS Phase 5, advanced procurement for the Mental Health EHR, and contributed to development of the organisational Cyber Response Plan with the EPRR team *(2D.5, 2D.9, 2D.14)*

Remainder of the financial year

- ePMA rollout will continue across acute hospital sites, supported through the Learning Management System and reallocation of resources (2D.10)
- Work will progress to replace 3,500 unsupported devices and operationalise the decommissioning of around 120 legacy systems *(2D.13)*
- The organisation-wide Cyber Response Plan will continue to move through governance *(2D.14)*
- Diagnostics actions include closing down the Radiology Programme to BAU by February 2026 and working with DHCW to address LIMS build and testing delays supported by local financial contingency proposals *(2D.4)*
- The Mental Health EHR Procurement Outcome Report and Business Case Addendum were approved at the January Private Health Board meeting. Next step will be to request Welsh Government approval to award the contract. This will be actioned in collaboration with Cwm Taf University Health Board (2D.5)

- WPAS Phase 5 work will continue through cancer-tracking testing released in January and securing a clear Q4 plan with DHCW to strengthen delivery confidence *(2D.9)*

Impact

- Digital infrastructure reliability, safety and resilience have already improved across North Wales as a result of 2D programme delivery
- Early ePMA go-live has strengthened medicines administration processes, reducing risks associated with handwritten prescribing and improving consistency for patients
- Implementation of the new RISP platform is enabling quicker, more reliable access to imaging information
- Replacement of unsupported devices and identification of obsolete systems is reducing cybersecurity risk and improving system performance for clinical teams
- Improvements to the NHS Wales App, particularly around referrals and outpatient reminders, are supporting better communication with patients and helping ensure timely attendance

2E Developing and delivering value and sustainability	**Executive Director of Finance**	**Delivery Confidence**
2E.3. Build on work to embed value principles into the wider organisational frameworks: planning, commissioning, multi-professional workforce modelling, performance, leadership and quality.		Q2 *
2E.1. Design and deliver a refreshed value and sustainability programme for 2025/26, which has clear outcomes based on broader measures of value, to deliver qualitative, performance and financial improvement. This includes delivery of nationally aligned initiatives under the five workstreams of: Clinical Value, Workforce, Continuing Healthcare, Medicines Management and Non-Pay and Procurement.		Q4
2E.2. Focus on Clinical Variation to take advantage of nationally identified opportunities to expedite reductions in waste, harm and unwarranted variation.		Q4
2E.4. Design a value training programme as part of the journey towards a Value Academy for North Wales and a longer-term commitment to building knowledge and capacity in delivering value-led improvement.		Q4

Overview

- The Developing and delivering value and sustainability sub objective is based around four priorities: Delivering a refreshed value and sustainability programme, maximising opportunities to reduce waste, harm and clinical variation ultimately building knowledge and capacity in delivering value-led improvement into the wider organisational frameworks.
- The programme consists of the following workstreams: 1) Medicines Management 2) Continuing Health Care (CHC) 3) Workforce 4) Non-Pay & Procurement 5) Clinical Variation & Service Reconfiguration 6) Value-Based Health Care

Current Position

- A new programme of delivery (as part of the four Major Change Programmes for 25/26) has been developed and initiated, replicating the national programme structure of five workstreams, and extended in-year to mirror the addition of Value-Based Health Care as a sixth mandated workstream *(2E.1)*
- Programme initiatives address nationally identified areas of opportunity through the Value & Sustainability Board, national workstream sub-groups, and Cabinet Secretary "Enabling Actions" in the National Planning Framework 25/26 *(2E.1)*
- The programme's primary function to date has been to identify, quantify and deliver the Health Board's £40m savings target, with a year-end forecast of £44.9m (over-delivery of £4.9m) and £36m delivered year-to-date (over-delivery of £4.5m) *(2E.1)*. A pipeline of £5.4m schemes has been identified for the 26/27 programme *(2E.1)*
- The programme also manages a portfolio of value-improvement schemes funded through ring-fenced Value-Based Health Care monies. Several projects have received local and national recognition, including the Lymphoedema Project winning the NHS Award and the Prehabilitation Project winning the Research, Transformation & Innovation Award *(2E.4)*
- Work is progressing to embed Value & Sustainability principles into organisational architecture, with Foundations for the Future acting as the mechanism to accelerate this cultural shift. Operating Principles have been rewritten through a value-lens, and a new competency framework for senior management has been created *(2E.3)*
- The value team now has increased visibility within the IMTP Development Collaborative Planning Group, supporting a value-led approach to planning *(2E.3)*
- Capability building continues, including promotion of the Value-Based Health Care Academy at Swansea University to strengthen staff subject-matter expertise *(2E.4)*

Remainder of the financial year

- Oversight of delivery of the remaining forecast £9m Q4 savings and identification of any further opportunities for in-year acceleration or inclusion in 26/27 plans *(2E.1)*

- Facilitate development of a dedicated Clinical Variation Workstream in early Q4 and develop a 26/27 programme delivery plan focused on wider value metrics (productivity, efficiency, outcomes, experience) and pathway redesign. Inaugural meeting set for February 2026, chaired by the Executive Medical Director, with full-time V&S team support *(2E.2)*
- Continue embedding value principles into organisational architecture through Foundations for the Future, including value-led planning, commissioning and performance frameworks. Significant progress has been made but may require inclusion in the 26/27 IMTP *(2E.3)*

Impact

- The programme is forecast to over-deliver by £4.9m, contributing positively to the Health Board's financial duty to break even and supporting the conditions for recurrent release of £42m Performance & Transformation Funding *(2E.1)*
- Value-funded projects show significant improvements in clinical quality and outcomes. As an example, the Cancer Prehabilitation Programme has delivered: 1,200 bed days saved, 560 HDU bed days saved, 30% reduction in post-operative complications, 5% reduction in readmission rates, reduced anxiety and depression, reduced mortality, improved functional scores, and 100% PREMs score (9+)

2F Improving workforce planning and development	Executive Director of People Services and Organisational Development	Delivery Confidence
2F.1. Fully embed the training programme for workforce planning across the organisation with easy access guides and how to access support for teams to develop their plans.		Q2 *
2F.5. Conduct a comprehensive workforce analysis for therapy services in a prioritised manner.		Q2 *
2F.8. Fully implement Variable Pay and agency control framework and ensure a 30% reduction in agency expenditure during 2025/26. This will be supplemented by no off-contract expenditure and reductions to zero spend for specific staff groups		Q2 *
2F.9. Ensure effective implementation of job planning policy to include ensuring that 90% of all Consultants have an agreed job plan in place at all times		Q2 *
2F.3. Develop a suite of workforce planning tools to support teams and services develop and maintain their workforce plans.		Q3 *
2F.4. Develop an organisational strategic workforce planning framework, including integration into the other relevant organisational frameworks such as Planning and Quality.		Q3 *
2F.6. Development of therapy services plan, contributing to new clinical service models to support reductions in waiting times.		Q3 *
2F.10. Reduce sickness absence levels through adherence to key policies such as Attendance at Work		Q3
2F.2. Detailed workforce plans to be in place for all key services across the organisation.		Q4
2F.7. Develop a Governance Framework to guide the operationalisation of the HEIW Professional Framework for Enhanced, Advanced and Consultant Clinical Practice in Wales (for HCPC registered professionals)		Q4

Overview

- The Improving workforce planning and development sub objective includes 10 priorities delivering a wide range of benefits for the organisation.
- Outputs from this workstream includes ensuring detailed workforce analysis and plans are in place supported by a suite of framework documents, planning tools, guidance and training. These outputs will be enablers to deliver better outcomes for patients like improved access to services, seeing the right clinician first time etc Resulting in measurable reduction in agency expenditure, effective job planning and reduced sickness levels together with better outcomes for patients, improved access to services and ensuring the right care in the right place at the right place.

Current Position

- Draft Strategic Workforce Planning Framework developed and refined following Executive Committee feedback, with further review scheduled for February 2026 *(2F.4)*
- Workforce planning resources have been expanded, including templates aligned to the Skills for Health Six-Step Methodology and IMTP requirements *(2F.1 / 2F.3)*
- A new Betsinet guidance page has been prepared to provide accessible workforce-planning support once the Framework is approved *(2F.1)*

- Digital tools, such as, the Power BI Workforce Planning Intelligence Dashboard, O365 Forms, Teams channels, and Mentimeter have been deployed to support data capture and workforce-planning discussions *(2F.3)*
- The 6 B's Regeneration Framework Template and action plan being used across services, with a review planned for 2026/27 to streamline and integrate available tools *(2F.3)*
- Workforce Planning Dashboard has been aligned to key services, improving visibility and enabling more data-driven planning *(2F.3)*
- Training and support sessions have been delivered to People Services Business Partners, Allied Health Professionals (AHP), and Healthcare Science Professionals *(2F.1 / 2F.3)*
- Alignment with the Corporate Planning Team has strengthened through ongoing participation in the IMTP Development Collaborative Planning Group *(2F.4)*
- Engagement with key services has continued throughout the year, with early work begun with AHP and Health Science leaders on workforce and education commissioning analysis *(2F.5 / 2F.6)*
- A 19% reduction in agency usage has been achieved to date, supported by insourcing of the Medical Bank Team and continued optimisation of temporary medical staffing *(2F.8)*
- Workstreams continue progressing the Variable Pay and Agency Control Framework in support of achieving the 30% reduction target *(2F.8*
- Local Job Planning guidance is in development for release in February 2026 *(2F.9)*
- A baseline assessment and action plan to reduce sickness absence has been completed and approved by the People & Culture Committee *(2F.10)*

Remainder of the financial year

- The programme remains on track to deliver the majority of its overarching aim by March 2026, with improvements already achieved or foundations in place to complete outstanding components within this timeframe or early 2026/27
- The overall RAG rating reflects steady progress, with some areas requiring continued focus as work progresses

Impact

- Cost savings have been realised through more efficient deployment of staff and a reduction in reliance on temporary or agency cover
- Staff wellbeing has improved, supported by actions developed to reduce sickness absence
- Strengthened relationships between departments have contributed to smoother service delivery and more coordinated approaches to workforce, finance and service planning
- Organisational awareness of the importance of workforce transformation has increased, encouraging more strategic thinking about skills, roles and workforce models of the future

Annual Delivery Plan Quarter 3 - Overview by Sub-Objective

KEY:	High Delivery Confidence	Medium Delivery Confidence	Low Delivery Confidence	Complete

*Not delivered in expected quarter

3A Culture Development	Executive Director of People Services and Organisational Development	Delivery Confidence
3A.1. Fully implement and embed the Values & Behaviours Framework into our organisational policies, processes and practices so that staff live the values and behaviours in their day-to-day work.		Q1
3A.2. Conclude the Discovery phase of the Culture & Leadership Programme through a Synthesis Report which will guide our future culture and leadership approaches		Q2
3A.3. Co-produce draft Design phase priorities for further development in 2026/27 which shapes our compassionate, diverse and inclusive leadership approaches, identify what is going well and which areas need to be strengthened.		Q3
3A.4. Complete roll out of the Culture Change Leader (CCL) programme. The CCL role has been established to support the Culture & Leadership Programme. Leaders are drawn from a cross section of staff across the organisation who come together to make a difference by looking at the Health Board's current culture and helping to shape culture for the future.		Q3
3A.5. Build staff engagement through implementation of the staff engagement plan (including staff survey actions, staff stories, common PADR objectives (golden thread) and engagement events/activities) hard wiring engagement throughout leadership and management structures to the front line.		Q4
3A.6. Improve governance arrangements so they align to and support delivery of the organisation's strategic objectives and enable whole system quality-based decision making. This alongside using the RACI model (Responsible, Accountable, Consulted, Informed) in role profiles to describe individuals roles and responsibilities for activities and deliverables will support creating high autonomy and accountability across all roles.		Q4
3A.7. The Health Board will improve its systems and processes to ensure the transfer of learning as a Learning Organisation is increasing the opportunity to share learning and improve patient care.		Q4

Overview

- The Cultural Development sub objective is covers seven priorities aiming to deliver a number of benefits for the organisation.
- Outputs from this workstream includes implementation of a new values & behaviours framework into each organisational activity, production of a synthesis report which will guide our future culture and leadership approach and complete roll out of the culture change leadership programme.
- The Health Board is implementing the Kings Fund, Culture and Leadership Programme, with support from HEIW and the author Professor Michael West.
- Improved governance arrangements will support and align to the delivery of the organisation's strategic objectives.
- Anticipated outcomes include improved staff engagement, morale, and well-being leading to better patient care.

Current Position

- Continued delivery of the NHS Culture & Leadership Programme, evidence-based model developed by Professor Michael West, the King's Fund, the Centre for Creative Leadership and NHS Improvement (3A.2)
- The Culture & Leadership Programme Design Group, with representation across professional groups, continues to steer and contextualise the programme locally (3A.2)
- A network of Culture Change Leaders (CCLs) continues to support programme delivery and local culture change across services (3A.4)
- Extensive engagement has taken place to develop and launch the Values & Behaviours Framework (3A.1)

- Resources developed to embed the Values & Behaviours Framework include a training package, local pledges, Values self-reflection and feedback selfie tools, and a toolkit with guidance, links and examples of best practice (3A.1)
- A comprehensive socialisation and embedding plan is in place, ensuring the Framework is integrated into policies, processes and systems (e.g., leadership programmes, staff recognition, corporate induction, job adverts, ward accreditation) (3A.1)
- The scoping and discovery phase of the Culture & Leadership Programme has taken place using discovery tools to understand the organisation's current culture (3A.2)
- Insights from the discovery phase were presented in a Synthesis Report to Board in November, incorporating wider organisational data (SWSS, staff survey feedback, OD insights, Occupational Health data). An Improvement Plan on the future approach was also included in the synthesis report (3A.2)
- A final Improvement Plan will be presented to the People & Culture Committee in February, the next stages of design and delivery involve further developing the actions highlighted in the improvement plan (3A.2 / 3A.3)
- Development of workstreams will require wider engagement and co-design with Culture Change Leaders, SMEs and staff, with workshops planned to shape priority areas (3A.3 / 3A.4)
- Collaboration with HEIW and Professor Michael West to create an organisational case study on best practice, impact and learning, as BCUHB is the only NHS Wales organisation implementing the programme at organisational wide scale (3A.2 / 3A.4)

Remainder of the financial year

- Focus will shift to developing actions highlighted in the Improvement Plan within the Synthesis Report (3A.2 / 3A.3)
- Identified workstreams will require co-design and engagement from Culture Change Leaders, SMEs and staff across the organisation (3A.3 / 3A.4)
- Workshops will be scheduled to shape these priority areas in response to workforce-identified needs (3A.3 / 3A.4)

Impact

- Evidence demonstrates improved staff experience and engagement positively influences patient care, safety and financial outcomes
- A 0.12 increase in staff engagement correlates with a 0.9% reduction in agency spend, equating to savings of £1.7m for the average trust (NHSE data)
- Culture & Leadership Programme findings have been cross-referenced with NHS Wales Staff Survey 2024 data and insights from Foundations for the Future to explore themes including retention, patient safety and freedom to speak up
- Since programme commencement in August 2023, the BCUHB Culture Dashboard shows improvements across several cultural metrics, including best in Wales performance in sickness absence and PADR compliance
- Staff Survey 2024 outcomes show above-average results in four of the seven Engagement Index components, including: ability to make improvements, involvement in decisions about change, enthusiasm for work, going the extra mile
- The NHS Wales Staff Survey 2025 results are yet to be launched but BCUHB have seen an increase in response rates from 2024. This indicates staff feel more motivated to contribute to organisational improvement
- Culture Change Leaders report early signs of local-level positive impact, improved conversations, stronger connections and a growing shared sense of purpose
- Early indication shows an increase in NHS Wales Staff Survey response rates

3B Leadership Development	Executive Director of People Services and Organisational Development	Delivery Confidence
3B.3. Review and evaluate the first senior level programme – Glyder Fawr (Advanced Clinical Leadership Programme) delivered in 24/25 in readiness for the second cohort of this national HEIW led programme commencing at the end of Q1 25/26.		Q1
3B.5. Evaluate the outcomes from previous cohorts of the Mynydd Mawr – Foundations of Leadership and Management programme (delivered 24/25) to identify learning outcomes and impact in the workplace.		Q1
3B.1. Design a series of workshops to strengthen key areas of the Integrated Leadership Development Framework (LDF), with a focus on developing leadership skills in specific areas for example, workshops to embed the principles of compassionate leadership to enable leaders and managers to understand the benefits of a compassionate approach		Q2

and how to apply compassionate behaviours in the workplace and to support to leaders and managers to have conversations with their staff through a compassionate lens, to build confidence and skills in managing difficult or challenging situations.	
3B.6. Launch new programme 'Leadership for All – 'Moel Famau', providing an introduction to leadership for all staff across the organisation irrespective of whether they are in a formal leadership role.	Q2
3B.7. Develop a set of metrics and reports from the Leadership hub, to analyse: user engagement, themes, attrition rates.	Q2
3B.2. Develop a core programme/offering for middle managers and leaders across the organisation. To be aligned with the ongoing national strategy building a core management competency framework across NHS Wales working with Health Education and Improvement Wales (HEIW) and a range of academic partners.	Q4
3B.4. Undertake a review of BCUHBs Coaching and Mentoring Network which will include: - A review of the effectiveness of the coaching network to ensure there are sufficient coaches to meet demand, that coaches on the network are actively coaching, that appropriate resources and support /supervision is in place. - A toolkit will be developed to support mentors across the organisation along with a co-designed mentoring network proposal.	Q4

Overview

- The Leadership Development sub objective is based around seven priorities delivering a number of benefits for the organisation.
- Focus is directed around the further development of the Integrated Leadership Development Framework combined with review and evaluation of existing leadership programmes.
- Outputs from this sub objective include building core management competency frameworks across NHS Wales professionalising operational management and leadership across the organisation.

Current Position

- Successful launch and delivery of multiple leadership pathways including Learning to Lead and Manage and Fundamentals of Leadership & Management, with strong uptake and positive evaluation feedback *(3B.1/3B.2)*
- Advanced programmes, including the Advanced Clinical Leadership Programme, have demonstrated measurable improvements in confidence and leadership capability *(+32%) (3B.3)*
- Supporting initiatives such as the BCUHB Leadership Hub, People Managers Forum, and focused workshops on compassionate leadership and coaching continue to strengthen the organisation's leadership culture. *(3B.1 / 3B.4)*

Remainder of the financial year

- Progress partnership work with Powys Health Board to facilitate two Clinical Leadership Immersive Programmes for middle managers (3B.2 / 3B.3)
- Strengthen evaluation of leadership programmes through longitudinal studies and align development pathways with the forthcoming NHS Wales competency framework (3B.2)
- Continue work to address operational barriers to maintain programme momentum, including review of the coaching provision and development of the coaching toolkit (3B.4)
- Alignment of the Integrated Leadership Development Framework may need to move into the next financial year due to delays in the HEIW Core Management Competency Framework (3B*)*

Impact

- Early indicators highlight strong engagement and high satisfaction levels across leadership development activity *(average 4.6/5)*
- Direct measurable impact on patients or population outcomes is not yet evidenced; however, early signs of positive shifts are emerging in staff behaviour and organisational culture, typically precursors to improvements in areas such as patient experience, complaints, incidents, access and flow

3C Citizen engagement and partnership working	Director Of Partnerships/communications And Engagement	Delivery Confidence
3C.6 - Reset the Health Board's representation at the Regional Partnership Board establishing a structured reporting process to improve decision making		Q1
3C.7 - Trial a surgery-style approach with local councillors in two local authorities to support issue identification, evaluating its effectiveness in improving communication and engagement, with a view to expanding the approach across all local authorities		Q2 *
3C.8 - Further the Health Board's commitment to children and young people by developing an approach to ensure their voices influence decision making (Youth Voice approach). (*Linked to 4L.2*)		Q2 *
3C.3 - Expand the engagement programme across at least five North Wales communities, collaborating with key partners to ensure added value for residents, stakeholders and the Health Board.		Q3 *
3C.4 - Review the strategic approach to engagement with communities, specifically mapping out the next two years		Q3 *
3C.1. Complete implementation of the recommendations in the independent review of engagement specifically: - Finalise and implement the 'Betsi Way' engagement framework, ensuring it is evidence-informed, high quality, and co-developed with agreed engagement principles. - Implement a structured reporting system to track and publicly share at least three concrete examples of how community feedback has influenced corporate plans, services and improvements - Establish a community of engagement practice within the Health Board, providing at least two training sessions and developing a toolkit to support staff with best practices and evidence-based approaches.		Q4
3C.2 - Increase engagement reach by 30% through targeted on-line community interactions, including at least four digital campaigns and expanded use of social media platforms		Q4
3C.5 - Conduct at least three community listening events in rural areas, ensuring participation from at least 50 local residents, to gather feedback on healthcare needs and service improvements		Q4
3C.9 - Co-develop and publish an Anchor Institution Principles and Charter with clearly defined principles ensuring alignment with community needs and organisational priorities		Q4

Overview

- The Citizen engagement and partnership working sub objective is based around nine priorities delivering a number of benefits for the organisation focused on full implementation of the recommendations of the independent review of engagement.
- Outputs from this sub objective include expansion of engagement programmes across North Wales.

Current Position

- Targeted digital engagement and online campaigns have been delivered, supporting increased reach and visibility of engagement activity *(3C.2)*
- Place-based engagement has expanded across at least five North Wales communities, including rural listening events and partnership-led engagement, with insight captured through a structured monitoring framework *(3C.3 / 3C.5)*
- A more systematic approach to capturing, analysing and reporting citizen feedback has been implemented, including a routine monitoring report and the Citizen Experience and Engagement paper demonstrating how feedback influences plans, services and improvements *(3C.1)*
- The Betsi Way Engagement Framework has progressed through discussions at the PPHP Committee, Strategic Planning and Service Change Group, the Engagement Practitioners Forum and Llais, and is now entering a formal change-management process *(3C.1)*
- Engagement with the Regional Partnership Board (RPB) has been reset, with improved attendance, contribution and interaction with regional partners (*3C.6)*
- First local authority councillor drop-in pilot delivered in Ynys Môn, with a second pilot in Wrexham in development *(3C.7)*
- Anchor Institution Principles and Charter in development and progressing to plan *(3C.9)*

- Youth Voice work is progressing using a deliberate, co-produced approach, paced to reflect the availability and preferences of children and young people *(3C.8)*
- Engagement activity has strengthened trust and relationships with communities, partners and local authorities, improved relevance and quality of insight gathered, and increased transparency about how citizen feedback shapes decision-making *(3C.1–3C.9)*
- Engagement reach has increased through expanded digital activity, public engagement events, rural listening sessions and partnership-led approaches, evidenced through monitoring and reporting mechanisms *(3C.2 / 3C.3 / 3C.5)*

Remainder of the financial year

- Overall delivery risk is being actively managed, and there is moderate to high assurance that the overarching aim will be achieved
- Most priorities remain on track for delivery by year-end, including expanded engagement reach, strengthened reporting and assurance mechanisms, improved local authority engagement, RPB reset, and development of the Anchor Institution Principles and Charter
- Youth Voice activity will continue to progress at a measured pace, with a key milestone being the planned North Wales-wide youth leadership and co-design workshop in March 2026 *(3C.8*

Impact

- Strengthened trust and relationships with communities, partners and local authorities has improved the relevance and quality of insight gathered and increased transparency how citizen feedback is influencing decision-making
- More place-based understanding of local priorities, particularly in rural areas, supporting more informed planning and service development discussions
- Increased engagement reach through digital activity, public engagement events, rural listening sessions and partnership-led approaches, evidenced through monitoring and update reports
- Areas such as Youth Voice have progressed more slowly, than originally anticipated, reflecting a conscious decision to prioritise meaningful co-production and reducing the risk of tokenistic engagement *(3C.8)*
- Overall, the work has contributed to a more systematic, credible and visible approach to citizen engagement across North Wales

3D Welsh Language & Culture	**Executive Director of Allied Health Professionals and Health Science**	**Delivery Confidence**
3D.5. Promote the use of Welsh language within the organisation		Q1
3D.3. Explore the potential of adopting a 'Welsh Language Champions Programme' in order to encourage and celebrate language development success within the workforce.		Q2
3D.1 - Build on the planning completed within 2024/25 and transition from planning to operational delivery of the Standards and 'More than just words', focusing initially on acute settings.		Q3
3D.2 - Adopt the Language Choice Scheme to a specific vulnerable patient group.		Q3
3D.4. In collaboration with the National Centre for Learning Welsh, deliver a tailored training programme in Speech and Language Therapy Services, which have been identified as a priority workforce group.		Q3

Overview

- The Welsh Language and Culture sub objective is based around five priorities delivering a number of benefits for the organisation focused around transition from planning to operational delivery of the Welsh Language Standards within the Welsh Language (Wales) Measure 2011 and the Welsh Governments Strategic Framework for Welsh Language Services in the Health Care sector 'More than just words'.

Current Position

- The team has consolidated its reputation as a specialised provider of high-quality translation services to external organisations. This has not only enhanced the Health Board's profile and credibility in this area, but has also delivered tangible financial benefits through income generation, supporting the sustainability of the service and reinvestment in core activities *(3D.5)*
- All contractual commitments with the National Centre for Learning Welsh were successfully delivered, including structured training and in-depth support through the funded Learners' Officer role *(3D.4)*

- Targeted interventions strengthened implementation of the Language Choice Scheme among dementia patients in the West area, ensuring more consistent language-appropriate, person-centred care *(3D.2)*
- Collaboration with schools and further education colleges helped promote the Health Board as an employer that values bilingual skills, supporting long-term workforce planning aims and reinforcing the strategic importance of Welsh language skills in healthcare settings *(3D.3 / 3D.5)*
- A comprehensive programme of Welsh language training was delivered across clinical and corporate teams, tailored to service needs and strengthening compliance with the Welsh Language Standards *(3D.1 / 3D.4)*
- Welsh Language Week activities raised awareness of language needs and statutory responsibilities, reinforcing language as integral to safe, effective, compassionate care *(3D.5)*
- Expanded use of social media platforms to share patient stories, highlighted activities, and promoted Welsh-language initiatives, increasing visibility and engagement with staff, patients, and the public and reinforced the Health Board's commitment to bilingual service provision *(3D.5)*

Remainder of the financial year

Although all sub-objectives for 2025-2026 have been completed, the Welsh Language Team's focus from now until the end of March 2026 further strengthens the work already undertaken:

- Delivery of the Learner of the Year celebration event in March 2026 *(3D.5)*
- Completion and invoicing of the Translation Service Level Agreement with Aneurin Bevan University Health Board for 2025-26, with a further contract already agreed for 2026-27 *(3D.5)*
- Development and piloting of an Active Offer Toolkit to support clinical teams in offering services in Welsh at ward level *(3D.1 / 3D.5)*
- Strengthening the Welsh-language impact assessment within EQIAs to ensure Welsh language is embedded in policy decisions and service changes *(3D.1)*
- A patient story video on St David's Day outlining how the Health Board actively provide stroke services in Welsh *(3D.1 / 3D.5)*

Impact

- Expansion of translation services and fulfilment of external contracts increased service capacity and generated income, supporting sustainable delivery
- Training delivered through the Learners' Officer role increased staff participation and confidence in using Welsh, enabling more staff to offer Welsh-language services
- Engagement with local schools and colleges improved longer-term workforce pipelines by raising awareness of the value of bilingual skills in healthcare
- Greater social-media reach has raised public awareness of Welsh-language services and initiatives
- Strengthened Language Choice Scheme delivery improved experience and dignity for vulnerable groups, particularly patients with dementia
- Welsh Language Week activities and internal awareness-raising have reinforced a cultural shift, recognising language as integral to safe, effective care
- Overall, the work has strengthened the Health Board's ability to meet statutory Welsh language requirements and, critically, has delivered tangible benefits to the population by improving communication, inclusivity, and quality of care across a range of settings

Annual Delivery Plan Quarter 3 - Overview by Sub-Objective				
KEY:	High Delivery Confidence	Medium Delivery Confidence	Low Delivery Confidence	Complete

*Not delivered in expected quarter

4A Prevention and Early Intervention	Executive Director of Public Health	Delivery Confidence
4A.1. Implement plan to target resources for our the most vulnerable groups (e.g. – those experiencing homelessness, Gypsy, Roma and Traveller communities) which will contribute to reducing inequalities in healthy life expectancy		Q4
4A.2. Creating the foundations for change, providing the Health Board with the means to demonstrate the impact of current prevention and early intervention activity across identified priority areas and determine where this could be improved.		Q4
4A.3. Develop proposals for Health Board capacity to prepare and respond to health protection threats, enhancing the delivery of Health Board services to protect people in North Wales against existing, new and emerging health protection threats and hazards.		Q4
4A.4. implement the National Immunisation Framework (NIF) for Wales locally and continue to provide improved resilience and variation.		Q4
4A.5. Refer to 'Section 4P – Diabetes' for the 2025/26 delivery priorities.		Q4

Overview

- The majority of what the NHS sees now is a result of long-term conditions - all of which have modifiable factors, and the majority have significant preventable factors.
- Our focus must be on reducing the prevalence (the number of people with long term conditions) and reducing the progression of these conditions (reducing the severe complications of long-term conditions) if we are to stop and then reverse the current widening gap between healthy life expectancy and life expectancy.
- There are four areas of focus as established in the 25/26-27/28:
  1. Working with partners to address the wider determinants of health
  2. Reducing Health Inequalities
  3. Improving the ability of people to maintain healthy lifestyles
  4. Improving the wellbeing of the population"

Current Position

- Completed a weight management service review, which will inform development of future plans for 2026/27–2028/29 to support the population to achieve and maintain a healthy weight through targeted approaches *(4A.1 / 4A.2)*
- Delivered grant-funded plans focused on healthy weight, smoking cessation, healthy schools, and arts in health and wellbeing *(4A.1 / 4A.2)*
- Worked collaboratively with partners to develop plans for co-commissioned social prescribing from 2026/27, supporting wider access to services. *(4A.1)*
- Co-produced, with the Regional Partnership Board, the basis for a North Wales Wellbeing and Prevention Anchor Framework, recognising the role of anchor organisations in improving population wellbeing *(4A.1 / 4A.2)*
- Strengthened population health intelligence, research and evidence, producing evidence reviews that inform service development and action to prevention and health inequalities *(4A.2)*
- Development of the population needs assessment will support the development of the Health Board Strategy *(4A.2)*

Remainder of the financial year

- Significant challenges continue across Wales in achieving vaccination and immunisation targets; the V&I Team has taken proactive steps to improve access and delivery across North Wales, including staff vaccination during the autumn/winter flu and RSV campaigns *(4A.4)*. Areas for improvement have been identified, with solutions being developed to increase uptake in 2026/27, including the use of data and intelligence to reduce vaccine inequity among vulnerable groups and individuals *(4A.4)*

Impact

- 203 out of 219 care homes have received an Infection Prevention Control review (93%), with 55 IPC reviews completed in the quarter 3
- 178 of these received follow-ups (88%), with 83 follow ups completed in quarter 3
- Ongoing programme of Hepatits B&C sampling in probation approved premises: Target 200, 147 completed in Q3
- Exceeded community sampling target for 25/26
- This work supports disease elimination agendas (Hepatitis B, Hepatitis C, HIV, TB) and strengthens protection against existing, new and emerging health protection threats
- The Vaccination & Immunisation Team has delivered protection against flu, COVID-19 and RSV, alongside ongoing delivery of MMR and HPV programmes
- At Q2, BCU ranked 2nd in Wales for Childhood Immunisation targets at 90.5% vs. 95% target
- As of 30th December 2025, BCU achieved 73.4% for flu vaccinations against the '65 Years and Older' flu metric (1.6% below the National target of 75%)
- The smoking cessation service continues to deliver national target expectations. At Q2, the % of adult smokers making a quit attempt via smoking cessation service was 4% (cumulative) with the target of 5%

4B Primary Care including Clusters	Chief Operating Officer	Delivery Confidence
4B.8 Implement the new GMS Contract Assurance Framework.		Q1
4B.15 Discussions (internally and with partners) will be progressed to a conclusion as to whether the current 14 cluster footprints are optimal or whether a change of focus to pan-cluster footprints would be preferable		Q1 *
4B.3 A pathways of care approach will be adopted to ensure that primary care professionals have access to the resources they need so that secondary care referrals only occur where they will add value to the patient.		Q2
4B.5 Access to primary care dentistry is a key priority and a GDS procurement process will be moved forward alongside consideration of new and innovation ideas to increase patient access. (*Linked to 4O.1*)		Q2
4B.9 Improve accuracy, visibility and use of primary care performance data.		Q2 *
4B.7 Progress the strategic approach to a mixed model of primary care that supports contractors to remain independent contractors and identifies ways in which directly managed practices can innovate, support independent contractor 'neighbours', test new ways of working, and increase involvement of primary care in research.		Q3 *
4B.11 Work with Primary Care providers in North Wales to prepare and expand suitable training environments for Medical Students from the North Wales Medical School.		Q3
4B.16 Generate a proposal to develop a community collaborative model as an integrated Health and Social Care provision for North Wales, ensuring 'pooled' resources for 7-day provision as a collective through utilising established practices such as Trusted Assessor.		Q3 *
4B.1 Full engagement in the implementation of the national 'Primary Care Model' for Wales and focus on delivering the national Primary Care Programme. This will include development of proposals to complete the rollout of the audiology first point of contact and earwax removal service (see also Diagnostics 4D.c.11)		Q4
4B.2 Develop the Primary Care 'same day' offer to provide more equitable access to primary care as alternatives to Emergency Department attendance. This relates to in-hours primary care access and also to the provision of out-of-hours primary care, 111 and Minor Injury Units.		Q4
4B.2 Develop the Primary Care 'same day' offer to provide more equitable access to primary care as alternatives to Emergency Department attendance. This relates to in-hours primary care access and also to the provision of out-of-hours primary care, 111 and Minor Injury Units.		Q4
4B.4 A 'Primary Care Academy' approach will support healthcare professionals to develop advanced skills within primary care that allow skill-mix changes and increased workforce stability		Q4
4B.6 Sustainability support will be reviewed in order to bolster support to contractors that are in difficulty. Where appropriate discussions will be held with national partners.		Q4

4B.10 Develop proposals that address areas of poor primary care estate impacting upon care	Q4
4B.12 Scope and test a model for commissioned community pharmacy services focused on long term condition management, starting with hypertension. (*Linked to 4M.4*)	Q4
4B.13 Develop proposals to expand the use of cluster-based Care Home support services that can provide timely assessment to minimise otherwise avoidable hospital conveyances and improve outcomes for Care Home Residents, including support to carers.	Q4
4B.14 'One stop' models of care that enhance the delivery of care for people with diabetes and related conditions will continue to be tested and if successful, expanded	Q4

Overview

- The primary Care sub objective is made up of 16 priorities the outcomes of which range from the implementation of the national 'Primary Care Model' for Wales and the national Primary Care Programme, dentistry, training, increased research opportunities, through too maximising opportunities for primary care as an alternative to ED attendance.

Current Position

- The Primary Care Model for Wales (PCMW) was designed as the delivery vehicle for A Healthier Wales, establishing a whole-system approach to sustainable, accessible local health and wellbeing care, focusing on place-based care, care closer to home and multi-professional working *(4B.1)*
- Within BCUHB, several PCMW component parts are already in place, including MDT working at practice and cluster level, a growing suite of directly accessible services, strong community resource teams delivering primary-care-led complex care in the community, and high levels of signposting and care navigation *(4B.1–4B.4)*. Development and implementation across North Wales remain inconsistent, with varying approaches to primary and community service delivery *(4B.3 / 4B.4 / 4B.7)*
- A Primary Care Board, chaired by the COO with senior representation from the Executive Team and Primary and Community has been established to drive PCMW implementation, develop a transformation plan, monitor progress, and address barriers *(4B.1)*
- The Board has progressed work to set out the Strategic Intent for focused investment in primary and community care for services currently delivered in secondary care, which will shape the 2026/27 IMTP *(4B.1 / 4B.2)*
- The PCMW is now being overtaken at an all-Wales level by the Community by Design (CbD) Transformation Plan, led by CMO, accelerating development of integrated community services, with preparatory groundwork completed in 2025/26 *(4B.1 / 4B.2)*
- A review of the current 14 cluster footprints has commenced to determine whether current arrangements remain fit for purpose and capable of delivering intended outcomes as the Health Board develops its 10-year Strategy and Clinical Services Plan *(4B.15)*
- There is a need to streamline currently fragmented services and referral routes across geographies to enable integrated neighbourhood care and more effective primary/community delivery *(4B.2 / 4B.3)*
- Work has begun to consider the introduction of a Federations to support GP practices and deliver services at scale, with initial groundwork underway for potential implementation in 2026/27 *(4B.7 / 4B.16)*

Remainder of the financial year

- Continue to build solid foundations, spread good practice, and ensure primary and community care services are innovatively developed and adequately supported to meet population need *(4B.1–4B.16)*
- Cluster footprint reviews must align with ambitions within the Transformation Plan and the forthcoming operating model, meaning delivery is expected in Q1 2026/27 rather than before year-end *(4B.15)*
- By end of March 2026, there will be broad agreement on initial Federation footprints to support delivery as outlined in the All Wales Transformation Plan, with further development required in 2026/27 to ensure readiness for commissioning *(4B.7 / 4B.16)*
- Progress development of a local Transformation Plan informed by the Primary Care Board's work this year *(4B.1)*

Impact

- The primary care workforce is now more diverse, with physios, OTs, paramedics, pharmacists, and access to Tier 1 mental health services embedded in GMS settings - improving access and quality of care
- Cluster funding and PCMW development have enabled innovative services such as wellbeing support for children and young people, breathlessness hubs, improved counselling access, and more
- Investment in community pharmacy and optometry contracts has supported sustainability and increased access, while practices continue to manage over 500,000 calls per month

- Groundwork undertaken places BCUHB in a strong position to implement the Community by Design approach, enabling primary and community care to deliver timely, high-quality services closer to home
- Specific service gains include expanded audiology first-point-of-contact and earwax removal services, benefitting patient care, alongside a range of cluster-led initiatives
- Foundations built this year will support qualitative and quantitative improvements in the years ahead, enabling sustainable, integrated, place-based care

4C: Community Care	Chief Operating Officer	Delivery Confidence
4C.1. Enhanced Community Care - Generate options to increase provision of Enhanced Community Care (ECC)		Q1 *
4C.5. Weekend Community Nursing - Review options to increase District Nursing provision at the weekend including the nature and level of weekend demand		Q1 *
4C.9. Weekend Specialist Palliative Care - Review opportunities to increase Specialist Palliative care capacity in the East to bring cover up to the same level as other parts of BCU i.e. 2 CNS's on duty at the weekend		Q1 *
4C.2. Enhanced Community Care - Develop a business case for increased ECC outlining options, costs, benefits, risks and possible funding streams		Q2 *
4C.6. Weekend Community Nursing - Develop a business case for increased weekend community nursing capacity outlining the options, costs, benefits, risks and possible funding streams.		Q2 *
4C.10. Weekend Specialist Palliative Care - Seek options to identify and secure funding additional weekend Palliative Care CNS hours		Q2 *
4C.3. Enhanced Community Care - Progress business case through Health Board governance to seek support for preferred option.		Q3 *
4C.7. Weekend Community Nursing - Progress business case through Health Board governance to seek support for preferred option		Q3 *
4C.11. Weekend Specialist Palliative Care - Commence recruitment for agreed SPC CNS hours and undertake consultation with existing staff on changing work patterns; subject to available funding.		Q3 *
4C.4. Enhanced Community Care - Subject to available funding, undertake any necessary staff consultation, commence recruitment for agreed staffing, implement pathway changes, commence delivery of increased provision for ECC.		Q4
4C.8. Weekend Community Nursing - Subject to available funding, successful recruitment and outcome of staff consultation, work to agree implementation plans, commence recruitment and commence increased community nursing for weekends		Q4
4C.12. Weekend Specialist Palliative Care - Develop implementation plans to commence increased SPC CNS capacity for weekends and bank holidays; dependent on staff consultation, recruitment and prioritisation of resources.		Q4

Overview

- The Community Care subobjective consists of 12 priorities, the outcomes of which aim to develop increased provision of Enhanced Community Care, through increasing District Nursing / community nursing and specialist palliative care weekend provision. However, a number of these proposals are subject to business case approval.

Current Position

- A baseline of activity and reporting arrangements has been established with Welsh Government, including an agreed trajectory for incremental increases to Enhanced Community Care (ECC) within existing resources *(4C.1–4C.4)*
- Referral documentation at YGC has been updated to include referrals for wider community services, not solely community hospital beds, resulting in increased referrals for Enhanced Care at Home *(4C.1)*
- Newly appointed palliative care staff in Conwy & Denbighshire have enabled increased weekend Palliative Care CNS cover *(4C.9–4C.12)*
- A Health Board–wide Establishment Review of District Nursing teams has commenced to inform the approach to increasing weekend district nursing provision *(4C.5–4C.8)*

Remainder of the financial year

- The Establishment Review of District Nursing teams continues across BCU (4C.5–4C.8)
- Work is ongoing to increase the number of GP practices in Conwy participating in Enhanced Care provision (4C.1–4C.4)
- Full optimisation of the service developments will require a project management approach and clear Health Board commitment to resourcing expanded community-based provision, including reallocating system resources to deliver more care in the community closer to home (4C.1–4C.12)

Impact

- Increased provision of Enhanced Care at Home, particularly in Conwy, with additional GP practices signed up to the Local Supplementary Service and supporting Advanced Nurse Practitioners
- Improved weekend access to advice from Palliative Care Clinical Nurse Specialists in Conwy & Denbighshire

4D.a Planned Care	Chief Executive / Chief Operating Officer	Delivery Confidence
4D.a.1. Develop and implement the next stage of the Validation Approach in the Health Board; focusing on delivering high levels of data quality, updated waiting lists and application of waiting list policies.		Q1
4D.a.2. Implement locally the 8 nationally agreed Interventions Not Normally Undertaken (INNU), and the pipeline of INNUs that follow.		Q1 *
4D.a.15. Recalibrate capacity from follow-ups to new appointments in priority specialties, following assessment of opportunity		Q1
4D.a.4. Assess the opportunities for Referral Triage and Alternative Pathways in high volume specialties as a priority; drawing up and commencing the implementation of service redesign proposals, learning from other organisations		Q2 *
4D.a.6. Implement specific specialty 'direct listing', specifically focused on ophthalmology as a priority		Q2
4D.a.8. Review and update outpatient clinic templates, incorporating GIRFT/Optimisation Framework standards, across high priority specialties		Q2 *
4D.a.9. Implement a revised DNA/CNA approach, including overbooking mechanisms where DNA/CNA rates are above 5%.		Q2 *
4D.a.5. Implement the Health Pathways (including Pathway Alliance Programme) in priority specialties		Q3 *
4D.a.10. Develop and implement the revised model for Pre-Operative Assessment		Q3 *
4D.a.12. Review each specialty to identify opportunities for increased day case, and minor-ops/procedure room (Right Patient, Right Place-type) approach. Implement priority specialty improvements.		Q3 *
4D.a.13. Undertake a systematic approach to validating, data cleansing all Follow-up lists.		Q3 *
4D.a.14. Implement See on Symptoms (SoS) and Patient Initiated Follow-up (PIFU) on all priority specialties (linked to Optimisation Frameworks/GIRFT)		Q3 *
4D.a.16. Introduce an enhanced demand and capacity modelling approach that takes into account all aspects of planned care and cancer pathways.		Q3 *
4D.a.3. Develop and implement best practice standards (GIRFT/Optimisation Framework) for referral advice and guidance (pre-referral) focusing on high volume, high opportunity specialties as a priority and rolling through other specialties thereafter.		Q4
4D.a.7. Progress the implementation of the new Booking Service, enabling a consistent approach across the organisation.		Q4
4D.a.11. Identify specialty by specialty high utilisation opportunities to enable focused and targeted approach to achieve the 85% utilisation threshold.		Q4
4D.a.17. Implement a programme of in-year commissioned capacity to support 2025/26 delivery		Q4

4D.a.18. Develop integrated specialty plans for 2026/27 based on the progress made across specialties in 2025, to include workforce, finance, commissioning aspects.	Q4

Overview

- Timely access to planned care is a core Health Board priority. Work throughout 2024/25 reduced the number of people waiting over two years for outpatient appointments, tests and surgical interventions, but significant numbers still face, or are at risk of facing, long delays without further action.
- Although planned care is a UK-wide challenge, the Health Board remains a notable outlier in the volume of long waits and in the slower adoption of improvement approaches. The creation of the Planned Care Major Change Programme, signals a strong commitment to accelerating improvement.
- National developments, including the National Planned Care Programme and the Optimisation Framework through Clinical Implementation Networks, provide essential guidance for local improvement.
- Getting It Right First Time (GIRFT) reviews offer detailed recommendations on delivering high-quality, efficient care. Many of these relate to core organisational processes and infrastructure, which will be strengthened alongside the Planned Care Programme.

Current Position

- Work during 2025/26 has focused on strengthening the foundations required to support assurance, improved access and a more consistent approach across Planned Care pathways *(4D.a.1–4D.a.18)*
- Workstream 1 – (Validation) has progressed clerical and clinical validation, supported by consistent pan-BCU validation checks, EBO chat-bot patient validation (T&O, Gastro, progressing into Gynae), launch of the clinical validation policy and hub, and profiling of frailty and EBIW (INNU) validation opportunities *(4D.a.1)*
- Workstream 2 – (Referral Advice & Guidance) continues to advance referral advice and guidance, with Community Health Pathways rolling out at pace. WAP-Full is live in six services with work underway to introduce it in a further six, alongside preparation for an exit strategy from nationally funded Consultant Connect as CHP and WAP-Full mature *(4D.a.3–4D.a.5)*
- Workstream 3 – (Booking) has delivered key elements supporting a more consistent, RTT-compliant booking approach. NHS App functionality has been implemented for Stage 1 new GP referrals accepted into secondary care and Stage 1 new appointments, with further scoping underway with DHCW for next-phase adoption. To support this, RTT Stage 1 training has been developed to implement a compliant approach to booking across the Health Board *(4D.a.7–4D.a.9)*
- Workstream 4 – (Preoperative and Operative Optimisation) has advanced the standardisation and implementation of the HSQ and POA process, with active trials across East, West and Centre, and use of the WPAS HCP module to capture HSQ outcomes and integrating the results into the PTL, supporting High Volume Low Complexity (HVLC) listings. Activity within 3Ps continues to support patients through single-point contact and waiting-well resources *(4D.a.10–4D.a.12)*
- Workstream 5 - (Follow-ups) early benefits have been seen through data cleansing and identification of unwarranted variation initiating alignment with SOS/PIFU discharge protocols *(4D.a.13–4D.a.15)*
- Workstream 6 – (Integrated Planning) has been intentionally re-phased into 2026/27 ADP to support stronger alignment with strategic planning, clearer ownership and disciplined delivery via formal Project Board structures *(4D.a.16–4D.a.18)*

Remainder of the financial year

- Effort will centre on stabilising delivery and embedding high-confidence activity across all workstreams rather than seeking full recovery across all enabling actions this year *(4D.a.1–4D.a.18)*
- Priority will be given to maintaining the integrity of validation activity *(4D.a.1)*, as well as completing live pilot activity within pre-operative and operative optimisation *(4D.a.10–4D.a.12)*
- Work will continue with Planning, Finance and Strategy teams to quantify cost pressures associated with scaling improvements to determine which enabling actions can progress safely and affordably within-year. Where progression is not feasible due to workforce, national or system-capacity dependencies, activity will be reassessed and learning will be carried forward into the 2026/27 Annual Delivery Plan *(4D.a.16–4D.a.18)*

Impact

- The work undertaken to date has primarily driven long-term, sustainable change that enhance efficiency, promote safer patient outcomes and contribute to system-wide waiting time reduction
- Validation activity has improved accuracy and credibility of waiting lists, supporting safer prioritisation and better clinical decision-making with over 15,000 pathways being validated since mid-December
- EBO chat-bot patient validation has achieved a 7% removal rate
- Early benefits are emerging through data cleansing and identification of unwarranted variation (Gynae – 383; Dermatology - 1374; T&O – 446)
- Digital delivery, including NHS Wales App notifications and EBO chat-bot validation, have improved communication and transparency for patients while they wait

- Referral and booking improvements have reduced unwarranted variation and laid crucial groundwork for effective demand management
- Pilot activity across pre-operative and operative optimisation shows clear potential to ensure patients are optimised for surgery to enhance utilisation of capacity, particularly for higher-risk patient cohorts
- EBO chat-bot patient validation has achieved a 7% removal rate
- The number of patients waiting for a first outpatient appointment has reduced significantly. Numbers fell from 12,261 in November to under 8,500 (unvalidated position on 12 January 2026), with reductions expected to continue (subject to specialty pressures) towards close to zero by year-end
- These activities have contributed to more accurate waiting list data, enhanced transparency for patients, reduced unwarranted variation and early improvements in referral quality and pathway optimisation
- Overall, the programme has delivered meaningful early benefits and established a clear understanding of opportunities, limitations and future cost pressures, enabling more informed planning for 2026/27.

4D.b Cancer Care	Chief Executive / Chief Operating Officer	Delivery Confidence
4D.b.3. Commission of additional external resource in endoscopy and dermatology whilst seeking to develop and recruit to more sustainable models of care to meet the needs of our population across north Wales.		Q1
4D.b.4. Work to improve referral pathways with the introduction of the Community Health Pathways tool.		Q2
4D.b.5. Introduction of nurse led triage model for patients with suspected colorectal cancer to increase the number of patients referred straight to test and reduce overall waiting times.		Q2
4D.b.7. Investigate the case for new models for the assessment of women with post-menopausal bleeding to reduce time to diagnosis of gynaecological cancers.		Q2 *
4D.b.9. Consider a proposal to repatriate some services from England to north Wales; some plastic surgery and specialist radiotherapy procedures.		Q3 *
4D.b.1. Recovery of the Health Boards cancer position and improved performance against the Suspected Cancer Pathway referral to treatment target, aiming to achieve 80% of cancer patients treated within 62 days of suspicion of cancer by March 2026.		Q4
4D.b.2. Clearance of the over 62-day waits is a priority as this is currently a large number of pathways. The Health Board will need to factor in the backlog clearance over the first 6 months towards delivering the 80% treated within 62 days standard by March 2026.		Q4
4D.b.6. Optimise the agreed teledermoscopy service and develop the evidence case to expand		Q4
4D.b.8. Develop a proposal for the expansion of robotic assisted cancer surgery.		Q4
4D.b.10. Work with the charity Maggie's and the Steve Morgan Foundation to open a new Maggie's cancer support centre in the grounds of Ysbyty Glan Clwyd in 2025		Q4

Overview

- The Health Board's Cancer Programme is aligned to the Welsh Government's national Planned Care and Cancer programmes.
- The Health Board continues to implement the 'Roadmap for Cancer Services in North Wales', developed by the North Wales Cancer Partnership Board in 2023/24.
- The Roadmap priorities include prevention, early detection and diagnosis, timely and effective treatment, and support for self-directed aftercare.
- Implementation plans by tumour site are being developed, including the Breast Cancer Strategic Work Plan.

Current Position

- Commissioned additional capacity in endoscopy and dermatology to support cancer pathway recovery *(4D.b.3)*
- Expanded the teledermoscopy service to include the West area *(4D.b.6)*
- Commenced nurse-led triage for suspected colorectal cancer referrals across all three sites to streamline diagnostics *(4D.b.5)*
- Repatriated some specialist radiotherapy services from the North West of England *(4D.b.9)*

- Launched the Community Health Pathways tool to support GPs with referral guidance *(4D.b.4)*
- Opened the Maggie's Centre on the YGC site to provide walk-in support for cancer patients and carers *(4D.b.10)*

Remainder of the financial year

- Reduce the wait to first appointment for suspected breast and skin cancer through additional capacity *(4D.b.1–4D.b.3)*
- Reduce the wait to endoscopy by prioritising suspected cancer patients and increasing capacity *(4D.b.3)*
- Reduce the wait to prostate biopsy through additional capacity *(4D.b.3)*
- Based on revised trajectories, the Health Board is unlikely to achieve the national 75% target for treatment within 62 days, but aims to achieve over 60% by the end of March 2026 *(4D.b.1 / 4D.b.2)*

Impact

- Repatriation of specialist radiotherapy has improved access by bringing care closer to home
- The opening of the Maggie's Centre at YGC has provided walk-in support for patients and their families
- As a result, the number of patients waiting over 62 days on an active suspected cancer pathway has reduced by 25% (from 3,554 in April 2025 to 2,694 December 2025 – which equates to 24%)

4D.c Diagnostics	Chief Executive / Chief Operating Officer	Delivery Confidence
4D.c.3. Undertake a rapid review of workforce capacity and skill mix to inform recruitment and retention strategy		Q2 *
4D.c.4. Deliver the major national information technology projects currently underway in Radiology and Pathology; subject to available resource prioritisation.		Q2 *
4D.c.8. Progress Endoscopy, Nuclear Medicine/PET-CT and Digital Cellular Pathology business cases.		Q3 *
4D.c.1. Complete demand and capacity reviews for all diagnostic services, with implementation of identified improvement plans to deliver sustainable services and to deliver against forecast trajectory targets for reportable diagnostic services		Q4
4D.c.2. Ensure service delivery is equitable and high-quality experience for patients		Q4
4D.c.5. Progress the development of the medical illustration service to support the teledermoscopy service.		Q4
4D.c.6. Complete estates reviews for all diagnostic services, with prioritisation and progression of identified improvement projects		Q4
4D.c.7. Progress the Regional Diagnostics Hub project within the Planned Care Programme		Q4
4D.c.9. Maintain capacity for a workstream to focus on transformational change, including AI		Q4
4D.c.10. Integrate diagnostics quality assurance approaches with the Health Board QMS.		Q4
4D.c.11. This will include development of proposals to complete the rollout of the audiology first point of contact and earwax removal service (see also Primary Care 4B.1)		Q4

Overview

- Effective, timely diagnostics are critical across Planned Care, Urgent and Emergency Care, and Primary Care.
- Demand rose again in 2024/25, increasing waiting times despite record activity, with further growth expected due to cancer treatment advances, planned care recovery, unscheduled care pressures and rising long-term conditions.
- Future diagnostics planning must incorporate technological developments such as AI and genomic medicine.
- Increased capacity in 2025/26 is essential to reverse waiting-time trends, aligned with the Welsh Government's *Diagnostics Recovery & Transformation Strategy 2023–2025*.

- Diagnostics underpin almost all pathways, including cancer, and sufficient capacity is required to meet national waiting-time standards. Radiology and endoscopy insourcing in 2024/25 boosted activity but could not stabilise waits. Additional radiology insourcing and a full year of endoscopy insourcing are required to tackle backlogs and demand growth.
- Physiological measurement services—cardiology, neurophysiology and urology—also need increased insourcing in 2025/26 to address persistent 8-week backlogs.
- The Health Board has a diagnostics plan for 2025–28 structured around three themes: service delivery, service transformation and service governance

Current Position

- Work during 2025/26 has focused on supporting the long-term aim of delivering safe and sustainable diagnostic services over the 2025–28 period, with year one activity centred largely on national, non-recurrent recovery programmes *(4D.c.1–4D.c.9)*. Increased demand has been generated by ministerial priorities for 0 patients waiting over 8 weeks for specified diagnostics, 0 patients waiting over 104 weeks RTT, and delivery of national OPD programme *(4D.c.1)*
- Higher activity levels and targeted performance improvements are supporting better access for patients through the year *(4D.c.1, 4D.c.2)*
- Radiology has successfully implemented the RISP IT project, creating a single BCUHB patient database that will eliminate regional variation and provide enhanced data for service improvement programmes *(4D.c.4)*
- Pathology has advanced the LIMS 2.0 programme, with partial rollout in 2025/26 and full completion planned for 2026/27; the blood transfusion element remains high-risk and is under active management *(4D.c.4)*
- The PET-CT/nuclear medicine business case has progressed, with the full business case approved by the Health Board and now moving to Welsh Government for approval *(4D.c.8)*
- Estates-related issues have progressed in areas such as RAAC pathology and YG audiology facilities, while other business cases such as endoscopy and digital cellular pathology are awaiting further scrutiny *(4D.c.6, 4D.c.8)*
- Direction for the Diagnostics Hub remains unclear, with this year's focus primarily on increasing local capacity within existing services *(4D.c.7)*
- Overall, improvements in patient access times have been seen across a range of specialties supported by increased levels of diagnostic activity throughout the year (4D.c.2)

Remainder of the financial year

- Objectives will require refinement into more specific and quantifiable SMART measures as part of 2026/27 planning
- Ministerial priority for timely access to diagnostics, with the 8-week target as the principal metric, will remain the top focus *(4D.c.1)*
- Establishing the new operational model for diagnostics is a broad metric for 2026/27
- Monitoring will centre on a small number of improvement projects under key programmes such as value and sustainability to maintain focused, high-impact delivery *(4D.c.9, 4D.c.10)*

Impact

- Improved access times for patients across a range of specialties, supported by significant increases in diagnostic activity throughout the year
- Progress in national IT systems (RISP, LIMS 2.0) is laying the groundwork for standardised quality, improved data visibility and more efficient pathways
- Increased diagnostic capacity has supported RTT and OPD programme delivery and contributed to more timely and equitable patient care

4E UEC	Chief Operating Officer	Delivery Confidence
Workstream 2 – Hospital Front Door 4E.5 - Implement the Welsh Health Circular (WHC) - Ambulance Patient Handover Guidance to ensure timely transfer of patients from ambulance crews to Emergency Department (ED) staff.		Q2 *
Workstream 1 - Support at the Individual's Front Door 4E.2 - Implement Community Based Falls Response Services to enhance outcomes and experience for those who fall by improving initial response times, reducing the risk of long lies and ensuring service users access community falls pathways when appropriate. This Community Service will be both a stakeholder of the SPOA hub as well as a pathway out of it. Both of these interventions will ensure that high risk patient groups (such as falls and breathlessness that make large contributions to the demand on ED) are supported in the most effective way		Q3 *

Workstream 1 - Support at the Individual's Front Door 4E.1 - Implementation of the remote clinical assessment services framework - Implement a 'Single Point of Access' (SPOA) hub for urgent and emergency care that simplifies access to services by offering clinicians advice and guidance to support onward referral, ensuring patients get the right care for their needs quickly and safely, to improve patient outcomes regardless of where they present. The work will include assessing the current pathways, their effectiveness, consistency of usage and implementing alternative pathways that both reduce attendance at ED and provide suitable alternative to admission for ED clinicians to access when patients do present in an emergency. This will include trialling appointments in areas such as Ophthalmology, SDEC, Urgent Primary Care Centre's and Dental.	Q4
Workstream 1 - Support at the Individual's Front Door 4E.3 Ensure implementation of Primary Care Model, including delivery of national Primary Care Programme, and development of Primary Care Same Day Offer (4B.1 & 4B.2) is fully integrated into this workstream and delivers expected outcomes in terms of attendance at Secondary Care	Q4
Workstream 2 – Hospital Front Door 4E.4. Implement an Acute Front Door Frailty Service at all acute hospitals – integrated with community frailty services - that ensures that older people with frailty dependent on prioritisation of available resources are streamed to the most appropriate services within the hospital when required as quickly as possible and, where possible, discharged home on the same day. This will include an evaluation of the different approaches to acute front door frailty services in place inside and outside the Health Board	Q4
Workstream 3 – Hospital Flow 4E.6 - Implement actions described in the Optimal Hospital Flow Framework to ensure people who possess a clinical need for admission to hospital are discharged home when clinically ready, with the right support and without delay. This will support a reduction in deconditioning, and the early identification within the first 24hrs of admission and communication of any support requirements on discharge which should support a reduction in pathways of care delays once embedded across both acute and community inpatient areas. This will be supported initially by two Optimal Hospital Flow Facilitators who will create and roll out training resources – a national initiative that is being tested in BCU to assess its impact. This work on reducing pathway delays is critical to removing surge capacity from routine use.	Q4
Workstream 4 – Discharge from Hospital 4E.7 - Introduce actions to improve pathways of care delays and discharge planning through: a) a single North Wales approach to validation of delays to support more effective reviews with Local Authorities, b) increasing the number of assessments undertaken by 'trusted assessors' including ensuring assessment takes place the right environment, reducing the dependency on contended social care resource, and reducing assessment delays, c) exploring options in relation to right sizing of both step up and step down community capacity, subject to the prioritisation of available resources.	Q4

Overview

- The UEC sub objective consists of seven priorities under four workstreams; 1. Support at the Individuals Front Door 2. Hospital Front Door 3. Hospital Flow 4. Discharge from Hospital
- Outputs from which will include implementation of a remote clinical services framework, a 'Single Point of Access' Hub, a community-based falls response service supported by an acute front door frailty service and community frailty service. It is anticipated that this work will ensure patients get the right care for their needs quickly reducing demand on acute sites, reducing deconditioning and optimising hospital flow.

Current Position

- A full business case has been developed for a therapy-led, multidisciplinary Community-Based Falls Response Service for Level 1 and Level 2 fallers, designed to reduce avoidable hospital admissions, improve patient outcomes and support care closer to home *(4E.2)*
- Implementation of Phase 1 of the Optimal Hospital Flow Framework has strengthened patient flow, enabling clinically ready patients to be discharged promptly with appropriate support *(4E.6)*
- The strengthened focus on improved discharge decision-making and robust Board Rounds has reduced delays and ensured patients leave hospital with the right support in place *(4E.6)*

Remainder of the financial year

- Continued planning and refinement of key actions in preparation for implementation of the 45-minute handover protocol, ensuring alignment with wider UEC improvement plans *(4E.5)*
- Ongoing development to support planned future implementation of Acute Front Door Frailty Services across all acute hospitals *(4E.4)*

Impact

- Targeted improvement work on hospital discharge, delivered through two agile sprints, has produced measurable gains, including a 28.9% reduction in package-of-care delays**,** directly improving hospital capacity and reducing length of stay
- Operational and clinical actions have contributed to some improvements in ambulance handovers and patient flow, helping to ease pressure across urgent and emergency care

4F Adult Mental Health & Learning Disability	**Executive Director of Allied Health Professionals and Health Science**	**Delivery Confidence**
4F.1. Work with the NHS Executive to deliver the emerging Mental Health strategic improvement programme including patient centred safety, crisis care and access to community services.		Q1
4F.2. Continue to improve quality and safety of care, including full delivery of the Royal College of Psychiatry (RCPsych) Mental Health Invited Service Review.		Q4
4F.3. Continue to improve access to and reduce waiting times for North Wales citizens needing support from Community Mental Health Service.		Q4
4F.4. Develop a coherent overarching model for the delivery of care to people experiencing mental health crisis.		Q4
4F.5.- Deliver phase 1 of the Mental Health Electronic Healthcare Record (EHR) programme as a developing template for the wider transformation above. (*Linked to 2D.5*)		Q4
4F.6. Deliver progress across specialist service improvement projects, including Perinatal and Eating Disorder services.		Q4
4F.7. Deliver, with Capital Estates colleagues the 2025/2026 programme for Anti-Ligature estates work.		Q4

Overview

- The Adult MHLD sub objective consists of eight priorities the outcomes of which include continued improvements to quality and safety of care, development of a coherent overarching model for delivery of care improving access and reduced waiting times for care.

