Bundle BCU Planning, Population Health and Partnerships Committee 3 September 2026

1 SUPPORTING PAPERS

1.1 PP26.93 Supporting Papers for Estates Strategy - Update
- PP26.93.1 Appendix 1 - Estates Strategy

1.2 PP26.97 Supporting Papers for Enhancing Care through Digital Development Report
- PP26.97.1 Appendix 1 - Benefits Management Framework
- PP26.97.2 Appendix 2 - Benefits Summary
- PP26.97.3 Appendix 3 - Digital Portfolio Prioritisation Framework
- PP26.97.4 Appendix 4 - PPMO Dashboard July 2026
- PP26.97.5 Appendix 5 - Digital Update July 2026

1.3 PP26.98 Supporting Papers for North Wales Approach to Prevention: Wellbeing, Prevention, Anchor Framework and Marmot Place
- PP26.98.1 Appendix 1 PPHP Prevention Missions V1
- PP26.98.2 Appendix 2 PPHP Anchor Charter

1.4 PP26.106 Supporting Papers for Health Improvement Menu of Interventions Report
- PP26.106.1 Draft BCUHB Health Improvement Menu of Interventions PPHP 03Sep26 v4

1.5 PP26.109 Supporting Papers for Board Assurance Framework 2026-2027
- PP26.109.1 Appendix 1 - PPHP Portal - Board Assurance Framework
- PP26.109.2 Appendix 2 - Extant Open BAF Actions - Mapping to new BAF to carry over

1.6 PP26.110 Supporting Papers for Corporate Governance Report
- PP26.110.1 Appendix 1 - Workplan for PPHP Committee (Live Version as at 12.08.26)
- PP26.110.2 Appendix 2 - Planning Population Health and Partnerships Committee ToR V1.01
- PP26.110.3 Appendix 3 - PPHP Committee Annual Report 2025-26 V1.0
- PP26.110.4 Appendix 4 - PPHP Committee Self Assessment Presentation 2025-26 V1.0

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

BCUHB
Estate Strategy

Final Report v1.0

27th January 2023

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Foreword

This document sets out BCUHB's Estate Strategy to 2033. The strategy has been developed between October - December 2022, building upon the previous (2019) estate strategy and includes the most recent data submitted to the Welsh Government via the Estates and Facilities Performance Management System (EFPMS) and published in October 2022.

The estate strategy has been developed to align with current BCUHB strategies including Living Healthier, Staying Well, Clinical Services Strategy, Digital Strategy, People Strategy and Plan, and the Decarbonisation Action Plan. Development of the strategy has included engagement with key stakeholders and regular reporting via forums including BCUHB's Capital Investment Group, Health Board Leadership Team, Clinical Senate, Board, and Community Health Council workshops.

Since the previous estate strategy was completed in Feb 2019 the COVID-19 pandemic has had a significant impact upon the Board's estate, particularly in terms of capacity, suitability and shifts to digital, which is reflected in the analyses and recommendations below.

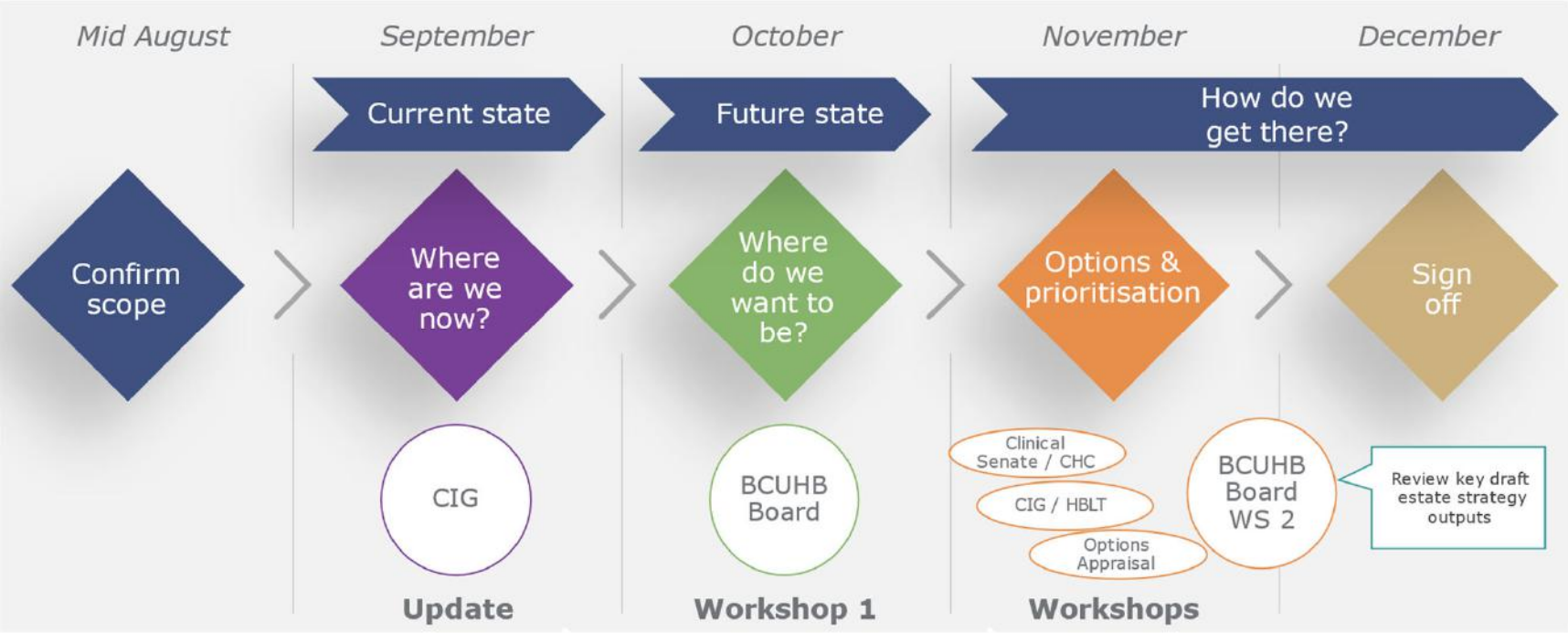
The document is structured to reflect national guidance and to answer the three key questions – Where are we now?, Where do we want to be ?, How do we get there?

The estate strategy will be continually reviewed to ensure alignment with the Integrated Medium Term Plan cycle.

1.0 Introduction

1.1 Background and Context

This Estate Strategy provides a refresh of the 2019 Betsi Cadwaladr University Health Board (BCUHB) Estate Strategy. It was developed over a four month period from September to December 2022 using the traditional 'Where, Where, How' approach (summarised below). Key tasks undertaken during the three phases include desk top review of key strategy and estates information, quantitative and qualitative analysis of existing available estate data and information, and stakeholder engagement via interviews and workshops (please refer to Appendix 1).



2.0 Current State (Where Are We now?)

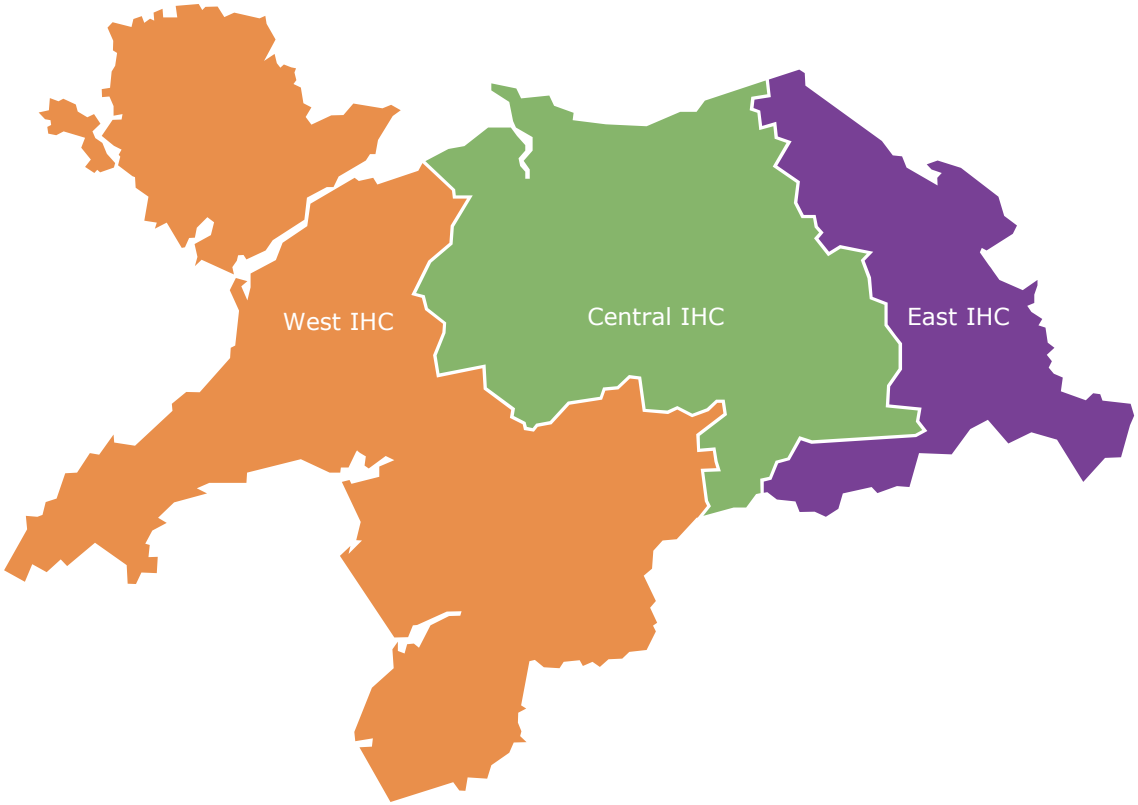
2.1 Existing Estate Overview

BCUHB currently has one of the largest property portfolios in Wales; services are delivered from c.238 properties (a total of c.420,000 m2) with a value of £569m[1] and an annual running cost of £73m[2] in 21/22.

Existing Estate Profile and Localities

Our services are delivered from, and our staff are based at a total of 238 properties (including GP owned, third party developer and private landlord primary care premises). The accommodation also hosts staff and services from other organisations including local authority and third sector.

A detailed breakdown of location and function of our estate across the three Integrated Health Communities (IHCs) is provided in Appendix 2.



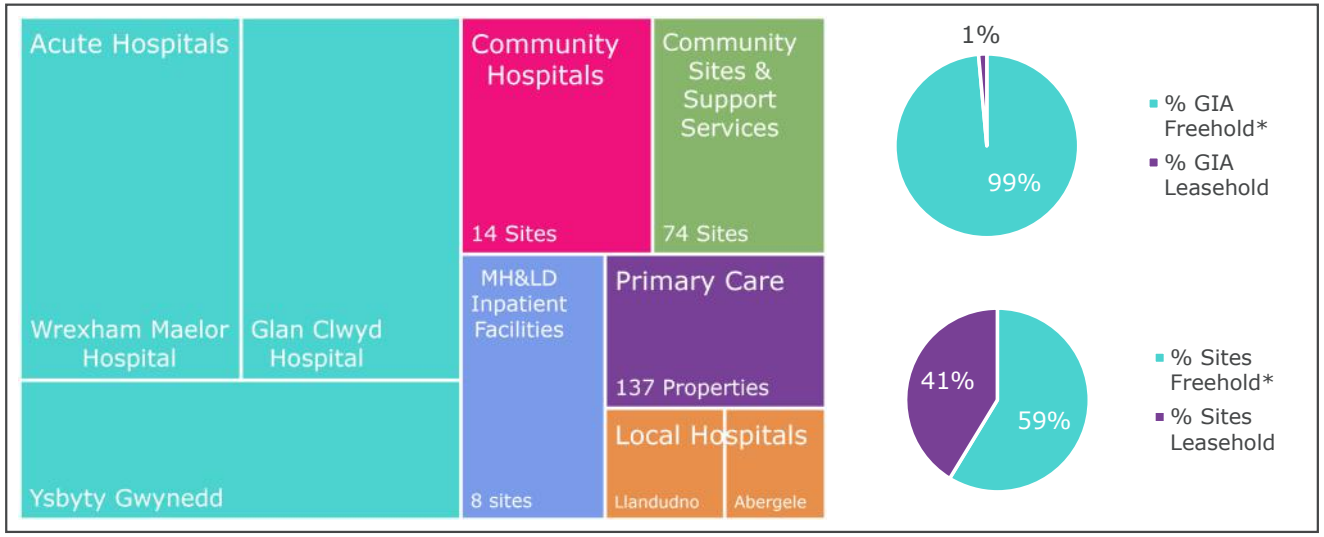
[1]Total freehold buildings, external works and land value as of 31/3/22; [2]Estates and facilities pay and non-pay costs

2.2 Existing Estate Type and Age Profile

Our estate comprises a range of property types, from acute hospitals to primary care facilities. Circa 45% of the estate is greater than 40 years old, compared to a Wales average of 49%. The majority of estate, by total Gross Internal Area (GIA) m^2, is freehold.

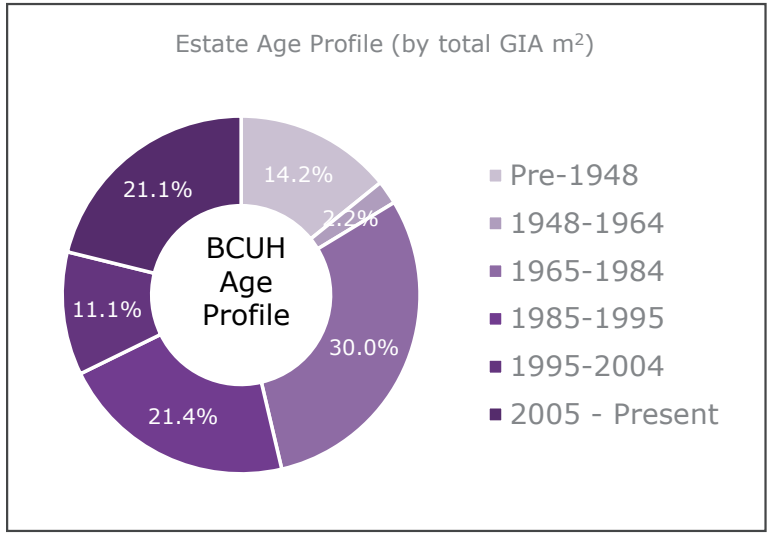
Existing Estate Type†

Our estate comprises a range of owned and leased property types. The breakdown, by number of properties and by total GIA m^2, is provided below.



Existing Estate Age Profile†

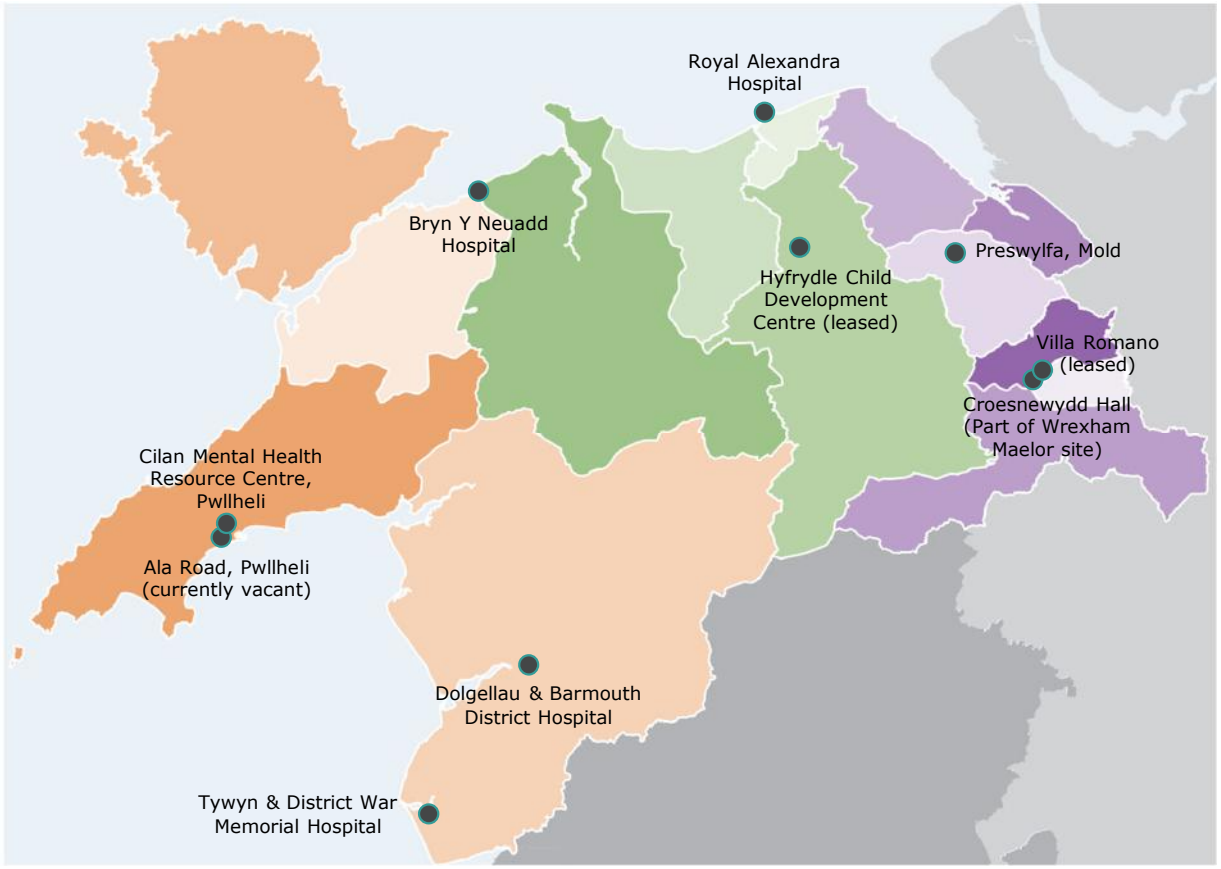
The age range of our estate, which varies widely from the 1813 Denbigh Infirmary to the Flint Health Centre, is summarised below.



†Data from Estates and Facilities Performance Management System (EFPMS) 2021/22 and Welsh Government Review of Primary Care Facilities - Primary Care Premises Database
*Data from Asset register, using Gross Internal Area (GIA) m^2 from EFPMS 2021/22 for sites where available. NHS Wales values exclude Welsh Ambulance Service NHS Trust.

2.3 Existing Estate - Listed Buildings/Sites

Our estate portfolio contains a number of Grade II listed historic building and grounds (shown below) which, in their own right, add a number of additional challenges regarding their listings and essential maintenance obligations.



West Integrated Health Community	
1	Bryn Y Neuadd Hospital
2	Ala Road, Pwllheli (currently vacant)
3	Cilan Penlan, Pwllheli
4	Dolgellau / Barmouth District Hospital
5	Tywyn District War Memorial Hospital

Central Integrated Health Community	
1	Royal Alexandra Hospital
2	Hyfrydle, Denbighshire (Leased)

East Integrated Health Community	
1	Croesnewydd Hall (Wrexham Maelor site)
2	Villa Romano (Leased)
3	Preswylfa, Mold

2.4 Estate Condition and Performance

At aggregate level for all estate*, our estate falls short of both national targets and NHS Wales average values for all estate condition and performance indicators, except space utilisation.

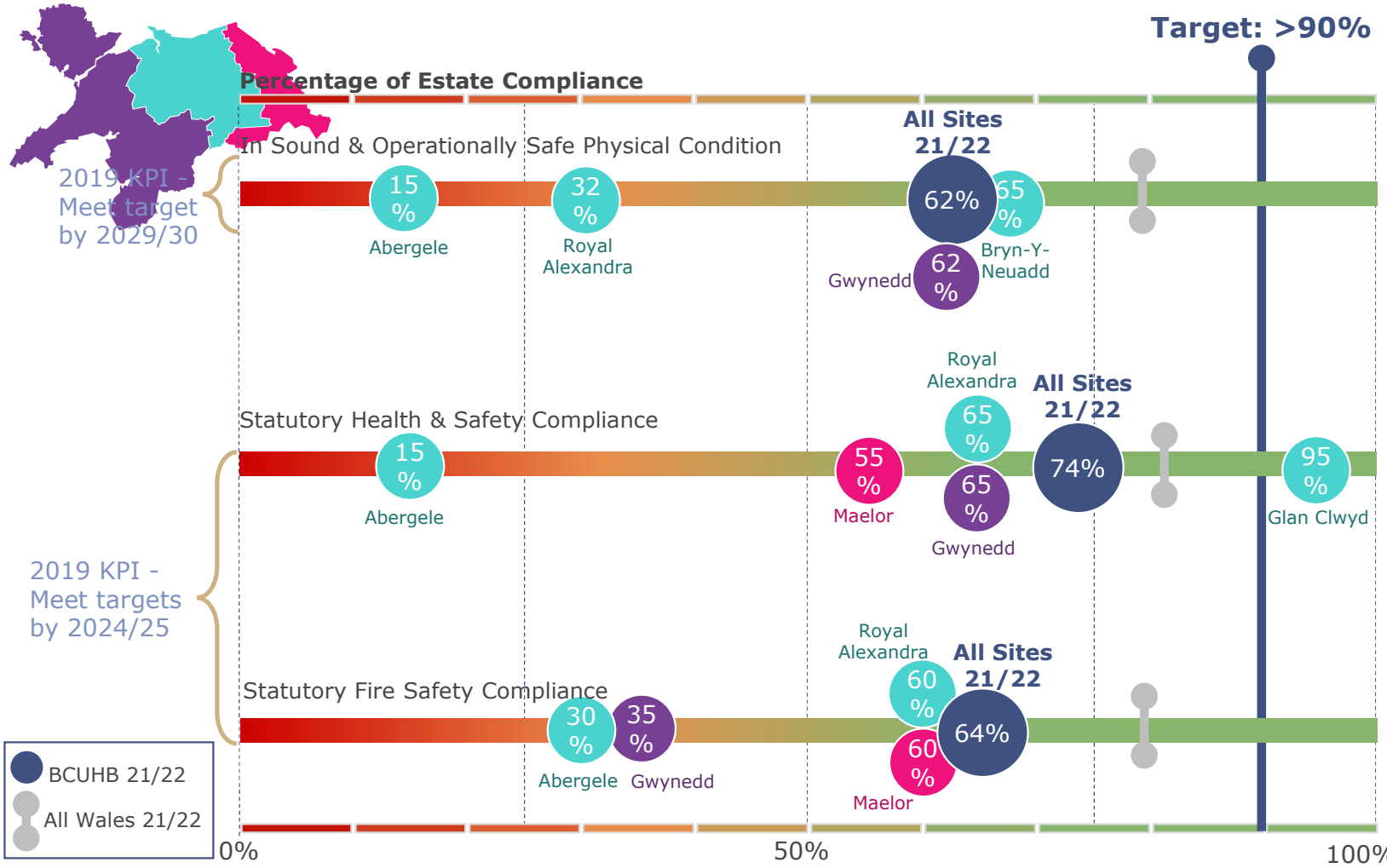
National Indicators for Evaluation

Estate condition and performance is evaluated against the standard indicators (defined by NHS Wales) opposite. Our estate currently falls short of all national targets except space utilisation. BCUHB estate also falls short of NHS Wales average values for all condition and performance indicators except space utilisation. In the 2019 Estate Strategy, compared to NHS Wales average values, our estate performed less well for all indicators except functional suitability. Since 2018/19, BCUHB estate condition and performance has reduced across all indicators except space utilisation.

Indicator	Definition	BCUHB 21-22*	Wales Average 21-22
Physical Condition	A minimum of 90% of the estate should be sound, operationally safe and exhibit only minor deteriorations.	62%	78%
Statutory Compliance	A minimum of 90% of the estate should comply with relevant statutory requirements.	74%	80%
Fire Safety Compliance	A minimum of 90% of the estate should comply with relevant statutory requirements.	64%	78%
Functional Suitability	A minimum of 90% of the estate should meet clinical and business operational requirements with only minor changes needed.	74%	81%
Space Utilisation**	A minimum of 90% of the estate should be fully used.	93%	93%
Energy Performance	The estate should consume no more than 410 kWh/m^2.	455 kWh/m^2	383 kWh/m^2

*Data for 98 sites from EFPMS 2021/22, including 3 acute sites, 8 mental health inpatient facilities and 15 community hospitals. Excludes significant proportion of primary care properties. NHS Wales values exclude Welsh Ambulance Service NHS Trust.
**Space utilisation based on EFPMS definition of unutilised space: 'Percentage of occupied floor area where space utilisation is classified as being either "empty" or "under-used" as defined in Estatecode and Developing an Estate Strategy documents.'

2.4.1 Overview - Physical Condition and Compliance (All Properties[1])



Physical Condition[2]: Only 62% of our estate is condition B or above (sound, operationally safe), compared to the national target of 90% and the NHS Wales average value of 78%.

Statutory Health & Safety[2]: Against a national target of 90%, only 74% of our estate complies with statutory requirements; the NHS Wales average value is 80%.

Statutory Fire Safety[2]: 64% of our estate complies with statutory fire requirements, compared to the national target of 90% and the NHS Wales average of 78%

On average, physical condition and statutory compliance of the estate has got worse since the 2019 Estate Strategy. In particular, the Abergele Hospital, Maelor Hospital, Royal Alexandra Hospital, and Ysbyty Gwynedd sites are in poor condition with low levels of compliance.

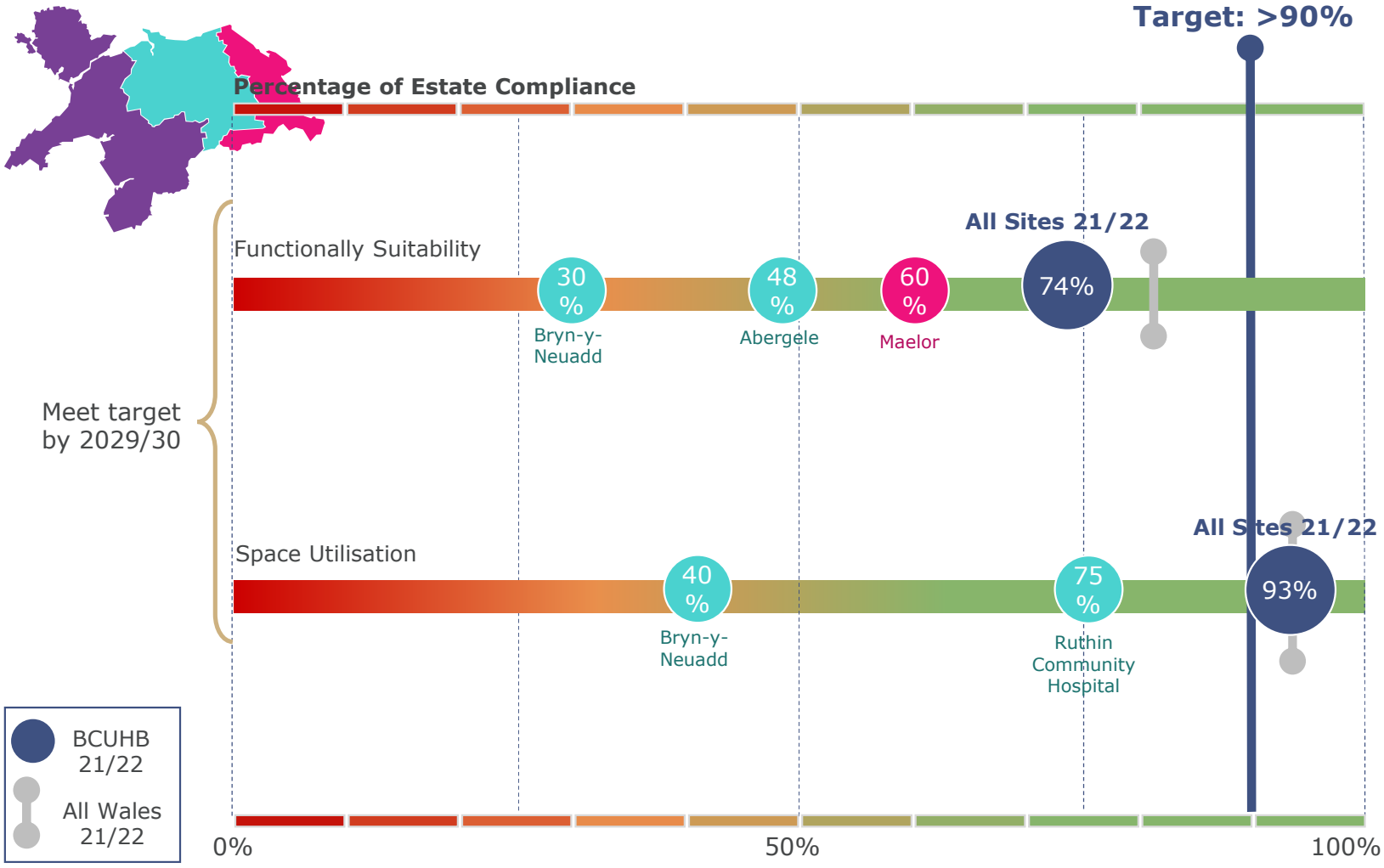
The planned Ysbyty Gwynedd Compliance Programme (currently at Programme Business Case stage on the BCUHB Capital Programme) will address key fire safety issues (compartmentation, evacuation and early warnings). BCUHB is also currently undertaking some fire precaution works through EFABS 2 All Wales funding.

Note, EFPMS currently reports that 20% of Wrexham Maelor Hospital occupied floor area is in sound and operationally safe condition. However, this value is known to be incorrect and realistically is closer to 55%.

[1] Excludes significant proportion of primary care properties. Values are per occupied floor area (OFA). NHS Wales values exclude Welsh Ambulance Service Trust.

[2] Physical condition and statutory compliance definitions are provided in Appendix 3.

2.4.2 Overview - Functional Suitability and Space Utilisation (All Properties[1])



Functional suitability[2]: 74% of our estate is considered to be functionally suitable, compared to the national target of 90% and the NHS Wales average value of 81%.

On average, there has been a reduction in the functional suitability of our estate (from 85% to 74%) since the 2019 Estate Strategy. In particular, Bryn-Y-Neuadd, Abergele and Wrexham Maelor estate all have low levels of functional suitability.

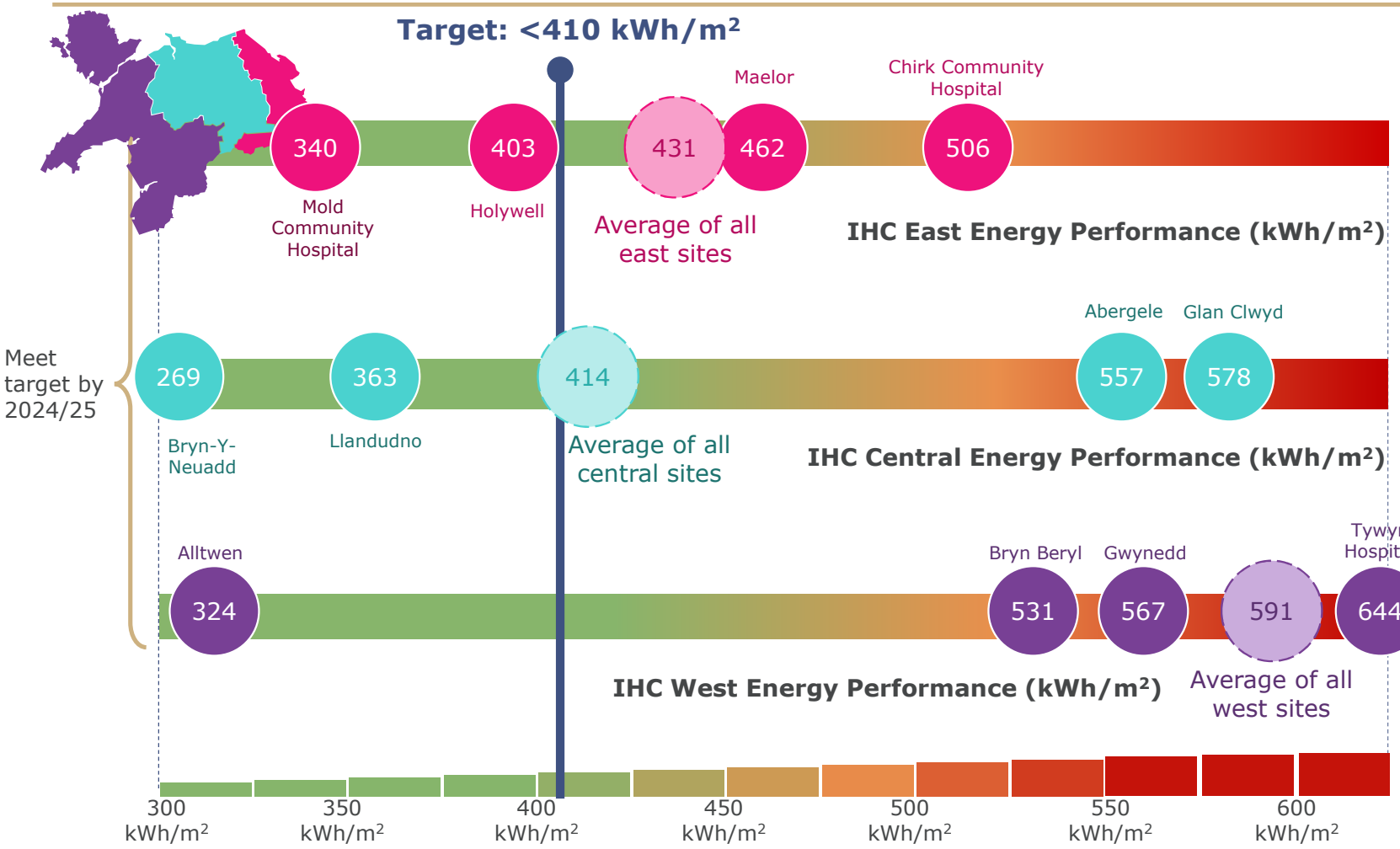
Space Utilisation[2]: 93% of our estate is utilised, compared to the national target of 90% and the NHS Wales average value of 93%.

Since the 2019 Estate Strategy, utilisation of the estate has increased (from 88% to 93%). However, this indicator does not identify whether space is being used at the required level of efficiency.

[2]Functional suitability and space utilisation definitions are provided in Appendix 3.

[1] Excludes significant proportion of primary care properties. Note that these values are per occupied floor area. NHS Wales values exclude Welsh Ambulance Service Trust.

2.4.3 Overview - Energy Performance (All Properties*)



Energy Performance : This indicator examines the total fossil and renewable non-fossil energy (electricity, gas, oil) consumed per occupied floor area.

IHC East & ICH Central: Average energy performance across sites is 431 kWh/m² and 414 kWh/m², respectively, both slightly above the national target of 410 kWh/m²; the NHS Wales average value is 383 kWh/m². Abergele Hospital has poor energy performance. Energy demand is higher at Glan Clwyd Hospital due to the high energy requirements of on site technical equipment e.g. linacs, which necessitate significant increases in plant, cooling systems, and modern ventilation systems with associated engineering.

IHC West: Average energy performance across sites is 591 kWh/m², significantly higher than the national target. Tywyn Hospital and Ysbyty Gwynedd have particularly poor energy performance.

Specific Site | Average for region

*kWh from BCUHB Utilities 2021 - 2022 report for each region. Occupied floor areas from EFPMS 2021/22. Excludes significant proportion of primary care properties.
Note that values are based on occupied floor area. NHS Wales values exclude Welsh Ambulance Service Trust.

2.5 Estate Overview

BCUHB
c.238 properties in BCUHB portfolio

c.420,000 m^2
Total size of the Betsi Cadwaladr estate (GIA)

19,200
staff employed

Total Building & Engineering Maintenance Cost per OFA
£49/m^2
(EFPMS*)

32%
built in last 27 years
(EFPMS*)

14%
built pre-1948
(EFPMS*)

£1.61bn
capital investment by 2031/32

176,000 tCO_2e
carbon footprint
(decarbonisation strategy)

3
Acute Sites
- Wrexham Maelor Hospital
- Glan Clwyd Hospital
- Ysbyty Gwynedd

8 Mental Health & Learning Disabilities inpatient facilities

16 community & local hospitals

74 community facilities

137
GP Practices

£240m
Risk adjusted backlog
(EFPMS*)

*EFPMS 21/22 data excludes significant proportion of primary care properties. Note that these values are per occupied floor area (OFA)
**Significant increase in backlog maintenance costs due to infrastructure risks at Ysbyty Gwynedd and Wrexham Maelor Hospital

BCUHB currently has one of the largest property portfolios in Wales. The estate comprises circa 238 properties with a total GIA of c.420,000 m^2.

The current estate comprises a mix of property types, from acute hospitals to primary care centres.

A significant proportion of the estate (c.45%) is greater than 40 years old.

The estate has a total backlog maintenance cost of £348m and a total risk adjusted backlog of £240m. Backlog costs have increased significantly since the 2019 Estate Strategy (from £142m to £348m)**.

Section 2.5 provides high level estate diagnostic infographics for each of the key property types within the BCUHB estate portfolio.

2.5.1 Acute Hospitals- Estate Condition and Performance

3 Acute Sites*

Total Area (GIA)

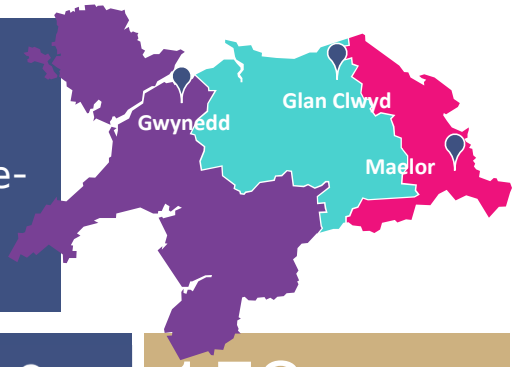
240,000m²

34%

built in last 27 years

5%

built pre-1948



42% of OFA in condition C + D

40% of space does not meet Statutory Fire Safety compliance

25% of space is not functionally suitable

158 kWh/m² Total electrical energy consumed per OFA

£254,500,000 Total backlog

28% of space does not meet statutory Health & Safety compliance

97% of space is utilised

512 kWh/m² Fossil & renewable non-fossil energy consumed per OFA

*All data for Glan Clwyd Hospital, Ysbyty Gwynedd & Wrexham Maelor Hospital from EFPMS 21/22. Includes Heddfan, Ablett & Hergest Units. Note that these values are per occupied floor area (OFA)

The three acute hospitals comprise c.37% of the total estate GIA m².

Circa 66% of the acute estate is greater than 27 years old.

Only 58% of the acute hospital estate is condition B or above (sound, operationally safe), compared to the national target of 90%.

A significant proportion of the estate does not meet statutory compliance requirements.

Acute backlog (c.£255m) accounts for c.73% of total estate backlog. Risk-adjusted acute backlog is c.£182m.

While c.97% of the acute space is utilised, 25% of this space is not functionally suitable.

The energy performance of the acute hospital estate falls short of the 410 kWh/m² national target.

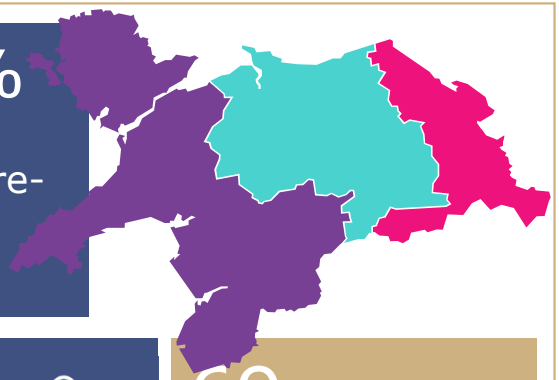
2.5.2 Mental Health & Learning Disabilities - Estate Condition and Performance

8
MH&LD Inpatient Facilities*

Total Area (GIA)*
31,900m²

18%
built in last 27 years

35%
built pre-1948



30% of OFA in condition C + D*

24% of space does not meet Statutory Fire Safety compliance

55% of space is not functionally suitable

69 kWh/m²
Total electrical energy consumed per OFA

£29,000,000
Total backlog

25% of space does not meet statutory Health & Safety compliance

54% of space is utilised

280 kWh/m²
Fossil & renewable non-fossil energy consumed per OFA

*8 MH&LD Inpatient Units in total (3 on acute sites). Information above from EFPMS 2122 data for the following 5 facilities: Bryn Hesketh, Bryn-Y-Neuadd Hospital, Coed Celyn, Cefni Hospital, Tan-Y-Castell. Note that these values are per occupied floor area (OFA)

Mental health and Learning Disability (MH&LD) services are provided from 8 inpatient facilities, three of which are located on the acute hospital sites. EFPMS data for these 3 MH&LD sites is amalgamated with acute facility data. The information opposite relates specifically to the 5 MH&LD inpatient facilities not located on acute sites.

MH&LD properties comprise c.8% of the total estate GIA m². Circa 82% of the MH&LD estate is older than 27 years.

70% of the MH&LD estate is condition B or above (sound, operationally safe), compared to the national target of 90%. A significant proportion of the estate does not meet statutory compliance. Backlog (£29m) accounts for c.8% of total estate backlog. Risk-adjusted backlog is c.£22.4m.

The energy performance of the MH&LD estate exceeds the national target of 410 kWh/m².

2.5.3 Community and Local Hospitals - Estate Condition and Performance

16
Community and Local Hospitals*

Total Area (GIA)
73,200m²

38%
built in last 27 years

32%
built pre-1948

30% of OFA in condition C + D

30% of space does not meet Statutory Fire Safety compliance

20% of space is not functionally suitable

93 kWh/m²
Total electrical energy consumed per OFA

£40,100,000
Total backlog

27% of space does not meet statutory Health & Safety compliance

94% of space is utilised

411 kWh/m²
Fossil & renewable non-fossil energy consumed per OFA

*All data for 16 community and local hospitals from EFPMS 21/22. Note that these values are per occupied floor area (OFA). Properties included within this analysis are detailed in Appendix 4.

The 16 community and local hospitals comprise c.17% of the total estate GIA m².

Circa 62% of the estate is greater than 27 years old.

70% of the community and local hospital estate is condition B or above (sound, operationally safe), compared to the national target of 90%.

Circa 30% of the estate does not meet statutory compliance requirements.

Community and local hospital backlog (c.£40m) accounts for c.12% of total estate backlog. Risk-adjusted acute backlog is c.£22m.

While c.94% of community and local hospital space is utilised, 20% of this space is not functionally suitable.

The energy performance of the community and local hospital estate is just short of the national target of 410 kWh/m².

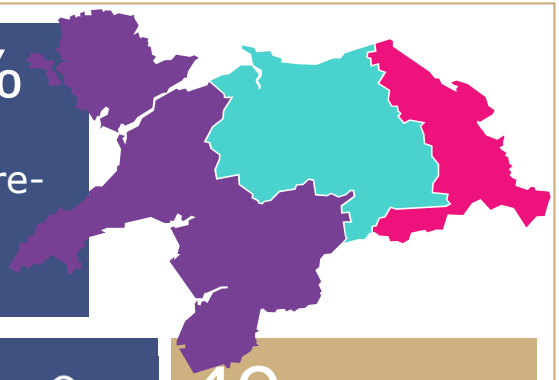
2.5.4 Community Facilities - Estate Condition and Performance

74
Community Sites*

Total Area (GIA)
44,000m²

17%
built in last 27 years

27%
built pre-1948



31% of OFA in condition C + D

28% of space does not meet Statutory Fire Safety compliance

22% of space is not functionally suitable

49 kWh/m²
Total electrical energy consumed per OFA

£24,800,000
Total backlog

£14,200,000
Risk Adjusted Backlog

16% of space does not meet statutory Health & Safety compliance

79% of space is utilised

292 kWh/m²
Fossil & renewable non-fossil energy consumed per OFA

*Data for 74 community facilities in aggregated in EFPMS 21/22data. Note that these values are per occupied floor area (OFA). Properties included within this analysis are detailed in Appendix 4. Note, the Royal Alexandra Hospital is included within this analysis.

The 74 community facilities comprise c.10% of the total estate GIA m².

Circa 83% of the estate is greater than 27 years old.

69% of the community facilities estate is condition B or above (sound, operationally safe), compared to the national target of 90%.

The estate falls below national targets for statutory compliance.

Community facilities backlog (c.£25m) accounts for c.7% of total estate backlog. Risk-adjusted acute backlog is c.£14m.

While c.79% of the community facilities estate is utilised, 22% of this space is not functionally suitable.

The energy performance of the community facilities estate is significantly better than the national target of 410 kWh/m².

2.5.5 Primary Care - Estate Condition and Performance

A complete recent data set for primary care estate condition and performance is currently not available to inform this estate strategy.

As a significant proportion of BCUHB area primary care properties are not reported on for EFPMS data returns, an accurate assessment of current primary care estate condition and performance is not available via EFPMS. The most recent assessment of 173 BCUHB primary care facilities (the vast majority of which are owned and managed by private providers) was undertaken by Lambert Smith Hampton in 2016. Summary findings on the physical condition, equality/DDA compliance, space utilisation and functional suitability of primary care properties are presented opposite. As there is no reason to assume that the overall condition of the estate has changed significantly since 2016, this assessment is considered to still provide a reasonable representation of condition and performance of the primary care estate. It is also assumed that those properties that were the most expensive in 2016 remain as so.

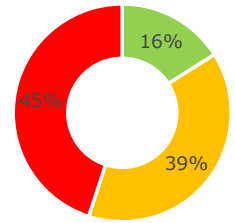
Physical Condition: In 2016, total required backlog maintenance across the whole estate was c.£4.5m (excluding VAT) and 45% of the primary care estate was rated as poor/unacceptable. Based on PUBSEC indices forecasts (to 4Q 2022), current backlog costs across the whole estate are estimated at c.£6.8m (excluding VAT).

Equality Act / DDA compliance: In 2016, it was estimated that c.£3.2m of work would be required for reasonable modifications to primary care properties to ensure compliance with Equality Act/DDA. Across the whole estate, more Equality Act/DDA compliance issues were identified in comparison to physical space and functionality issues. Based on PUBSEC indices forecasts (to 4Q 2022), current costs for reasonable modifications to primary care properties to ensure compliance with Equality Act/DDA are estimated at c.£4.8m (excluding VAT).

Space utilisation: In 2016, only 10% of primary care space was under utilised (typically, space within the more recently constructed properties designed to include future expansion space). This figure is likely to have reduced due to the impact of the COVID pandemic on additional space requirements within primary care properties.

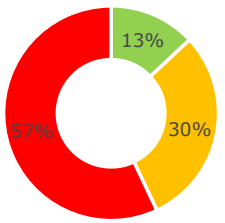
Functional suitability: In 2016, 25% of properties had a poor/unacceptable level of functional suitability (generally correlating to either overcrowded or old properties).

*Physical Condition – Summary



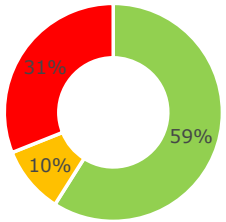
A - Excellent B - Good C - Poor/Unacceptable

Equality Act (DDA) Compliance - Summary



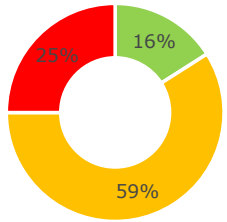
A - Full/Near Full Compliance
B - Non-compliance
C - High level of non-compliance

Space Utilisation – Summary



A - Fully used B - Under used C - Overcrowded

Functional Suitability - Summary



A - Excellent B - Good C - Poor/Unacceptable

*Physical condition ratings based on the following backlog maintenance costs per m^2: A – Excellent (<£15/m^2); B – Good (£15-70/m^2); C – Poor/Unacceptable (>£70/m^2)

Based on PUBSEC indices forecasts (to 4Q 2022), current backlog maintenance costs per m^2 are estimated as follows: A – Excellent (<£23/m^2); B – Good (£23-105/m^2); C – Poor/Unacceptable (>£105/m^2)

2.5.5 Primary Care - Estate Condition and Performance

Survey work is currently in progress to provide an updated primary care estate data set across Wales.

The Future for Primary Care Premises in Wales

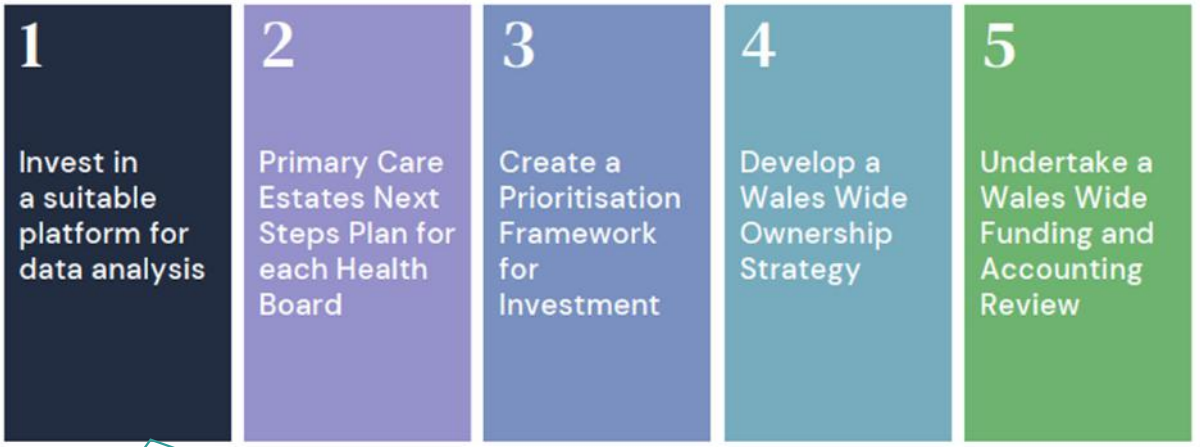
Welsh Government recently (Aug 2021) published the vision for primary care services and premises in Wales (Case for Change: Future for Primary Care Premises in Wales).

This document sets out a roadmap to improvement for primary care estate in Wales. Key steps are listed below:

- Invest in a suitable platform for data analysis
- Develop a primary care estate next steps plan
- Create a prioritisation framework for investment
- Develop a Wales wide ownership strategy
- Undertake a Wales wide funding an accounting review

Currently, significant gaps exist in primary care estate data (planning, condition, performance, ownership / leasing / licensing details) across Wales. Lack of data impacts on the ability to generate informed investment decisions.

To address this issue, a survey of all primary care premises in Wales is being undertaken. Examples of key estate metrics being collected are shown opposite. When available, this information will be used to inform and update our estate strategy.



Significant Gaps in Data

- The surveys have highlighted significant gaps in data on primary care estate.
- Gaps exist across the full estate life-cycle from planning data, estate condition, utilisation and ownership / leasing / licensing details.
- These data gaps prevent meaningful information being generated to inform investment decisions.
- For a case to be made to invest in primary care infrastructure, as a priority for Wales, these data gaps need to be filled.

Key All Wales Primary Care Estate Information Currently Being Collected

- Area occupied
- Property tenure
- Building age
- Physical condition
- Backlog maintenance costs
- Functional suitability assessment
- Statutory compliance rating
- Equalities Act /DDA compliance rating
- Space utilisation assessment
- Environmental rating

2.6 Estate Backlog Maintenance Costs

Our estate has a total backlog maintenance cost of £348m and a total risk adjusted backlog of £240m. Approximately 73% of total backlog relates to the 3 acute hospitals. Total backlog costs have increased significantly since the 2019 Estate Strategy (from £142m to £348m).

Backlog Maintenance

Backlog 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 is £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.

Profile of BCUHB 2021/22 Backlog Maintenance Costs (£m)

Property Type	Total backlog	High Risk	Significant Risk	Moderate Risk	Low Risk	Risk Adjusted
All Properties	*£348.79*	*£91.81*	*£142.50*	*£68.66*	*£45.42*	*£239.96*
Acute Hospitals*	£254.51	£64.42	£113.42	£45.21	£31.46	£181.49
Mental Health Inpatient*	£28.97	£16.22	£6.38	£4.48	£2.42	£22.41
Community & Local Hospitals*	£40.12	£5.84	£15.07	£12.10	£7.12	£21.82
Community Facilities*	£24.78	£5.33	£8.15	£6.88	£4.43	£14.23
Primary Care†	£0.41					

*All data from EFPMS 21/22.
†Data from Welsh Government Review of Primary Care Facilities - Primary Care Premises Database for 75/137 properties

2.7 Estate Revenue Costs

Our estate has an annual key estate cost of c.£34.7m. Since the 2019 Estate Strategy, annual estate costs have increased by 54% from £22.6m to £34.7m. Our key estate cost/m^2 of c£94 is above the NHS Wales average of c.£66/m^2.

Estate Revenue Costs

The table opposite provides a summary of the 2020/21 aggregated BCUHB annual estate costs compared to NHS Wales average costs. Our key total estate cost in 21/22 was c.£34.7m, of which approximately 70% relates to the 3 major acute hospitals, 20% to community hospitals, community facilities and corporate estate.

Since the 2019 Estate Strategy, annual estate costs have increased by 54% from £22.6m to £34.7m. Our key estate cost/m^2 of c£94 is above the NHS Wales average of c.£66/m^2. Factors influencing our increasing estate costs and higher costs/m^2 (compared to the NHS Wales average) are as follows:

- The age, scale and geographic spread of our estate across North Wales represents significantly more risk; the ageing estate profile requires more maintenance
- We are investing more revenue on estates due to the deteriorating condition of the estate
- We are spending more on the estate to make it more compliant
- Due to the COVID pandemic, there is an increased focus on compliance and environmental improvement.

2021/22 Key Estate Costs*	BCUHB Cost (£m)	BCUHB (£/m^2)	NHS Wales Average (£/m^2)
Estate Costs			
Building and engineering[1]	£18.10M	£48.79	£28.48
Total energy	£13.16M	£35.48	£29.96
Water	£1.37M	£3.69	£2.04
Sewage	£0.83M	£2.25	£1.77
Waste	£1.28M	£3.46	£3.29

*All data from EFPMS 2021/22. NHS Wales values exclude Welsh Ambulance Service NHS Trust. Definitions as per EFPMS. Excludes significant proportion of primary care properties.

[1]Building and engineering costs defined as *total pay and non-pay costs for the provision of building and engineering maintenance services, to maintain the whole of the building fabric sanitary ware, drainage, engineering infrastructure, systems and plants, etc. both internally and externally to the buildings. Includes labour and materials costs for all directly employed and contract staff. Includes all capital investment costs that have been expensed in support of the maintenance function but excludes all capital modernisation works involving adaptations improvements, and alterations included items that will be redefined as revenue to captain the final accounts.*

2.8 Stakeholder Engagement - Summary Priorities Statement

Engagement with stakeholders across BCUHB to understand current key estate issues revealed the requirement to address a number of immediate priorities (summarised below).

Current State – Stakeholder Engagement

Engagement with stakeholders from the following key groups was undertaken, either via structured interviews or workshops, to understand key current estate issues and priorities to inform development of the future estate vision.

Integrated Health Communities and clinical leads

- Ysbyty Gwynedd
- Glan Clwyd Hospital
- Wrexham Maelor Hospital
- Community Dental Services
- Primary and Community Care
- Mental Health and Learning Disabilities
- Midwifery and Women's Services
- Cancer and Diagnostics and Clinical support
- Patient Safety and Experience

Corporate and external

- Board
- Health Board Leadership Team
- Capital Investment Group
- Clinical Senate
- Community Health Council

Estates

- Health, safety, and equality
- Operational estates
- Property and asset management

Summary Priorities - Immediate issues

Maintenance, quality and safety issues
Significant concerns exist regarding the quality of both acute and community estate

Space utilisation
There is a common perception of underuse on a number of sites which will require targeted validation

Capacity
Capacity constraints exist across acute and community sites. Re-purposing the space released post-RTCs should reduce pressure in the acute hospitals

Approach to workspace
Recognising post-COVID changes to working practices (including a greater level of working from home), a flexible approach is expected

Flexibility
Given financial constraints and other complexity, flexibility and senior support is required to address some of the most critical immediate issues

2.9 Key Estate Risks and Challenges

Our 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.

Evaluation of key BCUHB estate condition and performance indicators (as per 2021/22 EFPMS data) can be summarised as follows:

Physical Condition: Only 62% of BCUHB estate is condition B or above (sound, operationally safe), compared to the national target of 90%; the NHS Wales average value is 78%.

Statutory Health & Safety: Against a national target of 90%, only 74% of BCUHB estate complies with statutory requirements; the NHS Wales average value is 80%.

Statutory Fire Safety: 64% of BCUHB estate complies with statutory fire requirements, compared to the national target of 90% and the NHS Wales average of 78%

On average, physical condition and statutory compliance of the estate has got worse since the 2019 Estate Strategy. In particular, the Abergele Hospital, Wrexham Maelor Hospital, Royal Alexandra Hospital, and Ysbyty Gwynedd sites are in poor condition with low levels of compliance.

Functional suitability: 74% of BCUHB estate is considered to be functionally suitable, compared to the national target of 90% and the NHS Wales average value of 81%.

On average, there has been a reduction in the functional suitability of BCUHB estate (from 85% to 74%) since the 2019 Estate Strategy. In particular, Bryn Y Neuadd Hospital, Abergele Hospital and Wrexham Maelor Hospital estate all have low levels of functional suitability.

Space Utilisation*: 93% of the BCUHB estate is utilised, compared to the national target of 90% and the NHS Wales average value of 93%. Since the 2019 Estate Strategy, utilisation of the estate has increased (from 88% to 93%). However, this indicator does not identify whether space is being used at the required level of efficiency.

Energy Performance: This indicator examines the total fossil and renewable non-fossil energy (electricity, gas, oil) consumed per occupied floor area.

IHC East & ICH Central: Average energy performance across sites is 431 kWh/m^2 and 414 kWh/m^2, respectively, both slightly above the national target of 410 kWh/m^2; the NHS Wales average value is 383 kWh/m^2. Glan Clwyd Hospital and Abergele Hospital have poor energy performance.

IHC West: Average energy performance across sites is 591 kWh/m^2, significantly higher than the national target. Tywyn Hospital and Ysbyty Gwynedd have particularly poor energy performance.

*Space utilisation based on EFPMS definition of unutilised space: 'Percentage of occupied floor area where space utilisation is classified as being either "empty" or "under-used" as defined in Estatecode and Developing an Estate Strategy documents.'

2.9 Key Estate Risks and Challenges

The major risks presented by our current estate may be summarised as follows:

Ysbyty Gwynedd (YG)

- The highest backlog maintenance in the property portfolio
- The age and resilience of the engineering infrastructure
- A significant percentage of occupied floor area is condition C/D, not compliant with statutory requirements, and not functionally suitable
- The design and layout of YG presents infection prevention and control risks, and does not comply with current guidance or support efficient working and new models of care
- The planned YG Compliance Programme (currently at Programme Business Case stage on the BCUHB Capital Programme) will address key infrastructure and fire safety issues (compartmentation, evacuation and early warnings) and focus on the following areas:
    - Fire packages
    - Evacuation packages
    - Low voltage infrastructure
    - Heating and ventilation
    - Medical gases and distribution pipework
    - Water systems
    - Building fabric
- BCUHB is also currently undertaking some fire precaution works through EFABS 2 All Wales funding

Wrexham Maelor Hospital (WMH)

- The second highest backlog maintenance in the estate
- The age and resilience of the engineering infrastructure
- 80% of occupied floor area is condition C/D, with high percentages not compliant with statutory requirements, and not functionally suitable
- The design and layout of WMH presents infection prevention and control risks, and does not comply with current guidance or support efficient working and new models of care
- The WMH Continuity Programme (currently at Full Business Case stage on the BCUHB Capital Programme) will address key infrastructure issues and focus on the following areas:
    - Completion of the existing HV Ring Main
    - New Intake and Phase 1 electrical sub stations

2.9 Key Estate Risks and Challenges

- Replacement of obsolete fire alarm panels
- Oxygen accessible pipework
- Heating and domestic hot and cold water to the former "EMS" area
- Replacement of critical damaged fire door sets across the site
- Replacement of vacuum plant to Nucleus phases 1&2; replacement of medical air plant to Nucleus Phase 2
- Address the red risks as identified within the fire survey

Glan Clwyd Hospital

- Backlog maintenance of c.£37m
- The Glan Clwyd Hospital compliance and electrical capacity project (currently on the BCUHB Capital Programme) will address key infrastructure issues focused on upgrading electrical infrastructure

Abergele Hospital

- Backlog maintenance of c.£15.5m; 80% of occupied floor area is condition C/D, with similar amounts of floor area not complaint with statutory requirements, and not functionally suitable
- 10% of occupied floor area is unutilised

Royal Alexandra Hospital (RAH)

- The age, design and physical condition of the building and engineering infrastructure
- Backlog maintenance of c.£15.3m
- 68% of occupied floor area is condition C/D, with 35-40% of occupied floor area not complaint with statutory requirements
- The RAH development project (currently at Full Business Case stage on the BCUHB Capital Programme) will address key infrastructure and statutory issues

Bryn Y Neuadd Hospital

- The age, design and physical condition of the building and engineering infrastructure
- Backlog maintenance of c.£27.7m
- 35% of occupied floor area is condition C/D, with moderate levels of statutory non-compliance
- 70% of occupied floor area is not functionally suitable, with 60% of area being underutilised
- 40% (c.10,800m^2) of the site GIA m^2 is unoccupied

2.9 Key Estate Risks and Challenges

The design and layout of the **Hergest Unit, Ablett Unit, Cefni Hospital and Bryn Hesketh Hospital** are not considered fit for purpose and do not support new models of Mental Health care (Hergest Unit and Ablett Unit redevelopment schemes are on the current BCUHB capital programme); this will particularly impact on the following:

- Provision of an appropriate physical environment for Mental Health and Learning Disabilities services
- Service user privacy and dignity, experience, behaviours and security
- Compliance with Royal College of Psychiatrists guidance

The age, design and physical condition of the building and engineering infrastructure of:

- Colwyn Bay Hospital
- Denbigh Hospital
- Eryri Hospital
- Ruthin Hospital

The design and engineering infrastructure of **Dolgellau Hospital.**

Space limitations within community properties may prevent colocation of large teams and impact on model of care delivery.

Insufficient provision of space for training purposes; lack of accommodation for people in training.

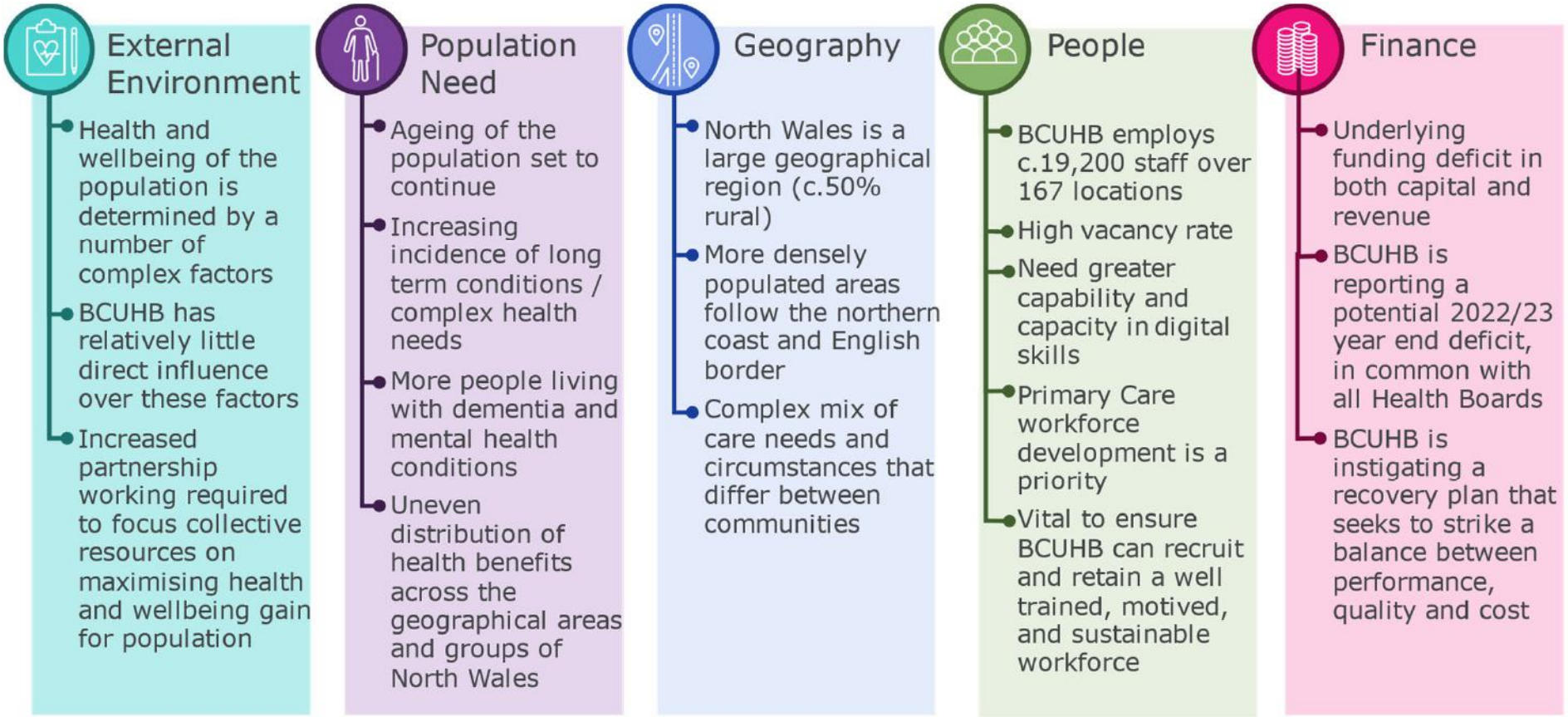
Net Zero Risks and Challenges

- Heat decarbonisation: To comply with NHS and Welsh Government targets, fossil fuelled boilers and CHP approaching end of life, such as at Glan Clwyd Hospital and the CHP plant at Ysbyty Gwynedd, must be identified and option appraisals conducted to switch to clean heat
- Transport: Progress on EV rollout across the estate, with 30% of lease cars electric, and 20x EV charging points having been installed at the Wrexham Maelor Hospital site, could be challenged by growing demand for charging on site
- Renewables: NHS Wales target to maintain 100% REGO backed electricity supply, could become difficult on the BCUHB estate given inflationary pressures in energy markets that are expected to continue into 2023/24
- Clinical emissions: NHS Wales ambition to use methods to minimise gas wastage and technologies to capture expelled medical gases has been identified as a significant concern by the clinical team at BCUHB

3.0 Future State (Where Do We Want To Be?)

3.1 Strategic Challenges

Operating in a complex and diverse environment, BCUHB faces a number of key strategic challenges as summarised below.



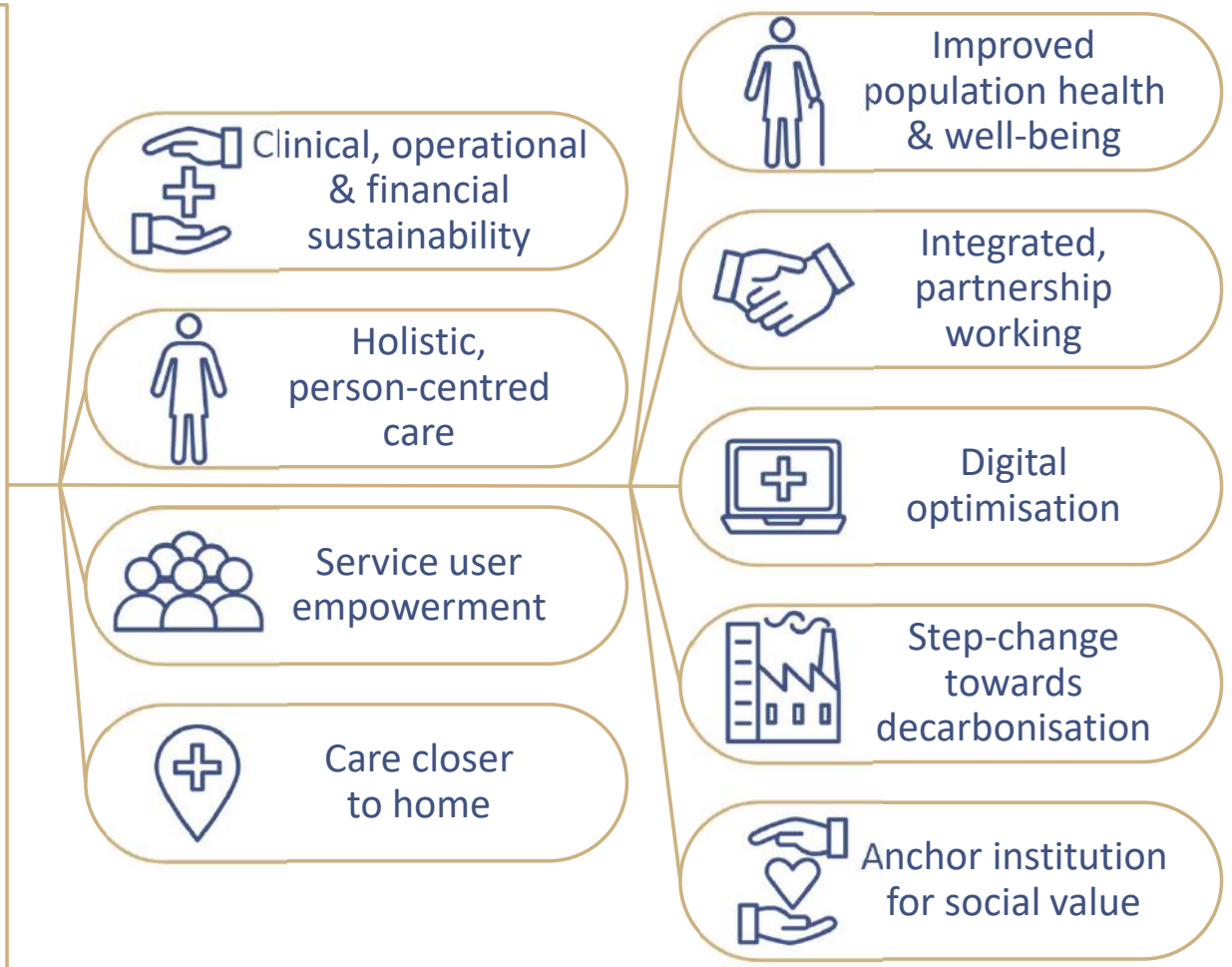
3.2 Strategic Context

In March 2018, BCUHB approved its long term strategy, Living Healthier, Staying Well, which outlines the vision for health, wellbeing and healthcare over the next ten years.

Living Healthier, Staying Well underpins the strategic framework for our future estate that will be designed to support health and wellbeing, primary and community services through a network of wellbeing centres. This network will be supported by three acute hospital campuses providing acute and specialist care together with key support services (clinical and non-clinical).