Current Position

- Access to and quality of MHLD services has improved during 2025/26, supported by ongoing engagement with service users, staff and partners to inform redesign aligned more closely with community partners *(4F.1–4F.7)*
- Health inequalities are being addressed through continued development of specialist services, improved access to core services and continued delivery against RCPsych recommendations, supported by engagement in the emerging national Patient Safety Programme *(4F.2)*
- Work is progressing on enabling staff through the introduction of the Mental Health HER. Procurement processes have been completed and the service is preparing to enter the purchasing phase in Quarter 4 *(4F.5)*
- Improvements in perinatal mental health are evidenced by support to the Chester-based Mother and Baby Unit, which is now providing inpatient care for Welsh patients. Alongside this, implementation of the physical health policy and roll-out of EMIS is contributing to improved care quality, with positive staff feedback reported *(4F.6)*

Remainder of the financial year

- Continue to operate within a structured project management framework feeding into divisional governance, ensuring project deliverables and risks are monitored and escalation routes and opportunities to accelerate milestones where possible *(4F.1–4F.7)*
- Development of the all-ages Mental Health EHR will continue in partnership with CAMHS and DDaT, with progress focused on areas not dependent on procurement outcomes, including training needs assessment and communication planning *(4F.5)*

Impact

- Health inequalities are continuing to reduce, supported by strengthened perinatal mental health services, including access to the Chester-based Mother and Baby Unit, now accepting Welsh patients

- Implementation of the physical health policy, supported by EMIS roll-out, is improving the management of wider physical health needs for people with mental health and learning disabilities, with positive staff feedback on usability
- Access to primary care mental health services has significantly improved, with over 80% of patients being seen within 28 days for first assessment and intervention, alongside improved access to specialist support for eating disorders and Early Intervention in Psychosis

4G CAMHS	Chief Operating Officer	Delivery Confidence
4G.3. Incorporate learning through sharing best practice across Wales for a sustainable service provision as the service eliminates long waits.		Q1
4G.1. Develop a CAMHS Strategic Workforce Plan and refreshed Training Strategy which will be informed by our Training Needs Analysis undertaken across CAMHS.		Q2
4G.2. Sustain Mental Health Measure Part 1a compliance against target for assessment and deliver the Part 1b target for intervention across all teams		Q3 *
4G.4. Develop proposals for Alternatives to Admission with our partners to ensure holistic provision of CAMHS is accessible for all children and young people including those young people who have chaotic lives with no access to safe accommodation.		Q4
4G.5. Evaluate the implementation of Schools In Reach into core CAMHS offer within IHCs to provide sustainable whole school approach to emotional health and well - being at the most accessible and consistent environment in young people's lives within all schools across North Wales.		Q4

Overview

- The CAMHS sub objective consists of five priorities the outcomes of which focus around revised workforce planning and training, actions to ensure continued compliance with Mental Health Measure (MHM) Part 1a (targets for assessment) and attainment of Part 1b (targets for intervention across all teams), together with associated actions to sustain service provision as the service eliminates long waits.

Current Position

- A performance trajectory review identified that East CAMHS was off track for Quarter 4 delivery, impacting the regional BCU position *(4G.2)*
- East CAMHS developed a Quarter 4 Recovery Plan to address anticipated temporary dips in Part 1b compliance during December/January *(4G.2)*
- Short-term additional agency staffing has been built into the recovery plan to increase capacity and reduce the intervention waiting list backlog, supporting sustained Part 1b compliance. Recruitment challenges have caused delayed start dates, though March compliance remains recoverable *(4G.2 / 4G.3)*
- Getting Started groups commenced in February across East and West teams, enhancing support and improving sustainability of performance delivery *(4G.2 / 4G.5)*
- Recruitment to substantive posts across both teams will further strengthen long-term workforce stability and delivery *(4G.1 / 4G.2)*

Remainder of the financial year

- Weekly Mental Health Measure trajectory tracking will continue at East, West, Central and BCU levels, supported by monthly reporting *(4G.2)*
- Early warning triggers will be monitored, including forecast breaches, weeks ahead, and staffing gaps *(4G.2)*
- Each team has an operational lead responsible for recovery delivery, with weekly monitoring involving IHCs and monthly Welsh Government touchpoint meetings. Daily dashboard review with operational and clinical managers will continue to drive performance *(4G.2)*

Impact

- Increased capacity will improve throughput and reduce intervention waits and is performance persists the service will meet the criteria for Part1b of the Mental Health measure
- Recruitment to substantive roles will support long-term stability and compliance

4H Neurodevelopment	Chief Operating Officer	Delivery Confidence
4H.3. Incorporate learning through sharing best practice across Wales for a sustainable service provision as the service eliminates long waits.		Q1
4H.1. Complete the waiting list stratification exercise and consider prioritisation criteria.		Q2
4H.2. Launch a prudent assessment process across the teams.		Q2
4H.4. Gain approval for an Information Sharing Protocol with partners.		Q2
4H.5. Engage fully with the Children's RPB to develop a needs-led service model.		Q4

Overview

- The Neurodevelopment sub objective consists of five priorities focused on improving services for children and young people with Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD).
- Support for children and young people whilst on the waiting list and post-diagnosis relies on a whole-system approach working closely with partners across education and social services supported by the Children's Regional Partnership Board (RPB).
- The priorities relate to reducing waiting lists and the development of a needs-led service model combined with greater information sharing protocols with partners.

Current Position

- Collaborative work is underway with the Children's Regional Partnership Boards to develop a needs-led service model under the Neurodevelopment (ND) Improvement Programme *(4H.5)*
- A Strategic Partnership Group has been established, supported by working groups focused on transition, needs-led profiling, and information sharing *(4H.3 / 4H.4 / 4H.5)*
- Priority actions include reducing waiting times and redesigning assessment pathways to provide more responsive support without relying on a formal diagnosis *(4H.1 / 4H.2 / 4H.3)*
- Children's Area Groups are contributing to locality planning to implement regional plans that both reduce waiting lists and shift from diagnosis-centred services toward needs-led support *(4H.1 / 4H.2)*
- The RPB is developing early help and intervention offers to support families in communities and schools *(4H.5)*
- ND training and awareness programmes have been expanded across health, education and social care, embedding needs-led practices and providing consultation via dedicated regional training coordinators. One of three posts has been appointed, with RPB funding allocated until March 2027 *(4H.3 / 4H.5)*

Remainder of the financial year

- Continued monitoring and evaluation of new ways of working and interventions that demonstrate reductions in demand for specialist ND services *(4H.1–4H.5)*
- Ongoing sharing of learning from interventions that have met need without requiring a diagnosis, supported through communities of practice *(4H.3 / 4H.5)*
- Collection of patient and family experience data to inform future service improvement *(4H.5)*

Impact

- Workforce ND training has expanded across social care and education, increasing capacity and knowledge *(4H.3 / 4H.5)*
- Needs-led practices, such as profiling tools and early help hubs, have been piloted and are helping families earlier in the process, contributing to a reported 33% reduction in demand for specialist pathways *(4H.1–4H.3)*
- New data collection and reporting systems will be introduced to better monitor ND service performance across agencies *(4H.4 / 4H.5)*
- Stronger partner collaboration and regional integration have improved joined-up planning and information sharing, enabling families to be guided to appropriate support without requiring a formal diagnosis *(4H.4 / 4H.5)*

4I Dementia	Executive Director of Nursing and Midwifery	Delivery Confidence
4I.6. Dementia-appropriate Environments: Facilitate extensive assessment of environments		Q1 *
4I.9. Prevention: Creation/collate/share prevention resources		Q1 *
4I.2.Emergency Department experience: Identify good practices elsewhere		Q3 *
4I.3. Emergency Department experience: Identify current BCUHB Emergency Department (ED) practices		Q3 *
4I.4. Education & Training: Enhance range and volume of dementia education and training		Q3 *
4I.7. Dementia-appropriate Environments: Local action plan development and monitoring		Q3 *
4I.10. Prevention: Identify opportunities to promote prevention		Q3 *
4I.1. Emergency Department experience: Embed Emergency Department (ED) dementia improvement work in Integrated Health Communities (IHC)		Q4
4I.5. Education & Training: Evaluate training		Q4
4I.8. Dementia-appropriate Environments: Allocation of improvement resources		Q4
4I.11. Prevention: Collaborate with related specialities e.g. stroke		Q4

Overview

- Dementia care is complex and requires skilled, person-centred approaches across all health services.
- Patients with dementia often occupy a significant proportion of hospital beds and present unique challenges that, if unmet, negatively impact outcomes, experience, and resource use.
- With dementia prevalence rising rapidly, the Health Board must strengthen care standards, reduce variation, and invest in workforce training and service improvements.
- A regional partnership and the Dementia Improvement Team are driving progress aligned with national policies and guidance, focusing on diagnosis, education, and personalised care.
- Effective dementia care benefits patients, families, and the wider health system by improving resource utilisation and supporting strategic goals.
- The Dementia subobjective consists of 11 priorities focused on prevention activities and patient experience improvements through training, best practice and environment improvements.

Current Position

- A 0.4 WTE pathway practitioner resource is in place to support dementia pathway improvements *(4I.1–4I.11)*
- The Dementia Hospital Charter Group will commenced in January 2026 to support improved consistency and standards across Emergency Departments *(4I.1–4I.3)*
- Dementia governance has strengthened through the Strategic Patient Carer Experience Group, reporting to the Executive Quality Delivery Group *(4I.1–4I.11)*
- A second Consultant Dementia Nurse (MHLD) has been appointed to support leadership, clinical expertise and service improvement *(4I.1–4I.5)*
- Improvement initiatives have been partially implemented across Emergency Departments following a full review of practices affecting people with dementia and their families *(4I.1–4I.3)*
- Training scoping has been undertaken by the regional dementia workforce group, with partial completion of ESR modules including dementia-appropriate environment assessment *(4I.4–4I.7)*
- Minimum core education standards for dementia have been agreed for MHLD, alongside partial completion of a dementia training needs analysis *(4I.4–4I.5)*
- Hybrid dementia training via Finding the Light (tier 3 / advanced) has been implemented *(4I.4–4I.5)*
- A toolkit of dementia-related prevention resources has been agreed, and the regional dementia group has been re-established, jointly chaired with the Local Authority *(4I.9–4I.11)*
- A Dementia Practice Educator pilot is underway for 18 months, focused on the prevention of deconditioning and contractures in care home residents in the Central area *(4I.4–4I.11)*
- The BCUHB Dementia Care Improvement Plan has been structured into four areas: ED Experience, Education, Environments, Prevention *(4I.1–4I.11)*
- The Memory Support Pathway (MSP), commissioned by BCUHB, supports inpatients through signposting, advocacy, financial advice, activities and GP liaison, acting as the single point of contact for dementia support beyond primary care *(4I.9–4I.11)*
- The Dementia Improvement Team conducted a full tour of all three EDs to understand current practice and identify areas for improvement *(4I.1–4I.3)*

- A national Datix change from July 2025 now includes a dementia-specific field for incident reporting *(4I.1–4I.3)*
- Pilot and ongoing roll-out of the Red Bag Scheme to support safer transfers of care *(4I.1–4I.11)*
- Pilot of community pre-diagnosis OT support people with suspected dementia *(4I.9–4I.11)*
- Funding has been secured for a six-month Behaviourist-in-Residence pilot at Alltwen and Llangefni hospitals from July 2025 *(4I.4–4I.11)*
- Public-facing dementia initiatives include the Living Better with Dementia film, police partnership work on dementia safety, and co-designed Return Home interviews for people with dementia who go missing *(4I.9–4I.11)*
- Dementia education initiatives include teaching playing cards, activity handbooks, environmental training aids, and a dementia workbook for Facilities staff; memory boxes and Welsh-language playing cards are now available on loan *(4I.4–4I.7)*
- Delirium audits undertaken in the Central and West areas support improved recognition and management *(4I.4–4I.7)*

Remainder of the financial year

- Bi-weekly monitoring of delivery plan priorities will continue to ensure pace through Q4 and into Q1 2026 *(4I.1–4I.11)*
- Dementia improvement plan reporting will be further strengthened through IHC/Services patient and carer experience groups, feeding into the Strategic Patient Experience Group *(4I.1–4I.11)*
- Secure additional pathway practitioner resource of 0.2 WTE to increase capacity from April 2026 *(4I.1–4I.11)*
- Re-engagement with the patient experience team to agree priority actions for the next phase of improvement *(4I.1–4I.11)*

Impact

- Reported improvement in Emergency Department experience for people living with dementia, as measured through CIVICA feedback
- Memory Support Pathway performance data shows reductions in Memory Assessment waiting lists and improved completion of the Memory Assessment Dementia Pathway
- Improvements identified in the National Audit for Dementia 2024 North Wales report, published in Spring 2025

4J.a Challenged Services: Urology	Chief Operating Officer	Delivery Confidence
4J.a.10 Additional capacity: Review Multi-Disciplinary Team (MDT) utilisation: complex regional MDT and local MDT with a view to reducing duplication and recovering lost clinical capacity.		Q1 *
4J.a.1 Workforce: In-depth review to scope out non-medical workforce opportunities, ensuring their contribution to service delivery is maximized. Close remaining clinical and managerial lead role gaps supported by effective IHC leadership currently in post		Q2
4J.a.3 Quality / standard / practice / configuration: Develop plans to deliver specialist services at a regional level aligned to the GIRFT and Royal College of Surgeons recommendations following stakeholder engagement and consultation if required		Q2 *
4J.a.5 Quality / standard / practice / configuration: Deliver equitable Interventional Radiology across the Health Board, including out of hours services (where appropriate). This will reduce the need for staff and patient travel as well as increasing the available treatment options.		Q2 *
4J.a.6 Quality / standard / practice / configuration: Develop a long-term plan around robotic assisted urology surgery for the patients of North Wales, benefitting the recruitment and retention and whilst building a futureproof service model.		Q2
4J.a.7 Additional Capacity: Improve the pre-investigation of patients via Straight to Test pathways with a focus on suspected cancer pathways. Ensuring nurse-led approaches are optimised to create consultant capacity where able.		Q2
4J.a.8 Additional capacity: Monitor Did Not Attend (DNA) and Could Not Attend (CNA) rates and implement mechanisms to mitigate reduced activity when the combined rate is greater than 5%, minimising the loss of clinical capacity.		Q2
4J.a.9 Additional capacity: Maximise day case and outpatient urology procedures, converting from inpatient where appropriate, to support improved in-patient average length of stay.		Q2 *

4J.a.2 Quality / standard / practice / configuration: Establish a sustainable on-call model through a review of the current on call arrangements on a regional level, providing a resilient unscheduled care service to patients.	Q3 *
4J.a.4 Quality / standard / practice / configuration: Improve patient outcomes, deliver increased service efficiencies and reduced waiting times.	Q3
4J.a.11 Patient Experience: Utilise patient experience data to inform service delivery such as care closer to home, commissioning of major surgery, and timelier access to diagnostics and treatment.	Q4

Overview

- The Urology service is a network service within BCUHB with each Integrated Health Community (IHC) managing its own Urology team, inclusive of its on-call arrangements.
- Variation across BCUHB exists in workforce staffing, treatment options, and access to urological diagnostic services.
- Performance against the Suspected Cancer Pathway standards is below the national target, and the majority of urological cancer treatments are outsourced to tertiary centres across the UK.

Current Position

- Interim escalation is in place for out-of-hours Interventional Radiology while a formal SLA is developed by Diagnostics; cases are escalated via the BCUHB Silver/Gold on-call structure to transfer to North West providers as required *(4J.a.5)*
- Executive approval has been secured to proceed with commissioning commitments for vasectomy services, supporting a stable and sustainable service offer *(4J.a.4)*
- An integration paper for My Medical Record (MyMR) has been submitted to DHCW and progressed through local meetings to support implementation and more efficient follow-up pathways *(4J.a.4)*
- Implementation of Local Anaesthetic Transperineal Prostate (LATP) biopsies is progressing, including staff training, pathway mapping (with insourcing responsibilities), and improved waiting list coding for better demand/capacity oversight; insourcing currently supports activity whilst training is completed *(4J.a.7)*

Remainder of the financial year

- The LATP biopsy programme remains on a clear trajectory, with staff sign-off planned by end of September 2026; insourcing provides resilience in the interim as agreed through Executive Committee *(4J.a.7)*
- MyMR integration is moving through national and local governance and remains aligned to delivery expectations, noting timelines depend on DHCW processes *(4J.a.4)*
- Vasectomy service commissioning, having received Executive approval, is moving into delivery *(4J.a.4)*
- Primary risk to full delivery in the absence of a formal out-of-hours IR SLA; mitigations maintain patient safety but delays/inefficiencies persist. Timely completion and approval of the SLA are critical to achieving the overarching aim by March 2026 *(4J.a.5)*

Impact

- Patient safety and continuity have been maintained via interim out-of-hours IR escalation, preventing service failure while longer-term arrangements are finalised *(4J.a.5)*
- Agreement with The Wirral for cystectomy procedures provides robust care closer to home and creates opportunities to phased approach to RAS prostatectomies currently managed at UCLH (London), with a goal to repatriate major cancer surgery to North Wales through partnership *(4J.a.6)*
- Vasectomy commissioning strengthens future access and equity, widening delivery opportunities across multiple providers and supporting care closer to home *(4J.a.4)*
- MyMR follow-up pathways reduce face-to-face appointments for prostate cancer patients, improving patient experience and reducing unnecessary outpatient activity. The introduction of an integrated system allows patients results to flow through to local systems and creating the foundations to potentially support PSA tracking beyond just secondary care *(4J.a.4)*
- LATP implementation is expected to reduce diagnostic waits; improved coding and pathway clarity already enhance visibility of demand, while insourcing has maintained throughput during the training phase which will result in increased local diagnostic capacity and reduce reliance on external providers *(4J.a.7)*

4J.b Challenged Services: Vascular	Chief Operating Officer	Delivery Confidence
4J.b.3 Quality / standard / practice / configuration: Establish a sustainable medium-to-long-term model for Abdominal Aortic Aneurysm (AAA) services that ensures optimal patient outcomes.		Q2 *
4J.b.5 Quality / standard / practice / configuration: Progress the quality improvement plan aligned to health board's QMS system to ensure that quality improvement underpins all that the service does, including clearly documenting leadership structures, escalation processes, including processes for managing risk,		Q2
4J.b.6 Additional capacity: Establish an improvement programme for Chronic Limb threatening Treatment Ischemia with the aim of increasing the numbers of people being re-vascularised within five days of admission.		Q2 *
4J.b.8 Patient Experience: Work with delivery partners (e.g., Care of the Elderly (COTE), stroke, palliative care, psychology, pain management, microbiology) to strengthen and build opportunities for the development of proposals for a greater, more integrated multi-disciplinary team around the patient approach, in order to ensure the holistic needs of the patient are met.		Q2 *
4J.b.1 Workforce: Agree sustainable clinical workforce model that: (i) ensure patients are seen by the most appropriate professional for their needs, therefore increasing capacity and ensuring consultants are freed up to support the most complex cases. (ii) ensure that all staff are supported to work to the top of their competencies, through active training and learning. (iii) Develop network-wide to support job planning to ensure our workforce are deployed where demand is greatest		Q3 *
4J.b.4 Quality / standard / practice / configuration: Commence work on implementing the revised patient-centric transfer, discharge and repatriation pathways and protocols to improve patient experience, reduced re-admissions and/ or 'failed discharges; and ensure appropriate follow-up arrangements are in place once patients are back in the community		Q3 *
4J.b.7 Technology: Develop proposal for a patient information system that will enable tracking of vascular patients through their pathway, identify blockages and ensure patient care is expedited where necessary		Q3 *
4J.b.2 - Workforce: Develop integrated workforce plan to address recruitment and retention challenges within the service and support implementation of a positive working culture, which fosters inclusion and respect across all staffing levels.		Q4

Overview

- The Vascular service is a network service across BCUHB which operates a 'hub and spoke' model whereby access to the service is via the patient's local acute hospital, where they can access vascular specialists and receive outpatient care and imaging as well as undergo minor procedures (spoke).

Current Position

- The 2025/26 ADP forms part of the 3-year Vascular Challenged Service Plan, aligned to national standards in the Vascular Society's Provision for Vascular Services (2021) and 2024 guidance
- Focus this year has been on integrated network working and strengthening MDT collaboration to improve outcomes
- A training plan for SAS grade doctors has been developed and agreed with consultants, supporting development, retention and ability to work at the top of competencies *(4J.b.1 / 4J.b.2)*
- Nurse-led urgent review clinics have been established at YGC, increasing capacity for urgent referrals and reducing consultant demand *(4J.b.1 / 4J.b.2)*
- These developments contribute to the longer-term aim of increasing clinic capacity and reducing waits across pathways *(4J.b.1 / 4J.b.2)*
- External reviews of clinical activity and inter-professional standards have identified improvement activity; SOPs outlining roles, responsibilities and expectations have been drafted and audit tools developed to monitor compliance *(4J.b.8)*
- Work is progressing to strengthen MDT links, particularly with palliative care and diabetic foot services, including a multi-disciplinary workshop scheduled for February *(4J.b.8)*
- A review of the delivery model has been undertaken with agreed design principles to improve centralisation and alignment with regulation *(4J.b.8)*
- A clinical audit into Critical Limb Threatening Ischaemia (CLTI) admissions has been completed, with a further in-depth audit underway and an improvement plan being developed *(4J.b.3 / 4J.b.4 / 4J.b.5 / 4J.b.6)*

- Following patient safety concerns raised in relation to open elective Abdominal Aortic Aneurysm (AAA) repair, elective and emergency open AAA surgery is currently commissioned from University Hospital North Midlands *(4J.b.3 / 4J.b.4 / 4J.b.5 / 4J.b.6)*

Remainder of the financial year

- Some milestones for 2025/26 will not be achieved this year and will roll forward into 2026/27, recognising the longer-term nature of the improvement programme
- A Vascular Improvement Group has been established to maintain progress and drive the wider 3-year plan
- A clinical audit group is being established, supported by new audit tools to monitor quality, compliance and impact across pathways and SOPs

Impact

- Much of the work to date has created the conditions for change, with full implementation and measurable impact expected over the next 12–18 months
- Early analysis of emergency and elective AAA referrals to UHNM shows more favourable mortality and morbidity outcomes under the current commissioning arrangement; qualitative feedback will be gathered to inform future service design
- Nurse-led urgent review clinics have delivered 30 urgent vascular reviews. 148 long-wait patients brought in from the waiting list leading to a reduction in overdue follow-up patients from 50.95% (Jan 2025) to 46.58% (Jan 2026)
- Clinical audit tools now being developed will support monitoring of delays, pathway performance and compliance with national and local standards overseen by the newly established clinical audit group

4J.c Challenged Services: Dermatology	**Chief Operating Officer**	**Delivery Confidence**
4J.c.3 Quality / standard / practice / configuration: Introduce dermatological Community Health Pathways to support effective referral management processes, reducing secondary referrals through better informed resources within Primary Care to deliver some Dermatological services.		Q2
4J.c.5 Additional capacity: Increase medical consultant support where resources allow for primary care to support integrated working and extended roles, opening up educational opportunities to enhance knowledge and confidence with skin conditions, which will lead to fewer referrals into secondary care reducing the demand on the service and waiting times for patients		Q2 *
4J.c.6 Additional capacity: Open Connah's Quay facility to provide increased clinic and operating space including dressing clinics. Subject to available resources Connah's Quay will release 10 Minor Op sessions on a weekly basis, alongside opportunity to run one-stop sessions.		Q2 *
4J.c8. Technology: Optimise referral and triage processes to support e-referral (Welsh Admn Portal) roll out		Q2
4J.c.1 Workforce: Implement strategic and operational Workforce Planning to systematically analyse, forecast, and plan workforce capacity and demand. Identify critical gaps and develop targeted recruitment, retention, and workforce development strategies, including the utilisation of alternative and emergent roles, to ensure the organisation maintains a highly skilled, flexible, and appropriately staffed workforce. This approach supports the achievement of strategic objectives and the delivery of high-quality, patient-centred care.		Q3 *
4J.c.2 Workforce: Job planning to appropriately reflect all duties undertaken to better understand the workforce capacity and match it to patients' needs		Q3 *
4J.c.4 Additional capacity: Ensure Minor Operation Procedure (MOP's) capacity is optimised within the available resources, to support expansion of Teledermoscopy i.e. the provision of dermatology services at a distance, using technology.		Q3 *
4J.c.7 Technology: Roll out Teledermoscopy across West IHC to maximise benefits across BCUHB		Q3
4J.c.9 Technology: Develop business cases for technological solutions to reduce follow-up appointments, late cancellations and non-attenders (DNA's).		Q3 *
4J.c.10 Patient Experience: Act based on the insights gathered from patients within the dermatology service, delivering patient experience improvements such as delivering care closer to home where feasible, through integrated working and pathway development with primary care		Q4

Overview

- As one of the most common reasons for seeing a GP, skin (including nail and hair) diseases can range in severity with skin cancer accounting for approximately half of all cancers in the UK. At present, Secondary Care provision is largely Urgent Suspected Cancers (USC), alongside urgent and routine activity for chronic skin conditions, often requiring complex medications to be prescribed. There has been a significant rise in skin cancer referrals noted over the last 10 years due to patient education and social awareness. A number of practices within Primary Care have the benefit of GPs with a Specialist Interest in Dermatology, enabling treatment of non-cancerous lesions in a primary care setting, overall reducing the demand in Secondary Care.
- Dermatology currently faces significant workforce challenges, specifically in relation to Senior Medical Clinicians in the West Integrated Health Community (IHC). Inability to recruit to Senior Medical Workforce has contributed to long waits for patients to be seen in outpatients for urgent suspected cancer, urgent and routine skin conditions. The Health Board has recently introduced the implementation of Teledermoscopy with a targeted approach towards Urgent Suspected Cancer lesions. The aim is to improve and reduce the overall journey in the patient pathway and re-directing patients where necessary for ongoing treatment e.g., Plastics / Oral and Maxillofacial Surgery / Primary care. Dermatology provides sub specialist services in Patch Test, Phototherapy (treatment units across North Wales within the IHCs), Wig Service, Paediatric Dermatology, Skin Cancer Nurse Specialist Service.

Current Position

- Dermatology services continue to experience significant workforce pressures, particularly in the West, where recruitment to senior clinical posts remains challenging. Recruitment activity is ongoing, with 1 Specialist Doctor recruited for East. 2 Consultant posts remain vacant *(4J.c.1 / 4J.c.2)*
- An interim service model has been agreed to maintain service delivery while longer-term sustainability is developed through Foundations for the Future and the Clinical Service *Plan (4J.c.1 / 4J.c.2)*
- Referral streamlining work is progressing, with Community Health Pathways being developed to reduce unnecessary secondary care referrals *(4J.c.3 / 4J.c.8*)
- Teledermoscopy services have now been expanded across all three sites, supporting earlier triage, reduced outpatient demand, and faster escalation for patients requiring further assessment *(4J.c.7)*

Remainder of the financial year

- Progress to date is meaningful; however, the overall position is Amber due to key dependencies, particularly the inability to appoint senior clinical staff - most notably in the West *(4J.c.1 / 4J.c.2)*
- Improvements in long waits and urgent cancer pathways demonstrate strong progress despite workforce constraints, but full delivery by March 2026 remains challenging without accelerated recruitment *(4J.c.4–4J.c.7)*
- Interim service model and the recruitment of three specialty doctors remain essential mitigation actions but have not yet translated into the stable staffing capacity *(4J.c.1 / 4J.c.2)*
- Continued redesign through Foundations for the Future and the Clinical Service Plan will support long-term sustainability but will take time to embed *(4J.c.1 / 4J.c.2*)
- Expansion of Teledermoscopy and improved referral processes will continue to support efficiency, though full benefits will depend on workforce stabilisation *(4J.c.7 / 4J.c.8 / 4J.c.9)*

Impact

- Waiting times have improved significantly since national insourcing activity began in September 2025, with the overall RTT waiting list reducing from 12,950 to 7,857, stage-1 over-52-week waits falling from 3,339 to 682, and long waits over 104 weeks remaining broadly stable (34 to 47) as at early February 2026.
- The number of patients on a suspected cancer pathway waiting over 62 days has reduced from 1,380 (September) to 1,325 (December), and urgent suspected cancer (USC) first outpatient waits within 14 days have improved from 1,874 to 1,698 as of December 2025
- Teledermoscopy expansion is enabling earlier triage, reducing unnecessary face-to-face appointments, and improving timely identification of patients who require further care, supporting a more responsive and efficient model
- Despite ongoing workforce shortages, interim measures, and referral redesign are delivering tangible service improvements for patients across North Wales

4J.d Challenged Services: Plastics	Chief Operating Officer	Delivery Confidence
4J.d.3 Additional capacity: Develop the proposal to open Connah's Quay as a joint facility with dermatology to provide increased clinic and operating space and capacity including dressing clinics. (duplicate of 4J.c.3)		Q2 *
4J.d.4 Additional capacity: Consider options for further outreach capacity across North Wales to increase access across the region as the Connah's Quay facility will provide capacity for patients within the East and Central Integrated Health Communities only		Q3 *
4J.d.5 Additional capacity: Review opportunities for increasing theatre throughput within existing facilities in East and West IHCs		Q3
4J.d.1 Quality / standard / practice / configuration: Review of commissioning arrangements when they change in 2025 (actual date to be confirmed) - it is important to note providers will continue the outreach service irrespective of the commissioning arrangements.		Q4
4J.d.2 Quality / standard / practice / configuration: Handover of waiting list management to MWL following agreed threshold as limited demand and capacity information is currently held by BCUHB (Central and West waiting lists are still held by BCUHB even though MWL are the service provider).		Q4
4J.d.6 Technology: Generate a business case for the expansion of 'My Medical Record' to manage skin cancer follow-up patients; My Medical Record gives access to patients own online health record containing jointly managed information between the patient and the service		Q4
4J.d.7 Patient Experience: Act based on the insights gathered, delivering patient experience improvements such as delivering care closer to home where feasible, through integrated working and pathway development with primary care		Q4

Overview

- The Plastics service is a secondary care service commissioned by the Joint Commissioning Committee (JCC) and delivered by Mersey and West Lancashire NHS Trust, with referrals coming from other secondary care specialties. Close alignment with Dermatology, ENT, Maxillofacial and Oncology is essential due to shared pathways such as skin tumour management.
- Although the service is externally commissioned, the Health Board provides accommodation for visiting clinicians, and limited activity is delivered within each Integrated Health Community.
- The service has been identified as a clinical concern due to inequitable access, delays in appointments, limited local capacity, and inadequate infrastructure and operational support.
- Commissioning arrangements will change in 2025, giving the Health Board an opportunity to review the current model and consider redesign options where feasible.

Current Position

- Minor operations capacity has increased in West, moving from 3 to 4 patients per list, improving throughput *(4J.d.4 / 4J.d.5)*
- Capital funding has been secured to equip Connah's Quay Medical Centre to support additional minor operating capacity for plastics patients in Central and East *(4J.d.3)*
- Working relationships with MWL (Mersey and West Lancashire Teaching Hospitals NHS Trust) have strengthened through continuation of the Plastics Task and Finish Group and progress in delivering the agreed recovery action plan *(4J.d.2)*

Remainder of the financial year

- Open Connah's Quay Medical Centre for plastics outpatient and minor operating capacity; estates work is on track for dermatology opening on 23 February, with plastics start date to be agreed via JCC and dependent on financial approval (4J.d.3)
- Handover of the West and Central RTT waiting lists to MWL was discussed at the January 2026 contract meeting, with MWL confirming continued commitment to assume management once Connah's Quay becomes operational (4J.d.2)
- Prepare for transfer of commissioning responsibility to Health Boards; JCC has decided this will not proceed in 2026 (4J.d.1)
- National PIFU guidance being revisited for some skin cancer follow-up patients. Awaiting final version before implementation can commence; local processes are ready to implement (4J.d.6)

Impact

- Reduced waiting times and expanded local capacity mean more patients are being seen sooner and closer to home, decreasing travel need to Merseyside for treatment
- Waiting times for new plastics referrals have reduced, maintaining a position of zero 104-week waits, and cutting 52-week waits from 126 (March 2025) to 43 (December 2025)
- Follow-up backlogs have improved: overdue follow-ups reduced from 65% (March 2025) to 50% (December 2025), and those over 100% overdue reduced from 46% to 21%

4J.e Challenged Services: Oncology	Chief Operating Officer	Delivery Confidence
4J.e.2. Workforce: Substantive recruitment to multi-professional roles across oncology (nursing, operational and pharmacy) to meet the current demands and improve service provision and patient safety following recurrent funding approval		Q2
4J.e.4. Quality/Standard/Practice/Configuration: Complete business case for 2 linear accelerators to replace machines which are coming to the end of their safe working life. Funding is secured via Welsh Government and replacement will ensure reduced machine downtime which impacts on treatment capacity for patients. This will also give the department the opportunity to purchase machines with the latest developments which could provide greater access and/or more capacity.		Q2
4J.e.5. Quality/Standard/Practice/Configuration: Establish SABR (Stereotactic Ablative Radiotherapy) - a highly targeted form of radiotherapy which targets a tumour with radiation beams from different angles) service in North Wales, commencing with treatment of lung cancers. This type of treatment is delivered in fewer numbers of treatments (with potentially minimal side effects) than conventional radiotherapy		Q2
4J.e.6. Technology: : Engagement with the implementation of the Electronic Health Record (EHR); this is an essential element for Oncology as currently oncology records are stored within dedicated oncology records and are not visible to the wider services through the main patient notes, placing a risk to patient safety when patients are admitted/seen elsewhere across the Board and the clinician does not have access to up-to-date clinical records		Q2
4J.e.3. Quality/Standard/Practice/Configuration: Develop a fully integrated service strategy to support future demand and innovation		Q3 *
4J.e.7. Technology: Collaborate with the development of a single Welsh contract for Chemocare software to standardise the system across Wales with a view to reduce contract/service costs and ensure data is comparable.		Q3
4J.e.1. Workforce: Increase the number of substantive oncology consultants dependent on levels of available funding; providing greater continuity of care (replacing short term locums)		Q4
4J.e.8. Patient Experience: Act based on the insights gathered, delivering patient experience improvements such as delivering care closer to home where feasible		Q4

Overview

- Oncology services are delivered across the three acute hospitals, with the North Wales Cancer Treatment Centre at YGC acting as the main hub for radiotherapy and Systemic Anti-Cancer Treatment (SACT), including chemotherapy, targeted therapies and immunotherapy.
- The service manages solid tumour care across 11 tumour sites, referring patients with rare or complex cancers to specialist centres such as Clatterbridge or The Christie.
- Workforce shortages, particularly medical staff, alongside rising demand, increasing case complexity and reliance on non-recurrent funding have limited the service's ability to maintain timely access and progress planned developments.

Current Position

- Three substantive Medical Oncology Consultant posts have been prepared and released for recruitment within the 2025/26 financial year, supporting the stabilisation of senior clinical leadership *(4J.e.1)*
- BCUHB has successfully delivered its first SABR (Stereotactic Ablative Radiotherapy) treatment for lung cancer, marking phase 1 implementation of the SABR programme with further tumour sites explored for phase 2 *(4J.e.5)*
- A Clinical Strategy Working Group has been established to provide governance and oversight for development of a sustainable Oncology service strategy, targeted for completion by March 2026 *(4J.e.3)*
- Engagement with Welsh Government continues, with a decision pending regarding the de-escalation of Oncology from Challenged Service status *(4J.e.3 / 4J.e.8)*

Remainder of the financial year

- Delivery remains broadly on track, with progress in workforce recruitment, SABR implementation, and strategic governance *(4J.e.1–4J.e.5)*
- Recruitment of substantive consultants continues as planned, though national shortages, especially for tumour-site specialists, represent an ongoing risk *(4J.e.1)*

- The successful launch of SABR and the commencement of strategic development work indicate positive progress toward service sustainability and improved regional access *(4J.e.5)*
- The Oncology Clinical Strategy remains on course for completion in March 2026 due to the governance structure now in place *(4J.e.3)*
- The pending Welsh Government decision on de-escalation may influence future planning assumptions but does not currently hinder delivery of 2025/26 milestones *(4J.e.8)*

Impact

- Introduction of SABR has improved patient experience by allowing lung cancer patients to receive specialised radiotherapy locally rather than travelling to Liverpool, reducing travel burden and improving continuity of care *(4J.e.5)*
- SABR represents increased equity of access for the population of North Wales and aligns with the aim of delivering more treatment locally and lays foundations for increased capacity as phase 2 tumour sites are introduced *(4J.e.5)*
- Consultant recruitment progress supports longer-term sustainability, though risks remain due to national workforce shortages *(4J.e.1)*
- The Clinical Strategy Working Group is enabling structured progression toward a coherent and sustainable Oncology Strategy, supporting improved planning, measurable outcomes and long-term resilience *(4J.e.3)*

4J.f Challenged Services: Ophthalmology	Chief Operating Officer	Delivery Confidence
4J.f.1 Workforce: Recruit to funded regional clinical (medical and Optometry) and operational business support leadership roles to drive forward service delivery and improvements		Q2 *
4J.f.4 Quality / standard / practice / configuration: Make best use of available resources to expand locally agreed regional integrated care pathways (glaucoma and retinopathy) with community Optometrists. Develop opportunities for the WGOS (Welsh Government Optometry Services) (extended workforce) to provide equity in care and treatment delivery and reduce demand across the region (Linked to 4L.f.3 and 4L.f.1)		Q2 *
4J.f.6 Quality / standard / practice / configuration: Undertake an estates review to identify challenges and risks (ageing buildings, fragile infrastructure and access issues) and explore further estate and modular opportunities in community settings to prevent loss in available capacity for care and treatment and providing care closer to home.		Q2 *
4J.f.7 Quality / standard / practice / configuration: Ensure improvements in data quality		Q2 *
4J.f.9 Additional Capacity: Introduce See on Symptom (SOS) and Patient Initiated Follow Up (PIFU) by default, for effective outpatient delivery, empowering patients to take control by giving them the choice and flexibility around when they access care and treatment.		Q2 *
4J.f.11 Technology: Ensure consistent use across North Wales of interim digital solutions (e-referral and Consultant Connect) to improve the referral process and reduce delays between referral and treatment whilst awaiting national systems delivery.		Q2
4J.f.2 Workforce: Implement strategic and operational Workforce Planning to systematically analyse, forecast, and plan workforce capacity and demand. Identify critical gaps and develop targeted recruitment, retention, and workforce development strategies, including the utilisation of alternative and emergent roles, to ensure the organisation maintains a highly skilled, flexible, and appropriately staffed workforce. This approach supports the achievement of strategic objectives and the delivery of high-quality, patient-centred care.		Q3 *
4J.f.10 Additional Capacity: Undertake demand and capacity modelling to establish patient volume waiting times and appointment backlog for all sub specialities including the recruitment of Eye Care Validators (Linked to 4J.f.3b and C)		Q3 *
4J.f.3 Quality / standard / practice / configuration: Optimise to NICE/GIRFT evidenced based pathways for all ophthalmology sub specialities, delivered through pan BCUHB sub speciality networks. (Linked to 4L.f.4 and 4L.f.1)		Q4
4J.f.5 Quality / standard / practice / configuration: Deliver cataract pathway efficiencies to improve timely access through: Pre – Operative Assessment Clinic (POAC)process improvement, direct listing, increased theatre utilisation (including High Volume Low Complexity (HVLC) and Minor Operating Procedures (MOPs), and monitoring of Hospital cancelled appointments and Did Not Attend to ensure maximum utilisation of available capacity and resources.		Q4

4J.f.8 Additional Capacity : Develop a business case for a centralised cataract hub and a centralised complex services centre to support regional service delivery (predeterminant of regional delivery would be 'go-live' of the ophthalmology national EPR	Q4
4J.f.12. Patient Experience: Act based on the insights gathered within existing Harm Review process, delivering improvements in patient experience through direct referrals and expansion of alternative community based pathways	Q4

Overview

- Ophthalmology services for planned and emergency care are delivered across all three IHCs, with acute sites in the East and West and a central unit at Abergele Community Hospital.
- Outreach clinics operate in community hospitals, and tertiary/specialist care is commissioned from providers in the North-West of England.
- Around 70 accredited Eye Health Examination Wales optometry practices provide eye tests, acute eye-care management and referrals, with many delivering extended services previously undertaken by hospital eye services through locally agreed pathways.
- Demand for ophthalmic care, especially high-volume areas such as cataract and glaucoma, continues to rise due to North Wales' ageing population.
- Services face workforce gaps, limited financial resources, ageing facilities and a post-pandemic surge in waiting times, resulting in significant backlogs.
- Delayed follow-up and treatment increase the risk of avoidable sight loss, making ophthalmology performance a key improvement priority for the Health Board.

Current Position

- Progress has been made across data quality, clinical capacity, and demand management
- The Pan-BCU Cataract Network continues to support rollout of the One-Stop Pre-Operative Assessment Clinic (POAC) and High-Volume Low Complexity (HVLC) model: fully embedded in Central IHC, East IHC in the embedding phase, and West IHC temporarily paused to manage the return of 104-week outsourcing activity, with plans to recommence early Q4 2025/26 *(4J.f.5)*
- 2,500 cataract cases were re-coded during Q3, improving data accuracy and enabling more effective HVLC streaming and outsourcing options *(4J.f.7)*
- Additional community and primary care capacity have been created to reduce secondary care demand. Four optometrists achieved the Glaucoma Higher Certificate through the Deeside Teach & Treat programme, contributing to a reduction of over 700 long-wait (>104 weeks) appointments and enabling >4,160 community appointments annually *(4J.f.4 / 4J.f.10)*
- WG-funded Teach & Treat programmes (Glaucoma, Prescribing, Medical Retina) will continue until end of Q4 *(4J.f.4)*
- WGOS pathways in Independent Prescribing, HCQ and Medical Retina are now live, with glaucoma onboarding underway; postgraduate accreditation continues to support workforce expansion *(4J.f.4 / 4J.f.9)*

Remainder of the financial year

- Progress is positive, but overall delivery is Amber due to the temporary pause in West. Full rollout of POAC and HVLC remains dependent on West IHC resuming implementation *(4J.f.5)*
- Demand management measures, such as, backlog reductions and expanded community optometry capacity have made strong early impact, but require sustained funding, continued workforce development and full roll-out to maintain improvements *(4J.f.4 / 4J.f.10)*
- Full achievement of the overarching aim by March 2026 remains challenging due to a combination of operational pressures, phased rollout and the ongoing data quality enhancements *(4J.f.7 / 4J.f.11)*

Impact

- Re-coding of 2,500 cataract cases has strengthened data accuracy, enabled improved planning and supporting more efficient HVLC streaming and reduced waiting times
- Community-based capacity increase has reduced long-wait backlogs, including the removal of over 700 >104-week cases through optometry-led activity, and improved patient flow across the region
- New WGOS pathways and postgraduate optometry training have increased local access; reducing hospital dependency and improving continuity of care
- The continued rollout of POAC and HVLC pathways is enhancing patient experience through earlier assessment, reduced travel, and more streamlined surgical pathways

4J.g Challenged Services: Orthodontics	Chief Operating Officer	Delivery Confidence
4J.g.1. Workforce: Consolidate the Orthodontic and Oral Maxillo Facial Surgery (OFMS) services to become a networked single service with one operational manager and budget working across the three IHCs		Q2 *
4J.g.2. Workforce: Support the recruitment of funded consultant vacancies and implement a strategic and operational Workforce Planning review to systematically analyse, forecast, and plan workforce capacity and demand. Identify critical gaps and develop targeted recruitment, retention, and workforce development strategies, including the utilisation of alternative and emergent roles, to ensure the organisation maintains a highly skilled, flexible, and appropriately staffed workforce. This approach supports the achievement of strategic objectives and the delivery of high-quality, patient-centred care.		Q2 *
4J.g.3. Quality / Standard / Practice / Configuration: Create and deliver an improvement plan, implement and monitor GIRFT recommendations as supported by the Royal College of Surgeons (Faculty of Dentistry) and the British Orthodontic Society.		Q2 *
4J.g.6 Additional Capacity: Improve effective utilisation of theatre capacity, optimising the right procedure in the right place to reduce unnecessary theatre utilisation		Q2 *
4J.g.4. Additional Capacity: Introduce See on Symptom (SOS) and Patient Initiated Follow-Up (PIFU) by default, for effective outpatient delivery, empowering patients to take control by giving them the choice and flexibility around when they access care and treatment.		Q3 *
4J.g.5. Additional Capacity: Deliver improvements in daycase surgery rates and ring-fenced beds		Q3 *
4J.g.7. Additional Capacity: Review management of, and validate, waiting list to support prioritisation of new patients, longest waiters and those requiring oral surgery as part of their pathway of care. Monitor DNA/CNA rates.		Q3 *
4J.g.8. Patient Experience: Review and act prudently on introducing improvements to patient experience based on insights gathered to date, such as access to care and the CHC review of harm to children waiting for appointments and treatments.		Q4

Overview

- Orthodontics sits within the Head and Neck service alongside Oral Maxillofacial Surgery and Restorative Dentistry, focusing on facial growth, dental development, and the diagnosis and treatment of malocclusions and facial irregularities, including the use of appliances and corrective surgery.
- A small number of orthodontists provide services across all three IHCs. As seen nationally, workforce shortages, especially limited consultant capacity, restrict the ability to provide timely and effective care.
- Demand significantly exceeds capacity across both primary and secondary care, resulting in substantial backlogs and delays in accessing treatment.

Current Position

- A mini-workshop was convened to review Orthodontic GIRFT recommendations and inform short, medium and long-term service planning *(4J.g.3)*
- The workshop identified strengths including strong workforce cohesion and an established, experienced team, providing a foundation for future improvements *(4J.g.1 / 4J.g.2)*
- Workshop outputs are informing a comprehensive plan covering workforce and training, clinical service delivery (including MDT working and estates/capital needs), digital and system development, governance and finance, with initial work feeding into the 2026/27 IMTP *(4J.g.1–4J.g.3)*
- Long-term planning is underway to define a sustainable vision for Orthodontic services across North Wales *(4J.g.3)*
- Insourcing arrangements are in place for patients awaiting new appointments, reducing waiting times for first appointments and helping address immediate capacity challenges *(4J.g.4–4J.g.7)*

Remainder of the financial year

- The programme is currently off track to fully meet the overarching aim by March 2026, as several underpinning elements are required for long-term sustainability remain in development *(4J.g.1–4J.g.8)*
- Sustainable solutions are required across workforce, estates, MDT working, digital systems and governance, and these have not fully defined and enacted *(4J.g.1–4J.g.3)*
- Achieving full delivery by March 2026 is unlikely without accelerated planning, resource decisions and implementation *(4J.g.1–4J.g.8)*

Impact

- The workshop has provided clarity on future opportunities and service development needs, strengthening strategic planning and laying the groundwork for a more sustainable and cohesive Orthodontic service
- While early planning progress is positive, significant challenges remain, especially regarding future capacity pressures as patients convert from first appointments into follow-up and treatment pathways (4J.g.7)
- Insourcing of first appointments has delivered immediate, measurable benefits in Orthodontics, reducing the overall RTT waiting list from 1,031 to 382, cutting stage-1 over-52-week waits from 427 to 5, and lowering over-104-week waits from 214 to just 2 since activity began in late November 2025.
- Collectively, these actions support improved access, better service planning and a more resilient model of care for the population of north Wales

4J.h Challenged Services: Trauma & Orthopaedics	Chief Operating Officer	Delivery Confidence
4J.h.5. Standard/Quality/Practice/Configuration: Improve data quality at a subspecialty level through more effective coding practices, therefore allowing better understanding of the underlying issues and as such where improvements are required.		Q2*
4J.h.7. Additional Capacity: Review current outsourcing and external commissioning arrangements and through demand and capacity mapping establish whether there is appetite and potential to repatriate activity, providing patients with care closer to home.		Q2 *
4J.h.8. Additional Capacity: Generate a proposal to increase patient activity in Abergele Hospital through an expansion of current Abergele criteria and / or investment into enhanced recovery on the site. Testing the link between optimising theatre utilisation and improving treat in turn rates.		Q2
4J.h.10. Patient Experience: Utilise patient experience data to improve patient care with initiatives such as providing care closer to home and timelier access to diagnostics and treatment.		Q2
4J.h.1. Workforce: Work with orthopaedic clinical leadership to deliver standardised effective job planning and subspecialty focused North Wales services', to enable a reduction in unwarranted clinical variation.		Q3 *
4J.h.2. Workforce: Address workforce shortages through recruitment and upskilling of existing non-medical workforce led by effective pan-BCUHB and IHC clinical leadership.		Q3 *
4J.h.3. Standard/Quality/Practice/Configuration: Reduce unwarranted clinical variation to increase productivity and improve patient outcomes through implant rationalisation, improved multi-disciplinary team working, job planning, trauma rota and demand/capacity mapping, and increased utilisation of SOS, PIFU and PROMs pathways.		Q3 *
4J.h.4. Standard/Quality/Practice/Configuration: Development and adherence to BMI guidelines for surgery to increase conversation rates >70%. This will entail some patients partaking in the lifestyle management programme to reduce their BMI in order to increase their appropriateness for surgery and as such improve their post-operative outcomes.		Q3 *
4J.h.6. Standard/Quality/Practice/Configuration: Implement condition specific pathways for Carpel Tunnel Syndrome and Hip/Knee arthroplasty through collaboration with the national clinical implementation network and respective sub-specialty groups. This will reduce unwarranted variation in clinical practice and afford patients the same opportunities across the Health Board.		Q3 *
4J.h.9. Additional Capacity: Implement consistent application of See On Symptom and Patient Initiated Follow Up pathways across North Wales. This will reduce the need for traditional in-person follow up appointments, creating capacity for patients that need to be seen		Q3 *

Overview

- Trauma and Orthopaedics operates as a network service across all three IHCs, each delivering its own elective and trauma activity. Since 2023, the IHCs have collaborated to use Abergele Hospital as a network arthroplasty hub, providing ring-fenced "cold site" capacity for hip and knee replacements.
- All IHCs deliver the same subspecialties, with spinal surgery and highly specialised procedures outsourced to tertiary centres. Long waits, especially for hip and knee arthroplasty, persist due to the ageing Abergele site and the impact of unscheduled care on elective beds.
- Rising demand linked to an ageing population will significantly increase pressure on Orthopaedic services across North Wales.

- A new orthopaedic unit at Llandudno Hospital, with two theatres and ring-fenced beds, is being developed to address current constraints and establish a more sustainable model.

Current Position

- The West Integrated Health Community (IHC) has progressed implementation of the See on Symptoms (SOS) follow-up reduction initiative, with an initial test cohort receiving letters advising patients to contact the service only if symptoms persist. Early results show positive operational impact *(4J.h.9 / 4J.h.10)*
- The East IHC has agreed to adopt the SOS model, supporting spread and scale across the organisation *(4J.h.9)*
- IHCs are using a combination of core capacity, insourcing, and outsourcing to support achievement of Q3 and Q4 waiting time targets, strengthening system resilience *(4J.h.7 / 4J.h.8)*
- A decision in principle has been reached regarding hip implant rationalisation for the Llandudno unit, subject to approval by the Llandudno Project Board; work on knee implant rationalisation is also progressing *(4J.h.3 / 4J.h.4 / 4J.h.6)*
- Uptake of Minor Operating Procedures (MOPs) coding practice continues to grow in the West, improving accuracy and visibility of activity data for better demand and capacity planning *(4J.h.5)*
- The My Mobility App is seeing increased uptake in the East, providing patients with a supported and personalised recovery pathway, tailored education and communication with their care team *(4J.h.10)*

Remainder of the financial year

- Overall progress indicates delivery is on track, with key initiatives now implemented, expanding or progressing through governance
- The SOS model has demonstrated safe and effective impact in the West and is now being adopted in the East, supporting backlog reduction and improved efficiency *(4J.h.9)*
- System capacity is being actively managed through combined use of insourcing, outsourcing and internal resources to support delivery against planned trajectories *(4J.h.7 / 4J.h.8)*
- The rationalisation of orthopaedic implants is progressing well and aligns with the overarching aim of standardising practice and improving value, pending formal approval *(4J.h.3 / 4J.h.4 / 4J.h.6)*
- Continued improvement in MOPs coding uptake and increased use of the My Mobility App reflect strengthening operational processes and enhanced patient experience *(4J.h.5 / 4J.h.10)*
- While dependent on governance approvals and ongoing clinical engagement, current progress suggests overarching aims and impact remain achievable by March 2026

Impact

- The SOS follow-up reduction work has delivered a 2% re-engagement rate, meaning 98% of patients did not require follow-up. Demonstrating that the majority of scheduled appointments were unnecessary and can be safely removed from waiting lists
- Improved efficiency through SOS enables release of clinical capacity for those who need to be seen, while also providing patients with clearer information and a more flexible care model
- The use of insourcing, outsourcing and internal capacity has supported progress toward waiting time targets and improved timeliness of access across North Wales
- Hip implant rationalisation and future work on knee implants will support more consistent, standardised and cost-effective orthopaedic care
- Increasing uptake of MOPs coding is improving data quality and enabling more informed planning and resource allocation
- Growing use of the My Mobility App is enhancing patient experience and engagement in the East by supporting personalised recovery support, improved communication and improved self-management and potentially improved clinical outcomes

4K Women's	Chief Operating Officer	Delivery Confidence
4K.1. Support the local establishment of a Women's Health Hub by March 2026 as a Ministerial Priority; dependent on the prioritisation of available resources. Principles of which will focus on preventative based women's health initiatives, accessibility to information and services with care as close to home as possible.		Q4
4K.2. Lead on the recovery of Gynaecology Cancer and Planned Care in line with GIRFT recommendations and Ministerial Targets.		Q4
4K.3. Progress business cases to secure Cancer and Planned Care Pathway Trackers and a Single Point of Access System for Gynaecology referrals to support recovery and pathway re-design.		Q4

4K.4. Support the implementation of the Preconception Strategy to include preventative based women's health initiatives.	Q4
4K.5. Develop a measurable plan to enable delivery of the Quality Management for Maternity and Neonatal Services, prioritising the 7 key actions which align to the MatNeo Safety Support Programme.	Q4
4K.6. Progress the business case to implement the Digital Maternity Solution for Services.	Q4
4K.7. Work in partnership with the NHS Executive to develop an implementation plan to deliver the Perinatal Engagement Framework commitments.	Q4
4K.8. Collaborate with HEIW to prioritise year 1 actions to ensure delivery of the Perinatal workforce plan.	Q4
4K.9. Develop a Perinatal Quality Surveillance Dashboard with key standard matrix with both network and national oversight in line with policy direction.	Q4
4K.10. Progress the business case to support the equitable implementation of a specialist infant feeding - lactation support service team in the 3 IHC areas - to improve breastfeeding outcomes in North Wales	Q4

Overview

- The Women's services sub objective contains 10 priorities including the establishment of women's health hubs, implementation of prevention-based women's health initiatives, digital infrastructure improvements and prioritisation of seven key actions which align to the MatNeo Safety Support Programme.

Current Position

- Significant progress has been made on the Women's Health Hub programme, with both the Discovery and Design phases completed. This has included population health assessment, demand modelling, stakeholder mapping, an engagement strategy, and development of the pathfinder model *(4K.1)*
- Funding and accommodation for the Women's Health Hub have been secured at Llandudno General Hospital, and a dedicated project group is now leading implementation *(4K.1)*
- Preparatory work has begun to introduce PREMs and PROMs to strengthen patient-reported insights *(4K.1)*
- The Preconception Strategy has been refreshed, completing the baseline assessment against the Perinatal Engagement Framework, rolling out cultural competency training within community teams
- Phases 3–5 of the All-Wales Maternity Survey have been delivered, improving understanding of women's experiences *(4K.5)*
- Strong progress has been made against the seven key actions within the Quality Statement for Maternity and Neonatal Services, including confirmation of a digital maternity system go-live date of 10 March 2026 *(4K.5 / 4K.6)*
- Neonatal services continue to make progress, with all three units signing the Bliss pledge, YGC and Wrexham achieving bronze accreditation, and the BAPM Fi Care Framework completed across all units *(4K.5)*
- Workforce planning has progressed, including completion of the baseline assessment against the HEIW perinatal workforce plan, while national service specifications are awaited *(4K.8)*
- KPI mapping for the Perinatal Quality Surveillance Dashboard has been completed, with an initial version expected early in 2026 *(4K.9)*
- Work is underway to develop a business case for recurrent funding to establish a specialist infant feeding and lactation support service across the three Integrated Health Communities *(4K.10)*

Remainder of the financial year

- Continued project oversight, workforce planning and recruitment activity will ensure progress remains on track, although some areas remain dependent on national *developments (4K.1–4K.10)*
- Ongoing monitoring through the Women's Integrated Performance Group, with reporting through the Women's Senior Leadership Team and Service Board *(4K.1–4K.10)*
- Efforts will continue to ensure appropriate digital and operational support for delivery of the Women's Health Hub, digital maternity solution and perinatal framework commitments *(4K.1 / 4K.6 / 4K.7)*

Impact

- Strengthened engagement with women and families has enhanced understanding of local needs and supported development of more accessible, integrated models of care, particularly through the Women's Health Hub
- Workforce initiatives, including leadership development, enhanced sonography capacity, and improved bereavement and transitional care pathways, have strengthened capability and contributed to a better patient experience
- Diagnostic capacity has increased, and KPI mapping has enhanced readiness for perinatal quality surveillance
- Early patient insight mechanisms (PREMs, PROMs and surveys) are beginning to generate actionable data to improve service design
- Foundations laid for the specialist infant feeding service, and refreshed preconception strategy, are expected to improve breastfeeding outcomes and strengthen prevention
- While full measurable impact will follow as models mature, progress made this year has created a strong platform for more equitable access and improved health outcomes for women across North Wales

4L Children & Young People	Chief Operating Officer	Delivery Confidence
4L.3. Progress the Health Board signing of the Wales Corporate Parenting Charter to support care experienced children to have the same opportunities as all children.		Q2
4L.1. Work on raising awareness and implementing the Children's Charter across the Heath Board.		Q4
4L.2. Work towards the establishment of a Youth Voice Board in the Heath Board to ensure children's rights are upheld and children are consulted and involved in the development and provision of services. (Linked to 3C.8)		Q4
4L.4. Further improvements in children's Immunisation uptake levels.		Q4
4L.5. Develop transition pathways.		Q4
4L.6. Work with partners on the Right Door approach to support children with complex needs.		Q4

Overview

- The Children and Young People sub objective contains six priorities focused around supporting the Children's Charter and the Parenting Charter together with initiatives to increase the 'youth voice' within the organisation, as well as a focus on increasing the uptake levels of Children's immunisation and further support to children with complex needs.

Current Position

- Work has progressed on endorsing and raising awareness of the Children's Charter across the Health Board, supporting an organisational commitment to improving the health and well-being of children and young people *(4L.1)*
- The Health Board has signed the Wales Corporate Parenting Charter, reinforcing its commitment to ensuring care-experienced children have the same opportunities as all children *(4L.3)*
- Early development work has commenced to establish a Youth Voice Board, ensuring children and young people are consulted and involved in shaping services *(4L.2)*
- Regional collaboration via the RPB has strengthened significantly, particularly in progressing the Right Door Approach to support children with complex needs, and improving emotional health and well-being pathways, including for children with neurodevelopmental needs *(4L.6)*
- The maturing RPB Children's Group provides improved structure, momentum and shared learning, supporting earlier identification and response to children's needs *(4L.6)*

Remainder of the financial year

- Focus will be on gathering and consolidating evidence of progress from across regional children's services to demonstrate achievements against all six priorities

Impact

- Strengthened partnership working across the region has created a more robust and influential RPB Children's Group, driving improvement through active multiagency sub-groups focused on priority areas
- These strengthened partnerships have created better momentum for local teams, enabling new approaches, improved coordination, and earlier identification and response to children's needs

4M Pharmaceutical Services	Chief Operating Officer	Delivery Confidence
4M.2. Establish a Medicines Value prevention arm that leverages diabetes prescribing and Value-Based outcomes while optimising cost efficiencies.		Q2 *
4M.5. Launch the first Mpharm cohort at Bangor University in 2025, working with General Pharmaceutical Council (GPhC) towards achieving Step 4 accreditation by the 2025/26 academic year		Q3
4M.1. Implement the prioritised actions from the Independent Review of Hospital Clinical Pharmacy Services across all hospital settings (including MHLD, Cancer, Women's) subject to available resources.		Q4
4M.3. Develop a business case to centralise Radiopharmacy services, aligned with the nuclear medicine programme and supported by the national TrAMs programme team.		Q4
4M.4. Scope and test a model for commissioned community pharmacy services focused on long-term condition management, starting with hypertension.		Q4

Overview

- Work within the Pharmaceutical Services sub objective is based around five priorities: Implementing prioritised actions from the Independent Review of Hospital Clinical Pharmacy Services across all hospital settings, cost efficiencies through Medicines Value prevention (particularly in diabetes care), additional community pharmacy services, and the launch of a general pharmaceutical council approved master in pharmacy qualification with Bangor University.

Current Position

- Significant progress has been made during 2025/26 in strengthening and modernising Pharmaceutical Services across North Wales, with delivery focused on establishing sustainable foundations, progressing national programmes and enhancing workforce and service models *(4M.1–4M.5)*
- Engagement in national Delivery Assurance Groups continues to support implementation of the Independent Review of Hospital Clinical Pharmacy Services, ensuring readiness to adopt consistent national standards as they are completed *(4M.1)*
- Progress has been made across areas including medicines advice (WMAS), radiopharmacy via the TrAMS programme, and prioritisation of pharmaceutical care planning *(4M.1, 4M.3)*
- A major achievement this year has been the launch of the first MPharm cohort at Bangor University in September 2025, establishing a local education pipeline to support long-term workforce sustainability *(4M.5)*
- The community pharmacy-led hypertension pilot has been fully delivered, including patient recruitment, activity data collection and experience feedback, with independent evaluation arrangements well progressed *(4M.4)*
- Monitoring of diabetes prescribing spend is now embedded across primary care, supporting improved transparency and enabling future value-based medicines approaches *(4M.2)*
- The TrAMS programme has expanded into a broader Pharmacy Technical Services transformation, with agreed governance, national support and a programme manager appointed *(4M.3)*

Remainder of the financial year

- Overall delivery is partially on track, reflecting differing progress levels across component areas and national dependencies extending beyond March 2026 *(4M.1–4M.5)*
- By the end of March 2026, the Health Board expects to have fully embedded participation in the national Delivery Assurance Groups and to be prepared to implement national standards from the Clinical Pharmacy Review as they are finalised *(4M.1)*
- Independent evaluation of the hypertension pilot will be completed and fed into national policy and service development, supporting wider adoption *(4M.4)*
- The MPharm programme will be established as a functioning and sustainable education pipeline, with the first cohort progressing through its academic year *(4M.5)*
- The TrAMS Pharmacy Technical Services transformation programme will be mobilised, supported by governance arrangements, a programme manager and an agreed forward plan following joint estate and scoping work *(4M.3)*
- Some elements will not be completed this year, including full implementation of the Independent Review recommendations for clinical pharmacy services, measurable population-level outcomes from diabetes medicines optimisation and value-based prescribing, and radiopharmacy reconfiguration, all of which rely on multi-year national programmes *(4M.1–4M.3)*

Impact

- The work completed this year has strengthened the foundations for sustainable improvement in pharmaceutical care, patient safety, equitable access and workforce resilience across North Wales
- Nationally coordinated delivery of clinical pharmacy review recommendations is improving consistency and professional leadership, and assurance, supporting clearer standards and more equitable hospital pharmacy models over time
- The hypertension pilot has demonstrated the feasibility, acceptability and value of pharmacy-led long-term condition management, with feedback evidencing positive patient experience and effective use of community pharmacy capacity
- The launch of the MPharm programme has delivered a major workforce impact, with 31 students enrolled and 10 more joining via the preparatory year route, forming a long-term supply pipeline to address historic workforce challenges
- Improved monitoring of diabetes prescribing spend has enhanced transparency and governance, enabling better informed decision making; even though measurable population outcomes will emerge over a longer period
- Overall, this year's delivery has created strong enabling conditions for future improvements, with meaningful early benefits and clear trajectories for continued progress through 2026/27

4N Palliative, End of Life and Bereavement Care	Executive Director of Nursing and Midwifery	Delivery Confidence
4N.1 Develop a Strategic Delivery Plan for Palliative Care and End of Life Care (PEoLC).		Q4
4N.2. Commence implementation of the SWAN model for bereavement care, to support and guide the care of patients and their loved ones during end-of-life care and afterwards.		Q4
4N.3. Develop a model and workforce plan to improve PEoLC in line with the Welsh Government Quality Statement for Palliative and End of Life Care		Q4
4N.4. Finalise the Quality Improvement Strategy for End of Life Care Decision making. Develop an options appraisal and business case to improve PEoLC in accordance with the Quality Improvement Strategy for End of Life Care decision making.		Q4

Overview

- The Palliative, End of Life and Bereavement Care sub objective contains four priorities all of which are scheduled for delivery within Q4.
- The outcomes of these priorities include development of a Strategic Delivery Plan for Palliative Care and End of Life Care (PEoLC), supporting patients and their families through implementation of the Sign/Words/Actions/Needs) SWAN model for bereavement care and revision of operating model and supporting workforce plan to improve PEoLC in line with the Welsh Government Quality Statement for Palliative and End of Life Care.

Current Position

- Since August 2025, significant groundwork has strengthened governance, strategic direction and operational delivery for Palliative and End of Life Care (PEoLC) *(4N.1–4N.4)*
- Strengthened Governance has improved through 6-weekly meetings with the Executive Lead and a full review of the Strategic PEoLC Group's membership and Terms of Reference *(4N.1)*
- A draft Strategic PEoLC Plan has been developed, aligned with national direction and supported by a working group undertaking a gap analysis against the All-Wales Service Specification for PEoLC *(4N.1, 4N.3)*
- Rollout of the SWAN Model of Care is progressing in line with the local implementation plan. Pilot wards have been identified in each District General Hospital, with training commencing ahead of wider rollout scheduled for 2026 *(4N.2)*
- Workforce planning is underway to support the updated Welsh Government Quality Statement. A full review of Specialist Palliative Care (SPC) capacity is required but currently limited by the absence of formal activity recording. A business case will be developed in Q4 to address this *(4N.3)*
- Additional weekend SPC nursing cover has been introduced in the Central Integrated Health Community through Further Faster funding, improving timely access to specialist support and enhancing clinical decision-making for community teams *(4N.3)*

- Quality improvement planning continues, Quality Improvement Strategy will be integrated into the wider Strategic PEoLC Delivery Plan once approved, providing a structured approach to continuous improvement *(4N.4)*

Remainder of the financial year

- The programme will continue into the next financial year due to earlier delays arising from prolonged gaps in Head of Nursing support and the absence of dedicated operational and administrative resource *(4N.1–4N.4)*
- Capacity constraints have slowed progress in key areas; however, momentum is increasing, and foundational work established in 2025 provides a stronger platform for accelerated delivery in 2026

Impact

- Increased weekend SPC nursing cover in the Central IHC has improved responsiveness, strengthened clinical decision-making, increased capacity for home visits and supported continuity of care at weekends, while the West IHC has maintained strong performance and the East IHC continues to develop its capacity
- Cross-IHC collaboration has enhanced resilience and improved timely access to advice across geographical areas, strengthening teamwork and service responsiveness
- Early implementation of the SWAN Model is beginning to enhance patient, family and carer experience, with expected improvements in compassionate, personalised and coordinated care. Impact will be monitored through feedback, Datix themes, complaints and compliments, and audit findings

4O Dental	Chief Operating Officer	Delivery Confidence
4O.6. Review and revise the dental budget to ensure appropriate support is given to services. This work will be revenue neutral and aims to leverage better value from the financial resources currently supporting the provision of dental services.		Q2 *
4O.10. Improve Board visibility of primary care dentistry performance data.		Q2
4O.1. Work to increase GDS service provision, this will require consideration of new and innovative solutions alongside existing methods. The Health Board will continue to liaise with partners such as the Chief Dental Officer for Wales and the Local Dental Committee, to support this in addition to working with other Health Boards where primary care dental services are performing well.		Q3
4O.4. Use the 'Primary Care Academy' approach to support healthcare professionals to develop advanced skills within primary care that allow skill-mix changes and increased workforce stability. The aim is to expand this work in order to offer development opportunities both within CDS and GDS which will ultimately benefit patient care.		Q3 *
4O.8. Undertake a demand and capacity review for CDS services to understand activity patterns to be able to effectively forecast when staffing will be required and to what degree.		Q3 *
4O.2. Re-evaluate areas of need and go back out to procurement for GDS access in 2025, working with the procurement team to improve the framework of the tender in order to expand the pool of potential bidders.		Q4
4O.3. Progress dental education strategy, setting out plans for all workforce in line 'Primary Care Model for Wales'. The aim of the strategy is to make North Wales a centre of excellence for all Dental professions by providing upskilling, training and development opportunities for all members of the dental team, including working with Bangor University to build on the Dental Hygienist and Dental Therapist courses, supporting a community based service.		Q4
4O.5. Work with Public Health team in continued delivery of national programmes such as 'Designed to Smile' and 'Gwên am Byth'.		Q4
4O.7. CDS waiting lists to be addressed to ensure patients are not waiting significant lengths of time. Solutions include optimising front line clinical resource, improving the patient appointment booking centre (PABC), and creating key performance indicators (KPIs) to underpin operational management.		Q4
4O.9. The formation of a clear domiciliary dental pathway with a robust eligibility criterion. Agreeing the right approach will involve dental officers who are responsible for delivering the activity. As most of the domiciliary activity takes place within care homes, an inclusive approach will be taken to codesign any agreed pathways.		Q4

Overview

- The Dental sub objective consists of 10 priorities incorporating a wide range of activities, the outcomes of which are designed to increase GDS provision, capacity and performance whilst also leveraging better value from current financial resources.
- Together with measures to enhance workforce stability and provide upskilling, training and development opportunities whilst supporting a community-based service and reducing waiting times for treatment.

Current Position

- A significant procurement process has been completed, awarding approximately £6 million of contracts to dental providers across north Wales *(4O.1, 4O.2)*
- Board visibility of primary care dentistry has improved through establishment of the Primary Care Board and sub-group structure, providing stronger accountability and assurance, with monthly reporting to IPEDG ensuring sustained executive oversight *(4O.10)*
- A dental education plan is in development, supported by the Primary and Community Care Academy *(4O.3, 4O.4)*
- Progress continues with national oral health promotion programmes such as Designed to Smile and Gwên am Byth, where BCUHB is one of the top performers nationally. These programmes which aim to deliver preventative guidance and advice to people in care home and school settings *(4O.5)*
- The dental budget is under review to establish a clear structure for 2026/27 *(4O.6)*
- Work is underway to improve waiting times within the Community Dental Service, with operational and clinical teams reviewing the waiting list and prioritising patients who have waited the longest *(4O.7, 4O.8)*

Remainder of the financial year

- A series of established oversight meetings will monitor progress and ensure the overarching aim is achieved by March 2026, involving senior leaders from the dental service and the Primary and Community Care Academy *(4O.1–4O.10)*

Impact

- The award of approximately £6 million of new dental contracts is expected to have significant population-level impact; while some contracts have already commenced, full benefits will be realised once all are mobilised by May 2026
- The dental education plan will support a sustainable and skilled workforce by providing improved access to education and training, promoting skill-mix development and supporting recruitment and retention
- Continued delivery of targeted oral health promotion initiatives will support prevention, early intervention and self-care, helping drive behavioural change and improving oral health outcomes across communities
- Effective financial management will support the delivery of sustainable dental services and support future commissioning options and efficient resource use within CDS

4P Diabetes	Executive Director of Public Health	Delivery Confidence
4P.1. The Health Board Diabetes Programme will contribute to increasing the % of those aged 12+ receiving the 8 Care Processes		Q4
4P.3. The Health Board will seek to strengthen the multi-disciplinary specialist diabetes team to support transition to adult services and to respond quickly to the increasing number of new presentations.		Q4
4P.4. In adult diabetes teams a more comprehensive service model will be required to deliver diabetes technology to people with Type 1 diabetes in line with the national directive		Q4
Secondary care 4P.2. Implementation of the NICE Technology Appraisal to provide 'artificial pancreas' technology called Hybrid Closed Loop (HCL) systems which offer people who develop this particular auto-immune condition the opportunity to enjoy normal glucose control. There is a significant resource requirement associated with this development, which is planned for implementation over a 5-year period, subject to the agreement of funding.		Q4

Overview

- The Diabetes programme focuses on delivery of the Cabinet Secretary priorities and on improving the outcomes of people with diabetes in our population.
- It also sets out to respond to wider delivery targets associated with the change pathway for Diabetes treatment, prevention and early intervention.

Current Position

- Baseline data for the Diabetes 8 Care Processes has been established *(4P.1)*
- Improvements against targets for the 8 Care Processes have already been achieved during the year *(4P.1)*
- A business case for the Hybrid Closed Loop (HCL) system has been developed with input from senior managers, intended for further refinement ahead of 2026/27 planning and funding allocations *(4P.2)*
- An evaluation of key elements of transition services has taken place. Findings will inform future plans and align with broader organisational work such as the Clinical Services Plan, Foundations for the Future, and pathway redesign programmes *(4P.3)*

Remainder of the financial year

- Rollout of the Hybrid Closed Loop programme will now begin in 2026/27 as part of wider planning and allocation processes for that year *(4P.2)*
- Work to improve delivery of the 8 Care Processes will continue, using the established baseline and variation identification, with practices identifying key areas requiring additional support *(4P.1)*
- Strengthening of multidisciplinary diabetes teams is planned as part of the ongoing development of the Diabetes Change Programme for 2026/27 *(4P.3, 4P.4)*

Impact

- Moderate improvement has been seen in the number of people receiving all 8 Care Processes; where all are completed, evidence shows improved outcomes and reduced risk of complications
- The Hybrid Closed Loop programme is supported by a prioritisation schedule to identify groups for transfer, with the business case demonstrating the expected benefits of HCL technology. Using clinically and cost-effective diabetes technology will ease daily burdens for people with Type 1 diabetes and their families.
- Overall impact has been modest to date; however, key foundational work undertaken during 2025/26 will enable greater improvements across the diabetic population of North Wales from 2026/27 onwards

Annual Delivery Plan Quarter 3 - Overview by Sub-Objective				
KEY:	**High Delivery Confidence**	**Medium Delivery Confidence**	**Low Delivery Confidence**	**Complete**

*Not delivered in expected quarter

5A University and Further Education Partnership	Executive Medical Director	Delivery Confidence
5A.1. The Health Board will seek to build the relationships with all higher and further education partners to improve the impact across research and development, education and training and innovation thus supporting our continued achievement of University Designation.		Q3 *
5A.5 (4M.5) - Launch the first MPharm cohort at Bangor University in 2025, with General Pharmaceutical Council (GPhC) Step 4 accreditation achieved by 2025/26		Q3
5A.6 (2C.7) - Work with the University of Wales Bangor to support the development and growth of the North Wales Medical School.		Q3
5A.2 . Having maintained and developed relationships, BCU will explore the value in a regional approach to partnership with all stakeholders.		Q4
5A.3. Work with education providers in the development of the Health Board's Clinical Services Plan to increase their understanding and open up opportunities for transformational and innovative change to be reflected.		Q4
5A.4. Building on the successful establishment of the North Wales Medical School, we will continue to work with and support all partners in achievement of strategic projects.		Q4
5A.7 (4O.3) - Progress dental education strategy, setting out plans for all workforce in line 'Primary Care Model for Wales'. The aim of the strategy is to make North Wales a centre of excellence for all. Dental professions by providing upskilling, training and development opportunities for all members the dental team, including working with Bangor University to build on the Dental Hygienist and Dental Therapist courses, supporting a community-based service.		Q4

Overview

- The University and Further Education Partnership sub objective is based around seven priorities delivering a number of benefits for the organisation focused around further developing relationships with all higher and further education partners in North Wales to improve research and development, education and training, all supporting continued University designation.

Current Position

- The Health Board's work to develop relationships with further and higher education partners is at an advanced stage *(5A.1)* Memoranda of Understanding (MoUs) are now in place with GLLM and Bangor University, with an MoU scheduled for signing with Wrexham University in February and similar arrangements expected with Coleg Cambria in March *(5A.1 / 5A.2)*
- Closer alignment with HE and FE partners is progressing as the first stage in broader partnership arrangements, enabling the organisation to begin analysing workforce needs for education and training across all professions *(5A.1 / 5A.3)*

By 31 March 2026, the following will have been achieved:

- Development and signing of MoUs with both FE and both HE institutions *(5A.1)*
- Establishment of Strategic Steering Groups to support bilateral relationships with each of the four organisations *(5A.2)*
- Consideration of how a regional partnership approach may operate and the collective benefits *(5A.2)*
- Completion of an internal discovery report for education and training, submitted to the People & Culture Committee *(5A.3)*
- Collation and analysis of all training currently commissioned directly by BCUHB *(5A.3)*
- Development of a draft Strategy for Research & Development with Bangor University for review at the next Strategic Steering Group *(5A.4)*

Remainder of the financial year

- Drive forward the regional partnership approach by engaging all four education institutions to obtain the necessary agreement

Impact

- Strengthened and formalised partnerships with all higher and further education institutions will create a more coordinated and sustainable pipeline for the future workforce, improving recruitment, retention and development across clinical and non-clinical roles
- A clearer, system-wide understanding of education and training needs will support more responsive planning, ensuring the organisation can better align skills, capacity and capability with service requirements
- Improved collaboration with HE and FE partners will enhance opportunities for research, innovation and knowledge exchange, contributing directly to the Health Board's ambition to sustain its University designation
- Greater consistency and shared governance across partners will support more efficient commissioning, reduce duplication and enable resources to be targeted where they have greatest impact
- The establishment of Strategic Steering Groups and a regional partnership approach will strengthen decision-making and enable long-term alignment on key strategic programmes such as the Medical School, MPharm developments and dental workforce strategy

5B Research, Development and Innovation	Executive Medical Director	Delivery Confidence
5B.1. Completed development of a support infrastructure and expert panel with M-SParc, OpTIC Technology Centre, Bangor University and Wrexham University, supported by Welsh Government. Innovators will be able to access the expert panel for advice and guidance.		Q4
5B.2. Continue to increase research activity, both commercial and non-commercial research.		Q4
5B.3. Increase the number of joint appointments and honorary research appointments with our academic partners.		Q4

Overview

- The Research, Development and Innovation sub objective is based around three priorities focused around increasing both commercial and non-commercial research activity and to further develop supporting infrastructure with partners.

Current Position

- A support infrastructure and expert panel has been established with key partners supported by Welsh Government, enabling local innovators to access expert advice and guidance *(5B.1)*
- This infrastructure has facilitated several collaborative projects being taken forward through the All-Wales Innovation Framework *(5B.1)*
- Although recruitment to portfolio and commercial trials has not increased, significant numbers of the population have still been offered opportunities to participate in research *(5B.2)*
- Appointment of research fellows has strengthened research delivery capacity and enhanced collaboration with Bangor University and clinical services *(5B.3)*

Remainder of the financial year

- Sub-objectives 5B.1 and 5B.3 remain on track for delivery
- Progress on delivering 5B.2 is not on track

Impact

- Research activity has enabled the population of North Wales to participate in high-quality studies, providing access to new technologies and drugs that may improve future care and treatments
- Evidence suggests research-active organisations achieve better outcomes, improved mortality rates and stronger recruitment and retention of high-quality staff
- Appointment of research fellows will support increases in research activity and contribute to developing further collaborative posts with Bangor University

- The innovation support structure enables innovators to bring forward ideas that may improve health outcomes for the population of Wales and contribute to potential product commercialisation

5C Academic Careers	Executive Director of Allied Health Professionals and Health Science	Delivery Confidence
5C.1. Whilst awaiting a national definition, hold a multidisciplinary workshop with those currently working in academic careers, and with those who aspire to this career pathway, to agree a local working definition.		Q2 *
5C.2. Explore the academic career pathway framework, utilising the outputs from the workshop to inform a paper, which will be built upon with proposals for the supporting governance framework, and supplemented by learning and best practice from other health and academic organisations.		Q4

Overview

The Academic Careers sub objective is based around two priorities delivering a revised academic careers pathway, however pending agreement of a formal national definition of academic careers scope of this sub objective will be limited to provision of a local working definition.

Current Position

- The Community of Interest Working Group was established in November 2025 and has developed Terms of Reference and agreed membership to support delivery of the academic careers agenda *(5C.1)*
- An outline Academic Careers Framework has been developed as a key deliverable for the Annual Delivery Plan *(5C.2)*
- An outline programme for the Community of Interest workshop has been drafted, intended to inform the local working definition of academic careers pending national definition *(5C.1)*
- Links have been established with the national programme led by Health and Care Research Wales, as well as related policy work underway within People and Organisational Development, ensuring alignment and shared learning *(5C.2)*
- Although no formal metrics are associated with the work, baseline information will be gathered in 2025/26 to support monitoring and reporting from 2026/27 onward. This will also inform research and development objectives *(5C.2)*

Remainder of the financial year

- The multidisciplinary workshop originally planned for Q2 will now take place in Q4. Outputs from the workshop will be essential to finalising the academic careers framework *(5C.1)*
- The Academic Careers Working Group is progressing actions through the Informal Executive Committee ahead of Formal Executive Committee *(5C.2)*
- A draft outline of the framework has been prepared and agreed, but further refinements will depend on the workshop outputs. Completion of the framework is expected by 31 March 2026, although consultation and executive submission may extend into April or early May 2026 *(5C.2)*

Impact

- No formal metrics are currently in place, but baseline information gathered during 2025/26 will underpin future monitoring and reporting beginning in 2026/27, supporting broader Research and Development aims

5D Intelligence Led	Chief Digital and Information Officer	Delivery Confidence
5D.5. As part of the Operational dashboard (IRIS2) rollout, implement the necessary foundations that will enable use across all types of devices in an intuitive and bespoke manner.		Q1
5D.6. Building on the progress made with Planned care data, the Health Board will undertake a data maturity assessment of urgent and emergency care and develop a programme of work to develop the use of intelligence and insight in this area.		Q2
5D.1. Build on proof-of-concept work to develop proposals for Robotic Process Automation (RPA) to reduce reliance on manual processes.		Q4
5D.2. Delivery of a Health Board data quality kite-mark to improve data for decision making, supported by the extension of data models written for RTT.		Q4
5D.3. Continued development of forecasting capabilities and proposals for the introduction of predictive analytics that will in turn support improved planning and decision making around planned and urgent and emergency care.		Q4
5D.4. Roadmap for the further development of data warehousing will be documented, incorporating the de-commissioning of the Health Board's legacy warehouse. Commence implementation of Cloud Based Technology through transition to the National Data Analytics Platform for submitting data and establishing arrangements for transition from On-Premise to Cloud, all aligned to the Care Data Resource.		Q4

Overview

- The Intelligence Led organisation sub objective is based around six priorities delivering enhanced automation of processes to reduce reliance on manual intervention, support improved decision making and reduce reliance on legacy systems.

Current Position

- Delivered strong progress toward developing an intelligence-led organisation capable of using high-quality data, forecasting and automation to support operational management and improved outcomes *(5D.1–5D.6)*
- Completed Robotic Process Automation (RPA) proof-of-concepts to streamline administrative tasks in the Welsh Patient Administration System and expanded automation into data preparation for messaging services *(5D.1)*
- Established a formal governance process through the Clinical Design Authority to ensure safe and prioritised RPA expansion *(5D.1)*
- Launched a data-quality kite-mark for Referral to Treatment data, supported by user-education webinars, strengthening data quality and trust in RTT datasets *(5D.2)*
- Advanced forecasting across urgent and emergency care, cancer pathways and diagnostics, including embedding winter modelling into operational planning *(5D.3)*
- Significant progress in modernising our data infrastructure included major dataset migration from the legacy data warehouse, with preparatory work for cloud-based analytics using the National Data Analytics Platform *(5D.4)*
- Launched a redeveloped IRIS intelligence portal, improving access to live operational data *(5D.5)*
- Completed a data-maturity assessment for urgent and emergency care and initiated a structured improvement plan to enhance intelligence and insight *(5D.6)*

Remainder of the financial year

- A structured plan for expanding RPA capability will be progressed through a newly established working group, including exploration of opportunities for clinical coding automation in collaboration with other Welsh Health Boards *(5D.1)*
- The data-quality kite-mark will be extended to cover referrals, removals and outpatient appointments, strengthening consistency and trust in high-value datasets *(5D.2)*
- Forecasting and predictive modelling will continue to be enhanced across urgent and emergency care, cancer and diagnostics *(5D.3)*
- Final decommissioning of the legacy data warehouse will be completed by March 2026, supported by technical, reporting and analytics workstreams preparing for full cloud-based analytics capability *(5D.4)*
- Ongoing development of the IRIS portal, using structured user feedback, will ensure intelligence is increasingly accessible and actionable *(5D.5)*
- Delivery of the urgent and emergency care data-maturity improvement plan, including standardised dashboards and enhanced forecasting, will continue to embed a data-driven culture *(5D.6)*

Impact

- Improved quality, usability and timeliness of intelligence available to clinical and operational teams, supporting better patient flow, waiting-list management and service planning
- The RTT data-quality kite-mark provides clearer assurance on completeness and validity of pathway information, strengthening decision-making
- Improved forecasting for urgent and emergency care and winter planning has strengthened operational resilience during periods of high demand
- The modernised IRIS portal is improving day-to-day operational responsiveness by enabling rapid access to live information
- Early RPA implementations are already reducing administrative burden, freeing staff time for higher-value patient-facing tasks
- Modernised data infrastructure provides the foundation for more advanced predictive analytics, supporting population-level planning and transformational redesign

5E Learning Organisation	Executive Director of Nursing and Midwifery	Delivery Confidence
5E.1. The Health Board will evaluate how the organisation learns from its investigations of serious incidents and complaints following the introduction of the Integrated Concerns and Complaints Policy.		Q4
5E.2 The Health Board will improve its systems and processes to ensure the transfer of learning as a Learning Organisation is increasing the opportunity to share learning and improve patient care.		Q4
5E.3. Develop a discovery report to inform an Education Strategic Plan for the Health Board.		Q4
5E.4 Improve processes to prepare for, respond to and embed learnings from any requests made by national Inquiries		Q4

Overview

- The Learning Organisation sub objective is based around four priorities delivering improvements to how the organisation learns from its own investigations of serious incidents and complaints together with any requests arising from national inquiries. Combined with improvements to systems and processes used to ensure transfer of learning to improve patient care.

Current Position

- Significant progress has been made in strengthening the organisation's approach to learning, assurance and improvement, with the Integrated Concerns Policy now fully embedded and learning reviewed systematically through local operational groups and the Executive Integrated Concerns Oversight Panel *(5E.1)*
- Monthly Learning Forum sessions continue to develop organisational learning capability, aligned to strategic priorities, alongside the launch of a centralised Learning Repository - initially piloted within Medication Management to standardise and improve access to learning resources *(5E.2)*
- A structured programme of thematic reviews has been introduced, supported by a tracker and a standardised methodology to identify system-wide issues and support targeted improvement *(5E.1, 5E.2)*
- A Discovery Report has been produced to inform the Education Strategic Plan, ensuring organisational learning and training needs are clearly understood and aligned to future workforce requirements *(5E.3)*
- Strengthened readiness for national inquiries has been established through clearer governance and oversight arrangements, contributing to improved organisational responsiveness *(5E.4)*
- A more mature and accessible organisational learning culture is emerging through the Learning Forum and Learning Repository, with staff contributions increasing in relevance and engagement; although attendance has not yet risen, feedback reflects strong value placed on practical learning and peer-to-peer insight *(5E.2)*
- Governance structures supporting incident learning have matured further, with learning pathways now strengthened across operational groups, thematic review functions, and organisational learning forums. This supports clearer escalation routes and alignment with patient safety, patient experience and regulatory assurance workstreams *(5E.1)*

Remainder of the financial year

- Work will continue to progress the actions outlined in the Discovery Report to shape improvements in learning, education and quality governance during Q4 *(5E.3)*
- The Learning Repository will move from pilot to early adopter rollout by the end of Q4, supporting more consistent organisational learning and improving access to shared knowledge *(5E.2)*
- Engagement with the Learning Forum will be strengthened through revised Terms of Reference, targeted assessments to identify barriers to participation, enhanced communication and additional thematic learning presentations to reinforce relevance and visibility *(5E.2)*

- Engagement assessments will also be used to ensure alignment between the Forum, Repository and other organisational learning initiatives, avoiding duplication and supporting a maturing system-wide learning culture *(5E.2)*
- The Thematic Review Group and Learning Forum will continue to disseminate learning from incidents, with ongoing system oversight to reduce never events, complaints and Prevention of Future Death reports. Patient stories insights through surveys and stories will remain central in shaping future learning and improvement work *(5E.1, 5E.2)*

Impact

- The Learning Forum and Repository are strengthening the organisation's learning culture and improving accessibility of shared knowledge
- Early feedback confirms strong value in practical insights and peer learning opportunities
- Thematic reviews continue to align with strategic priorities and identify areas for system-wide improvement, helping to focus organisational attention on recurring themes and drivers for change

Performance Finance & Information Governance Committee

2025-26 BCU Finance Report – Month 10 (January)

Date of Meeting	24 February 2026
Publication Status	Open/ Public
	Not Applicable
Report Author name and title	Michelle Jones, Head of Financial Reporting Daniel Eyre, Head of Capital Development
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 financial position of the Health Board as at the end of Month 10 (January 2026). In addition, the report includes an update on delivery of the approved Capital Programme and Savings delivery against target.

Finance Report

The Health Board is reporting a year-to-date deficit of £17.3m as at 31st January 2026, driven by the year to date impact of £20.5m local pressures (£4.9m JCC pressures, £8.3m Capacity pressures, £5.5m Out of Area MHLD placements and £1.8m cost overruns including contracting pressures & CHC) and £7.3m national pressures (year to date impact of £3.8m English tariff pressure above Cost Uplift Factor (CUF) funded uplift and £3.5m Employers NIC), offset by £9.0m additional savings and £1.6m mitigating actions.

The in-month (January 2026) position is reporting a marginal surplus of £0.03m, with the below table summarising monthly actual and forecast variance for 2025/26:

	2025/26													
	Actual										Forecast			
	April £m	May £m	June £m	July £m	August £m	Sept £m	Oct £m	Nov £m	Dec £m	Jan £m	Feb £m	Mar £m	Total Year to Date £m	Forecast Outturn Position £m
Total Monthly Surplus/ (Deficit)	(3.7)	(2.4)	(1.6)	(3.6)	(2.3)	(1.4)	(1.2)	(1.0)	0.0	(0.0)	(0.1)	(0.1)	(17.3)	(17.4)

As at Month 9 (December 2025), the forecast outturn position has been revised to report a projected deficit of £17.4m, with additional financial controls implemented to seek to reduce underlying cost overruns and improve the outturn within the remaining months of the financial year ending 31st March 2026.

The movement from break-even to a forecast deficit was in part driven through the Health Board being unable to mitigate national pressures that materialised following submission of the plan. The shortfalls in resource allocation for the Employers National Insurance uplift and Cost Uplift Factors (CUF) not matching the increased inflationary impact from provision of cross border services with additional pressures from JCC of £6.8m for cross border patients. In addition, the drivers of the financial deficit in year centre upon servicing additional capacity areas, Mental Health out of area placements and Continuing Healthcare (CHC).

Risk to delivery of the plan was highlighted in July 2025, with recommendations for implementation of enhanced controls developed by the Executive, the risk to delivery estimated at £20m. Initially a 1% cost improvement ask was levied to the Directorates, with further escalation to the August 2025 Health Board resulting in the formation of the Board-level Financial Oversight Group (first meeting in September 2025).

The Financial Oversight Group considered implementation of the additional controls, and whilst implementation of the approach was not supported as presented the Group requested services reduce expenditure by 1.5% from October 2025. This request shared with the wider leadership of the Health Board through the Integrated Performance – Executive Delivery Group and Operational Leadership Team forums.

Whilst this request generated some reductions, the proposals submitted were insufficient to bring the run rate within budget. As a result, in December 2025, the Financial Oversight Group agreed implementation of further centrally controlled measures developed within the Executive, designed at minimum to prevent a further deterioration in the position whilst maintaining access and quality of services for the local population.

Additional areas of control implemented include:

- **Non-Pay Expenditure Controls –** Additional controls will be widened to all non-pay categories which do not directly impact clinical care, 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, noting an escalation process to be in place through Executive Director to the Directorate of People Services and Organisational Development.
- **Temporary Workforce –** Additional oversight and scrutiny for use of temporary workforce through the relevant Clinical Executive leadership

Risks

The Health Board received in the current financial year £82m of conditionally recurrent funding, the conditions centring upon attainment of the financial plan. The current forecast deficit places at risk receipt of this allocation in future financial years.

Containment and reversal of cost overruns is now key to deliver the current forecast and improving the forecast outturn over the remaining months of the year ending 31st March 2026.

Savings

The Health Board has delivered the targeted savings of £40.0m contained within the financial plan for 2025/26. As at the end of January (Month 10), the Health Board having identified £37.6m Green saving schemes and fortuitous Accountancy Gains of £10.5m, giving a combined total of £48.1m, an increase of £3.1m from previous month.

Of these savings, £25.4m are recurring schemes with a full year effect of £31.7m and £22.7m identified as non-recurring saving schemes. It is essential that recurrent savings total £40m as we enter 2026/27 to avoid increasing the planned savings requirement for 2026/27. In addition, developing further savings will support mitigation of cost overruns in year.

Full year plan value of Red Schemes totals £1.3m and full year plan value of further pipeline opportunities totals £3.1m. Further work is required to convert red and pipeline opportunities into green schemes and identify further opportunities to mitigate cost overruns and secure recurrent savings as we approach 2026/27 to

provide assurance over delivery of the financial plans contained within the Integrated Medium-Term Plan (IMTP). <u>Capital Programme</u> The approved Capital Resource Limit (CRL) for 2025/26 is £59.2m, which includes £1.2m IFRS16 and £58.0m Capital. Year to Date expenditure is £30.2m.

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

Acronyms / Glossary of Terms	
CHC	Continuing Healthcare
CUF	Cost Uplift Factor
IMTP	Integrated Medium Term Plan
CRL	Capital Resource Limit
FOG	Financial Oversight Group

BCU 2025-26 M10 Finance Report

***Please see Appendix A* - BCU 2025/26 M010 Finance Report – January 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 If more than one applies, please list below:
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.*) **Link to Corporate Risk Register:** CRR24-06 Suitability and Safety of Sites CRR24-05 Delivery of the 25/26 Financial Plan
Wellbeing of Future Generations Act – Wellbeing Goals	A Resilient 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:	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 non-recurrent funding from Welsh Government that requires attainment of the 2025/26 plan (a) delivery of financial balance £40m and (b) de-escalation from Special Measures £42m for these funds to be received recurrently (available for future financial years). If the plan is not attained then the funding of £82m will be at risk of clawback from Welsh Government and this places risk on the sustainability of existing service models.	

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Respect

Finance Report – Health Board January - Month 10 2025/26

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**	• £17.3m Year to Date deficit driven by the impact of £20.5m local pressures (£4.9m JCC pressures, £8.3m Capacity pressures, £5.5m Out of Area MHLD placements and £1.8m cost overruns (including contracting pressures & CHC) and £7.3m national pressures (£3.8m English tariff inflationary pressure above funded uplift and £3.5m shortfall in ENIC funding), offset by £9.0m additional savings and £1.6m mitigating actions. • £17.4m Forecast outturn position. Additional financial controls implemented with immediate effect to seek to improve the outturn over the remaining months of the year ending 31st March 2026.
	Cash	• Closing Cash Balance as at 31st January 2026 was £5.1m, including £4.8m for Revenue expenditure and £0.3m for Capital projects. The Health Board is currently forecasting a closing cash balance for 2025-26 of £5.9m made up of £3.0m revenue cash and £2.9m capital cash.
	Savings	• The Health Board's financial plan has set a savings target of £40.0m to be delivered in 2025/26 profiled equally across the financial year • Full year forecast value of Green Schemes totals £37.6m and £10.5m Accountancy Gains, giving a combined total of £48.1m. • Year to Date Savings delivery is £42.3m, of which £20.9m is recurring • Contained within the £37.6m are £25.4m recurring savings with a full year effect of £31.7m which is below the £40m targeted in 2025/26 • Red schemes and pipeline opportunities total £4.4m, work is progressing to convert into green schemes and increase the level of opportunities. This would both support mitigations to in year financial pressures and offer schemes that will be required as we move into 2026/27.
	Capital	• Approved Capital Resource Limit (CRL) for 2025/26 is £59.2m. Year to date expenditure totals £30.2m.
	PSPP	• Quarter 3 PSPP for paying non-NHS invoices was 97.1% by number and 98.5% by value (Welsh Government target 95.0%).
Key Risks & Matters for Escalation		➢ Risk to delivery of the plan highlighted in July 2025 through the Executive, with recommendations for implementation of enhanced controls developed by the Executive, the risk to delivery estimated at £20m. Initially a 1% cost improvement ask was levied to the Directorates, with further escalation resulting in the formation of the Board-level Financial Oversight Group. ➢ Implementation of additional controls identified from the Executive were considered and whilst implementation of the approach was not supported as presented, the Group requested services reduce expenditure by 1.5% from October 2025 shared with the wider leadership of the Health Board through the Integrated Performance – Executive Delivery Group and Operational Leadership Team forums. ➢ In December 2025, the Financial Oversight Group agreed to implement a further centrally controlled measures developed within the Executive, at a minimum to prevent a further deterioration in the position whilst maintaining access and quality of services for the local population. Additional controls implemented include: ❖ **Non-Pay Expenditure Controls –** Additional controls will be widened to all non-pay categories which do not directly impact clinical care 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

Key Performance Indicators

Month 10 Position

In Month: £196.9m against plan of £196.9m
Balanced

Year to Date: £1984.9m against plan of £1967.6m
£17.3m adverse

2025/26 Full Year Position

Forecast revised in M9 showing a £17.4m deficit against plan

YTD Divisional Variance

Division	Variance
West IHC	£12.1m adverse
Central IHC	£11.4m adverse
East IHC	£10.8m adverse
Womens	£2.2m adverse
MH & LD	£15.1m adverse
Commissioning Contracts	£9.4m adverse
ICD Primary Care	£1.6m favourable
ICD Regional Services	£4.1m adverse
Support Functions	£2.2m adverse
Other Budgets	£52.6m favourable

Savings

In Month: £6.2m against target of £3.3m

£2.9m favourable

Full Year Savings Delivery

£48.1m against target of £40.0m

Target Surpassed by £8.1m (Additional red schemes and opportunities of £4.4m are under review)

COVID-19 Impact

£9.2m Year to Date Cost

£13.0m COVID funding allocation from WG

Year to Date Income

£147.6m against budget of £139.8m

£7.8m favourable

Year to Date Pay

£993.3m against budget of £949.2m

£44.1m adverse

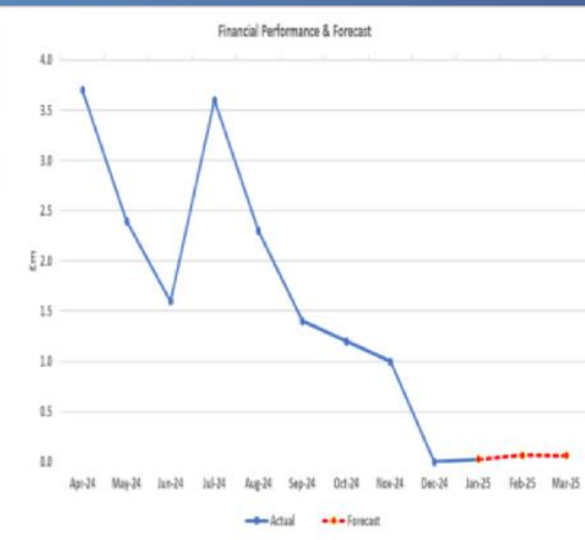
Year to Date Non-Pay

£1,139.2m against budget of £1,158.2m

£19.0m favourable

Revenue Position

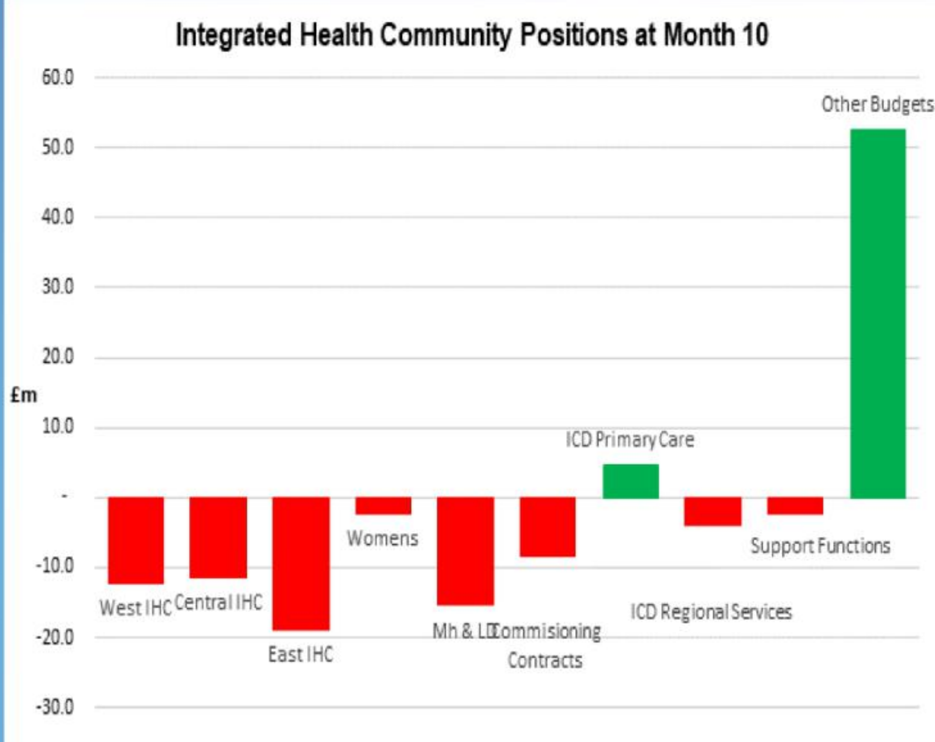
	Actual										Forecast		2025/26 Cumulative against Plan				Full Year Forecast
	M01 £m	M02 £m	M03 £m	M04 £m	M05 £m	M06 £m	M07 £m	M08 £m	M09 £m	M10 £m	M11 £m	M12 £m	Budget £m	Actual £m	Variance £m	Variance %	
Revenue Resource Limit	(186.5)	(189.5)	(189.9)	(194.9)	(207.5)	(198.1)	(200.4)	(194.6)	(205.8)	(200.3)	(194.7)	(204.9)	(1,967.6)	(1,967.6)	**0.0**	0.0%	(2,367.2)
Miscellaneous Income	(13.4)	(13.6)	(13.9)	(13.9)	(14.7)	(14.6)	(13.4)	(16.4)	(18.0)	(15.7)	(15.1)	(14.8)	(139.8)	(147.6)	**(7.8)**	5.6%	(177.4)
Health Board Pay Expenditure	94.9	96.4	96.0	96.1	110.6	99.9	100.4	98.8	100.2	100.1	92.8	97.4	949.2	993.3	**44.1**	4.6%	1,183.5
Non-Pay Expenditure	108.8	109.2	109.4	116.2	113.8	114.3	114.6	113.3	123.6	116.0	117.0	122.4	1,158.2	1,139.2	**(19.0)**	-1.6%	1,378.5
Total Deficit / (Surplus)	**3.7**	**2.4**	**1.6**	**3.6**	**2.3**	**1.4**	**1.2**	**1.0**	**0.0**	**0.1**	**0.1**	**0.1**	**0.0**	**17.3**	**17.3**		**17.4**



- Year to Date position is reporting a deficit of £17.3m,a balanced position is being reported in-month.
- Key drivers of the year to date deficit include £20.5m local pressures (£4.9m JCC pressures, £8.3m Capacity pressures, £5.5m Out of Area MHLD placements and £1.8m cost overruns (including contracting pressures & CHC) and £7.3m national pressures (£3.8m English tariff inflationary pressure above funded uplift and £3.5m Employers NIC) offset by £9.0m additional savings and £1.6m of mitigating actions.
- As expenditure continued to exceed the financial plan and the Health Board required to absorb several national pressures following submission of the plan, the risk to delivery was flagged from August onwards. In direct response, the Health Board established the Financial Oversight Group in September 2025. Subsequently, all areas were asked to reduce expenditure by 1.0% in September 2025, which was later increased to 1.5% in October 2025.
- Additional centrally controlled measures implemented from December 2025, designed at minimum to prevent a further deterioration in the position include:
  - **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.
- The above actions to support delivery of the 2025/26 financial plan are in addition to the Grip and Control actions implemented in 2024/25 that have been retained throughout 2025/26 and the additional mitigations implemented from August 2025.

Divisional Positions

	In Month				Cumulative				Forecast Year End Variance against the Plan
	Budget £m	Actual £m	Variance to Plan £m	Variance to Plan %	Budget £m	Actual £m	Variance to Plan £m	Variance to Plan %	£m
WG RESOURCE ALLOCATION	(196.9)	(196.9)	0.0	0%	(1,967.6)	(1,967.6)	0.0	0%	0.0
WEST INTEGRATED HEALTH COMMUNITY									
Management	0.1	0.1	0.0		1.1	1.1	0.0		0.0
West Area	18.1	17.8	0.3		177.7	180.3	(2.6)		(4.7)
Ysbyty Gwynedd	12.1	12.8	(0.8)		117.9	127.1	(9.1)		(11.4)
Facilities	1.2	1.2	(0.0)		12.0	12.5	(0.5)		(0.5)
Total West	31.5	31.9	(0.5)	-2%	308.8	321.0	-12.1	-4%	(16.5)
CENTRAL INTEGRATED HEALTH COMMUNITY									
Management	0.1	0.1	(0.0)		1.2	1.3	(0.1)		(0.1)
Central Area	24.0	23.5	0.5		236.4	234.4	2.0		(0.2)
Ysbyty Glan Clwyd	15.1	15.9	(0.8)		147.8	160.9	(13.1)		(16.4)
Facilities	1.5	1.5	(0.1)		14.6	14.8	(0.3)		(0.3)
Total Central	40.8	41.1	(0.4)	-1%	400.0	411.4	(11.4)	-3%	(17.0)
EAST INTEGRATED HEALTH COMMUNITY									
Management	0.1	0.1	0.0		1.0	0.9	0.1		0.1
East Area	26.5	26.5	(0.0)		261.7	271.6	(10.0)		(11.9)
Ysbyty Wrexham Maelor	13.1	13.9	(0.8)		127.8	136.8	(9.1)		(11.1)
Facilities	1.4	1.4	(0.0)		13.8	13.7	0.1		0.0
Total East	41.1	41.9	(0.8)	-2%	404.2	423.1	(18.8)	-5%	(22.9)
Total Midwifery and Women's Services	4.7	4.6	0.1	2%	43.6	45.7	(2.2)	-5%	(2.9)
Total Mental Health and LDS	15.6	15.9	(0.3)	-2%	153.5	168.8	(15.4)	-10%	(18.4)
Total Commissioning Contracts	26.9	27.3	(0.4)	-2%	270.8	279.2	(8.4)	-3%	(11.3)
INTEGRATED CLINICAL DELIVERY PRIMARY CARE									
Dental North Wales	3.1	2.5	0.6		31.2	27.0	4.2		4.7
Community Dental Services	0.6	0.6	0.0		6.3	5.8	0.5		0.6
Other Primary Care	0.1	0.1	0.1		1.4	1.5	(0.1)		(0.3)
Total Integrated Clinical Delivery Primary care	3.9	3.2	0.7	18%	38.9	34.2	4.6	12%	5.0
INTEGRATED CLINICAL DELIVERY REGIONAL SERVICES									
Provider Income	(1.9)	(2.2)	0.3		(19.2)	(21.8)	2.6		2.9
Diagnostic and Specialist Clinical Support	7.8	7.9	(0.1)		73.5	78.4	(4.9)		(6.3)
Cancer Services	6.5	6.7	(0.2)		62.9	64.7	(1.8)		(2.6)
Total Integrated Clinical Delivery	12.4	12.4	(0.1)	-1%	117.2	121.3	(4.1)	-3%	(6.1)
Total Service Support Functions	15.2	15.1	0.1	1%	146.7	148.9	(2.2)	-2%	(3.1)
Total Other Budgets	4.9	3.4	1.6	32%	84.0	31.4	52.6	63%	75.8
Total Health Board Position	0.0	(0.0)	(0.0)		0.0	(17.3)	(17.3)		17.4



- In-month position is reporting a balanced position the same as December's in month position. As at Month 9 (December) the forecast outturn was revised to report a projected deficit of £17.4m against the financial plan for the year.
- Variable pay costs have reduced in January by £0.4m from December driven by reductions across various categories. A breakdown of these costs are reported in slide 7.
- Further detail on Pay and Non-Pay spend is reported in Slide 6 and 11.

Expenditure – Pay & Non-Pay

Pay Costs	2025-26												Cumulative			Full Year Forecast
	Actual										Forecast					
	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	YTD Budget	YTD Actual	YTD Variance	
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Administrative & Clerical	13.2	13.3	13.3	13.3	15.2	13.8	13.8	13.7	13.8	13.6	13.4	14.1	141.6	136.9	4.7	171.0
Medical & Dental	22.3	22.7	22.2	23.0	26.7	23.7	24.1	23.3	24.2	23.8	20.7	21.7	214.3	236.2	(21.8)	263.9
Nursing & Midwifery Registered	28.8	29.1	29.2	28.9	33.6	30.1	30.4	29.7	30.0	30.4	28.7	30.1	284.4	300.3	(15.9)	365.7
Additional Clinical Services	14.2	14.7	14.6	14.4	16.2	14.8	14.8	14.6	14.6	15.0	14.2	14.9	137.6	148.1	(10.5)	181.0
Add Prof Scientific & Technical	3.9	3.9	3.9	4.0	4.8	4.1	4.2	4.3	4.2	4.1	3.6	3.8	44.6	41.5	3.1	46.2
Allied Health Professionals	6.4	6.3	6.4	6.4	7.5	6.8	6.7	6.7	6.7	6.7	6.2	6.5	64.0	66.7	(2.7)	78.5
Healthcare Scientists	1.7	1.7	1.7	1.7	2.0	1.8	1.8	1.8	1.8	1.8	1.5	1.6	18.3	18.1	0.2	19.6
Estates & Ancillary	4.3	4.4	4.5	4.3	4.7	4.5	4.4	4.4	4.5	4.5	4.4	4.6	43.6	44.5	(0.9)	56.5
Students	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.1	0.1	0.1	0.9	1.1	(0.2)	1.1
Health Board Total	**94.9**	**96.3**	**96.0**	**96.1**	**110.7**	**99.9**	**100.4**	**98.8**	**100.2**	**100.1**	**92.8**	**97.4**	**949.2**	**993.3**	**(44.1)**	**1,183.5**
Other Services (Incl. Primary Care)	3.1	3.1	3.1	3.0	3.3	3.4	3.0	3.0	3.1	3.3	3.2	3.2	28.6	31.6	3.0	37.9
Total Pay	**98.0**	**99.4**	**99.1**	**99.2**	**114.0**	**103.3**	**103.4**	**101.8**	**103.3**	**103.3**	**96.0**	**100.5**	**977.8**	**1,024.9**	**(47.1)**	**1,221.4**

Non-Pay Costs as per Monitoring Return Table	2025-26												Cumulative			Full Year Forecast
	Actual										Forecast					
	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	YTD Budget	YTD Actual	YTD Variance	
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Primary Care Contractor (excluding drugs, including non resource limited expenditure)	20.8	20.5	21.1	20.6	20.5	20.4	19.6	20.9	27.2	20.9	22.0	22.0	220.3	212.4	7.9	256.3
Primary Care - Drugs & Appliances	10.9	10.9	10.8	11.5	11.6	11.8	11.3	11.0	12.2	11.9	11.1	12.2	110.7	113.9	(3.2)	137.1
Provider Services - Non Pay (excluding drugs & depr	18.6	18.3	18.2	21.1	18.6	20.0	19.8	17.9	19.9	20.2	19.2	17.7	232.1	192.8	39.3	229.7
Secondary Care - Drugs	8.4	9.4	8.8	9.3	8.4	9.7	9.3	8.6	9.6	9.0	8.9	9.1	86.4	90.5	(4.2)	108.5
Healthcare Services Provided by Other NHS Bodies	32.2	31.9	31.1	33.5	34.4	32.9	33.1	34.1	30.9	33.1	34.3	34.2	314.5	327.2	(12.7)	395.7
Continuing Care and Funded Nursing Care	11.5	11.6	11.7	11.7	12.0	10.7	11.9	11.0	11.6	10.8	10.8	11.8	111.7	114.4	(2.7)	137.0
Other Private & Voluntary Sector	2.7	2.8	2.5	3.5	3.5	3.9	4.5	4.3	7.1	5.4	5.7	5.2	33.5	40.2	(6.7)	51.0
Joint Financing and Other	0.3	0.3	0.3	0.3	0.4	0.4	0.3	0.8	0.4	0.3	0.4	0.4	2.7	3.8	(1.1)	4.6
Losses, Special Payments and Irrecoverable Debts	0.2	0.4	0.2	0.6	0.3	0.4	0.5	0.4	0.4	0.0	0.4	0.4	2.5	3.5	(1.0)	4.2
Non-pay costs	**105.7**	**106.1**	**104.7**	**112.1**	**109.8**	**110.3**	**110.2**	**109.0**	**119.3**	**111.6**	**112.6**	**112.9**	**1,114.3**	**1,098.7**	**15.6**	**1,324.3**
AME/DEL Depreciation	3.2	3.2	4.7	4.0	4.0	4.0	4.3	4.3	4.3	4.3	4.3	9.5	40.5	40.5	0.0	54.3
Total non-pay	**108.8**	**109.2**	**109.4**	**116.2**	**113.8**	**114.3**	**114.6**	**113.3**	**123.6**	**116.0**	**117.0**	**122.4**	**1,154.8**	**1,139.2**	**15.6**	**1,378.6**

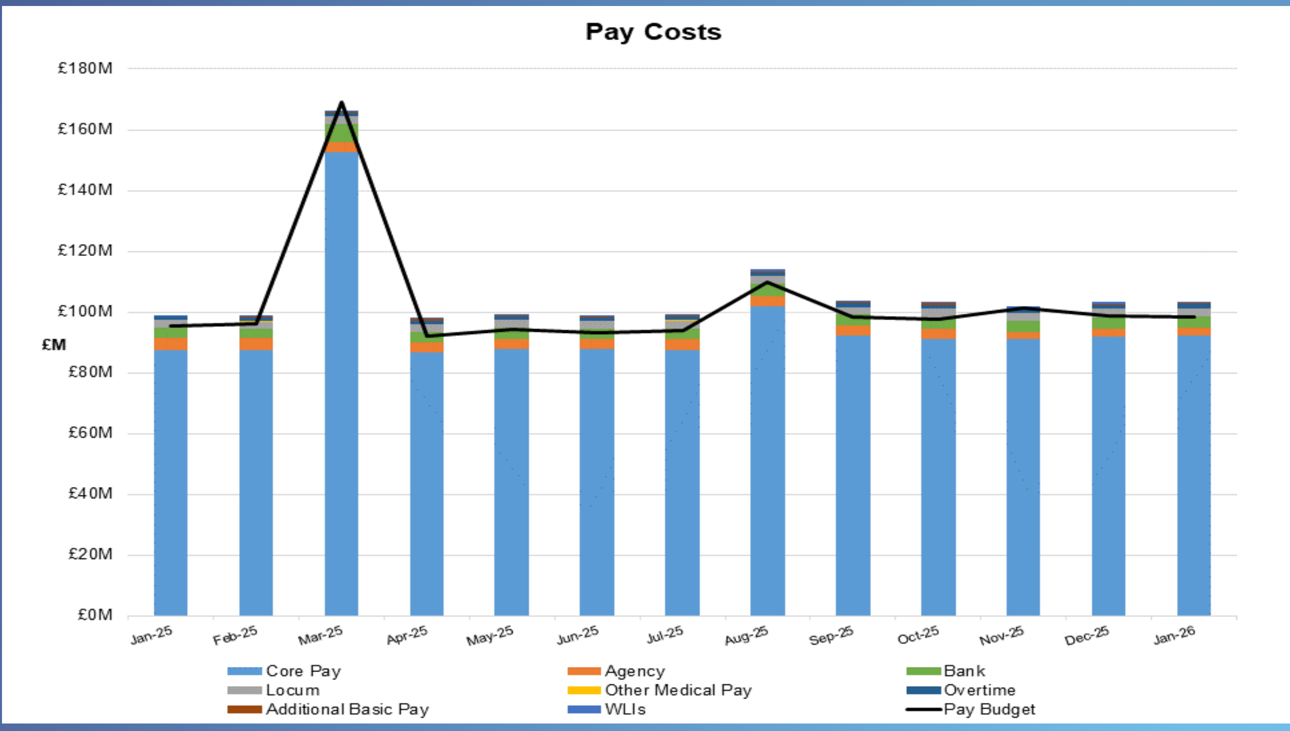
Health Board Pay:

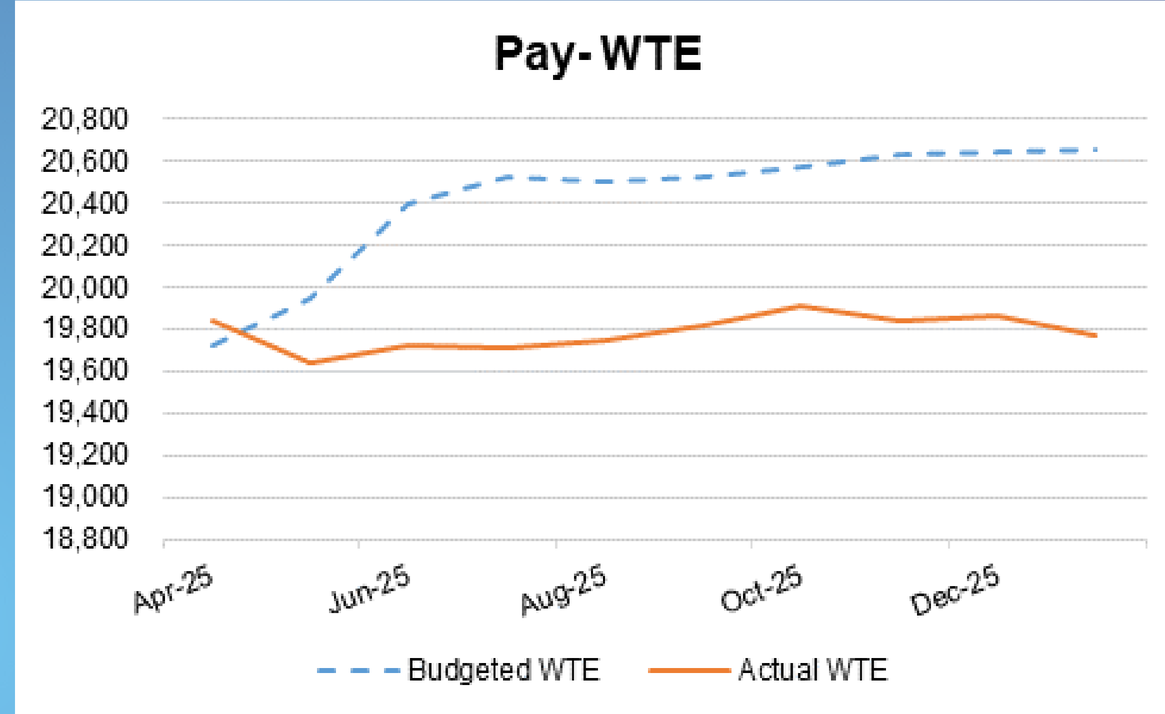
- Month 10 (January) Provider Services Pay reduced by £0.1m from previous month.
- Variable Pay totals £11.2m for January, a reduction of £0.4m from previous month driven by a reduction of £0.3m reduction in Agency and £0.3m in Locums offset by increases in other areas.
- Further detail on Variable Pay 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 £7.6m from previous month.
- Further detail on Non-Pay expenditure movements is reported in Slide 11.

Expenditure – Pay





Variable Pay	Actual 2025-26										YTD £m
	M01 £m	M02 £m	M03 £m	M04 £m	M05 £m	M06 £m	M07 £m	M08 £m	M09 £m	M10 £m	
Agency	3.3	3.5	3.3	3.6	3.4	3.3	3.1	2.3	2.9	2.6	31.3
Overtime	1.1	1.1	1.2	1.2	1.2	1.2	1.3	1.2	1.1	1.3	12.0
Locum	2.6	2.7	2.4	2.8	2.6	2.4	3.0	2.3	3.0	2.7	26.5
WLIs	0.4	0.4	0.5	0.4	0.5	0.1	0.6	0.6	0.5	0.5	4.6
Bank	3.2	3.5	3.6	3.4	3.9	3.6	3.7	3.8	3.6	3.8	35.9
Other Non Core	0.1	0.0	0.1	0.1	0.1	0.0	0.1	0.1	0.1	0.1	0.6
Additional Hours	0.4	0.3	0.4	0.4	0.4	0.4	0.4	0.5	0.4	0.4	3.9
Total	11.2	11.7	11.3	11.8	12.1	11.1	12.2	10.7	11.6	11.2	114.8

- January budgeted WTE increased by 6 WTE from December. See Slide 8 for further detail.
- Variable Pay totals £11.2m for January, a reduction of £0.4m from previous month driven by reductions of £0.3m in Agency and £0.3m in Locums offset by increases in other areas.

Pay - WTE

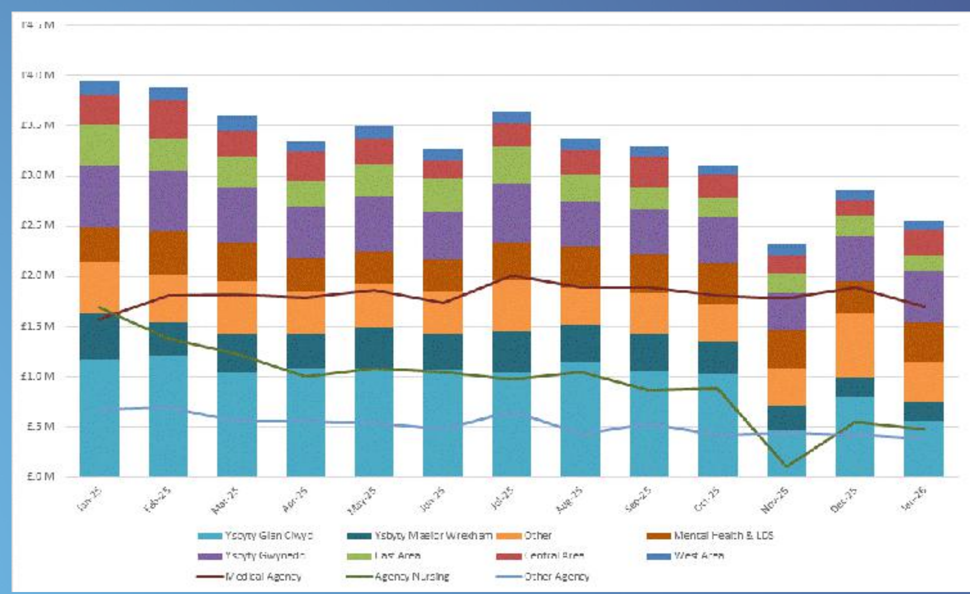
	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Movement M10 V M9
Budgeted WTE	19,719	19,941	20,400	20,522	20,502	20,527	20,575	20,637	20,649	20,655	6
Actual WTE	19,839	19,635	19,720	19,708	19,741	19,822	19,907	19,844	19,869	19,767	-102

- Budgeted WTE increased by 6 WTE in January from previous month, with the below table providing further detail on Budgeted WTE movements.
- Actual worked in January is 19,767, a reduction of 102 WTE from December.

	25/26											
	WTE Budget											
	M01 Apr	M02 May	M03 Jun	M04 Jul	M05 Aug	M06 Sep	M07 Oct	M08 Nov	M09 Dec	M10 Jan	In Month Movement	Explanation of in-month movements (>5WTE)
West IHC - Management	8	8	8	8	8	8	8	8	8	8	0	
West IHC - West Area	1,473	1,512	1,583	1,573	1,572	1,568	1,575	1,572	1,572	1,572	1	
West IHC - Ysbyty Gwynedd	1,721	1,722	1,812	1,815	1,814	1,829	1,839	1,838	1,840	1,841	1	
West IHC - Facilities	368	368	368	380	380	380	382	382	382	382	0	
Centre IHC - Management	7	7	7	7	7	7	8	8	8	8	0	
Centre IHC - Central Area	2,098	2,159	2,309	2,320	2,311	2,304	2,312	2,310	2,309	2,303	-6	-4WTE reduced HEIW placements (Pharmacy), -6WTE correction to base budget due to duplication, +4WTE Six Goals funding (Frailty)
Centre IHC - Ysbyty Glan Clwyd	2,174	2,176	2,237	2,235	2,231	2,239	2,241	2,243	2,245	2,245	0	
Centre IHC - Facilities	408	408	408	422	422	422	422	422	421	421	0	
East IHC - Management	10	10	10	10	10	10	10	10	10	10	0	
East IHC - East Area	2,439	2,466	2,464	2,467	2,468	2,466	2,476	2,483	2,485	2,481	-4	
East IHC - Ysbyty Wrexham Maelor	1,868	1,874	1,835	1,892	1,893	1,896	1,906	1,954	1,962	1,970	8	5WTE new junior doctor posts, 2WTE Colorectal Specialist Nurses, 0.5WTE Pain Management Doctor; 1WTE Endoscopy Admin post funded non recurrent from Diagnostics Additionality
East IHC - Facilities	356	356	365	365	365	365	365	365	365	365	0	
Midwifery & Womens Services	687	693	694	694	694	694	694	695	696	696	0	
Mental Health & LDS	2,286	2,287	2,325	2,318	2,319	2,320	2,319	2,327	2,327	2,326	0	
COVID Programmes	149	150	151	0	0	0	0	0	0	0	0	
Dental GDS	14	14	14	14	14	14	14	14	14	14	0	
Dental CDS	167	167	167	168	169	169	168	168	167	165	-1	
Other Primary Care	15	15	15	15	15	15	15	15	15	15	0	
Diagnostics & SCS	982	1,008	1,010	1,014	1,016	1,020	1,024	1,028	1,028	1,029	2	
Cancer Services	416	416	423	423	425	424	423	423	423	424	0	
Corporate	1,958	2,009	2,079	2,265	2,250	2,255	2,251	2,249	2,249	2,255	6	7WTE Chief Digital Information Officer Outpatient Insourcing
Med ED/R&D	115	116	116	117	119	122	123	124	125	125	0	
Health Board Total	**19,719**	**19,941**	**20,400**	**20,522**	**20,502**	**20,527**	**20,575**	**20,637**	**20,650**	**20,656**	**6**	

Pay Costs - Agency

	2025-26 Agency Spend £m												Full Year Expenditure £m
	Actual Apr-25	Actual May-25	Actual Jun-25	Actual Jul-25	Actual Aug-25	Actual Sep-25	Actual Oct-25	Actual Nov-25	Actual Dec-25	Actual Jan-26	Forecast Feb-26	Forecast Mar-26	
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	1.2
Central Area	0.3	0.3	0.2	0.2	0.2	0.3	0.2	0.2	0.2	0.3	0.3	0.3	3.0
East Area	0.3	0.3	0.3	0.4	0.3	0.2	0.2	0.2	0.2	0.2	0.2	0.2	2.8
Ysbyty Gwynedd	0.5	0.5	0.5	0.6	0.5	0.5	0.5	0.4	0.4	0.5	0.5	0.5	5.8
Ysbyty Glan Clwyd	1.1	1.1	1.1	1.0	1.2	1.1	1.0	0.5	0.8	0.6	0.8	0.8	11.0
Ysbyty Maelor Wrexham	0.3	0.4	0.4	0.4	0.4	0.4	0.3	0.2	0.2	0.2	0.2	0.2	3.6
Mental Health & LDS	0.3	0.3	0.3	0.4	0.4	0.4	0.4	0.4	0.3	0.4	0.3	0.3	4.3
Womens	0.1	0.2	0.2	0.2	0.2	0.1	0.1	0.1	0.2	0.1	0.2	0.2	1.9
Other incl pan BCU Cancer Servcies and	0.3	0.3	0.2	0.3	0.2	0.3	0.2	0.3	0.4	0.3	0.2	0.3	3.3
Total Agency	**3.3**	**3.5**	**3.3**	**3.6**	**3.4**	**3.3**	**3.1**	**2.3**	**2.9**	**2.6**	**2.8**	**2.8**	**36.9**



- Agency expenditure for January is £2.6m representing 2.5% of total pay, a reduction of £0.3m compared to previous months spend. (2024/25 Monthly average £3.9m). 2025/26 Agency annual forecast outturn is £36.9m, a £0.6m reduction compared to the £37.5m annual forecast outturn reported at Month 9 and a £9.5m (20.2%) reduction from 2024/25 total Agency spend of £47.0m. It is also expected that Agency costs will continue to reduce further following implementation of the additional centralised controls.

- January Medical Agency expenditure is £1.7m, £0.2m lower than previous month spend. (2024/25 Monthly average £1.6m). In-month Medical Agency spend is predominantly within Ysbyty Glan Clwyd (£0.7m), Ysbyty Gwynedd (£0.3m), Women's (£0.1m), Mental Health (£0.2m), and Central area (£0.1m) covering Medical vacancies and sickness.