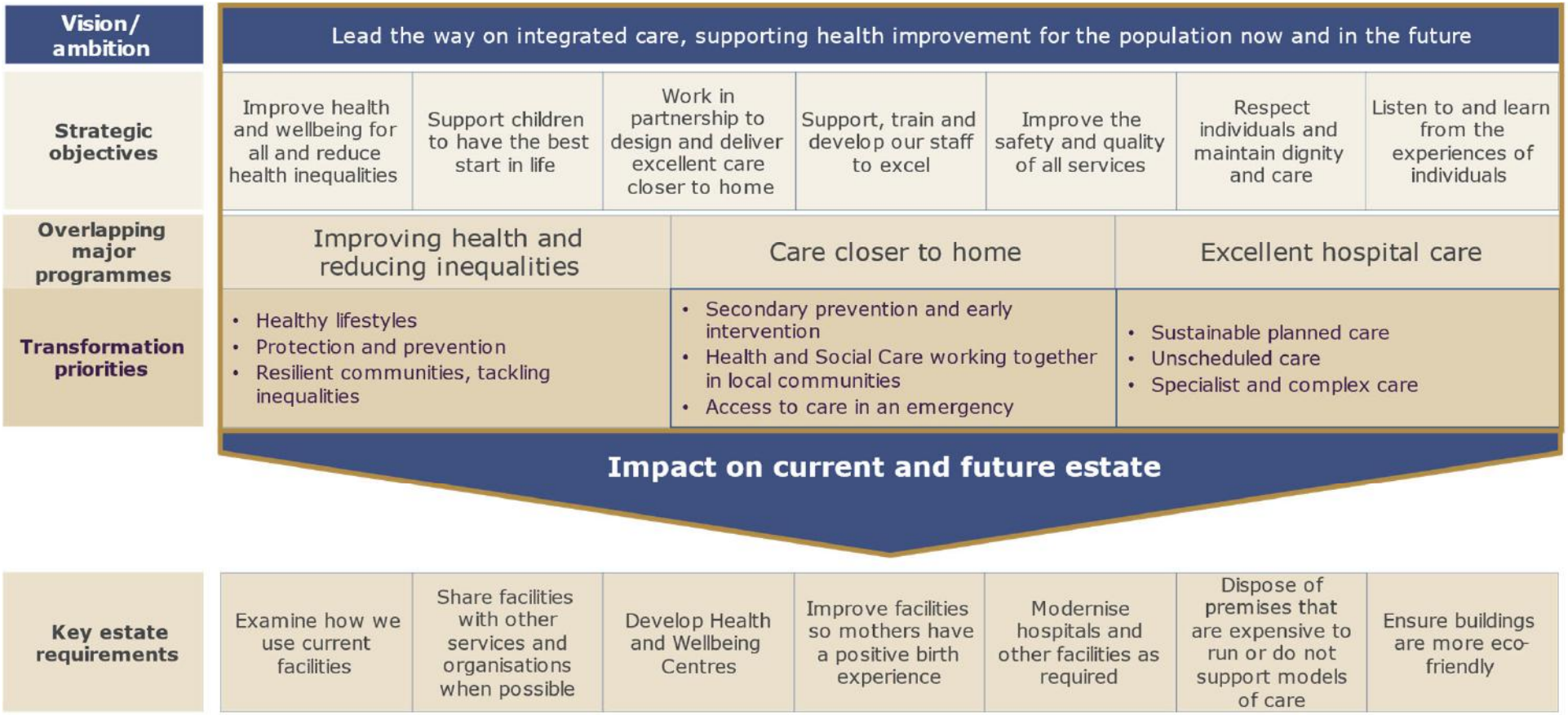
Through targeted development, repurposing, reconfiguration and rationalisation the property portfolio will be aligned to support the 14 clusters and three acute hospital campuses, with estate capacity and size reflecting the shift in care closer to home and new models of working. The future estate will support the development of regional facilities providing centres of clinical excellence and support services to all of North Wales and will be designed to be sustainable, reduce environmental impact and to support the wider economic, social and cultural wellbeing of North Wales.

The BCUHB Clinical Services Strategy (June 2022) sets out the future direction and strategic intentions for clinical services in North Wales. It provides a 'blue print' for large-scale service redesign and in conjunction with Living Healthier, Staying Well will guide implementation of the estate strategy.



3.3 Strategic Service and Business Objectives Informing Estate Need

The impact of BCUHB's vision, strategic objectives, major programmes and transformation priorities on future key estate requirements is summarised below.

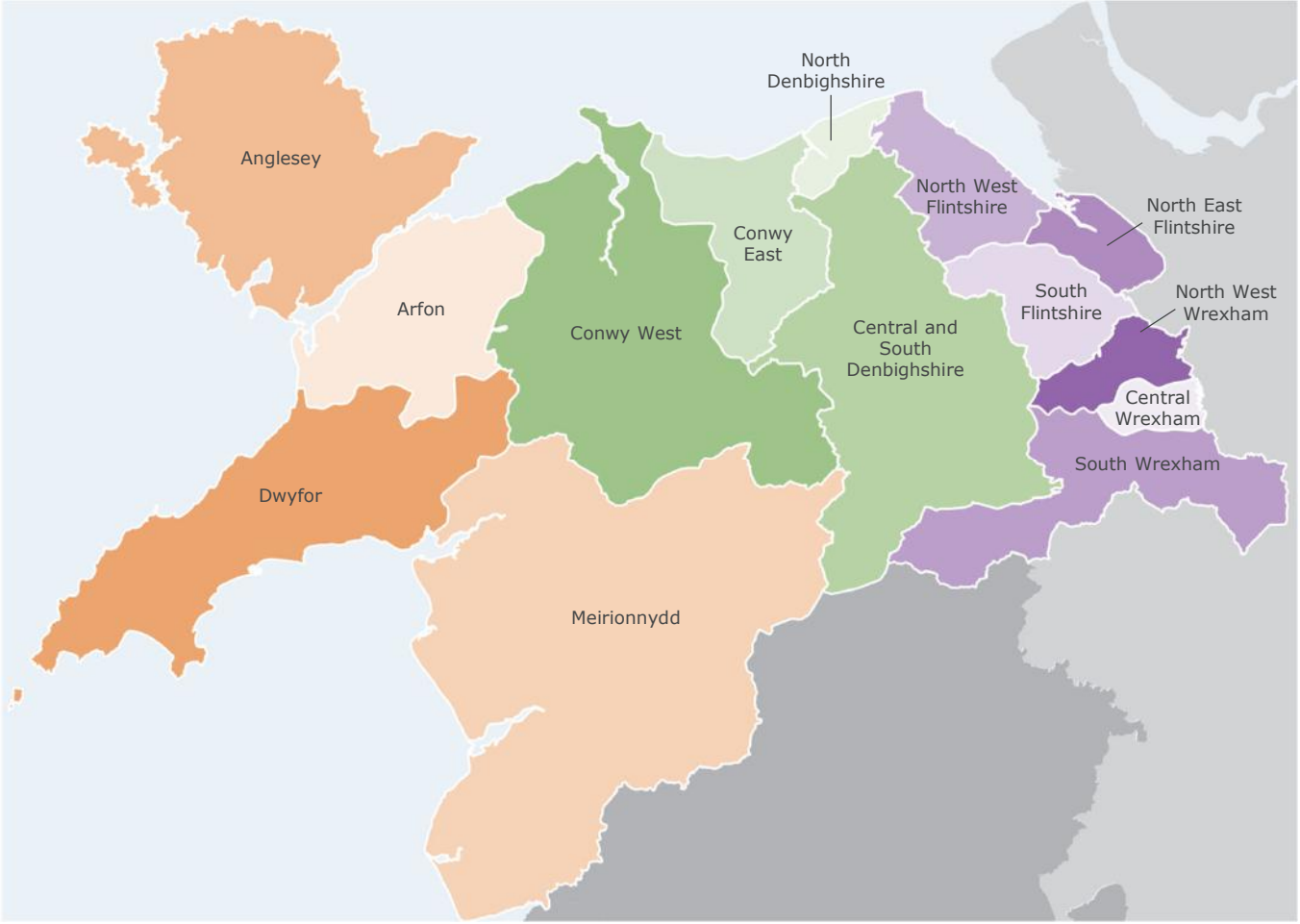


3.4 Opportunities - Context

The long term strategy, Living Healthier, Staying Well, outlines the vision for health, wellbeing and healthcare over a 10 year period from 2018 and defines future models of care delivery for BCUHB.

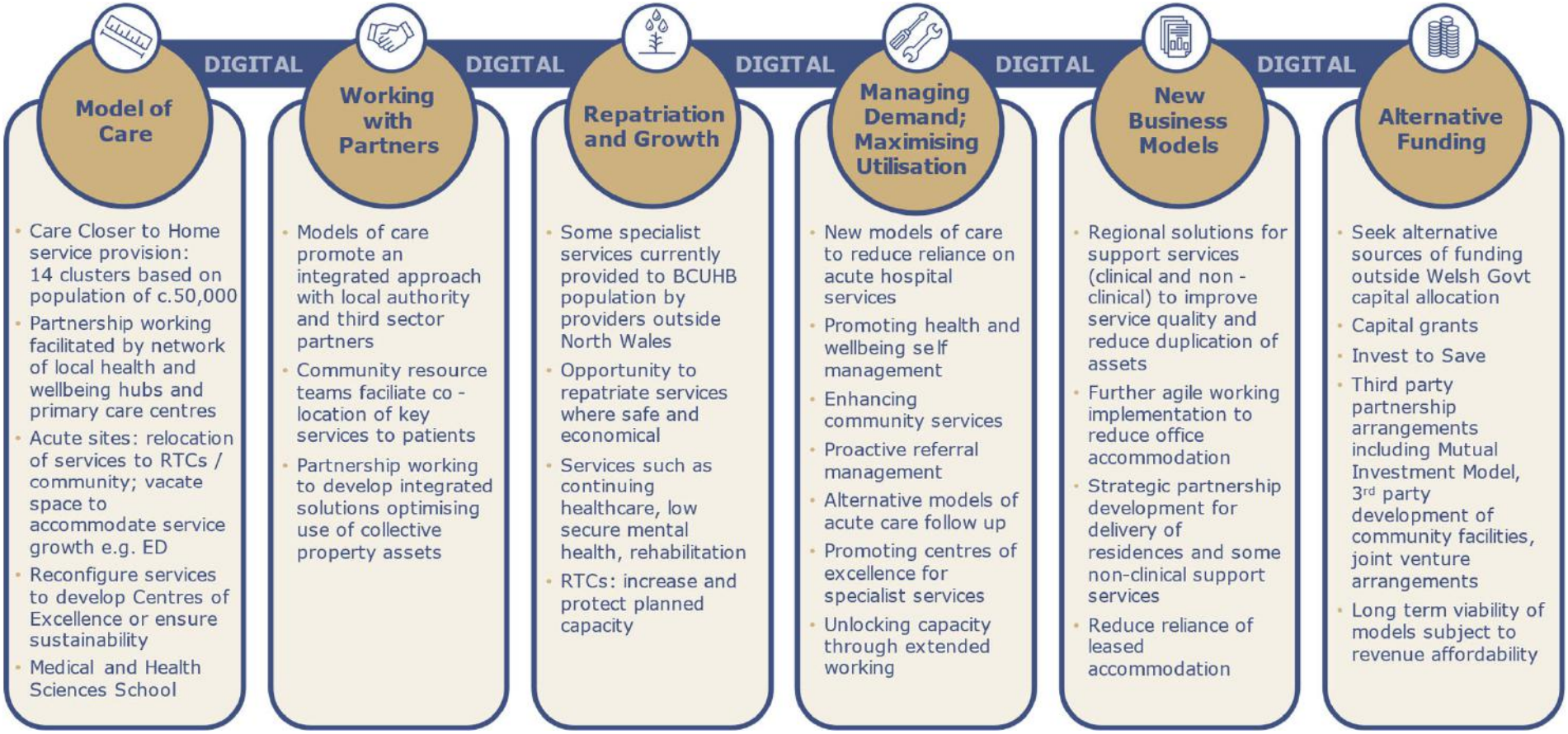
Across the three Integrated Healthcare Communities, 14 clusters, broadly coterminous with local authorities and based on a population of c.50,000, will form the footprint through which Care Closer to Home services are delivered. Within each cluster local community resource teams, GPs and mental health services will work together with local authority and the third sector partners offering a range of advice, assessment and treatment services.

To support enhancement of services within communities, there will be further development of networks of Health and Wellbeing Hubs and Primary Care Centres. Primary care facilities incorporating primary care, community services and partner organisation services will be supported by Health and Wellbeing Hubs providing a wider range of services typically incorporating urgent care (minor injuries), ambulatory consultations and treatment, and inpatient activity.



3.5 Opportunities - Detail

Key high level opportunities informing our strategic estate framework fall within the following broad categories: new models of care, integrated partnership working, repatriation/growth of activity, managing demand and maximising utilisation, new business models and alternative funding routes. Further specific detail on these opportunities is provided below.



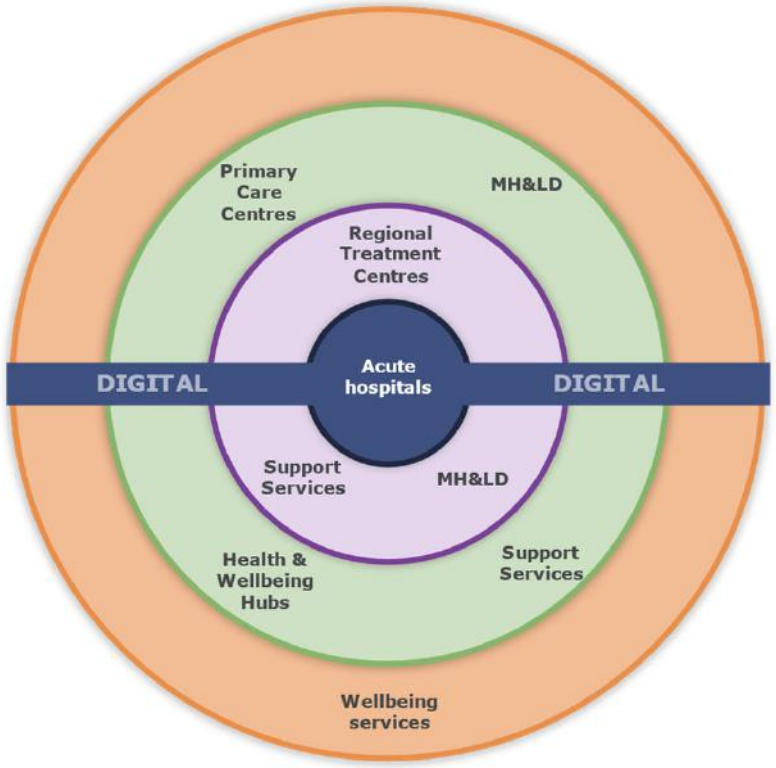
3.6 Vision for the Future Estate

Living Healthier, Staying Well defines the ambition for delivery of BCUHB health and care services that provide the strategic framework for our future estate. This vision, framework and detail regarding specific services and property types for delivery of services is summarised below. Additional detail is provided in the following pages.

Summary of Vision for Future Estate

- Estate that is fit for purpose; provides a safe and effective environment for patients, carers, visitors and staff
- The estate is aligned to clinical and enabling strategies and supports transformation plans
- The efficiency of the estate is improved through appropriate utilisation and investment
- Duplication is eradicated to enable release of assets for direct patient care or disposal
- Assets are employed effectively to deliver value for money
- An agile estate that is able to respond to new growth requirements of services
- Estate that enables a step-change towards decarbonisation and net zero targets

Strategic Framework for Future Estate



Wellbeing services : delivered in a range of public and commercial settings, and at home; focus on improving health and reducing inequalities

Primary care centres: A network of primary care facilities to enhance the existing portfolio of primary care centres and health centres

Health and Wellbeing hubs : Each geographical care cluster supported by at least one Health and Wellbeing hub

Mental Health, Learning Disabilities and Substance Misuse services : Community services colocated with community resource teams; additional accommodation required for inpatient, rehabilitation, specialist support and interventional services.

Regional Treatment Centres : Provide outpatient appointments, diagnostic tests and day surgery.

Excellent hospital care : Commitment to provide acute hospital care from three hospital campuses (Wrexham Maelor, Glan Clwyd, Ysbyty Gwynedd)

Support services estate : Including offices, training and academic centres, residences, medical records storage, HSDU, laundry, workshops and call centre.

3.6 Vision for the Future Estate

3.6.1 Improving Health and Reducing Inequalities

Services focused on supporting health and wellbeing and reducing inequalities will be delivered in a range of settings to facilitate ease of public access. Locations for delivery may include:

- Public community facilities, such as sports and fitness centres, community halls, and libraries
- Commercial premises such as pharmacies, supermarkets, health stores, theatres/cinemas
- Health facilities (including primary care and general dental services)
- Local authority and third sector properties

3.6.2 Care Closer to Home

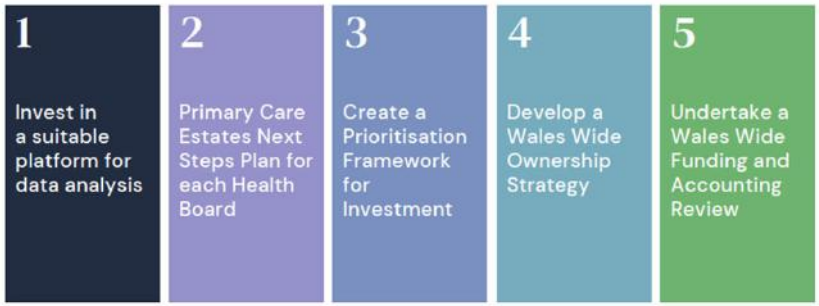
The future network of community facilities required to deliver primary care, community, and mental health, learning disability and substance misuse services will be developed to align with the 14 clusters across the three integrated health communities, meet population needs and consider the impact of geographical factors such as location, transportation links and travel times.

Health and Wellbeing Hubs

It is expected that each of the 14 clusters will be supported by at least one Health and Wellbeing Hub. This network of hubs will build upon the existing portfolio of community and local hospitals and Health and Wellbeing Centres. Health and Wellbeing Hubs may be delivered via use of existing properties, by reconfiguration of existing facilities or development of new properties.

Primary Care Centres

Welsh Government recently (Aug 2021) published the vision for primary care services and premises in Wales (Case for Change: Future for Primary Care Premises in Wales). This document sets out a roadmap to improvement for primary care estate in Wales. Key steps are listed below:



Key stages in this roadmap for all Health Boards focus on development of a next steps plan for primary care and creation of a prioritisation framework for investment.

The BCUHB clinical strategy for primary care is currently emerging. While the focus on Accelerated Cluster Development and delivery of place-based care within clusters is currently at the early stages, there are some notable examples of where BUCHB has begun to move forwards with the vision.

3.6 Vision for the Future Estate

As described within Living Healthier, Staying Well, the proposed network of primary care facilities will build upon the existing portfolio of primary care centres and health centres and will provide access points to health and wellbeing services in primary care settings. Primary Care Centres may be delivered by using existing properties, by reconfiguring existing facilities or by development of new properties. There should also be a drive to deliver primary care services from appropriate non-healthcare (e.g. town centre) premises.

Options for delivery of the primary care centre vision must ensure the provision of sufficient accommodation within facilities to enable delivery of effective and efficient education and training requirements. This will require further evaluation of preferred approaches for education and training (e.g. face to face vs virtual) and alignment with existing primary care space capacity and utilisation (likely to require investigation via the use of room occupancy software).

Delivery of the Care Closer to Home vision via Primary Care Centres and Health and Wellbeing Hubs should also consider the possibility of extended working to maximise asset utilisation and reduce capital investment.

BCUHB will continue to seek Welsh Government funding for the delivery of primary care services via the Health and Social Care Integration and Rebalancing Capital Fund (IRCF).

The Board will also continue to seek opportunities to access Welsh Government improvement grants to support improvement of the condition, functional suitability, performance and sustainability of non-BCUHB primary care estate, subject to value for money assessments.

3.6.3 Mental Health, Learning Disabilities and Substance Misuse

The BCUHB Mental Health Strategy (2017) outlines a vision to support prevention, early intervention, support of service users within the community and a reduction in acute admissions.

Inpatient care will continue to be focused on the three acute sites together with facilities providing secure/rehabilitation services, learning disability units, and Child and Adolescent Mental Health Services facilities.

Community services may be delivered from existing facilities or from Health and Wellbeing Hubs to normalise/destigmatise attendance and enhance service user experience. Community Mental Health Teams will be co-located with the wider community resource teams with some additional accommodation required for specialist support and interventional services.

Similarly, primary care mental health teams will deliver services from primary care premises.

3.6 Vision for the Future Estate

3.6.4 Excellent Hospital Care

There is a commitment to provide acute hospital care from the three hospital campuses at Ysbyty Gwynedd, Glan Clwyd Hospital and Wrexham Maelor Hospital.

There are plans for investment on all three acute sites, especially Wrexham Maelor Hospital and Ysbyty Gwynedd.

Relocation of activity to Regional Treatment Centres (RTCs), and potential relocation/consolidation of services across the three acute hospitals (to develop Centres of Excellence or ensure sustainability) present opportunities to vacate space on acute sites to accommodate growing services.

Administration space requirements on acute sites will be aligned with BCUHB's agile working policy and support the Welsh Government's target for 30% of the Welsh workforce to work remotely supported by technology and smart working processes. This will enable rationalisation of existing administration space and consolidation on acute sites or relocation off-site if essential functional relationships are not required (e.g. some corporate administration). Vacated administration space on acute sites may be used to accommodate growing clinical services or new care models.

3.6.5 Regional Treatment Centres

To increase and protect planned capacity, RTCs will provide outpatient appointments, diagnostic tests and day surgery.

Relocation of activity from the acute hospital sites to RTCs will vacate space on the acute sites to accommodate key service growth e.g. Emergency Department, Same Day Emergency Care, ambulatory care, GP out of hours, and facilitate compliance.

In addition, plans are being developed to expand capacity for orthopaedics under a separate initiative.

3.6.6 Support Services

BCUHB currently provides important clinical and non clinical support services from a range of freehold and leasehold properties. These services include:

- Administration (office space)
- Education and Training (Academic/Training centres)
- Staff/student accommodation (residences)
- Medical records (storage)
- Sterilisation and decontamination (Hospital Sterilisation and Decontamination Unit)
- Workshops
- Call centre

The future support services estate will be built upon strategic hubs, providing regional solutions whilst supporting local delivery e.g. centralised decontamination, regional administration hubs supporting IHCs (aligned with BCUHB's agile working policy and the Welsh Government's target for 30% of the Welsh workforce to work remotely).

This focus will reduce the current reliance on leased accommodation, eradicate duplication and rationalise the current owned assets to facilitate a more sustainable estate.

3.6 Vision for the Future Estate

3.6.7 Net Zero and Carbon Reduction

The Welsh Government has put sustainable development high on the agenda and, in 2021, announced their ambition of achieving net zero carbon status within the public sector by 2030. BCUHB has accordingly produced a decarbonisation plan aligned with NHS targets for emissions reduction, and this estates strategy triggers additional priorities that will support BCUHB to move 'beyond carbon'. Key priorities in terms of deliverables, outcomes and governance with the aim of future-proofing, greening and decarbonising our estate, are as follows:

Priority	Reduce carbon footprint	Ensure inclusive design	Address local economic inequality	Support sustainable transport	Compliance and best practice	Net zero estate	Resilience
Objective	2040 and 2045 net zero	Ensure inclusive design through the participation of local communities	Optimise local procurement and labour to support the local economy	Improved access for patients, staff and visitors	Comply with statutory regulations and best practice guidance	BREEAM standard of "very good" as a minimum	Reduced climate risk
KPI	Carbon emissions equivalent (CO_2e)	Compliance: Environment Act (Wales) 2016; Well-being of Future Generations (Wales) Act 2015	PM2.5, PM10 and nitrogen dioxide	Ratio of journeys-single occupancy against active/public/ sustainable	Organisational compliance risk score	Carbon emissions equivalent (CO_2e)	Exposure rating
Mechanism	Decarbonisation Plan	Accessibility audit	Clean Air Hospital Framework	Green Travel Plan	EMS	Heat Decarbonisation Plan	Climate Change Adaptation Plan

3.6 Vision for the Future Estate

3.6.8 Climate Adaptation

Whilst the mitigation of BCUHB's carbon footprint is vital to achieve Wales's ambition of a net zero Welsh public sector by 2030, it is also imperative to consider the risk that the physical effects of climate change pose to our future estate.

To account for future risk, a climate adaptation analysis has been run across our estate using Cervest's EarthScan climate intelligence interface. The software incorporates global and regional climate models, including the Coupled Model Intercomparison Project (CMIP6) and the Coordinated Regional Downscaling Experiment (CORDEX), to produce accurate future projections of physical climate risks over historical observational baselines.

The physical climate risks modelled across the BCUHB estate include heat stress, extreme precipitation, drought, extreme wind, flooding and wildfire.

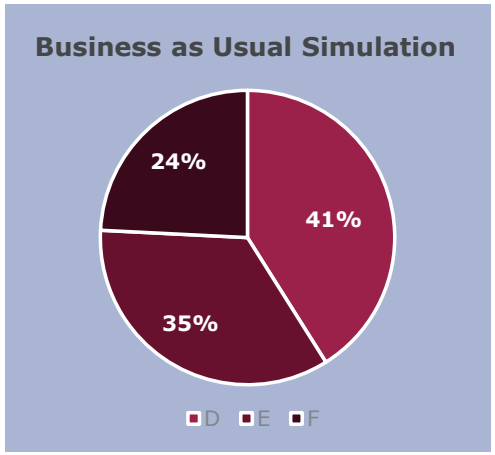
The EarthScan interface allows for the manipulation of climate modelling parameters. In line with the UK's net zero target of 2050, the BCUHB analysis has been tailored to model climate risk for the year of 2050 across two differing climate scenarios:

1) Business as Usual (no-policy highest emitting climate scenario)
2) Paris Aligned (<2°C global warming with best efforts to limit to 1.5°C)

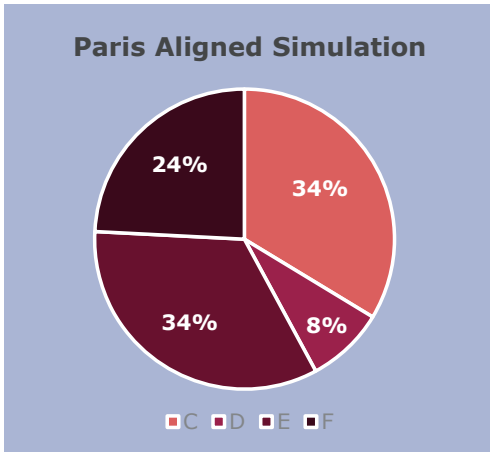
The climate risks generated for each building are quantified via a numerical scope that corresponds to a graded rating. Ratings provide a quick and clear indication of climate related risk, to reveal vulnerabilities and identify opportunities.

Cervest Rating	Cervest Score	Description
A	833-999	Excellent: very low climate-related risk
B	667-832	Good: low climate-related risk
C	501-666	Moderate: medium climate-related risk
D	334-500	Poor: high climate-related risk
E	167-333	Very poor: very high climate-related risk
F	0-166	Extremely poor: extremely high climate related risk

The graphs below display the combined physical risk rating across the two modelled scenarios. This rating is the result of the synthesis of all projected physical climate risks to facilitate comparison of building assets across multiple modelled climate risks. Addressing risks identified will be part of the site specific analysis.



Combined physical risk rating of BCUHB estate under BAU scenario



Combined physical risk rating of BCUHB estate under Paris aligned scenario

4.0 How Do We Get There?

4.1 Summary Priorities Statement

Engagement with stakeholders across BCUHB revealed a number of common themes around strategic ambitions for the estate.

Future State - Stakeholder Engagement

Engagement with stakeholders from the following key groups was undertaken, either via structured interviews or workshops, to understand key priorities to inform development of the future estate vision.

Integrated Health Communities and clinical leads

- Ysbyty Gwynedd
- Glan Clwyd Hospital
- Wrexham Maelor Hospital
- Community Dental Services
- Primary and Community Care
- Mental Health and Learning Disabilities
- Midwifery and Women's Services
- Cancer and Diagnostics and Clinical support
- Patient Safety and Experience

Corporate and external

- Board
- Health Board Leadership Team
- Capital Investment Group
- Clinical Senate
- Community Health Council

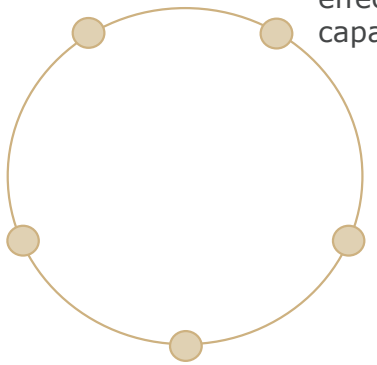
Estates

- Health, safety, and equality
- Operational estates
- Property and asset management

Balancing Strategic Ambitions

New space for growth
A legacy of underestimating the estates impact of new or expanded services reported by respondents

Service interdependencies
Desire for co-locations limited by cost effectiveness and capacity



Financing
Extremely tight capital and revenue funding will initially constrain realisation of our ambition in the short term

Fixed points
3 DGH model will remain with opportunities for consolidation and off-site transfers

New models of care
The recently formed IHCs face the challenge of balancing system-wide objectives with legitimate local variation

4.2 Initial Agreed Priorities

The proposed development of the estate to support BCUHB's suite of enabling strategies provides the opportunity to repurpose, reconfigure and rationalise the current estate portfolio.

This estate strategy proposes repurposing and reconfiguring some existing community facilities, and providing new build facilities where required, to deliver the Health & Wellbeing Hub and Primary Care Centre infrastructure to support Care Closer to Home.

Particular focus should be given to the identified high risk properties, including addressing the issues on the Wrexham Maelor and Ysbyty Gwynedd acutes sites. Consideration must also be given to the roles of Abergele Hospital and Bryn Y Neuadd Hospital sites, within the context of the key strategies of BCUHB and the Welsh Government, as both hospital sites are not sustainable in their current forms.

The Full Business Case for the new North Denbighshire Community Hospital, planned to be built next to the replaced existing Royal Alexandra Hospital, was submitted to Welsh Government in March 2021 (approval decision is currently pending). This remains a priority project for BCUHB.

From 2019/20 to 2021/22, the size (GIA m2) of our property portfolio size has decreased by 8% (from 456,000 m^2 to 420,000 m^2) against a target reduction of 5%. This estate strategy suggests further opportunity to consolidate the estate, particularly to a smaller number of key strategic sites and rationalised support services such as administration.

To better understand this opportunity, there is a requirement to revisit the key targets for reduction in property portfolio size and estate revenue costs and undertake supporting detailed analysis and projections.

Based on recent reductions in the property portfolio, and subject to engagement and, when appropriate, formal consultation, there may be further opportunity for BCUHB to reduce the estate portfolio size against a confirmed target emerging from deep dive analysis. This would reduce some of the current estate risks and release resources to support the reconfigured estate and alternative funding models.

Initial pipeline of priorities identified by BCUHB

The following schemes have been identified by BCUHB as priorities on the capital programme, with business cases currently in progress or completed:

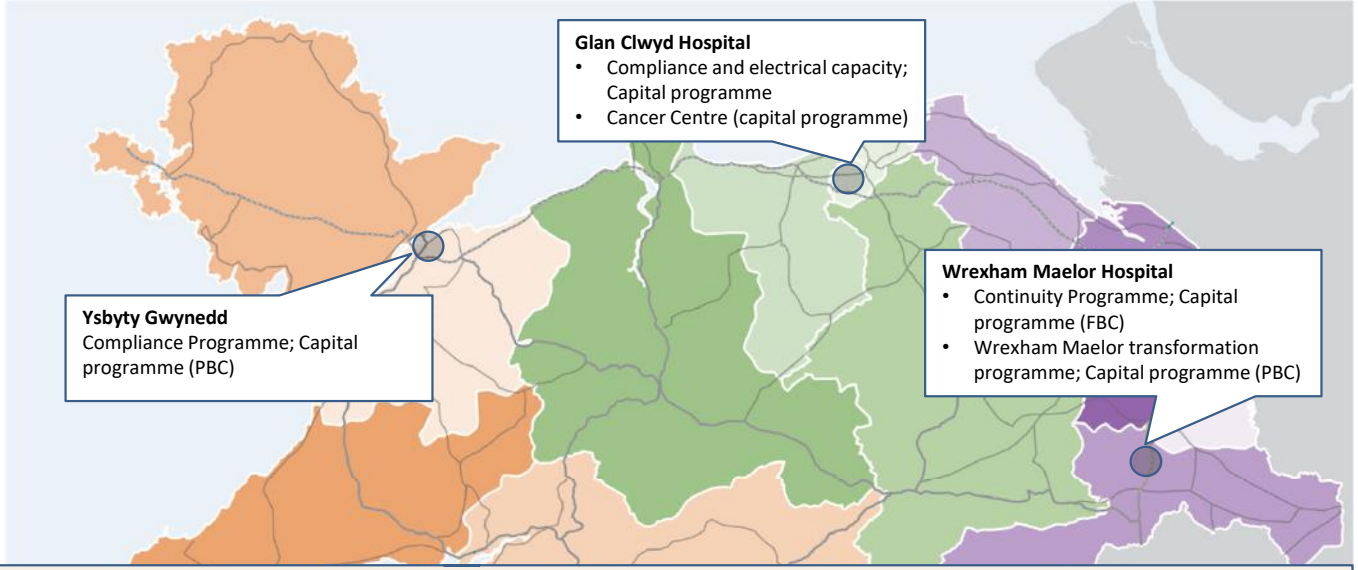
- Wrexham Maelor Hospital infrastructure continuity programme
- Ysbyty Gwynedd fire compliance programme
- Regional Treatment Centre programme and expanded orthopaedics capacity
- Royal Alexandra Hospital development project
- Replacement of the Ablett Unit at Glan Clwyd Hospital
- Medical and Health Sciences School

The estate strategy will be subject to regular review aligned with the IMTP cycle and will identify any changes in estate priorities.

Identified additional estate opportunities are detailed in section 4.3. These, and others, will be subject to further evaluation and development aligned to the estate vision.

4.3 Opportunities – Acute Sites

Following engagement with key BCUHB stakeholder leads, and review of options previously identified for the BCUHB 2019 Estate Strategy, estate strategy opportunities relating to acute hospital sites were identified (shown opposite and described below). These opportunities will require further investigation and discussion with key BCUHB stakeholders to confirm project options to be evaluated and prioritised for the capital investment plan. As a result of the estate response to clinical strategy implementation, there may be opportunities to repurpose, reconfigure or rationalise our estate. As discussed in section 4.13, as the priority areas identified within this estate strategy are taken forward, we will continue to engage with staff, communities and stakeholders to further develop the future estate requirements. In some areas these changes may require formal consultation.