- Nurse agency costs totalled £0.5m for the month, and is in line with previous month. (2024/25 Monthly average £1.7m). The use of agency nurses is within Ysbyty Maelor Wrexham (£0.1m), Ysbyty Gwynedd (£0.2m) and Mental Health (£0.1m). Agency nurses are used to staff escalated beds and cover ward vacancies. Other agency costs totalled £0.3m in month 10, a decrease of £0.1m from previous month spend. Other Agency costs mainly consist of Allied Health Professionals (£0.3m).

- Work continues to ensure the Cabinet Secretary workforce enabling action is met within the required areas. Nil agency spend is forecast for the remaining months of the year against Estates & Ancillary and Admin & Clerical Agency staffing group. There has been minimal spend reported to date against Healthcare Support Worker staffing group with spend forecast to reduce over the remaining months of the year.

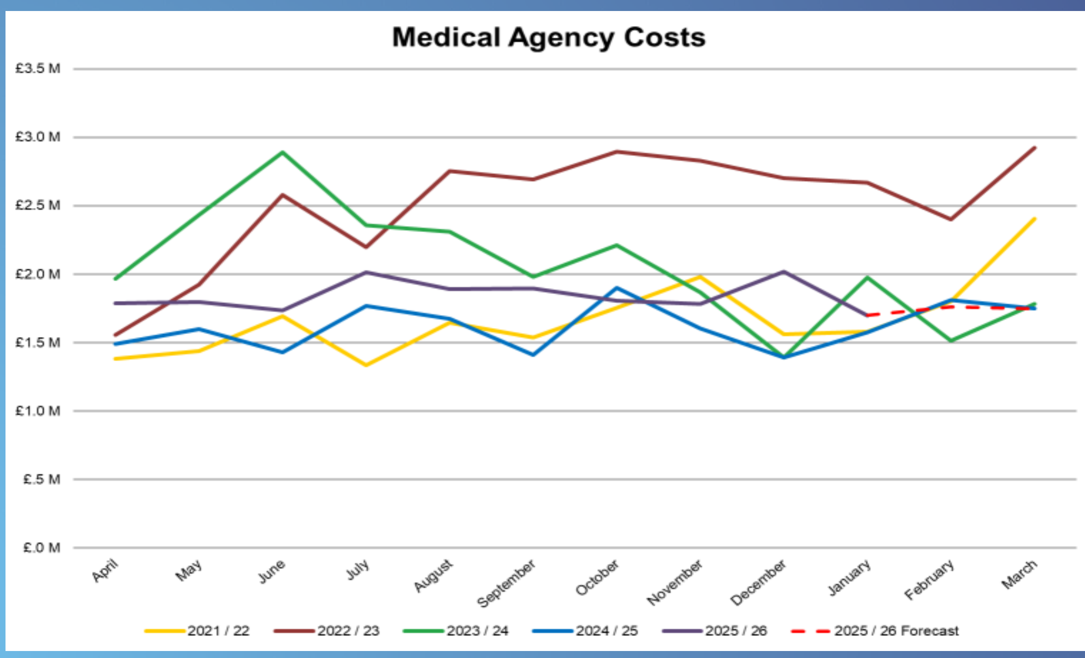
Pay Costs - Agency

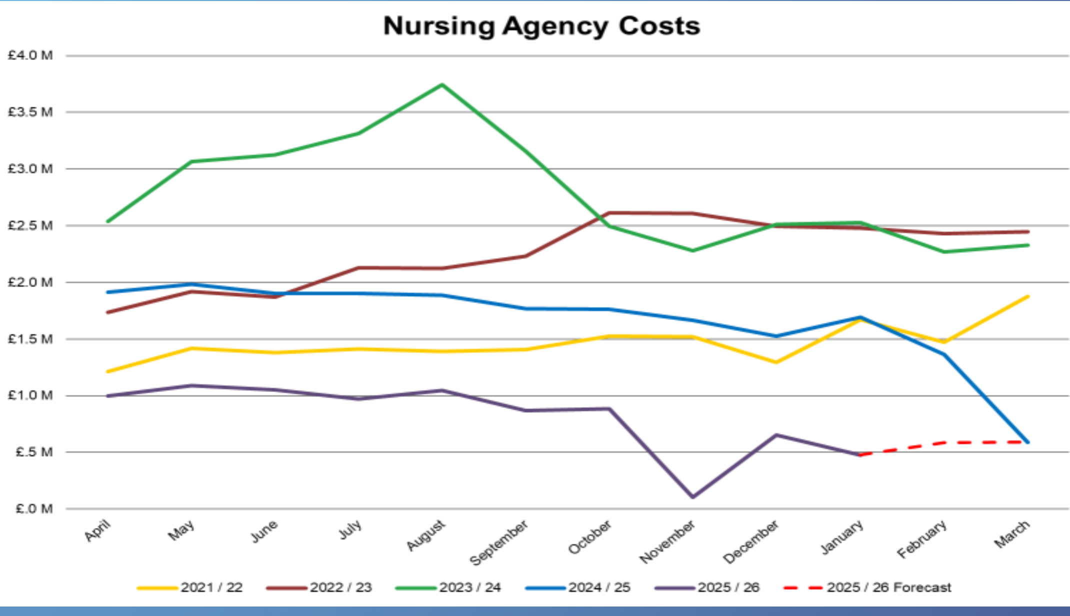
Agency Costs

2.5
2
1.5
1
0.5
0

Jan-25
Feb-25
Mar-25
Apr-25
May-25
Jun-25
Jul-25
Aug-25
Sep-25
Oct-25
Nov-25
Dec-25
Jan-26

Medical Agency
Agency Nursing
Other Agency





Expenditure Non-Pay

- **Primary Care Contractor:** January expenditure is £6.3m (23.1%) less than previous month being mainly due to the year-to-date impact of the GMS Dispensing/PADMS uplift, GMS Pay agreement uplift and 2025/26 Dental 4% pay uplift included within previous month's position.

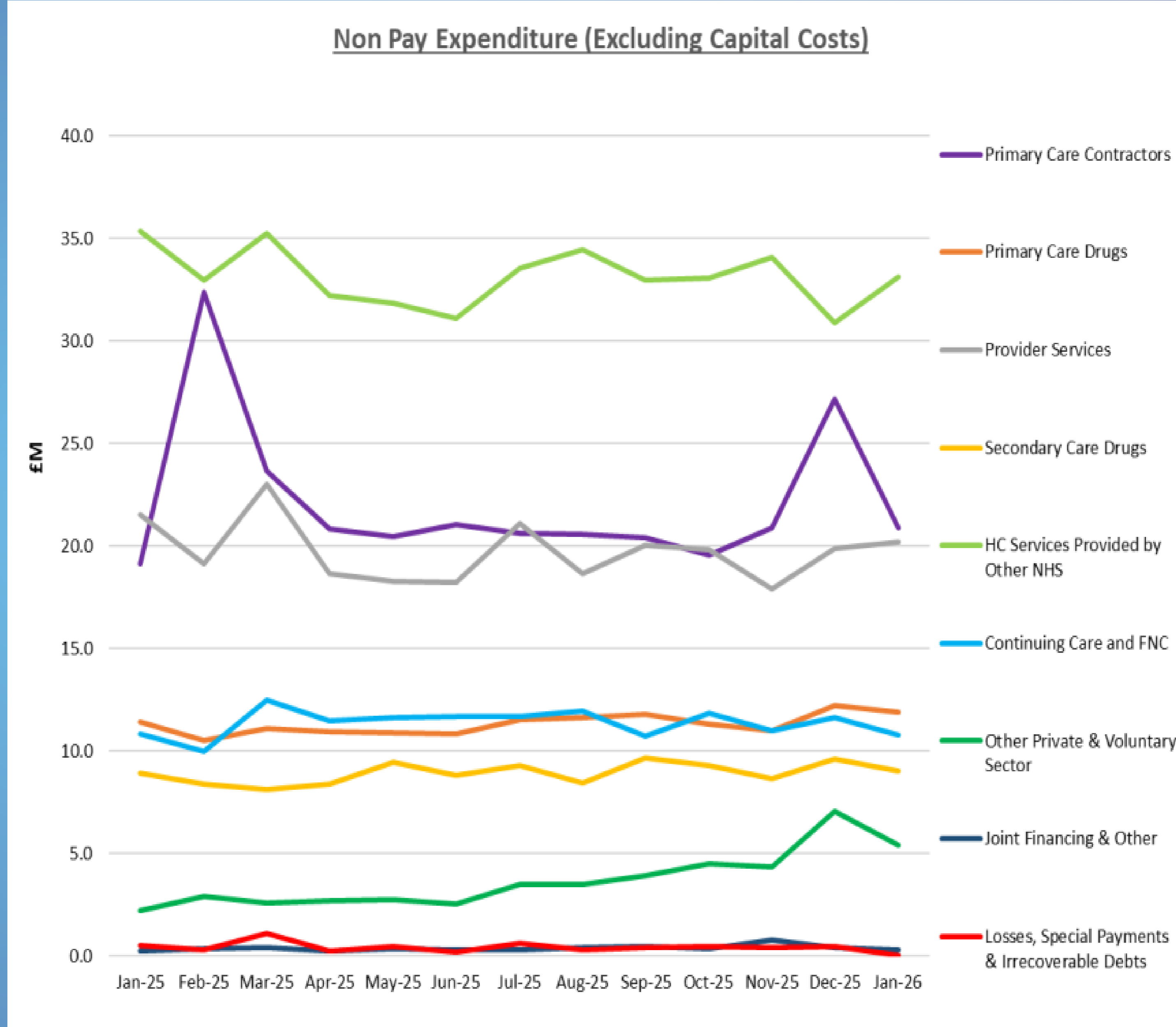
- **Primary Care Drugs:** Expenditure is £0.3m (2.5%) less than previous month due to the increase in GP prescribing weight loss medication partially offset by Pharmacy rebate income being higher in previous month's position.

- **Secondary Care Drugs:** Expenditure decreased by £0.6m (6.2%) from previous month, due to catch up of Cancer Services aseptic, Homecare Drugs and FP10 backdated spend also reported in previous month's position. In-month spend is in line when compared to previous months' monthly average.

- **Healthcare Services provided by Other NHS Bodies**: Expenditure is £2.3m (7.3%) higher than previous month, with the in-month movement distorted by the JCC pay award allocation and charge incorrectly included within previous month's position. In-month spend is £0.5m higher when compared to previous months monthly average, being mainly due to high non elective day cases excess bed charges.

- **Continuing Health Care (CHC) and Funded Nursing Care (FNC):** Expenditure decreased by £0.8m (7.2%) from previous month and £1.1m less than forecast for the month, of which £1.5m is an accountancy gain reported in month offset by FNC inflation backdated to April 2025 and increase in Children's CHC packages.

- **Other Private & Voluntary Sector:** In month spend decreased by £1.6m from previous month, being predominantly due to the ID medical insourcing contract invoice processed in December with spend backdated to September funded from the WG planned care funding allocation, offset by a £0.1m reduction in MHLD Out of Area Placements (OOA) spend.



Allocations

	£m
Total Allocations Received	2,342.7
Total Allocations Anticipated	24.5
Total Welsh Government Income	**2,367.2**

- 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 2,367.2m.
- Confirmed allocations to date are £2,342.7m. This includes £12.9m allocation for COVID-19, with £9.2m of COVID income profiled into the year-to-date position.
- Further anticipated allocations in year total £24.5m as detailed in the table.

Description	£m
Allocations Received	2,342.7
Total Allocations Received	**2,342.7**

Description	£m
Allocations anticipated	
DEL Non Cash Depreciation	0.9
Removal of IFRS-16 Leases (Revenue)	-4.6
IM&T Refresh Programme	2.5
Six Goals	2.7
RTT Waiting Times	1.6
Planned Care additional funding 2025-26 Phase 3 Outpatient support costs	0.6
Planned Care Additional funding Phase 5	2.0
Cataract funding 2025/26	5.8
Planned Care additional funding 2025-26 Phase 4 Diagnostics	3.6
Dermatology MOPs funding	1.3
Waiting Times – Minor Oral Surgery & additional OPD Capacity	2.2
Waiting Times – Outpatient Appointments	4.6
Other	1.1
Total Allocations Anticipated	**24.5**

Risks and Opportunities

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

Risks	£m	Level
Joint Commissioning Committee Performance	0.3	Medium
Total Quantifiable Risks	**0.3**	

Opportunities / mitigations for the identified risks	£m	Level
Potential to deliver improved outturn on identified mitigations	17.4	Low
Total Opportunities	**17.4**	

Balance Sheet

- The closing cash balance as at 31st January 2026 was £5.1m, which included £4.8m cash held for revenue expenditure and £0.3m for capital projects.
- The Health Board is currently forecasting a closing cash balance for 2025-26 of £5.9m made up of £3.0m revenue cash and £2.9m capital cash.

	Opening Balance Beginning of Apr 25 £'m	Closing Balance End of Jan-26 £'m	Forecast Closing Balance End of Mar 26 £'m
Non-Current Assets			
Property, plant and equipment	740.2	731.0	746.5
Intangible assets	0.8	0.4	0.8
Trade and other receivables	119.7	125.2	125.7
Non-Current Assets sub total	860.7	856.6	872.9
Current Assets			
Inventories	20.5	20.9	20.5
Trade and other receivables	128.7	171.4	166.7
Other financial assets	0.0	0.0	0.0
Cash and cash equivalents	5.9	5.1	5.9
Non-current assets classified as held for sale	0.6	0.0	0.0
Current Assets sub total	155.6	197.3	193.1
TOTAL ASSETS	1016.3	1053.9	1066.0
Current Liabilities			
Trade and other payables	232.3	212.7	198.8
Borrowings (Trust Only)	0.0	0.0	0.0
Other financial liabilities	0.0	0.0	0.0
Provisions	53.9	92.2	91.7
Current Liabilities sub total	286.2	304.9	290.4
NET ASSETS LESS CURRENT LIABILITIES	730.1	749.0	775.6
Non-Current Liabilities			
Trade and other payables	23.9	23.9	25.0
Borrowings (Trust Only)	0.0	0.0	0.0
Other financial liabilities	0.0	0.0	0.0
Provisions	120.9	126.2	126.9
Non-Current Liabilities sub total	144.7	150.1	151.9
TOTAL ASSETS EMPLOYED	585.3	598.9	623.7
FINANCED BY:			
Taxpayers' Equity			
General Fund	367.2	380.8	405.5
Revaluation Reserve	218.2	218.2	218.2
PDC (Trust only)	0.0	0.0	0.0
Retained earnings (Trust Only)	0.0	0.0	0.0
Other reserve	0.0	0.0	0.0
Total Taxpayers' Equity	585.4	598.9	623.7

Capital

- The approved Capital Resource Limit (CRL) for 2025/26 is £59.2m, which includes £1.2m IFRS16 and £58.0m Capital. Year to Date expenditure is £30.2m.

BUDGET 2025/26

1) Capital Resource Limit 2025/26	**£m**
WG Discretionary Capital	14.2
All Wales Scheme	43.8
Total CRL	**58.0**

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

CAPITAL PROGRAMME 2025/26	Initial Programme (£m)	Year to Date (£m)	Forecast Outturn (£m)	Current Over/Under Commitment (£m)	Comments
Divisions	3.4	2.8	3.0	0.4	Programmed planned works progressing supported by tenders/purchase orders.
Operational Estates	1.7	0.6	1.7	-	Programmed planned works progressing supported by tenders/purchase orders.
Medical Devices	3.5	1.7	3.5	-	Programmed planned works progressing supported by tenders/purchase orders.
Informatics	3.0	0.5	3.0	-	Programmed planned works progressing supported by tenders/purchase orders.
Mental Health	1.0	0.0	1.0		Programmed planned works progressing supported by tenders/purchase orders.
All wales funding brokerage to be re-provided from discretionary	1.5	0.0	1.5	-	Brokerage managed within the programme.
WG Discretionary Capital	**14.2**	**5.7**	**13.8**	**0.4**	**Under Commitment**

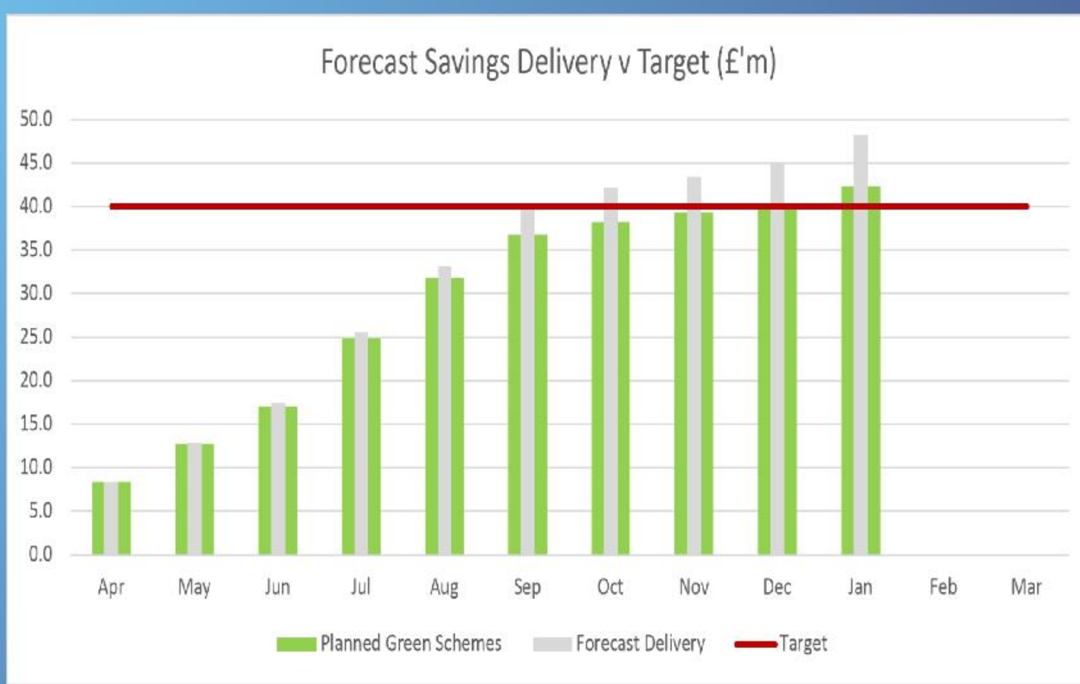
Capital

MAJOR CAPITAL SCHEMES (with in year spend)	Programme (£m)	Year to Date (£m)	Forecast Outturn (£m)	Current Over/Under Commitment (£m)	Comments
Regional Orthopaedic Hub, Llandudno Hospital	15.7	14.0	15.9	- 0.2	The project is progressing with completion forecasted early 2026. Welsh Government have confirmed any overspend will need to managed within the Health Board discretionary capital.
Year End Funding – October 2024	0.1	0.1	0.1	-	The programme has been revised as items have moved into the diagnostic programme, this is reflected in the revised CRL.
Electrical Infrastructure upgrade - Ysbyty Glan Clwyd	2.9	0.8	2.9	-	The project is programmed over the next 2 years. The contractor has commenced works in line with programme and CRL cashflow.
TEF - Fire	2.4	1.5	2.4	-	The TEF funding is across a number of projects. Business cases have been approved with allocations. The programme is being managed over 2 years, with any changes approved by WG and reprofiled to ensure CRL is achieved.
TEF - Infrastructure	2.4	0.8	2.4	-	The TEF funding is across a number of projects. Business cases have been approved with allocations. The programme is being managed over 2 years, with any changes approved by WG and reprofiled to ensure CRL is achieved.
TEF - Decarbonisation	0.2	0.0	0.2	-	The TEF funding is across a number of projects. Business cases have been approved with allocations. The programme is being managed over 2 years, with any changes approved by WG and reprofiled to ensure CRL is achieved.
TEF - Mental Health	2.0	0.8	2.0	-	The TEF funding is across a number of projects. Business cases have been approved with allocations. The programme is being managed over 2 years, with any changes approved by WG and reprofiled to ensure CRL is achieved.
TEF - Infection Prevention Control	0.8	0.0	0.8	-	The TEF funding is across a number of projects. Business cases have been approved with allocations. The programme is being managed over 2 years, with any changes approved by WG and reprofiled to ensure CRL is achieved.
TEF - Decontamination	0.8	0.4	0.8	-	The TEF funding is across a number of projects. Business cases have been approved with allocations. The programme is being managed over 2 years, with any changes approved by WG and reprofiled to ensure CRL is achieved.
IRCF - Conwy & Llandudno Junction Health & Social Care Centre	-0.2	0.0	0.0	- 0.2	It has been confirmed that the project will be deferred to 27/28 as part of the IRCF prioritisation. As a result, the Health Board has returned all this year and prior year funding as agreed with Welsh Government.
IRCF - Caledfryn, Denbigh Health and Wellbeing Hub – acquisition costs and related fees	0.3	0.2	0.3	0.0	The current CRL reflects the design costs which is profiled to spent in year.
DPIF - All Ages Mental Health Digital Solution	0.6	0.0	0.6	-	The hardware will be procured in 2025/26.
Nuclear Medicine Consolidation at YGC	0.7	0.3	0.7	-	The current CRL reflects the fees to progress to FBC which is profiled to be spent in year. Preconstruction work appointment is being reviewed and may impact full spend of CRL.
Replacement Diagnostic and Treatment Equipment	7.7	4.5	7.7	-	The project is for two Linear Accelerators and a Spect CT, all of which are profiled to be delivered in this financial year. £2m underspend has been returned to Welsh Government as a result of a competitive tender for the Linac's.
Non-Radiology Ultrasound Replacement	0.3	0.0	0.3	-	These medical devices will be procured in year.
Replacement Diagnostic and Treatment Equipment - Phase 2	3.9	0.2	3.9	-	The purchase of the equipment has already been instigated. The programme for enabling works to support the equipment will be realised in full within this financial year. £0.5m underspend has been returned to Welsh Government as a result of a competitive tender for the Mammography equipment.
DPIF - RISP	0.2	0.0	0.2	-	The Health Board went live 5th September 2025. Payment will be due once stable operation has been reached, which is reflected in the cashflow.
DPIF - Medicines and Prescribing: Electronic Prescribing and Medicines Administration (ePMA)	0.4	0.2	0.4	-	This project is over a two-year period with initiation in 24/25. It is forecasted that the project will complete in this financial year and the CRL will be spent in full.
DPIF - Digital Maternity Cymru	0.1	0.0	0.1	-	The project is currently in situ with the funding to be spent by the end of the financial year.
Mobile C-Arm/Image Intensifier Replacement	0.3	0.0	0.3	-	Procurement process is underway with confirmed lead time and delivery by 31st of March 2026.
Radiology Ultrasound Replacement	0.9	0.0	0.9	-	Procurement process is underway with confirmed lead time and delivery by 31st of March 2026.
End of Year Digital Funding 2025-26	1.0	0.7	1.0	-	End of year funding has been received for server replacements. The programme is currently in procurement stage and will be delivered by March 2026.
Trophon, Wrexham Maelor Theatre	0.0	0.0	0.0	-	Equipment will be delivered by March 2026.
DPIF - Connecting Care	0.5	0.0	0.5	-	Hardware for Connecting Care is being procured with delivery before the year end.
Entonox cracking devices	0.0	0.0	0.0	-	Equipment will be delivered by March 2026.
All Wales Capital	**43.8**	**24.5**	**44.2**	**-0.4**	**Over commitment**
Total Capital Funding Available	**58.0**	**30.2**	**58.0**	**0.0**	

Savings Performance against Target

- The Health Board's financial plan has set a target of £40.0m to be delivered in 2025/26, profiled on an equal twelfth's basis with savings identification, reporting and monitoring developed through a Value and Sustainability thematic model.
- Full year forecast value of Green Schemes is £48.1m (comprising of £36.0m Savings, £0.9m Income Generation, £0.7m Cost Avoidance and £10.5m Accountancy Gains). A forecast increase of £3.2m from month 9. Of these, £25.4m have been identified as recurring, with a full year effect of £31.7m, and £22.7m are non-recurring savings. · Full year plan value of Red Schemes totals £1.3m and full year plan value of further pipeline opportunities totals £3.1m.
- A series of financial recovery and expenditure reduction measures have been implemented, with all divisions instructed to identify a minimum of 1.5% expenditure reductions. This has generated a range of risk-assessed initiatives, where those identified as low risk have been implemented with immediate effect and where the criteria meet a savings definition these are reported as green savings schemes.
- In-month delivery includes Savings of £3.9m, £0.2m Income Generation/Cost Avoidance and £2.1m of Accountancy Gains, against a £3.3m Target
- The combined year to date delivery is £42.3m, of which £20.9m is recurring, against a target of £33.3m.

Service Performance against Target	Annual				Year to Date		
	Target £m	Forecast Delivery £m	Delivery v Target (+ve = adverse) £m	FYE £m	Target £m	Delivery £m	Delivery v Target (+ve = adverse) £m
West Integrated Health Community	7.9	6.7	1.1	6.3	6.6	5.5	1.0
Central Integrated Health Community	10.0	7.8	2.2	5.4	8.3	6.8	1.5
East Integrated Health Community	10.0	9.6	0.4	8.8	8.3	7.8	0.5
MHLD	3.9	6.1	-2.2	8.2	3.2	5.3	-2.1
Womens Services	1.2	0.6	0.6	0.4	1.0	0.5	0.5
Diagnostic and Specialist Clinical Support	1.8	1.9	0.0	0.4	1.5	1.6	-0.1
Cancer Services	1.5	1.6	-0.1	2.0	1.3	1.2	0.1
Community Dental Sevices	0.1	0.0	0.1	0.0	0.1	0.0	0.1
Corporate & Support Services	3.6	3.4	0.2	0.2	3.0	2.9	0.1
Saving Total	40.0	37.6	2.4	31.7	33.3	31.7	1.6
Accountancy Gains		10.5	-10.5			10.5	-10.5
Total		48.1	-8.1	31.7	33.3	42.3	-8.9



Performance Finance & Information Governance Committee

INTEGRATED QUALITY AND PERFORMANCE REPORT (IQPR)

Dyddiad y Cyfarfod Date of Meeting	24 February 2026
Statws Cyhoeddi Publication Status	Open/ Public
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Ed Williams Dirprwy Cyfarwyddwr Perfformiad Deputy Director for 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 paper provides an update on Access, Workforce and Financial performance for information and assurance.

with the full report included as an appendix and the key messages being;

- **Planned Care**
    - Patients waiting 52 weeks or more for their first outpatient appointment:

      The Operational teams have utilised national funds to deliver substantial reductions in patients waiting, from 31,905 patients waiting over 52 weeks to reporting 7,014 (a 77% improvement)
    - Patients waiting over 104 weeks for all stages of treatment

      The number waiting at the end of January 2026 was 3,584 (under the planned end of March trajectory of 3,782).
    - **Cancer (national standard 75%)**

      In December 2025 the Health Board treated 51.2% (229 out of 447) of patients within the targeted 62 days. However, performance has

improved in all but 3 tumour sites. The targeted performance to move out of special measures being 55% for four quarters. Plans are in train to achieve this targeted delivery, noting the level one targeted performance to be 75%.

- **Diagnostics**

  Against the 8-week standard has deteriorated over the past 12 months to 21,800 in January 2026. However, with additionality in place to deliver improvements in Magnetic Resonance Imaging (MRI), non-Obstetric Ultrasound and Endoscopy. Plans are being closely monitored to ensure delivery against the targeted performance of no more than 4,700 patients waiting over 8 weeks at the end of March 2026.

  Concerns over non-Obstetric Ultrasound remain and are being closely monitored through operational teams.

- **Urgent & Emergency Care**

  The Minister has identified performance in relation to patients waiting in excess of 12 hours and ambulance handovers exceeding 45 minutes as two priority areas of concern. Despite lower demand in January 2026 compared to the same period in 2025, performance was as follows:

  - Patients waiting in excess of 12 hours: 3,826 (28% of attendances)
  - Patients waiting in excess of 24 hours: 2,134 (15% of attendances)
  - Patients waiting in excess of 48 hours: 837 (6% of attendances)
  - Ambulance handover delays over 45 minutes: 2,465 (66% of conveyances)
  - Longest ambulance handover delay: 28+ hours

  Furthermore, whilst the number of patients experiencing delays to their pathways of care is lower at 322 in January 2026, the number of bed days lost has increased at 14,180. This is over 4,400 higher than the bed days lost in January 2025 (9,740) with 326 patients on delayed care pathways. Statistically, there has been no improvement in the number of pathways of care delays since April 2023.

  Whilst plans are in place to support improvements, performance within the urgent and emergency care space continues to deteriorate and will remain an area of concern and focus as we progress into 2026-2027.

- **Finances**

  The Health Board has implemented additional control measures. However, on assessment of the benefits expected in the remaining months of the financial year a recommendation has been made to revise the outturn to a £17.4m deficit for 2025/26.

The revision to outturn represents a deterioration of 0.6% of turnover and places at risk securing conditionally recurrent funding of £82m received in 2025/26 into 2026/27 and beyond.

Members are asked to note the above and further that contained within this summary report that highlights key performance for the Health Board. The appendix to the report (appendix A – The Integrated Performance Report) identifying further the wider performance metrics.

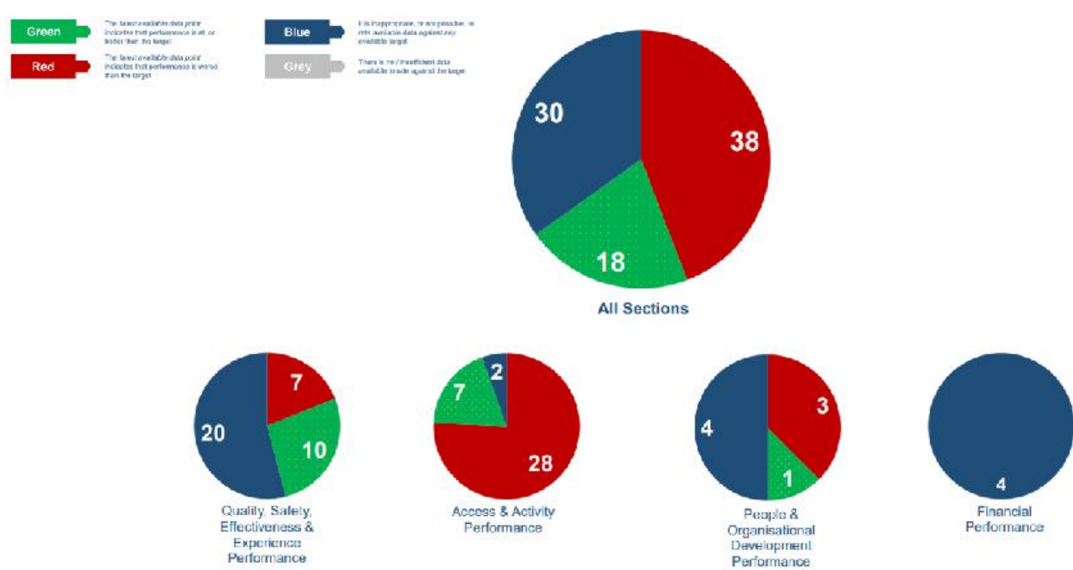
Ymgysylltu (mewnol/allanol) yr ymgymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp) **Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)**		
Pwyllgor / Grŵp / Unigolion **Committee / Group / Individuals**	**Dyddiad** **Date**	**Canlyniad,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

Acronymau / Rhestr Termau **Acronyms / Glossary of Terms**	
A&E	Accident and Emergency
AB	Aneurin Bevan Health Board
ADHD	Attention Deficit Hyperactivity Disorder
ASD	Autistic Spectrum Disorder
BCU/BCUHB	Betsi Cadwaladr University Health Board
C&V	Cardiff and Vale University Health Board
CRR	Corporate Risk Register Reference
CTM	Cwm Taf Morgannwg University Health Board
ENT	Ear, Nose, and Throat
GDS	General Dental Services
GP	General Practitioner
HDda	Hywel Dda University Health Board
HEIW	

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

REPORT - INTERGRATED QUALITY & PERFORMANCE REPORT
Author – Deputy Director of Performance
Executive – Executive Director of Finance

1. INTRODUCTION



1.1 Of the measures from the NHS Wales Performance Framework included in the report, 18 are on target, 38 are off target. This is a deterioration from December's report (21 on target, 35 off target). It remains clear that there continues to be significant risks to delivery on a number of key metrics for which the attached report at appendix I, gives further detail within the relevant dashboards for each of the four quadrants, as articulated within the above graphic.

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

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

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

1.5 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.

2 Y CEFNDIR BACKGROUND

2.1 The Performance Directorate now reports through to the Executive Director of Finance's portfolio, with development of the Integrated Quality and Performance Report (IQPR) a key objective to ensure the needs of Operational forums, Executive, Committees and the Health Board are met. The development of the report will build on the launch of the Foundations for the Future model for services, which is essential to ensure clarity on roles, responsibilities and accountability.

2.2 Statistical Process Control Charts (SPC) will be the main vehicle to report performance (historical, current and future trends) ensuring movements in performance are understood. In January 2026, Welsh Government have indicated the use of 'Making Data Count' methodology within all formal reports which has already been adopted by BCUHB and will be strengthened further in coming months. It is essential the users of the reports can ascertain the impact of key actions expected for future performance, and importantly how this compares to that contained within our Integrated Medium-Term Plans (IMTP) and national expectations.

2.3 Initial meetings with the Executive, Senior Leadership and the teams have occurred, with further debate to occur with Health Board colleagues to shape the future report model, the anticipation being this would be supported by;

- **2.3.1** Hierarchical reporting (the information tailored for the audience)
- **2.3.2** Review of metrics used for assessment, ensuring relevance
- **2.3.3** Engagement with Operational and Clinical teams, to ensure actions planned to improve performance are quantifiable and thus can be used to forecast delivery
- **2.3.4** A refreshed 'Performance and Accountability Framework' that will enable areas and directorates that require additional support to be identified and escalated

2.4 The implementation of 'Foundations for the Future' in providing clarity on roles and responsibilities will support identification of lines of accountability, it is important that the accountability framework recognises high performing areas and differentiates with those requiring support to deliver improvement. Reporting future performance requiring Operational & Clinical colleagues to determine action to be taken and expected impact.

2.5 Whilst these developments are progressed, the report will continue to be presented within the current format, each section will endeavour to enhance reporting with inclusion of;

- **2.5.1** A one-page high level summary of matters to be highlighted to members.
- **2.5.2** Then a page per quadrant, supporting a more focused view of the performance.
- **2.5.3** Finally, each performance metric is then articulated within the report to provide the detail should officers seek to understand more in regards to a particular metric.

3 MATERION PENODOL I'W HYSTYRIED
SPECIFIC MATTERS FOR CONSIDERATION

3.1 Of the measures from the NHS Wales Performance Framework included in the report, 18 are on target. It remains clear that there continues to be significant risks to delivery on a number of key metrics described within this report. In particular within the Urgent and Emergency Care space.

3.2 The Health Board continues to face significant challenges in attainment of the performance targeted within the national and local plans and escalation continues in these areas as a consequence. However, it is of note that in a number of areas performance continues to improve (many exceeding the requirement for exiting of special measures) with members invited to review the detail contained within the summary and full performance report to assess areas of key challenge and improvement opportunity.

3.3 Access and Activity Performance

3.3.1 Introduction to Planned Care Delivery

This section contains the greatest number of measures within the report and articulates the access to services experienced by our local population. The Health Board submission of the Integrated Medium-Term Plan (IMTP) indicating attainment of national directives for Planned Care on the basis of;

- Receipt of additional funds to support 104-week delivery
- Ability to commission activity from the private sector for key specialities

The Health Board received an allocation below that requested of £5m to support commissioning of external care provision and experienced difficulties in securing capacity within the private sector to service patients waiting, these two factors impacting on the ability of the Health Board to attain the trajectories of performance indicated within the IMTP.

The Health Board continues to seek to improve performance and has implemented additional oversight and escalation within the planned Care space (the Chief Executive Chairing a weekly oversight and escalation meeting) with additional oversight and governance through a weekly meeting of the Chair and Vice-Chair for the Health Board.

3.3.2 Planned Care Performance

3.3.2.1 Patients waiting over 52 weeks for a first outpatient appointment

The introduction of a centrally managed booking service for first outpatient appointment and adoption of GIRFT recommendations for each speciality in regards to clinic bookings resulted in a stabilisation of deterioration in performance that had been experienced throughout the Health Board.

In addition, the national initiative of placement for insourcing to service patients first new outpatient appointments has seen over 2,000 patients per weekend seen. This additionality has dramatically reduced the numbers of patients waiting for first outpatient appointment and this trend is set to continue for the remainder of the financial year. Whilst the November position was 12,261, the latest available validated position as at 12th January 2026 shows the number of patients waiting has reduced to under 7,014, and (subject to speciality challenges) is expected to be zero by close of the financial year.

Based on management information currently going through validation (hence draft at this stage), the number of patients waiting over 52 weeks for their first outpatient is as follows:

- 25th August 2025 31,905 patients were waiting over 52 weeks for their first outpatient appointment
- 30th November 2025 12,261 validated patients waiting over 52 weeks
- 31st January 2026 7,014 validated patients waiting over 52 weeks

Whilst the drive to reduce the number of patients awaiting over 52 weeks for their first outpatient appointment to zero by the 31st March 2026, it is important to note some of these patients will require further intervention and this will place pressure upon delivery of the future 104-week performance

(a) cohort of the stage 1 outpatients requiring a procedure with some of these urgent or even Urgent Suspected Cancer and displacing current routine capacity to service patients currently waiting in excess of 104 weeks.

3.3.2.2 Patients waiting greater than 104 weeks for all stages of care delivery

The Health Board had targeted zero patients waiting over 104 weeks by 31st March 2026. Whilst the Health Board has secured significant improvements in the 10 months to November 2025, with the latest numbers indicating 3,584 (a 60% reduction in patients waiting over that period) patients remain waiting above 104 weeks for conclusion of their care and the trajectory to attain zero by 31st March 2026 is no longer attainable. A revised forecast of approximately 3,780 patients still waiting over 104 weeks was submitted to Welsh Government at the end of December 2025. However, at 3,584 the Health Board is ahead of this trajectory.

Whilst this does not meet the trajectory submitted as part of the IMTP, the funds anticipated in the IMTP also did not materialise at the level planned / requested. Also, as the numbers reduce it has been more difficult to identify patients suitable for treatment through commissioned activity.

Performance beyond these levels can be achieved through the current contractual provision for insourcing and outsourcing, see below indicative values;

The Health Board continues to place focus on attainment of the 3,780 patients. The Health Board modelling indicates an increase in each month of those patients breaching the 104 weeks for waiting for care, as noted below;

- Leading up to December 2025 approximately 2,000 patients per month were added to the list of those waiting beyond 104 weeks
- January to March 2026 this number has increased on average to over 3,000 patients per month

The Health Board is required to therefore service (during the winter period) the forecast 3,890 plus each month the further additional 3,000 patients, this totals 12,890 patients for the three months to 31st March 2026. The resultant modelling indicating;

- Patients waiting beyond 104 weeks at 31st March 2026 will total 3,782
- Debate continues with WG officials in securing further resource to enable further commissioning where appropriate, with current forecasts indicating attainment of 3,333 patients waiting beyond 104 weeks at 31st March 2026.

The Health Board continues to drive improvements alongside the commissioning of activity through the Planned Care Major Programme, improvements in theatre utilisation (early and late starts plus reducing cancellations at short notice or on the day) will support improvements in delivery to that currently articulated.

3.3.2.3 Cancer Performance (national standard 75%)

In November 2025 the Health Board treated 51.2% (229 from 447) compared to (221 out of 422 in November) of patients within the targeted 62 days, as denoted within the below table;

	BCUHB Total	West	Central	East
Haematology	85% (17/20) ↑	71% (5/7)	88% (7/8)	100% (5/5)
Lung	73% (29/40) ↑	85% (11/13)	50% (7/14)	85% (11/13)
Skin	72% (62/86) ↔	76% (22/29)	80% (20/25)	63% (20/32)
Upper GI	66% (19/29) ↓	75% (6/8)	56% (5/9)	67% (8/12)
Breast	50% (35/70) ↑	75% (15/20)	43% (13/30)	35% (7/20)
Urology	35% (31/89) ↑	41% (15/37)	36% (9/25)	26% (7/27)
Gynaecology	34% (10/29) ↑	44% (4/9)	29% (2/7)	31% (4/13)
Colorectal	27% (15/56) ↑	19% (4/21)	33% (6/18)	29% (5/17)
Head & Neck	21% (4/19) ↓	38% (3/8)	0% (0/8)	33% (1/3)
Total	51% (229/447) ↓	56% (87/155) ↓	48% (70/146) ↔	49% (72/146) ↓

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

The principal reason for the continued decline in performance was an increase in the number of breast cancer patients treated after day 62. This was as a result of delays in the screening service and increased waits to first appointment over the summer period.

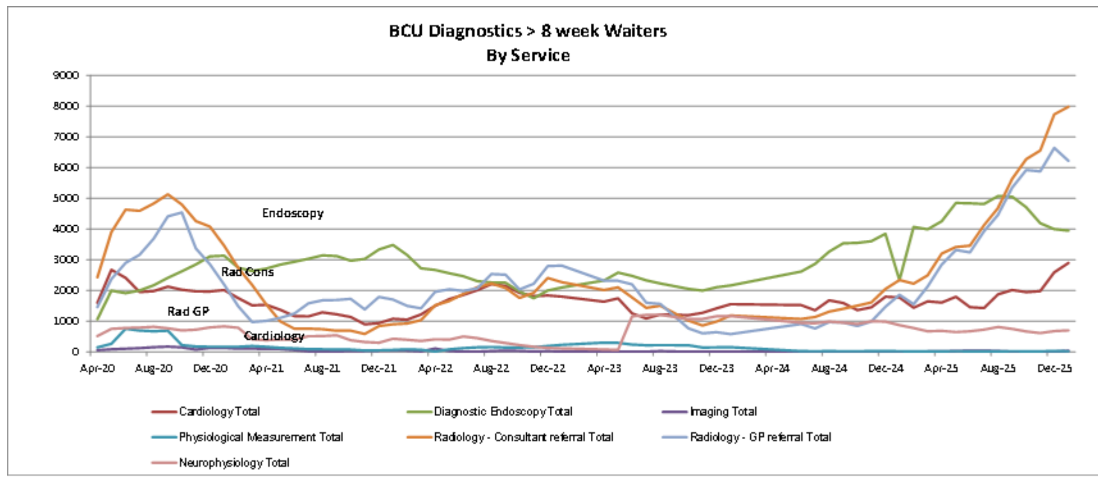
Performance across Wales on Cancer performance remains challenged, measures have been deployed to enhance delivery in Dermatology (skin) through insourcing contractual performance, Colorectal with additional endoscopy, Breast through a re-alignment of clinic capacity away from Mondays and additional recruitment to Head and Neck consultants.

3.3.2.4 Diagnostics (performance against the 8-week standard)

Diagnostics performance against the 8-week standard has deteriorated over the past 12 months, predominantly a consequence of demand for Radiology,

Magnetic Resonance Imaging (MRI), non-Obstetric Ultrasound and Endoscopy, key information being;

- With 21,800 patients waiting in excess of 8 weeks at end of January 2026
- Drivers being increased Endoscopy & Radiology from increased demand as we progress with the additional stage 1 outpatient activity and GP direct access, although now improving in Endoscopy
- Further allocation of £3.6m in year to improve towards 5,000 waits of 8 weeks at end of March 2026.



Key actions in the current quarter centring upon;

- Completion of procurements / Commence solutions (mobile MRI and mobile endoscopy suites on sites)
- Adoption of additional demand management measures

The increased access is set to reduce patient waiting times beyond 8-weeks to approximately 4,700 patients by 31st March 2026. However, the additional outpatient activity seen through the national 52-week first outpatient insourcing model will result in significant additional diagnostic activity being required, with this predicted to adversely impact on performance in this area, potentially leading to c6,000 waiting over 8 weeks at 31.03.2026.

Whilst the plan does not achieve a zero position by close of March 2026, the teams are attempting to improve on the current 4,700 plan submitted to Welsh Government, this number would representing the best performance on access for diagnostics.

3.3.2.5 Therapy Waits

There has been a substantial improvement in waits for Therapy intervention. However, the month on month improvement in performance and reduction in

waiting times seen previously has not continued through quarter 3. These patients are predominantly within Physiotherapy and Dietetics in the East IHC.

3.3.2.6 Adult Mental Health Measures Performance

Adult Mental Health Assessments and therapeutic interventions have consistently been performing above the 80% for the Division. Escalation remains as there are inequalities of waits across the region (Anglesey Denbighshire not achieving the 80% rate).

3.3.2.7 Children's & Adolescent Mental Health Services (CAMHS) and Neurodevelopment

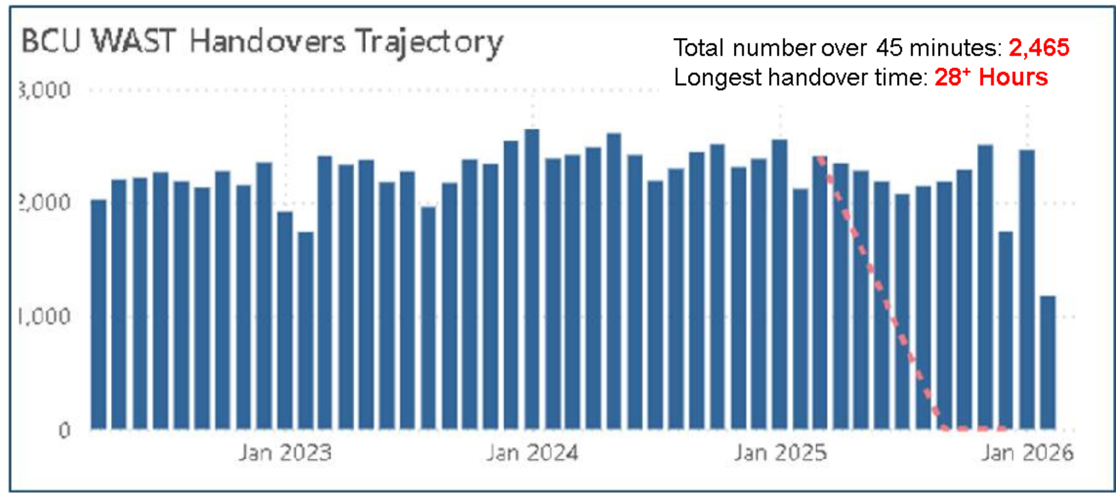
Neurodevelopment waiting times remain a concern, with the Health Board currently ranked as 6th of 7 in Wales with 11.9%. The All-Wales latest performance is 21% as at December 2025 and no Health Boards are achieving the target. However, at 11% BCUHB is achieving its internal improvement trajectory for January 2026.

3.3.3 Urgent & Emergency Care Performance

3.3.3.1 Ambulance Handovers within 45 Minutes

There is a focus placed upon performance in this area, the recent 45 minutes ambulance handover and acknowledgment of harm to patients owing to excessive waiting times is driving an immediate improvement requirement. At the end of December 2025, 52% of ambulance patient handovers were completed in under 45 minutes. This is a 20% improvement upon the November position. However, it is too early to speculate whether this level of improvement can be sustained through quarter 4 of 2025/26.

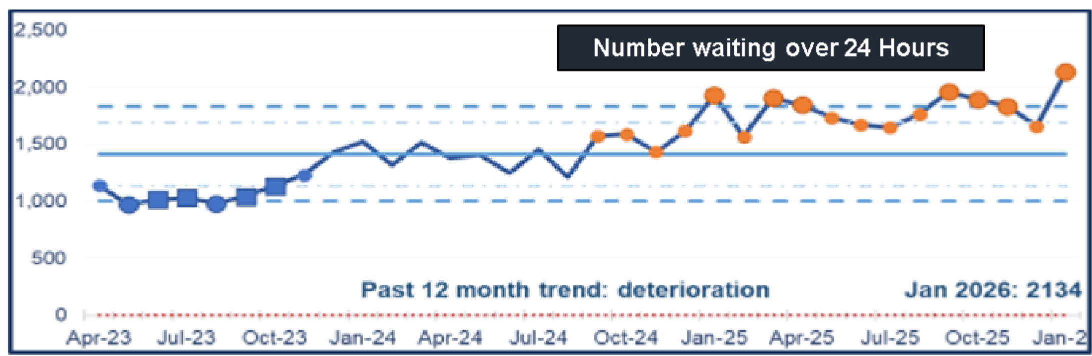
3.3.3.2 Number of patients waiting over 12 Hours in Emergency Departments



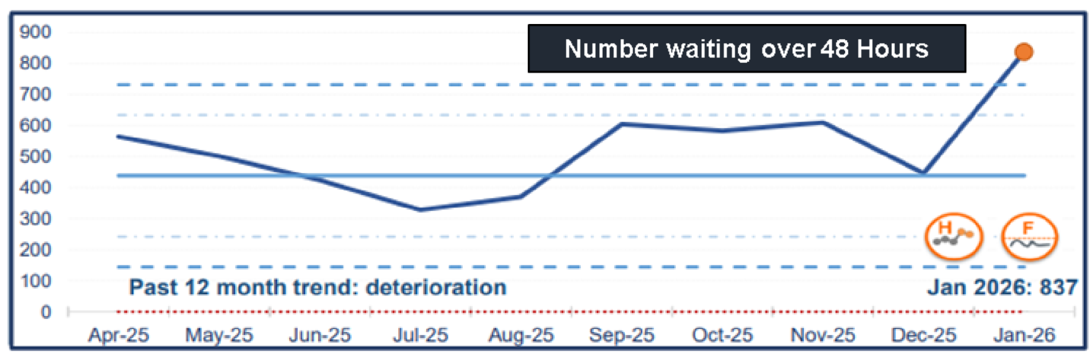
The number of 12-hour waits has increased to 3,826 (previously 3,656) and is the upper range of the SPC Chart below, measures to improve performance centre upon a focus on eradication of discharge delays (time of day and medically fit for discharge). The level of outliers significantly impacting the ability of the Health Board to flow through emergency patients. Details of what the Health Board is doing to improve this position can be seen in the IQPR.

Although the number of patients waiting beyond 24 hours has fallen at 1,834 it remains in a range exceeding normal deviation through the SPC Chart. Work is progressing with the teams on additional actions that would support enhanced performance in this area and this is detailed in the IQPR.

3.3.3.3 Number of patients waiting over 24 Hours in Emergency Departments



3.3.3.4 Number of patients waiting over 48 Hours in Emergency Departments



3.3.4 Summary

The Health Board has achieved improved access for patients waiting for outpatients new (77% reduction in patients waiting) and 104 weeks (60% reduction in patients waiting) for treatment. However, the pace of improvement does not match the ambition of the Health Boards Integrated Medium Term Plan (IMTP).

Major programmes of work in relation to Planned Care continue to drive productivity and efficiencies within the Health Board, this being the substantive solution to ensure access to services demands for services are able to be met.

However, the Urgent and Emergency Care space, requires urgent and greater focus in exploration of impactful solutions to drive improvement as it is clear current solutions aren't having the desired outcomes.

3.4 Workforce and Organisational Development

Key metrics for the People and Organisational Development centre upon;

- Sickness absence remains static at 6.4%

- The percentage of agency spend as a proportion of the total pay bill totals 2.5%
- After a steady decline over the last few months, the Personal Appraisal and Development Review (PADR) rates have dipped under the 80% mark for the first time since March 2025.over 80% across the Health Board

3.5 Financial Performance Month 10 (January 2026)

Having maintained a balanced in-month position for December 2025 and January 2026 the Health Board's cumulative deficit to month 10 remains at £17.3m (as reported in November 2025). The drivers being;

- Joint Commissioning Cost Pressures
- Capacity Pressures (additional beds open)
- Out of Area placements (Mental Health)
- English tariff inflation
- Employers National Insurance (funding shortfall)

The Health Board continues to seek mitigations, further costs centring upon national pressures associated with pay structures and Welsh Risk Pool are now to be offset through additional resource allocations (confirmation received 11th December 2025).

If unable to attain financial balance, the £82m conditional allocation for 2025/26 is placed at risk of receipt for 2026/27.

Whilst the financials remain a challenge in attainment for the 2025/26 financial year, it is of note that the savings ask of £40m for the Health Board has been attained and exceeded at month 9 reporting, see below;

In summary, the Health Board has a risk to delivery of plan totalling approximately £25m and will require additional measures to be deployed if the outturn and conditions associated with securing the £82m is to be attained. A Financial Oversight Group has been initiated in order to provide Board oversight to the deployment of measures to attain financial plan.

4 ARGYMHELLION
RECOMMENDATIONS

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

Review and comment upon the information presented.

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

<table>
<tr><td rowspan="3">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?</td><td>All Apply</td><td></td></tr>
<tr><td>Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:
If more than one applies, please list below:</td><td>Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:
If more than one applies, please list below:</td></tr>
<tr><td></td><td></td></tr>
<tr><td>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant
Wellbeing of Future Generations Act – Wellbeing Goals</td><td colspan="2">A Healthier Wales</td></tr>
</table>

<table>
<tr><td rowspan="3">Effaith Amgylcheddol / Cynaliadwyedd (5Rs)
Environmental /Sustainability Impact (5Rs)</td><td colspan="2">Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:
If more than one applies, please list below:</td></tr>
<tr><td colspan="2">No - Not Applicable</td></tr>
<tr><td>Os oes mwy nag un yn berthnasol, rhestrwch hynny:
If more than one applies, please list:</td><td></td></tr>
<tr><td rowspan="3">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?</td><td>Do/Yes: ☐</td><td>Naddo/No: ☒</td></tr>
<tr><td>Canlyniad/Outcome:</td><td></td></tr>
<tr><td>Os naddo, dylech gynnwys y rheswm:
If no, please include rationale:</td><td></td></tr>
<tr><td rowspan="3">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?</td><td>Do/Yes: ☐</td><td>Naddo/No: ☒</td></tr>
<tr><td>Canlyniad/Outcome:</td><td></td></tr>
<tr><td>Os naddo, dylech gynnwys y rheswm:
If no, please include rationale:</td><td></td></tr>
</table>

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., 24th February 2026

Integrated Quality & Performance Report

Performance, Finance & Information Governance Committee

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

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The data presented in this report is up to 31.01.2026 unless otherwise indicated. Data with an (IA) symbol is a month in arrears.

Escalated Performance Measures at a Glance

KEY: ☐ (green) = **Better** ☐ (red) = **Worse** than previous reporting period

Quality
CRR 24-04 Failure to Embed Learning

- ☐ New Never Events: 4 reported since October 2025 with 1 since downgraded (Target 0)
- ☐ National Reportable Incidents (NRI): **5** overdue (out of 49) in November 2025 (Target 0)
- ☐ Learning From Events Reports (LFERs): **17** in November 2025 (Target 0)

Finance
CRR 24-05 Financial Sustainability

Financial Position – January 2026
- ☐ (red) Year to date – Deficit versus Plan **-£17.3m**
- ☐ (green) In-month Variance to plan **£0.0m** (sustained balance of £0.0m)
- ☐ (red) Full year outturn position as re-forecast in January **-£17.4m** (**noting significant risks to delivery**)

Savings Position
- ☐ (green) In month Savings Delivery including Accountancy Gains v target **£6.2m** (£2.9m more than the £3.3m target)
- ☐ (green) Forecast Savings Delivery including Accountancy Gains v Target **£42.3m** (£8.9m above the target.

Capital Expenditure
Year to Date Plan is £33.2m. Spent £30.2m Underspend **£3.0m**.

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

- ☐ (green) CAMHS Part 1b Assessments within 28 Days of Referral: **54.0%** (Target 80%) IA
- ☐ (red) Neurodevelopment Assessment within 26 weeks: **11.0%** (*Target 95%)
- ☐ (green) Adult Psychological Assessment within 26 weeks: **71.6%** (Target 95%)

- ☐ (red) **Ambulance Handover Delays over 45 minutes: 2,465** (Target 0) **MP**
- ☐ (red) Emergency Department waits over 12 Hours: **3,826** (Target 0)
- ☐ (red) Emergency Department Waits over 24 Hours: **2,134** (Target 0)
- ☐ (red) Emergency Department Waits over 48 Hours: **837** (Target 0)
- ☐ (red) Number of patients left without being seen: **1,456** (Target 0)
- ☐ (red) Number of patients with Delayed Pathways of Care: **322** (Target 0)

- ☐ (red) Percentage compliance 62 Day Single Cancer Pathway: **51.2%** (Target 75%) IA
- ☐ (green) Referral to Treatment waiting over 52 weeks 1st Appointment: **7,014**
- ☐ (green) Referral to Treatment waiting over 104 weeks: **3,584** **MP**
- ☐ (green) Referral to Treatment waiting over 156 weeks: **56** (Target 0)
- ☐ (red) Number of patients waiting over 8 weeks for Diagnostics: **21,800** (Target 0)
- ☐ (red) Number of patients Over 100% due their clinical follow up: **119,302** (Target 0)
- ☐ (red) Number of patients waiting over 14 weeks for therapies: **1,518** (Target 0)

* Internal improvement trajectory for January 2026 is 12% **MP = Ministerial Priority**

People & Organisational Development

- ☐ (red) Personal Appraisal & Development Review (PADR): **79.3%** (Target 85%)
- ☐ (green) Sickness & Absence: **6.4%** (Target Reduce)
- ☐ (green) Agency Spend: **2.5%** (Target Reduce)

Performance Escalations Report

Access: Children's & Adolescent Mental Health Services (CAMHS) (Part 1b: Therapeutic Intervention within 28 days)

Escalated by:	Integrated Performance Executive Delivery Group (IPEDG)	Date :	April 2025	Reason:	Performance below plan	Status:	Improved

Whilst West and Centre Integrated Health Communities are performing well, East IHC has been compounded by lack of staffing thus impacting the overall position.

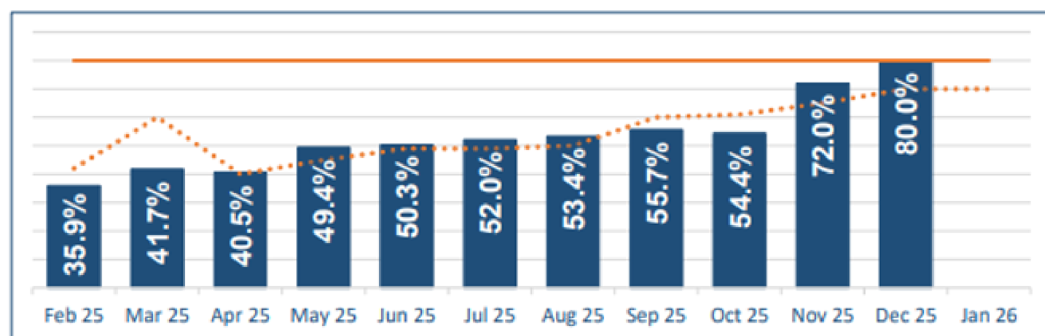
Part 1b: National Target 80% Improvement trajectory not achieved at 80%

Escalation: Delivery of the Part 1b intervention is off track in the East Integrated Health Community (IHC) against the Welsh Government (WG) trajectory, affecting the BCUHB regional year-end position. A recovery plan is in place.

Risks / Challenges: The service has been recruiting to substantive roles in an effort to reduce reliance on agency staff. The high vacancy levels within CAMHS East has adversely affected service capacity. The agency exit strategy and a 6% increase in demand has compounded ability to maintain the improvement in performance.

Recovery: Recruitment completed in Quarter 3 is expected to strengthen the workforce and increase capacity once new staff have taken up posts. To mitigate the 'gap' between now and when the new recruits are in post, four additional agency staff have been funded and in post. A further review of the East position identified that nine additional agency staff are required to deliver the revised recovery plan to reduce the waiting list backlog along with a phased introduction of group interventions, to achieve the 80% target by the end of Quarter 4.

The East IHC Recovery Plan has been approved by the IHC Senior Leadership Team with the aim of returning performance to trajectory in Quarter 4. As part of the recovery plan, small-scale group interventions (approximately four groups) will be introduced in February and March, with plans to roll these out as a standard offer in 2026/27 to support increased capacity and long-term sustainability.



Forecast Mental Health Measure Part 1b compliance %			
	Jan	**Feb**	**Mar**
East Integrated Health Community (IHC)	20%	46%	90%
BCUHB Region	58%	72%	92%

Access: Children's Neurodiversity (Assessed within 26 weeks of referral)

Escalated by:	Integrated Performance Executive Delivery Group (IPEDG)	Date :	April 2025	Reason:	Performance below plan	Status:	Not Improving

Performance against the measure remains poor, it is expected that no patients waiting over 3 years at 31.03.2026. However, this will **not** be sustained into 2026/27.

2026/27 Draft Trajectory

The trajectory shows a slight deterioration in performance in 2026–27 against the 26-week target, as anticipated, due to a residual capacity gap across all teams. Although this gap has reduced significantly, driven by a **63% increase in assessment** activity through a prudent approach and a **33% reduction in referrals** following the implementation of new ways of working with RPB compared to the previous year. A monthly shortfall of 98 assessments across the region remains. The trajectory assumes that all patients waiting over three years in 2025–26 will receive an assessment by the end of March, supported by the commissioning of additional capacity.

2026/27 Waiting times

Assuming there are no waits exceeding three years at the end of 2025–26, modelling of the 2026–27 waiting list indicates that 2,437 patients would exceed a three-year wait. Job planning is underway within IHCs, including recruitment to existing vacancies, to inform future capacity assumptions and improvement trajectories. However, without additional investment, current capacity will be insufficient to prevent waits exceeding three years during 2026–27.Confirmation of the 2026–27 WG NDIP funding allocation is awaited. Should funding again be directed towards waiting list management, as in 2025–26, arrangements are in place to continue the use of private provider contracts. Based on year-to-date 2025–26 activity, current estimated annual assessment capacity across IHCs is 840, although this may increase following completion of IHC-level job planning. On the basis of current capacity assumptions, an estimated shortfall of 1,597 assessments remains to sustain waits below three years in 2026–27.

Procurement for Outsourcing

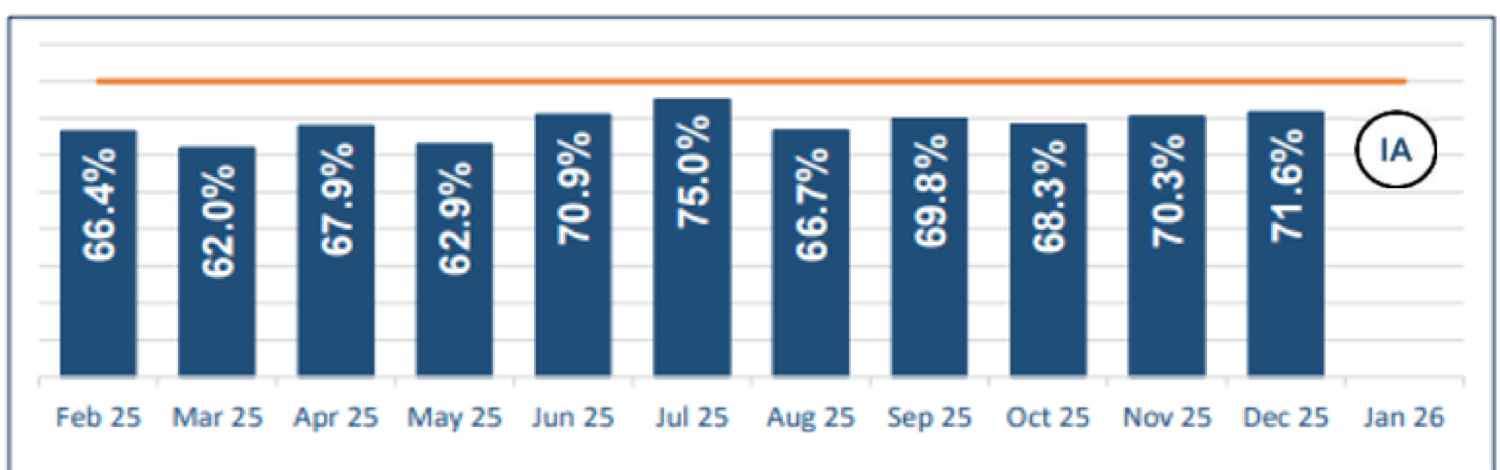
Two contracts have been awarded following a tender exercise, mobilisation meetings have taken place and contracts agreed and signed by all parties. Teams have commenced uploading of referrals. Trajectories received from both providers indicating capacity to complete assessment numbers by end of March.
Team also mapping out capacity for Medical review of ADHD initiated medication management with high assessment throughput and limited service capacity in IHCs system-level plan required with additional resources looking at opportunities for non-medical prescribing

Trajectory - 26 weeks	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Forecast Performance %	12%	12%	12%	12%	12%	12%	11%	11%	11%	11%	11%	11%

Access: Adult Psychological Therapies (Assessed within 26 weeks of referral)

Escalated by:	Integrated Performance Executive Delivery Group (IPEDG)	Date :	April 2025	Reason:	Performance below plan	Status:	Improving

Performance continues to improve and was 71.6% in December 2025.