Opportunities Applicable To All Acute Sites

Regional Treatment Centres

- To increase and protect planned capacity, Regional Treatment Centres (RTCs) will provide outpatient appointments, diagnostic tests and day surgery
- Relocation of activity from the acute hospital sites to RTCs will vacate space on the acute sites to accommodate key service growth e.g. Emergency Department, Same Day Emergency Care, ambulatory care, GP out of hours and facilitate compliance
- Plans are being developed to expand capacity for orthopaedics under a separate initiative

Relocate/consolidate services across North Wales (acutes)

- Potential relocation/consolidation of services across the three acute hospitals (to develop Centres of Excellence or ensure sustainability) presents opportunities to vacate space on acute sites to accommodate growing services

Administration space

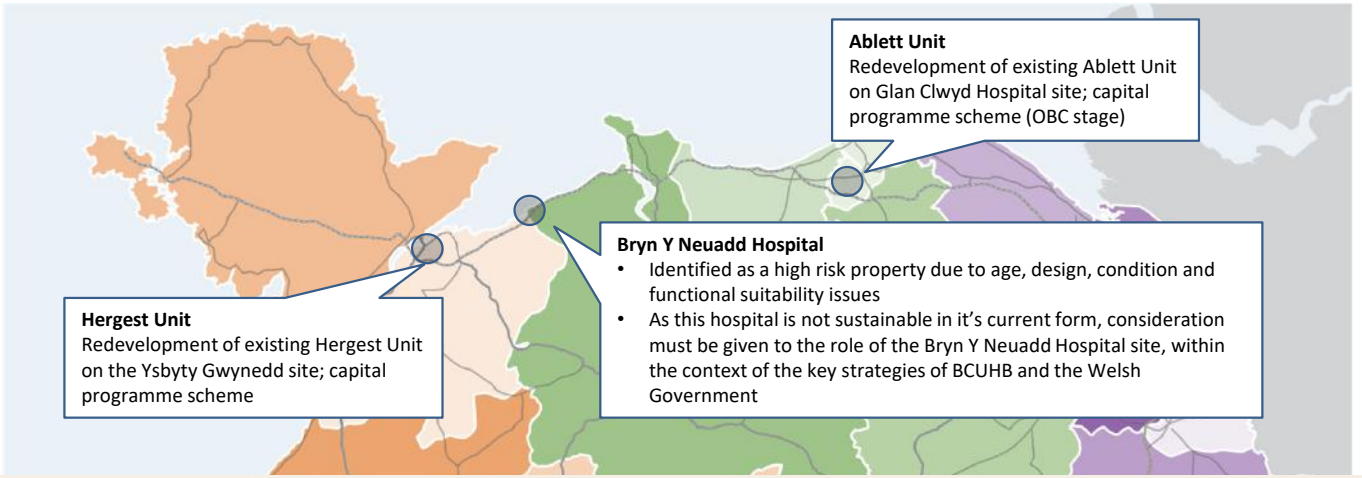
- Administration space requirements on acute sites will be aligned with BCUHB's agile working policy and support the Welsh Government's target for 30% of the Welsh workforce to work remotely supported by technology and smart working processes. This will enable rationalisation of existing administration space and consolidation on acute sites or relocation off-site (potentially to corporate administration hubs) if essential functional relationships are not required (e.g. some corporate administration)
- Vacated space may be used to accommodate growing clinical services / new care models

4.4 Opportunities – Mental Health & Learning Disabilities

Mental Health & Learning Disabilities

Following engagement with key BCUHB stakeholder leads, and review of options previously identified for our 2019 Estate Strategy, estate strategy opportunities relating to mental health and learning disability properties were identified (shown opposite and described below). These opportunities will require further investigation and discussion with key BCUHB stakeholders to confirm project options to be evaluated and prioritised for the capital investment plan.

As a result of the estate response to clinical strategy implementation, there may be opportunities to repurpose, reconfigure or rationalise our estate. As discussed in section 4.13, as the priority areas identified within this estate strategy are taken forward, we will continue to engage with staff, communities and stakeholders to further develop the future estate requirements. In some areas these changes may require formal consultation.



Opportunities Required for Current Issues

- **Space utilisation:** there is currently a lack of effective information to understand how well allocated space is being used e.g. Bryn Y Neuadd Hospital
- **Capacity issues in community facilities**: opportunities exist to optimise use of space, repurpose/reconfigure, and relocate teams and services to provide better colocation of staff and services
- **Current service provision gaps** e.g. perinatal mental health service, adult eating disorder clinic
- **Repatriation:** service users are still being sent out of area, specifically in terms of secure units (no provision for women in Wales at all); continuing healthcare patients with complex needs often have to be sent out of area (long term placements)
- **Estate gaps:** there is insufficient estate to establish equitable services (as per Royal College guidelines); require additional rented accommodation to deliver services
- **Older Person's inpatient capacity:** recent reduction in beds due to changing model for managing care; likely future capacity constraints due to ageing population (potentially more of an issue in west IHC)
- **Adult inpatient capacity Wrexham**: current inpatient capacity constraints
- **Inappropriate mixing of patient cohorts:** recent Health Inspector review; mixing older persons and adult 18+; appropriate segregation required

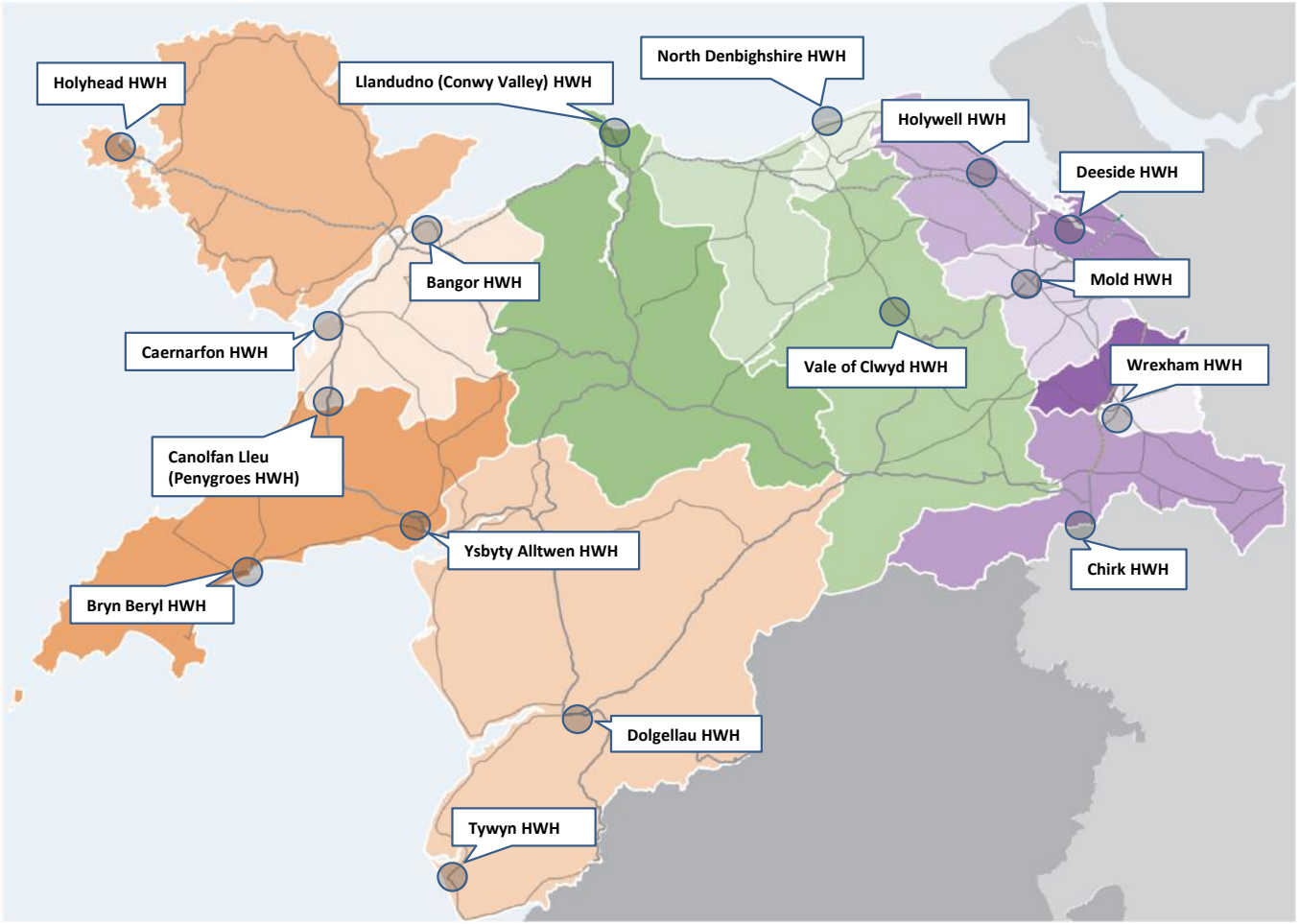
4.5 Opportunities - Health and Wellbeing Hubs

Health and Wellbeing Hubs

Following engagement with stakeholder leads from the three Integrated Health Communities, and review of options previously identified for the BCUHB 2019 Estate Strategy, opportunities to enable delivery of the network of Health and Wellbeing Hubs were identified (shown opposite).

These opportunities will require further investigation and discussion with key BCUHB stakeholders to confirm project options to be evaluated and prioritised for the capital investment plan.

As a result of the estate response to clinical strategy implementation, there may be opportunities to dispose of a number of BCUHB properties. As discussed in section 4.13, as the priority areas identified within this estate strategy are taken forward, we will continue to engage with staff, communities and stakeholders to further develop the future estate requirements. In some areas these changes may require formal consultation.



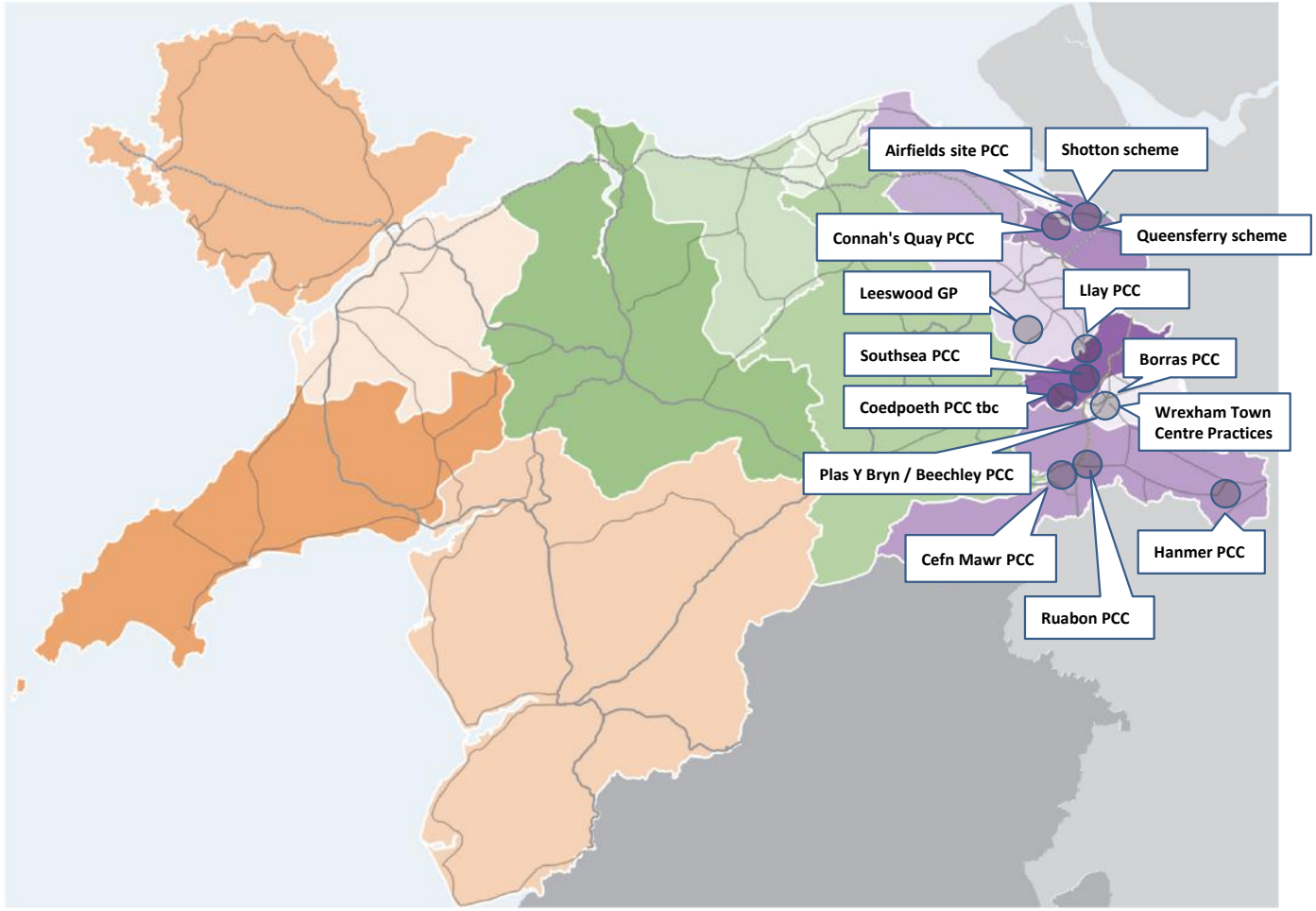
4.6 Opportunities - Primary Care Centres (East)

Primary Care Centres – East IHC

Following engagement with stakeholder leads from the East Integrated Health Community, and review of options previously identified for the BCUHB 2019 Estate Strategy, opportunities to enable delivery of the network of Primary Care Centres were identified (shown opposite).

These opportunities will require further investigation and discussion with key BCUHB stakeholders to confirm project options to be evaluated and prioritised for the capital investment plan.

As a result of the estate response to clinical strategy implementation, there may be opportunities to dispose of a number of BCUHB properties. As discussed in section 4.13, as the priority areas identified within this estate strategy are taken forward, we will continue to engage with staff, communities and stakeholders to further develop the future estate requirements. In some areas these changes may require formal consultation.



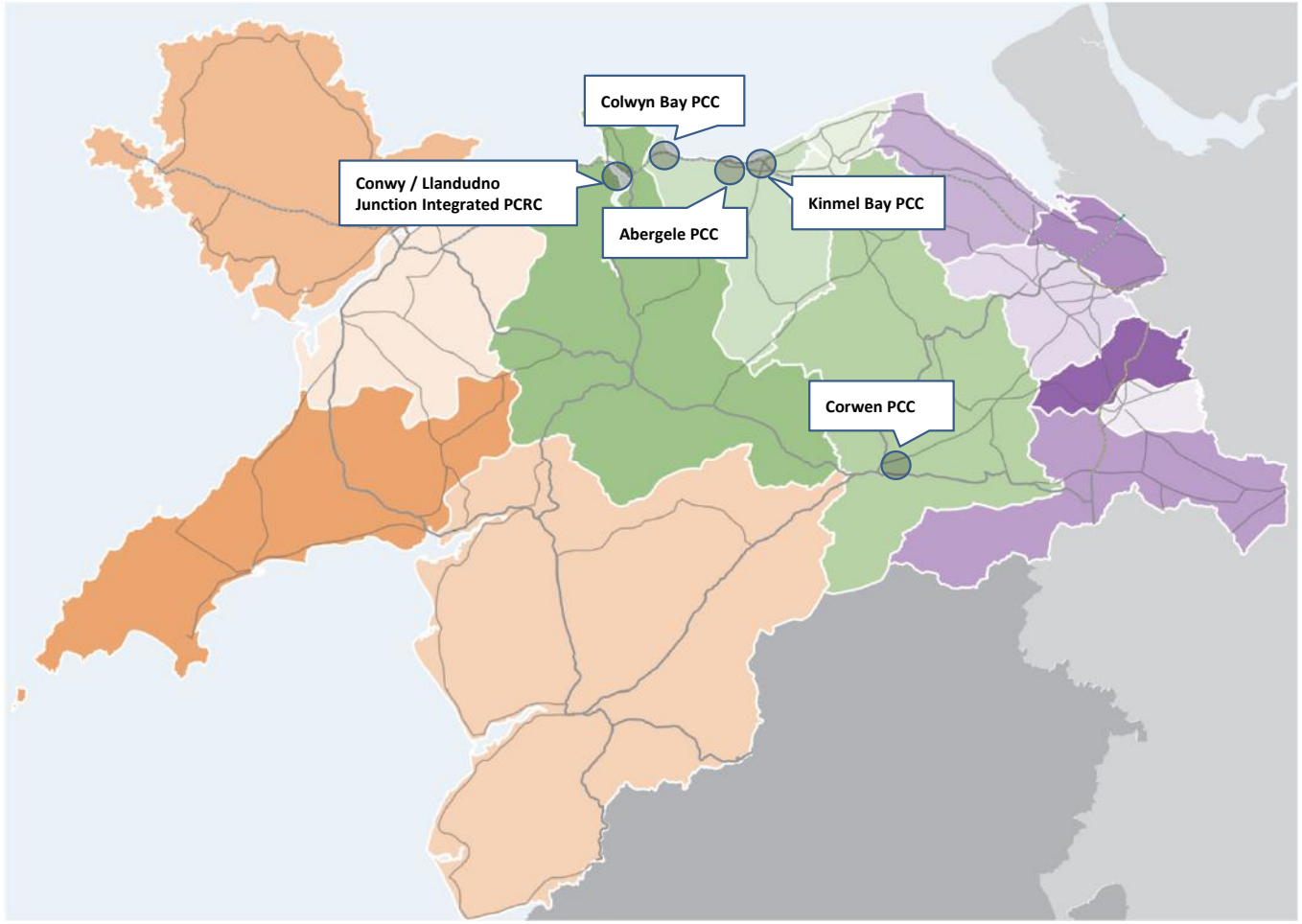
4.7 Opportunities - Primary Care Centres (Central)

Primary Care Centres – Central IHC

Following engagement with stakeholder leads from the Central Integrated Health Community, and review of options previously identified for the BCUHB 2019 Estate Strategy, opportunities to enable delivery of the network of Primary Care Centres were identified (shown opposite).

These opportunities will require further investigation and discussion with key BCUHB stakeholders to confirm project options to be evaluated and prioritised for the capital investment plan.

As a result of the estate response to clinical strategy implementation, there may be opportunities to dispose of a number of BCUHB properties. As discussed in section 4.13, as the priority areas identified within this estate strategy are taken forward, we will continue to engage with staff, communities and stakeholders to further develop the future estate requirements. In some areas these changes may require formal consultation.



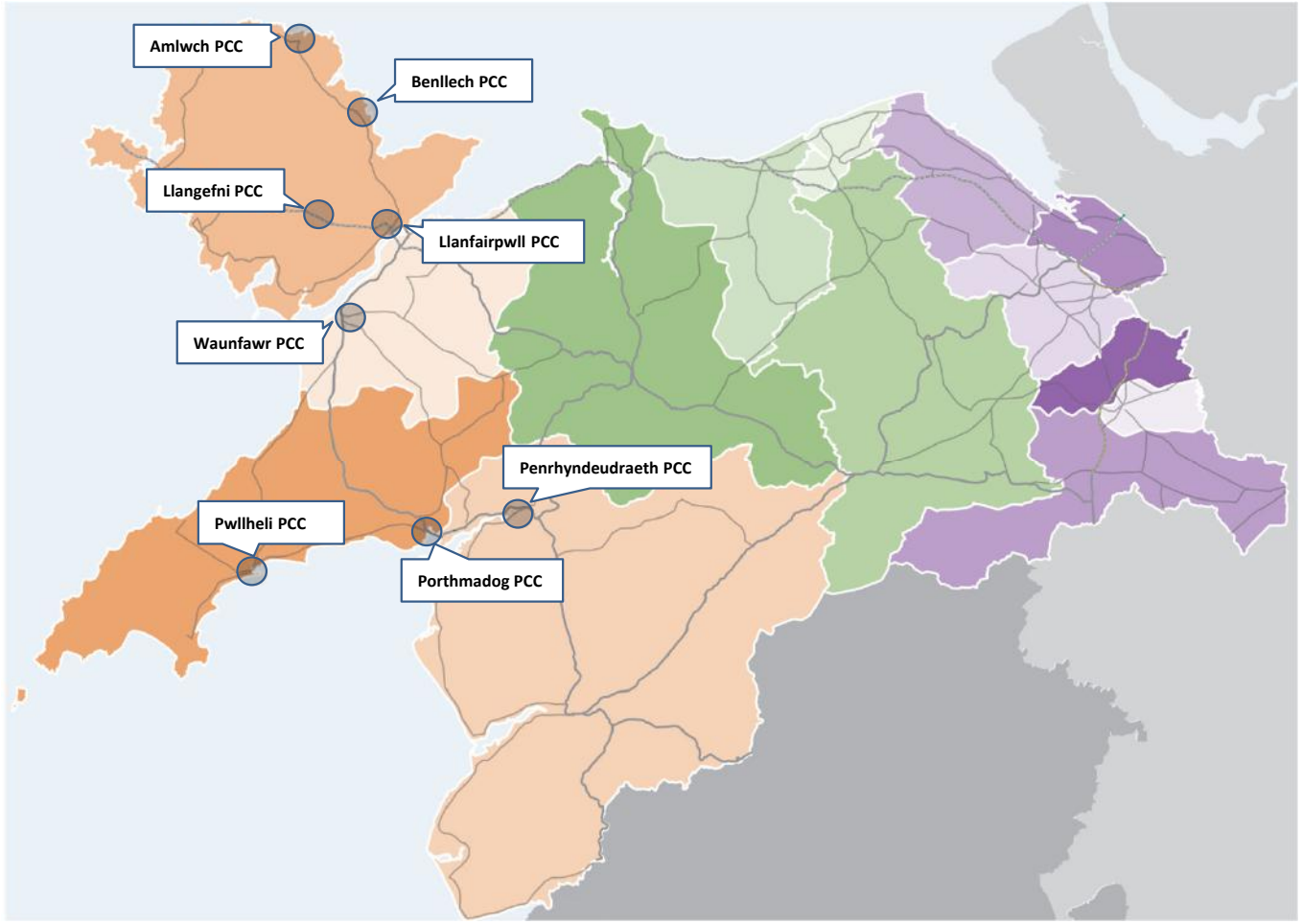
4.8 Opportunities - Primary Care Centres (West)

Primary Care Centres – West IHC

Following engagement with stakeholder leads from the West Integrated Health Community, and review of options previously identified for the BCUHB 2019 Estate Strategy, opportunities to enable delivery of the network of Primary Care Centres were identified (shown opposite).

These opportunities will require further investigation and discussion with key BCUHB stakeholders to confirm project options to be evaluated and prioritised for the capital investment plan.

As a result of the estate response to clinical strategy implementation, there may be opportunities to dispose of a number of BCUHB properties. As discussed in section 4.13, as the priority areas identified within this estate strategy are taken forward, we will continue to engage with staff, communities and stakeholders to further develop the future estate requirements. In some areas these changes may require formal consultation.



4.9 Delivering the vision

Prioritisation

- Financial criteria
- Non-financial criteria
- Banding methodology

Targeted deep dive analysis

For example:

- Utilisation, access
- Equality Impact Assessment
- Socio-Economic Impact Assessment

Collaborative delivery

- Integrated partnership approach (e.g. Health and Wellbeing Hubs)
- RPB Integrated care fund priorities
- BCUHB residence JV

Managing delivery

- Prioritised project pipeline
- Business case process
- Project Boards / Working groups
- Iterative implementation of strategy

April 2023 to April 2033

Strategy Alignment

- National
- BCUHB: Clinical, Digital, Workforce, Agile, Net Zero

Continued engagement and consultation

- Stakeholders, staff, communities
- Further develop estate requirements and implementation plans
- Formal consultation may be required

Repurpose, Reconfigure Rationalise

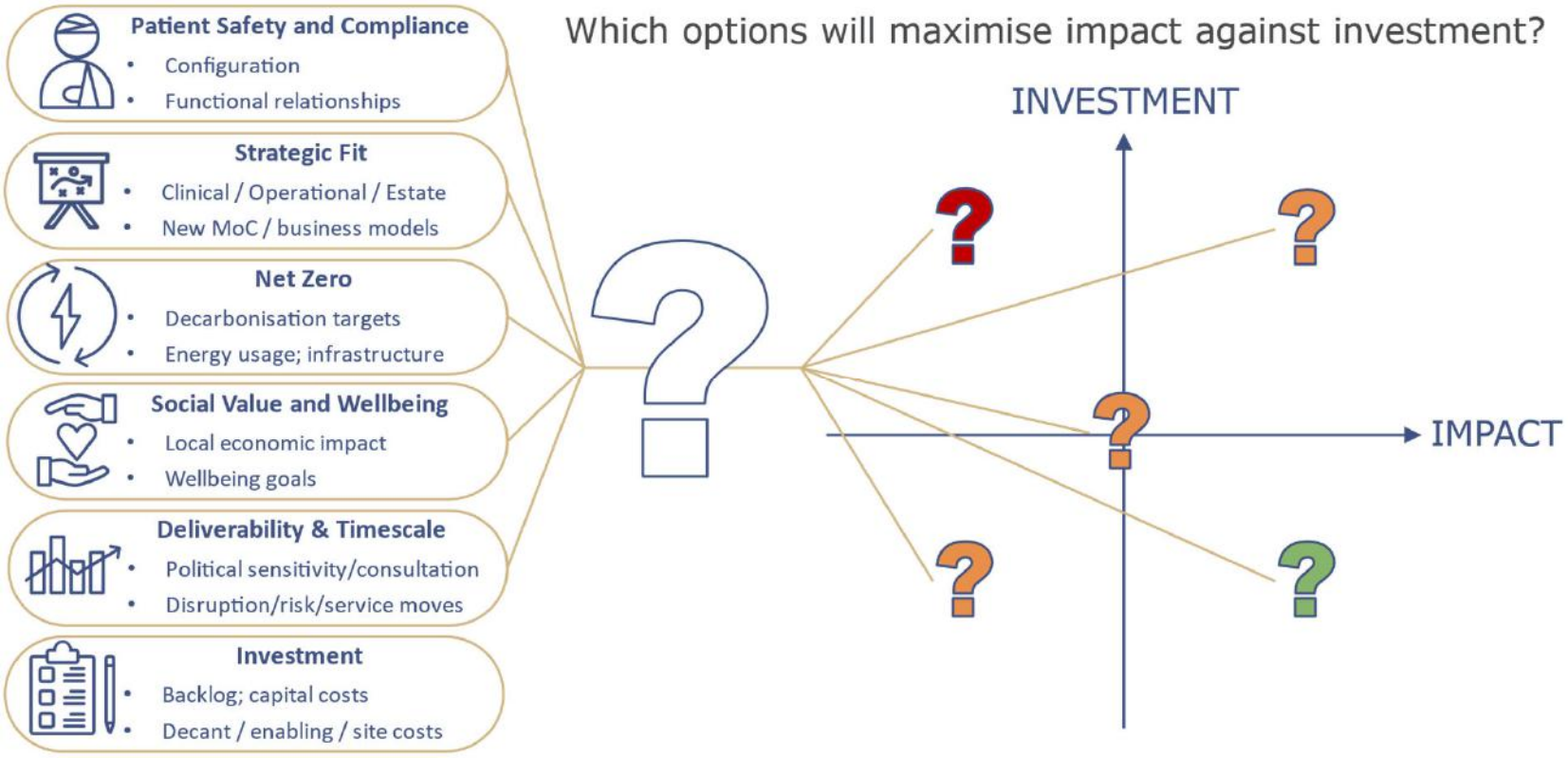
- In response to BCUHB strategies
- Improve patient pathways
- Contribute to net zero

Measuring success

- Monitoring of KPIs
- Improvement dashboard
- Review targets/strategy and update

4.10 Prioritisation and Impact: Evaluation Criteria

To determine future investment requirements and changes to the estate, evaluation and prioritisation of projects must be undertaken on an iterative basis to ensure alignment with key criteria and underpinning enabling strategies. The evaluation criteria summarised below have been agreed for use by the Board. These criteria will be applied to evaluate and determine the priority order of future projects to inform the BCUHB capital investment programme and project implementation plans.



4.11 Strategy Alignment

This Estate Strategy forms a vital component of a suite of BCUHB enabling strategies that both support key NHS Wales Strategies and BCUHB's Living Healthier, Staying Well vision and inform BCUHB transformation programmes and delivery plans (summarised below). The BCUHB enabling strategies are interdependent and must be complementary to ensure successful delivery. BCUHB strategies will require regular updating. Prioritisation of infrastructure projects should be aligned with the key suite of BCUHB strategies.

Key Strategies	Living Healthier, Staying Well; A Healthier Wales; Pan Wales Digital Strategy; NHS Wales Decarbonisation SDP						
Strategic Objectives	Improve health and wellbeing for all and reduce health inequalities	Support children to have the best start in life	Work in partnership to design and deliver excellent care closer to home	Support, train and develop our staff to excel	Improve the safety and quality of all services	Respect individuals and maintain dignity and care	Listen to and learn from the experiences of individuals
Overlapping Major Programmes	Improving health and reducing inequalities		Care closer to home		Excellent hospital care		
Key Enabling Strategies	BCUHB Clinical Services Strategy • Quality improvement and patient experience	BCUHB People Strategy & Plan • Whole health, care and support systems workforce	Our Digital Future • Digital roadmap for health in North Wales	BCUHB Decarbonisation Action Plan • Reduce carbon emissions	BCUHB Estates Strategy • Infrastructure to support delivery of BCUHB strategies		
Transformation Programmes	Three year Service Transformation Programmes (Integrated Medium Term Plans)						
Overlapping Major Programmes	Underpinning Divisional/Service Delivery Plans						

4.12 Targeted Deep Dive Analysis

Further detailed information and analysis may be required to inform projects and enable better evaluation and prioritisation of estate options. Targeted deep dive analysis may include as appropriate on a project by project basis:

- Demand and capacity modelling (clinical activity and administrative activity) to determine future capacity requirements
- Space utilisation studies to identify baseline capacity surplus/shortfall, support demand and capacity modelling, and inform options
- Site feasibility studies to understand the range of options
- Analyses to support patient/service user/staff access and travel times to specific properties and locations
- Impact of new models of care and site locations on staffing models and requirements
- Equality Impact Assessment for estate options
- Socio-Economic Impact Assessment for estate options

4.13 Continued Engagement and Consultation

This estate strategy has been developed in response to BCUHB's 10 year strategy to improve health, well-being and healthcare in North Wales. Living Healthier, Staying Well was subject to significant engagement and co-produced with partners and communities across North Wales. The foundations of this strategy have therefore been built on the priorities determined by the population of North Wales.

Also, this estate strategy forms a key component of a suite of BCUHB enabling strategies which are interdependent and complementary to successful delivery.

As we take forward the priority areas identified within this estate strategy we will continue to engage with staff, communities and stakeholders to further develop the future estate requirements and co-produce associated detailed implementation plans. It is clear that our estate must change if it is to be sustainable, viable and support the implementation of Living Healthier, Staying Well. In some areas these changes may require formal consultation.

4.14 Collaborative Delivery

Further partnership working between health, local authority and third sector partners to deliver integrated community services, together with new business models for non-clinical services, present opportunities for partners to develop integrated solutions, share collective property assets and promote joint developments.

The identification, evaluation and prioritisation of opportunities to promote collaborative delivery will form part of an iterative process.

These new models of delivery will require formal contractual agreements between each party to ensure clarity of responsibility, liability (financial and non-financial) and governance. Where such agreements impact upon BCUHB's accounting regime, for example joint ventures, formal support will also be required from Welsh Government.

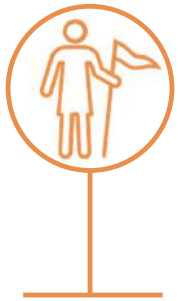
4.15 Managing Delivery

Following evaluation and prioritisation of projects, an agreed prioritised investment pipeline will be defined within BCUHB's Integrated Medium Term Plan.

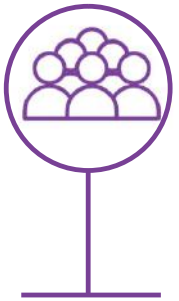
All projects will be subject to the development of appropriate business cases for formal approval in accordance with the Board's Standing Financial Instructions. Business cases will establish the benefits to be realised and define the quality, cost and time parameters.

Projects will be required to comply with BCUHB policy and procedures for managing capital projects. Discrete project boards will be established to deliver the agreed projects. Each project board will be led by a Project Director, under the overall leadership of a Senior Responsible Owner, with a clear responsibility to ensure that the project is delivered within the agreed parameters and realises the expected benefits.

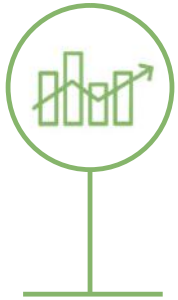
Implementation of the estate strategy will be an iterative process which must be flexible and able to respond to the changing needs, priorities and financial challenges of the BCUHB.



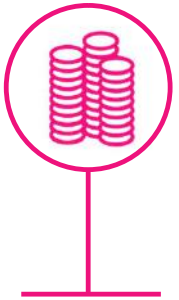
Leadership



People and capability



Data driven decisions



Investment

4.16 Measuring Success

Estate Strategy Implementation

The existing BCUHB Capital Investment Group (CIG) will advise the BCUHB Board and other key groups on the development and implementation of the estate strategy and ensure that property assets occupied by BCUHB services are utilised, managed and developed optimally and align with BCUHB service and business needs and available resources.

Monitoring of Key Performance Indicators

Key performance indicators (KPIs) have been established to monitor the delivery and success of the estate strategy. The estate strategy should target delivery of the KPIs shown opposite.

Improvement Dashboard and Performance Management Arrangements

The most efficient and effective way to ensure that focus is maintained on delivering the improvement expected is by embedding the measures within routine performance management arrangements. Within BCUHB, mechanisms already exist for appraising performance and testing progress against targets. Benefits from capital and revenue projects should be assimilated into this process.

Regular Review and Update

The estate strategy will be reviewed and updated to align with Integrated Medium Term Plan timescales.