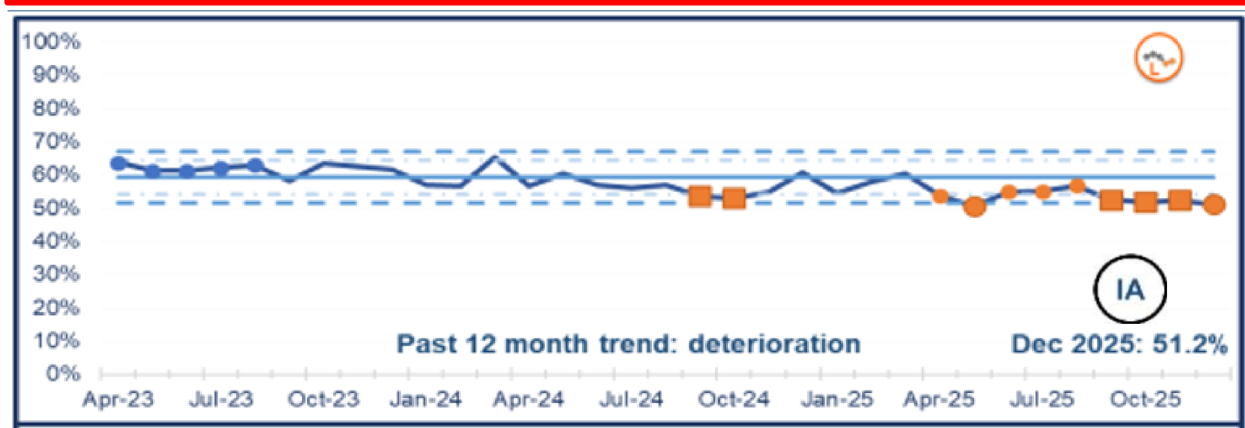


Actions from January 2026 onwards	Expected Impact	Monitoring
Continued Recruitment to vacant Psychology posts: • West and Central staff are now in post and improvement in performance is observed • Interview for East (Wrexham) CMHT Psychologist - January 26	Month on month improvement as staff fully integrate into the teams and as recruitment is finalised and staff appointed.	Continued monitoring of performance compliance Successful recruitment and start dates

Performance Escalations Report
Planned Care Section

Escalated by:	Integrated Performance Executive Delivery Group (IPEDG)	Date :	April 2025	Reason:	Performance below plan	Status:	Not Improving

Whilst overall performance against the target has fallen to 51% it should be noted that performance has improved in all but 3 tumour sites, and the backlog has reduced.



	BCUHB Total	West	Central	East
Haematology	85% (17/20) ↑	71% (5/7)	88% (7/8)	100% (5/5)
Lung	73% (29/40) ↑	85% (11/13)	50% (7/14)	85% (11/13)
Skin	72% (62/86) ↔	76% (22/29)	80% (20/25)	63% (20/32)
Upper GI	66% (19/29) ↓	75% (6/8)	56% (5/9)	67% (8/12)
Breast	50% (35/70) ↑	75% (15/20)	43% (13/30)	35% (7/20)
Urology	35% (31/89) ↑	41% (15/37)	36% (9/25)	26% (7/27)
Gynaecology	34% (10/29) ↑	44% (4/9)	29% (2/7)	31% (4/13)
Colorectal	27% (15/56) ↑	19% (4/21)	33% (6/18)	29% (5/17)
Head & Neck	21% (4/19) ↓	38% (3/8)	0% (0/8)	33% (1/3)
Total	51% (229/447) ↓	56% (87/155) ↓	48% (70/146) ↔	49% (72/146) ↓

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

In December 2025, BCUHB treated **51.2%** of new cancer patients within target i.e. within 62 days of suspicion of cancer. This is 1% lower than November 2025. Backlog continues to reduce most significantly in skin. Small increase seen in most sites over Christmas period but recovering in January. Overall reduction from 3,100 in October to 2,500 end of January 2026.

Performance by main tumour and hospital site is set out above; the actual number of patients treated is in brackets (number treated in target/total number treated). Of note is performance improved in all but 3 tumour sites (Head & Neck, Upper Gi and Skin).

- Haematology achieved 85% (10% over the 75% target)
- Skin performance remains below expected levels due to challenges within dermatology; insourced capacity continues and has led to a significant reduction in the number of patients awaiting a dermatology USC appointment – see chart on right
- Breast performance remains below expected levels due to challenges in the screening service; additional assessment clinics will commence in February
- Endoscopy remains a significant challenge on the colorectal pathway
- The majority of urology breaches are prostate cancer patients. The insourced prostate biopsy service will commence from the weekend of the 7th February.

Access: Planned Care Cancer Services (62 Days Single Cancer Pathway (SCP)) page 2 of 2

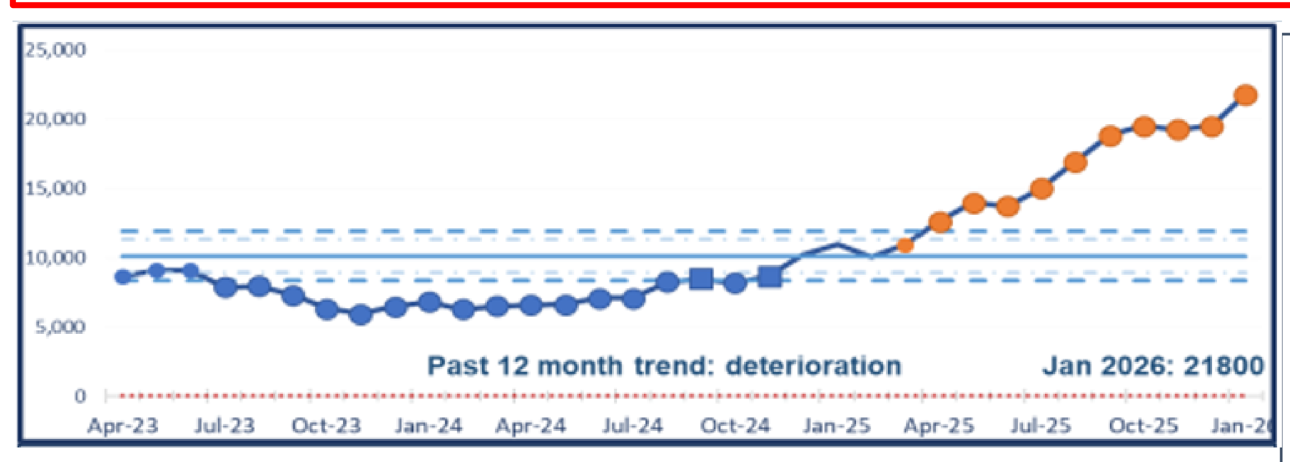
Action Plan

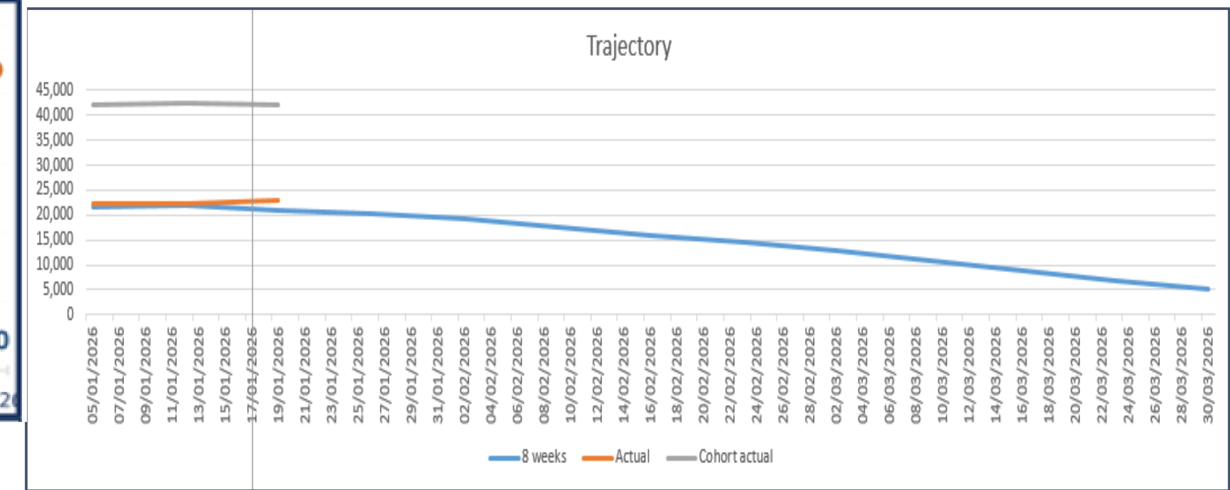
Tumour site	Agreed action	Progress since last meeting	Next steps
All	Ensure sufficient capacity to meet national optimal pathway (NOP) targets	Capacity and demand modelling continues	Complete capacity and demand modelling (by end Q4)
Breast	Ensure sufficient RABC capacity to see all women in 10 days	Number of patients over day 21 decreased from 242 end of Sept to 82 at end of December = 66% improvement	Complete implementation of audit recommendations (by end Q4) to ensure 100% clinic utilisation and no waits over day 10
	Establish breast pain pathway (reduce demand on RABCs)	Planning for service delivery continues whilst awaiting national funding decision	Hold first clinic (assuming positive national funding decision received) in Q4
Colorectal and UGI	Reduce waiting times for USC endoscopy	National validation of West waiting list and additional capacity secured	Complete West demand review and implement recommendations (Q4)
	Increase straight to test uptake	Nurse led triage service commenced in West in December so now live on all 3 sites	Embed nurse led triage and commence evaluation(Q4)
	Ensure sufficient surgical capacity to meet increased demand	Preliminary discussions re robotic assisted surgery strategy held	Relaunch robotic assisted surgery review programme (Q4)
Skin	Maximise potential of teledermoscopy	Telederm commenced in West in December via insourcing company – 3 sessions per week (72 patients)	Agree dermatology job plans to accommodate expanded service for Central and East (Q4)
	Increase MOPs capacity to meet demand	Minor works at Connah's Quay facility completed	Open Connah's Quay (Q4)
Urology	Increase straight to test on prostate pathway	n/a	Central IHC to establish requirements to introduce pathway (Q4)
	Ensure sufficient prostate biopsy capacity in place to meet demand	Insourcing secured for additional LATP capacity; training commenced for 3 non-medics	Commence insourced LATP capacity (Q4)
	Longer term plan to repatriate major urology cancer surgery to north Wales	Cystectomy pathway continues; prostatectomy pathway agreed	Commence prostatectomy referrals – awaiting start date from Arrowe Park (Q4)
Gynaecology	Implement PMB clinics	Exploration of alternative models continues	Finalise scanning model in north Wales (Q4)

Access: Planned Care Diagnostic Services (8 weeks & over)

Escalated by:	Integrated Performance Executive Delivery Group (IPEDG)	Date :	April 2025	Reason:	Performance below plan	Status:	Getting Worse

Latest validated position for January 2026 shows a deterioration to 21, 800 patients waiting over 8 weeks.





January 2026 Position

Whilst the 12 month performance illustrates a rapidly deteriorating position against the standard – the deterioration in performance has significantly slowed down over the last 4 months.

Key drivers are within Non-obstetric ultrasound (NOUS) and Endoscopy.

Key Actions

- Mobilise additional capacity solutions (mobile MRI and mobile endoscopy suites on sites) and additional Endoscopy facility
- Adoption of additional demand management measures and validation

Prediction

Trajectory profile indicates weekly step change in delivery from start of February as additional resources have impact.

Booking profiles to be reviewed to support assessment of delivery confidence.

Access: Planned Care Diagnostic Services (8 weeks & over)

Escalated by:	Integrated Performance Executive Delivery Group (IPEDG)	Date :	April 2025	Reason:	Performance below plan	Status:	Getting Worse

Latest validated position for January 2026 shows a deterioration to 21,800 patients waiting over 8 weeks. However, improvement plans implemented in January 2026.

Non-Obstetric Ultrasound Scans (NOUS): Current breaches 8,528. Forecast trajectory 1,703. Solution: insourcing staffing. Weekends 3 clinics / site 648 pts / week. Forecast trajectory high risk. Additional solutions required to close gap - working with provider for further solutions e.g. additional MSK clinics at higher productivity rate. Validation: National team visit 28-30 Jan. Audit of requests / validation guidance / cleanse of list to follow.

Magnetic Resonance Imaging (MRI): Current breaches 4,559. Forecast trajectory 2605. Solution: insourcing scanners / staffing at YG/YWM 7 days / 12 hours. YWM live from 20/01/26. Up to 175 additional pts / week.

Computed Tomography Scans (CT): Current breaches 2,145. Forecast trajectory 0. Solution: insourcing scanners / at YG/YGC weekends / 12 hours. Up to 205 pts / week.

Endoscopy: Current breaches 3,203 Forecast trajectory 298. Solutions: insourcing 4th room at YG, 4 lists per weekend/ Transfer of Care (ToC) to Countess of Chester Hospital (COCH) 30 pts/week/ ToC YGC to YWM 50 pts/week / mobile endoscopy unit approx. 700 pts live from February 2026 / clerical and clinical validation.

Echocardiogram: Current breaches 1,572 Forecast trajectory 0. Solution: insourcing at YGC 3-day weekends / 12 hours. Up to 168 pts / week. Contract moving to standstill. Commences 07/02/2026.

HRM: Current breaches 724 Forecast trajectory 0. Solution: outsourcing / batch / remote service. Procurement award pending, no standstill required. Commenced 07/02/2026.

Neurophysiology: Current breaches 704 Forecast trajectory 0. Solution: insourcing @ YWM 2 rooms / 50 pts per day. Procurement award pending, standstill required. Commences March 2026.

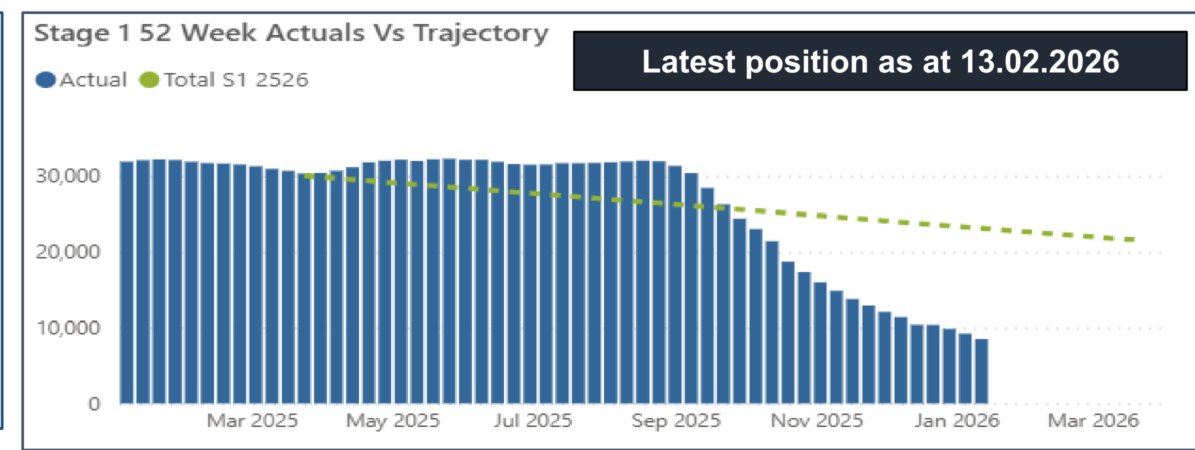
Cystoscopy: Current breaches 609 Forecast trajectory 0 insourcing commenced end of January 2026.

Key:
YG - Ysbyty Gwynedd
YGC – Ysbyty Glan Clwyd
YWM – Ysbyty Wrecsam Maelor

Access: Planned Care – Referral to Treatment Patients waiting over 52 weeks for new outpatient

Escalated by:	Integrated Performance Executive Delivery Group (IPEDG)	Date :	April 2025	Reason:	Performance below plan	Status:	Improving

Continued and sustained reduction in the number of patients waiting over 52 weeks for their first outpatient appointment.



- Latest national figures indicate BCU Position reduced from a high of 30,409 in August 2025 to 7,014 at 31st January 2026 a 77% reduction.
- Further reductions anticipated to the end of March 2026.
- On 13.02.2026, Welsh Government published the NHS Wales Performance Framework for 2026-2027. Of note is that the target for Stage One New Outpatients has been reduced from no patients waiting over 52 weeks to no patients waiting over 26 weeks.

Access: Planned Care – Referral to Treatment Patients waiting over 104 weeks (all stages)

Escalated by:	Integrated Performance Executive Delivery Group (IPEDG)	Date :	April 2025	Reason:	Performance below plan	Status:	Improving

The number of patients waiting over 104 weeks for treatment continues to fall. The end of January position is lower than the position predicted for the end of March 2026

- Refreshed plan developed in Quarter 2 and submitted to Welsh Government indicates 3,782 patients waiting beyond 104 weeks at the end of Quarter 4.
- Quarter 4 modelling indicates a substantial increase in cohort (those breaching 104 weeks in month) an increase from 2,000 to 3,000 per month
- Key areas of focus to improve on forecast performance centre upon; General Surgery, Urology, Trauma & Orthopaedics, ENT, Oral Surgery, Gastroenterology, Gynaecology
- NHS P&I support has commenced since Q3 and this is being further reviewed as part of the additional support arrangement where focus is being provided on;
    - reducing long waits for treatment
    - ensuring waiting list information is effectively validated
    - supporting the management of outsourced activity
    - optimising capacity and the use of theatres
    - establishing robust reporting of activity

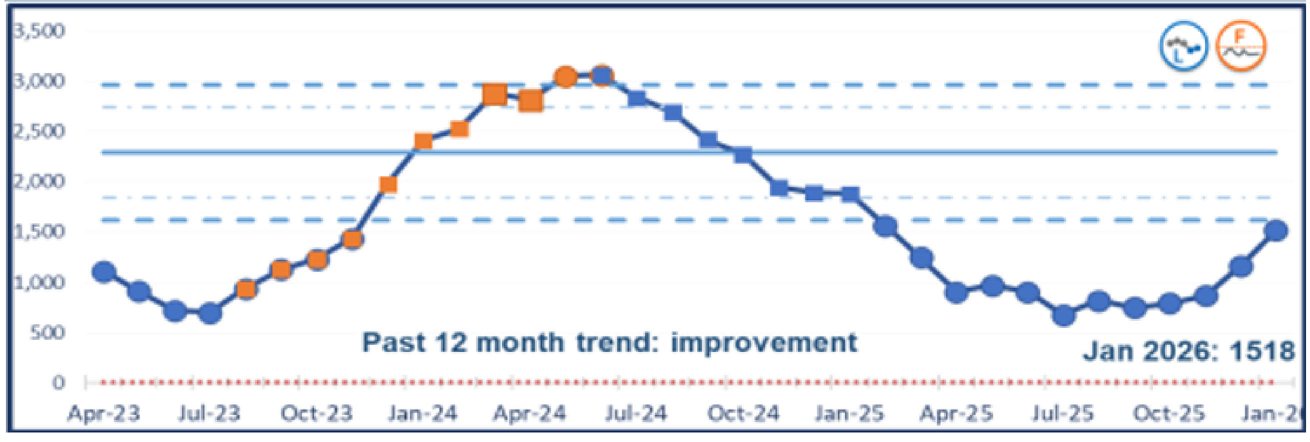
Forecast at 31.03.2026

Specialty	104w
General Surgery	1,073
Urology	405
Vascular Surgery	122
Trauma & Orthopaedics	380
ENT	684
Ophthalmology	129
Oral Surgery	395
Gastroenterology	250
Gynaecology	344
Total	**3,782**

Access: Planned Care Therapy Services (14 weeks & over)

Escalated by:	Integrated Performance Executive Delivery Group (IPEDG)	Date :	April 2025	Reason:	Performance below plan	Status:	Getting Worse

After a substantial period of sustained improvement, performance against this measure has stagnated and the numbers of patients waiting over 14 weeks slowly increasing



To Note from Graph

Whilst this graph demonstrates a twelve month improvement trend, the data for the latest 6 months shows a deteriorating trend which is predicted to continue into 2026/27.

Service	IHC	Grand Total	14 Weeks +
Physiotherapy	Cent Total	2126	0
Physiotherapy	West Total	2147	0
Physiotherapy	East Total	4408	745
Physiotherapy Total		8681	745
Podiatry	Cent Total	423	0
Podiatry	West Total	360	0
Podiatry	East Total	471	11
Podiatry Total		1254	11
Speech Language	Cent Total	327	6
Speech Language	West Total	397	1
Speech Language	East Total	406	0
Speech Language Total		1130	7
Occupational Therapy	Cent Total	176	0
Occupational Therapy	West Total	355	0
Occupational Therapy	East Total	166	0
Occupational Therapy Total		697	0
Dietetics	Cent Total	370	0
Dietetics	West Total	334	0
Dietetics	East Total	939	394
Dietetics Total		1643	394
Grand Total		13405	1157

Current Position

- Overall the number of patients waiting over 14 weeks has increased
- Physiotherapy East reported 745 patients over 14 weeks (increase of approx. 100)
- Dietetics East reported 394 patients over 14 weeks (increase of 20)

Physiotherapy (East IHC)

- Position has deteriorated with fewer patients on the waiting list but those patients waiting longer.
- Urgent post-operative patients must be seen before routine patients.
- Impact of outsourcing on the requirement for urgent new patient slots.

Dietetics (East IHC)

- Significant change in the model when the Gastro funding ceased has resulted in this waiting list backlog.
- Dietetic resource cannot be moved from within the service to cover these Gastro patients, due to clinical prioritisation.
- The Dietetic team are working with the Gastro leads to develop the evidenced business plan.

Performance Escalations Report
Urgent & Emergency Care Section

Access: Urgent & Emergency Care – Emergency Department Waits (4 Hrs, 12 Hrs and 24 Hrs)

Escalated by:	Integrated Performance Executive Delivery Group (IPEDG)	Date :	April 2025	Reason:	Performance below plan	Status:	Worse

Performance has deteriorated in all metrics compared to December 2025 position and the same period last year of January 2025. Added Over 48 Hour Waits for context

% Seen within 4 Hours

ED Only 43.3%
ED&MIU 56.9%

Past 12 month trend: deterioration

Number waiting over 24 Hours

Past 12 month trend: deterioration
Jan 2026: 2134

Number waiting over 12 Hours

Past 12 month trend: deterioration
Jan 2026: 3826

Number waiting over 48 Hours

Past 12 month trend: deterioration
Jan 2026: 837

Executive walkthroughs will continue at each District General Hospital to engage clinical and operational teams in opportunity and solution identification, as well as providing visible leadership and commitment of the Board to supporting improvement on the ground. A commitment of high visibility has been made, without seeking to disrupt the work of local teams

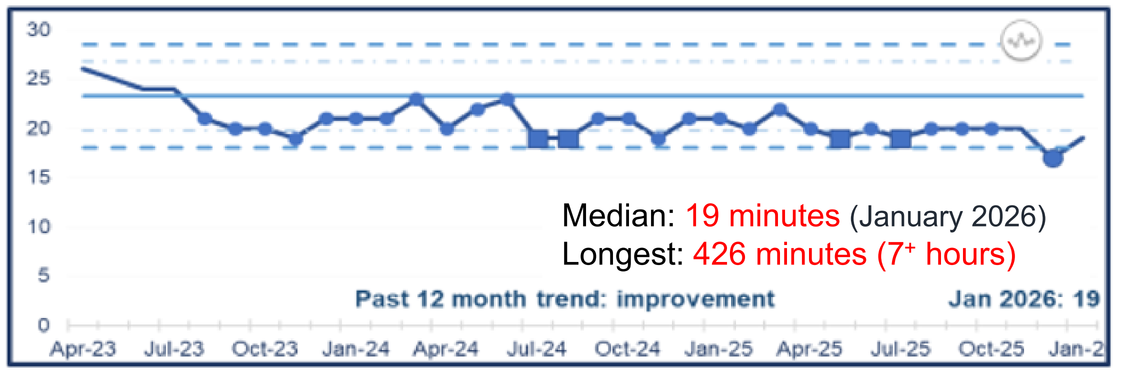
The Executive Medical Director led a **Rapid Quality Review** meeting drawing together clinicians to address :

- Specific and focused consideration to quality concerns and risks within the pathways passing through the ED
- Facilitate rapid and collective judgements about quality within these pathways
- Identify actions within these pathways as a result of the risk identified to measure quality of care and risk within the ED pathways
- Improve quality of care and reduce risk within ED pathways
- MADE event results to be acted on once report rationalised

Access: Urgent & Emergency Care – Emergency Department Process Time to Triage (Efficiency)

Escalated by:	Integrated Performance Executive Delivery Group (IPEDG)	Date :	April 2025	Reason:	Performance below plan	Status:	Not Improving

The median time to triage has remained on or around the 20 minute mark since April 20205. It should be noted that the longest times to triage remain in excess of 7 hours



Current position: Target 15 Minutes

January 2026 reported position for median time to Triage was 19 minutes. Performance against this measure has remained on or around the 20 minute mark throughout 2025, apart from a slight improvement to 17 minutes reported for December 2025. November2025.

Data Source: As Published on IRIS, accessed 15.02.2026

Next actions

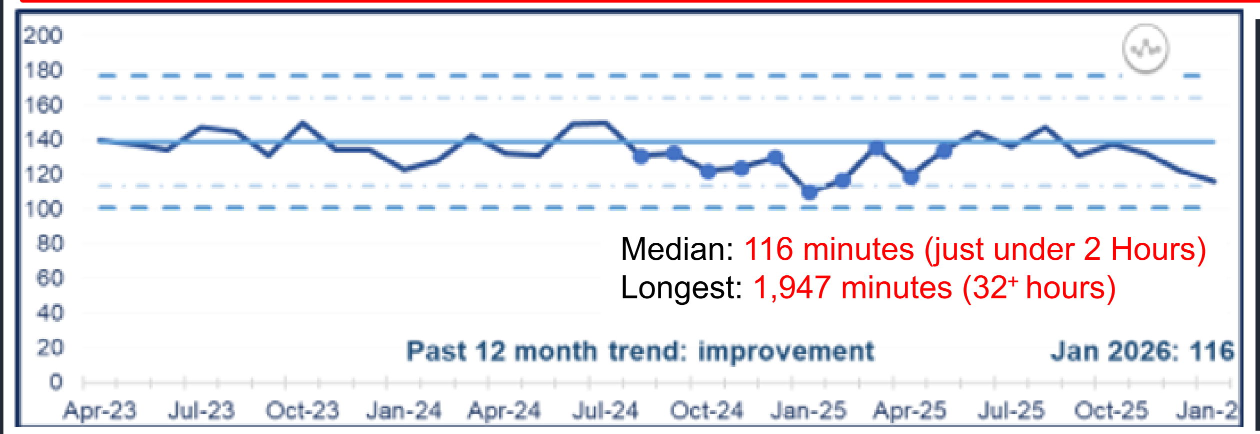
- The **workforce model** is being considered alongside the patient pathways and alternatives to ED, via streaming to other services, including SDEC.
- Ringfencing key clinical areas such as SDEC units from being used as a ward when the pressure for bed spaces becomes greatest.
- The existing '**Resilience Hub**' established provides system leadership and coordination, enabling the North Wales health system to work as one.
- Review resilience hub to improve focus on actions January 2026
- Acute Frailty pathway mapping and baseline assessment completed across all areas

A trigger is in place that activates the redeployment of staff to additional triage which is being used. The threshold for the trigger and the staffing pattern relating to triage activity is being urgently reviewed to enable an improvement to the standard of 15 minutes.

Access: Urgent & Emergency Care – Emergency Department Process Time to Clinician (Efficiency)

Escalated by:	Integrated Performance Executive Delivery Group (IPEDG)	Date :	April 2025	Reason:	Performance below plan	Status:	Improving

Median time arrival to clinician has improved slightly to 116 minutes (just under 2 Hours) However, the longest wait for a patient to see a clinician was **over 32 hours**



Current position: Target 60 minutes

The latest nationally reported position 116 minutes for median time from arrival to clinician for January 2026.This is an improvement of 15 minutes from the November 2025 position, 133 minutes.

However, the longest wait for a patient from arrival to clinician is 1,947 minutes (32+ hours, up from 19 hours in December 2025).

Data Source: As Published on IRIS, accessed 16.02.2026

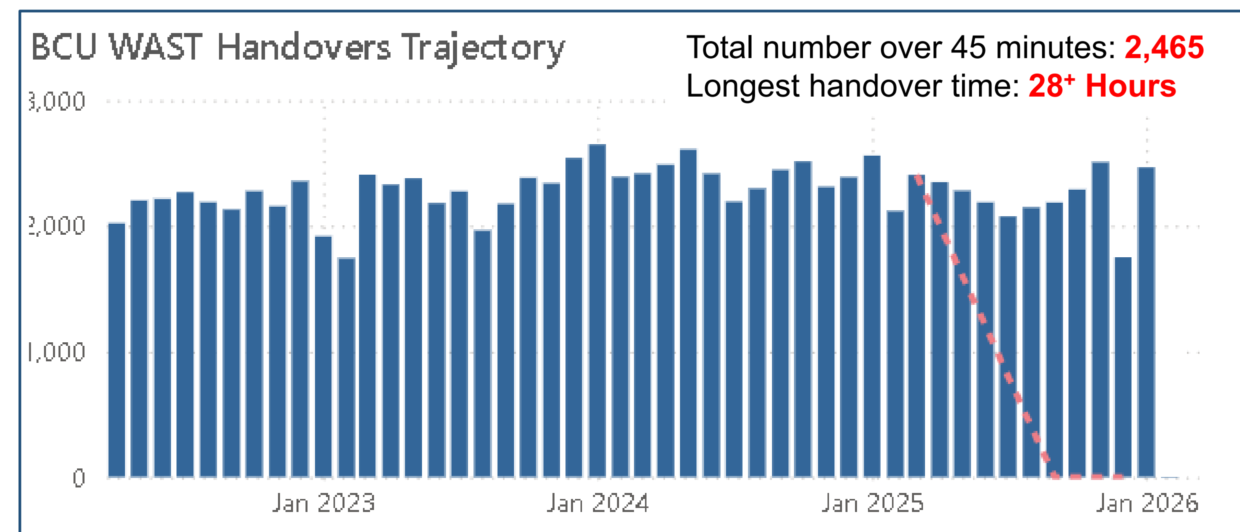
Next actions

- The Health Board's Clinical Executives have issued **Quality Standards** and the Chief Operating Officer **Operational Standards**
- Each ED will be assessed from an **environment and estate** perspective. A consistent theme at each ED whilst on Executive Walkthroughs has been the availability of clinical rooms to examine patients

Flow & Efficiency: Urgent & Emergency Care – Ambulance Conveyances and Handovers

Escalated by:	Integrated Performance Executive Delivery Group (IPEDG)	**Date :**	April 2025	**Reason:**	Performance below plan	**Status:**	**Getting Worse**

After improvement in December 2025, the number of ambulance handover delays **over** 45 minutes has returned to previous levels at 2,465 (over 66% of all conveyances)



Across BCU 66% (nearly a 20% increase) of patients waited over 45 minutes for ambulance handover in January 2026. This despite a reduction in the number of ambulance conveyances to acute sites compared to previous months.
Current Actions Include:

- Executive-level leadership of improvement actions and performance
- Weekly review with WAST
- Reducing avoidable admissions and ambulance conveyances to Emergency Departments
- Improving flow through the hospital including establishing an acuity-led discharge process and improved weekend flow
- Working with clinical and operational teams to strengthen system working.

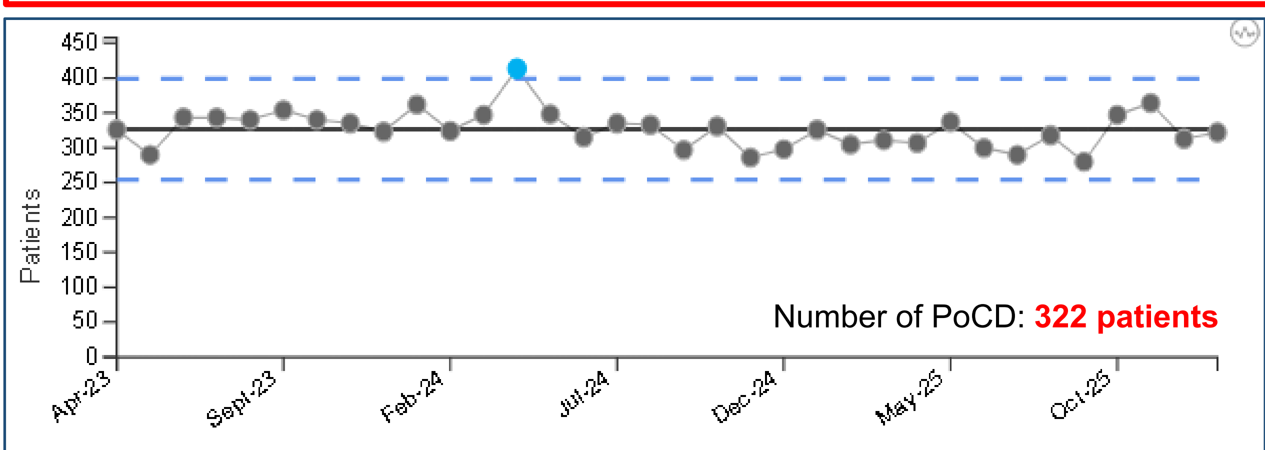
Next Actions

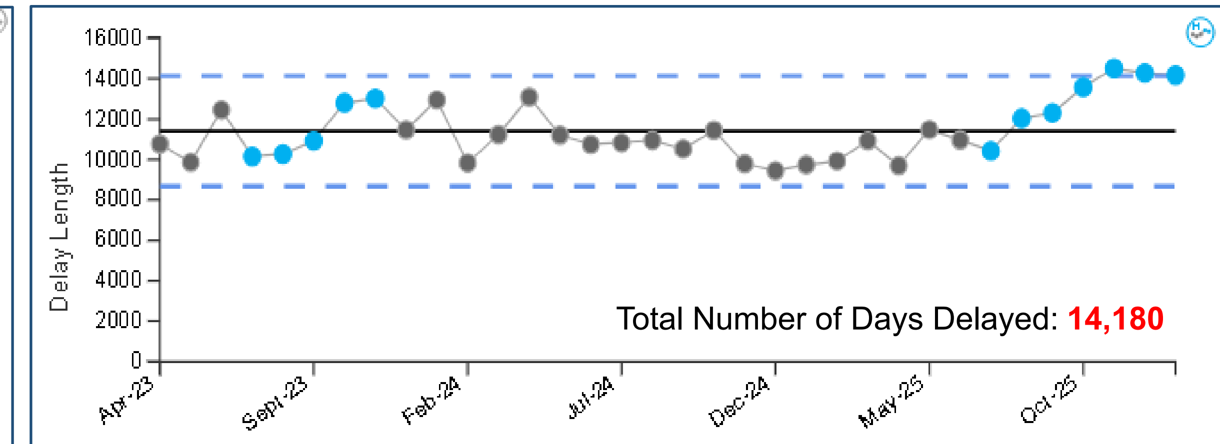
- Preparation in departments for immediate release protocol.
- Embed learning from 1st sprint and continue improvements through 2nd sprint to significantly increase number and timeliness of discharges including at the weekend to reduce congestion in the department and create more space for handovers.
- Weekly reviews with Welsh Ambulance Service NHS Trust (WAST) colleagues increased during January and February 2026
- Improved weekend planning process, and increased check and challenge in system resilience approach for plans to handovers.

Flow & Efficiency: Pathways of Care Delays

Escalated by:	Integrated Performance Executive Delivery Group (IPEDG)	Date :	April 2025	Reason:	Performance below plan	Status:	Not Improving

Whilst the number of patients delayed is lower than the same period last year, the number of days delayed has increased and at 14,500 is 5,000 higher than January 2025.





Current Position

- Latest nationally reported position **322 patients** recorded as a POCD in January 2026. Statistically no improvement since April 2023.
- Currently approximately **14,180 days are lost** to patients who could be in the right place (usually in their own home)
- Timely access to social care services remains a key issue, as well as inter-hospital reasons such as awaiting assessment or transfer to another hospital (including community hospital).

Next Actions

- A second 'Sprint' from 21st Jan to 4th February
- reviewing and improving system flow and hospital discharges
- maximising the number of people who should be discharged from hospital with specific attention on delayed discharges
- Admission avoidance
- Senior clinical decision making
- Efficiencies linked to in-hospital flow and discharge

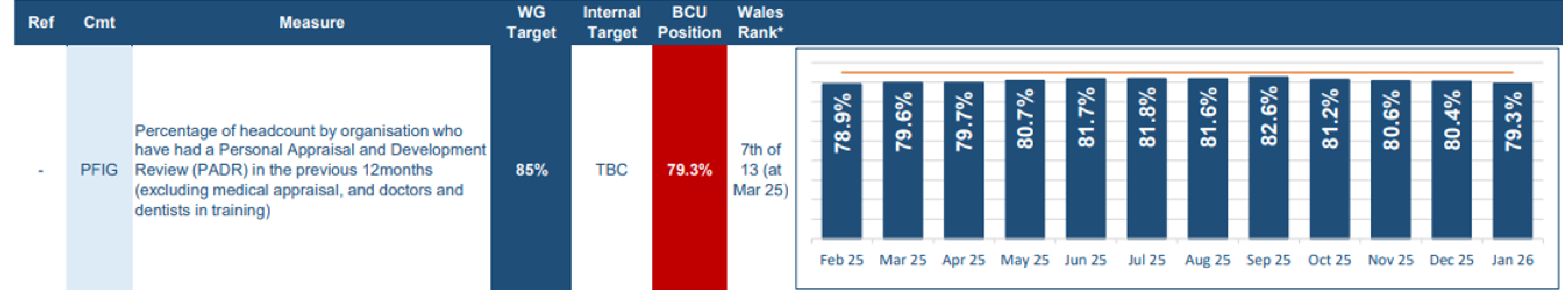
Performance Escalations Report

Workforce, Organisational Development and Finance Sections

People: Staff Wellbeing and Development

Escalated by:	Integrated Performance Executive Delivery Group (IPEDG)	Date :	April 2025	Reason:	Performance below plan	Status:	No Change

At 79.3%, the rate of Personal Appraisal & Development Reviews has fallen below the 80% mark for the first time since March 2025.



Ref	Cmt	Measure	WG Target	Internal Target	BCU Position	Wales Rank*
-	PFIG	Percentage of headcount by organisation who have had a Personal Appraisal and Development Review (PADR) in the previous 12months (excluding medical appraisal, and doctors and dentists in training)	85%	TBC	79.3%	7th of 13 (at Mar 25)

Finance

Escalated by:	Integrated Performance Executive Delivery Group (IPEDG)	Date :	April 2025	Reason:	Performance below plan	Status:	Improving

At the end of Month 9, the forecast outturn was revised to a deficit of £17.4m. The year to date position for Month 10 (January) is reporting a deficit of £17.3m

The year to date position is reporting a deficit of £17.3m with the table below showing the in month actual and forecast movements.

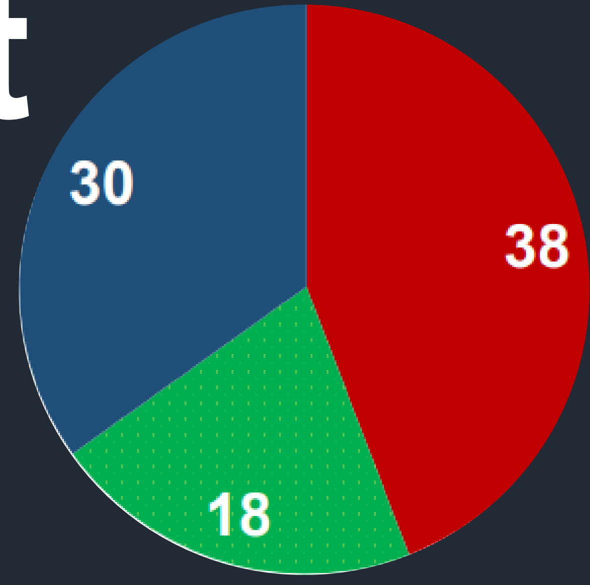
As at Month 9 (December), the forecast outturn has been revised to report a deficit of £17.4m. The Health Board has been required to absorb several national pressures following submission of the plan, having shortfalls in resource allocation for the Employers National Insurance uplift and Cost Uplift Factors (CUF) not matching the increased cost impact from provision of cross border services and additional pressures from JCC of £6.8m for cross border patients. In addition, the drivers of the financial deficit in year centre upon servicing additional capacity areas, Mental Health out of area placements and Continuing Healthcare (CHC).

	2025-26													
	Actual Position										2025/26 Forecast Position		Total Year to Date	Forecast Year End Position
	Apr £m	May £m	Jun £m	Jul £m	Aug £m	Sep £m	Oct £m	Nov £m	Dec £m	Jan £m	Feb £m	Mar £m	£m	£m
Total Monthly Surplus / Deficit	(3.7)	(2.4)	(1.6)	(3.6)	(2.3)	(1.4)	(1.2)	(1.0)	0.0	0.0	(0.1)	(0.1)	**(17.3)**	**(17.4)**

The Health Board's £40.0m savings target is profiled on an equal twelfth's basis. Full year forecast value of Green Schemes is £48.1m (comprising of £36.0m Savings, £0.9m Income Generation, £0.7m Cost Avoidance and £10.5m Accountancy Gains), a forecast increase of £3.2m from month 9. Of these, £25.4m have been identified as recurring, with a full year effect of £31.7m, and £22.7m are non-recurring savings. Further work is required to convert the remaining £1.3m Red Schemes and £3.1m pipeline opportunities to Green Schemes.

Total Savings delivered in-month is £3.9m against a target of £3.3m. The combined year to date delivery is £42.3m, against a year to date target of £33.3m. This includes Accountancy Gains of £10.5m, of which £2.1m were identified in month which contribute to the in-month achievement.

Integrated Quality & Performance Report



Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Presented on 24.02.2026

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

Summary of Performance to Month 9 (December 2025)

Status	Description
Green	The *latest available data point* indicates that performance is at, or better than the target
Red	The *latest available data point* indicates that performance is worse than the target
Blue	It is inappropriate, or not possible, to rate available data against any available target
Grey	There is no / insufficient data available to rate against the target

All Sections: Red 38, Green 18, Blue 30

Quality, Safety, Effectiveness & Experience Performance: Red 7, Green 10, Blue 20

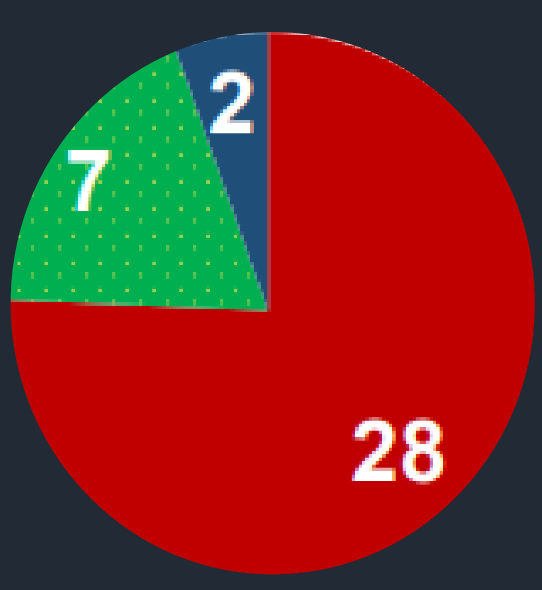
Access & Activity Performance: Red 28, Green 7, Blue 2

People & Organisational Development Performance: Red 3, Green 1, Blue 4

Financial Performance: Blue 4

Section 2

Access & Activity Performance



Access: Children's & Adolescents Mental Health Services CAMHS (Under 18 years of age)

Ref	Cmt	Measure	WG Target	Internal Target	BCU Position	Wales Rank
SM: DM16	PFIG	Percentage of Local Primary Mental Health Support Service (LPMHSS) assessments undertaken within (up to and including) 28 days of the date of receipt of referral (for those aged under 18 years)	80%	80.0%	90.1%	4th of 7 (at Apr 25)
SM: DM15	PFIG	Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS (for those aged under 18 years)	80%	70.0%	80.0%	6th of 7 (at Apr 25)
SM: DM16	QSE	Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan (for those age under 18 years)	90%	90.0%	94.2%	5th of 7 (at Apr 25)

Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26
95.7%	96.9%	96.7%	95.2%	98.5%	95.0%	86.0%	94.5%	95.3%	83.8%	90.1%	

Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26
35.9%	41.7%	40.5%	49.4%	50.3%	52.0%	53.4%	55.7%	54.4%	72.0%	80.0%	

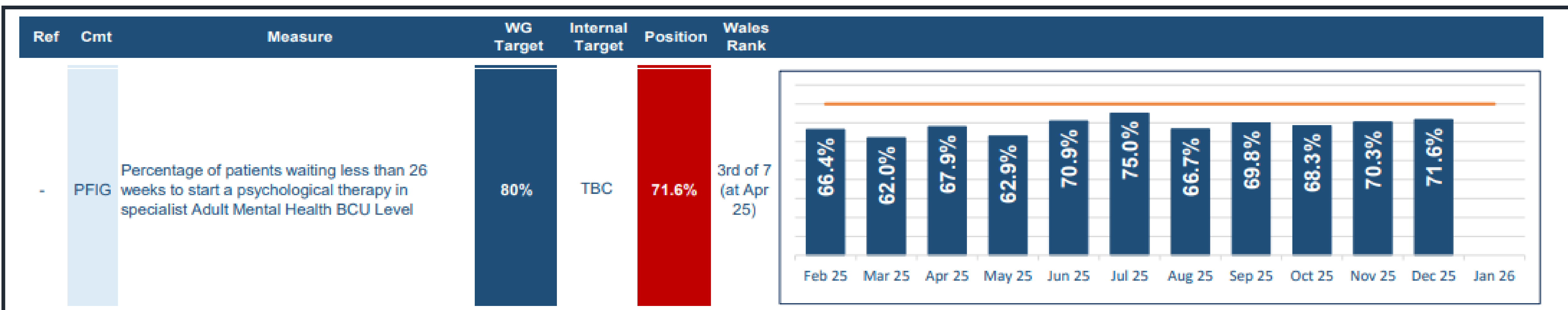
Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26
93.9%	94.1%	95.2%	91.5%	94.6%	97.6%	99.2%	93.8%	96.0%	95.7%	94.2%	

Access: Neurodiversity (Under 18 years of age)

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-11	PFIG	Percentage of children and young people waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment	80%	TBC	11.2%	6th of 7 (at Mar 25)

Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26
12.5%	15.1%	14.4%	14.3%	14.0%	12.4%	11.9%	11.9%	12.6%	12.4%	11.5%	11.2%

Access: Adult Psychological Services (26 weeks)



Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	PFIG	Percentage of patients waiting less than 26 weeks to start a psychological therapy in specialist Adult Mental Health BCU Level	80%	TBC	71.6%	3rd of 7 (at Apr 25)

Access: Mental Health & Learning Disabilities (18 years of age and over)

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
SM: DM11	PFIG	Percentage of Local Primary Mental Health Support Service (LPMHSS) assessments undertaken within (up to and including) 28 days of the date of receipt of referral (for those aged 18 years and over)	80%	TBC	79.4%	5th of 7 (at Apr 25)
SM: DM12	PFIG	Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS (for those aged 18 years and over)	80%	TBC	88.9%	7th of 7 (at Apr 25)
SM: DM13	QSE	Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan (for those age 18 years and over)	90%	TBC	83.2%	5th of 7 (at Apr 25)

Access: GP Practice National Access Standards

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	PFIG	Percentage of GP practices that have achieved all standards set out in the National Access Standards for In-hours	100%	TBC	99.0%	6th of 7 (at Mar 23)

Quarter	Value
Q4 24/25	99.0%
Q1 25/26	96.9%
Q2 25/26	95.8%
Q3 25/26	99.0%

Access: General Dental practice Access Standards

Access to Cancer Services

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank	
CRR: 24-11 SM: DM01	PFIG	Percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)	Increas-ing trend (to 80%)	TBC	51.2%	6th of 6 (at Apr 25)	Past 12 month trend: deterioration Dec 2025: 51.2%

Access to Diagnostic Services

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank	
CRR: 24-13 SM: DM04	PFIG	Number of pathways waiting 8 weeks for specific diagnostic	0	TBC	21800	6th of 7 (at Apr 25)	Past 12 month trend: deterioration Jan 2026: 21800

Access – Referral to Treatment (52 weeks Stage 1 (new outpatient) 52 Weeks (all stages)

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-11	PFIG	Number of patients waiting over 52 weeks for a new outpatient appointment	0	TBC	7014	7th of 7 (at Apr 25)
CRR: 24-11 SM: DM02	PFIG	Number of patients waiting more than 52 weeks for referral to treatment	Decreasing trend (to 0 by Jun 25)	TBC	37878	7th of 7 (at Mar 25)

Past 12 month trend: improvement — Jan 2026: 7014

Past 12 month trend: improvement — Jan 2026: 37878

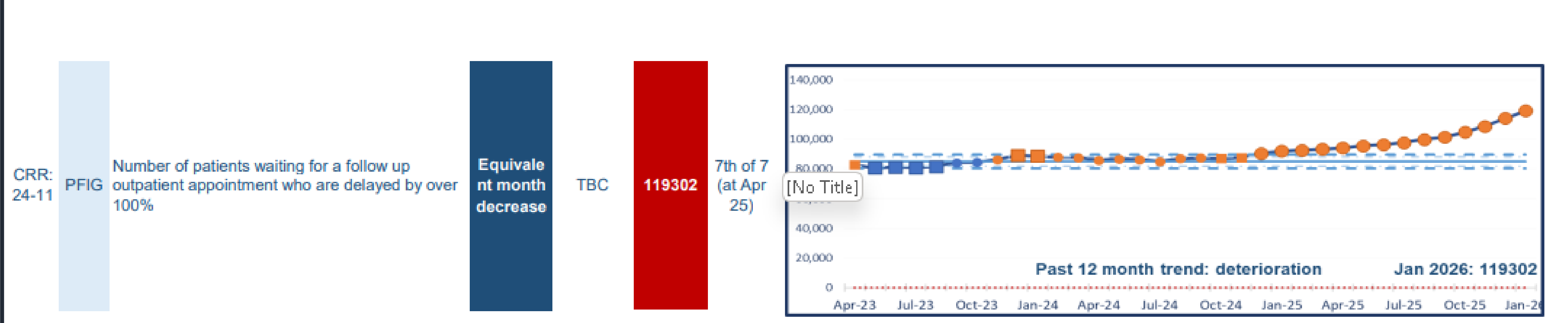
Access – Referral to Treatment (104 Weeks and 156 weeks)

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-11 SM: DM03	PFIG	Number of patients waiting more than 104 weeks for referral to treatment	0	TBC	3584	7th of 7 (at Apr 25)
CRR: 24-11	PFIG	Over 156 weeks all stages	N/A	TBC	56	

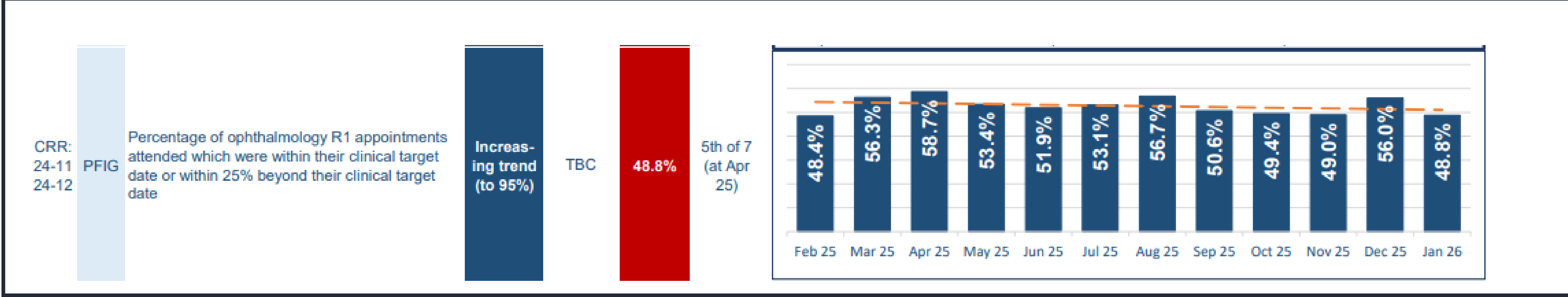
Past 12 month trend: improvement

Jan 2026: 3584

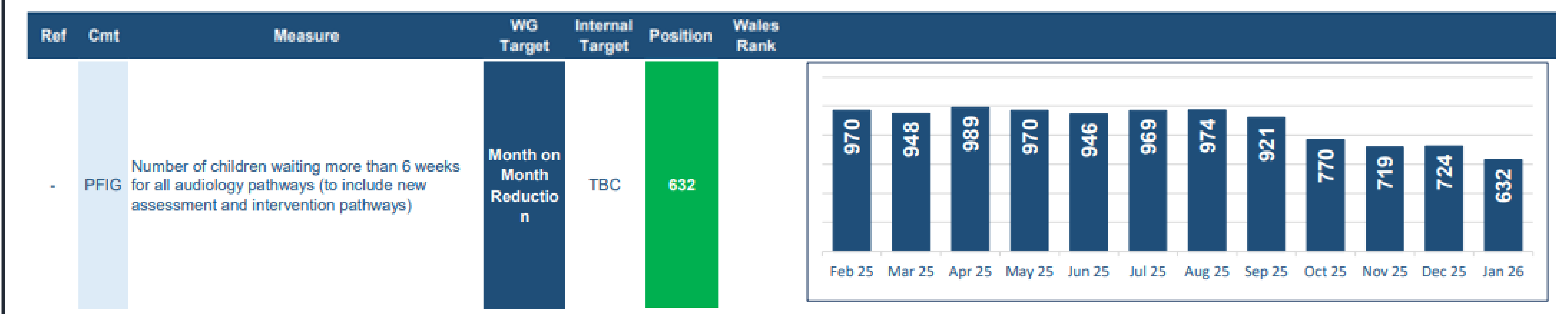
Access – Follow up Backlog over 100% overdue their Clinical Review date



Access –Ophthalmology Backlog of urgent R1 Patients



Access – Therapies for Under 18 years old



Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	PFIG	Number of children waiting more than 6 weeks for all audiology pathways (to include new assessment and intervention pathways)	Month on Month Reduction	TBC	632	

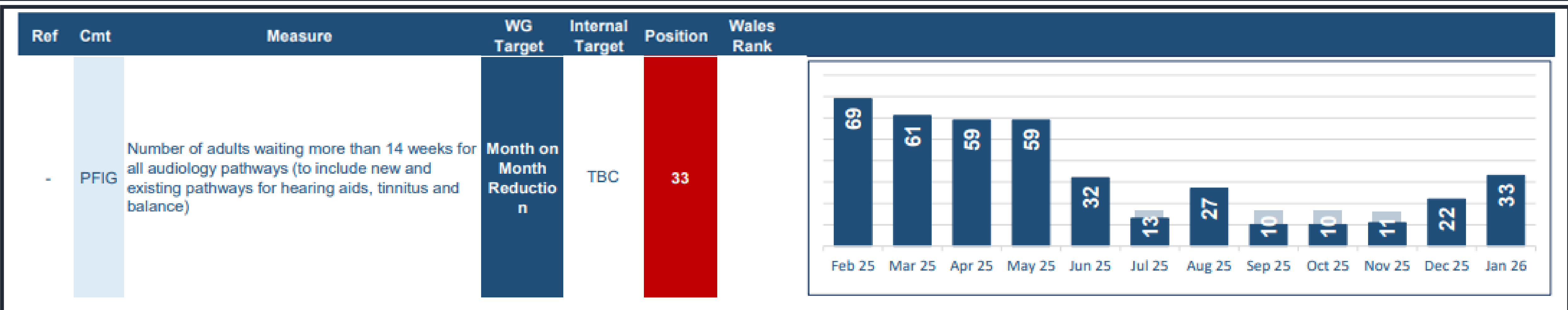
Access – Therapies All ages – Excluding Audiology

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-11 SM: DM05	PFIG	Number of patients (all ages) waiting more than 14 weeks for a specified therapy (excluding audiology)	0	TBC	1518	6th of 7 (at Apr 25)

Past 12 month trend: improvement

Jan 2026: 1518

Access – Therapies Adult Audiology



Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	PFIG	Number of adults waiting more than 14 weeks for all audiology pathways (to include new and existing pathways for hearing aids, tinnitus and balance)	Month on Month Reduction	TBC	33	

Efficiency & Productivity – Effective utilisation of theatre capacity (Part 1)

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	PFIG	Number of cases per theatre session	2.5	TBC	2.0	
-	PFIG	Percentage of lists with a start time 15 minutes or more past the scheduled start time	<10%	TBC	46.0%	
-	PFIG	Percentage of lists with an end time of over 60 minutes before the scheduled finish time	<10%	TBC	24.9%	

	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26
Cases per theatre session	2.1	2.0	2.1	2.1	2.1	2.1	2.2	2.1	2.1	2.0	2.0	2.0
Late start ≥15 min	46.8%	46.4%	43.2%	46.4%	41.5%	41.2%	39.1%	46.3%	46.5%	45.6%	42.1%	46.0%
Early finish >60 min	25.4%	25.2%	22.8%	27.6%	23.9%	22.2%	18.7%	23.8%	23.1%	21.8%	28.6%	24.9%

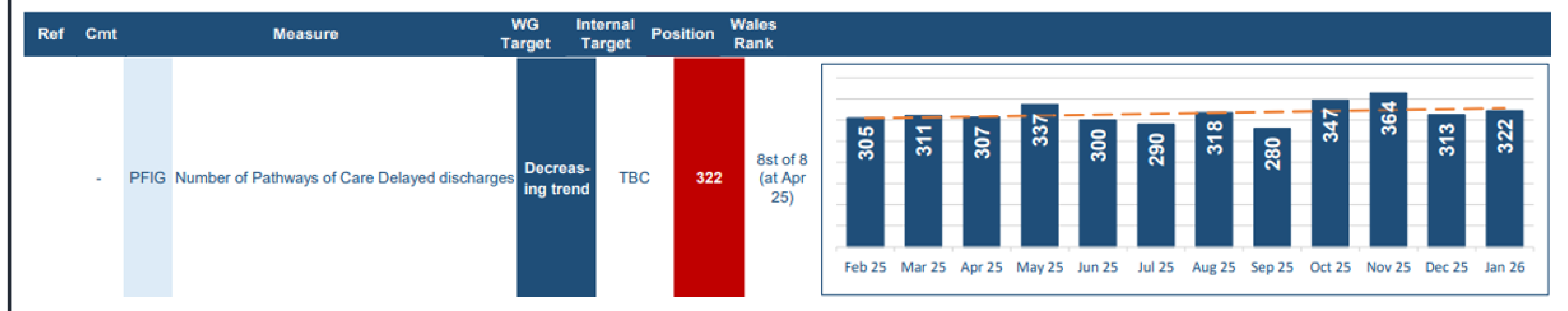
[No Title]

Efficiency & Productivity – Effective utilisation of theatre capacity (Part 2)

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	PFIG	Percentage of scheduled operations cancelled either on the day or the day before the scheduled operation	<5%	TBC	13.1%	N/A
-	PFIG	Percentage of scheduled operations cancelled on the day of the scheduled operation	0.0%	TBC	9.8%	
-	PFIG	Number of Pathways of Care Delayed discharges	Decreas-ing trend	TBC	322	8st of 8 (at Apr 25)

Month	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26
Cancelled on the day or day before	11.6%	10.6%	9.3%	10.9%	8.6%	10.8%	8.6%	10.8%	12.2%	11.2%	12.4%	13.1%
Cancelled on the day	8.2%	8.2%	7.4%	8.3%	6.5%	8.2%	6.3%	7.8%	9.0%	9.2%	9.5%	9.8%
Pathways of Care Delayed discharges	305	311	307	337	300	290	318	280	347	364	313	322

Efficiency – Patient Flow Pathways of Care Delays



Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	PFIG	Number of Pathways of Care Delayed discharges	Decreas-ing trend	TBC	322	8st of 8 (at Apr 25)

Access – Urgent & Emergency Care: Emergency Department Waits

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-10	PFIG	Percentage of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge	Equivalent month increase (2025/26 to 2024/25) to 95%	TBC	56.9%	7th of 7 (at Apr 25)
CRR: 24-10 SM: DM08	PFIG	Number of patients who spend 12 hours or more in all hospital major and minor emergency care facilities from arrival until admission, transfer or discharge	Equivalent month reduction (2025/26 to 2024/25) to 0	TBC	3826	7th of 7 (at Apr 25)
-	N/A	Number of patients who spend 24 hours or more in all hospital major and minor emergency care facilities from arrival until admission, transfer, or discharge	N/A	TBC	2134	

Past 12 month trend: deterioration — Jan 2026: 56.9%

Past 12 month trend: deterioration — Jan 2026: 3826

Past 12 month trend: deterioration — Jan 2026: 2134

Flow – Urgent & Emergency Care: Emergency Department process wait times

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-10	PFIG	Median time from arrival at an emergency department to triage by a clinician	15 minutes or less	TBC	19.0	4th of 6 (at Apr 25)
CRR: 24-10 SM: DM07	PFIG	Median time from arrival at an emergency department to assessment by a clinical decision maker	60 minutes or less	TBC	116.0	6th of 6 (at Apr 25)
CRR: 24-10	PFIG	Median emergency response time to amber calls	Decreasing trend	TBC	112.3	2nd of 7 (at Apr 25)

Presented on 24.02.2026

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

Flow – Urgent & Emergency Care: Ambulance Conveyances and Handover Times

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	PFIG	Percentage of ambulance handovers within 15 minutes	Equival-ent month increase (2025/26 to 2024/25) to 100%	TBC	12.6%	N/A
CRR: 24-10 SM: DM06	PFIG	Number of ambulance patient handovers over 1 hour	0	TBC	2184	6th of 6 (at Apr 25)
CRR: 24-10	PFIG	Number of ambulance patient handovers over 4 hour	0	TBC	917	

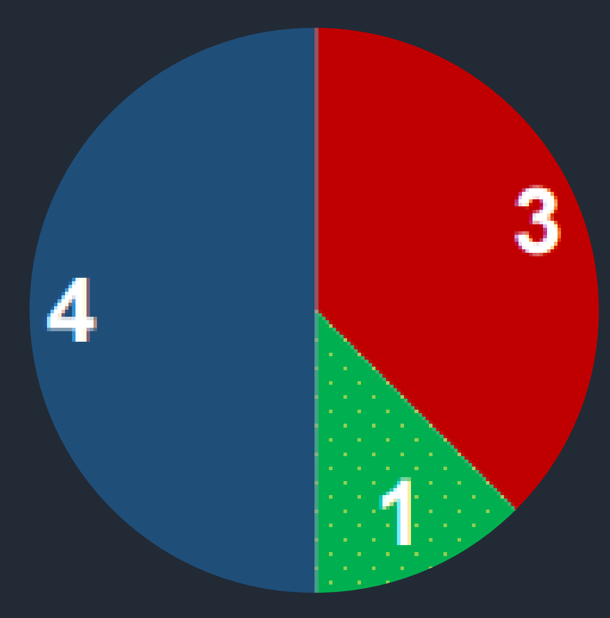
Flow – Ambulance Percentage Red Call Responses within 8 minutes

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

Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26
52.3%	47.6%	52.5%	50.0%	49.1%							

Section 2

People & Organisational Development Performance



Staff Wellbeing and Development (includes Sickness, PADR, Mandatory Training and Disciplinary Proceedings)

Ref	Cmt	Measure	WG Target	Internal Target	BCU Position	Wales Rank*
-	PFIG	Percentage of headcount by organisation who have had a Personal Appraisal and Development Review (PADR) in the previous 12months (excluding medical appraisal, and doctors and dentists in training)	85%	TBC	79.3%	7th of 13 (at Mar 25)
-	PFIG	Percentage of sickness absence rate of staff	Decreasing trend	TBC	6.4%	7th of 13 (at Mar 25)
CRR: 24-05	PFIG	Agency spend as a percentage of total pay bill	Decreasing trend	TBC	2.5%	9th of 12 (at Mar 25)

Measure	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26
PADR	78.9%	79.6%	79.7%	80.7%	81.7%	81.8%	81.6%	82.6%	81.2%	80.6%	80.4%	79.3%
Sickness absence	6.3%	5.6%	5.7%	5.4%	5.9%	6.0%	6.0%	6.1%	6.4%	6.4%	6.9%	6.4%
Agency spend	3.9%	2.2%	[illegible]	3.5%	3.3%	3.7%	3.0%	3.2%	3.0%	2.3%	2.8%	2.5%

[No Title]

Staff turnover

Ref	Cmt	Measure	WG Target	Internal Target	BCU Position	Wales Rank*
-	PFIG	Turnover rate for nurse and midwifery registered staff leaving NHS Wales (HEIW data)	Decreas-ing trend against 2019/20	TBC	8.9%	
-	PFIG	Turnover rate for nurse and midwifery registered staff leaving BCUHB (monthly, not 12 month rolling figure)	N/A	TBC	0.5%	
-	PFIG	12 month rolling turnover rate (External)	N/A	TBC	7.23%	

	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26
Turnover rate leaving NHS Wales (HEIW data)	8.8%	8.8%	8.9%	8.8%	8.9%	8.7%	8.7%	9.0%	9.0%	8.9%		
Turnover rate leaving BCUHB (monthly)	0.3%	1.0%	0.4%	0.5%	0.6%	0.4%	0.6%	0.7%	0.6%	0.5%	0.4%	0.5%
12 month rolling turnover rate (External)	7.9%	7.9%	8.0%	7.9%	7.9%	7.7%	7.7%	7.7%	7.7%	7.7%	7.4%	7.2%

Value and Efficiency – Agency and Locum Usage

Ref	Cmt	Measure	WG Target	Internal Target	BCU Position	Wales Rank*
CRR: 24-05	PFIG	Agency spend as a percentage of total pay bill	Decreas-ing trend	TBC	2.5%	9th of 12 (at Mar 25)

Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26
3.9%	2.2%	3.4%	3.5%	3.3%	3.7%	3.0%	3.2%	3.0%	2.3%	2.8%	2.5%

B - Agency / Locum (premium) Expenditure - Analysed by Type of Staff		1	2	3	4	5	6	7	8	9	10	11	12		
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	Forecast year-end position
REF	TYPE	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
1	Administrative, Clerical & Board Members	105	76	46	115	(9)	72	(8)	(1)	69	12	4	6	477	487
2	Medical & Dental	1,787	1,866	1,737	2,012	1,889	1,894	1,807	1,780	1,892	1,699	1,762	1,748	18,363	21,873
3	Nursing & Midwifery Registered	999	1,087	1,049	973	1,048	869	885	102	547	478	586	590	8,037	9,213
4	Prof Scientific & Technical	15	8	22	29	31	53	(2)	40	9	16	19	19	221	259
5	Additional Clinical Services	2	35	(39)	6	(9)	2	12	7	4	1	0	0	21	21
6	Allied Health Professionals	424	403	435	486	418	393	405	361	319	333	406	430	3,977	4,813
7	Healthcare Scientists	16	20	16	21	3	12	12	13	20	18	18	18	151	187
8	Estates & Ancillary	0	0	(3)	3	0	0	0	20	0	1	1	1	21	23
9	Students	0	0	0	0	0	0	0	0	0	0	0	0	0	0
10	TOTAL AGENCY/LOCUM (PREMIUM) EXPENDITURE	3,348	3,495	3,263	3,645	3,371	3,295	3,111	2,322	2,860	2,558	2,796	2,812	31,268	36,876
11	Agency/Locum (premium) % of pay	3.4%	3.5%	3.3%	3.7%	3.0%	3.2%	3.0%	2.3%	2.8%	2.5%	2.9%	2.8%	3.1%	3.0%

Section 3

Financial Performance

Financial Position for Month 10 (January) and Forecast Outturn for 31st March 2026

BCU Wide and Divisional Positions (Red = overspend against plan)											
	April £m	May £m	June £m	July £m	August £m	September £m	October £m	November £m	December £m	January £m	YTD £m
West IHC	(2.0)	(2.2)	(2.1)	(2.6)	(1.3)	(1.9)	(1.6)	2.9	(0.9)	(0.5)	(12.1)
Central IHC	(3.4)	(2.3)	(2.6)	(3.0)	(1.4)	(2.0)	(2.6)	7.9	(1.5)	(0.4)	(11.4)
East IHC	(3.4)	(3.5)	(3.8)	(3.5)	(2.1)	(3.2)	(3.3)	6.3	(1.6)	(0.8)	(18.8)
Womens	(0.3)	(0.3)	(0.3)	(0.4)	(0.3)	(0.3)	(0.3)	0.2	(0.3)	0.1	(2.2)
MH & LD	(1.6)	(1.5)	(1.8)	(1.9)	(1.8)	(1.9)	(2.2)	(0.8)	(1.4)	(0.3)	(15.4)
Commissioning Contracts	(1.2)	(2.2)	0.2	(1.6)	(1.7)	(0.9)	(1.2)	0.0	0.6	(0.4)	(8.4)
ICD Primary Care	0.2	0.4	0.1	0.2	0.6	0.1	0.5	1.2	0.7	0.7	4.6
ICD Regional Services	(0.8)	(1.6)	(1.3)	(1.1)	1.6	(1.3)	(1.1)	1.1	0.5	(0.1)	(4.1)
Support Functions & Other Budgets	8.9	10.8	9.9	10.4	4.0	10.1	10.6	(19.8)	3.9	1.7	50.4
BCU Wide	**(3.7)**	**(2.4)**	**(1.6)**	**(3.6)**	**(2.3)**	**(1.4)**	**(1.2)**	**(1.0)**	**0.0**	**0.0**	**(17.3)**

Financial Savings Position at Month 10 (January) and forecast delivery for 31st March 2026

Service Performance against Target	Annual				Year to Date		
	Target £m	Forecast Delivery £m	Delivery v Target (+ve = adverse) £m	FYE £m	Target £m	Delivery £m	Delivery v Target (+ve = adverse) £m
West Integrated Health Community	7.9	6.7	1.1	6.3	6.6	5.5	1.0
Central Integrated Health Community	10.0	7.8	2.2	5.4	8.3	6.8	1.5
East Integrated Health Community	10.0	9.6	0.4	8.8	8.3	7.8	0.5
MHLD	3.9	6.1	-2.2	8.2	3.2	5.3	-2.1
Womens Services	1.2	0.6	0.6	0.4	1.0	0.5	0.5
Diagnostic and Specialist Clinical Support	1.8	1.9	0.0	0.4	1.5	1.6	-0.1
Cancer Services	1.5	1.6	-0.1	2.0	1.3	1.2	0.1
Community Dental Sevices	0.1	0.0	0.1	0.0	0.1	0.0	0.1
Corporate & Support Services	3.6	3.4	0.2	0.2	3.0	2.9	0.1
Saving Total	**40.0**	**37.6**	**2.4**	**31.7**	**33.3**	**31.7**	**1.6**
Accountancy Gains		10.5	-10.5			10.5	-10.5
Total		**48.1**	**-8.1**	**31.7**	**33.3**	**42.3**	**-8.9**

Year to date position and forecast risks to delivery of the statutory duty to break-even

Key messages;

In month position and year to date;

- £2.5bn organisation (WG funding and other income)
- Year to date **£17.3m** deficit
- Year end forecast outturn position has been revised to report a projected deficit of **£17.4m**, with additional financial controls implemented to seek to improve the outturn within the remaining months of the financial year ending 31st March 2026.

2025/26 Financial position	Year to Date at Month 10 £m	Full Year Forecast Outturn £m
Local pressures		
JCC pressures (shortfall on Savings £6.8m offset by minor underspends)	4.9	5.9
Capacity pressures, including premium working, escalated beds	8.3	10.0
Out of Area Mental Health placements	5.5	6.6
Cost overruns, including local contracting pressures & CHC	1.8	2.1
Total local pressures	**20.5**	**24.6**
National pressures		
English tariff CUF inflationary pressure above uplift methodology	3.8	4.6
Employers National Insurance funding shortfall	3.5	4.2
Total national pressures	**7.3**	**8.8**
Mitigating actions and savings		
Additional savings achieved	(9.0)	(8.1)
Mitigating actions	(1.6)	(7.9)
Total mitigating actions and savings	**(10.6)**	**(16.0)**
Total Financial Position	**17.3**	**17.4**

Financial Risks and Mitigations in place to achieve forecast position 31st March 2026

The forecast outturn position has been revised to report a projected deficit of £17.4m, with additional financial controls implemented to seek to improve the outturn over the remaining months of the financial year ending 31st March 2026.

The movement from break-even to a forecast deficit is in part driven through the Health Board being unable to mitigate national pressures that materialised following submission of the plan. The shortfalls in resource allocation for the Employers National Insurance uplift and Cost Uplift Factors (CUF) not matching the increased inflationary impact from provision of cross border services with additional pressures from JCC of £6.8m for cross border patients. In addition, the drivers of the financial deficit in year centre upon servicing additional capacity areas, Mental Health out of area placements and Continuing Healthcare (CHC).

The risk to delivery of the plan was highlighted in July 2025 through the Executive, with recommendations for implementation of the enhanced controls developed by the Executive, the risk to delivery estimated at £20m. Initially a 1% cost improvement ask was levied to the Directorates, with further escalation to the August 2025 Health Board resulting in the formation of the Board-level Financial Oversight Group (first meeting in September 2025).

The implementation of the additional controls identified from the Executive were considered and whilst implementation of the approach was not supported as presented, the Group requested services reduce expenditure by 1.5% from October 2025. This request shared with the wider leadership of the Health Board through the Integrated Performance – Executive Delivery Group and Operational Leadership Team forums.

In December 2025, the Financial Oversight Group agreed to implement a further centrally controlled measures developed within the Executive, at a minimum to prevent a further deterioration in the position whilst maintaining access and quality of services for the local population. Additional controls implemented include:

- **Non-Pay Expenditure Controls –** Additional controls will be widened to all non-pay categories which do not directly impact clinical care 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

Additional Information

Integrated Quality & Performance Report
Betsi Cadwaladr University Health Board

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

Our website www.bcu.wales.nhs.uk

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

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

follow @bcuhb

http://www.facebook.com/bcuhealthboard

Abbreviations

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

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

Performance Finance & Information Governance Committee

INFORMATION GOVERNANCE QUARTER 1 & 2 2025/26 KEY PERFORMANCE INDICATORS REPORT / INFORMATION GOVERNANCE ANNUAL REPORT 2024-25

ADRODDIAD DANGOSYDDION PERFFORMIAD ALLWEDDOL. CHWARTER 1 A 2 2025/26 / ADRODDIAD BLYNYDDOL LLYWORDAETH GWYBODAETH 2024-25

Dyddiad y Cyfarfod **Date of Meeting**	24 February 2025
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**	Dylan Roberts/Justine Parry Prif Swyddog Digidol a Gwybodaeth Chief Digital and Information Officer

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, 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.

For completeness, please note both Q1 & Q2 reports have been submitted and approved by PFIG 18th December, however members requested the

Committee cover sheet be updated to the new template and include the following update regarding the Q2 amendment which was omitted from the original cover sheet for Q2 in error but was discussed/recorded at the meeting.

During the December Executive meeting, it was identified that the FOI compliance figures reported in the original Q2 KPI Report for WOD were inaccurate. The Information Governance team subsequently carried out a review to investigate and correct these discrepancies. The figures have now been updated, and apologies have been issued to the affected departments. A detailed summary of the corrective actions taken and lessons learned will be included in the Q3 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	25/11/2025	Presented to group, chaired by Clara Davies. Included in minutes and Chairs Assurance Report.
Executive Meeting	10/12/2025	Presented to Group by Justine Parry.
PFIG	18/12/2025	Presented by Justine Parry

Appendices / Atodiadau	
Appendix 1	Information Governance - Q1 KPI 2025-26
Appendix 2	Information Governance - Q2 KPI 2025-26

Information Governance Quarter 1 & 2 2025/26 Key Performance Indicators Report.

Adroddiad Dangosyddion Perfformiad Allweddol. Chwarter 1 a 2 2025/26

1. **Y SEFYLLFA**
SITUATION

1.1 The Information Governance KPI report provides 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 KPI 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 Improvement is needed in FOI compliance, particularly around the time taken to source information and obtain the required approvals. Delays in these stages continue to impact statutory response times, and more efficient internal coordination will be essential to increasing overall compliance.

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** – The updates outlined in the Executive Summary include the introduction of a revised cover sheet and the addition of further comments to ensure completeness, particularly in relation to FOI compliance. These amendments have been made to improve clarity, accuracy, and alignment with reporting requirements.

<table>
<tr><th colspan="2">ASESIAD / ASSESSMENT</th></tr>
<tr><td rowspan="2">Cyswllt â'r Blaenoriaethau Strategol
Link to Strategic Priorities</td><td>
1. Building an effective organisation</td></tr>
<tr><td>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.</td></tr>
</table>

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<tr><td></td><td>

- Strengthen relationships with IHC clusters to improve Information Governance compliance with Primary Care Contractors.
- Increase service user and Regulator confidence in the Health Board and its staff with increased visibility and working relationships, including a refresh of the IG Webpages and the exploration of introducing IG Champions.
- Encourage and support the professional development of team members by providing opportunities for training, skill enhancement, and knowledge acquisition in relevant areas and to include the development of training programmes.

</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</td><td>15</td><td>12</td><td>6</td><td>Unchanged</td></tr>
</table>
</td></tr>
</table>

	Management function				
	ID5239 - BCU site wide audit to identify health and corporate records store in vulnerable locations	15	12	4	Unchanged
	Risk Register - Tier 3				
	ID8301 - Failure to develop and make improvements to the Information Asset Register	9	4	4	Decreased

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**	**Galluogwyr Ansawdd Enablers of Quality** Choose an item.	**Meysydd Ansawdd Domains of Quality** Choose an item.

<table>
<tr><td rowspan="2">Have you undertaken a Quality Impact Assessment Screening?</td><td>Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:
If more than one applies, please list below:</td><td>Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:
If more than one applies, please list below:</td></tr>
<tr><td></td><td></td></tr>
<tr><td>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant
Wellbeing of Future Generations Act – Wellbeing Goals</td><td colspan="2">Choose an item.</td></tr>
</table>

<table>
<tr><td rowspan="3">Effaith Amgylcheddol / Cynaliadwyedd (5Rs)
Environmental /Sustainability Impact (5Rs)</td><td colspan="2">Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:
If more than one applies, please list below:</td></tr>
<tr><td colspan="2">No - Not Applicable</td></tr>
<tr><td>Os oes mwy nag un yn berthnasol, rhestrwch hynny:
If more than one applies, please list:</td><td></td></tr>
<tr><td rowspan="3">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?</td><td>Do/Yes: ☐</td><td>Naddo/No: ☐</td></tr>
<tr><td>Canlyniad/Outcome:</td><td></td></tr>
<tr><td>Os naddo, dylech gynnwys y rheswm:
If no, please include rationale:</td><td></td></tr>
<tr><td rowspan="3">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?</td><td>Do/Yes: ☐</td><td>Naddo/No: ☐</td></tr>
<tr><td>Canlyniad/Outcome:</td><td></td></tr>
<tr><td>Os naddo, dylech gynnwys y rheswm:
If no, please include rationale:</td><td></td></tr>
<tr><td></td><td>Do/Yes: ☐</td><td>Naddo/No: ☐</td></tr>
</table>

<table>
<tr><td rowspan="2">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</td><td>Canlyniad/Outcome:</td><td></td></tr>
<tr><td>Os naddo, dylech gynnwys y rheswm:
If no, please include rationale:</td><td></td></tr>
<tr><td rowspan="2">Cyfreithiol
Legal</td><td colspan="2">Yes (Include further detail below)</td></tr>
<tr><td colspan="2">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;</td></tr>
<tr><td rowspan="2">Enw Da
Reputational</td><td colspan="2">Yes (Include further detail below)</td></tr>
<tr><td colspan="2">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.</td></tr>
<tr><td rowspan="2">Effaith ar Adnoddau
(Pobl / Ariannol)
Resource Impact
(People / Financial)</td><td colspan="2">Yes (Include further detail below)</td></tr>
<tr><td colspan="2">Non-compliance with the legislation can lead to significant fines imposed by the Information Commissioners office.</td></tr>
</table>

Atodiad 1 - Dangosyddion Perfformiad Allweddol

Chwarter 1 – Ebrill i Mehefin 2025

Appendix 1 - Key Performance Indicators

Quarter 1 – April to June 2025

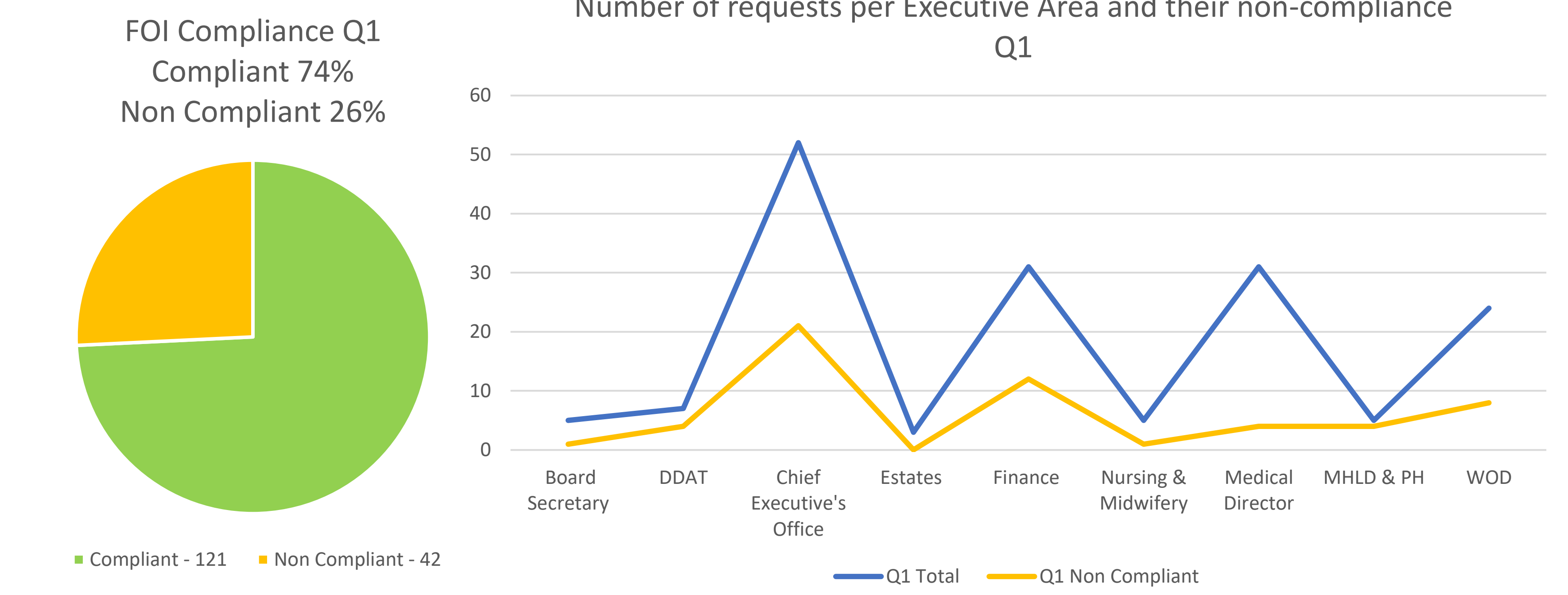
Appendix 1 - Key Performance Indicators: Quarter 1 – April to June 2025

Freedom of Information (FOI) Compliance

During Quarter 1 of 2025/26, the Information Governance Team received a total of **163** Freedom of Information (FOI) requests, a decrease from the 193 requests received in Quarter 4 of 2024/25. Compliance with FOI requests showed an improvement, rising to **74%** from the previous quarter's rate of 71%.

The total time spent processing these requests amounted to **749** hours, which equates to an estimated cost of **£18,725** under the Freedom of Information Act. While the number of cases declined this quarter, the time spent processing requests has risen. This increase is attributed to the growing complexity of the cases and the extended time required to gather necessary information.

This figure includes contributions from the Information Governance Team, Divisional Leads, and Executive Directors.



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	10	0	
Section 21 - reasonably accessible to an applicant by other means.	Absolute – No Public Interest Test Required	11	1	Upheld
Section 31 - Law Enforcement	Public Interest Test applied	2	1	Partially Overturned
Section 40 - Personal Information	Absolute – No Public Interest Test Required	7	0	
Section 43 – Commercially Sensitive	Public Interest Test applied	2	1	Overturned
No Exemption applied	N/A	131	0	

Freedom of Information: Highest reported reasons for delays/breaches

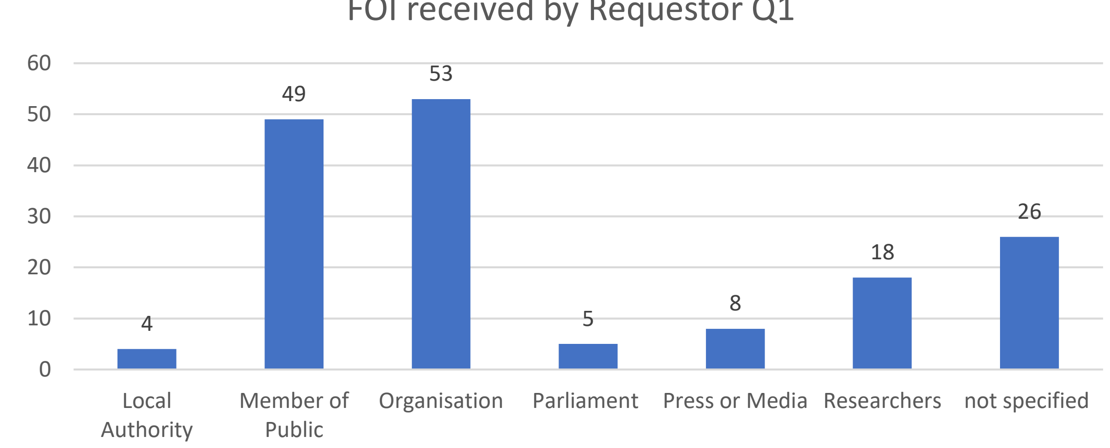
- **20** delays due to Executive approval.
- **10** delays reported due to receiving the information from Divisional Leads.
- **4** delays due to the request being of a complex nature.
- **2** delays due to formulation of response from IG Team.

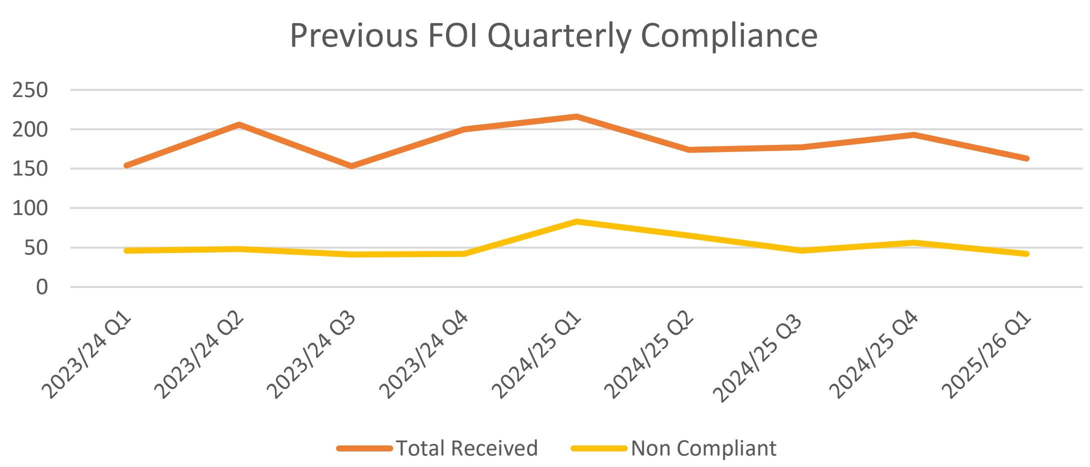
The Divisions with the lowest percentage of compliance	Trends in Freedom of Information Subject
• Mental Health & Learning Disabilities (MHLD) - 4 out of 5 **(80%)** non-compliant. • Digital, Data & Technology – 4 out of 7 **(57%)** non – compliant • Chief Operating Office - 21 out of 52 **(40%)** non-compliant. • Director of Finance – 12 out of 31 **(39%)** non-compliant. • Workforce & Organisational Development – 8 out of 24 **(33%)** non-compliant.	• **29** requests related to the number of patients treated for specific diagnoses and their associated treatment pathways. • **10** requests sought information on Policies and Procedures. • **7** requests focused on waiting list volumes and waiting times. • **6** requests concerned the Health Board's expenditure on agency staff. • **5** requests inquired about the use of Artificial Intelligence and other software solutions.

2025/26 Improvement Actions

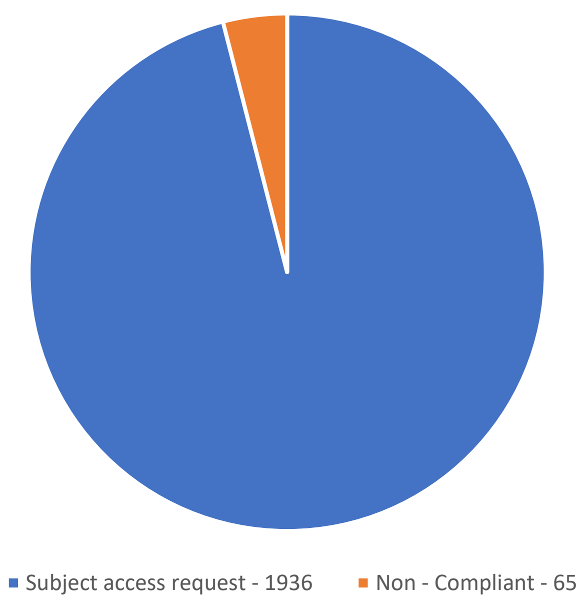
To further improve compliance with Freedom of Information (FOI) requests, the Information Governance Team will implement the below initiatives during Quarter 2 of 2025/26:

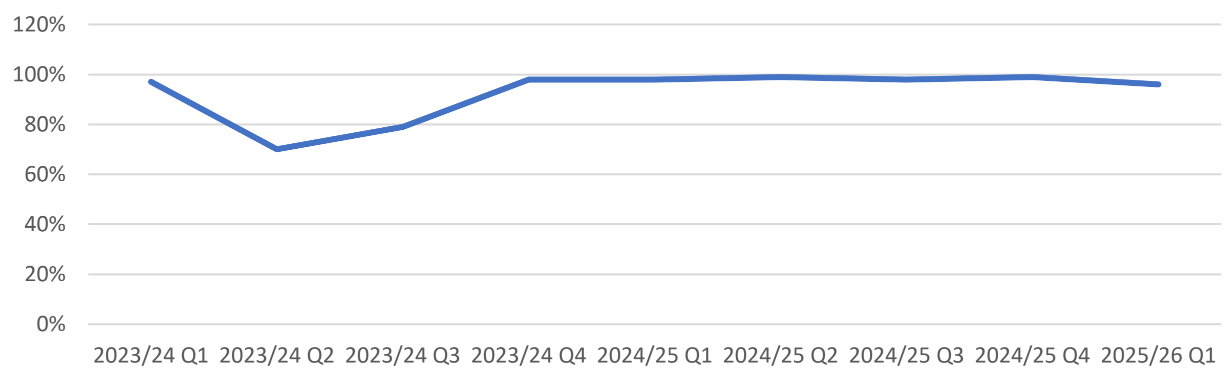
- **Strengthen Executive Engagement –** Improve communication with Executive Team to expedite the approval process and proactively address potential delays in FOI responses.
- **Drive Divisional Commitment to Compliance –** Actively collaborate with divisions showing low FOI compliance to gain leadership support, uncover underlying issues, and drive tailored improvement measures.
- **Enhance Publication Scheme Content –** Continue evaluating and updating the Health Board's publication scheme to increase the availability of routinely published information.

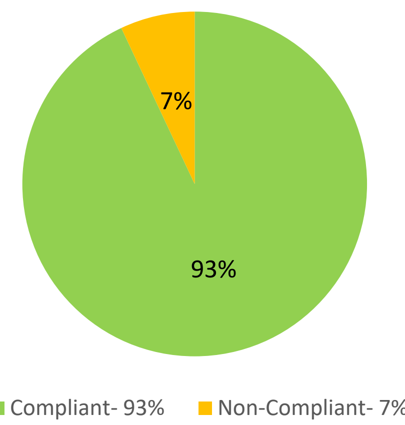




Subject Access Request Compliance
During Quarter 1, the compliance for Subject Access Requests (SAR) has decreased slightly from 99% in Quarter 4 to **96%**, with requests for non-clinical information being **93**% this quarter. This figure reflects the overall compliance rate across all departments handling requests under Data Protection legislation The requests received during this quarter include all requests received into the Access to Health Record Team, Information Governance Team, Managed GP Practices and HMP Berwyn.
2025/26 Improvement Actions
Throughout Quarter 1, the Information Governance and Access to Health Records Teams maintained regular collaboration to review and resolve complex requests that involve both services. This joint approach supports consistency in handling and facilitates the sharing of lessons learned. Additionally, the Information Governance Team continues to work in close partnership with the Health Board's Complaints Team to address complex complaints that evolve into information requests.







Information Governance Incidents and Complaints Information Quarter 1 - April to June 2025.

Incident Category	Sub Category	Number of incidents	Self-Reported to Information Commissioners Office (ICO) / Welsh Government (WG)	Number of complaints
Confidentiality Breach (External)	PPI in public place	13	-	-
	Email	17	-	-
	External Mail	30	-	2
	Records	22	-	-
	Prescription Error	12	-	-
Confidentiality Breach (Internal)	PPI in public place	6	-	-
	Email	5	-	-
	Records	17	-	-
	Other	2	-	-
Information Management & Technical Security	ID Badge Loss	7	-	-
	Records	1	-	-
	BCU Device Loss	2	-	-
	Inappropriate Access	5	-	-
Non Compliance	IG01 – Records Management Policy	8	-	-
	IG08 – E-mail Procedure	2	-	-
	IG13 – Confidentiality Code of Conduct	4	-	-
	IG14 - IM&T Security Procedure	7	-	-
	IG15 - Safe storage & transport of Personal Data	19	-	-
Total		**179**	**0**	**2**

Quarter 1 has seen a notable increase in the number of reported incidents, exceeding the 143 incidents recorded in Quarter 4 by more than 25%. The Records category, covering both internal and external incidents, saw the most significant rise in reported cases. Additionally, there was an rise in incidents involving Personally Identifiable Information (PPI) in public settings and email-related breaches. On a positive note, the number of incidents related to the Records Management policy and prescription handling has shown a marked improvement. To address this trend, the Information Governance Team will emphasize this issue in the Quarter 2 training sessions, with the aim of reducing future incident rates.

Outcomes

- Staff were reminded of the importance of thorough data verification.
- Management of paper-based handovers was addressed during the team safety briefing.
- Department has reinstated the use of the Digi Lock system to enhance security measures, with staff awareness raised and the Security Team informed.
- Collaborative efforts between the Information Governance Team, Health Records, and the Health Board's confidential waste destruction company have been undertaken to ensure the secure disposal of confidential documents.

Near Misses	Legal Claims
0 near misses reported in Quarter 1.	**1** new claim was received in Quarter 1 concerning unauthorised access to a patient's medical records by their former partner. The claim was subsequently withdrawn by the individual who lodged it.

Complaints

During Quarter 1, **4** Data Protection complaints were received, consistent with the number reported in Quarter 4. Of these, 3 have been resolved and formally closed, while 1 remains open and is currently under review.

Complaints Received

- 2 Patient letters sent to incorrect address – both closed.
- 1 Confidentiality breach by pharmacist to patients relative – closed.
- 1 Medication prescribed to incorrect patient due to error on drug chart – open.

Lessons Learnt:

1. Staff were reminded of the relevant procedures, and the complainant was informed of the actions taken. The complainant expressed satisfaction with the outcome, and no further action is required.
2. Incident was disseminated amongst team for reflective learning. Staff were also formally reminded of their responsibility to maintain compliance with information governance training.

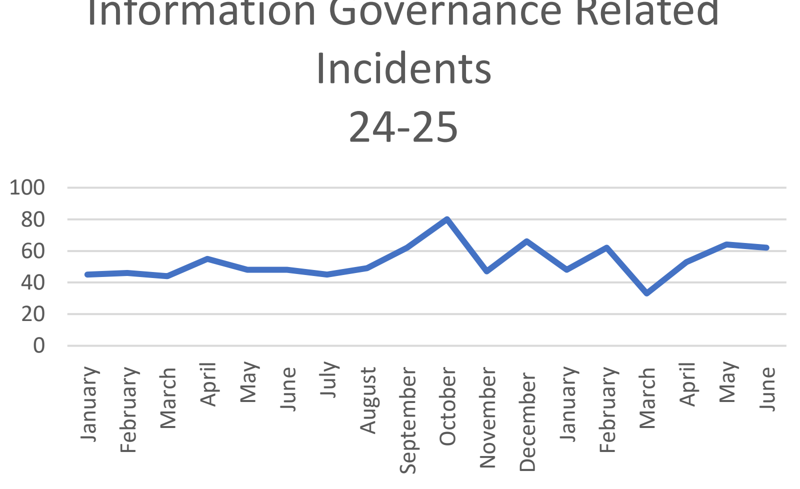
Information Commissioners Office (ICO) Complaints

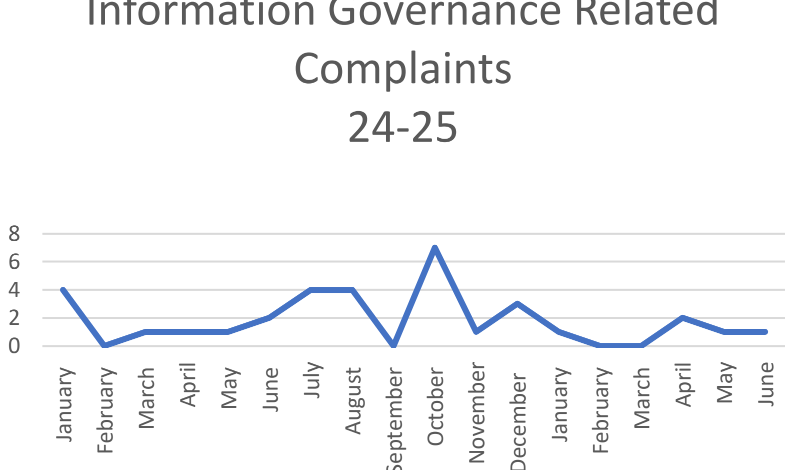
Self-reported incidents to the Information Commissioners Office Quarter 1

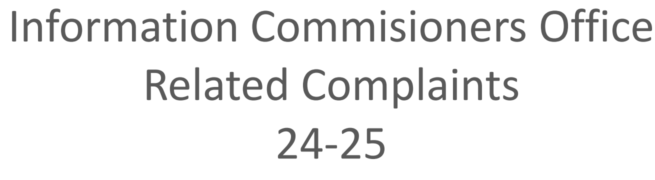
In Quarter 1, no self-reported incidents were submitted to the Information Commissioner’s Office, consistent with the reporting figures from Quarter 4.

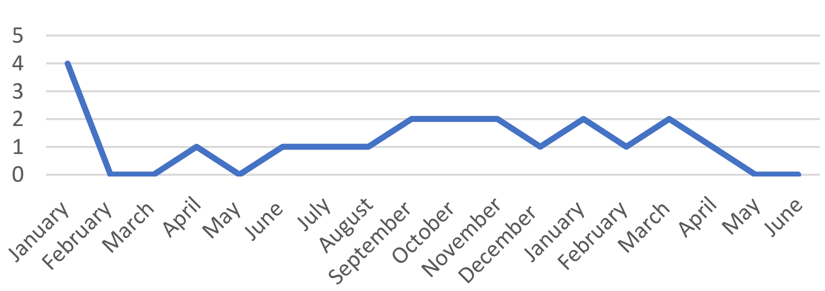
Complaints received from the Information Commissioners Office Quarter 1

In Quarter 1, one complaint notification was received, consistent with the volume reported in the previous quarter. The complaint related to the receipt of incomplete medical notes from a GP practice. A comprehensive investigation determined that the remaining documentation had been prepared for collection but was not made available at the time of the patient's arrival. The identified actions were communicated to the complainant, and the case was subsequently closed.









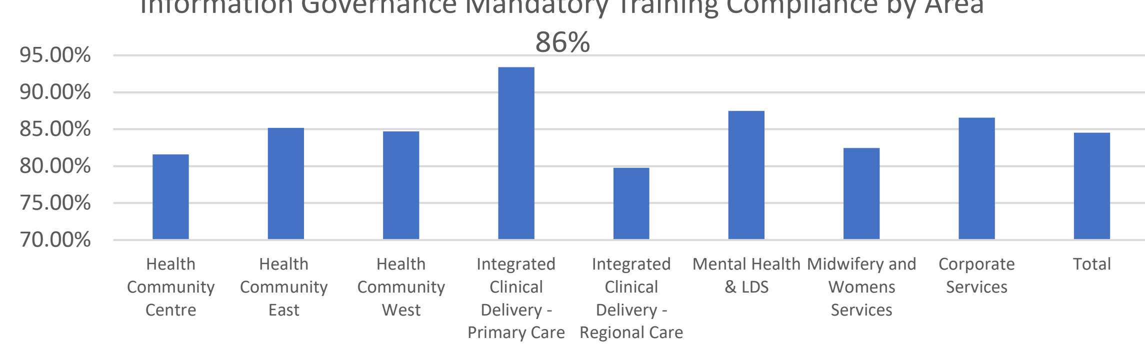
Information Governance Training and Budget Information Quarter 1

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	854,301	164,093	49,453 underspend (not a true reflection, please see below comments)

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

1. Covering post on maternity within existing structure (returned to work during May 2025);
2. Delays in invoicing for confidential waste expenditure;
3. Continued agile / home working thus reducing travel costs;
4. Service reduced run rate to support overall Health Board Financial Position with scrutiny of spend.

Onsite compliance audits / due diligence checks / face to face training delivery has recommenced which will increase travel costs and will reduce the level underspend in 2025/26.



Information Governance Mandatory Training

Mandatory training sessions have continued, 9 taking place in Quarter 1 with a total number of 99 staff attending. This is a slight increase from the 96 who attended in Quarter 4 of 2024-25. Included in the figures above was training delivered during mandatory training days which was well received. Plans to attend future training will be discussed later in the year.

The Information Governance team are seeing an increase in the request for bespoke training to be delivered to staff groups such as a new cohort of 45 bank admin staff.

In addition, 3101 staff members have completed their Information Governance training online during this quarter.

The overall compliance for mandatory Information Governance training across the Health Board is **86%**

National Intelligent Integrated Auditing Solution (NIIAS), Service Desk and IG10 Information Quarter 1 – April to June 2025.

IG10

A total of **17** IG10 requests were submitted in Quarter 1, all of which were approved. 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:

- CCTV – 5
- Door Swipe Access – 1
- Email Access – 1
- System Access – 8
- Login Audit - 2

Service Desk – Information Governance Portal

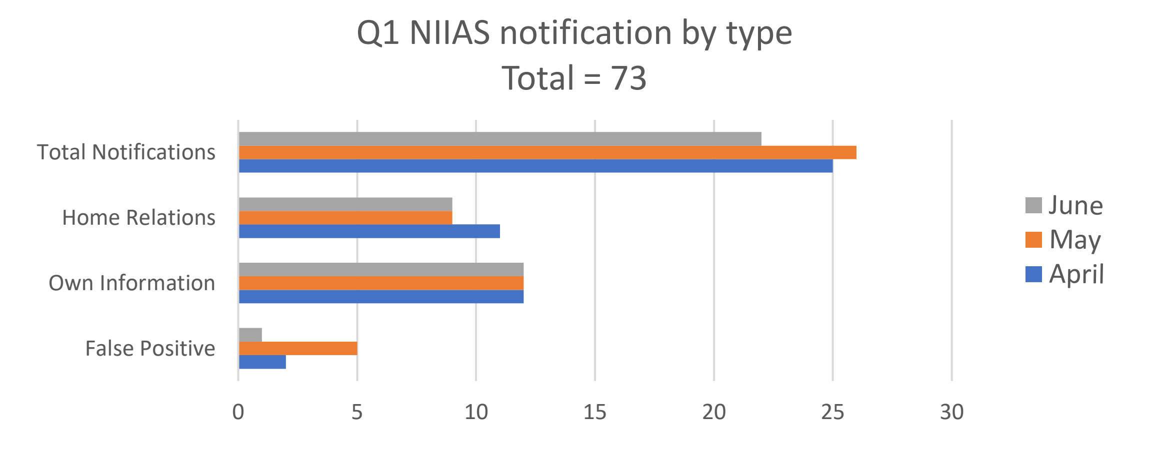
The total number of Halo queries rose significantly to 168 in Quarter 1, compared to 79 in Quarter 4. This increase may be attributed to the Information Governance Team's more frequent circulation of call logging guidance, as well as the continued establishment and integration of the Halo system during this period.

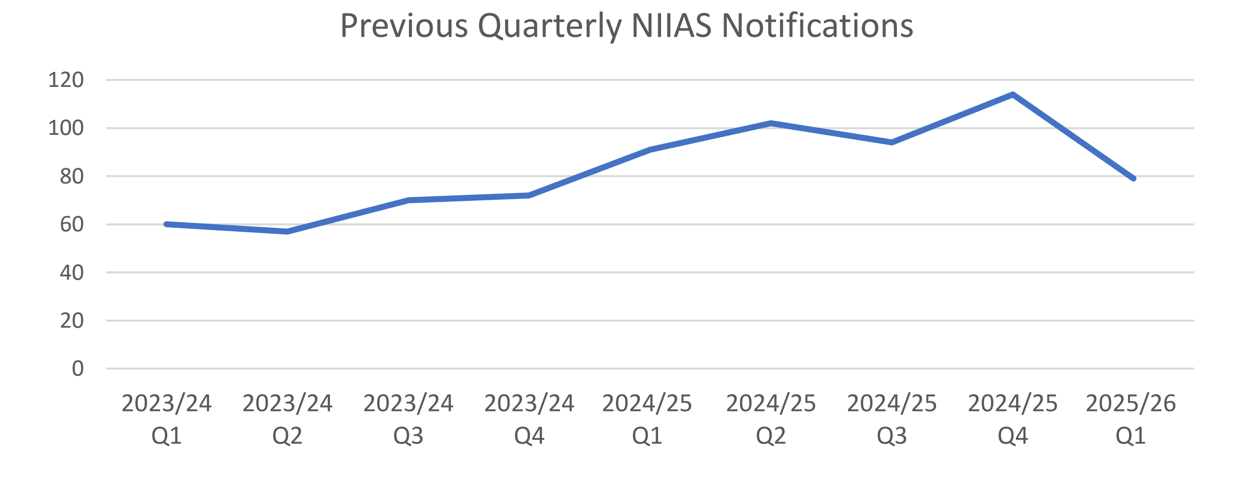
Some key trends identified during the quarter were:

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

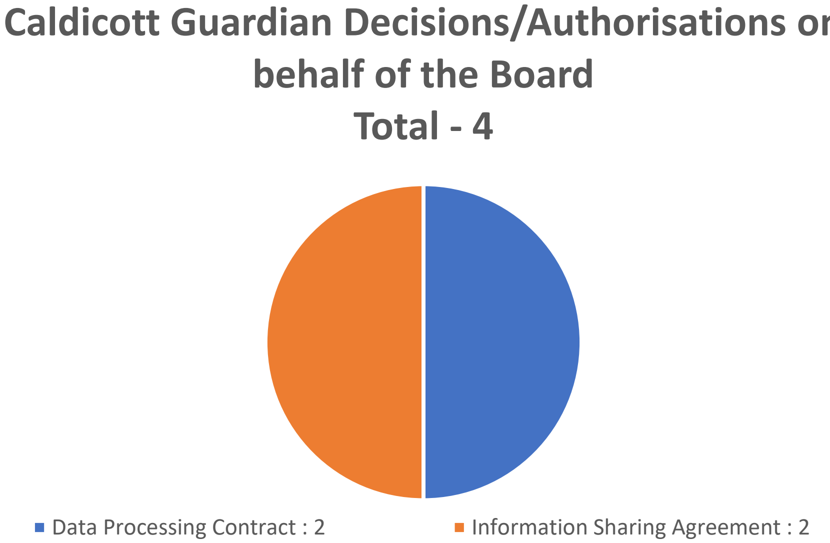
NIIAS (National Intelligent Integrated Auditing Solution)

During Quarter 1 there were 73 NIIAS notifications received for staff inappropriately accessing records on Health Board systems. A breakdown of the cases with People Services involvement was not available at the time of writing this report.





Caldicott Guardian Decisions, Data Protection Impact Assessments, Compliance Audits & Asset Register Quarter 1 – April to June 2025.



Compliance Audits

During Quarter 1, **5** face-to-face compliance audits were conducted across BCUHB sites. In addition, 25 audit pre-assessments were completed remotely. Feedback from departments who have undertaken the pre-assessments has been positive with recommendations being received well. Guidance regarding the use of WhatsApp groups has been circulated to departments with some ceasing groups all together. During the pre-assessments it was also discovered some departments had keys to confidential waste consoles, work is underway with the Information Governance Officers to retrieve these.

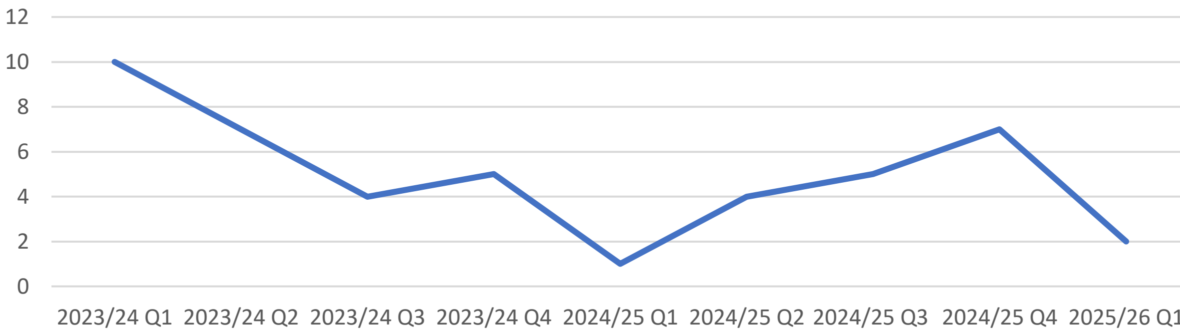
Work is currently underway to review and enhance the audit process, with a focus on ensuring pre-assessments are completed prior to scheduling face-to-face visits. This approach aims to improve the efficiency and productivity of site visits for both the Information Governance Team and Health Board services.

Asset Register

The Information Asset Register is in the final stages of User Acceptance Testing (UAT). A list of Information Asset Owners (IAOs) and Information Asset Administrators (IAAs) has been created to confirm that the appropriate leads have been assigned to each asset. This also helps the team to track current asset ownership, assess whether owners are at the appropriate level of seniority, identify who the correct owner should be if not, and flags assets without any listed ownership.

Data Protection Impact Assessments (DPIAs)

During Quarter 1, **8** DPIAs were approved, representing an increase compared to 7 approvals in Quarter 4 of 2024/25. Currently, 32 DPIAs are under review, either with the Information Governance Team, with project leads for further input, or have not yet progressed.
The IG team will continue to work closely with project leads throughout 2025/26 to support the timely progression of DPIAs through each stage of the process.
Additionally, the team is developing a more streamlined DPIA workflow. This includes the introduction of weekly review meetings for in-progress assessments and the digitalisation of the DPIA form to improve accessibility and efficiency.



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Chwarter 2 – Gorffennaf i Medi 2025

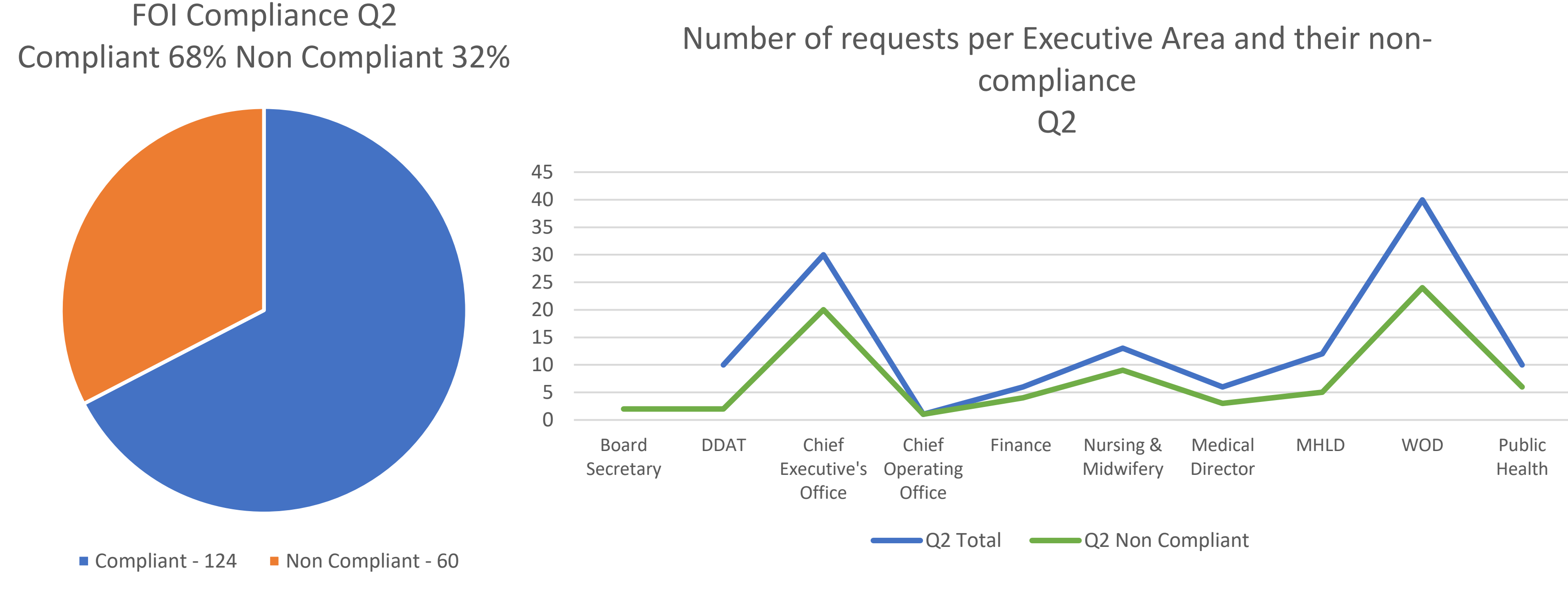
Appendix 2 - Key Performance Indicators

Quarter 2 – July to September 2025

Appendix 1 - Key Performance Indicators: Quarter 2 – July to Medi 2025

Freedom of Information (FOI) Compliance

In Quarter 2 of 2025/26, the Information Governance Team handled 184 FOI requests, a 13% increase from Quarter 1. Compliance fell from 74% to 68%, largely due to the growing complexity of requests. Many now require input from multiple departments and detailed data analysis, which significantly increases processing time. Responding to these requests took 618 hours, costing an estimated £15,450 under the FOI Act, involving contributions from the IG Team, Divisional Leads, and Executive Directors. The rise in both volume and complexity has placed additional strain on resources, impacting response times and compliance. Plans to address these challenges and improve compliance will be outlined later in this 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	17	0	
Section 21 - reasonably accessible to an applicant by other means.	Absolute – No Public Interest Test Required	11	1	Upheld
Section 31 - Law Enforcement	Public Interest Test applied	2	1	Partially Overturned
Section 40 - Personal Information	Absolute – No Public Interest Test Required	7	0	
Section 43 – Commercially Sensitive	Public Interest Test applied	2	1	Overturned
No Exemption applied	N/A	144	0	
Total		184	3	

Freedom of Information: Highest reported reasons for delays/breaches	The Divisions with the lowest percentage of compliance
• 29 delays reported due to receiving the information from Divisional Leads. • 14 delays due to Executive approval. • 8 delays due to formulation of response from IG Team. • 4 delays due to the request being of a complex nature. • 4 delays due to unable to identify correct lead.	• Director of Finance – 19 out of 28 **(68%)** non-compliant. • Mental Health & Learning Disabilities – 4 out of 6 (67%) non-compliant. • Chief Operating Office - 9 out of 14 **(64%)** non-compliant. • Director of Nursing & Midwifery– 9 out of 20 **(45%)** non – compliant

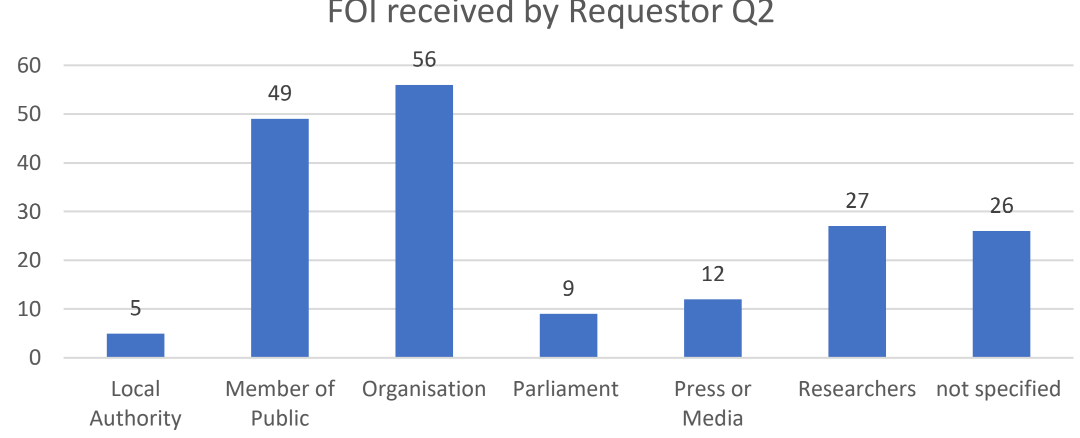
Trends in Freedom of Information Subject

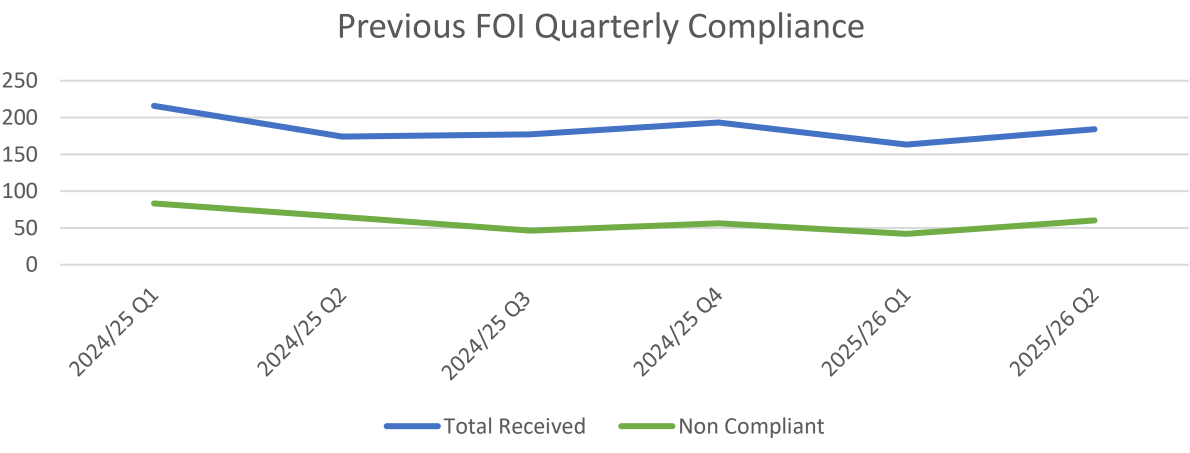
- **Medication-related FOIs (51)** are the single largest category, spanning multiple therapeutic areas.
- **Workforce and agency spend (34)** remain a major concern, with detailed breakdown requests for locums and nursing.
- **Access and waiting times (17)** for services (especially mental health and dentistry) are a recurring theme.
- **Technology and equipment (13)** queries suggest growing interest in digital transformation and infrastructure.
- **Financial transparency (11)** is a consistent focus, including cost improvement plans and compensation payments.

2025/26 Improvement Actions

FOI compliance decreased slightly in Quarter 2 (74% to 67%). While the Information Governance Team continues to use an established escalation process and hold weekly monitoring meetings, additional actions will strengthen performance:

- **Executive Engagement –** Maintain escalation and share compliance summaries with the Executive Team to ensure timely approvals.
- **Targeted Divisional Support –** Use weekly data to identify low-compliance areas and provide focused guidance.
- **Risk-Based Reporting –** Highlight cases nearing deadlines in weekly meetings for immediate intervention.
- **Expand Publication Scheme –** Publish high-demand information (e.g., agency spend, staffing, medication) to reduce repeat requests.
- **Training & Awareness –** Issue quick-reference guides and deliver short refresher sessions for divisional contacts.





Subject Access Request Compliance

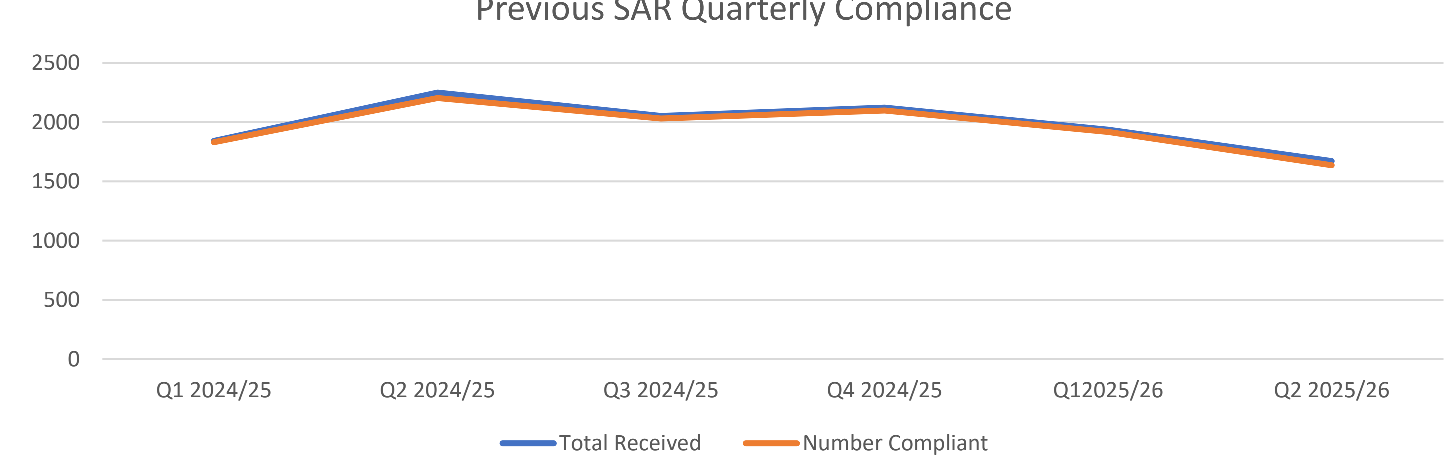
During Quarter 2, the compliance for Subject Access Requests (SAR) has remained the same as Quarter 1 at **98%,** with requests for non-clinical information being **100**%. This figure reflects the overall compliance rate across all departments handling requests under Data Protection legislation

The Information Governance Team has observed an emerging trend of requestors increasingly using AI tools when submitting and interpreting requests. This includes drafting initial requests, refining wording for clarity, and in some cases, generating follow-up queries based on responses.

The requests received during this quarter include all requests received into the Access to Health Record Team, Information Governance Team, Managed GP Practices and HMP Berwyn.

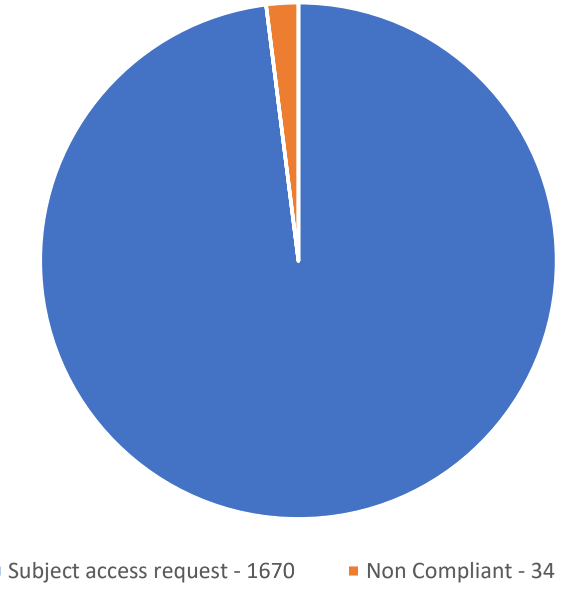
2025/26 Improvement Actions

The Information Governance and Access to Health Records Teams will continue to strengthen collaboration on complex requests, with a particular focus on improving communication with requestors. This will include providing clearer guidance on processes, expected timeframes, and the scope of information available, to ensure transparency and manage expectations effectively. Additionally, we plan to enhance joint working with the Health Board's Complaints Team to streamline responses where complaints evolve into information requests, ensuring a consistent and coordinated approach. These improvements aim to deliver a more efficient, user-focused service while maintaining compliance with statutory requirements.

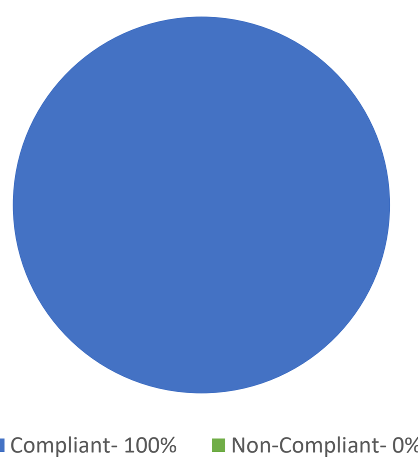


Data Protection Subject Access Requests (SAR) for non-clinical information by type Q2

Compliant: 98% Non Compliant: 2%



Data Protection Subject Access Requests (SAR) for non-clinical information Q2



Information Governance Incidents and Complaints Information Quarter 2 - July to September 2025.

Incident Category	Sub Category	Number of incidents	Self-Reported to Information Commissioners Office (ICO) / Welsh Government (WG)	Number of complaints
Confidentiality Breach (External)	PPI in public place	6		2
	Email	10		2
	External Mail	16		1
	Inappropriate Access	1		1
	Records	38	1	1
	Prescription Error	4		
Confidentiality Breach (Internal)	PPI in public place	12		
	Email	4		
	Internal Mail	2		
	Records	8		
Information Management & Technical Security	Hardware	4		
	ID Badge Loss	8		
Non Compliance	IG01 – Records Management Policy	17		
	IG02 – Corporate Records Management Procedure	2		
	IG03 – Procedure for Compliance with FOI/EIR	0		1
	IG08 – E-mail Procedure	3		
	IG13 – Confidentiality Code of Conduct	7		
	IG14 - IM&T Security Procedure	5		
	IG15 Safe storage & transport of Personal Data	11		
	IG17 – Photography, Video & Audio Recording Procedure for a Non-Clinical Purpose	3		
Total		**161**	**1**	**8**

During this reporting period, 161 information governance incidents were recorded and managed in line with organisational policy, compared to 179 in the previous quarter. The majority were low-risk and resolved promptly. Root cause analysis and targeted actions, including staff training and process improvements, have been implemented to reduce recurrence and strengthen compliance.