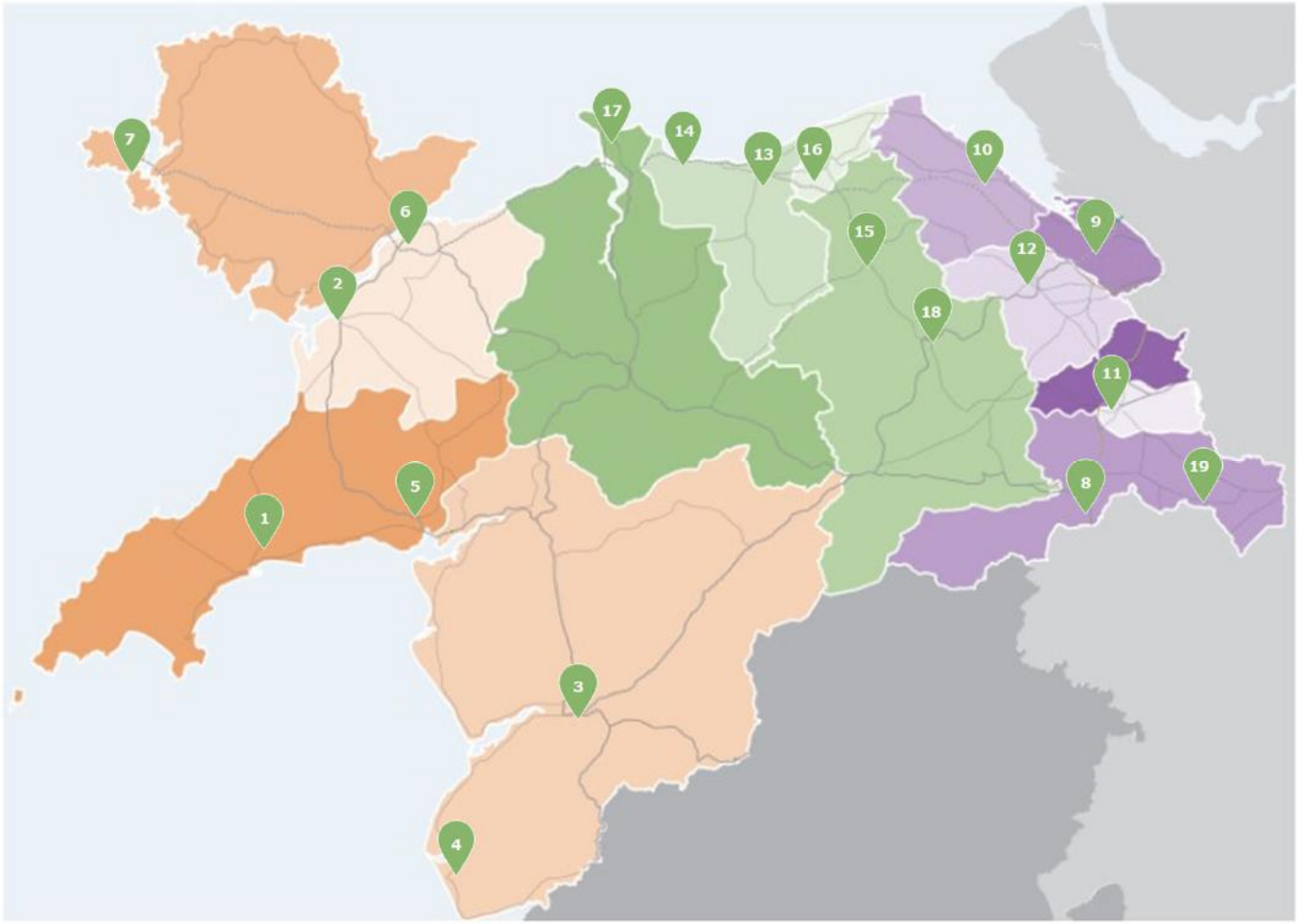
Indicator	Definition	Target
Revenue cost	Reduction in estate revenue cost	3% per IMTP cycle
Property portfolio	Planned reduction in property portfolio	5% per IMTP cycle
Statutory Compliance	A minimum of 90% of the estate should comply with relevant statutory requirements	Meet national target within 10 years
Fire Safety Compliance	A minimum of 90% of the estate should comply with relevant statutory requirements	Meet national target within 10 years
Energy Performance	The estate should consume no more than 410 kWh/m^2	Meet national target within 10 years
Backlog maintenance (BLM)	• 90% reduction in high risk BLM • 75% reduction in significant risk BLM • 70% reduction in risk adjusted BLM	Meet target within 10 years
Physical condition	A minimum of 90% of the estate should be sound, operationally safe and exhibit only minor deterioration	Meet national target within 10 years
Functional Suitability	A minimum of 90% of the estate should meet clinical and business operational requirements with only minor changes needed	Meet national target within 10 years
Space Utilisation	A minimum of 90% of the estate should be fully used	Meet national target within 10 years

Appendix 1 – Stakeholders Engaged

- Alison Kemp - Associate Director Community and Primary Care Central IHC
- Alyson Constantine - Director of Operations, Central IHC
- Andrea Williams - Head of Informatics Programmes, Assurance, and Improvement
- Anita Pierce - Deputy Medical Director Mental Health & Learning Disabilities
- Arwel Hughes - Head of Operational Estates
- Barry Williams - Hospital Director, Ysbyty Gwynedd
- Carolyn Owen - Assistant Director of Patient and Carer Experience
- Chris Lindop - Head of Planning and Performance, Mental Health, and Learning Disabilities
- Clive Ball - Head of Property Services Cardiff
- David Fletcher - Divisional General Manger, Diagnostics and Clinical Support
- Eleri Roberts - Associate Director, Community, West IHC
- Gemma Nosworthy - Primary Care Academy Manager
- Geraint Roberts - Divisional General Manager, Cancer
- Hazel Davies - Hospital Director, Wrexham Maelor Hospital
- Ian Donnelly - Director of Operations, East IHC
- Jo Flannery - Senior Health Planning Manager
- Jodie Berrington - Primary Care West
- John Thomas - Head of ICT Digital Services
- Laura Vernon - Deputy Divisional General Manager- Cancer
- Liz Davis - General Manger Midwifery and Women's Services
- Martin Woodcock - Senior Property and Asset Manager
- Neil Rogers - Director of Operations, West IHC
- Paul Andrews - Hospital Director, Glan Clwyd Hospital
- Paul Bowker - Principal Programme Manager, North Wales Community Dental Services
- Paul Clarke - Head of Facilities Management
- Peter Bohan - Associate Director of Health, Safety and Equality
- Rachel Wright - Patient and Carer Experience Lead
- Rachael Page - Associate Director Primary Care, East IHC
- Rod Taylor - Director of Estates and Facilities
- Shaun Taylor - Planning and Commissioning Manger
- Wyn Thomas - Associate Director, Primary Care, West IHC
- BCUHB Capital Investment Group
- BCUHB Leadership Team
- BCUHB Board
- BCUHB Clinical Senate
- BCUHB Community Health Council

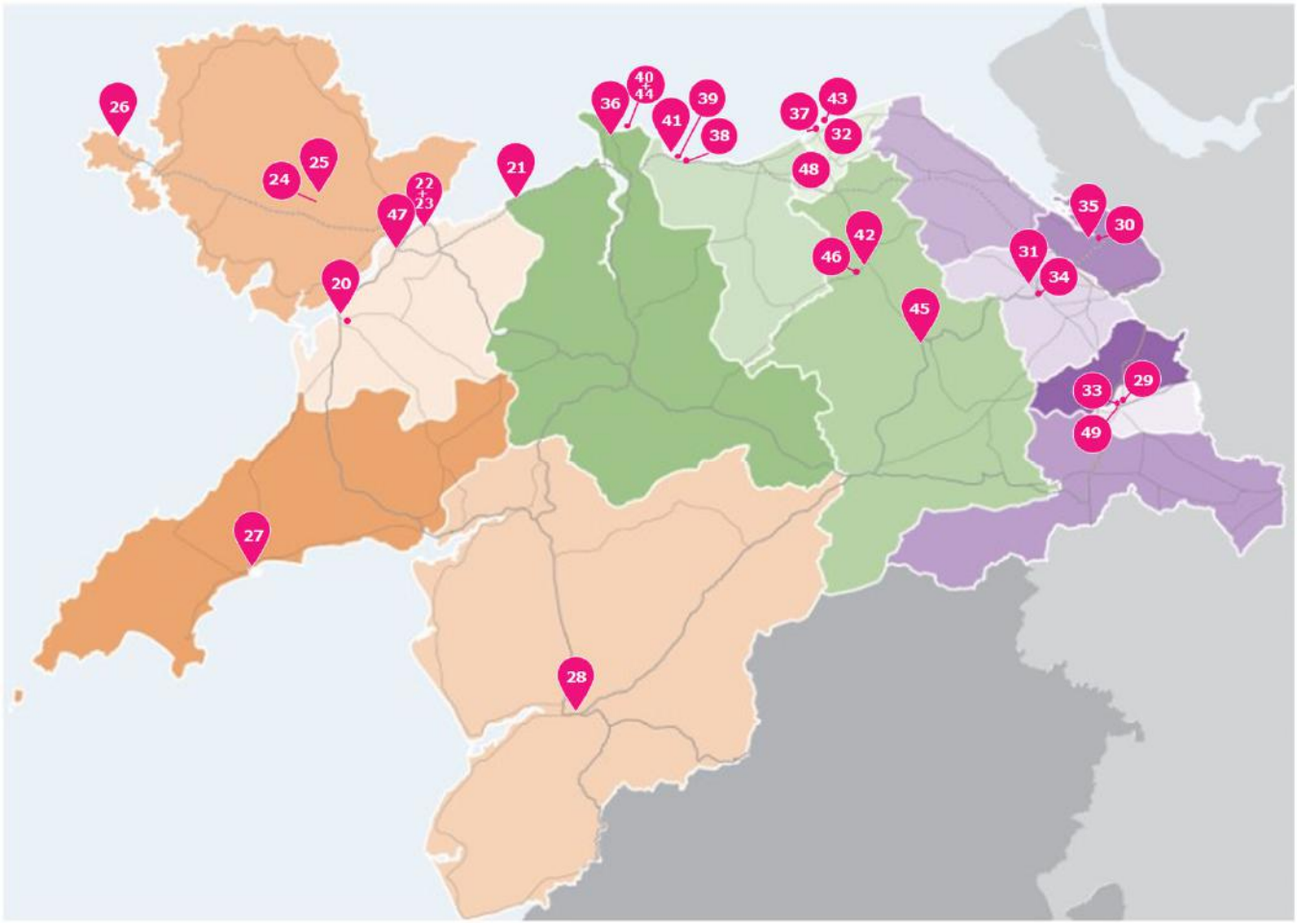
Appendix 2 – BCUHB Estate Locality Maps

BCUHB Estate Locality Map - Hospitals



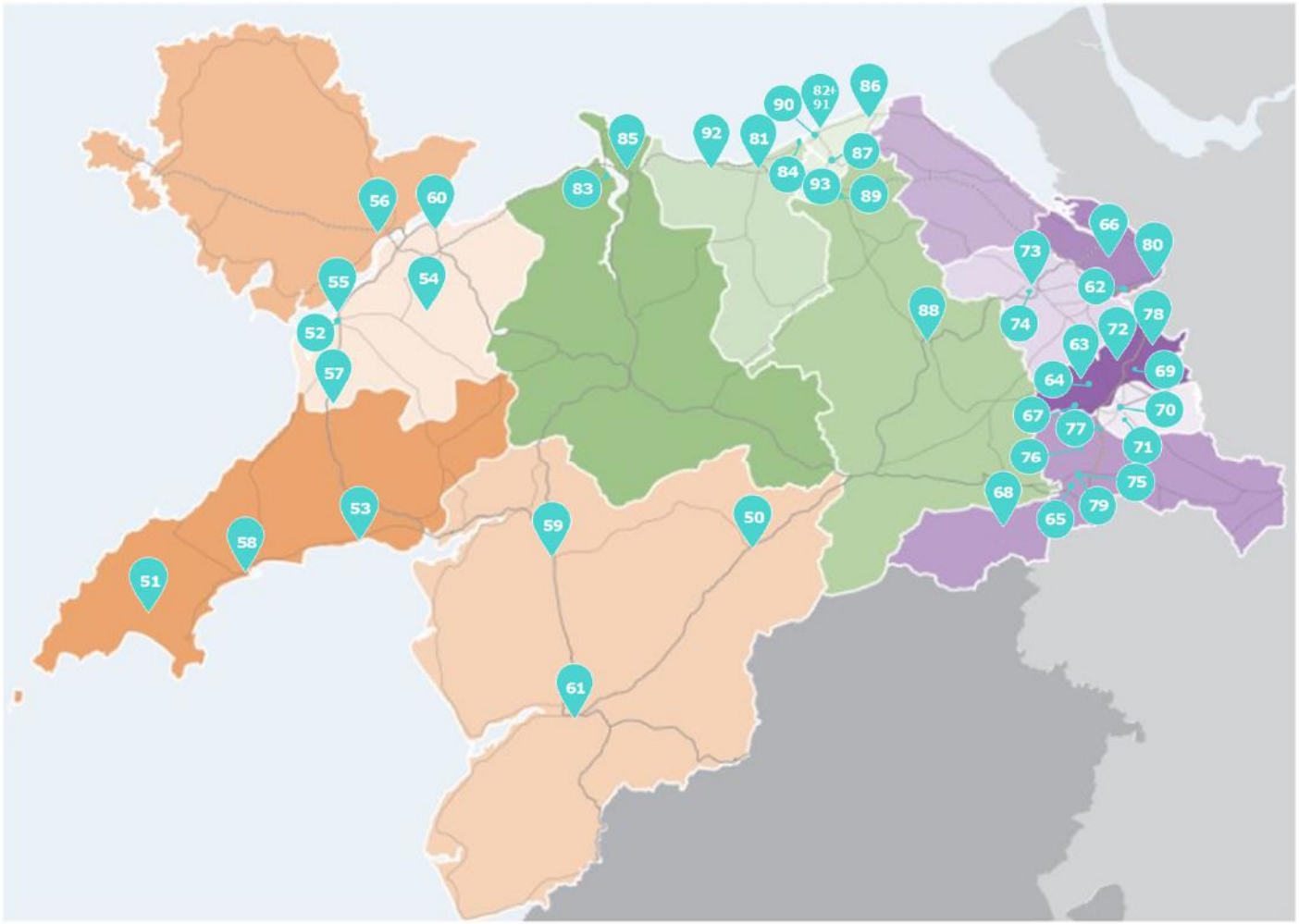
1	Bryn Beryl Hospital
2	Eryri Hospital & Bodfan, Caernarfon (Rehabilitation)
3	Dolgellau & Barmouth District Hospital
4	Tywyn & District War Memorial Hospital
5	Ysbyty Alltwen
6	Ysbyty Gwynedd
7	Ysbyty Penrhos Stanley
8	Chirk Community Hospital
9	Deeside Community Hospital
10	Holywell Community Hospital
11	Wrexham Maelor Hospital
12	Mold Community Hospital
13	Abergele Hospital
14	Colwyn Bay Community Hospital
15	Denbigh Community Hospital & Clinic
16	Glan Clwyd Hospital
17	Llandudno Hospital
18	Ruthin Community Hospital
19	Penley Rehabilitation Hospital (Rehabilitation)

BCUHB Estate Locality Map - Mental Health & Learning Disabilities



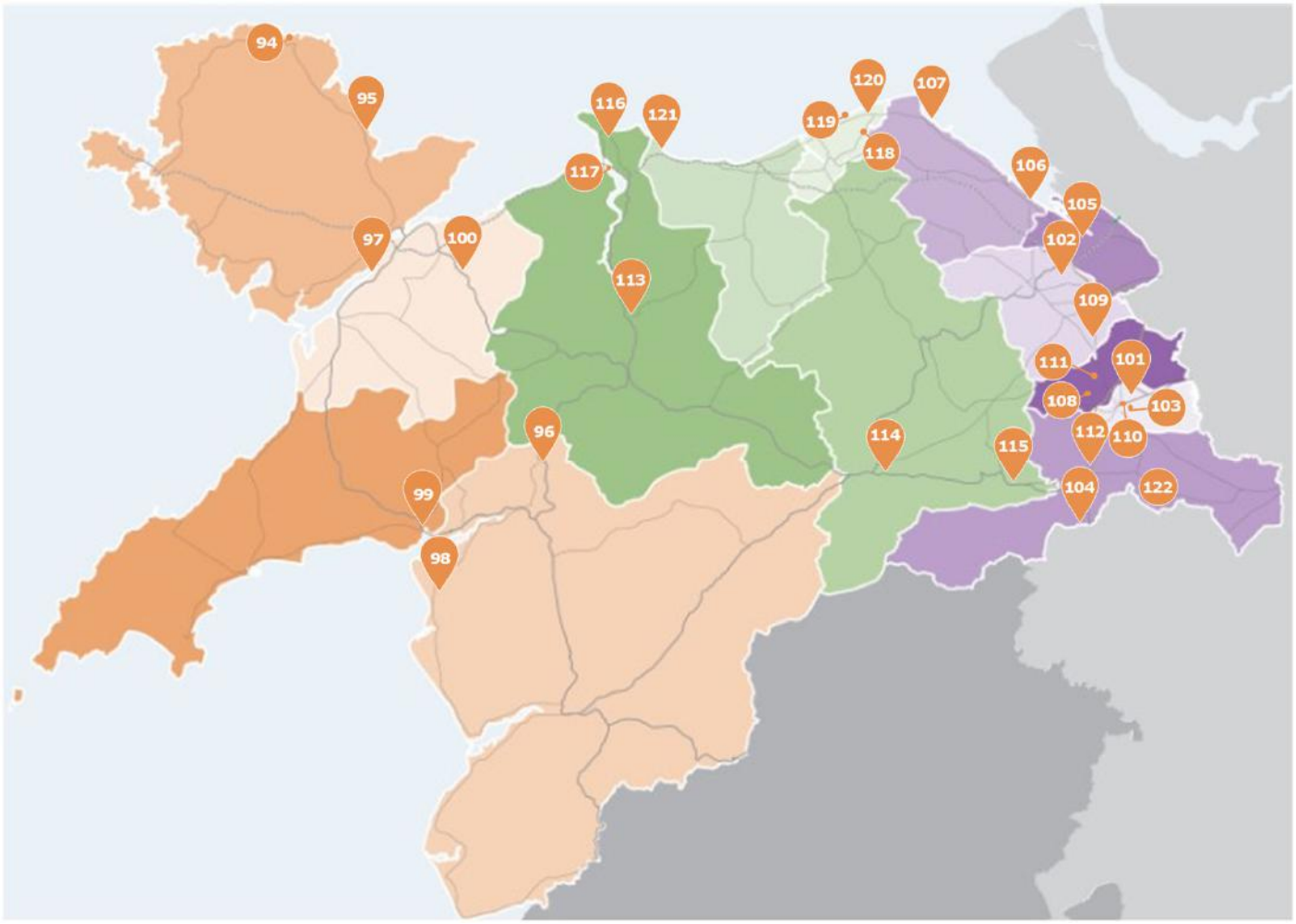
20	Bron Y Castell (Substance Misuse Service)
21	Bryn Y Neuadd Hospital (Rehabilitation/LD/secure)
22	Child Development Centre, Bangor (CAMHS)
23	Talarfon Child Development Services, Bangor (CAMHS)
24	Cefni Hospital
25	Isgraig Clinic, Llangefni (Substance Misuse Service)
26	Craig Hyfryd, Holyhead (Mental Health Resource Centre)
27	Cilan Mental Health Resource Centre, Pwllheli
28	Plas Brith Health Centre (Mental Health Resource Centre)
29	Coed Celyn & Swn Y Coed Wrexham (Rehabilitation)
30	Deeside Counselling Centre, Shotton (Substance Misuse Service)
31	Mold Mental Health Resource Centre
32	Glan Traeth, Rhyl (Memory Service)
33	The Elms, Wrexham (Substance Misuse Service)
34	Unit 14 Mold (Mental Health Resource Centre)
35	Wepre House, Connahs Quay (Mental Health Resource Centre)
36	Bodnant, Llandudno (Community Mental Health Team Unit)
37	5&7 Brighton Road, Rhyl (Substance Misuse Service)
38	Bryn Hesketh, Colwyn Bay (Older People's IP and Day Unit)
39	Colwyn Bay Mental Health Resource Centre
40	Conwy Child Development Centre, Llandudno
41	Dawn Centre, Colwyn Bay (Substance Misuse Service)
42	Dyffryn Clwyd CMHT, Denbigh
43	Hafod, Rhyl (Community Mental Health Team Unit)
44	Roslin Mental Health Resource Centre, Llandudno
45	Tan–Y–Castell Mental Health Unit, Ruthin (Rehabilitation)
46	Treferian Mental Health Day Centre, Denbigh
47	Hergest Unit (on Ysbyty Gwynedd site)
48	Ablett Unit (on Glan Clwyd Hospital site)
49	Heddfan Unit (on Wrexham Maelor Hospital site)

BCUHB Estate Locality Map - Health Clinics



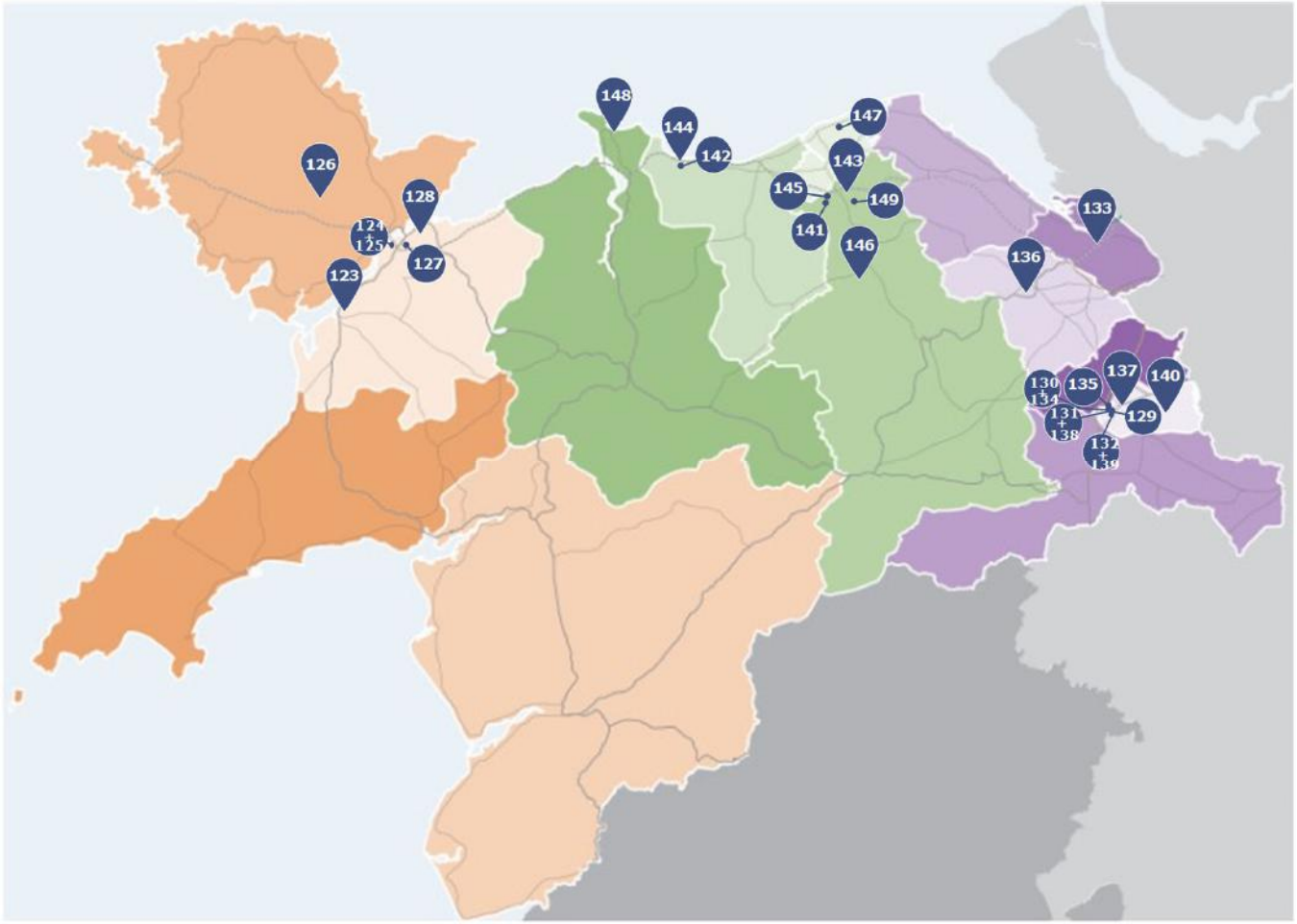
50	Bala Health Centre
51	Botwnnog Health Centre
52	Bron Hendre Health Clinic
53	Criccieth Health Centre
54	Deiniolen Health Clinic
55	Hafan Iechyd Surgery
56	Llanfairpwll Health Centre
57	Penygroes Health Clinic
58	Pwllheli Health Clinic
59	Trawsfynnydd Health Centre
60	Ty Cegin, Bangor (Flying Start)
61	Y Lawnt Health Clinic
62	Broughton Clinic
63	Brymbo Health Clinic
64	Brynteg Clinic Southsea
65	Cefn Mawr Clinic
66	Mancot Clinic, Catherine Gladstone House
67	Coedpoeth Clinic
68	Glyn Ceiriog Clinic
69	Gresford Health Centre
70	Grove Road Health Centre
71	Beechley Medical Centre
72	Llay Health Centre
73	Mold Clinic
74	Mold Primary Care Centre
75	Plas Madoc Acrefair
76	Rhosllannerchrugog Health Centre
77	Rhostyllen Clinic
78	Rossett Clinic
79	Ruabon Clinic
80	Saltney Clinic
81	Abergele Clinic
82	Fforddlas Clinic
83	Gyffin Surgery
84	Kinmel Bay Clinic
85	Maes Derw Clinic
86	Prestatyn Clinic
87	Rhuddlan Clinic
88	Ruthin Clinic
89	St. Asaph Health Centre
90	West Rhyl Primary Care Centre
91	Royal Alexandra Hospital
92	Child Health Clinic Colwyn Bay (Child Services)
93	Community Dental Centre, Glan Clwyd Hospital)

BCUHB Estate Locality Map - Primary Care Centres



94	Amlwch Primary Care Centre
95	Benllech Primary Care Centre
96	Blaenau Ffestiniog Health Centre
97	Felinheli Primary Care Centre
98	Harlech Primary Care Centre
99	Porthmadog Health Centre
100	Yr Hen Orsaf Medical Centre
101	Borras Park Surgery, Wrexham
102	Buckley Medical Centre
103	Caia Park Primary Care Centre
104	Castle Health Centre, Chirk
105	Connah's Quay Primary Care Centre
106	Flint Health & Wellbeing Centre
107	Ffynongroyw Primary Care Centre
108	Forge Road Surgery
109	Hope Health Centre
110	Hillcrest Medical Centre
111	Pen Y Maes Clinic, Summerhill
112	Ruabon Medical Centre
113	Canolfan Crwst Primary Care Centre
114	Corwen Health Centre
115	Llangollen Health Centre
116	Llys Dyfrig Primary Care Centre, Llandudno
117	Llys Meddyg Conwy Primary Care Centre
118	Meliden Primary Care Centre
119	Seabank Primary Care Centre
120	Ty Nant Primary Care Centre
121	West End Medical Centre
122	Overton Primary Care Resource Centre

BCUHB Estate Locality Map - Other Property Types



123	Erylodon Caenarfon (Administrative Services)
124	Intec, Unit 10, Parc Menai Bangor (Administrative Services)
125	Intec, Unit 11, Parc Menai Bangor (Administrative Services)
126	Mon Sector Offices (Administrative Services)
127	Mountain View, Bangor (Occupational Health)
128	Plumbing Centre, Bangor (Covid 19 Vaccination Centre)
129	ALAC Centre, Wrexham (Artificial Limb / Appliance Centre)
130	Berwyn House, Wrexham (Education & Training)
131	Cambrian House, Wrexham (Education & Training)
132	Block B, Clwydian House, Wrexham (Administrative Services)
133	Deeside Enterprise Centre, Shotton (Administrative Services)
134	Gwenfro Wrexham Technology Park (Administrative Services)
135	Plas Gororau, Wrexham (Multipurpose Building)
136	Preswylfa, Mold (Administrative Services)
137	Villa Romano, Wrexham (Administrative Services)
138	Wrexham Hospital Sterilisation and Decontamination Unit (HSDU)
139	Wrexham Medical Institute (Education & Training)
140	Dutton Road Dental Unit, Wrexham (Workshop/Storage)
141	87 Bowen Court, St Asaph (Administrative Services)
142	Brain Injury Service Unit, Colwyn Bay (Brain Injury Service)
143	Carlton Court, St Asaph (Administrative Services)
144	Eirias Park Health Precinct (Joint Care Administrative Services)
145	72 Fford William Morgan, St Asaph (Administrative Services)
146	Hyfrydle, Denbigh (Child Development Centre)
147	Oasis Dental Centre, Rhyl (Dental Centre)
148	Sector House, Llandudno (Covid 19 Vaccination Centre)
149	St Kentigerns Hospice, St Asaph (Hospice)

Appendix 3 – Key Definitions*

- **Backlog maintenance cost:** is the cost to bring estate assets that are below condition B in terms of their physical condition and/or compliance with mandatory fire safety requirements and statutory safety legislation up to condition B
- **Physical condition rankings**
  - A - As new and can be expected to perform adequately to its full normal life
  - B - Sound, operationally safe and exhibits only minor deterioration
  - B(C) - Currently as B but will fall below B within five year
  - C - Operational but major repair or replacement is currently needed to bring up to condition B
  - D - Operationally unsound and in imminent danger of breakdown
  - X - Supplementary rating added to C or D to indicate that it is impossible to improve without replacement
- **Mandatory fire safety requirements / statutory safety legislation rankings**
  - A - Complies fully with current mandatory fire safety requirements and statutory safety legislation
  - B - Complies with all necessary mandatory fire safety requirements and statutory safety legislation with minor deviations of a non-serious nature
  - B(C) - Currently as B but will fall below B within five years as a consequence of unabated deterioration or knowledge of impending mandatory fire safety requirements or statutory safety legislation
  - C - Contravention of one or more mandatory fire safety requirements and statutory safety legislation, which falls short of B
  - D - Dangerously below conditions A and B
- **Risk categories**
  - **Low risk elements** can be addressed through agreed maintenance programmes or included in the later years of an estate strategy
  - **Moderate risk elements** should be addressed by close control and monitoring. They can be effectively managed in the medium term so as not to cause undue concern to statutory enforcement bodies or risk to healthcare delivery or safety. These items require expenditure planning for the medium term
  - **Significant risk elements** require expenditure in the short term but should be effectively managed as a priority so as not to cause undue concern to statutory enforcement bodies or risk to healthcare delivery or safety
  - **High risk elements** must be addressed as an urgent priority in order to prevent catastrophic failure, major disruption to clinical services or deficiencies in safety liable to cause serious injury and/or prosecution
- **Risk-adjusted backlog:** Backlog costs and associated risk rankings are combined to produce a risk-adjusted backlog figure for comparative purposes and as a driver for the eradication of high-risk sub-elements and buildings with short remaining lives

$$\text{Risk-adjusted backlog (£)} = \frac{\text{Non-critical backlog}}{\text{Remaining life of building/block}} + \text{Safety-critical backlog}$$

  - Non-critical backlog (£) = Total backlog cost relating to low and moderate risk sub-elements for the building/block
  - Safety-critical backlog (£) = Total backlog cost relating to significant and high risk sub-elements for the building/block

*As per 'A risk-based methodology for establishing and managing backlog' NHS England (https://www.england.nhs.uk/publication/a-risk-based-methodology-for-establishing-and-managing-backlog)

Appendix 3 – Key Definitions*

- **Gross internal site floor area:** Total internal floor area of all buildings including temporary buildings or premises or part therein, occupied or non-occupied, which constitute the site operated by the NHS Organisation and is either owned by the NHS Organisation or is defined within the terms of a lease, Service Level Agreement, or tenancy agreement. Includes embedded education and training facilities, university accommodation and areas temporarily in the possession of building contractors. Excludes any leased-out areas. This figure should be the sum of the occupied and non-occupied floor areas.
- **Occupied floor area:** Total internal floor area of all buildings or premises or part therein which are in operational use and required for the purpose of delivering the function/activities of the NHS Organisation (i.e. occupied by the NHS Organisation), and either owned by the NHS Organisation or defined within the terms of a lease, license, Service Level Agreement or tenancy agreement. Include leased-in areas, industrial process areas, embedded education and training facilities and university accommodation which are occupied. Measured as for the Gross Internal Floor Area, inclusive of plant rooms, and circulation spaces, but excluding areas which are not required for operational purposes (i.e. non-occupied areas and not in use). The total of the non-occupied floor area and occupied floor area should equal the gross internal floor area. Excludes leased-out and licensed-out areas. PLEASE NOTE FROM 2013/14 EXCLUDES MULTI-STOREY CAR PARKS
- **Unoccupied floor area:** Total internal floor area of all buildings or premises or part therein, which are not used by the NHS Organisation for the purpose of delivering the function/activities of the NHS Organisation (i.e. non-occupied area) but are in the ownership of the NHS Organisation or within the terms of a lease, license, Service Level Agreement or tenancy agreement. Includes unoccupied embedded education and training facilities, university accommodation and areas temporarily in the possession of building contractors. Measured as for the Gross Internal Floor Area, inclusive of any associated plant rooms, and circulation spaces, or part therein, which are directly related to the nonoccupied area(s). The total of the non-occupied floor area and occupied floor area should equal the gross internal floor area. Excludes leased-out and licensed-out areas.
- **Not functionally suitable:** Percentage of occupied floor area that is below Estatecode Condition B for functional suitability (i.e. below an acceptable standard, or unacceptable in its present condition, or so below standard that nothing but a total rebuild will suffice).
- **Un-utilised space:** Percentage of occupied floor area where space utilisation is classified as being either "empty" or "under-used" as defined in Estatecode and Developing an Estate Strategy documents.

*As per 'Estates & Facilities Performance Management System: Data Definitions and Completion Notes (2020 / 2021); Welsh Government

Appendix 4 – Properties included in community estates diagnostic

Community and Local Hospitals - Estate Condition and Performance

Section 2.5.3 provides and overview of community and local hospital estate condition and performance (based on EFPMS 2021/22 data). The following 16 community and local hospitals are included within this analysis.

Abergele Hospital, Bryn Beryl Hospital, Eryri Hospital, Penley Hospital, Deeside Community Hospital, Colwyn Bay Community Hospital, Chirk Community Hospital, Denbigh Community Hospital, Dolgellau & Barmouth District Hospital, Holywell Community Hospital, Llandudno General Hospital, Mold Community Hospital, Ruthin Community Hospital, Tywyn & District War Memorial Hospital, Ysbyty Alltwen, Ysbyty Penrhos Stanley

Community Facilities - Estate Condition and Performance

Section 2.5.4 provides and overview of the condition and performance of community facilities (based on EFPMS 2021/22 data). The following 74 community facilities are included within this analysis.

5 & 7 Brighton Road, Abergele Clinic, Alder House, Bodnant, Maes Du Road, Blaenau Ffestiniog Pcc, Bala Health Clinic, Bowen Court, Unit 87, Bron Hendre, Broughton Clinic, Brymbo Health Clinic, Brynteg Clinic (Southsea), Caia Park Pcc, Catherine Gladstone House, Cefn Mawr Clinic, Child & Adolescent Mh, Talarfon, Child Development Centre, Ymca Holyhead, Coedpoeth Clinic, Corwen Health Clinic, Deiniolen Health Clinic, Deeside Counselling Centre, Criccieth Health Clinic, Denbigh Stores, Drug & Alcohol, High Street, Rhyl, Dyffryn Clwyd Cmht, Denbigh Clinic, Eryldon, Fforddlas Clinic, Flint Pcrc, Glyn Ceiriog Clinic, Gresford Health Clinic, Grove Road Dental Clinic, Hafan Iechyd (Clinic Section), Hightown Medical Centre, Hyfrydle, Llanfairpwll Health Clinic, Kinmel Bay Clinic, Iscraig (Substance Misuse), Llangollen Health Clinic, Bishops Walk, River Lodge, Llay Health Clinic, Maes Derw Clinic, Llandudno, Mhrc Cilan, Mhrc Craig Hyfryd, Mhrc Plas Brith, Mold Clinic, Mold Mhrc (Pwll Glas), Occupational Health Dept, Mountain View, Overton Pcrc, Pen Y Maes Clinic, Summerhill, Penygroes Health Clinic, Preswylfa, Prestatyn Clinic, Plas Madoc, Acrefair, 51-52 Bodlyn, Rhosllanerchrugog Health Clinic, Rhostyllen Clinic, Rhuddlan Clinic, Roslin Mhrc, Rossett Clinic, Royal Alexandra Hospital, Ruabon Clinic, Ruthin Clinic, Saltney Clinic, St Asaph Health Clinic, Swn Y Coed, The Elms, Unit 14, Mold, Treferian Mh Day Centre, Trawsfynydd Health Clinic, Villa Romano, Wepre House, West End Medical Centre, Rysseldene, Wrexham Hsdu, Y Lawnt Health Clinic, Ysgol Gogarth, Llandudno, Hafod Mhrc, Pwllheli Health Clinic

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Digital Data & Technology (DDaT) Benefits Management Framework

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Contents

1. Introduction

This Benefits Management Framework, designed to support digital Project and Programme Mangers, defines the processes and practices for identifying, planning and realising benefits. It ensures alignment with strategic and investment objectives and is central to the successful delivery of projects.

To maximise value, appropriate time and attention must be dedicated to benefits from the earliest feasibility stages and throughout the project lifecycle. This approach helps shape clear objectives and fosters a deep understanding of stakeholder needs and expectations. Active and effective benefits management provides a compelling rationale for undertaking a project.

The realisation of benefits demonstrates that a project has delivered value, showing that the investment of time, money, and resources has positively impacted stakeholders. Project benefits should be measured not only by time, cost, and quality, but also the tangible, measurable improvements they have delivered for stakeholders.

DDaT programmes and projects must adopt a robust approach to benefits realisation to justify continued investment and contribute to organisational improvement and financial sustainability. This framework supports project teams in developing their benefits management capabilities and ensuring that benefits practices mature alongside other areas of project delivery.

It is important to recognise that the Benefits Management Framework operates alongside the Change Management Framework. These two frameworks are complementary, working together to ensure both the realisation of *value* and the successful *adoption* of change. The Change Management framework supports key aspects of benefits management, such as identifying stakeholders and understanding the processes involved.

2. Purpose of the Framework

The purpose of this Benefits Framework is to ensure:

a consistent, structured, and standardised approach to benefits management is applied throughout DDaT;
the use of consistent terminology and categorisation of benefits;
a clear understanding of how the investment contributes to the Health Boards strategic goals;
a defined process for the identification, definition, tracking, realisation and optimisation of benefits;
a central source of detailed guidance on benefits management practices.