Outcomes

- Addressed secure handling of paper-based handovers during team safety briefings to reduce physical data risks.
- Maintained collaborative processes with Health Records and the confidential waste destruction provider to ensure secure disposal of sensitive documents.
- Increased staff awareness of reporting procedures and escalation routes for information governance incidents.
- Highlighted the requirement for regular audits of shared drives and folders to prevent unauthorised access and ensure data minimisation.
- Addressed the risks associated with using personal devices for work-related communication and reiterated organisational policy on approved devices.

Near Misses	Legal Claims
0 near misses reported in Quarter 2.	**0** new claim was received in Quarter 2.

Complaints

During Quarter 2, **8** Data Protection complaints were received, increasing from the number reported in Quarter 1. Of these, 7 have been resolved and formally closed, while 1 remains open and is currently under review. The complaints that have been formally closed were all upheld.

Complaints Received

- 6 Data / Confidentiality Breach – all closed.
- 1 Inappropriate disclosure / Verbal Breach – closed.
- 1 Confidentiality Concerns in Service Delivery – open.

Lessons Learnt:

- Emphasised confidentiality obligations both inside and outside the workplace, particularly in informal settings.
- Identified the importance of accurate manual data entry and the need for additional checks when onboarding new staff.
- Highlighted the value of prompt and clear communication with complainants to ensure timely resolution and maintain trust.

Information Commissioners Office (ICO) Complaints

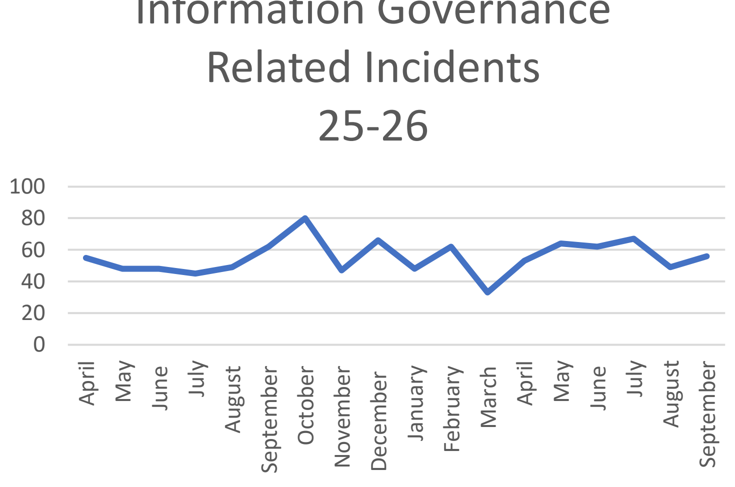
Self-reported incidents to the Information Commissioners Office Quarter 2

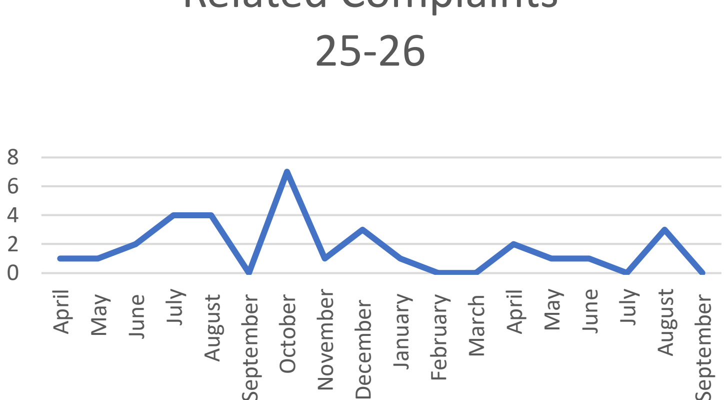
In Quarter 2, one self-reported incident was notified to the Information Commissioner’s Office. This related to a staff member using a personal mobile phone to photograph patient records within EMIS. The incident remains under review, and the outcome will be reported in the Quarter 3 update.

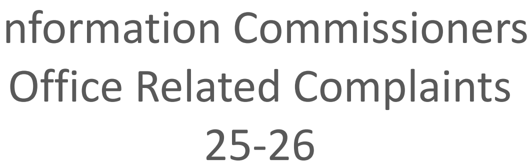
Complaints received from the Information Commissioners Office Quarter 2

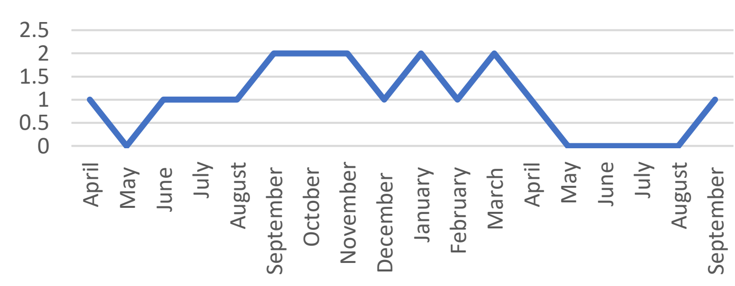
In Quarter 2, four complaint notifications were received, an increase from one in the previous quarter. The complaints related to: (1) dissatisfaction with the application of Section 40 in response to a Freedom of Information request; (2) a request for compensation following the incorrect sharing of contact details with a debt collection agency; (3) an Access to Health Records Subject Access Request (SAR) being sent to the wrong address and co-mingled when opened ; (4) concerns about meeting recording shared with Third Party.

Each case was investigated in line with policy, and appropriate actions and responses were communicated to the complainants.









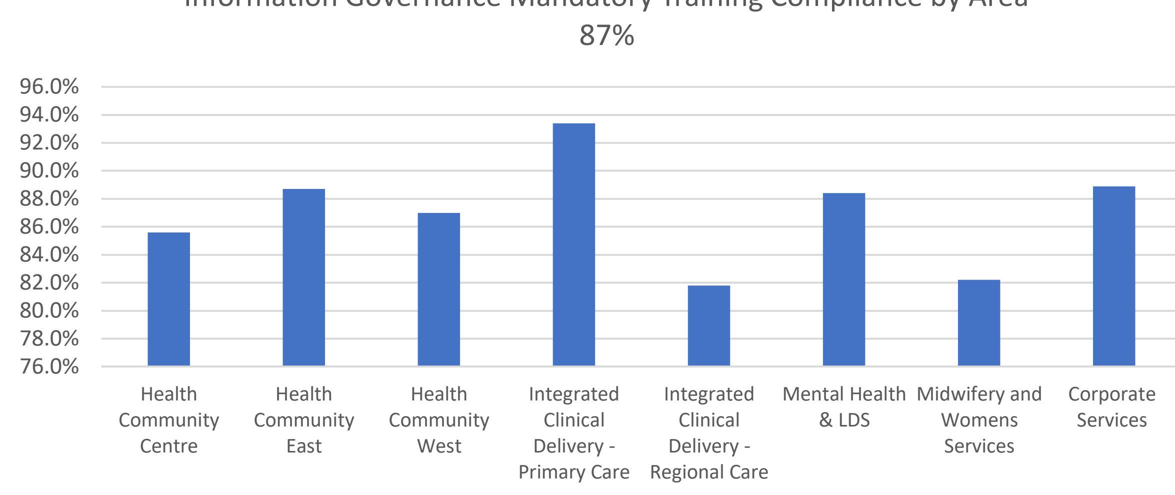
Information Governance Training and Budget Information Quarter 2

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	872,665 (uplift from 854,301)	337,926	98,340 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.

Onsite compliance audits / due diligence checks / face to face training delivery has recommenced which will increase travel costs and will reduce the level underspend in 2025/26.



Information Governance Mandatory Training

Mandatory training sessions have continued, 4 taking place in Quarter 2 with a total number of 42 staff attending. Included in the figures above was training delivered during mandatory training days which was well received. Plans to attend future training will be discussed later in the year.

During Q2, there have been 26 staff members nominated to be IG Champions. Of the 26, 16 have received specialist training.

The Information Governance Team are seeing an increase in the request for bespoke training to be delivered to staff groups. Further training sessions for bank staff has been requested which will see over 30 delegates attend.
In addition, 3482 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 increased to **87%.**

National Intelligent Integrated Auditing Solution (NIIAS), Service Desk and IG10 Information Quarter 2 – July to September 2025.

IG10

A total of **14** IG10 requests were submitted in Quarter 2, all of which were approved. This is a decrease from the 17 reported in Q1. 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:

- CCTV – 4
- Door Swipe Access – 1
- Email Access – 3
- System Access – 6

Service Desk – Information Governance Portal

The total number of Halo queries decreased significantly to 49 in Quarter 2, compared to 168 in Quarter 1. This decrease 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:

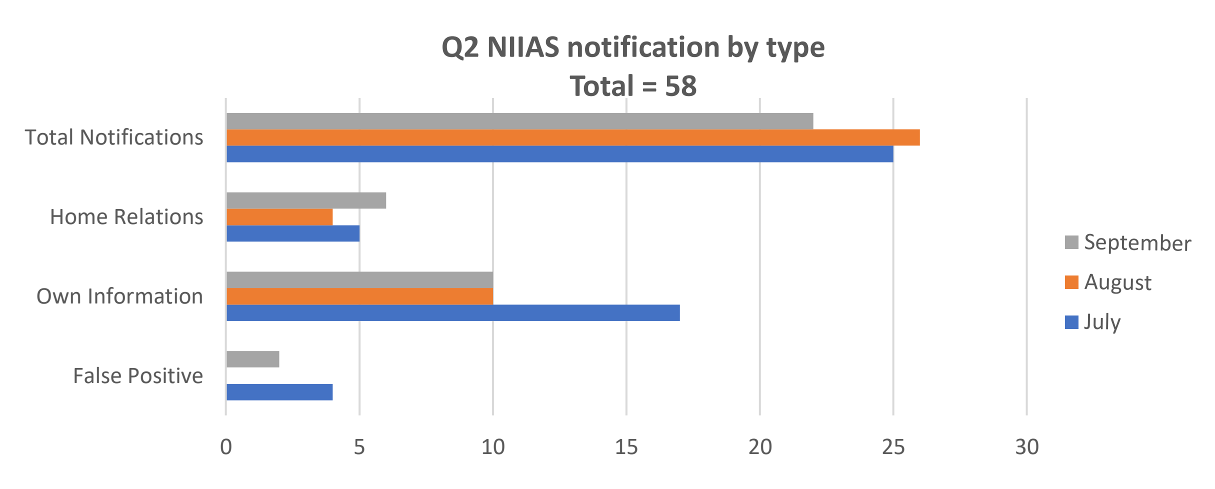
- Sharing information with other Health Boards
- Datix queries
- Local & National Research Projects
- Policies & Procedures

NIIAS (National Intelligent Integrated Auditing Solution)

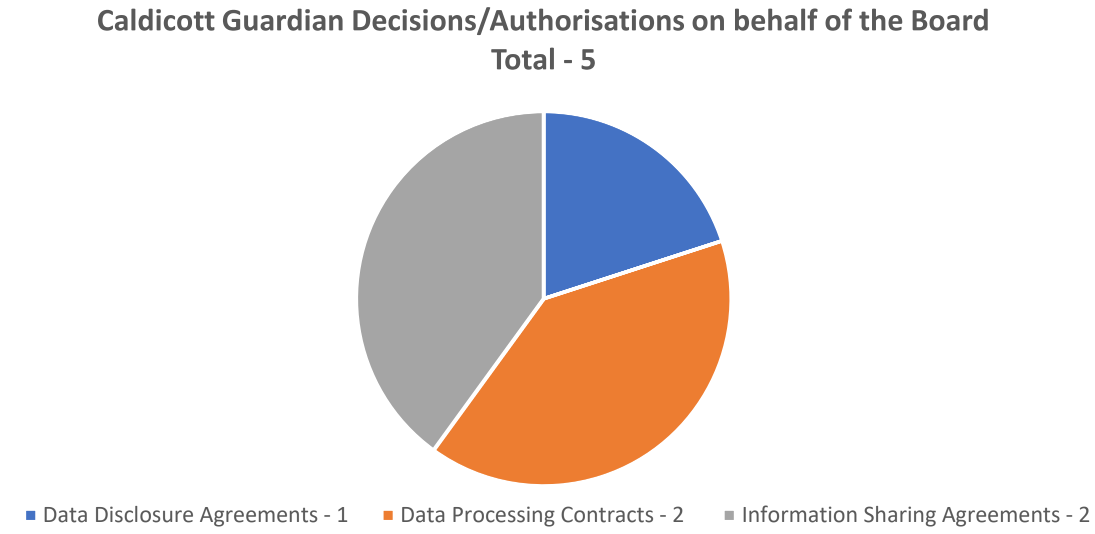
During Quarter 2 there were 58 NIIAS notifications received for staff inappropriately accessing records on Health Board. Unfortunately, information regarding cases involving People Services was not available for Q1 however, please see information below for Q2.

Cases involving People Services.

Area	Case not proven	Informal Action	No Case to Answer	Referred to Hearing	To be confirmed
West	0	0	0	0	4
Central	0	2	0	0	1
East	0	0	0	0	0
Pan BCU	0	2	0	0	2



Caldicott Guardian Decisions, Data Protection Impact Assessments, Compliance Audits & Asset Register Quarter 2 – July to September 2025.



Compliance Audits

During Quarter 2, two face-to-face compliance audits were carried out across BCUHB sites. In addition, 20 remote audit pre-assessments were completed. Feedback from departments that participated in the pre-assessments has been positive, with recommendations well received.
Guidance on the secure storage of confidential documents was provided during both face-to-face audits. The pre-assessments also prompted discussions around information sharing, during which existing information sharing agreements were identified to provide assurance to departments.

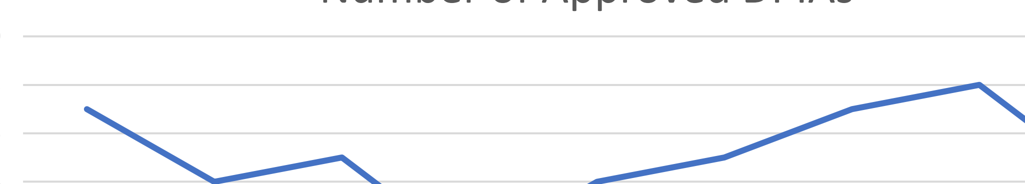
A recent review highlighted significant risks in physical records management across BCUHB, following a major data breach at Abergele Hospital. Investigations revealed widespread use of insecure storage (e.g., containers, staff kitchens), abandoned records exceeding retention periods, and systemic gaps in oversight. Immediate actions include relocating records from unsafe areas, implementing structured storage with alarms, assigning ownership via the Information Asset Register, and ensuring proper labelling for archived records. These measures aim to strengthen compliance, security, and patient confidentiality across all sites.

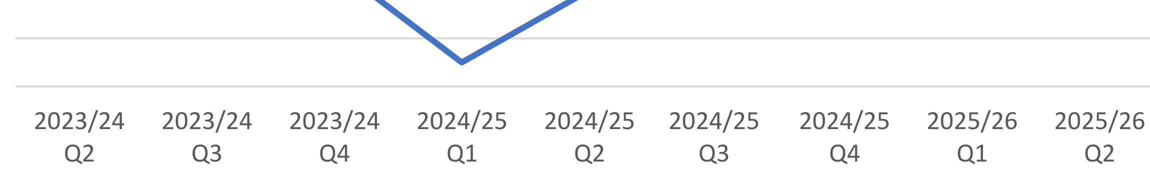
Asset Register

The Information Asset Register (IAR) was successfully re-launched during Quarter 2, supported by six drop-in sessions held across the three acute sites to promote awareness and provide hands-on guidance. The Information Governance Team has actively engaged with Information Asset Owners (IAOs) and Information Asset Administrators (IAAs) to assist with the addition of new assets and the review and updating of existing entries, ensuring the register remains accurate and comprehensive. Further monthly drop-in sessions have been scheduled until the end of 2025 to maintain momentum, provide ongoing support, and encourage compliance with information governance requirements.

Data Protection Impact Assessments (DPIAs)

During Quarter 2, 4 DPIAs were approved. There are 28 are currently under review, either with the Information Governance (IG) Team or project leads, and a further 20 are awaiting additional information. The IG Team will continue to work closely with project leads throughout 2025/26 to support the timely progression of DPIAs through each stage of the process.
In addition, the Team is developing a more streamlined DPIA workflow. Key improvements include the introduction of weekly review meetings for in-progress assessments and the digitalisation of the DPIA form to enhance accessibility and efficiency.





Performance Finance & Information Governance Committee

INFORMATION GOVERNANCE ANNUAL REPORT 2024-25

ADRODDIAD BLYNYDDOL LLYWODRAETHU GWYBODAETH 2024-25

Dyddiad y Cyfarfod **Date of Meeting**	24 February 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**	Dylan Roberts /Justine Parry Prif Swyddog Digidol a Gwybodaeth Chief Digital and Information Officer

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.

- Continued to meet the objectives set within the BCUHB IG Strategy for 2024/25.
- Met the national compliance target of 85% for IG mandatory training incorporating the following actions:
  - Re-commenced face to face training sessions and attended the Health Boards Mandatory training days.
  - FOI workshop delivered.
  - Continued to target areas with a low compliance rate.
- Continued to meet statutory legal requirements and obligations with Data Protection Legislation and Freedom of Information Act 2000.

- Improved compliance with Data Protection Subject Access Requests to 98%.
- Successful submission of the All-Wales Information Governance Toolkit meeting all the minimum requirements and exceeding in 8 of the 11 requirements
- Continued collaborative working with DDaT to support the roll out of new projects and initiatives.
- Provided continuous IG support across BCUHB and national teams to help deliver and implement new ways of working / projects.
- Development and continued improvements made to the replacement Information Asset Register which now incorporates Cyber Security, Data Protection Impact Assessments and other key functionalities to ensure the full life Cycle of Information Assets are recorded.
- Full review and streamlining of the Data Protection Impact Assessment process
- undertaken.
- IG Business Continuity Pan fully reviewed and implemented.
- Records of Processing Activities (ROPA) review undertaken and a gap analysis
- conducted against the requirement. Alignment with the Information Asset Register.
- Introduced the new Information Governance compliance audit process as business as usual (BAU) with a view to further improvements to be made.

The main emphasis for 2025/26 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:

- 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.
- To embed the updated Information Asset Register within the organisation, providing support to Information Asset Owners and Administrators, provide training and risk assess all assets.
- Ensure priorities set for the 2024/25 IG toolkit submission are implemented, and work with the IG Toolkit leads to improve standards for the 2025/26 toolkit submission.

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	09/06/2025	Presented to group, chaired by Justine Parry, Assistant Director of Compliance and Business Management on behalf of the Chair. Included in minutes and Chairs Assurance Report.

Executive Meeting	01/10/2025	Presented to Group by Justine Parry.

Acronymau / Rhestr Termau Acronyms / Glossary of Terms	

Appendices / Atodiadau	
Appendix 1	Information Governance Annual Report Charts 2024-25
Appendix 2	Information Governance Annual Report 2024-25 Final Approved

INFORMATION GOVERNANCE ANNUAL REPORT 2024-25

ADRODDIAD BLYNYDDOL LLYWORDAETH GWYBODAETH 2024-25

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 2024/25. 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 The term 'Information Governance' is used to describe how organisations manage the way information is handled. It covers the requirements and standards that Betsi Cadwaladr University Health Board (BCUHB) needs to achieve to fulfil its

obligations that information is handled legally, securely, efficiently, effectively and in a manner which maintains public trust.

Information Governance applies the balance between privacy and sharing of personal confidential data and is therefore fundamental to the health care system, both providing the necessary safeguards to protect personal information and an effective framework to guide those working in health to decide when to share, or not to share.

There is a comprehensive and complex range of national guidance and legislation which BCUHB must operate within, including compliance with:

- Data Protection Act 2018
- EU General Data Protection Regulation 2016
- UK General Data Protection Regulation 2021
- Freedom of Information Act 2000
- Environmental Information Legislation 2004
- Public Records Act 1958
- Access to Health Records Act 1990
- Computer Misuse Act 2000
- Caldicott Principles in Practice (C-PIP)
- Welsh Information Governance (IG) Toolkit
- Common Law duty of confidentiality
- Wales Accord to Share Personal Information (WASPI)
- Data Quality
- Information Security assurance - ISO 270012013 Information security management
- Records Management NHS Code of Practice
- Information Commissioners Codes of Practice
- NIS (Networks and Information Systems) regulations

A robust Information Governance Framework has been put in place to provide assurance against these which is monitored and administered via the Information Governance Team and the wider Digital, Data and Technology Team.

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 2025/2026.

There will be challenges around the ability to meet the All-Wales IG toolkit new requirement with the introduction of the CCTV requirement.

To note the continual struggle to improve FOI compliance rates due to complexity of some 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 a refresh of the IG Webpages and the exploration of introducing IG Champions. • Encourage and support the professional development of team members by providing opportunities for training, skill enhancement, and knowledge acquisition in relevant areas and to include the development of training programmes.
	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**	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.

Risk Register - Tier 2				

	ID4306 – Data Flow Mapping and Records of Processing Activity (ROPA)	9	9	6	Unchanged
	ID5238 - Development and ongoing management of Corporate Records Management function	9	9	6	Unchanged
	ID5239 - BCU site wide audit to identify health and corporate records store in vulnerable locations	9	9	9	Unchanged
	Risk Register - Tier 3				
	ID2803 - Data Protection Legislation / Freedom of Information Act 2000	9	6	6	Unchanged – with a view to close during 2025/26 as target now met.
	ID3803 - MS Office 365 - Management of HB Records	12	8	6	Unchanged
	ID3801 – Failure to develop and improve the Asset Register System	9	6	4	Decreased

	*Please note: as of 06/02/2026 there are 3 open risks.
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** Choose an item.	**Meysydd Ansawdd** **Domains of Quality** Choose an item.
	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) 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.

Atodiad 1 - Adroddiad Blynyddol Llywodraethu Gwybodaeth

2024/25

Appendix 1 – Information Governance Annual Report

2024/25

Information Governance Toolkit

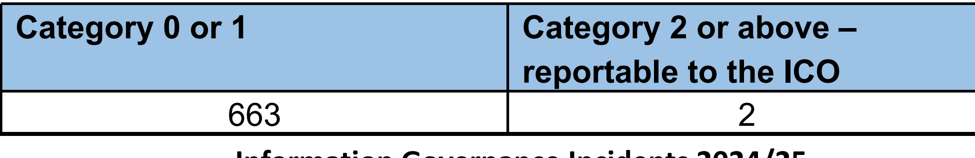
The 2024/25 Information Governance (IG) toolkit self-assessment was successfully completed within the given timescales and submitted on the 25th March 2025. Please find below

Level	Total
Expectations Not Met	0
Minimum Expectations Met	3
Expectations Exceeded Met	8

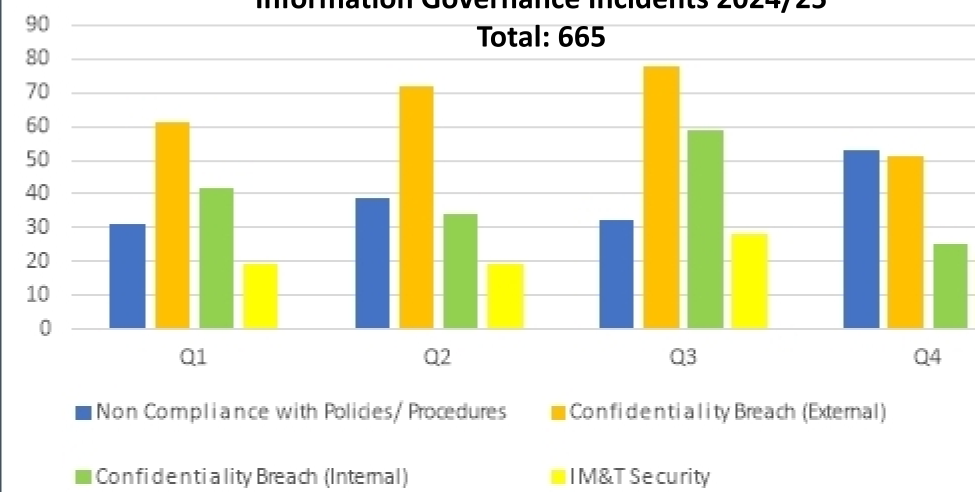
Requirement	Minimum Expectations	Expectations Exceeded
Leadership & Oversight	100%	100%
Policies & Procedures	100%	100%
Training & Awareness	100%	80%
Individual Rights	100%	100%
Record of Processing and Lawful Basis	100%	0%
Contracts and Information Sharing	100%	42%
Risks and Data Protection Impact Assessments (DPIAs)	100%	100%
Breach Response and Monitoring	100%	100%
Freedom of Information (FOI) and Environmental Information (EIR)	100%	100%
Information Security	100%	100%
Business Continuity	100%	100%

Requirement	Priorities for 2024/25
Leadership & Oversight	1. Look at different ways to utilise decision-makers such as DPO, SIRO and Caldicott Guardian to promote a proactive, positive culture of Information Governance and Data Protection compliance across the organisation.
Policies & Procedures	1. Data Quality Policy to be drafted with a view to implementation 2026/27. This will be reliant on the ongoing standardisation work within the DDaT Roadmap.
Training & Awareness	1. Maintain compliance with the 85% National target. 2. Continue to target lower areas of compliance with escalation to Executives where appropriate. 3. Continue to strive to meet the new exceeded national training target of 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. Where consent for processing information is obtained from individuals, the robustness of the processes in place for the recording of consent needs to be strengthened.
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)	1. More detail to be provided in KPI reports on the DPIAs which have been approved per quarter. 2. Publish a list of approved DPIAs on the Health Boards website by name of project and any high-level risks identified.
Breach Response and Monitoring	No priorities required/identified/added
Freedom of Information (FOI) and Environmental Information (EIR)	1. FOI workshop to be undertaken annually and to become business as usual. 2. Continue to support / encourage and promote services to publish information on the Health Boards website publication scheme.
Information Security	1. Overarching Access Control Procedure to be finalised and implemented across the Health Board. 2. Ensure use of BCUHB apps on personal devices is covered in the Leavers / Movers process. 3. Risk assess the assets submitted onto the Health Boards Information Asset Register. 4. Review of current supply chain of systems to be undertaken.
Business Continuity	Test the Information Governance Business Continuity Plan.

Incidents & Complaints 2024/25



Category 0 or 1	Category 2 or above – reportable to the ICO
663	2



The Health Board self-reported 2 data security breaches that triggered referral to the Information Commissioner's Office and Welsh Government. This was in relation to:

All self-reported incidents have been closed by the Information Commissioner's Office with no further action required by them due to the immediate actions and improvements put in place by the Health Board. The Information Commissioners Office made recommendations to the Health Board, some of these included;

Confidentiality Breach-External	2
Total	**2**

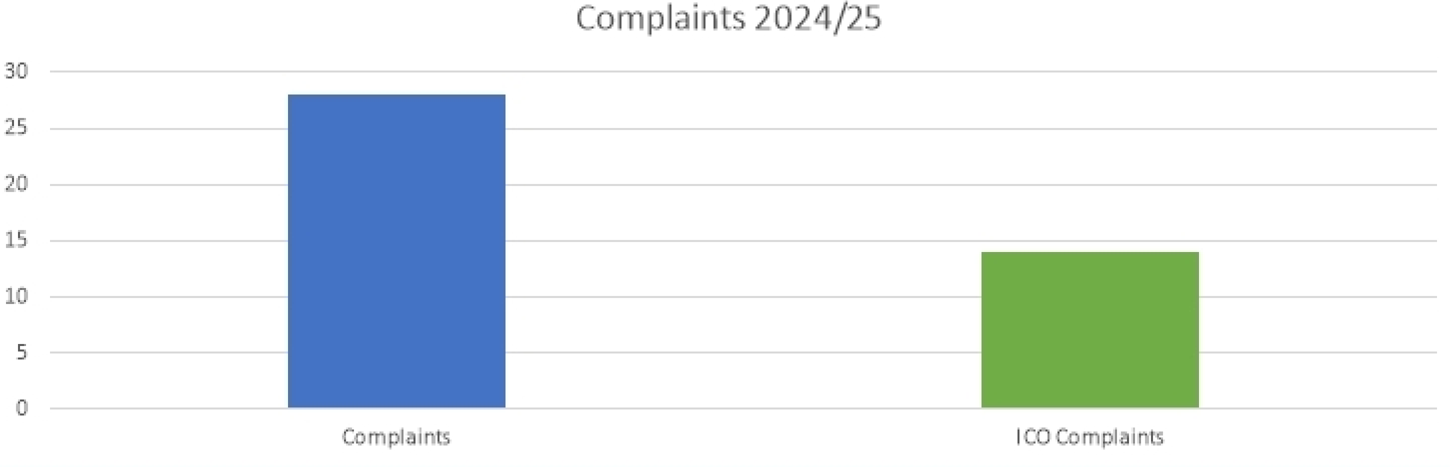
During 2024/25 there was an increase in the number of data breaches which included: -

- External mail being sent to the incorrect address.
- Patient records being incorrectly stored or misplaced.
- Duplication of the same incident being reported by separate individuals.

The Information Governance Team have updated the Information Governance training package to ensure staff members are aware of the potential impact of the incident and how they can be avoided. Examples of incidents including national incidents are frequently used in the mandatory training sessions.

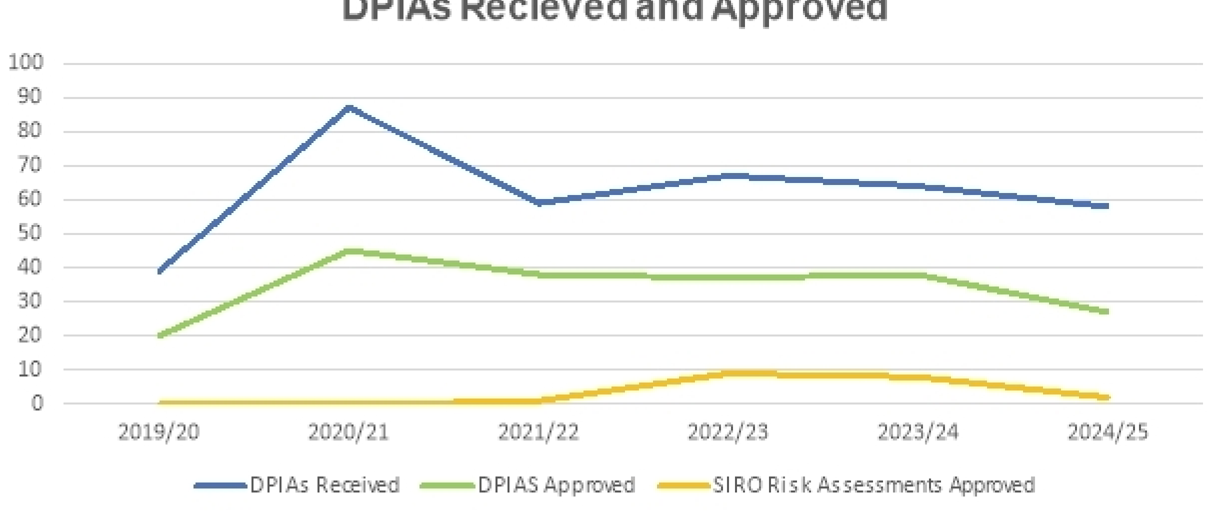
Any lessons learned are disseminated throughout the Health Board and published in the Information Governance bulletin. The following topics have been covered in the bulletins circulated to all staff during 2024/25:

- Laptop Security.
- Cyber Security Advice Whilst on Foreign Travel.
- Secure Printing.
- Inappropriate Access to Personal Data.



During 2024/25 the Health Board has received two personal injury claims for harm and distress caused by a data breach and has settled two claims totalling £19,010.64 during the year. The Information Governance Team will continue to raise awareness of these types of incidents within our training and through publishing alerts in the Health Board bulletin to avoid these situations occurring and to raise awareness of the consequences of data breaches.

Data Protection Impact Assessments, Caldicott Authorisations and Compliance Audits



There were **58** requirements for a DPIA logged during 2024/25 with 27 of those being approved and an additional 2 being approved from 2023/24.

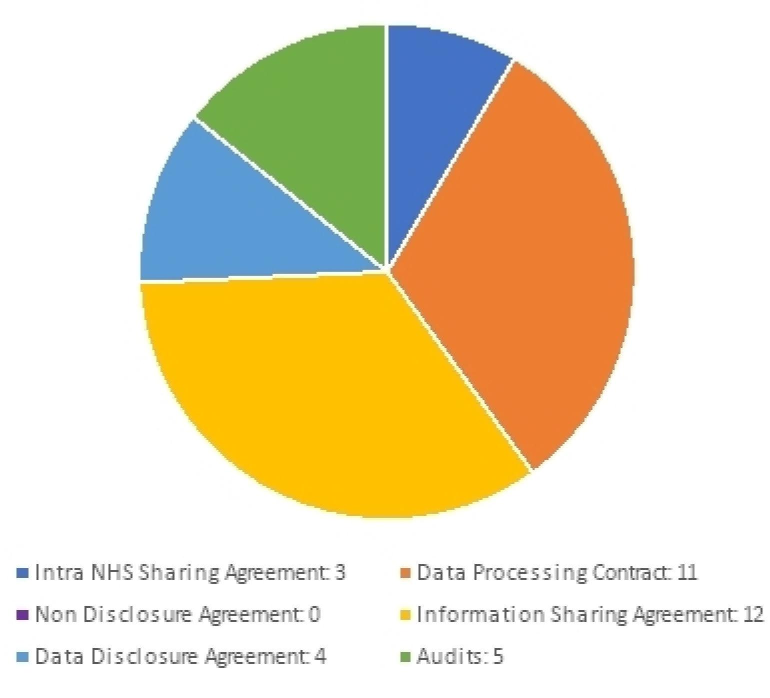
Status	Total
No Longer Required	10
Awaiting DPIA	1
Declined	0
Approved in 2024/25	27
In Progress	20

Information Governance Compliance checks

During 2024/25 the compliance audit process continued to incorporate a pre-assessment over Microsoft Teams with a member of the IG Team to support and prompt them with any questions or concerns that they had.
5 face to face audits were conducted in the following sites:

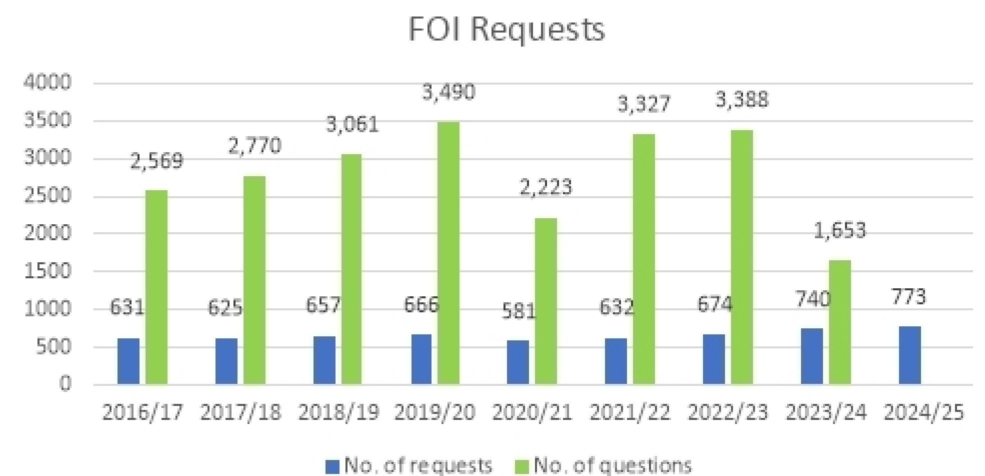
1. Trauma & Orthopaedic Department, Wrexham Maelor Hospital;
2. District Nursing Team, Bethesda;
3. Emergency Department, Ysbyty Gwynedd;
4. Children's Mental Health Service, Talrafon;
5. Mental Health Department, Cefni Hospital.

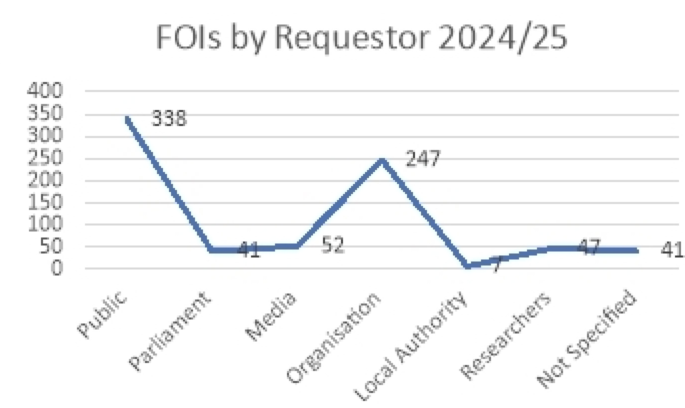
A further 18 IG reviews were undertaken across the Health Board with two face to face visits completed following the submission in the Renal service in Ysbyty Gwynedd and Bethesda District Nursing Team.
The Information Governance Team will also continue to complete ad hoc face to face audits and conduct audits on the back of any incidents where there is a high risk or particular trends identified.

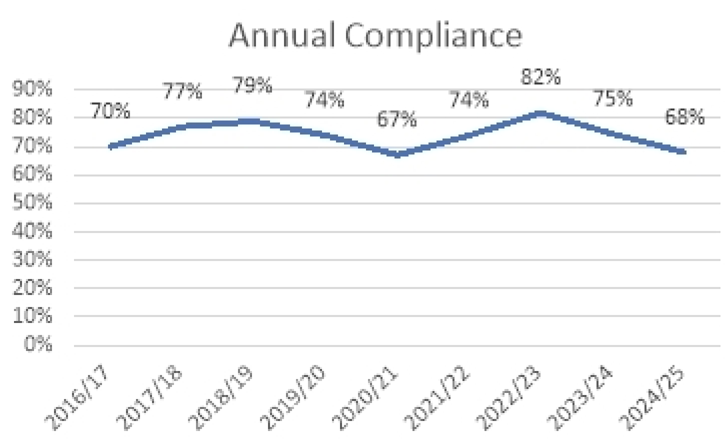


Freedom of Information Requests

During 2024/25 BCUHB received and processed **773** Freedom of Information (FOI) requests, an increase of just over 4% from the previous year (740), with compliance decreasing from 75% to **68%.** This was due to the increase in the total number of requests being the most received to date and also a number of these being complex cases spanning across multiple services. The total number of hours spent processing these requests totalled 3136 hours. This number is made up from the resources spent by both the Information Governance Team, the FOI leads and Executive Team approvals.



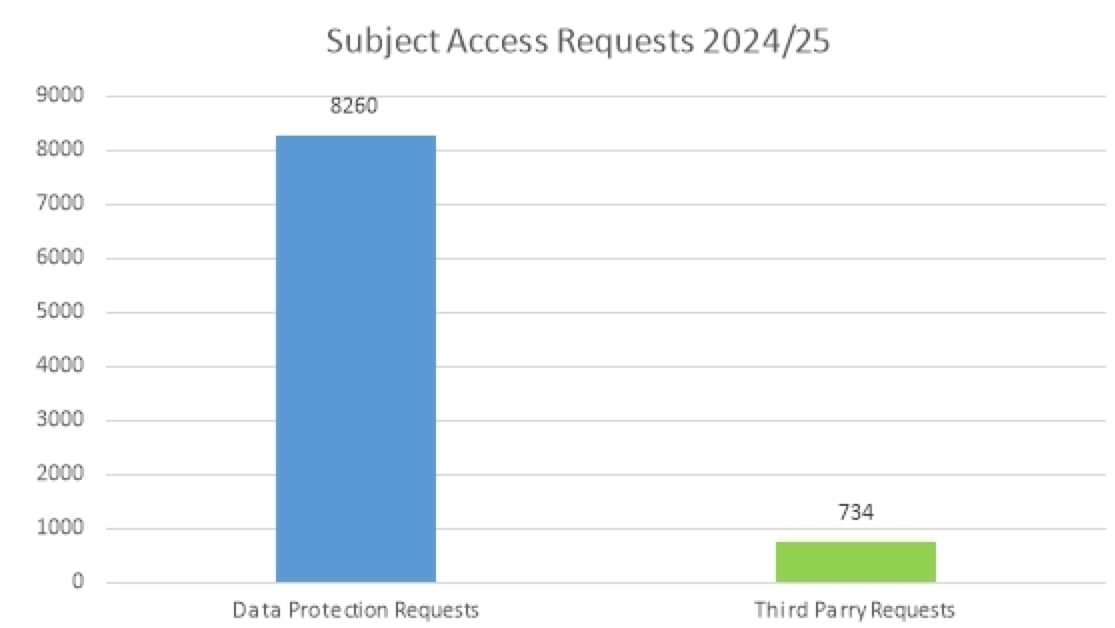




*Please note due to the way in which the new FOI system records information we are unable to provide the total number of questions asked for 24/25.

Exemption	Exemption Category	Total	Internal Review	Upheld/ Overturned	ICO	Upheld/ Overturned
Section 17 – Refusal Notice	Section 12 – fee limit.	72	3	3 x upheld	-	-
Section 21 - Information accessible by other means	Absolute – No Public Interest Test required	24	0		-	-
Section 22 – Information intended for future public release	Class Based, so Public Interest Test assessed	0	0		-	-
Section 36 - Qualified Person Statement	Class Based, so Public Interest Test assessed	0	0		-	-
Section 31 – Law Enforcement	Class Based, so Public Interest Test assessed	3	0	-	-	-
Section 40 - Personal Information	Absolute – No Public Interest Test required	20	1	1 x upheld	-	-
Section 43 - Commercial interests	Class based, so Public Interest Test assessed	9	1	1 x upheld	1	1 x overturned
No Exemptions Used		645	7	3 x partial overturn 4 x upheld	-	-
Total		**773**	**12**	**-**	**1**	**-**

Subject Access Requests & National Intelligent Integrated Auditing System (NIIAS) Notifications



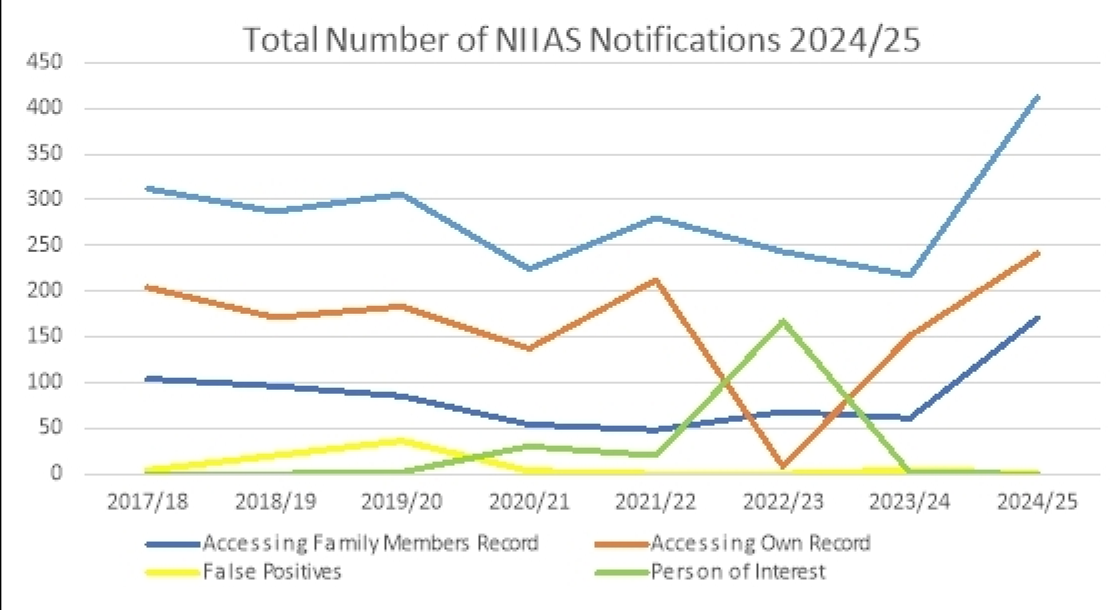
Data Protection Act Subject Access Requests (DPA SAR)

During quarter 4 of 2023/24 it was agreed to report on the compliance of subject access requests as a whole, with one figure showing the overall compliance for requests received into, Information Governance, Access to Health Records, HMP Berwyn and Managed GP Practices. During 2024/25, **8,260** requests were received into the Health Board an increase from 6400 in 2023/24, with the average overall compliance increasing to **98.5%.** 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

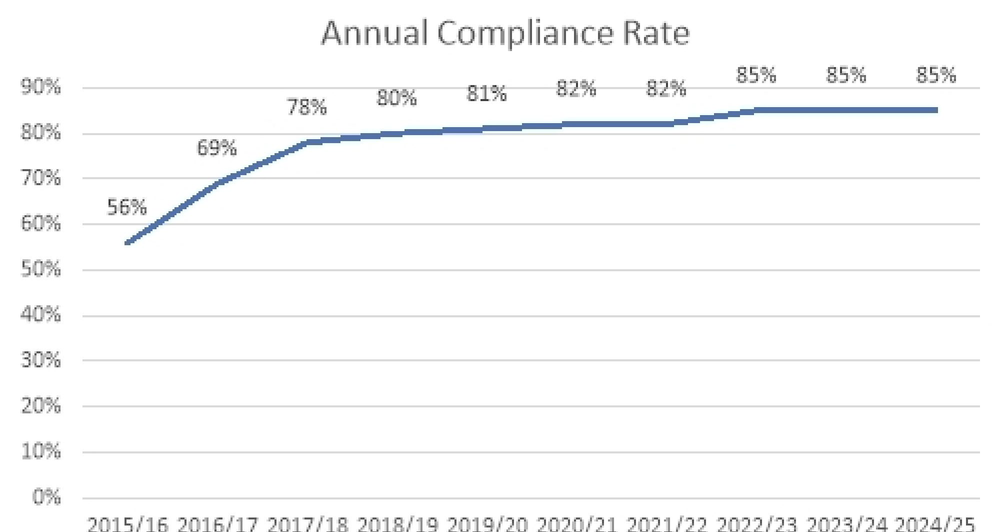
The Information Governance Team and Access to Health Record Team have received **73** requests for information from North Wales Police during 2024/25. Some examples of requests are Medical Records, Personnel Records, CCTV, Witness Statements and Telephone Records, these were all processed in a timely manner



National Intelligent Integrated Auditing System (NIIAS)

In 2024/25, the National Intelligent Integrated Auditing System (NIIAS) generated 412 notifications of alleged inappropriate access to family or own health records, an increase of 217 from the previous year. This rise is attributed to a technical issue following the software transfer in 2023/24, which resulted in a backlog being processed in 2024/25.Throughout 2025/26 we will continue to monitor trends and work with Workforce & Organisational Development to report disciplinary outcomes, which will remain included in quarterly KPI reports to the Information Governance Group. We will also engage with the Executive Director of Nursing, the Office of the Medical Director, and the Executive Director of Allied Health Professions & Health Science to escalate any increase in notifications. During 2024/25, 20 cases progressed through workforce processes, all of which are now closed.

Information Governance Training, Risks and Policies & Procedures



Information Governance Mandatory Training

During 2024/25 we continued to hold our training sessions virtually on Microsoft Teams, with 19 sessions taking place across the year and **340** staff members completing these sessions.
During 2024/25 we also re-commended face to face training sessions in the lecture theatres and attending the Health Boards mandatory training days on the acute sites with 12 sessions taking place and 73 staff members attending. **3,111** staff have also completed their training via E-Learning in this period.

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. The overall compliance for staff passing their mandatory IG training continued to meet the national target of **85%**.

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 updates and is reported through the Information Governance Group (IGG).A full review of the existing Information Governance risks by the Head of Information Governance has resulted in a number of risks being closed and other risks with minor outstanding actions being merged into ongoing programmes of work for consistency.

During 2024/25 there were 6 risks being monitored on the register as follows:

1. MS Office 365 - Management of Health Board Records – Tier 3.
2. Data Protection Legislation / Freedom of Information Act 2000 – Tier 3.
3. Failure to develop and make improvements to the Information Asset Register – Tier 3.
4. Data Flow Mapping - Tier 2.
5. Development and ongoing management of Corporate Records Management function. – Tier 2.
6. BCU site wide audit to identify health and corporate records stored in vulnerable locations – Tier 2.

Policies and Procedures

During 2024/25 the following Information Governance policies and procedures were reviewed and approved in line with legislation:

- IG1 - Information Governance Strategy
- IG01 – Records Management Policy
- IG02 – Records Management Procedure
- IG03 – BCUHB FOI and EIR Procedures
- IG04 – Access to Information Policy
- IG07 – Procedure for dealing with SARs
- IG08 – Email Procedure Policy
- IG10 – Procedure for requesting approval and review of an information system
- IG14 – ICT Security Procedure
- IG17 – Photo Video Audio Procedure

Policies and procedures will continue to be developed or updated during 2025/26 to further support the Information Governance Framework.

<table>
<tr><td>Teitl adroddiad:

Report title:</td><td colspan="4">Information Governance Annual Report 2024/25</td></tr>
<tr><td>Adrodd i:

Report to:</td><td colspan="4">Performance, Finance and Information Governance Committee</td></tr>
<tr><td>Dyddiad y Cyfarfod:

Date of Meeting:</td><td colspan="4">TBC</td></tr>
<tr><td>Crynodeb Gweithredol:

Executive Summary:</td><td colspan="4">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, areas of good practice and overall achievements.</td></tr>
<tr><td>Argymhellion:

Recommendations:</td><td colspan="4">The Performance, Finance and Information Governance Committee is asked to:

• Note the report and receive assurance on compliance with Data Protection and Freedom of Information Legislation.</td></tr>
<tr><td>Arweinydd Gweithredol:

Executive Lead:</td><td colspan="4">Dylan Roberts - Chief Digital and Information Officer</td></tr>
<tr><td>Awdur yr Adroddiad:

Report Author:</td><td colspan="4">Carol Johnson – Head of Information Governance</td></tr>
<tr><td>Pwrpas yr adroddiad:
Purpose of report:</td><td>I'w Nodi
For Noting
☐</td><td colspan="2">I Benderfynu arno
For Decision
☐</td><td>Am sicrwydd
For Assurance
☒</td></tr>
<tr><td>Lefel sicrwydd:

Assurance level:</td><td>Arwyddocaol
Significant
☒</td><td>Derbyniol
Acceptable
☐</td><td>Rhannol
Partial
☐</td><td>Dim Sicrwydd
No Assurance
☐</td></tr>
</table>

	Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	· Ensure that BCUHB meets its legal and statutory obligations as defined in the Data Protection Act 2018, UK GDPR and European GDPR 2016; · Ensure IG Strategies, policies, procedures and training plans are all updated to reflect best practice and changes in legislation; · Improve overall compliance with Freedom of Information and Subject Access request response times in line with legislative requirements by supporting governance leads, and raising awareness and improving overall availability and publication of information to enable improved transparency to the public; · Ensure that privacy by design and default is considered at all stages of service design, system procurement and partnership working; · Maintain IG Training Compliance of 85% to raise staff understanding and awareness; meeting the national target. · Work with ICT and responsible owners across the Health Board to support the

<table>
<tr><td></td><td>delivery of an improved Information Asset Register;

· Learn from outcomes and put improvement plans in place to ensure lessons can be learnt and acted upon to avoid reoccurrence.</td></tr>
<tr><td>Goblygiadau rheoleiddio a lleol:

Regulatory and legal implications:</td><td>Data Protection Act and Freedom of Information Act</td></tr>
<tr><td>Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?

In accordance with WP7 has an EqIA been identified as necessary and undertaken?</td><td>N/A</td></tr>
<tr><td>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?

In accordance with WP68, has an SEIA identified as necessary ben undertaken?</td><td>N/A</td></tr>
<tr><td>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)

Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)</td><td>Non-compliance with the legislation can lead to penalties imposed by the Information Commissioner and loss of confidence by the public in the Health Board’s ability to protect the privacy of their information. There are currently six Information Governance risks being managed and monitored by the Information Governance Group, three of which are Tier 2 and three at Tier 3.

<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>9</td><td>9</td><td>6</td><td>Unchanged</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><td></td><td>
<table>
<tr><td>ID5239 - BCU site wide audit to identify health and corporate records store in vulnerable locations</td><td>9</td><td>9</td><td>9</td><td>Unchanged</td></tr>
<tr><td colspan="5">Risk Register - Tier 3</td></tr>
<tr><td>ID2803 - Data Protection Legislation / Freedom of Information Act 2000</td><td>9</td><td>6</td><td>6</td><td>Unchanged – with a view to close during 2025/26 as target now met.</td></tr>
<tr><td>ID3803 - MS Office 365 - Management of HB Records</td><td>12</td><td>8</td><td>6</td><td>Unchanged</td></tr>
<tr><td>ID3801 – Failure to develop and improve the Asset Register System</td><td>9</td><td>6</td><td>4</td><td>Decreased</td></tr>
</table>
</td></tr>
<tr><td>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith

Financial implications as a result of implementing the recommendations</td><td>Non-compliance with the legislation can lead to significant fines imposed by the Information Commissioners Office.</td></tr>
<tr><td>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith

Workforce implications as a result of implementing the recommendations</td><td>N/A</td></tr>
<tr><td>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori

Feedback, response, and follow up summary following consultation</td><td>To be presented to Information Governance Group 18/08/2025</td></tr>
<tr><td>Cysylltiadau â risgiau BAF:
(neu gysylltiadau â’r Gofrestr Risg Gorfforaethol)

Links to BAF risks:
(or links to the Corporate Risk Register)</td><td>Board Assurance Framework
BAF-SP13 - There is a risk of failing to meeting the Health Board’s strategic and operational objectives caused by having inadequate arrangements for the identification, commissioning and delivery of Digital, Data and Technology enabled projects and change.

Corporate Risk Register</td></tr>
</table>

	CRR24-07 – Availability and Integrity of Patient Information CRR24-17 – ICT Failure and Cyber Security
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A

Next Steps:

- Ensure working to and meeting the objectives within the BCUHB IG Strategy;
- Continue to meet statuary requirements and obligations with Data Protection Legislation and Freedom of Information Act 2000;
- Ensure the remaining priorities set for the 2024/25 IG toolkit submission are implemented, and work with the IG Toolkit leads to improve standards for the 2025/26 toolkit submission;
- Continue to improve IG training compliance and maintain the national target of 85%;
- Work with ICT and roll out the newly developed Information Asset Register, working with Information Asset Owners to ensure they understand their role and that the Information Asset Register remains up to date and is robustly monitored.
- Make available additional improvement tools and guidance for Freedom of Information leads and continue to build relationships to improve overall compliance to FOI requests.
- Continue to monitor and progress the remaining Corporate Records Rapid Review findings.
- Continue to support and work collaboratively with specialist teams to promote and consider the introduction of Artificial Intelligence (AI) where permitted ensuring all biases have been taken into consideration.

List of Appendices:

Appendix 1 - Information Governance Annual Report 2024/25 - Full Report

Appendix 1

Information Governance Annual Report 2024/25

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Background

The term 'Information Governance' is used to describe how organisations manage the way information is handled. It covers the requirements and standards that Betsi Cadwaladr University Health Board (BCUHB) needs to achieve to fulfil its obligations that information is handled legally, securely, efficiently, effectively and in a manner which maintains public trust.

Information Governance applies the balance between privacy and sharing of personal confidential data and is therefore fundamental to the health care system, both providing the necessary safeguards to protect personal information and an effective framework to guide those working in health to decide when to share, or not to share.

There is a comprehensive and complex range of national guidance and legislation which BCUHB must operate within, including compliance with:

- Data Protection Act 2018
- EU General Data Protection Regulation 2016
- UK General Data Protection Regulation 2021
- Freedom of Information Act 2000
- Environmental Information Legislation 2004
- Public Records Act 1958
- Access to Health Records Act 1990
- Computer Misuse Act 2000
- Caldicott Principles in Practice (C-PIP)
- Welsh Information Governance (IG) Toolkit
- Common Law duty of confidentiality
- Wales Accord to Share Personal Information (WASPI)
- Data Quality
- Information Security assurance - ISO 270012013 Information security management
- Records Management NHS Code of Practice
- Information Commissioners Codes of Practice
- NIS (Networks and Information Systems) regulations

A robust Information Governance Framework has been put in place to provide assurance against these which is monitored and administered via the Information Governance Team and the wider Digital, Data and Technology Team.

1.0 Purpose

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 2024/25. 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.

2.0 Accountability and Responsibilities

6.1 **Chief Executive** - The Chief Executive takes overall responsibility for the Health Board's information governance performance and in particular is required to ensure that:

- The Health Board can demonstrate accountability against the requirements within the Data Protection Act;
- Decision-making is in line with the Board's policy and procedure for information governance and any statutory provisions set out in legislation;
- The information risks are assessed and mitigated to an acceptable level and information governance performance is continually reviewed;
- Suitable action plans for improving information governance practice are developed and implemented;
- Ensure Information Governance training is mandated for all staff and is provided at a level relevant to their role.

To satisfy the above, the Chief Executive has delegated this responsibility to the Chief Digital and Information Officer who will be accountable for the Board's overall information governance arrangements.

6.2 **The Chief Digital and Information Officer** has responsibility for ensuring that the Board corporately meets its legal responsibilities, and for the adoption of internal and external information governance requirements. They will act as the conscience for information governance on the Board and advises on the effectiveness of information governance management across the organisation. The Chief Digital and Information

Officer has overall responsibility for the technical infrastructure to ensure the security and data quality of the information assets and systems held within the Health Board.

6.3 **Caldicott Guardian** - The Executive Medical Director has been nominated as the Board's Caldicott Guardian and is responsible for protecting the confidentiality and reflecting patients' interests regarding the use of patient identifiable information. They are responsible for ensuring patient identifiable information is shared in an appropriate, ethical and secure manner. The Caldicott Guardian is the Chair of the Information Governance Group.

6.4 **Executive Medical Director** - The Executive Medical Director has been nominated by the Board and has overall responsibility for the management of all patient record types.

6.5 **Executive Lead for Corporate Records** - The Chief Digital Information Officer (CDIO) is responsible for the overall management and performance of the Corporate Records Management within the Health Board.

6.6 **Senior Information Risk Owner (SIRO)** - The Chief Digital Information Officer (CDIO) has been nominated as the Boards Senior Information Risk Owner and has overall ownership of the information risks and plays a key role in successfully raising the profile of information risks and embedding information risk management into the Health Board's culture. The SIRO has undertaken additional training specific to the role.

6.7 **Data Protection Officer (DPO)** - The Assistant Director of Compliance and Business Management undertakes the designated role of the Health Boards Data Protection Officer. They are responsible for providing the Health Board with independent risk-based advice to support its decision-making in the appropriateness of processing 'Personal and Special Categories of Data' as laid down in the General Data Protection Regulation (GDPR) and the UK Data Protection Act. The DPO is required to provide advice and guidance on all data protection legislation queries to staff, patients and the Board. The Health Board recognises its obligations and accountability responsibilities with the GDPR and Data Protection Laws.

The Information Governance structure sits within this area.

6.8 **Information Governance Team -** The Head of Information Governance is responsible for the development, communication and monitoring of policies, procedures and action plans ensuring the Board adopts information governance best practice and standards. This role will report to the Assistant Director of Compliance and Business Management and is supported by the Information Governance Team who will also work in collaboration with the Information Governance Leads and Information Asset Owners.

6.9 **Assistant Director / Chief Technology Officer (CTO)** – Leads on all matters relating to the Health Board's ICT infrastructure security and regulatory compliance. Furthermore, provides strategic direction and expert advice on all technical matters relating to sustained compliance and conformance against the NHS Wales Code of Connection and NIS Directive.

6.10 **Cyber Security and Compliance Manager** - Acts as the Health Board's expert on cyber security protection, detection, response, and recovery. The Cyber Security and Compliance Manager is responsible for the strategic approach to cyber threat management and leads the strategic planning of current and future IT security solutions. The Cyber Security and Compliance Manager leads and advises on compliance with the NIS Directive and Cyber Essentials certification.

6. 11 **Assistant Director of Patient Records Management** – This role is responsible for the overall management and performance of the Health Records Service within BCUHB including the provision of organisation-wide access to health records and providing assurance against record management standards across all patient record types both paper and digital.

6.12 **Executive Directors/ Directors/ Integrated Health Community Directors (IHC)** - Each Director is responsible for the information within their area and therefore must take responsibility for information governance matters.

6.13 **Information Governance Leads** – The Information Governance Leads work with the IG Team to ensure compliance with corporate IG policies, procedures, standards, legislation and to promote best practice within their areas. The Information Governance Leads will be reviewed in 2025/26 to ensure we have the correct individuals in place and they know what's expected of them.

6.14 **Information Asset Owners (IAO) -** Are senior responsible individuals involved in the running of their relevant services. Their role is to understand what information assets are held, and for what purpose. They have an understanding of how the information held in the asset is created, amended, added to, quality assured and processed. They will know who has access to the information and why, be responsible for any identified risks and provide assurance to the SIRO. They will have overall responsibility to understand procurement requirements around contracts and licencing; put in place and test business continuity and disaster recovery plans, control access permissions and ensure the system asset record is regularly reviewed and updated on the asset register.

6.15 **Information Asset Administrator (IAA) –** Are staff who normally use the system as part of their daily routine. They will recognise actual or potential security incidents, consult with their IAO on appropriate incident management, access controls and system level security issues and ensure that information asset registers are accurate and up to date.

6.16 **All Staff** - All employees, contractors, volunteers and students working for or supplying services for the Health Board are responsible for any records or data they create and what they do with information they use.

All staff have a responsibility to adhere to information governance policies and procedures and standards which are written into the terms and conditions of their contracts of employment and the organisations Staff Code of Conduct.

6.17 **Third Party Contractors** – appropriate contracts and confidentiality agreements shall be in place with third parties where potential or actual access to the Health Board's confidential information assets is identified.

3.0 Information Governance Operational Plan

The Health Board continues to remain committed to achieving the objectives detailed in the Information Governance Operational Plan and the Information Governance Strategy for 2025/26. The plan is located on the Microsoft planner platform, where all actions and position updates are recorded, allowing for easier real time reporting and monitoring.

The plan includes:

- High Level Objectives.
- Outstanding actions from the 2024/25 Operational Plan.
- Recommendations made by the Information Commissioners Office.
- Recommendations made by Internal and External Audits / Reviews.
- Priorities identified as a result of the Welsh IG Toolkit submission 2024/25.
- National programmes of work.
- Local programmes of work identified for implementation which includes transformation and improvement, and the move towards the Electronic Health Record

4.0 Information Governance Toolkit

The 2024/25 Information Governance (IG) Toolkit self-assessment was successfully completed within the given timescales and submitted on the 25th March 2024.

The monthly IG Toolkit Subgroup meetings re-commenced in October 2024 as normal in readiness for the 2024/25 IG Toolkit being released and continued to receive support and the appropriate compliance evidence from the Health Records, IT, Mental Health and Learning Disabilities, Community Services, Procurement, Health & Safety/Security, Contracting Services-Finance and Workforce departments which enabled a timely and smooth submission.

Please find below the final submission levels:

Level	Total
Expectations Not Met	0
Minimum Expectations Met working towards exceeded	3
Both minimum and exceeded Expectations Exceeded Met	8
Total	11

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%	42%
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	100%	100%
Business Continuity	100%	100%

The Health Board met all the standard requirements set for the Information Governance Toolkit for 2024/25.

The 2025/26 question set has been reviewed and updated. The Health Board is continuing to strengthen current practices to ensure all elements of the toolkit continues to be met for the 2025/26 submission

Please find details below of the priorities identified which form part of the 2025/26 Information Governance Toolkit Action Plan and are incorporated into the IG Operational Work Plan along with IG Toolkit Leads operational plans where required:

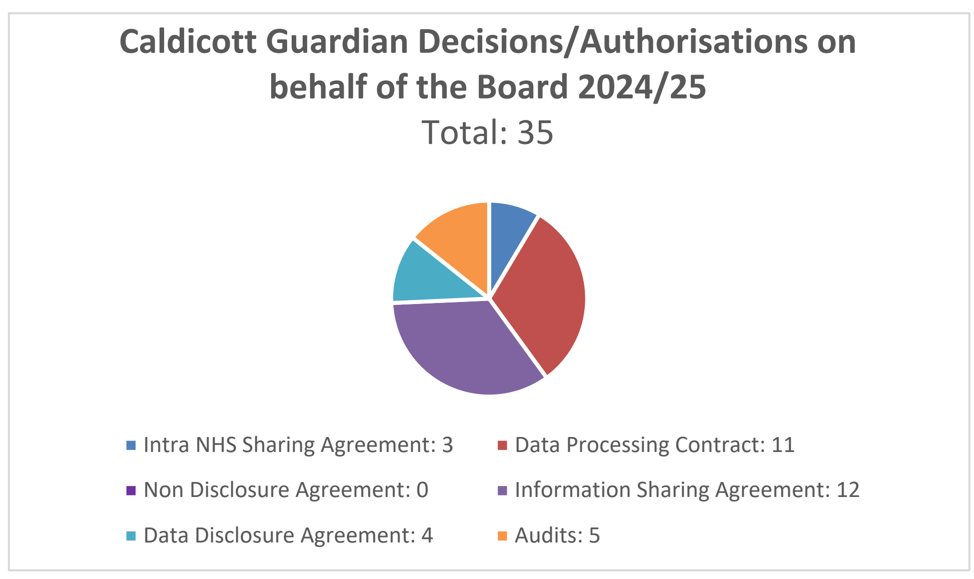
Requirement	Priorities for 2024/25
Leadership & Oversight	1. Look at different ways to utilise decision-makers such as DPO, SIRO and Caldicott Guardian to promote a proactive, positive culture of Information Governance and Data Protection compliance across the organisation.
Policies & Procedures	1. Data Quality Policy to be drafted with a view to implementation 2026/27. This will be reliant on the ongoing standardisation work within the DDaT Roadmap.
Training & Awareness	1. Maintain compliance with the 85% National target. 2. Continue to target lower areas of compliance with escalation to Executives where appropriate. 3. Continue to strive to meet the new exceeded national training target of 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. Where consent for processing information is obtained from individuals, the robustness of the processes in place for the recording of consent needs to be strengthened.
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)	1. More detail to be provided in KPI reports on the DPIAs which have been approved per quarter. 2. Publish a list of approved DPIAs on the Health Boards website by name of project and any high-level risks identified.
Breach Response and Monitoring	No priorities required/identified/added
Freedom of Information (FOI) and Environmental Information (EIR)	1. FOI workshop to be undertaken annually and to become business as usual. 2. Continue to support / encourage and promote services to publish information on the Health Boards website publication scheme.
Information Security	1. Overarching Access Control Procedure to be finalised and implemented across the Health Board. 2. Ensure use of BCUHB apps on personal devices is covered in the Leavers / Movers process. 3. Risk assess the assets submitted onto the Health Boards Information Asset Register. 4. Review of current supply chain of systems to be undertaken.
Business Continuity	Test the Information Governance Business Continuity Plan.

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 2024/25 the following information sharing was authorised by the Caldicott Guardian.



5.0 Senior Information Risk Owner

5.1 Information Security

Similar to previous years, during 2024/25, the risk posed by Cyber threats continued at a heightened level due to global tensions and the increasing sophistication used by Cyber Criminals in their attacks.

Throughout the year there were numerous high profile Cyber-attacks on healthcare organisations and critical suppliers throughout the home nations which resulted in disclosure of sensitive patient information and long-term ICT outages which impacted on patient treatment.

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 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 has been made in aligning processes and procedures with the ISO27001 best practice framework and several exercises have been held to test major incident recovery plans. A comprehensive Cyber Awareness Programme has been implemented and now operates as business as usual, the aim being to continuously improve awareness of Cyber threats amongst staff. 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.

5.2 Information Governance Incidents

There have been 665 incidents reported for this period against 633 in the previous year, an increase of 32 (5%). All were categorised and reported as information governance incidents.

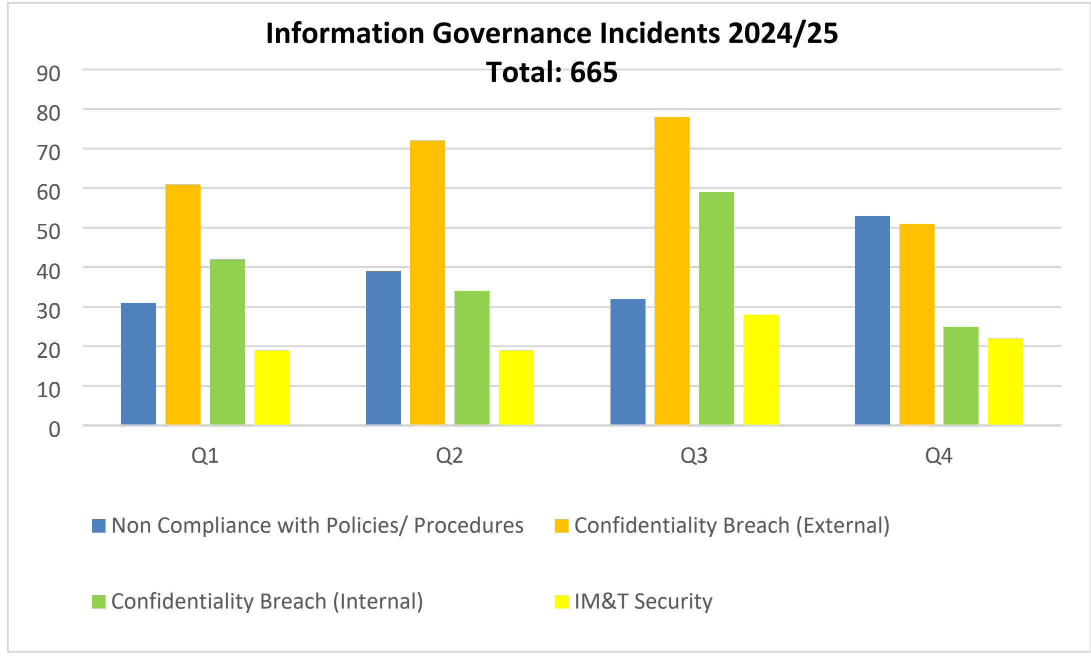
During 2024/25, the Information Governance Team continued to look at trends to identify if there was any pattern to the increase. No significant trends have been identified, external mail breaches, remain high and records management errors have slightly increased. Any areas identified in having repeat incidents or concerns raised are now required to undertake / complete an information governance self-assessment audit to enable the team to identify gaps and measure overall compliance. If required a face-to-face visit will follow to support the service to make improvements. We will continue to monitor any increase in incidents and report these findings through the Information Governance Group via the quarterly key performance indicator reports and Integrated Health Community reports.

The Health Board has guidance in place on the Notification of Information Security Breaches which follows the Department of Health's Checklist for Reporting, Managing and Investigating Information Governance Serious Incidents. The guidance assists in categorising incidents to be scored appropriately in terms of the severity and the likely consequences of harm to the freedoms and rights of the individual affected. All incidents scored as 2 or above are notifiable to the Information Commissioners Office in line with new data protection laws within 72 hours of the incident taking place.

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
663	2

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



During 2024/25 there was an increase in the number of data breaches which included: -

- External mail being sent to the incorrect address.
- Patient records being incorrectly stored or misplaced.
- Duplication of the same incident being reported by separate individuals.

The Information Governance Team have updated the Information Governance training package to ensure staff members are aware of the potential impact of the incident and how they can be avoided. Examples of incidents including national incidents are frequently used in the mandatory training sessions.

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 2024/25:

- Laptop Security.
- Cyber Security Advice Whilst on Foreign Travel.
- Secure Printing.
- Inappropriate Access to Personal Data.

5.3 Serious Information Governance Incidents

The Health Board self-reported 2 data security breaches that triggered referral to the Information Commissioners Office and Welsh Government. These were in relation to:

Confidentiality Breach-External	2
Total	**2**

All self-reported incidents have been closed by the Information Commissioners Office with no further action required by them due to the immediate actions and improvements put in place by the Health Board.

All of these recommendations have or will be implemented by the Health Board and are 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 members to remain vigilant and use secure record bags provided to carry diary. Continue good practice of only having minimal patient details in a diary.
2. All admin staff to be extra vigilant when printing patient appointment letters in bulk for all letters to be checked prior to being placed in envelopes.
3. Reminder issued to all Health Board staff of the importance of secure printing and not to leave information unattended on printers.
4. A reminder issued to all staff with regards to inappropriate access to their own and / or family records.

5.5 Personal Injury claims

The Health Board did not incur a financial penalty during the year. During 2024/25 the Health Board has received two personal injury claims for harm and distress caused by a data breach and has settled two claims totalling £19,010.64 during the year. The Information

Governance Team will continue to raise awareness of these types of incidents within our training and through publishing alerts in the Health Board bulletin to avoid these situations occurring and to raise awareness of the consequences of data breaches.

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).

A full review of the existing Information Governance risks by the Head of Information Governance has resulted in 2 new risks being added, 1 risk being closed and a number of risk actions being met.

During 2024/25 there were 6 risks being monitored on the register as follows:

1. MS Office 365 - Management of Health Board Records – Tier 3.
2. Data Protection Legislation / Freedom of Information Act 2000 – Tier 3.
3. Failure to develop and make improvements to the Information Asset Register – Tier 3.
4. Data Flow Mapping - Tier 2.
5. Development and ongoing management of Corporate Records Management function. – Tier 2.
6. BCU site wide audit to identify health and corporate records stored in vulnerable locations – Tier 2.

6.0 Complaints/Concerns & Outcomes

During 2024/25 BCUHB received 28 complaints, which has remained the same from 2023/24, 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 **14** complaints received from the ICO during 2024/25 which is a decrease from 2023/24 (24). These cases continue to be linked to the increase in the total number of complex cases received and dealt with between Information Governance, Access to Health Records and the Complaints Team.

All 14 complaints have been investigated and closed with the ICO.

Please find below a breakdown of these complaints:

Subject Access Requests

There were **6** complaints received from the ICO regarding delays and incorrect recipients when responding to subject access requests for patient information during 2024/25, all were closed by the ICO with no action required.

Freedom of Information Requests

There were **6** complaints received from the ICO due to being dissatisfied with how the request was handled, 5 of these were upheld and 1 decision notice was issued requesting the release of contractual information for Halo the new ICT service desk solution. This was initially withheld under Section 43 – Commercially sensitive. The Information Governance Team have reviewed their internal process when considering the use of Section 43 to ensure that FOI leads fully understand when it can be applied.

Ad-Hoc

The remaining **2** complaints relate to allegations of inappropriate sharing of personal information.

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.

7.0 Compliance Audits/Assurance/Reporting

Compliance is measured in a number of ways as follows:

7.1 Compliance Audit

As part of the Health Boards requirement to ensure compliance with legislation, national and local standards, compliance checks are essential to provide assurance that the information is being safeguarded; areas of good practice are identified and areas of weaknesses are addressed via the production of an action plan. The Information Governance Team prioritised compliance audits in areas identified with a high frequency of incident reported.

During 2024/25 the compliance audit process continued to incorporate a pre-assessment over Microsoft Teams with a member of the IG Team to support and prompt them with any questions or concerns that they had.

5 face to face audits were conducted in the following sites:

1. Trauma & Orthopaedic Department, Wrexham Maelor Hospital;
2. District Nursing Team, Bethesda;
3. Emergency Department, Ysbyty Gwynedd;
4. Children’s Mental Health Service, Talrafon;
5. Mental Health Department, Cefni Hospital.

A further 18 IG reviews were undertaken across the Health Board with two face to face visits completed following the submission in the Renal service in Ysbyty Gwynedd and Bethesda District Nursing Team.

The Information Governance Team will also continue to complete ad hoc face to face audits and conduct audits on the back of any incidents where there is a high risk or particular trends identified.

During 2025/26 there will be a robust schedule in place to undertake additional IG reviews which will allow the Information Governance Officers to carry out observation checks where required. This will be reported in the Information Governance Quarterly Key Performance Indicator report, which reports into the Information Governance Group and then to the Performance Finance and Information Governance Committee for assurance.

7.2 Internal Audit/ External Audit

No specific internal audit reviews on information governance compliance audits were carried out during 2024/25, although wider Digital, Data and Technology audits have been undertaken which the IG Team have contributed to.

At the 31st March 2025, 38 of the 48 actions from the Information Governance Rapid Review were complete with the remaining 10 actions being continually monitored until they can be closed.

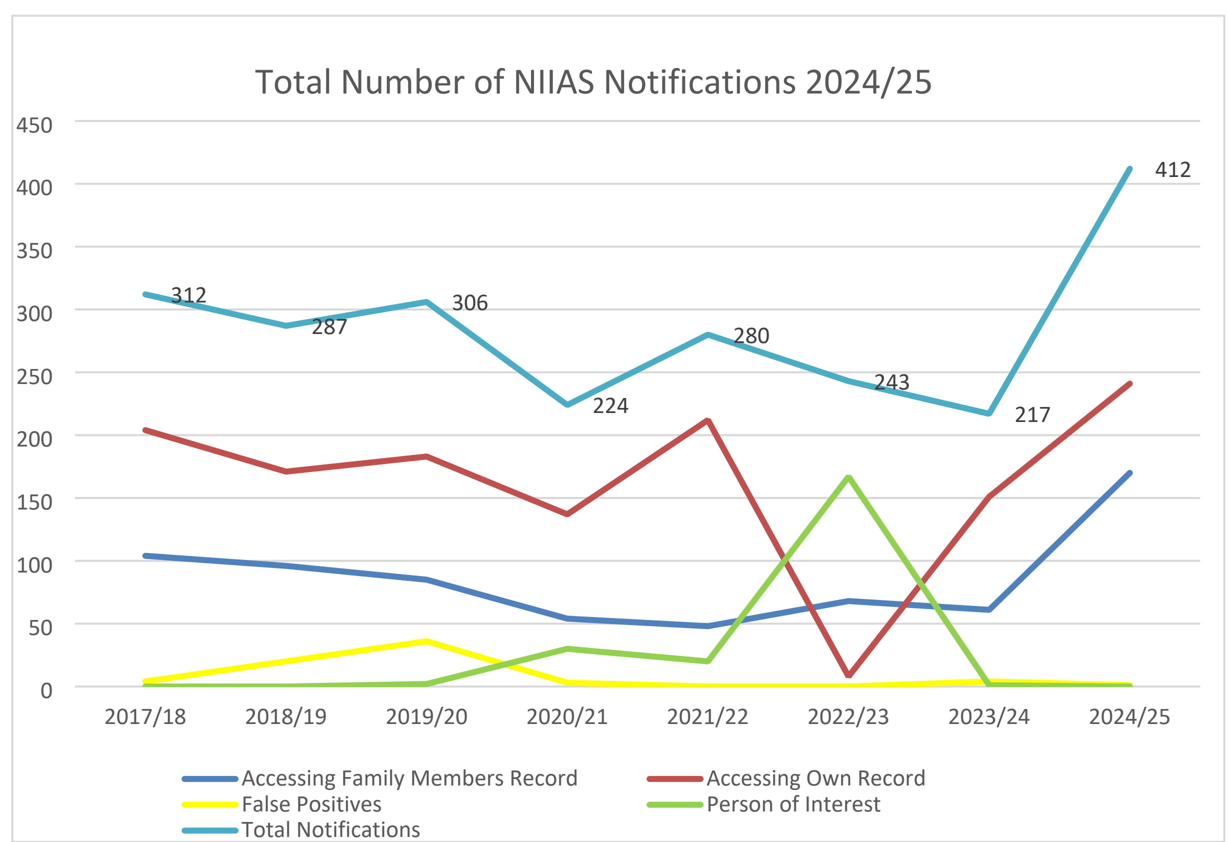
Overarching Recommendation	Number of Open Actions
The Health Board establish appropriate Corporate Records Management arrangements to ensure it is clear where accountability lies, that records management is recognised as a core corporate function and is appropriately resourced.	1
To ensure a robust and effective Records Management framework is in place. That the Records Management and other associated policies, procedures, and guidance be reviewed to ensure that they are up to date and reviewed regularly to reflect the latest legislative requirements and represent current IG/Records Management mandatory requirements, good practice, standards, and guidance.	3
Due to recent organisational changes arrangements for Information Asset Management should be assessed to ensure they are up to date, that IAO's are aware of their responsibilities and staff are aware of who the IAOS are.	4
That to increase security of information and reduce the risk of unauthorised disclosure of the Health Board consider implementation of additional security measures/controls.	2

7.3 Auditing of systems

During 2024/25 the National Intelligent Integrated Auditing System (NIIAS) generated 412 notifications of alleged inappropriate access to family records or own health records, which is an increase (217 notifications) compared to the previous year.

A technical issue following the transfer of the NIIAS software to the new platform was reported during 2023/24, this meant a backlog of notifications has been included in 2024/25 which is the reason for the significant increase this year.

During 2025/26 we will continue to monitor any trends and work with the Workforce & Organisational Development Department to report on disciplinary outcomes. This will continue to be reported in our quarterly key performance indicator reports to the Information Governance Group. We will also be working with the Executive Director of Nursing, Office of the Medical Director and Executive Director of Allied Health Professions & Health Science to escalate any increase in notifications to them. During 2024/25 there were **20** cases that progressed through workforce processes, all of which are now closed.



7.6 Reporting Responsibilities

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 Patient Records Group was disbanded during 2024/25 with the immediate introduction of the Information Governance and Health Records meeting to enable the Health Records department to report and discuss areas of concern. The Access to Health Records team continues to report via the Information Governance Group (IGG), The Information Communication Technology (ICT) Governance and Security Group continues to meet and

reports issues of significance into the Information Governance Group (IGG), who in turn report into the Performance, Finance and Information Governance Committee. There is representation from the Information Governance Department at both of these groups.

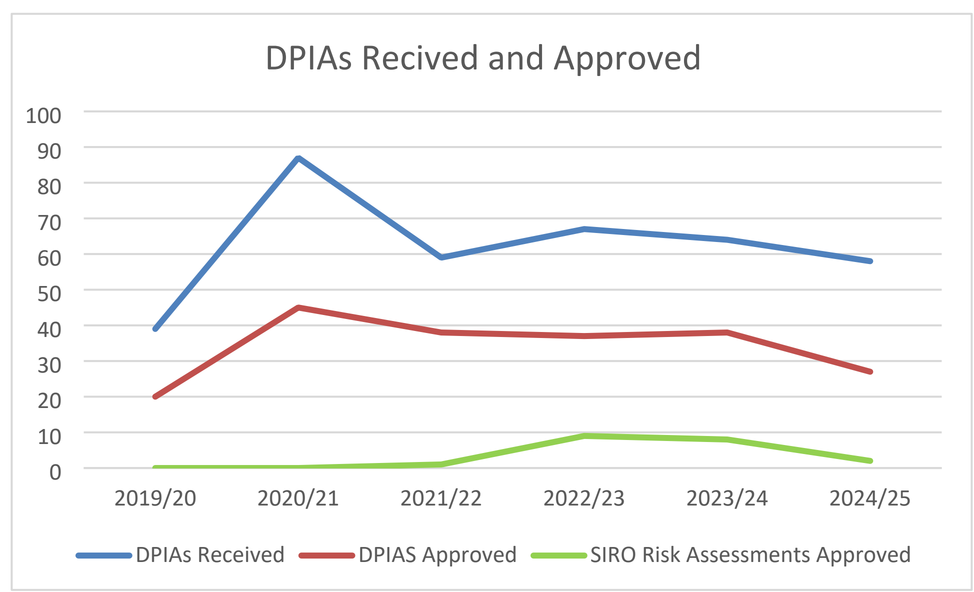
The Information Governance Toolkit Subgroup reports issues of significance into the Information Governance Group (IGG).

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.

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)



There were **58** requirements for a DPIA logged during 2024/25 with 27 of those being approved and an additional 2 being approved from 2023/24.

Status	Total
No Longer Required	10
Awaiting DPIA	1
Declined	0
Approved in 2024/25	27
In Progress	20

During 2024/25 there were 4 SIRO risk assessments submitted, 2 of these were approved with the remaining 2 still under review. These are required to be undertaken when a supplier does not meet the Cyber Security and Information Governance Welsh Health Circular

guidance WHC/2017/025. It should be noted that the WHC circular pre dates GDPR and the NIS regulations. The SIRO risk assessments aim to outline the risk mitigations and other assurances provided or put in place by the supplier in the absence of what is in the outdated guidance. Decisions to approve are made by the Senior Information Risk Owner (SIRO) after discussions with the Cyber, IT and Information Governance Teams.
Welsh Government have acknowledged the concerns raised nationally.

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.

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 put 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.

A proof of concept, data quality kite mark was developed in 2024. Initially focused on referral to treatment (RTT) waiting times data, this indicates levels of data quality in relation to timeliness, completeness, validity, consistency, duplication and (data warehouse) load processes. As this is refined it will be applied to further data sets and become a regular feature of information products published via the IRIS portal.

10.0 Policies and Procedures

During 2024/25 the following Information Governance policies and procedures were reviewed and approved in line with legislation:

- IG1 - Information Governance Strategy
- IG01 – Records Management Policy
- IG02 – Records Management Procedure
- IG03 – BCUHB FOI and EIR Procedures
- IG04 – Access to Information Policy
- IG07 – Procedure for dealing with SARs
- IG08 – Email Procedure Policy
- IG10 – Procedure for requesting approval and review of an information system
- IG14 – ICT Security Procedure
- IG17 – Photo Video Audio Procedure

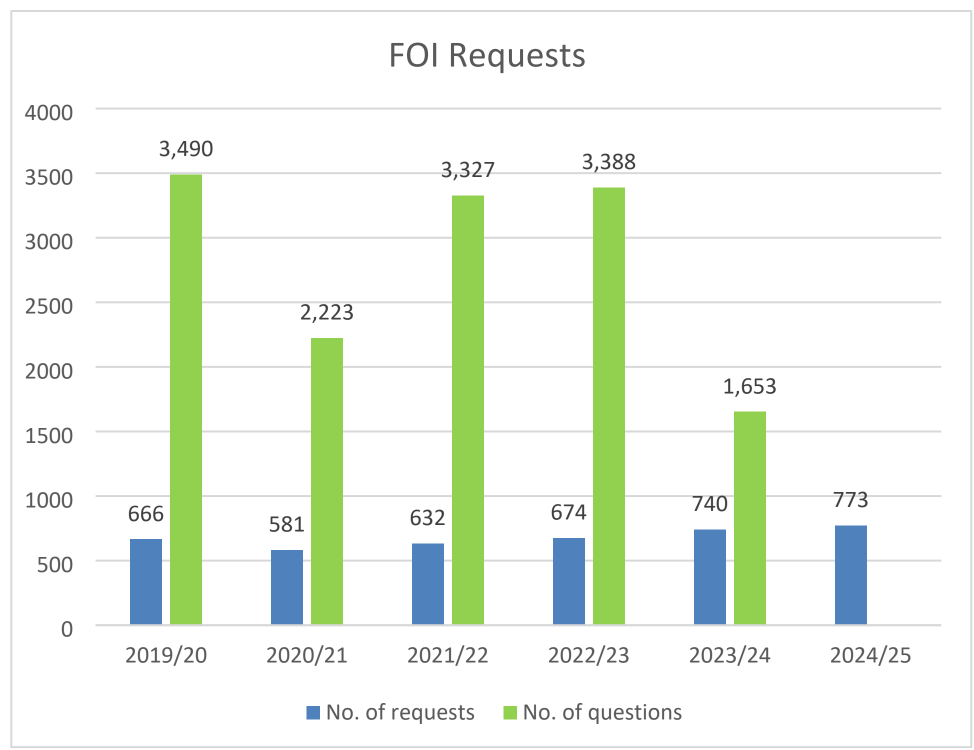
Policies and procedures will continue to be developed or updated during 2025/26 to further support the Information Governance Framework.

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.

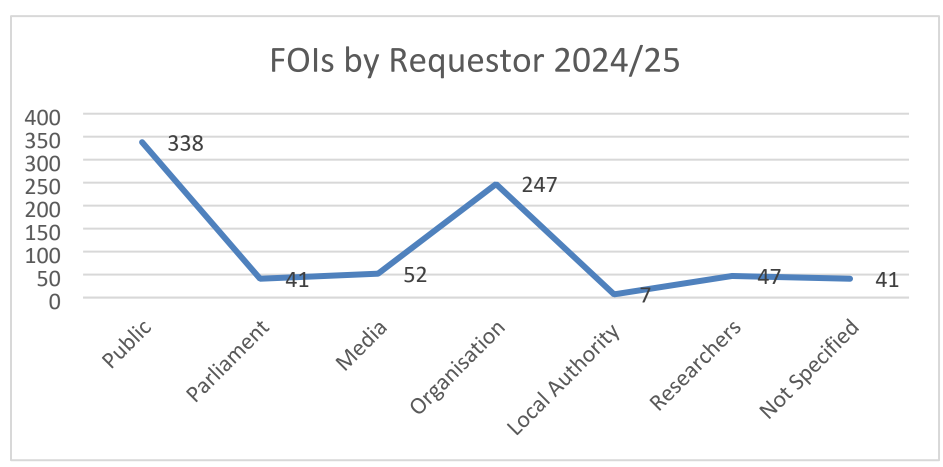
11.1 Freedom of Information Act 2000 / Environmental Information Regulations 2004 Requests

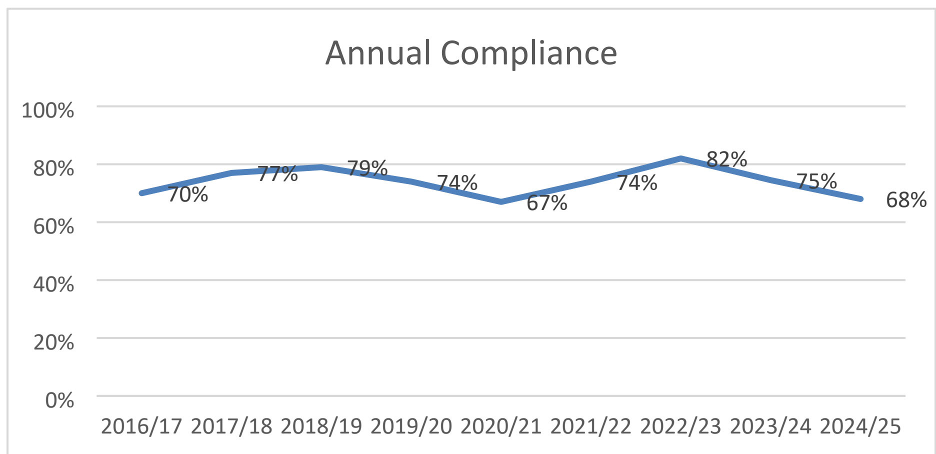
During 2024/25 BCUHB received and processed **773** Freedom of Information (FOI) requests, an increase of just over 4% from the previous year (740), with compliance decreasing from 75% to **68%.** This was due to the increase in the total number of requests being the most received to date and also a number of these being complex cases spanning across multiple services.



Please note due to the way in which the new FOI system records information we are unable to provide the total number of questions asked for 24/25.

The total number of hours spent processing these requests totalled 3136 hours. 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 12 requests in total for an internal review during 2024/25, a decrease compared to the 14 received in 2023/24. It should be noted a number of the internal reviews received are linked to complex cases.

FOIs received, Internal Reviews and exemptions applied 2024/25

Exemption	Exemption Category	Total	Internal Review	Upheld/ Overturned	ICO	Upheld/ Overturned
Section 17 – Refusal Notice	Section 12 – fee limit.	72	3	3 x upheld	-	-
Section 21 - Information accessible by other means	Absolute – No Public Interest Test required	24	0		-	-
Section 22 – Information intended for future public release	Class Based, so Public Interest Test assessed	0	0		-	-
Section 36 - Qualified Person Statement	Class Based, so Public Interest Test assessed	0	0		-	-
Section 31 – Law Enforcement	Class Based, so Public Interest Test assessed	3	0	-	-	-
Section 40 - Personal Information	Absolute – No Public Interest Test required	20	1	1 x upheld	-	-
Section 43 - Commercial interests	Class based, so Public Interest Test assessed	9	1	1 x upheld	1	1 x overturned
No Exemptions Used		645	7	3 x partial overturn 4 x upheld	-	-
Total		**773**	**12**	**-**	**1**	**-**

11.3 Data Protection Act Subject Access Requests (DPA SAR)

During 2024/25, **8,260** requests were received into the Health Board an increase from 6400 in 2023/24, with the average overall compliance increasing to **98.5%.** 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 **73** requests for information from North Wales Police during 2024/25. 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

During 2024/25, the UK Covid-19 Inquiry continued and subsequently closed, leading to the destruction of records previously affected by the embargo.

The Thirlwall inquiry continued to examine events at the Countess of Chester Hospital and their implications following the trial, and subsequent convictions, of a former neonatal nurse, but the Inquiry Chair drew all evidence and submissions in the Inquiry to a close at the end of March 2025. This Inquiry may still also require records to be held for longer than their minimum retention period. The embargo on the destruction of records remains in place.

12.0 Training

During 2024/25 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.

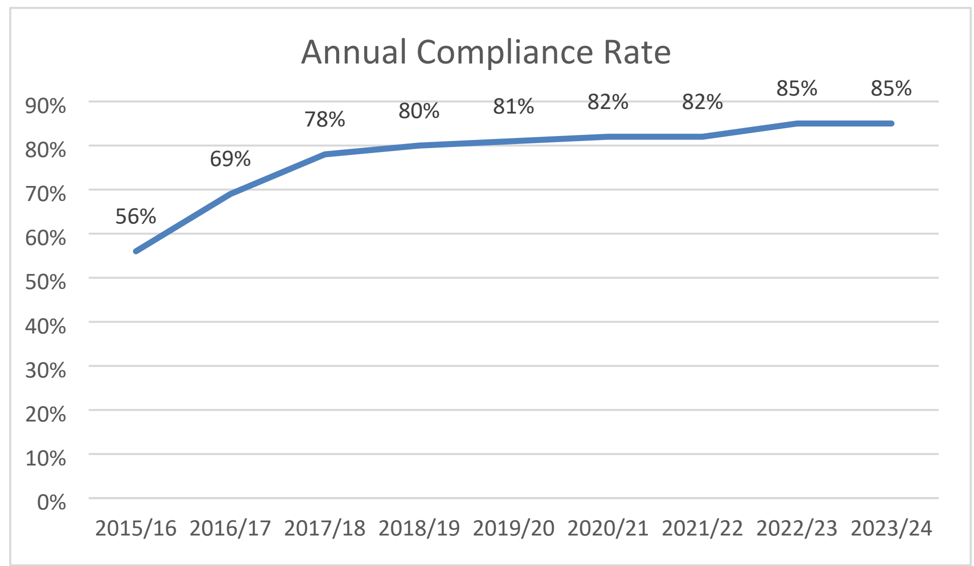
During 2024/25 we continued to hold our training sessions virtually on Microsoft Teams, with 19 sessions taking place across the year and **340** staff members completing these sessions.

During 2024/25 we also re-commended face to face training sessions in the lecture theatres and attending the Health Boards mandatory training days on the acute sites with 12 sessions

taking place and 73 staff members attending. **3,111** staff have also completed their training via E-Learning in this period.

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.

During 2024/25 Freedom of Information refresher training was provided to the Health Boards FOI Leads, with 44 leads attending the session, this will now become an annual event session to ensure all our staff who have the additional responsibility for assisting with FOI requests are up to date on FOI regulations and requirements.



13.0 Information Governance within Primary Care

Unfortunately, due to a change in reporting mechanisms from Digital Health and Care Wales (DHCW) we are unable to present data for the whole 96 practices within North Wales. However, we are able to provide data for the 12 BCUHB managed practices. Please see below:

Non-Submitters: **1**
Minimum Expectations Met: **11**
Minimum Expectations Not Met: **0**
Expectations Exceeded: **11**
Total Practices: **12**

During 2025/26 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 2025/26 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 2024/25 there has been a number of significant achievements across the Health Board which include:

- Continued to meet the objectives set within the BCUHB IG Strategy for 2024/25.
- Met the national compliance target of 85% for IG mandatory training incorporating the following actions:
  - Re-commenced face to face training sessions and attended the Health Boards Mandatory training days.
  - FOI workshop delivered.
  - Continued to target areas with a low compliance rate.
- Continued to meet statutory legal requirements and obligations with Data Protection Legislation and Freedom of Information Act 2000.
- Improved compliance with Data Protection Subject Access Requests to 98%.
- Successful submission of the All-Wales Information Governance Toolkit meeting all the minimum requirements and exceeding in 8 of the 11 requirements
- Continued collaborative working with DDaT to support the roll out of new projects and initiatives.
- Provided continuous IG support across BCUHB and national teams to help deliver and implement new ways of working / projects.
- Development and continued improvements made to the replacement Information Asset Register which now incorporates Cyber Security, Data Protection Impact Assessments and other key functionalities to ensure the full life Cycle of Information Assets are recorded.
- Full review and streamlining of the Data Protection Impact Assessment process undertaken.
- IG Business Continuity Pan fully reviewed and implemented.
- Records of Processing Activities (ROPA) review undertaken and a gap analysis conducted against the requirement. Alignment with the Information Asset Register.
- Introduced the new Information Governance compliance audit process as business as usual (BAU) with a view to further improvements to be made.

15.0 Conclusion

There has been continued improvements made over the last year despite increased workloads and pressures both nationally and locally within the team. The Information Governance Team has worked tirelessly to drive the IG agenda forwards in all areas. This has enabled the Health Board to continue to meet its legal and statutory duties. Despite this increase we have continued to:

Be consistent in our approach to the IG toolkit submissions for the past six years to Digital Health & Care Wales (DHCW). There is ownership and accountability in place across the Health Board to ensure the requirements are either met or have action plans in place which are being worked towards. The department will continue to strive to make the necessary improvements and are already preparing for the next submission of the updated 2025/26 toolkit. One of the main focuses for this period was to look at the requirements of Records of Processing Activities (ROPA), this was undertaken successfully and has been incorporated into the Information Asset Register. This year there is a new section which requires assurance around CCTV, colleagues in Security and Estates will work closely with Information Governance to meet the requirements.

Improving staff training and awareness will continue to be driven forward by the IG Department. We have continued to remain consistent and maintained compliance above the National target of 85%. During 2025/26 we will continue to monitor compliance in all services and target areas of low compliance.

We have continued to support the management of complex complaints / incidents, sometimes totalling hundreds of hours of resources required. Work continues to learn from these cases and address the gaps in systems and processes, which will be reported through the Information Governance Key Performance Indicator reports to the Information Governance Group and on to the Performance, Finance and Information Governance Committee (PFIG).

We look forward to seeing the benefits of the recent upgrades made to the improved Information Asset Register which will provide detailed information and give assurance to the board around the management and oversight of our Information assets and the whole lifecycle journey of those assets.

The Information Governance Department continues to have robust monitoring and reporting arrangements in place which are continuously reviewed. The work output continued to increase in most areas for this period which resulted in additional pressures being placed on the whole department. This was due to increased requests for information, supporting new initiatives, national projects and programmes of work. In addition, the team had reduced capacity due to a senior role being on maternity leave, which resulted in the team having to pull together even more due to the restrictions on recruitment to cover the leave.

The overall achievements within this report once again should be recognised, as there has been continuous improvements throughout. There has always been a continued drive and commitment from the team to improve year on year in order to maintain a robust Information Governance framework. It is acknowledged that there are still many areas for improvement which the team will continue to work with all staff to achieve.

16.0 Looking forward

The main emphasis for 2025/26 will be to ensure there is continued improvements made throughout the Health Board and appropriate support is provided to all areas. Plans are already in place for the following high-level objectives which have been included in the IG Operational work plan for 2025/26:

- Delivery of the objectives in the Information Governance Strategy for 2025/26:
- Ensuring that BCUHB continues to meet its legal and statutory obligations as defined in the Data Protection Act 2018, UK GDPR, European GDPR 2016, Data Access Use Bill which has recently received royal accent 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). In the absence of an agreed Corporate Records Management function, we will support staff as best we can on how to manage their records. Until this is in place it is

not clear where accountability lies. Corporate Records should be recognised as a core corporate function and needs to be appropriately resourced.

- 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 minimum national target of 85% with an aim to meet the exceeded target of 95% to help improve staff understanding and continuous awareness.
- Strengthen relationships with IHC clusters to improve Information Governance compliance with Primary Care Contractors.
- Increase service user and Regulator confidence in the Health Board and its staff with increased visibility and working relationships, including a refresh of the IG Webpages and the exploration of introducing IG Champions.
- Encourage and support the professional development of team members by providing opportunities for training, skill enhancement, and knowledge acquisition in relevant areas and to include the development of training programmes.
- Continue to support and implement the remaining actions from the IG Rapid Review undertaken by Veritau.
- Fully embed the updated Information Asset Register within the organisation, providing support to Information Asset Owners and Administrators, provide training and risk assess all assets.
- Continue to pro-actively look at ways to increase the amount of information the Health Board publishes on our publication scheme.
- Continue to support and work collaboratively with specialist teams to promote and consider the introduction of Artificial Intelligence (AI) where permitted ensuring all biases have been taken into consideration.
- Ensure priorities set for the 2024/25 IG toolkit submission are implemented, and work with the IG Toolkit leads to improve standards for the 2025/26 toolkit submission.

**** Further details and a breakdown of the Information Governance work plan can be requested from the Head of Information Governance***

Quality Safety & Experience Committee

CORPORATE GOVERNANCE REPORT

Dyddiad y Cyfarfod **Date of Meeting**	24 February 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
- **NOTE** the forward workplan

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 18 December 2025:

- Llandudno Orthopaedic Hub
- Performance Data Delays

4.2 **Committee Forward Work Plan**

4.2.1 The Forward Work Plan sets out the Committee's priorities and scheduled business outside of the normal Cycle of Business, helping ensure a structured, timely, and transparent approach to decision-making and oversight. It collates suggested referral items from other Committees and the Board.

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

5.1 There are no matters for escalation.

6 **ARGYMHELLION**
RECOMMENDATIONS

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

- **NOTE** the matters considered in Private at the 6 November 2025 meeting.
- **NOTE** The Committee forward workplan.

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: 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**	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report

Have you considered the Armed Forces Covenant Due Regard Duty?		
Asesiad o Effaith ar Ddiogelu Data *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?* **Data Protection Impact Assessment** *Have you undertaken a Data Protection Impact Assessment Screening?*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report
Asesiad o Effaith ar Atal Twyll *A ydych chi wedi ystyried yr effeithiau ar atal twyll?* **Counter Fraud Impact Assessment** *Have you considered the counter fraud impacts*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report
Cyfreithiol **Legal**	There are no specific legal implications related to the activity outlined in this report.	
Enw Da **Reputational**	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith ar Adnoddau *(Pobl / Ariannol)* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

Performance, Finance & Information Governance Committee – Non-Routine Committee Business Workplan

This forward plan is only to be used for one-off Adhoc items that do not require inclusion as routine business on the Annual Committee Cycle of Business.

Date of Request	Origin of Request	Requestor	Item Summary / Title	Nature of Request	Lead Officer	Executive Lead	Intended Meeting Date	Status
19.01.26	PFIG Agenda Setting 19.01.26	PFIG	Evaluation of Business Cases Implemented	Review Business Cases and identify those for review	TBC	Russ Caldicott	April 2026	
18.12.25	PFIG Meeting 18.12.25	Chair	Allied Health Professional Bank Update	Update on the AHP bank to be received at the October 2026 meeting to review progress.	Nick Graham	Russ Caldicott	October 2026	To be included on Oct 2026 agenda.
12.11.25	PFIG agenda setting 12.11.25	PFIG	Performance Management Framework	Update to be deferred to January 2026 meeting	Russ Caldicott	Russ Caldicott	January 2026	To be included on Jan 2026 agenda. January Meeting stood down. To be discussed in February meeting. 19.01.26 – on Feb draft agenda
25.06.25	PFIG 25.06.25	PFIG	Corporate Services Financial Overview	Return with an update on Corporate Services Financial overview towards the end of the calendar year.	Russ Caldicott	Russ Caldicott	April 2026	Discussed in agenda setting 24.09.25 – deferred to Jan 2026 meeting January Meeting stood down. To return in April.
27.03.25	Action from Board 25/66.2	Board	Commissioning Review	Complete a commissioning review relating to funding for the third sector and report back to the PFIG Committee with progress noted to the PPHP Committee.	Russ Caldicott	Russ Caldicott Gareth Williams Pam Wenger	TBC	
25.02.25	PFIG 25.02.25	Chair	Shared Services and how we manage our own internal processes		Russ Caldicott	Executive Director of Finance	TBC	
20.10.24	PFIG 30.4.24	Chair	Planning Independent Review	To schedule Planning within the Board Development programme and schedule the Review's action plan update to the August PFIGC meeting.	Pam Wenger	Director of Corporate Governance		Initial session scheduled for July 24 and further sessions to be included in the Board Development Plan. To be included on the forward work plans **25.6.24** Committee requested to leave open until completed **20.10.24** Suggest add to the Forward Plan and consider for the December meeting.
11.07.24	Action from Private Board Meeting Action 24/122.4	Pam Wenger via email	Bangor Health & Wellbeing Centre	Pam requested this is on the PFIG forward workplan – Action from Board "Outline the future governance route of Bangor H&WB Centre development, and	Pam Wenger	Pam Wenger	TBC	

				ensure that the Board is provided with regular progress updates"				
27.8.24	Action from PFIG 27.08.24	PFIG	Integrated Performance Report	Integrated Performance Report Invite Russ to give an overview on how the Integrated Planning Framework is operating.	Russ Caldicott		TBC	On agenda for Feburay 26

Closed

18.11.25	Request via email	Pam Wenger	NWJCC Highlight Report	For information – from JC Meeting on 16.09.25	Pam Wenger	Pam Wenger	18.12.25	24.11.25 – PPJ to include in Corporate Governance Report for Dec 2025 meeting. Discussed in December meeting. Complete.
13.10.25	Request via email	Matthew Joyes	Legal Update	Deferred to December 25 meeting from November 25 meeting	Matthew Joyes	Pam Wenger	18.12.25	To be included on Dec 2025 agenda. Discussed in December meeting. Complete
20.03.25	Via email from Joanne Janes, Commissioning Manager, MHLD 06.03.25	Joanne Janes	Recommission of the Substance Misuse Detoxification Service	The MHLD Directorate are looking to gain Corporate approval to recommission the substance misuse detoxification service as the current contract expires in 2025.	Joanne Janes	Teresa Owen	29.04.25	complete
5.11.24	Audit Committee 5.11.24	Audit Committee 5.11.24	Internal Audit Progress Report	Due to lack of regular oversight of the Llandudno Hospital Orthopaedic Surgical Hub, note this via PFIG Committee and provide an update back to Audit Committee. Potentially invite Chris Stockport to join the January 2025 Audit Committee meeting.		Executive Director of Finance	TBC	Complete
25.7.24	Action from 25.7.24 Public Board meeting	Health Board action	24/154.9 Performance report	Follow up on the lack of contemporaneous performance data within the Performance report given that Financial reporting was made available to the Board in a timely manner. Explore strong variation between East, West and Centre and whether successful progress within one area was sufficiently shared to learn lessons elsewhere.	Director of Performance and Commissioning	Executive Director Finance	December 2024	Complete.

Performance Finance & Information Governance Committee

CORPORATE RISK REGISTER

Dyddiad y Cyfarfod **Date of Meeting**	24 February 2026
Statws Cyhoeddi **Publication Status**	Open/ Public Not Applicable
Enw a theitl Awdur(on) yr Adroddiad **Report Author name and title**	Nesta Collingridge, 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**	For Assurance

Crynodeb Gweithredol
Executive Summary

The Committee is asked to **receive assurance** of the three updated Corporate Risks and will fall under the remit and oversight of the Performance, Finance and Information Governance Committee (see appendix 3):

- CRR25-06 'Value Delivery and Financial Sustainability'
- CRR25-09 'Safe Environment'
- CRR25-10 'Health and Safety'

No proposed changes in risk scoring. All 3 risks have a current risk score which sits outside the risk tolerance level set within the risk appetite.

Action Progress

A total of 19 actions have been developed across the three corporate risks.

- 4 actions are complete
- 15 actions are progressing

A number of additional actions across several risks fall due in March 2026, and these require ongoing monitoring to ensure that timescales remain realistic and achievable.

Risk Scrutiny and Governance
All corporate risks have been reviewed and updated by Executive Leads. The following risks have undergone recent deep dive review at the Risk Scrutiny Group (RSG):

- September 2025: CRR25-06 'Value Delivery and Financial Sustainability'
- November 2025: CRR25-09 'Safe Environment' and CRR25-10 'Health and Safety'.

The Committee is asked to:

- Note progress and receive assurance.

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**
Head of Risk Management	16/01/2026	The Head of Risk Management conducted an assessment on all corporate risks, this has been presented to RSG and the risk leads. The risk action plans are both due to be updated and should be outcome focused and measurable (including metrics where possible). However, assurance is provided to this committee that the majority of actions are correct and in line with reducing the score, minor changes suggested.
Risk Scrutiny Group : CRR25-09 'Safe Environment' and CRR25-10 'Health and Safety'.	November 2025	Feedback following the group to review the action plan has been completed, making the risk action plan in line with the description

		and avoiding duplication from the BAF.

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 Quality, Safety and Experience Committee (see appendix 3):

- CRR25-06 'Value Delivery and Financial Sustainability'
- CRR25-09 'Safe Environment'
- CRR25-10 'Health and Safety'

2. Y CEFNDIR
BACKGROUND

Following two informal Executive Committee Development sessions to review the Corporate Risk Register, held on the 16th July and 20th August, it was decided that the current Corporate Risk Register would benefit from consolidation of the current 26 risks to a more strategic Corporate Risk Register for presentation to the Board and oversight at relevant committees.

As a result, the Corporate Risk Register now consists of 11 strategic risks, of which 3 risks will fall under the remit of the Performance, Finance and Information Governance Committee

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

Overdue/Delayed Actions

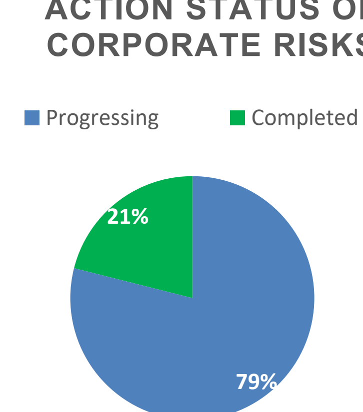
None

Risks above Health Board 25/26 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, 19 actions have been developed to mitigate the risks, with 15 open actions progressing and on track. 4 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. Both risks have a current risk score which sits outside the risk tolerance level set within the risk appetite.

5. ARGYMHELLION RECOMMENDATIONS

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

- **Note** the update on the three strategic risks **CRR25-06** and **CRR25-09, CRR25-10** and remaining above the Health Board's risk tolerance**.**
- **Endorse** both risks for submission to the Board**,** noting no proposed scoring changes.

6. CAMAU NESAF NEXT STEPS

1. Risk Scrutiny Group deep dive and considering feedback from the group and Head of Risk Management.
2. Approved Corporate Risks to be monitored as business as usual by senior risk leads, Executives, the Risk Scrutiny Group and the Executive Committee
3. Submission of Corporate Risks to Board.

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**	People First Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd **Corporate Risks and Board Assurance Framework**	Corporate Risks linked to Board Assurance Framework risks
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**	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	

Have you undertaken a Socio-Economic Impact Assessment		
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	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:	
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**	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.	

Appendix 1 - Corporate Risk Register Dashboard – Performance, Finance and Information Governance (PFIGC) – January 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	4	2	0	
DoE	CRR25-09	Safe Environment	4x5 20	12	Regulatory (<15) Above Tolerance	Performance, Finance and Information Governance Committee	9	0	0	Review of the risk undertaken by the service to align to operational aspects of the risk
DoE	CRR25-10	Health and Safety	4x4 16	8	Regulatory (<15) Above Tolerance	Performance, Finance and Information Governance Committee	6	2	0	6 open actions, 2 actions completed with 4 open actions on track

Key:

Executive Lead	
Executive Director of Finance	EDoF
Director of Estates and Environment	DoE

Appendix 2 – Corporate Risk Register Heatmap

Corporate Risk Register Heat Map – Jan 26

Impact							
Catastrophic	5				Extreme • **Timely Patient Access to Safe and Effective Care** • **Modernising our Infrastructure** • **Value Delivery and Financial Sustainability** • **ICT Failure and Cyber**	Extreme
Major	4				• **Future Demand & Sustainable Workforce** • **Population Needs** • **Leadership and Operating Model** • **Non-Compliance with Regulatory and Legislative Requirements** • **Health and Safety**	Extreme • **Safe Environment**
Moderate	3				• **Strategic Change – Impacting Care and Staff Delivery**	
Minor	2					
Negligible	1					
		1	2	3	4	5
		Rare	Unlikely	Possible	Likely	Almost Certain 2

Possibility

Corporate Risks

Performance, Finance and Information Governance Committee

Appendix 3 - Corporate Risk Register PFIGC Committee – January 2026

<table>
<tr><td rowspan="2">CRR25-06</td><td colspan="2">Risk Title: Value Delivery and Financial Sustainability</td><td>Date Opened: 21/08/2025
(version 2 refined from 01/04/2024)</td></tr>
<tr><td colspan="2">Assuring Committee: Performance, Finance and Information Governance Committee</td><td>Date Last Committee Review: 22/10/2025</td></tr>
<tr><td>Date Last Reviewed:
22/12/2025</td><td>Director Lead: Executive Director of Finance</td><td>Link to BAF: BAF24-03</td><td>Target Risk Date: 31/03/2026</td></tr>
<tr><td colspan="4">There is a risk that the Health Board is unable to secure current non-recurrent (one off) allocations in future financial years, these allocations conditional on attainment of financial plans. If this reosurce is not secured then services will be required to deliver within a reduced envelop of funds and as a consequence patients may experience patient harm, reduced access to high-quality, timely and innovative care. The objective is to achieve long-term financial sustainability or maximise value from its spending.
The key risks centre upon cost overruns from out of area referrals for mental health patients and patient flow out of the Hospital resulting in cost exposure from requiring additional capacity areas to remain open and additional costs within Emergency Care front of house, combined with an inability to deliver savings plans, reduced investment in transformation.</td></tr>
</table>

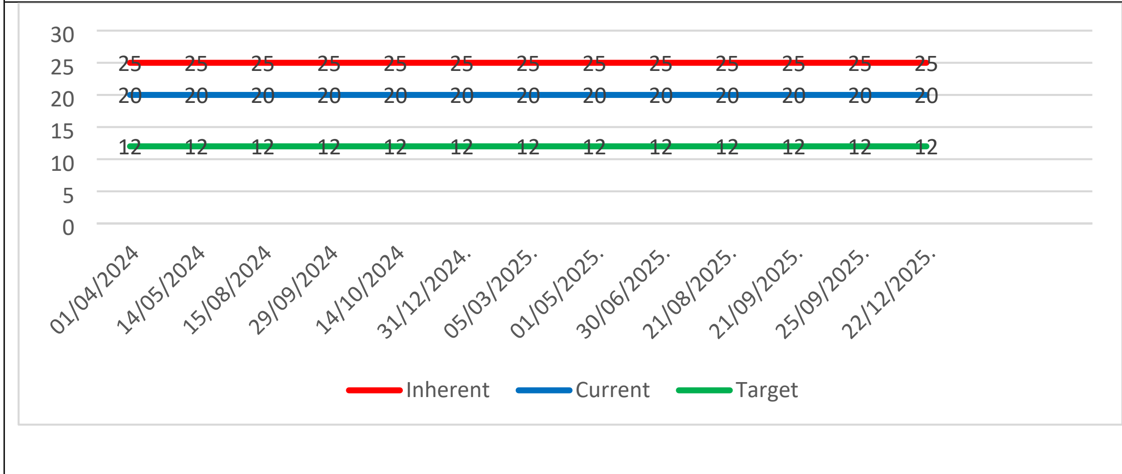
Mitigations/Controls in place	Additional Controls required
1. Core Savings targets for IHCs, Non-IHC Directorate and Corporate functions have been issued and performance to be challenged at Integrated Performance Executive Delivery Group – chaired by the Chief Executive. 2. Value and Sustainability programme 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.	a. Prior year and current year financial performance material deterioration and therefore additional actions are required to control the run rate and reduce the deficit to a balanced position. These have been previously endorsed for implementation

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 excluding Mental Health. Mental Health to be included 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.	through the Integrated Performance – Executive Delivery Group. b. 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 c. 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 d. Gaps in delivery of savings targets mandated to be met on a recurrent basis e. Escalation meetings where improvements are not realised will continue to be held with leadership teams by the Chief Executive. In these forums support is offered to improve performance and trajectories supported for improvement. f. Prioritisation exercise involving £42m transformation funding received on a conditionally recurrently basis to the end of 2025/26 completed for clinical schemes, with

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 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	requirement to disinvest / identify alternative funding streams prior to new developments being funded. g. Consideration of additional strengthening of enhanced establishment controls and vacancy freeze for non-patient facing roles and continued reduction in variable staffing costs

Actions	Action Owner	Due Date	Progression Analysis
B 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	Director of Finance (DoF)	30/11/2025	Complete
C Enhanced 'Check and Challenge' discussions with Chief Finance Officers, on a monthly basis, to ensure the forecast expenditure is robust. Escalation of Out of Area Mental Health Placements, through the Chief Executive Officer. Maintain increased controls.	Director of Finance	31/03/2026	Progressing

B Continued oversight and holding to account via the Integrated Performance Executive Delivery Group, and holding to account against expenditure control reductions identified for the remainder of the financial year.	Chief Executive Officer (CEO) / Director of Finance	Monthly	Progressing
Directorate teams to review medical devices capital replacement plans. 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



	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		

<table>
<tr><td rowspan="2">CRR 25-09</td><td colspan="2">Risk Title: Safe Environment</td><td>Date Opened: 04/01/2024</td></tr>
<tr><td colspan="2">Assuring Committee: Performance, Finance and Information Governance Committee</td><td>Date Last Committee Review: 22/10/2025.</td></tr>
<tr><td>Date Last Reviewed:
23/01/2026</td><td>Director Lead: Director of Environment and Estates</td><td>Link to BAF: BAF 24-03</td><td>Target Risk Date: 31/03/2030</td></tr>
<tr><td colspan="4">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.</td></tr>
</table>

Mitigations/Controls in place	Additional Controls required
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	a) 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. b) 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. c) Ensure that the Health Board has an Estates rationalisation programme in place that will support the

£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 aligns with the capital prioritisation form that we will submit to Welsh Government.	capital prioritisation programme and reduce backlog maintenance. d) Internal Audit review of Fire Safety – Agreed Management Action Plan being implemented and being managed through the Fire Safety Management Group e) Timely progression of major Capital Schemes which address Estates Safety such as Wrexham Maelor Continuity Plan – Phase and Ysbyty Gwynedd PBC f) Assurance around the progress made with the BCUHB Estates Strategy and the lack of clarity around the BCUHB Clinical Strategy. g) Internal Audit review of Asbestos Management – Agreed Management Action Plan developed and managed through the Asbestos Management Group h) NWSSP Authorising Engineer – Water – Audit on water safety undertaken and agreed action developed to improve compliance which are reported at the Water Safety Group i) NWSSP Authorising Engineer – Electrical– Audit on Electrical Systems undertaken and agreed action developed to improve compliance which are reported at the Electrical Safety Group

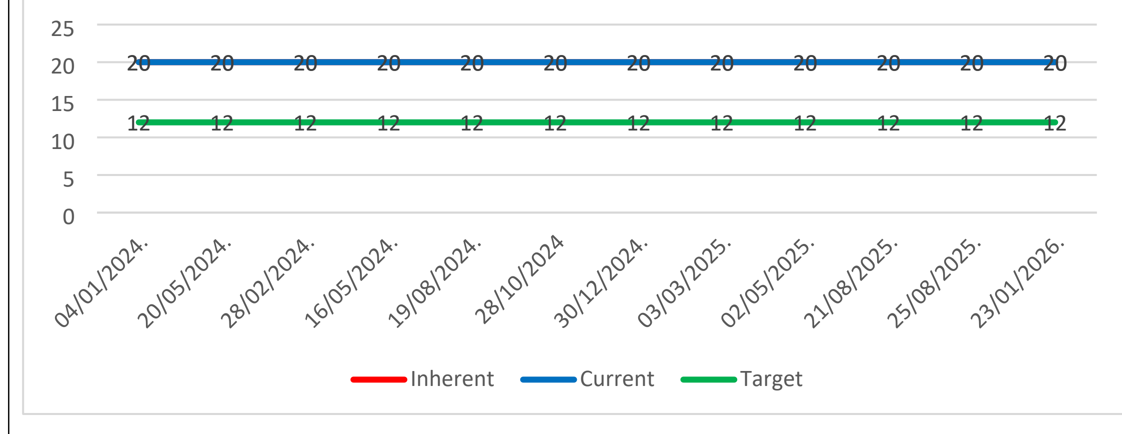
12. Updated agreed protocol for use of Annual Discretionary Slippage in place for developing Business Justification Cases (BJC) for essential estates works and discretionary capital schemes that could be aligned with in-year additional Capital Funding provided by WG. 13. Review of Reinforced Autoclaved 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	

Actions	Action Owner	Due Date	Progression Analysis
a.) 6-Facet Survey Undertake actions to deliver a 6-facet survey across the Health Board over the next 5 years. Due to financial constraints within the Health Board a review of the 6-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** - Functional Suitability Review	Head of Operational Estates	31/03/2027	Progressing

Facet 4 - Environmental Management Audit **Facet 5** - Space Utilisation **Facet 6 -** Quality of the Environment			
b.) Develop ToR Develop a standardised Terms of Reference to be considered and endorsed by Capital Investment Group	Director of Environment & Estates	31/03/2026	Progressing
c.) Estates Rationalisation Programme Undertake action to deliver a Health Board Estates Rationalisation Programme. Estates Rationalisation Programme being developed and in draft format. The Draft will be submitted to a multi-disciplinary group for initial comment, with a final version to be ratified by Capital Investment Group. Health Board Rationalisation Programme to be presented to CIG on 12th September 2024. Estate's rationalisation plan is being reviewed and updated taking into account disposal that have been approved in 2024-2025 and opportunity for disposals in 2025-2026 as part of rationalisation of our estates that supports the Caledfryn Project.	Head of Operational Estates	31/03/2026	Progressing
d.) 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	Head of Operational Estates	31/03/2030	Progressing

Infrastructure Board. In response to Programme Business Case Welsh Government have asked the Health Board to identify within the Programme Business Case those elements that relate to Fire safety only. Wrexham Maelor - Health Board submitted a PBC to address the infrastructure compliance issues on the Ysbyty Maelor site (Wrexham Resilience Programme) through the Welsh Government Infrastructure Board. In response to Programme Business Case, Welsh Government have asked the Health Board to identify high risk priority improvement projects			
e.) 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	Director of Environment & Estates	31/03/2026	Progressing
f.) BCUHB Estates Strategy Progress with delivering on the Estates Strategy by engagement with stakeholders across BCUHB and identifying a number of common themes around strategic ambitions for the estate that aligns with the Health Board's Clinical Strategy.	Director of Environment & Estates	31/03/2026	Progressing

g.) 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	Head of Operational Estates	31/03/2026	Progressing
h.) 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	Head of Operational Estates	31/03/2026	Progressing
i.) 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	Head of Operational Estates	31/03/2028	Progressing
	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 was £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 6 facet survey for the Estates, these surveys will commence in 2024 focussing on Acute sites and then community hospitals with a target to complete within 2 years. This will be a significant part of the estates 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 aligns 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 2025. 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.

<table>
<tr><td rowspan="2">CRR 25-10</td><td colspan="2">Risk Title: Health and Safety</td><td>Date Opened: 21/08/2025</td></tr>
<tr><td colspan="2">Assuring Committee: Performance, Finance and Information Governance Committee</td><td>Date Last Committee Review: 22/10/2025</td></tr>
<tr><td>Date Last Reviewed:
11/12/2025</td><td>Director Lead: Director of Environment and Estates</td><td>Link to BAF: BAF24-03</td><td>Target Risk Date: 31/03/2026</td></tr>
<tr><td colspan="4">There is a risk that the organisation will not maintain a safe environment for staff and patients in line with health and safety legislation.
This may be caused by inadequate oversight of health and safety risks, gaps in estates and equipment compliance, and insufficient resources to address safety priorities.
This may lead to patient and staff harm, enforcement action, reputational damage, and increased legal claims</td></tr>
</table>

Mitigations/Controls in place	Additional Controls required
1. Gap Analysis has been reviewed. Strategy and plan to March 2026. 2. NHS Employer Health and Safety Standards are being developed 3. Health and Safety Policies report into the Strategic Occupational Health & Safety Group (SOSHG). 4. Health and Safety eLearning and short courses in place. 5. Health and Safety Policies and Procedures are on BetsiNet. 6. Programme of Health and Safety Reviews are in place.	a) A review of resources required following the internal audit. b) BCUHB Executive Team and Board of Directors to complete health and safety training. c) The business model aligned to the NHS Manual Handling Passport Scheme to be reviewed d) Investment in training venues is required for manual handling training delivery. e) Senior Leaders to nominate staff to support with Divisional delivery of manual handling refresher training.

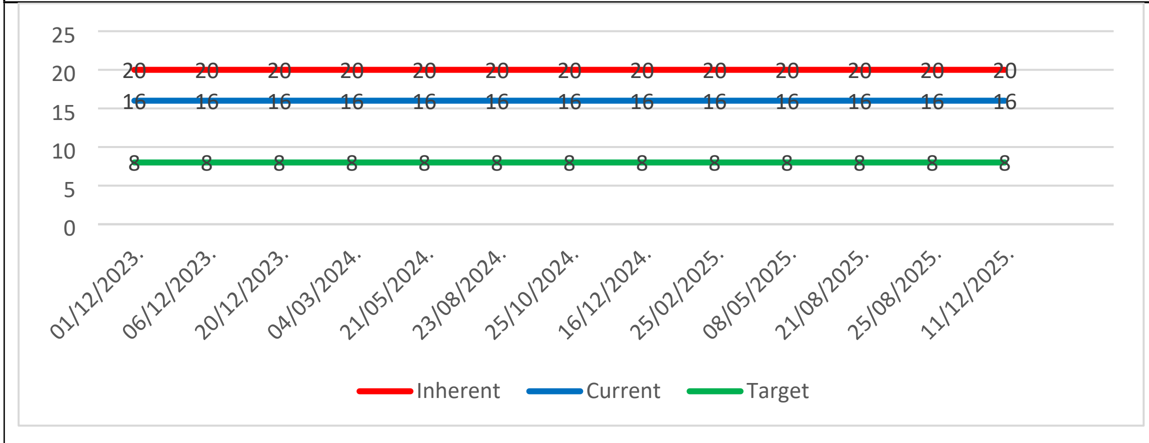
7. Programme of Health and Safety Self-Assessments are in place for completion twice yearly. 8. Health and Safety presentation delivered to Board members in February 2025, to raise awareness of requirements.	f) Review of health and safety policies within the next 12-24 months. g) A Health and Safety Risk Assessment and Management Framework needs developing. h) A pan BCUHB Health, Safety and Security Training Needs Analysis is required. i) Utilise the Violence Prevention and Reduction Standards to provide a framework for a safer environment. j) Intranet pages for Health, Safety and Security Services require development.

Actions	Action Owner	Due Date	Progression Analysis
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	Head of Health, Safety and Security	31/12/2025	Complete

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.			
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. 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 01/08/2026.	Director of Estates	01/08/2026	Progressing (revised date from 31/03/2026)
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	31/12/2025	Complete

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, and a completed 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. Address audit recommendations, ensures adequate resourcing, and supports delivery of Health & Safety objectives across BCUHB. Complete the resource review and business case by September 2026, following confirmation of Foundations for the Future outcomes.	Director of Estates	30/09/2026	Progressing (revised date from 31/12/2025)
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.	Director of Estates	31/08/2026	Progressing (revised date from 31/07/2025)
Implement an Electronic Document Management System (EDMS) across BCUHB to centralise health and safety compliance reporting and risk management documentation. Ensure 100% of health and safety risk assessments, compliance reports, and key	Director of Estates	01/01/2027	Progressing

documentation are uploaded and accessible through the EDMS within 12 months of go-live. Risk Management software is already approved; project team and resources will be allocated by Head of Health, Safety and Security for the health and safety element to support implementation. Improves transparency of health and safety risks, enhances visibility, and reduces non-compliance by enabling easy access and sharing of documentation. Complete EDMS implementation and staff training by **December 2026**, with full operational use from **January 2027**.



	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 & 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 in summer 2024, with Health and Safety moving from Workforce Directorate to a new role of Director of Environment, reporting directly to CEO (Chief Executive Officer)