3. Aims & Objectives

The primary objective of benefits management within DDaT is to maximise return on investment by selecting the right projects and tracking their benefits through to realisation. This will be achieved by:

ensuring benefit forecasts are complete and realistic;
managing benefits consistently throughout the project lifecycle;
realising benefits as early as possible;
capturing emerging and unplanned benefits;
applying a consistent and proportionate approach to benefits management;
providing a ‘level playing field’ for comparing and prioritising projects;

enabling relevant changes to take place to support benefits realisation;
evidencing the realisation of benefits through measurable outcomes.

The delivery of benefits is the fundamental reason for making an investment. Benefits management is therefore essential to ensuring that a project achieves its intended outcomes. It begins with defining the required business change and the benefits and outcomes expected.

Projects and programmes that fail to deliver on their benefit promises, risk disappointing stakeholders and missing planned financial or operational improvements. Effective benefits management enables better delivery of project and programme outcomes that contribute to organisational objectives and strategic goals.

4. Benefits Management

What is a Benefit?

Benefit - *A benefit is a measurable improvement resulting from an outcome which is perceived as an advantage by a stakeholder, and which contributes to organisational (including strategic) objectives.* *[1]

Benefits Management - *The identification, quantification, analysis, planning, tracking, realisation and optimisation of benefits.* *[1]

The following key elements arise from these definitions:

Benefits are measurable improvements – such as cost savings, improved customer satisfaction, increased revenue, reduced risk etc;
Benefits contribute to Organisational/Strategic objectives;
Benefits are advantageous to stakeholders, both within and outside the Health Board;
Benefits management extends from identification of desired benefits through to benefits realisation and application of lessons learnt;
Benefits management is concerned with informing investment decisions and optimisation of benefits realisation;
Benefits management seeks to optimise rather than maximise benefits realisation.

Dis-benefits – In addition to intended benefits, projects may also result in dis-benefits. A dis-benefit can be defined as *"the measurable result of a change, perceived as negative by one or more stakeholders, which detracts from one or more organisational objectives".* *[1] A benefit to one stakeholder may be a dis-benefit for another.

Benefits Management Objectives

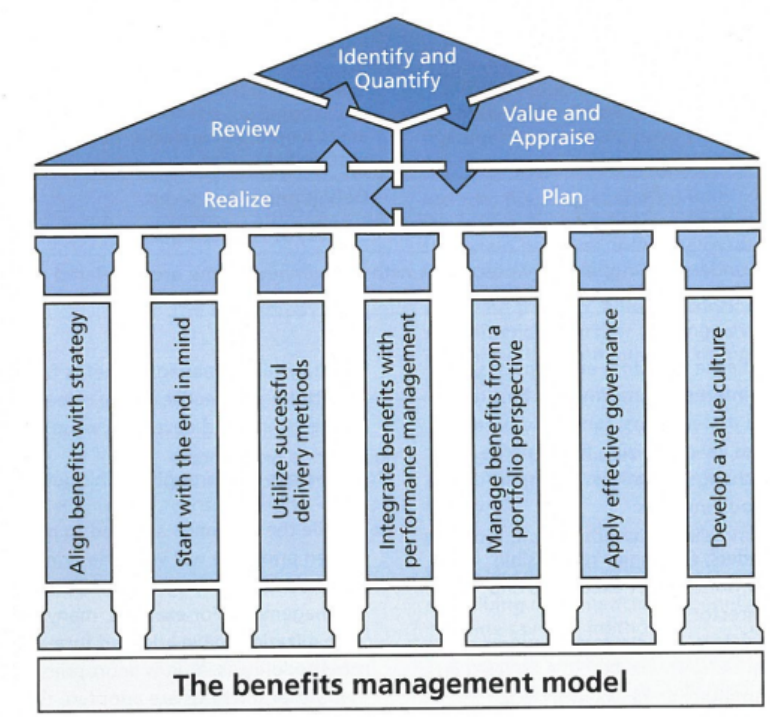
Ensure forecast benefits are complete, realisable and represent value for money, enabling investment in the right projects;
Ensure forecast benefits are realised in practice, supported by the necessary enabling, business and behavioural changes;
Ensure benefits are realised as early as possible and sustained for as long as possible;
Capture and leverage emergent or unplanned benefits that arise during or after delivery

An example of a benefit and dis-benefit is included within the Benefits Register Template *(Appendix A)*.

*1 *(APMG Managing Benefits, Steve Jenner, 2nd Edition)*

5. The Benefits Management Principles

The following Benefits Management Principles are described in APMG's *Managing Benefits by Steve Jenner*. The effectiveness of the benefits management practices depends on a series of enabling factors or **principles** that represent the foundations upon which successful benefits management practices are built. These principles, and their relationship with the practices in the cycle, are illustrated below.



(APMG Managing Benefits, Steve Jenner, 2nd Edition)

Principle 1: Align benefits with strategy
Organisational / strategic objectives should be expressed in meaningful, quantifiable terms. Benefits represent the measurable improvements which contribute towards one or more organisational or strategic objectives. It is therefore important that objectives are clearly articulated so that this contribution can be measured consistently.

Principle 2: Start with the end in mind
With benefits-led change, where initiatives are established to realise the required benefits rather than benefits being used to justify a pre-selected solution.

Principle 3: Utilise successful delivery methods
Combining appropriately tailored delivery methods with effective approaches to change management, so enabling benefits realisation.

Principle 4: Integrate benefits with performance management
With benefits (and the measures used) being integrated into the organisation's operational and HR performance management systems.

Principle 5: Manage benefits from a portfolio perspective

With consistent approaches applied to all initiatives included within the change portfolio, benefits led investment appraisal and portfolio prioritisation, effective management of dependencies between change initiatives, and tracking benefits realisation beyond initiative closure.

Principle 6: Apply effective governance
Including clear accountability and responsibility for the enabling and business changes upon which benefits realisation is dependent, and for realisation of the required benefits.

Principle 7: Develop a value culture
Where benefits and benefits management are taken seriously, and the focus is on creating and sustaining value from the organisation's investment in change.

6. Procedure

The identification of benefits should happen before a project is formally initiated. Once identified, the benefits must be monitored throughout the project lifecycle, measured both during delivery and after project closure to assess their realisation.

Dis-benefits should follow a similar process to benefits. They should be identified, categorised, quantified and measured using the same structured approach to ensure a balanced view of project impact.

Benefits should be identified using an unrestricted, open-minded approach, ensuring that all potential benefits and dis-benefits are captured without bias or restriction.

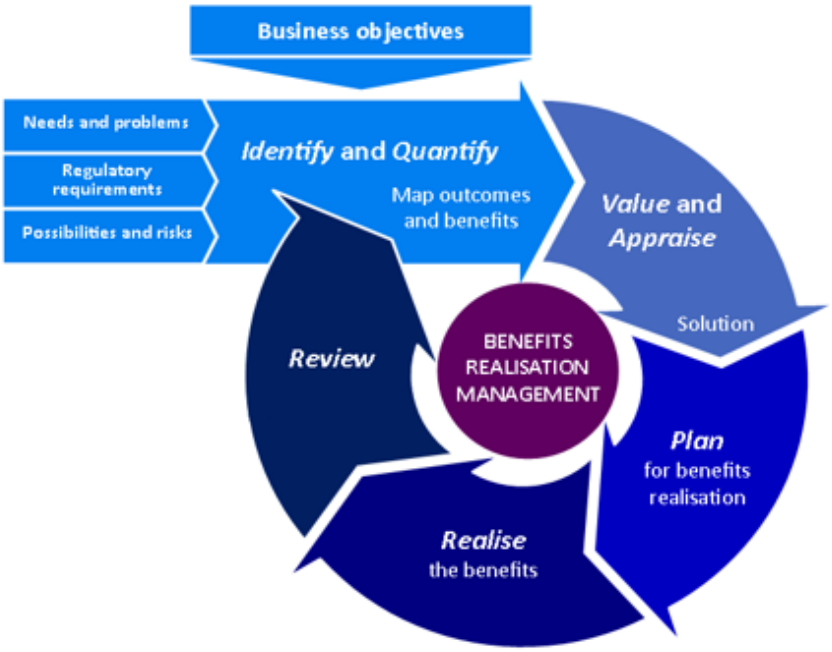
Before a benefit can be formally claimed, the following criteria must be met to ensure it is valid and eligible:

it is **realistic** (deliverable and achievable);
it has been **categorised**;
it is clearly **mapped** to the capability being delivered;
it can be **measured** (and therefore delivery can be evidenced);
it has been **agreed** (by key stakeholders);
it has been **assigned** an owner (responsible for delivery and tracking);
it has an identified **recipient** who will experience the benefit;
it is included in the **Benefits Register.**

All identified benefits will be entered onto the project benefits register template *(Appendix A)* using a unique ID *(see section 9: Benefits Naming Convention)*.

7. The Benefits Management Cycle

This section introduces the Benefits Management Cycle, a structured approach to ensuring that benefits are actively considered throughout the lifecycle of a project. The cycle consists of five practices: Identify and Quantify, Value and Appraise, Plan, Realise and Review. The five stages follow each other sequentially, but one or more of these stages may be occurring at any given time.



7.1 Identify and Quantify Practice

Objectives:

The objective of the *Identify and Quantify* practice is to lay the basis for: informed options analysis, investment appraisal and portfolio prioritisation, and the management of benefits realisation in due course. This practice includes:

The identification of benefits - Primarily via benefits discovery workshops, benefits mapping and customer insight.

Quantification of benefits – Forecasting / estimating the scale of benefits anticipated and addressing the main problems faced in developing reliable benefits forecasts and the solutions.

Process:

The processes involved in this practice include:

Identify

Benefits discovery workshops are an effective method for:

Identifying the strategic drivers, investment objectives and benefits of a project;
Ensuring that the benefits identified are sound;
Identifying the enabling business and behavioural changes required to achieve the benefits desired;
Establishing a clear line of sight from investment objectives through to the required solution;
Engaging stakeholders and building consensus around, and commitment to, a project - and so improving the likelihood of benefits realisation;
Building commitment to the benefits management cycle itself.

Before identifying benefits, it is essential to understand the strategic drivers behind a change initiative and the investment objectives that stem from them. In essence, clarity is needed on the problem being addressed or the opportunity being pursued. These drivers and investment objectives guide the identification of meaningful benefits.

Other techniques that are useful to help identify strategic drivers and investment objectives for change are:

SWOT and PESTLE analysis: Used to evaluate the internal and external factors that affect an organisation's ability to achieve its objectives.

SWOT Internal Factors: Strengths –attributes that provide an advantage (to be leveraged or exploited), Weaknesses – limitations or areas for improvement (to be circumvented); External Factors: Opportunities – external conditions that could support growth or improvement (to exploit using our strengths), Threats – external risks or challenges that could hinder success (to be mitigated or avoided).

PESTLE The external or environmental factors that could influence and organisation's strategy and operations: Political, Environmental, Social, Technological, Legal and Environmental.

Customer / User Insight informs the design of initiatives by understanding user needs, wants and expectations - brining the 'voice of the customer' into the development process. This can be done through methods such as: focus groups, interviews and surveys. Customer journey mapping describes the end-to-end experience of a customer interacting with a service or set of services - from initial need to final outcome. It highlights the opportunities to improve the experience and deliver greater value.

Benefits mapping is another valuable tool, often used alongside workshops. A benefit map visually represents the enabling and business changes required for benefits realisation and illustrates how these benefits contribute to organisational objectives. Please refer to section 12 for further detail about benefits mapping.

Quantify

The first step in quantification is to establish a clear understanding of current performance – the 'as-is' state. This baseline provides a reference point against which improvements anticipated in the 'to-be' state, can be forecast and measured. **Baseline performance** should be recorded as part of the 'as is' information in the business case along with the 'to be' state. Baseline performance is also captured in the benefits register and benefits profile. Wherever possible, relate baseline measures to existing data from the organisation's management information system.

A technique to assist **benefits forecasting** is a benefits quantification workshop – building on the benefits mapping and the benefits discovery workshops, they are undertaken with subject-matter experts to agree the scale of improvement that can realistically be attributed to the initiative, taking into account current performance and other planned change initiatives.

Note on Optimism Bias

During benefits identification and quantification, there is a risk of optimism bias—overestimating benefits or underestimating challenges. This can be mitigated through independent validation, reference class forecasting, and stakeholder challenge sessions.

Outputs:

The outputs expected from this practice include:

- A documented list of potential benefits;
- A benefits map linking changes to outcomes;
- Baseline performance data for key metrics;
- Initial benefit forecasts.

7.2 Value and Appraise Practice

Objectives:

The objective of the *Value and Appraise* practice is to ensure resources are allocated to change initiatives that, individually and collectively, represent the best value for money. This practice encompasses the valuation of benefits in monetary terms and supports:

Options analysis - comparing various options or alternative ways of achieving the desired outcomes and benefits;
Investment appraisal - assessing whether the benefits justify the cost required;
Portfolio prioritisation - ranking potential investments in priority order where resources are limited.

Process:

The processes involved in this practice include:

Value

Cashable financial benefits such as cost savings, increased revenue, and reduced unit cost, are typically straightforward to value.

Cost avoidance benefits require careful consideration. For example:

Improved service reliability resulting in less system outages and downtime e.g. internal systems which when down result in people having to do slower, manual workarounds. Such benefits are not really cost/efficiency savings but time savings and consequently the focus should be on determining how the time saved will be used.

Efficiency improvements - when valuing efficiency improvements, particularly those involving staff time, the focus should be on the use of time saved, not just cost. For example:

If staff leave the organisation without being replaced, there will be a budget saving and this saving will be the financial benefit derived, net of any redundancy costs.
If staff are able to undertake more of the same type of work, the unit costs should fall, and this would be the financial benefit derived.
If staff time is redirected to some other activity, the benefit will be this other activity.

Non-financial Benefits - Benefits that are quantified in non-financial terms can be difficult to value e.g. improved staff engagement. Monetary valuations can be elicited by determining end users or customer willingness to pay or willingness to accept the outcome of an initiative.

Appraisal

Once benefits are valued, the next step is to appraise the initiative to determine whether:

The benefits exceed the costs;
The benefits are realisable;
There is a compelling case for investment.

The three main appraisal approaches most commonly used are:

Cost-benefit analysis - quantify in monetary terms as many of the costs and benefits of an initiative as possible to determine whether the benefits exceed the costs and whether investment is justified.

Cost-effectiveness analysis – Compares the costs of alternative ways of realising the desired benefits. It helps decision-makers identify the option that delivers the greatest value for money by evaluating both the financial investment and the expected outcomes.
Multi-criteria analysis – Evaluates initiatives from multiple perspectives, especially when forecasts are uncertain. Multi-criteria analysis seeks to overcome the problems of unreliable forecasts by examining an initiative from more than one perspective. In summary this approach:

- Identifies decision-making factors (e.g., financial return, strategic contribution, technical complexity, user commitment);
- Weights these factors by importance;
- Scores projects against the weighted factors to calculate overall Attractiveness and Achievability;
- Combines these scores and dividing by cost to assess relative strategic value or "bang for your buck."

Outputs

The outputs expected from this practice include:

A documented list of valued benefits, categorised by type (e.g., financial, non-financial, tangible, intangible);
Monetary valuations for benefits where applicable;
Appraisal results using cost-benefit analysis;
Understanding whether the investment represent value for money.

7.3 Plan Practice

Objectives:

The objective of the *Plan* practice is to ensure accountability and transparency for the realisation of identified benefits, the changes on which they are dependent, mitigation of dis-benefits and identification and leveraging of emergent benefits.

The objectives of the plan practice is to ensure that:

Forecasted benefits are validated;
Benefits are prioritised;
Pre-transition activity is managed (the preparation and planning work that takes place before a change is implemented);
Appropriate benefits measures are selected;
Benefits threats and opportunities are managed;
Stakeholder engagement and communications are effectively planned;
Benefits documentation is prepared and maintained.

Process:

The processes involved in this practice include:

Validating the benefits forecast

A check by the Digital Portfolio and Project Management Office to ensure that benefits claimed are consistent with any eligibility rules. This is to test the assumptions underpinning the benefits forecast by asking whether they are reasonable and reflective of benefits likely to be realised. Conducting a **benefits horizon scan** that assesses not only the identified benefits, but also explores whether there any additional benefits may have been overlooked. This helps mitigate the

risk of focusing solely on the stated benefits and encourages consideration of other potential sources of value.

Checks for overlaps and dependencies with other projects. Double counting occurs when the same benefit is counted across multiple projects or workstreams, leading to an inflated perception of the project's overall value. Managing double counting in project benefits is crucial for maintaining credibility and ensuring accurate reporting. This is especially important if a project is linked to a programme where several projects are contributing to the same outcomes. The Digital Project and Portfolio Management Office can support in managing duplication of benefits across projects and programmes.

Validation of each benefit with the benefit owner. This ensures that benefits are both realistic and achievable.

Prioritising the benefits

Focus attention and resources on the most significant and strategically aligned benefits. Techniques that can be applied to help prioritise the benefits include:

Benefits mapping – to relate benefits to the investment objectives to enable identification of those benefits that make the greatest strategic contribution.

Pareto – applying the 80:20 rule helps focus on the 20% of the benefits that represent 80% of the value.

Multi criteria analysis – a decision-making tool used to evaluate and compare different options or projects based on multiple criteria. It supports structured decision-making across different types of benefits. The process typically involves: Defining the criteria; Weighting the criteria; Scoring each option; Aggregating the scores to produce and overall ranking or evaluation.

Managing pre transition activity

Transition Management is the process by which transition from the current ('as-is') to the future ('to-be') ways of working is managed effectively. It is a critical component of change management and involved preparing people, processes and systems for change.

Selecting Appropriate Benefits Measures

The specific measures to be used for each benefit should be recorded on the benefit profile and benefits register.

Adequate baselining performance has been undertaken;

Appropriate metrics have been identified;

Managing benefits threats and opportunities

Benefit threats and opportunities should be managed in a similar way to managing project risks, with structured identification, assessment and response planning.

Planning Effective Stakeholder Engagement

Ensure that stakeholder engagement is planned and that stakeholders have been given the opportunity for active participation throughout the lifecycle, building a commitment to realising the benefit. The benefits stakeholder engagement tracker *(Appendix E)* can be used to capture stakeholder engagement. Project stakeholders are also captured in the Change Management Approach section of the Project Initiation Document (PID).

Benefits documentation

Ensure that benefits documentation such as the Benefits Register, and the Benefits Profile have been completed. Refer to Section 12 for a list of key benefits documentation.

Outputs:

The outputs expected from this practice include:

A validated list of forecasted benefits;
A prioritised benefits register;
Managed pre-transition activities
Defined and agreed-upon benefit measures and baselines;
A process to capture benefits threats and opportunities;
Stakeholder Communication is managed;
A completed Benefits Register.

7.4 Realise Practice

Objectives:

The objective of the *Realise* practice is to optimise benefits realisation by actively managing planned benefits through to their realisation, capturing and leveraging emergent benefits, and minimising and mitigating any dis-benefits. This includes ensuring benefits are consistently recorded, monitored, and reported at both project and portfolio levels to demonstrate the overall value delivered by the digital programme.

The realise practice encompasses the following elements:

Ensuring that project outputs, deliverables, and solutions are fit for purpose and can be integrated into business operations;
Tracking and reporting benefits realisation at a project level and contributing to consolidated portfolio-level- reporting;
Going beyond processes and practices to consider the softer side of business change.

Process:

The processes involved in this practice include:

Transition Management

Post-transition activities focus on embedding change, sustaining performance, and ensuring that the anticipated benefits are measured, reported, and realised.

Managing Transition encompasses the following stages:

Commence transition;
Ongoing communication with stakeholders;
Monitor business changes;
Manage performance.

Post-transition actions include:

Measure and report on benefits realisation using the standardised Benefits Tracker and Project for the Web;
Continue to monitor and manage performance;
Remove access to legacy systems;
Review transition.

Tracking and reporting of benefits

Effective tracking and reporting ensure that planned and emergent benefits (as well as any dis-benefits) are monitored and communicated to confirm that projects are delivering their intended outcomes. This process support transparency, accountability, and continuous improvement. Activities may include:

- Track planned benefits and emergent benefits and dis-benefits through a benefits realisation report;
- Obtain qualitative as well as quantitative feedback;
- Confirm that benefits 'booked in' have been achieved;
- Utilise dashboards for visibility and reporting including dashboards that support portfolio-level aggregation of benefits.

To strengthen organisational oversight, benefits information captured at project level will be collated and reviewed at a portfolio level. The Benefits Manager will analyse progress across all digital initiatives and provide regular benefits realisation reports to the Digital Portfolio Delivery Group, enabling visibility of cumulative value delivered across the digital portfolio.

Optimising Benefits Realisation

To maximise the value of change initiatives, benefits must go beyond tracking metrics – it must also foster commitment, understanding and ownership across the organisation. Activities may include:

- Conversations – initiative level, conversation for understanding, conversations for performance, conversation for closure;
- Develop measures that engage and influence;
- Use narrative leadership and stories.

Outputs:

The outputs expected from this practice include:

- Optimised realisation of planned benefits;
- Identification and leverage of emergent benefits;
- Mitigation of dis-benefits;
- Comprehensive tracking and reporting of benefits realisation (i.e., via a Benefits Realisation Report, Benefits Dashboard);
- Successful integration of project outputs into business operations.

7.5 Review Practice

Objectives:

The objectives of the *Review* practice is to ensure and assure that:

- The benefits to be realised are achievable and continue to represent value for money;
- Appropriate arrangements have been made for benefits monitoring, management, and evaluation;
- Benefits realisation is being effectively managed;
- Lessons are learned from the current project as a basis for more effective benefits management practices generally.

Process:

The processes involved in this practice include:

Benefit reviews include consideration of:

- **Planned benefits**, i.e., are the forecast benefits still realisable / being realised?
- **Emergent benefits** i.e., are unplanned benefits identified and leveraged?
- **Dis-benefits** (both anticipated and unanticipated), i.e., are dis-benefits mitigated effectively?

Is **value for money** being maximised?
Are the **practices** used to manage benefits efficient and effective?

Gateway reviews - are structured checkpoints used to assess progress, validate outcomes and ensure that benefits are being realised as planned. The appropriate gateway reviews should be undertaken in line with the Digital Project and Portfolio Management Office Gateway Review Questionnaire. Aligned with the project lifecycle, these reviews provide an opportunity to pause, reflect and make informed decisions about whether to continue, adjust or close a programme or project.

Lessons learned – should be captured throughout the benefits lifecycle to support continuous improvement. The purpose is to share lessons and trigger actions that help embed learning into the organisation's ways of working. At the review stage a benefits-focused lessons learnt review should be undertaken - considering what went well, what went could have gone better, and recommendations for current and future projects. This process should be aligned with the Digital Project and Portfolio Management Office Lessons Learned process.

Outputs:
The outputs expected from this practice include:

Updated benefits register with cost-benefit analysis;
Value-for-money assessment report;
Scheduled periodic benefits evaluation;
Benefits realisation progress reports;
Lessons learned log to include benefits.

8. Benefits Categorisation

Benefits should be grouped into categories and aligned with strategic objectives to support effective monitoring, reporting and decision-making.

The Benefits Register (provided in *Appendix A*) contains several benefit categories and classifications that must be understood before completing the plan.

Benefit Recipient
When identifying benefits, it is important to consider the net impact of a project or programme on BCUHB as a whole, as well as individual departments and, most importantly, the benefit to the patient. There are five distinct groups which may benefit from BCUHB projects and programmes;

BCUHB (whole organisation) – benefits that will have an impact on the whole organisation;
BCUHB Services – benefits that will have an impact on one or more service;
Patients/Carers – benefits that will have an impact on patients/carers;
Staff - benefits that will have an impact on staff;
Third Parties / External to BCUHB – benefits that will have an impact on organisations external to BCUHB.

Benefit Type
Benefits will be allocated to the following type:

Benefit Type	Benefit Description

Cash Releasing Benefit (CRB) *[Financial]*	These are economic benefits quantified in monetary terms that can be directly removed from budgets and reallocated elsewhere. Example: *Reduction in paper and printing costs through implementation of an Electronic Health Record*.
Non-Cash Releasing Benefit (NCRB) *[Financial]*	These are economic benefits expressed in monetary terms, but they do not result in direct budgets reductions. Instead, they reflect improvements in efficiency or productivity Example: *Reduction in time saved spent delivering medication charts to pharmacies*.
Societal Benefit (SB) *[Financial]*	These are non-cash releasing benefits that occur outside the NHS, benefiting the wider community or society. They NHS does not directly receive these benefits. Example: *Reduction in carbon emissions as a result of virtual appointments being offered to patients*.
Qualitative Benefit (QB) *[Non-Financial]*	These are benefits that add value, but cannot be measured in monetary terms. These are typically assessed through stakeholder feedback and qualitative methods such as surveys or focus groups. Example: *Improved patient satisfaction as a result of a patient portal, making it easier for patients to manage their care*.
Dis-benefit	Dis-benefits are negative outcomes or unintended consequence of a project or programme. They can be financial, qualitative or societal. Example: *An increase in operational costs due to the need to increase data storage resulting in an increase in electricity usage*.

Benefit Sub-Category
Benefits will be allocated to the following sub-category that are either financial or non-financial categories:

Financial:

Cost savings (Recurring) - i.e., changes that reduce expenditure and allow for ongoing budget reductions;
Cost savings (non-recurring) - i.e., one-off savings resulting from a specific change or intervention;
Revenue generation - i.e., changes that lead to new income streams or increased revenue;
Cost avoidance - i.e., changes that prevent future costs from being incurred, such as avoiding regulatory penalties or unnecessary investments.

Non-Financial:

Patients – i.e., improvements to patient experience, satisfaction, or outcomes;
Family / Carers – i.e., enhancements to the experience and involvement of families and carers;
Staff / Workforce – i.e., improvements in staff experience, job satisfaction, recruitment and retention;
Quality & Safety – i.e., changes that will improve the quality of care and patient safety;
Productivity & Efficiency – i.e., improvements in how services are delivered, leading to better use of time, resources, or capacity;
Reputational – i.e., changes that will positively impact the Health Board's reputation;

Environment – i.e., reductions in environmental impact, such as lower carbon emissions or more sustainable use of estate and resources;
Social Value – i.e., broader benefits to communities or society, such as promoting inclusion, wellbeing, or local economic development.

Benefits categories will be regularly reviewed in line with corporate and national benefits categorisation.

9. Benefits Naming Convention

In order to manage benefits from a Digital Portfolio and Portfolio Management perspective the following naming convention should be followed when referencing benefits:

"Abbreviation of Project" "Benefits Type" "Number" e.g. MHCRB01 ("Mental Health" "Cash Releasing Benefit" "Number 1").

10. Benefits Tolerance Levels

Benefits tolerance refers to the acceptable range of deviation from forecasted benefits targets before escalation to the Project Board is required. These tolerance levels are formally approved by the Project Board and documented in the Benefits Management Approach.

The Project Manager is authorised to deliver the project within these agreed tolerances. However, if forecasts indicate that benefits will fall outside the approved limits – whether due to changes in assumptions, external factors, or delivery constraints - the Project Manager must escalate the issue to the Project Board for review and decision-making.

For example:

A benefit around travel costs savings has been forecasted to save £25,000 (based on annual spend of £500,000 for the year 23-24, and a 5% saving applied).
A tolerance has been set by the Project Board allowing a 10% shortfall in the benefit compared to the original target – this would be £22,500.
However a review of travel cost saving for 24-25 shows that the annual spend had reduced to £350,000.
The benefit has been re-calculated to account for the travel spend during 24-25 – and the benefit forecast is now £17,500.
As this new figure exceeds the permissible threshold (by £5,000) it triggers escalation and the Project Manager would need to escalate this benefit to the Project Board.

Critically, benefits tolerance is not just about tracking outcomes – it's about actively monitoring the factors that influence benefits forecasts.

Any deviations may prompt a reassessment of the project's viability, scope or strategic alignment. Establishing and actively monitoring benefits tolerance is essential to ensure that the project continues to deliver value to end users. This enables proactive management, protects investment, and provides ongoing assurance of project viability.

11. Benefits Governance

Effective governance ensures benefits are identified, tracked, and realised in alignment with strategic objectives across the digital portfolio.

Project Level

Projects must allocate adequate resources to support effective identification, management and realisation of benefits. This process should be underpinned by clearly defined accountability and robust reporting mechanisms to ensure transparency, alignment with strategic objectives, and timely decision-making. Resource for benefits management should be drawn both from within the project team and from the service area undergoing change, ensuring operational insight.

Digital Project and Portfolio Management Office (PPMO)

The Digital PPMO will act as a central hub for assurance, governance, alignment and oversight of benefits management across the digital portfolio. Its responsibilities include ensuring that:

project benefits are aligned with the organisation's strategic objectives;
the Benefits Management Framework and tools and templates are kept up to date and aligned with best practice;
there are governance structures to monitor benefits realisation across the digital portfolio;
there is support for project teams in benefits planning;
there are mechanisms for tracking benefits throughout the project lifecycle and post-implementation;
training and guidance is available to project teams on effective benefits management practices;
post-implementation reviews are co-ordinated and any lessons learnt are captured;
capture and track benefits post implementation.

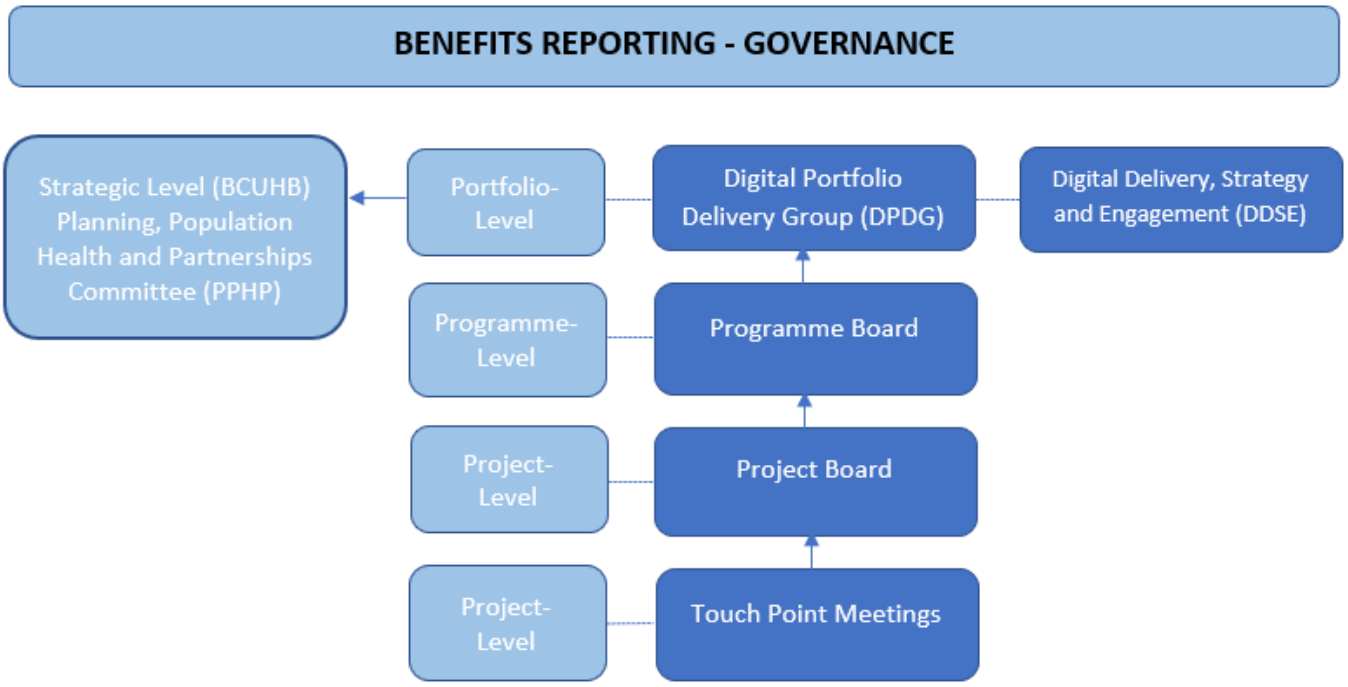
Forums and Reporting

Regular governance forums and clear reporting lines are essential for oversight and decision-making related to benefits realisation. The following table suggests the forums (at Project, Programme and Portfolio Level) that should be established to support benefits governance. This layered approach supports strategic alignment, transparency, and timely decision-making.

Forum / Meeting Type	Benefits Management Responsibilities	Named Forum
Strategic / Executive-Level Governance Committee	***Purpose:*** *Provides committee level assurance that programmes and projects deliver the intended strategic outcomes and demonstrate value for money. This offers oversight of whether benefits linked to strategic investment decisions are being realised, sustained, and aligned to corporate priorities and system commitments, without managing operational delivery.* ***Attendees:*** *Senior BCUHB Executives and Managers* ***Frequency:*** *6-Monthly*	Planning, Population Health and Partnerships Committee

	Inputs: Executive benefits assurance reports, Headline outcomes and exceptions requiring executive attention ***Outputs:*** Executive assurance on benefits realisation, Strategic decisions and prioritisation	
Strategic / Portfolio-Level Governance Meetings	***Purpose:*** Overall strategic oversight of benefits portfolio, alignment with organisational and digital objectives, approval of the benefits management framework and documentation, oversees progress against the portfolio benefits realisation plan, receives and approves the conclusions and recommendations of gateway reviews, resolution of portfolio-level issues. ***Attendees:*** Assistant DDaT Directors, Nursing / Medical Information Officers, Programme Managers, Project Managers, PPMO Manager. ***Frequency:*** Monthly or as required. ***Inputs:*** Benefits Realisation Framework and associated documentation, Portfolio Benefits Realisation Reports, Portfolio Benefits Register, strategic performance dashboards, and escalated issues. ***Outputs:*** Strategic decisions, prioritisation, resources re-allocations, and escalation where required.	Digital Delivery Portfolio Group
Strategic / Portfolio-Level Governance Meetings	***Purpose:*** *Provide operational oversight and assurance of benefits management activity across the digital portfolio. Review the maturity of benefits management arrangements and readiness for benefits tracking and reporting, providing visibility of progress across the portfolio and supporting accountability for benefits management activities. Identify matters requiring escalation to DPDG.* ***Attendees:*** *Assistant Director and Head of DDSE, PPMO Manger, Programme Managers* ***Frequency:*** Monthly ***Inptus:*** Benefits management performance dashboards, project benefits progress updates, and benefits assurance information. ***Outputs:*** Assurance findings, prioritisation of benefits management activities, identification of support requirements, and escalation where required.	Digital Delivery, Strategy and Engagement
Programme-Level Governance Meetings	***Purpose:*** Oversee programme progress, ensure benefit delivery, manage risks and issues, and provide direction to constituent projects.	Programme Board

	Attendees: Programme SRO, Programme Manager, Project Managers, key Benefit Owners, relevant stakeholders. ***Frequency:*** Monthly or bi-monthly. ***Inputs:*** Programme Benefits Register updates, Project Benefits contributions, project level risk and issue logs, progress reports. ***Outputs:*** Programme decisions, prioritisation, resource reallocations, resolution of programme-level issues and mitigation of programme level risks, escalation of strategic issues.	
Project-Level Governance Meetings	***Purpose:*** Monitor project progress, ensure project deliverables support the realisation of benefits, manage project risks and issues. ***Attendees:*** Project SRO, Project Manager, key Project Team Members, relevant Benefit Owners. ***Frequency:*** Bi-weekly or monthly. ***Inputs:*** Project status / highlight reports, exception reports and exception plans, deliverable updates, risks and issues impacting benefits. ***Outputs:*** Project decisions (decision to make a change, to progress to the next project phase), resource allocation, escalation of project-level issues.	Project Board and / or other Specific Project Meetings
Benefit Owner Review Sessions	***Purpose:*** Dedicated sessions for Benefit Owners to provide focused oversight of individual benefits and informally report on the status of their specific benefits. Attendees: Benefit Owner, Programme/Project Manager, Benefits Manager, relevant stakeholders. ***Frequency:*** As defined in the Benefits Management Approach document (e.g., quarterly or when a benefit is due for measurement). ***Inputs:*** Benefit Measurement data, performance against baselines/targets. ***Outputs:*** Benefit status updates, identification of variances, development of corrective actions.	Touch Point Meetings



12. Benefits Management Documentation

The key benefits management documents are:

Benefits Management Approach Document

The Benefits Management Approach document forms part of the Project Initiation Document (PID) and outlines the actions and review processes required to ensure the successful realisation of project benefits. It defines how benefits will be managed throughout the business change lifecycle. This document ensures that the benefits for which the project was initiated are clearly defined, actively managed, and ultimately realised.

The objectives of the Benefits Management Approach document is to describe the approach ('how to') and the expected outputs during each phases of the benefits management cycle. It should:

describe what the high-level benefits look like;
detail how benefits will be identified, quantified and measured;
document the systems and processes used to track progress;
explain how benefits realisation will be achieved;
detail how and by whom benefits will be managed;
outline governance arrangements.

The Benefits Management Approach document template is attached at *Appendix B*. This Benefits Management Framework should be used to support completion of the Benefits Management Approach Document.

Benefits Register (Benefits Plan)

The benefits register provides a consolidated view of the benefits forecast by type / category and which represents the baseline against which benefits realisation can be monitored and evaluated. It is a centralised, living document that records all the expected benefits associated with a project.

The benefits register should contain the following key information about each benefit including:

- benefit name;
- benefit description;
- measurement metric;
- calculation methods;
- data source;
- current baseline measurement and target;
- timeframe for realisation;
- benefit ownership.

The Benefits Register template is attached at *Appendix A*.

Benefits Map

A Benefits Map - also known as a Dependency Network - visually illustrates how project outputs and deliverables, when combined with enabling business changes, lead to the realisation of benefits that contribute to project's investment objectives.

Benefits mapping is a technique used to:

- identify the benefits a project aims to deliver;
- ensures the solution is designed to realise the benefits;
- create a shared understanding among stakeholders.

Benefits Mapping helps clarify:

- what the project is trying to achieve (the project objectives);
- what benefits will be realised;
- how these benefits align with strategic and organisational objectives;
- how enablers (inputs) and enabling changes combine to realise benefits.

A Benefits Map serves as a concise, one-page, visual narrative of a project's value proposition. It is useful for:

- stakeholder engagement and communication;
- driving focused discussion on key deliverables and outcomes;
- modelling interdependencies between outputs, changes, and benefits.

A Benefits Map template is provided in *Appendix C*.

Benefit Profiles

The document used to record each agreement (with the benefit owner) on the key details about a benefit (or dis-benefit) including categorisation, scale, ramp up and tail off measures and any dependencies.

The benefit profile is a view of a single benefit, showing all key attributes including measures, estimated value and dependencies. The data can be extracted from the benefits register. A benefit profile supports good governance, as it enables the benefit owner and other stakeholders to quickly appraise all the attributes of a benefit. The benefit owner will be responsible for approving the target measures and the extent of improvement that is achievable.

A benefits profile generally contains the following information:

- unit of measure;
- method of measurement;
- benefit calculation methods (if appropriate);
- data source;
- baseline measurement;
- improvement timescale;
- beneficiary of the expected improvement;
- approved by benefit owner;
- rationale.

A Benefits Profile template is provided in *Appendix D*.

Benefits Stakeholder Engagement Register

The Benefits Stakeholder Engagement Register is used to document and manage interactions with stakeholders involved in the identification of benefits. It records all communication and engagement activities, helping ensure that relevant stakeholders are appropriately involved and informed. The stakeholder list developed as part of the Change Approach can serve as a valuable starting point for identifying benefit-specific stakeholders.

The Benefits Stakeholder Engagement Register template is attached at *Appendix E*.

Benefits Realisation Report

This provides progress information on benefits realised compared with the benefits register, details of any emergent benefits and dis-benefits, and revised forecast.

The Benefits Realisation Report template is attached at *Appendix F*.

Benefit Management Toolkit

This is visual of the guidance, template documents and reports that support effective benefits management within digital projects. It also describes the enablers required and assurances that it will support. The Benefits Management Toolkit Visual is attached at *Appendix G*.

13. Roles and Responsibilities

Key Roles	Benefits Management Responsibilities
Senior Responsible Owner / Sponsor / Executive	The individual who is accountable for a project achieving its objectives and optimising benefits realisation. Owns the business case including the overall cost-benefit position. Ensures that benefits forecasting is reliable. Approves the benefits management approach. Approves the benefits register. Approves the benefits profiles. Approves the benefits map. Approves transition from the old to new ways of working (following recommendation by the business change manager(s)).

	Chairs project-level benefit reviews.
Senior User	The role responsible for ensuring that the solution meets the needs of the users and delivers the expected benefits. A key representative from the business area that will benefit from the project, with sufficient authority and influence. Represents the user community and is accountable for the approach taken to capture user requirements and the specification of benefits aligned to the business case. Commit people and user resource. Contribute to stakeholder analysis Ensure that the project solutions are fit for purpose and that anticipated benefits are achieved. Focuses on ensuring the project's outputs meet user needs and deliver the intended benefits. Demonstrating to the business that the forecasted benefits in the business case are on track to be realised. Involved in post-project activities to confirm that the benefits are realised and sustained over time.
Programme / Project Manager	The role responsible for the day-to-day management of the project / programme, including the coordination of projects and change management activities. Develops and maintains the benefits management approach, the benefits register and business case in consultation with the Benefits Manager. Initiates benefits reviews during the life on the project. Reviews the benefit profiles prepared by the Benefits Manager
Change Manager	The role responsible for managing the Change Approach and represents the link between the project and the business. Helps structure the change approach by understanding the intended benefits. Ensures a link between the deliverables and benefits. Ensures that adequate preparation is made for transition. Advises the SRO / Sponsor on business readiness for transition. Engages stakeholders to ensure that the change is implemented smoothly. Liaises with the Benefits Manager regarding any benefits identified during stakeholder engagement opportunities. Monitors successful transition and checks that all required project outputs / deliverables and business changes occur so that benefits are realised.
Benefits Manager (at project / programme level)	To provide a benefits realisation support service to programmes, business managers and business change managers. Facilitates benefits discovery workshops. Drafts benefits maps, and circulates them for stakeholder agreement. Reviews and provides input to the benefits management approach. Reviews and provides input to the benefits register. Identifies and quantifies benefits with the support of service teams. Develops and maintains the benefits profiles in consultation with the benefits owners – including agreeing the scale and timing of benefits realisation. Consolidates reports on the realisation of benefits. Supports in identifying and leveraging emergent benefits and minimising dis-benefits. Assesses change requests for their impact on benefits realisation. Briefs the SRO for benefits reviews. Monitors and reports on benefits realisation throughout the project's life, including emergent benefits and dis-benefits. Monitors and reports on benefits realisation post-project closure.

	Initiates benefits reviews after closure of the project. Ensures that from a Project and Portfolio Management Perspective: the benefits management approach is consistent with the portfolio benefits management framework, double counting is identified, benefits realisation progress and revised forecasts are reported, and benefits management practice are adapted to reflect lessons learned. For smaller project this could be the Project Manager.
Benefits Owner	The person responsible for the realisation of a specific benefit, usually from within the service. Note that the role may well extend beyond the life of a programme. Agrees the benefit profile prepared by the Benefits Manager. Monitors the successful delivery of enabling and business changes upon which realisation of the benefits depends. Reports on the realisation of the benefit.
Other roles that support benefits (internal)	Business Analyst – to support data gathering / reporting Finance Lead – to help identify and quantify financial benefits, support for the valuation and appraisal of cash releasing and non-cash releasing benefits for the business case, support documenting any assumptions that feed into cash-releasing and non-cash releasing benefits modelling. Service Mangers / Practitioners – provide insight into the operations, process and local practices to help identify and inform the benefits
Other roles that support benefits (external)	DHCW Benefits Leads – to provide advice and guidance around DHCW reporting requirements and national benefits registers.
Benefits Manager (at portfolio level)	Supports the Digital Project and Portfolio Management Office in ensuring that effective approaches to benefits management are applied across the portfolio. Writes and maintains the portfolio benefits management framework. Maintains benefits documentation under change control. Monitors dependencies and the enabling and business changes on which benefits realisation is dependent. Monitors benefits realisation against the benefit realisation plan. Trains project staff on the application of the portfolio benefits management framework. Reviews business cases to ensure compliance with the portfolio benefits management framework and checks that there is no double counting. Works with project and programme managers to promote more effective benefits management practices. Advises on project on benefits forecasting. Advises projects on the development of benefits management strategies that are consistent with the portfolio benefits management framework. Provides assurance to the Head of Project and Portfolio Management Office on the efficiency and effectiveness of benefits management practices across the portfolio. Maintains an up-to-date portfolio-level benefits register. Consolidates benefits realisation progress reports for the portfolio dashboard report and for periodic portfolio-level reviews. Escalates any benefits-related issues to the Head of Project and Portfolio Management Office Monitors effective management of dependencies and threats that could compromise benefits realisation.

	Monitors issues arising from post- implementation reviews, and participates in post-investment reviews to evaluate benefits realised against forecast and to identify lessons learned. Develops and maintains the organisation's benefits reference class database to inform forecasting.

14. Appendices

Appendix A - Benefits Register Template	*Benefits Register Template 2026.01.19 DDaT -Gen-N Final V0.01.xlsx*
Appendix B - Benefits Management Approach Template	PID-0.04 - Benefits Approach 2025.05.08 DDaT-INI-N FINAL V1.docx
Appendix C - Benefits Map Template	*To be finalised*
Appendix D - Benefits Profile Template	Benefits Profile Template 2026.01.19 DDaT -Gen-N Final V0.01.xlsx
Appendix E - Benefits Stakeholder Engagement Tracker	Benefits Stakeholder Engagement Register Template 2026.01.19 DDaT -Gen-N Final V0.01.xlsx
Appendix F - Benefits Realisation Report	*To be finalised*
Appendix G - Benefits Management Toolkit - Visual	*Link to be attached*

Completed examples of the appendices can be obtained by the DDSE's Benefits Realisation and Change Manager.

Digital Benefits Summary

Introduction

This document provides a summary of the benefits position across digital programmes and projects. It outlines the anticipated and emerging benefits associated with each initiative, together with the current status of benefits management, measurement and reporting arrangements. As projects are at different stages of delivery, the summaries reflect the level of benefits evidence currently available and highlight progress towards future benefits realisation.

ePMA

The implementation of ePMA is delivering early evidence of benefits across patient safety, clinical effectiveness, operational efficiency and sustainability. A structured approach to benefits management is now in place, with defined measures, reporting arrangements and governance processes supporting the ongoing monitoring, validation and realisation of benefits. Several benefits have already been fully realised through system design, including the elimination of illegible prescribing, unsafe insulin abbreviations, prescription rewrites, time spent locating medication charts and the physical delivery of medication charts to pharmacy.

Early indicators demonstrate improvements in medicines safety and quality. ePMA has eliminated unsafe abbreviations and illegible prescribing through system design, removing established sources of medication error. In addition, blank medication administration records have reduced significantly following implementation, improving the quality and completeness of medicines administration records. These changes provide early evidence that ePMA is helping to reduce medication-related risk and supporting safer medicines management.

The programme is also beginning to release time previously spent on paper-based medicines management processes. The removal of chart handling, chart searching and prescription rewriting has streamlined clinical workflows and created additional capacity that can be redirected to patient care. Further benefits relating to nurse medication rounds and medicines reconciliation are expected to emerge as use of the system becomes more embedded.

Environmental benefits are already measurable, with the removal of paper medication charts resulting in a conservatively estimated saving of 22.84 trees by the beginning of June 2026. In addition, the standardisation of prescribing processes through ePMA has established the mechanisms through which longer-term medicines optimisation and financial benefits can be monitored and evaluated as further evidence becomes available.

Benefits Position: Benefits realisation is progressing in line with expectations for this stage of implementation. Five benefits have already been realised through system design, while early indicators demonstrate positive progress across patient safety, quality and operational efficiency. Longer-term benefits continue to be monitored through established governance and reporting arrangements.

RISP

The implementation of the Radiology Information System (RISP) has established the foundations for delivering improvements across referral management, diagnostic workflows, patient safety and service efficiency.

Approximately 80% of referrals are now received electronically and are available within RISP on the day they are submitted, supporting faster referral receipt and processing, reducing reliance on manual processes and streamlining referral management. Benefits governance arrangements are in place and work is progressing with the national programme to develop reporting and measurement approaches.

A number of planned benefits remain dependent on further system optimisation activity. As system maturity increases, benefits relating to productivity, patient safety, reporting efficiency, radiation dose management and cross-organisational working will continue to be monitored and evaluated.

Benefits Position: Benefits realisation remains at an early stage. Benefits are emerging through the digitisation of referral processes and reduced reliance on manual referral handling. Further work is underway to establish the expected timeline for the realisation of longer-term benefits as system capability and adoption mature.

WPRS

The Welsh Patient Referral System (WPRS) is a key project to deliver the IMTP commitment - 3B.2 A range of initiatives to support a reduction in referrals to outpatients in high-volume specialties, adopting best practice in waiting list management including the continuing roll-out of the community health pathways, to ensure better prioritisation of available capacity for the longest waiting patients with a particular focus on unwarranted variation and associated referral threshold management. For example, dashboard reporting within Urology demonstrates that Urgent Suspected Cancer (USC) referrals are triaged within 1 day, while only 0.46% of referrals required additional information, indicating a high level of referral completeness.

WPRS reduces reliance on paper-based referral processes supporting a fully paperless process, providing a complete digital audit trail, with less lost referrals, strengthening governance, transparency and confidence in referral management. The system also provides greater visibility of referral pathway data, supporting reporting, performance monitoring and service oversight.

In addition, WPRS provides clinicians with structured referral information accessible from anywhere which supports the place of care, and supports communication between primary and secondary care. This enables referral information to be reviewed within a single digital system and supports consistent referral management processes.

Benefits Position: Benefits realisation is being demonstrated through improved visibility of referral pathway activity, enhanced data quality and increased digital traceability. The availability of dashboard reporting and structured referral data provides a strong foundation for ongoing monitoring of referral performance and the identification of opportunities for future service improvement

Digital Maternity

The implementation of the Digital Maternity System has established a single digital maternity record, creating the foundations for improvements in clinical workflows, data quality, continuity of care, patient experience and operational efficiency.

The introduction of a digital maternity record has reduced reliance on paper-based processes and enables maternity information to be accessed more readily by authorised staff. The system also strengthens data quality, governance and auditability through the use of standardised digital records, improving the completeness of patient information and providing a stronger foundation for reporting, performance monitoring and service improvement.

A number of the benefits identified within the benefits register remain dependent on further phases of delivery and optimisation activity.

Benefits Position: Benefits realisation remains at an early stage. The implementation of a digital maternity record has established the foundations necessary to realise longer-term benefits and work is underway to understand the anticipated timeline for benefits realisation as subsequent phases are delivered and embedded into operational practice.

All Ages MHLD EHR

The All Ages MHLD Electronic Health Record (EHR) programme has undertaken detailed benefits planning ahead of go live. Work with clinical, operational and finance stakeholders has resulted in a benefits register aligned to the programme's investment objectives, with both cash releasing and non-cash releasing benefits profiled and baselined where appropriate.

The programme has identified benefits relating to clinical quality and safety, improved access to information, more efficient referral and assessment processes, reduced administrative burden, improved care co-ordination and enhanced reporting capabilities. Benefits workshops and value assurance sessions have helped refine measures, assumptions and data sources, providing a clearer basis for future tracking and reporting.

As the system has not yet gone live, benefits are not yet expected to be realised. However, work is underway to ensure that measures, baselines, reporting arrangements and governance processes are established in advance of implementation. Further work is planned to finalise quality benefit measures, benefit ownership and timeframes.

Benefits Position: Benefits realisation remains in the scoping phase. The programme has a well-developed benefits approach and there is confidence that the governance, measurement and reporting arrangements required to support benefits realisation will be in place before go live, providing a sound foundation for future benefits tracking and evaluation.

LIMS

The LIMS programme is being implemented through a phased approach across pathology services, with some specialties already live and others progressing through deployment. Benefits have been identified at both a national and local level, with a benefits register in place to support future tracking and reporting.

The programme is expected to deliver benefits relating to improved clinical safety, reduced transcription errors, standardisation of tests and workflows, improved laboratory productivity, enhanced cross-site working and increased use of electronic test requesting. The implementation of a single national platform also supports the consolidation of legacy systems and improved visibility of pathology activity and performance.

While benefits realisation remains at an early stage, some benefits are beginning to emerge within services that are already live. Benefits realised to date include increased use of electronic test requesting within Primary Care and the decommissioning of a legacy system. Work is continuing to develop benefit profiles, confirm measures and establish reporting arrangements to support benefits tracking as implementation progresses across the remaining pathology services.

Benefits Position: Benefits realisation remains in the scoping phase. Benefits have been identified at both a national and local level, with some benefits beginning to emerge in services already live. Work is underway to further develop the programme's benefits approach and strengthen measurement, governance and reporting arrangements to support future benefits realisation and evaluation.

Digital Eyes (OPERAi and OpenEyes)

The Digital Eyes programme has identified a range of anticipated benefits relating to patient safety, clinical effectiveness, operational efficiency, improved communication and information sharing between primary and secondary care, enhanced data quality and reporting, workforce productivity and patient experience. The introduction of digital referrals, clinical records and imaging is expected to support more standardised ways of working, improved care coordination and greater visibility of patient information across the ophthalmology pathway.

As implementation progresses, work is underway to further develop the benefits registers and profile individual benefits, including the identification of measures, baselines and targets to support future monitoring and evaluation across both OPERAi and OpenEyes. This will help provide greater visibility of the impact of the programme on patient care, service delivery and operational performance.

Benefits Position: Benefits realisation remains at an early stage. A range of anticipated benefits have been identified and work is underway to further profile them and strengthen the measurement and reporting arrangements required to support future benefits tracking and evaluation.

BENEFITS - ePMA

Planned benefits:

Qualitative

Benefits relating to:
Improved antimicrobial stewardship
95% mandatory adult VTE screening
95% mandatory adult VTE treatment
<2% blank administration doses
100% elimination of illegible prescriptions
Reduction in prescribing errors
100% compliance with allergy documentation
96% compliance of medicines reconciliation within 24 hours of admission

Cash Releasing

£124,000

Benefits relating to:

Reduction in Drug Spend

Non -Cash Releasing

Benefits relating to:
120 hours per annum locating paper charts (per individual) – Total time saved = 288,426 hours

22,593 re-writes saved

2% reduction in total drug round duration

6 minutes 16 seconds per journey saved delivering medication charts to pharmacies - Total time saved = 3,177 hours

Societal

Benefits relating to:

Reduction of environmental impact of paper medication charts

BENEFITS – RISP

Planned benefits:

Qualitative

Benefits relating to:

Reduced system downtime

Reduced variations in turn around times

Reduced risk – errors (80% reduction), missing urgent diagnosis, repeat examination, inappropriate radiation dosages

Earlier diagnosis and improved clinical decision making

Improved patient experience

Support effective MDT meetings and cross boundary work

Improved understanding of demand management

Improved workforce experience

Improved radiation dose management

Cash Releasing

Benefits relating to:

Reduced reporting costs

Paper based system costs – paper, printing, storage

Non -Cash Releasing

Benefits relating to:

Reduced time to imaging referral (3 days saved)

Average time from request to receipt of report

Time saved spent on manual processes (saving over 500 hours) - referrals processing, review of unfiltered lists

Reduction in amount of unreliable / unusable data

Societal

Benefits relating to:

Reducing Carbon Footprint – reduced number of devices, cloud-based system

BENEFITS - WPRS

Planned benefits:

Qualitative

Benefits relating to:

Improved patient outcomes

Reduction in lost referrals

Improvement in the quality of referrals

Improving communication between primary and secondar care

Improved end-to-end data quality

Improved waiting list management through use of clinical conditions

Improved triage process

Non -Cash Releasing

Benefits relating to:

Efficiency of the booking process - reduced time taken to process referral from receipt of referral to triage

Improvement in Booking Clerk Capacity

BENEFITS – Digital Maternity System

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

Planned benefits:

Qualitative

Benefits relating to:

Patient Experience, Staff Experience

Quality and Safety of Care

Regulatory Compliance

Reduction in Preventable Mortality and Morbidity

Improved information Governance

Service Optimisation through Data-Driven Care

Improved Digital Maturity

Cash Releasing

£143,899

Benefits relating to:

Bank Midwifery Expenditure

Medical Record

Travel

Research Income

Non -Cash Releasing

12,148 hours saved = 1,619 working days

Benefits relating to:

Clinical Admin Duties for Midwives

Responding to Complaints and Incidents

Societal

Benefits relating to:

Reduction in Litigation

Reducing Carbon Footprint

BENEFITS - ALL AGES MHLD ELECTRONIC HEALTH RECORD

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Planned Benefits:

Qualitative

Benefits relating to: Patient Experience, Staff Experience, Quality and Safety, Co-ordination of Care, Regulatory Compliance, Understanding of Demand and Capacity, Waiting List Management

Cash Releasing

£581,331

Benefits relating to: Medical Record, Travel, Non-clinical staff resource, Overtime and Bank Spend, Medical Agency, Litigation

Non -Cash Releasing

£1,019,852

37833 hours saved = 5044 working days

Benefits relating to: Productivity gains for - Administrative Processes, responding to Subject Access Requests, Complaints and Incidents, Clinical Admin Time, Accessing Records

MHLD - Hours Saved: 31,158
Admin Time: 10,652
Clinical Time: 20,506

CHILDRENS- Hours Saved: 6,675
Admin Time: 4,593
Clinical Time: 2,082

Societal

Benefits relating to: Reduction of avoidable deaths, Reducing Carbon Footprint

BENEFITS – LIMS

Planned benefits:

Qualitative

Benefits relating to:
Improved clinical and patient safety
Reduction in repeat tests
Easier result comparison
Increased service capacity
Ability to achieve ISO9001 standard
Higher rate of electronic test requesting
Improved clinical responses
Consolidation of legacy systems
Improved Business Intelligence reports and dashboards
Enhanced system reliability and uptime
Improved provision of cross site care
Improved digital resilience

Cash Releasing

£43,692

Benefits relating to:
Decommissioning of Legacy Pathology Systems (ICE)

Non -Cash Releasing

Benefits relating to:
Faster reception processing
Improvement in NPEX (National Digital Exchange Service) turnaround time
Immunology processing time improvements
Haemonetics Time-to-treatment improvements
Reduced repeat tests / reagent usage
Cellular Pathology Productivity

Digital Projects Prioritisation Framework

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Contents

Introduction

Effective prioritisation is essential to ensure that resources across Digital, Data, and Technology (DDaT) including project management, ICT, change management, benefits realisation, and subject matter experts, are allocated where they deliver the greatest impact. This supports BCUHB's strategic goals and maximises value for both the organisation and our patients.

The Digital Project and Portfolio Management Office (PPMO) leads a formal prioritisation exercise twice a year to review the current portfolio and pipeline of digital projects. This process recommends which projects should be resourced over the following six months and supports structured, evidence-based decision-making, aligned to organisational priorities.

The process is carried out in collaboration with key stakeholders, including the Integrated Health Community (IHC) leads, Medical Information Officers, Digital and Technical leadership, Project Leads, and Senior Responsible Owners (SROs), ensuring both strategic priorities and operational insight are reflected in the outcomes.

This framework outlines the process for scoring, reviewing, and prioritising digital projects using a Prioritisation Matrix. It ensures consistent evaluation, transparency, and alignment with organisational goals.

This Digital Prioritisation Framework aligns with the BCUHB's corporate prioritisation framework. Projects are evaluated across five key dimensions: Alignment, Value, Risk, Deliverability, and Political Imperative.

The framework has been tailored to reflect digital delivery requirements, with defined sub-categories and visual outputs, including stacked bar charts and summary tables, to support comparison across the portfolio.

Prioritisation Methodology

A phased approach is applied, comprising three stages:

Step 1 - Prioritisation Scoring Tool
Projects are assessed using a scoring matrix across five dimensions to determine their overall priority within the digital portfolio:

Alignment: Measures how closely the project aligns with the Annual Plan and major change programmes

Value: Assesses the anticipated benefits or impact of the project, including improvements in quality, safety, harm reduction, patient outcomes, effectiveness, efficiency, and user experience. It also considers the potential to address corporate underperformance or clinical risk, environmental impact, regulatory or contractual obligations, and financial return on investment.

Risk: Assesses the residual risk to the organisation if the project is not delivered. It also considers whether the proposal mitigates existing risks or addresses significant service gaps in current service provision.

Deliverability: Evaluates the feasibility of delivering the project within scope and timeframe. Factors include complexity, scale, affordability (both initial and long-term), available capacity and capability, team commitment, and clarity of scope.

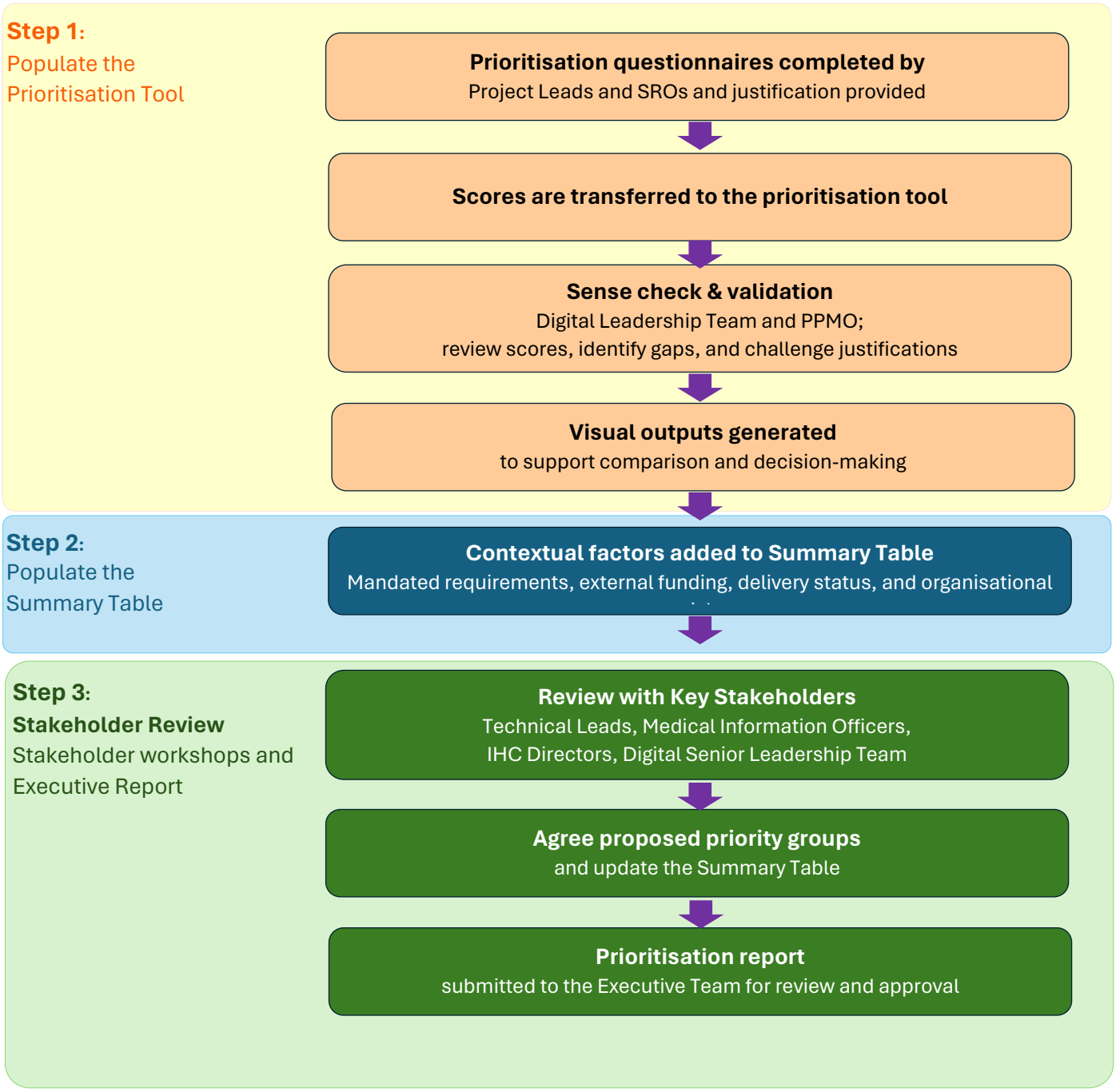
Political Imperative: Considers the extent to which the project responds to ministerial or public priorities, enhances the Health Board's reputation, improves public confidence, or addresses critical scrutiny.

Step 2 – Contextual Factors
Additional factors are considered to reflect practical delivery considerations, including mandated requirements, external funding, delivery status, and organisational risk.

Step 3 – Stakeholder Review
Outputs are reviewed by the Digital PPMO and key stakeholders to validate findings and agree final priority groupings.

Overview of the Digital Prioritisation Process

The diagram below provides a visual summary of the process.



Step 1- Populate the Prioritisation Scoring Tool

The scoring tool is populated with updated or new scores for all projects within the portfolio.

Project Leads and SROs complete a prioritisation questionnaire (see appendix), providing justification for their responses. Support sessions may be provided where required.

Projects are assessed across five key dimensions: Alignment, Value, Risk, Deliverability, and Political Imperative.

Scoring Mechanism

Projects are initially scored by Project Leads and SROs. To minimise bias, questionnaires use letter grading rather than numeric scoring (e.g. 1 = A, 2 = B, 3 = C).

Scores are reviewed by the Digital PPMO, Medical Information officers, IHC Directors, and the Digital Senior Leadership Team to ensure consistency and challenge assumptions.

A combination of:

Objective measures (e.g. alignment to Annual Plan)

Subjective measures (e.g. value and risk assessed through professional judgement)

is applied to ensure a balanced evaluation.

Scoring Scales

Scores are validated by the Digital PPMO and relevant stakeholders.
Most categories use a 0–3 scale (No impact to substantial impact).
Binary factors use 0 (No), 3 (Yes)
Higher scores indicate higher priority

Weighting of criteria:

Criteria are weighted according to their relative importance:

Weighting 3 (Highest): Criteria deemed critical to safeguarding of patient care receive the highest weighting. These include: quality, safety and harm reduction, regulatory, mandatory, or contractual requirements, significant risk to the organisation, addressing major risks or areas of corporate under performance, and affordability.

Weighting 2 (Moderate): Criteria with strategic relevance or operational impact are assigned a weighting of 2. These include alignment with strategic priorities, patient outcomes and benefits, increased effectiveness and efficiency, criticality to service or organisation, complexity of implementation, and politically sensitive considerations.

Weighting 1 (Lower): Sub-category questions considered lower priority within their respective domains are given a weighting of 1. Examples include user experience, environmental impact, financial return on investment, size of change, capacity and capability, commitment, and clarity of proposal.

Weightings are aligned with corporate priorities and agreed collaboratively across Digital, Clinical, ICT, and Operational teams.

A detailed breakdown of the weightings assigned to each criterion is provided in the table below.

Table of categories, dimensions, scoring scales and weights

Category	Sub-Category	Question	Scoring Scale	Weighting
Alignment	Alignment with Annual Plan	Is the project in the Annual Plan?	0 = no 3 = yes	2
	Alignment with the Major Change Programme	Is it a Major Change Programme?	0 = no 3 = yes	2
Value	Quality, Safety & Harm Reduction	What is the extent to which the project has an impact on quality, safety and harm reduction?	0 = No impact 1 = minimal impact 2 = moderate impact 3 = substantial impact	3
	Patient Outcomes & Benefits	What is the extent to which the project has an impact on patient outcomes and benefits?	0 = No impact 1 = minimal impact 2 = moderate impact 3 = substantial impact	2
	Increased Effectiveness	What is the extent to which the project has an impact on the effectiveness of operations?	0 = No impact 1 = minimal impact 2 = moderate impact 3 = substantial impact	2
	Increased Efficiency	What is the extent to which the project has an impact on the efficiency of operations?	0 = No impact 1 = minimal impact 2 = moderate impact 3 = substantial impact	2
	User Experience	What is the extent to which the project has an impact on user experience?	0 = No impact 1 = minimal positive or negative impact 2 = moderate positive impact 3 = high positive impact	1
	Regulatory, mandatory or contractual requirement	Is the project a mandatory / contractual requirement?	0 = No 3 = Yes	3
	Critical to Service or Organisation	Is it critical to Service or Organisational Delivery?	0 = No 2 = Yes to Service 3 = Yes to Organisation	2
	Financial Return on Investment	What is the amount of financial return on investment from the project?	0 = No financial return 1 = low < £50k 2 = mod between £50-£100k 3 = high >£100k	1

Risk	Residual risk to organisation if not delivered	What is the residual risk to the organisation if the project is not delivered?	0 = No risk 1 = Low risk 2 = Moderate risk 3 = High risk	3
	Does the proposal mitigate risks (or potential risks) or address significant gaps in current service provision?	To what extent does the proposal mitigate risks (or potential risks) or address significant gaps in current service provision?	0 = No mitigation or addressing of gaps 1 = Does little to mitigate risk or address gaps 2 = Addresses some risks or gaps but leaves areas unresolved 3 = Effectively mitigates major risks and comprehensively addresses gaps	3
	Identified corporate under performance or significant risk or clinical risk	What is the extent to which the project has an impact on under-performance, significant risks or clinical risks?	0 = No impact 1 = minimal impact 2 = moderate impact 3 = substantial impact	3
Deliverability	Complexity	How complex is the project?	1 = High complexity 2 = Moderate complexity 3 = Low complexity	2
	Size of Change	What is the size of the project?	1= large project 2 = medium project 3 = small project	1
	Affordability (to implement)	Can we afford the costs of project delivery?	0 = No funding secured 1 = Early funding secured (<50%) 2 = Major funding secures (50% or above) 3 = Fully funded (100%)	3
	Affordability (long-term)	Is recurring Business as Usual (BAU) funding secured to sustain the project in the long term?	0 = No funding secured 1 = Early funding secured (<50%) 2 = Major funding secures (50% or above) 3 = Fully funded (100%)	3
	Capacity	Do we have sufficient staff, time and equipment?	0 = No capacity 1 = Low – less than 50% capacity secured 2 = Medium – 50% or above capacity secured 3 = High – 100% capacity secured	1
	Capability	Do we have the right people, specialist resources, skills and equipment?	0 = No capability 1 = Low – Less than 50% capability acquired	1

			2 = Medium – 50% or above capability acquired 3 = High – 100% capability acquired	
	Commitment	How committed are the key stakeholders?	0 = No commitment 1 = Low commitment 2 = Medium commitment 3 = High commitment	1
	Clarity	Do we have enough information to make a decision?	0 = No clarity 1 = Low clarity 2 = Medium clarity 3 = High clarity	1
Political Imperative	Cabinet Secretary Priority	Does the proposal address a significant Cabinet Secretary's priority or public concern?	0 = Does not address 1 = Barely addresses 2 = Somewhat addresses 3 = Effectively addresses	2
	Reputation (including Recruitment & Retention)	Does it enhance the Health Board's reputation among staff and the public, or respond to critical scrutiny?	0 = No impact or negative impact 1 = minimal positive impact 2 = moderate positive impact 3 = high positive impact	2

Sense check and Validation

Completed questionnaires are returned to the Digital PPMO and scores are transferred into the prioritisation tool.

The Digital PPMO review scores and justifications, challenging and check for any gaps, ensuring consistency, comparability, and fairness across the portfolio.

Visual Outputs Generated

Scores entered into the prioritisation tool, generate visuals to support comparison and decision-making, including:

- Stacked bar charts
- Risk bar charts
- Summary tables

These outputs support transparent comparison across the portfolio.

Stacked Bar Chart

The stacked bar chart shows projects ranked from highest to lowest total score. Each bar is divided into segments representing the five dimensions, with segment size reflecting the score achieved. Larger segments indicate a greater contribution to overall priority.

This chart reflects scoring across the five dimensions only and does not represent final priority groupings.

Colour Key and Interpretation

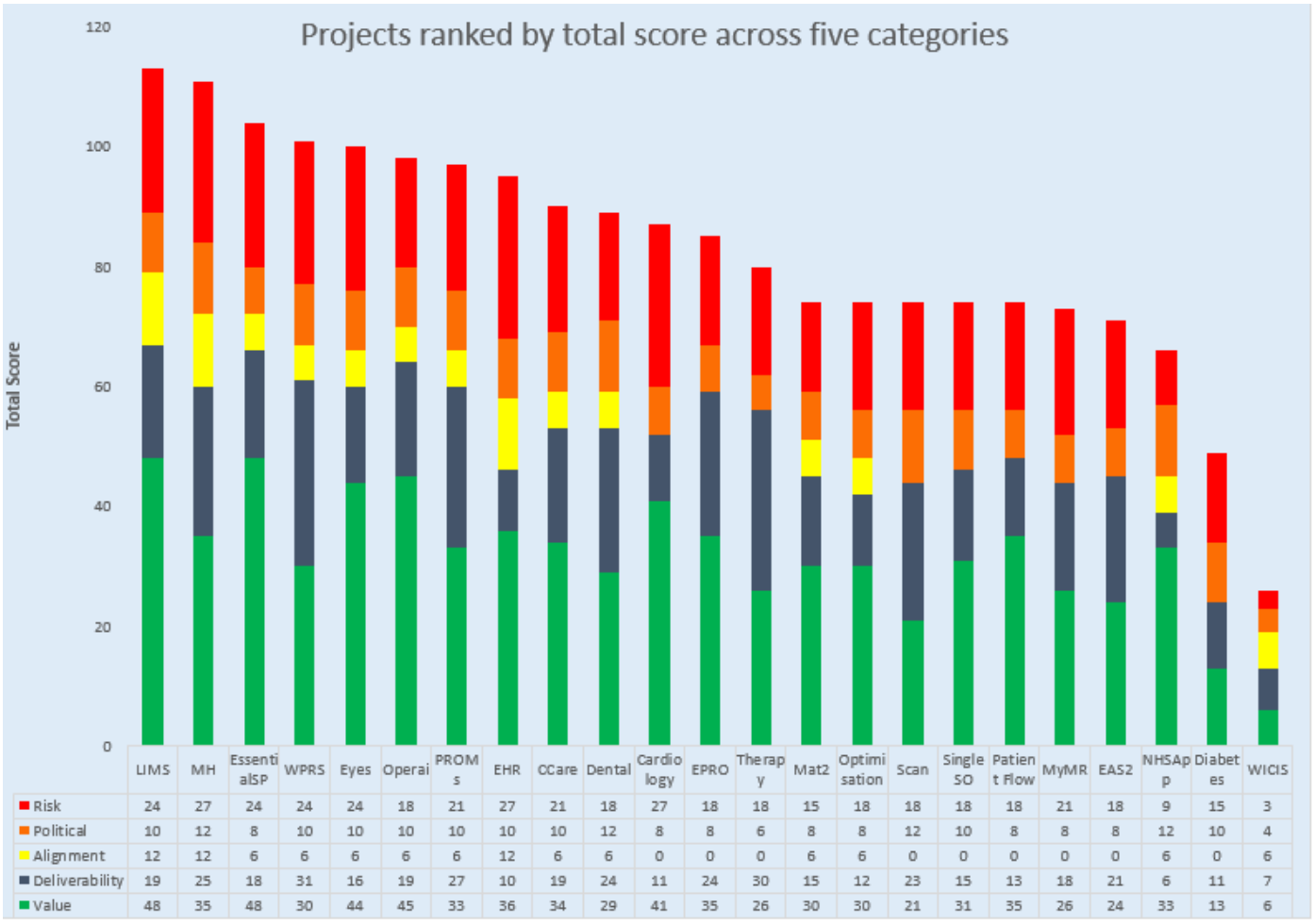
Green (Value): Indicates the extent to which the project has an impact on quality, safety, harm reduction, and the anticipated benefits or impact the project would deliver. A larger green segment reflects greater value.

Blue (**Deliverability)**: Shows the complexity and scale of the change, the affordability of implementation and long-term sustainability, and the organisation's capacity, capability, commitment, and clarity to deliver it. A larger blue segment suggests the project is more easily delivered.

Yellow (Strategic Alignment): Reflects how well the project is aligned with the Annual Plan and Major Change Programmes. A larger yellow segment signals stronger strategic fit.

Orange (Political Considerations): Signifies the extent to which the project will address Cabinet Secretary priorities and enhance the Health Board's reputation. A larger orange segment indicates greater political imperative.

Red (Organisational Risk): Represents the extent to which the project mitigates risks or gaps in current service provision, addresses underperformance, and the residual risk to the organisation if the project is not delivered. A larger red segment signals higher exposure to risk.

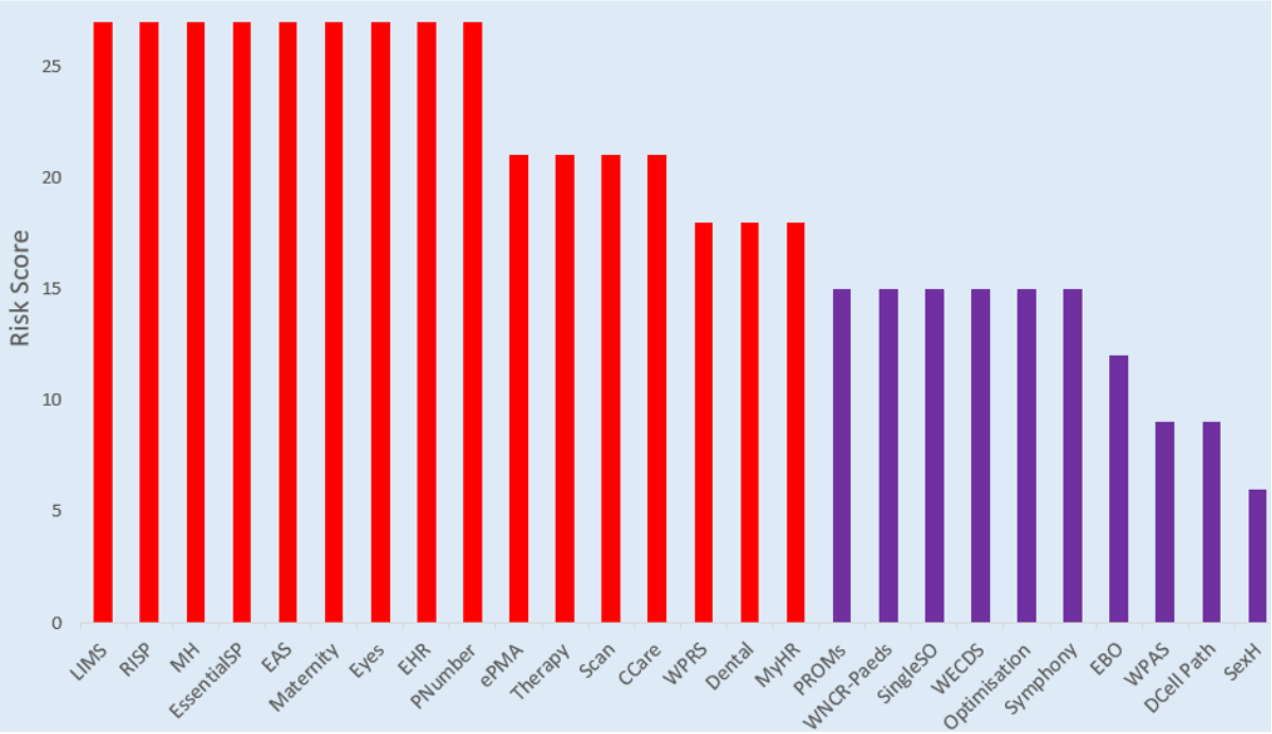


	LIMS	MH	EssentialSP	WPRS	Eyes	Operai	PROMs	EHR	CCare	Dental	Cardiology	EPRO	Therapy	Mat2	Optimisation	Scan	SingleSO	Patient Flow	MyMR	EAS2	NHSApp	Diabetes	WICIS
Risk	24	27	24	24	24	18	21	27	21	18	27	18	18	15	18	18	18	18	21	18	9	15	3
Political	10	12	8	10	10	10	10	10	10	12	8	8	6	8	8	12	10	8	8	8	12	10	4
Alignment	12	12	6	6	6	6	6	12	6	6	0	0	0	6	6	0	0	0	0	0	6	0	6
Deliverability	19	25	18	31	16	19	27	10	19	24	11	24	30	15	12	23	15	13	18	21	6	11	7
Value	48	35	48	30	44	45	33	36	34	29	41	35	26	30	30	21	31	35	26	24	33	13	6

Risk Bar Chart

Risk scores are determined using three key criteria:

The residual risk to the organisation if the project is not delivered
The extent to which the initiative mitigates existing risks or addresses significant gaps in current service provision
Whether the project highlights corporate underperformance, significant organisational risk, or clinical risk.



Step 2: Contextual Factors – Completing the Summary Table

In addition to scoring, the following factors are considered:

Mandated requirements
External funding
Delivery status
Organisational risk

These ensure that practical delivery constraints are reflected in prioritisation decisions.

Summary Table

The summary table brings together scoring and contextual information to support overall prioritisation decisions.

Table Columns

Rank: Indicates the final priority order
Project Name: Each project is listed by name. See Project Descriptions. See also High-Level Timelines.
Five-Dimension Scores: Individual scores for Alignment, Value, Risk, Deliverability, and Political Imperative.
Conditional formatting is applied to each column based on the scored range:

- **Green shading** indicates higher priority

- **Red shading** indicates lower priority
  This visual gradient enables quick comparison across projects

Total Score: Combined score across all five-dimensions.

Additional Indicators

Green ticks highlight key contextual factors:

- **Mandated or Externally Funded:** Must be delivered or tied to specific funding
- **High Risk:** Score above 15
- **Delivery Phase:** Currently in delivery (where reprioritisation is less feasible due to existing progress and momentum).
- **IMTP Alignment:** Included in IMTP commitments
- **Ministerial Priority:** Aligns with national priorities.

Stakeholder Prioritisation

Highlights degree of focus by stakeholders: Critical Priority (dark red), High Priority (pink), or Lower Priority (grey).

- **IHC Directors**
- **Medical Information Officers**
- **Digital Senior Leadership Team**

Priority Groups

Indicates whether the project is considered Critical, High, or Lower priority

- **Priority Group:** Final grouping from 1 (highest) to 4 (lowest)

Rank	Project Name	Align 0 - 12	Val 0 - 51	Risk 0 - 27	Del 3 - 39	Polit 0 - 12	Total Score 3 - 141	Mandated or Externally Funded	High Risk	In Delivery	IHC Director Focus	MIO Focus	Digital SLT Focus	IMPT 26-29	Ministerial Priority	Priority Ranking
1	LIMS Laboratory Information Management System	12	48	24	19	10	**113**	✓	✓	✓	✓	✓	✓	✓	✓	priority 1
2	Mental Health	12	35	27	25	12	**111**	✓	✓	✓	✓	✓	✓	✓	✓	priority 1
3	Essential Services Programme	6	48	24	18	8	**104**	✓	✓	✓	✓	✓	✓	✓	-	priority 1
4	WPRS Welsh Patient Referral System	6	30	24	31	10	**101**	✓	✓	✓	✓	✓	✓	✓	✓	priority 1
5	Open Eyes	6	44	24	16	10	**100**	✓	✓	✓	✓		✓	✓	-	priority 1
6	Operai	6	45	18	19	10	**98**	✓	✓	✓			✓	✓	-	priority 1
7	Connecting Care (Community Health)	6	34	21	19	10	**90**	✓	✓	-	✓	✓	✓	✓	✓	priority 1

8	Therapies	0	26	18	30	6	80	-	✔	✔	✔		✔	-	-	Priority 1
9	PROMs Patient Reported Outcome Measures	6	33	21	27	10	97	-	✔	-		✔	✔	✔	✔	priority 2
10	Dental	6	29	18	24	12	89	-	✔	-	✔		✔	✔	-	priority 2
11	Cardiology PACS	0	41	27	11	8	87	-	✔	-	✔		✔	-	-	priority 2
12	EPRO - Digital Dictation Upgrade	0	35	18	24	8	85	✔	✔	-	✔	✔	✔	-	-	Priority 2
13	EHR Programme Electronic Health Records	12	36	27	10	10	95	-	✔	-	✔	✔	✔	✔	-	priority 3
14	Digital Maternity Cymru (Phase 2)	6	30	15	15	8	74	✔	-	✔				✔	✔	Priority 3
15	Optimisation / Legacy Systems Decommissioning	6	30	18	12	8	74	-	✔	-	✔	✔		✔	✔	Priority 3
16	Scanning Project	0	21	18	23	12	74	-	✔	-	✔	✔		✔	-	Priority 3
17	Single Sign-On (Optimised)	0	31	18	15	10	74	-	✔	-	✔	✔		-	-	Priority 3
18	Patient Flow (Stream)	0	35	18	13	8	74	-	✔	-	✔	✔		-	-	Priority 3
19	My Medical Record / My Health Record	0	26	21	18	8	73	-	✔	-				-	-	Priority 4
20	Emergency Admissions System (Phase 2) (Admissions and Handover System)	0	24	18	21	8	71	-	✔	-		✔		-	-	Priority 4
21	NHS App	6	33	9	6	12	66	-	-	✔	✔			✔	-	Priority 4
22	Diabetes (full scores pending)	0	13	15	11	10	49	-	-	-	✔			-	-	Priority 4
23	WICIS Welsh Intensive Care Information System	6	6	3	7	4	26	✔	-	-				-	-	priority 4

Key:

✔	Condition Met
–	Condition Not Met

✔	Immediate Focus
✔	Planned Focus

	Longer-Term Consideration

Step 3: Stakeholder Review

Findings are reviewed by the Digital PPMO and key stakeholder groups, including Technical Leads, Medical Information Officers, IHC Directors, and the Digital Senior Leadership Team.

This provides validation, challenge, and alignment, ensuring a balanced and transparent final position.

Final Ranking

Final scores and contextual factors are shared with stakeholders to allow further input and confirmation of priority groupings before submission to the Executive Team.

Final Ranking including Contextual Factors

1	LIMS	1
2	Mental Health	1
3	Essential Services Programme	1
4	WPRS - Welsh Patient Referral System	1
5	Open Eyes	1
6	Operai	1
7	Connecting Care	1
8	Therapies	1
9	PROMs	2
10	Dental	2
11	Cardiology PACS	2
12	EPRO - Digital Dictation Upgrade	2
13	EHR - Electronic Health Records	3
14	Digital Maternity (Phase 2)	3
15	Optimisation / Legacy Systems Decommissioning	3
16	Scanning Project	3
17	Single Sign-On	3
18	Patient Flow (Stream)	3
19	My Medical Record / My Health Record	4
20	Emergency Admissions System (Phase 2)	4
21	NHS App	4
22	Diabetes	4
23	WICIS	4

Must Do	Priority 1 & 2
Could Do	Priority 3
Hold	Priority 4

Limitations and Considerations

Subjectivity
Despite efforts to standardise the prioritisation process, assessing project benefits and risks still involves a degree of subjectivity. Broader stakeholder engagement will help mitigate bias and improve transparency.

Mandated Projects with Incomplete Data
Projects mandated by external bodies or subject to tight delivery timelines often lack key information - such as benefits baselines and target outcomes -typically derived from options appraisals. This limits the ability to assess their strategic value.

Key Stakeholders Involved

Project Leads/Managers – provide detailed project information for scoring

Clinical Leadership – ensure projects meet patient care and clinical improvement objectives

Finance and Operational Teams – evaluate financial value and resource requirements

IT/Digital Teams – assess technical risks, complexity, and deliverability

Executive Leadership – provide strategic oversight and ensure alignment with organisational goals

Scoring workshops are used to:

Review proposals

Agree scores

Ensure consistency

Review Frequency

The ranking of digital projects is periodically revisited to reflect any changes in project scope, resource availability, or organisational priorities. The following process should be followed:

Half Yearly Review – Conduct a full review of all prioritised projects every 6 months to revalidate scores.

Ad-hoc Reviews – If there is a significant change in project scope, resources, or external factors (e.g., funding cuts, regulatory changes), a special review should be conducted to adjust scores accordingly.

In addition to ad-hoc reviews for existing projects, any **new projects** proposed during the interim period between half yearly reviews should undergo an expedited scoring process. These projects can be preliminarily assessed by a smaller, cross-functional group of key stakeholders, using the same scoring criteria outlined in the matrix.

Once scored, these projects can be integrated into the prioritisation matrix alongside existing projects and revisited during the next formal review session. This ensures that emerging priorities or opportunities are considered promptly without waiting for the next full review cycle, maintaining flexibility in the Health Board's strategic approach.

During each review, all stakeholders should reassess the project scores and update the matrix as needed.

Appendix 1: Prioritisation Questionnaire

Project Name:	
SRO	
Project Lead:	
Date of latest update:	
Information provided by:	
Description of the project	
What problem does this solve?	
Mandated by WG?	
Mandated by BCUHB?	
Externally Funded?	
Current Delivery Stage	
Is there a business case?	
Business Case Status	
Update on any Business case	
Is there any funding & what does funding cover?	
What are the funding gaps and timescales?	
Current major issues/risks	
Risk of not Progressing	

Category	Sub-Category	Question	Options	Current Score	Alternative Score (if applicable)	Justification – Please provide justification for your selection	PPMO Review Comments
Alignment	**Annual Plan**	Is this project within the Annual Plan?	A = No B = Yes (if Yes, provide the Reference Number)				
	Major Change Programme	Is this project a Major Change Programme?	A = No B = Yes				
Value	**Benefits**	What is the extent to which the project has an impact on quality, safety and harm reduction?	0 = no impact A = minimal impact B = moderate impact C = substantial impact				
	Patient Outcomes and Benefits	What is the extent to which the project has an impact on patient outcomes and benefits?	0 = no impact A = minimal impact B = moderate impact C = substantial impact				
	Increased Effectiveness	What is the extent to which the project has an impact on the effectiveness of operations?	0 = no impact A = minimal impact B = moderate impact C = substantial impact				
	Increased Efficiency	What is the extent to which the project has an impact on the efficiency of operations?	0 = no impact A = minimal impact B = moderate impact C = substantial impact				
	User Experience	What is the extent to which the project has an impact on user experience?	0 = No impact A = minimal positive or negative impact B = moderate positive impact C = high positive impact				
	Regulatory, mandatory or contractual requirement	Is the project a mandatory or contractual requirement?	A = No B = Yes				

Digital Projects Prioritisation Framework

	Critical to Service or Organisation	Is it critical to Service or Organisational Delivery?	A = no B = yes to service C= yes to organisation				
	Financial Return on Investment	What is the amount of financial return on investment from the project?	0 = No financial return or negative return A= low < £50k B = moderate: between £50k-£100k C = high >£100k				
Risk	**Residual risk to organisation if not delivered**	What is the residual risk to the organisation if this project is not delivered?	0 = No Risk A = Low Risk B = Moderate Risk C = High Risk				
	Does the proposal mitigate risks (or potential risks) or address significant gaps in current service provision?	To what extent does the proposal mitigate risks (or potential risks) or address significant gaps in current service provision?	0 = No mitigation or addressing of gaps A = Does little to mitigate risk or address gaps B = Addresses some risks or gaps but leaves areas unresolved C = Effectively mitigates major risks and comprehensively addresses gaps				
	Identified corporate under performance or significant risk or clinical risk	What is the extent to which the project has an impact on under-performance, significant risks or clinical risks?	0 = No impact A = minimal impact B = moderate impact C = substantial impact				
Deliverability	**Complexity**	How complex is the project?	A = High Complexity B = Moderate Complexity C = Low Complexity				
	Size of the change	What is the size of the project? (see Project Sizing Matrix tab attached)	A = Large Project B = Medium Project C = Small Project				
	Affordability - Project (to implement)	Can we afford the costs of project delivery?	0 – No funding secured A – Early funding secured (< 50%) B – Majority funding secured (50% or above) C – Fully funded (100%)				

	Affordability (long term)	Is recurring Business as Usual (BAU) funding secured to sustain the project in the long term?	0 – No BAU funding secured A – Early BAU funding secured (< 50%) B – Majority BAU funding secured (50% or above) C – BAU Fully funded (100%)				
	Capacity	Do we have sufficient staff, time and equipment for this project?	0 = No capacity A = Low - Less than 50% capacity secured B = Medium - 50% or above capacity secured C = High = 100% capacity secured				
	Capability	Do we have the right people, skills and equipment for this project?	0 = No capability A = Low - Less than 50% capability acquired B = Medium - 50% or above capability acquired C = High = 100% capability acquired				
	Commitment	How committed are the key stakeholders?	0 = No commitment A = Low commitment B = Medium commitment C = High commitment				
	Clarity	Do we have enough information to make decisions?	0 = No clarity A = Low clarity B = Medium clarity C = High clarity				
Political Imperative	**Cabinet Secretary Priority**	Does the proposal address a significant Cabinet Secretary's priority or public concern?	0 = Does not address A = Barely addresses B = Somewhat addresses C = Effectively addresses				
	Reputation (Recruitment & Retention)	Does it enhance the Health Board's reputation among staff and the public, or respond to critical scrutiny?	0 = No impact or negative impact A = minimal positive impact B = moderate positive impact C = high positive impact				

Digital PPMO Report

Date: July 2026

Trugaredd
Compassion

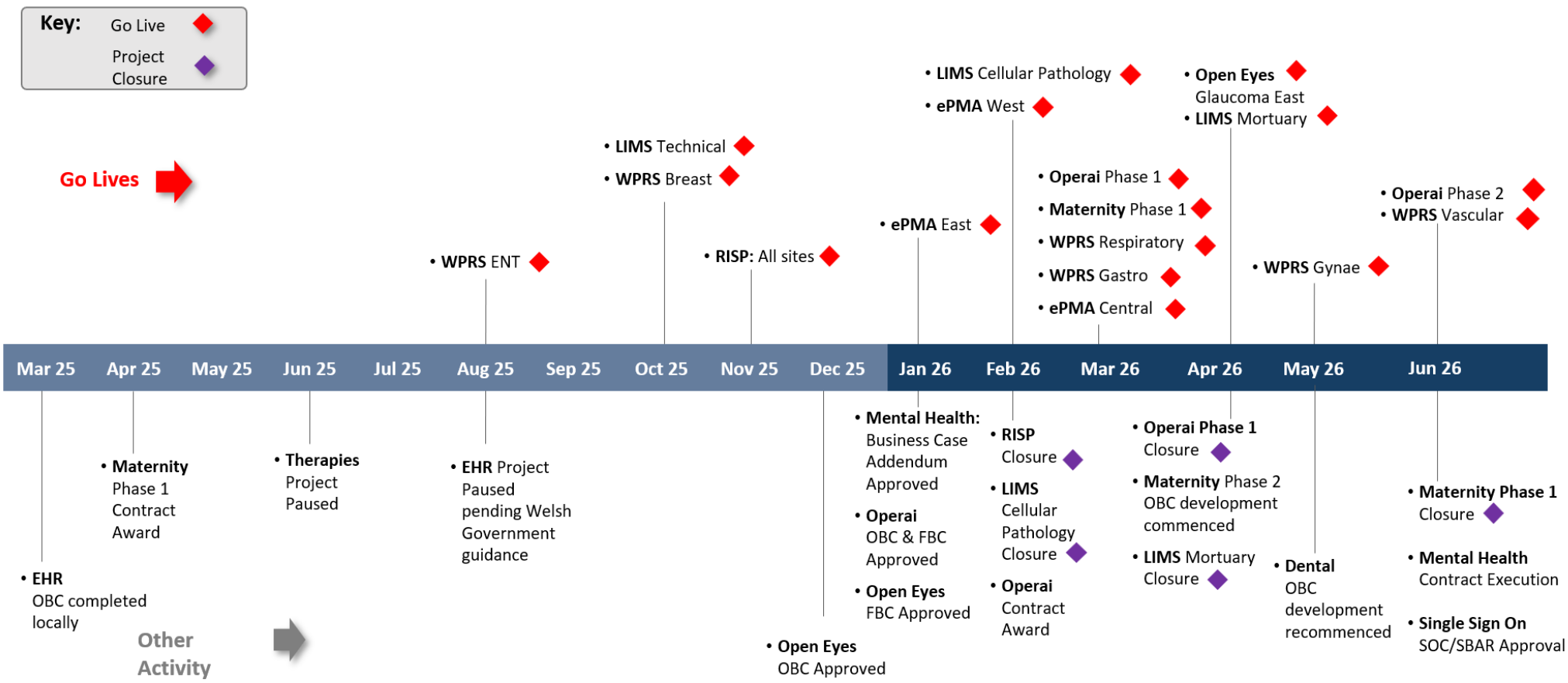
Agored
Openness

Parch
Respect

BCUHB Digital Data & Technology,

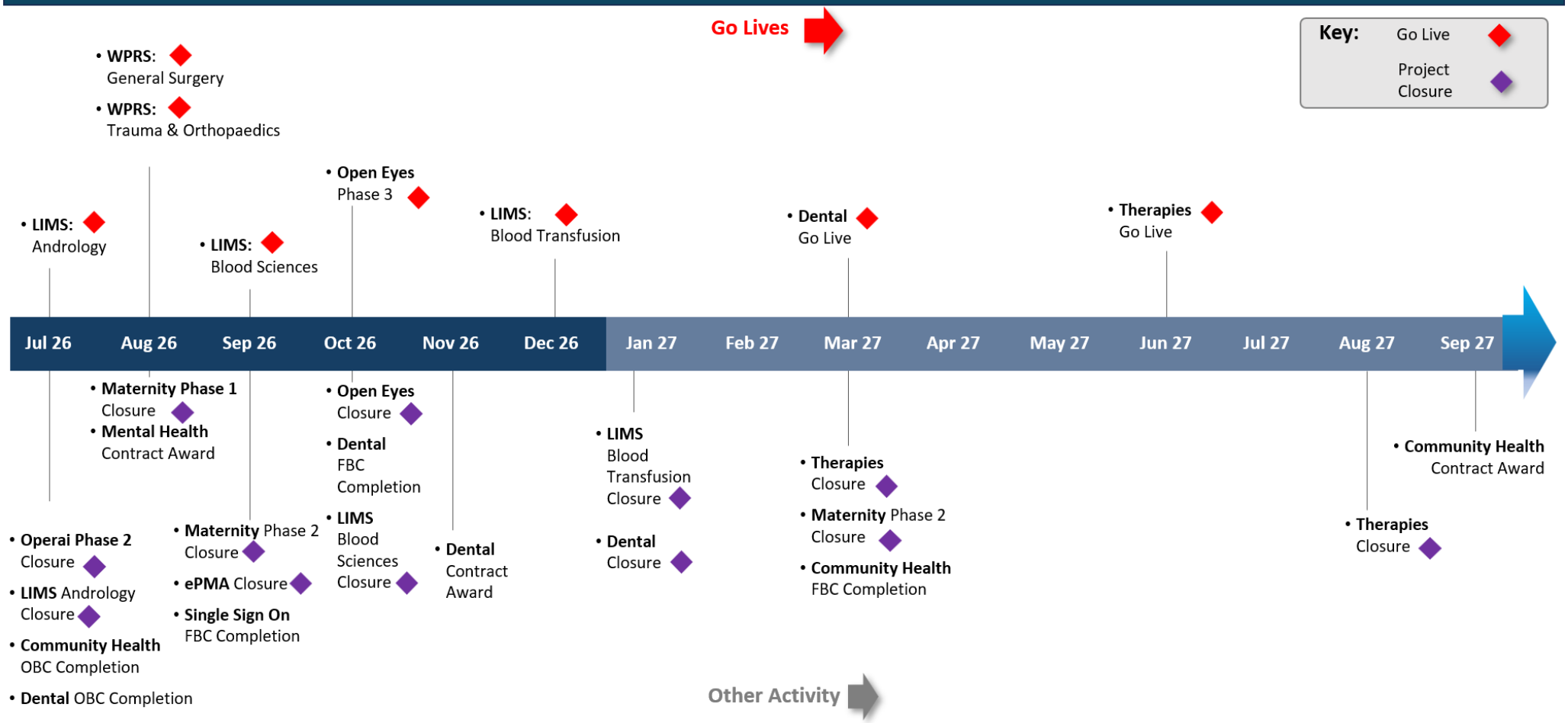
Digital Project & Portfolio Management Office

Project Key Milestones – To Date



Project Key Milestones – Future

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board



Project Lifecycle

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Feasibility	Start Up (OBC)	Initiation (FBC)	Delivery	Go Live	Closure	BAU
Artificial Intelligence	EHR		LIMS	WPRS Phase 2	ePMA	RISP
Diabetes	Maternity Phase 2		Mental Health		Maternity Phase 1	
EBO Expansion	Community Health		Open Eyes			
Emergency Admissions (Phase 2)	Dental		Operai			
My Medical Record			Therapies			
NHS App						
Optimisation / Legacy Systems						
Patient Flow (Stream)						
Remote Patient Monitoring						
Scanning Project						
Single Sign-On						
Symphony in SDEC						
Re-procurement of clinical document repository						
WICIS						

Total Projects	On Track	Off Track but Managed	Off Track	Complete
13	3	5	4	1

Digital Project Update – July 2026

LIMS Digital Programme – National System, partial National Funding

Summary:

The national LIMS Programme continues to experience further delays, increasing delivery risk, particularly for Blood Sciences (Tranche 4) and the impact upon the patient critical Blood Transfusion (BT) (Tranche 5) implementation. BCUHB continues to progress readiness activities for a safe Go-Live while managing operational, clinical and financial risks through robust contingency planning and mitigations.

Current Position:

Ongoing national delays resulting in increased uncertainty around timelines, benefits realisation and overall confidence in delivery.
Deployment dates to be confirmed for Tranche 4 (Blood Sciences) and Tranche 5 (Blood Transfusion (BT)).
Telepath (Legacy Blood Transfusion system) contract due to expire 15th December 2026 – Executive Team approved extension of the contract to March 2027 to mitigate service continuity risks.
Andrology, Cellular Pathology and Mortuary services (Tranche 2) are now live on the new LIMS, operational teams continue to embed new processes.

Key Risks and Mitigations:

Configuration of key functionality not yet finalised, adding pressure for timely completion of end-to-end testing, clinical validation and sign off.
Impact: implementing a system with incomplete functionality could lead to disruption to patient pathways, leading to possible delays to treatment / diagnosis and adversely operational / reputational impact.
Mitigation: Continue to work closely with National Team and Supplier to collaborate on finalising key functionality. Also, to closely monitor critical path activities with National Team and escalate where required.

The Legacy Blood Transfusion system is due to expire on 15th December 2026. The proposed go live date of 23rd Nov is now unachievable due to delays in critical path activities.
Confidence of delivery of Blood Transfusion within 2026 is now low.
Impact: Failure to deliver a viable blood transfusion system before the current system reaches end of life may result in disruption or loss of blood transfusion services across BCUHB. This represents a significant operational and clinical risk, with the potential for serious patient safety impacts, service disruption, and inability to meet clinical requirements. There could also be financial implications, with additional costs to BCUHB if timescales continue to slip with the National LIMS Programme.
Mitigation: Executive Team have approved an extension of the legacy system contract until March 2027 removing the immediate risk of service disruption. The Blood Transfusion service continues to work with the National Programme Team to establish readiness and confirm timelines. In addition, longer term continuity options and associated costs are being reviewed by Executives for a decision.

Ongoing delays to the National LIMS Programme, compressed timelines and overlap of critical path, system configuration ongoing, high volume of outstanding defects and system workarounds, data migration risks for Blood Transfusion.
Impact: Severity of impact could range from treatment delays to serious patient safety incidents in high-risk clinical scenarios. Also reduced confidence in the new LIMS system with the high volume of workarounds adding inefficiencies and unnecessary steps within the workflow overall impacting sample turnaround times. Operational / reputational impact.
Mitigation: The revised National LIMS revised plan was presented for approval at the National Programme Board on 14th July 2026. Close monitoring of critical path activities, defect resolution, prioritise key activities and escalate through programme governance if required.

Delays to the LIMS programme extending further into FY 2026/27 resulting in slippage into Q3 for Tranches 4 and 5 creating additional financial pressures on BCUHB.
Impact: Added costs due to National Programme slippage, resulting in financial cost pressures to BCUHB. Failure to implement the new Pathology system will lead to the reliance on unsupported legacy systems with potential impact on patient treatment timelines, staff workload and patient experience. Operational / reputational impact. The reliance on unsupported systems will be a breach in MHRA regulations when the current BT system (Telepath) contract expires in March 2027.
Mitigation: Escalating through BCUHB governance to ensure timely executive awareness and decision-making. Also, prepare a local business case demonstrating the operational, financial and patient safety implications of further postponement to support funding discussions for Blood Transfusion.

Commented [ER1]: @Anna Richards (BCUHB - Digital, Data and Technology) @Sarah Tyler (BCUHB - Digital, Data and Technology) does this also breach regulations?

Commented [ST2R1]: Yes MHRA when contract for Telepath ends in March. I have added narrative.

Ongoing delays to the National LIMS 2.0 Programme have resulted in the proximity of the legacy LIMS system Storage Area Networks (SANs) will be end-of-life on 31st August 2026. This is now an extremely high risk.
Impact: Hardware failure, corruption or a cyber incident due to security updates no longer being available post 31st August 2026. This could lead to loss of current LIMS system for an unknown period of time impacting the safe and efficient running of Pathology Services. The impact could be catastrophic with delays to Pathology sample processing, impacting delays to patient treatment / diagnosis / medication. In addition, there could be potential Data Protection and Network and Information Security Regulations (NIS-R) implications where personal data or essential services are affected.
Mitigation: DHCW have secured a contract to provide replacement hardware should the SAN hardware fail. DHCW have also advised that the database is mirrored and that relevant published vulnerabilities will be monitored with mitigations applied where possible. BCUHB Cyber and Project Team have documented an Information Security Risk Report for review by BCUHB Senior Information Risk Owner (SIRO). This report has been approved by the SIRO and shared with the Executive Medical Director.

Plan To Go Forward:

Delivery confidence dependent on a revised national deployment plan, defect resolution, milestone assurance and financial clarity
Deployment readiness activities will continue with end-user training, user access, cutover planning and operational readiness
Continued engagement with DHCW and Supplier to progress deployment readiness activities

Milestones:

Cellular Pathology Go-live – 3rd February 2026
Mortuary Go-Live – 16th April 2026
Andrology service Go-Live – 14th July 2026

Microbiology Go-Live – Delayed from 10th Aug, date TBC (no BCUHB activity
Blood Sciences Go-Live – 12th October (at risk due to T3 delay)
Blood Transfusion Go-Live - 23rd November (at risk due to delays with data migration critical path and T3 go live)

Deliverables:
Streamline separate legacy Pathology Systems to implement the new LIMS with TrakCare Enterprise (TCLe).

Mental Health & Learning Disabilities EHR Programme - Local procurement and Implementation, National Funding

Summary:
This is a critical safety-driven programme addressing long-standing digital gaps in All Ages Mental Health and Learning Disability services highlighted in regulatory reviews.
Procurement is now completed and the successful supplier has been announced following the standstill period. The project is now moving into the Contracting phase.

Current Position:

Welsh Government funding confirmed for FY 2026/27
Supplier Contracting workshops commenced

Key Risks & Mitigations:

Funding beyond March 2027 has not been confirmed by Welsh Government. Mitigation: Welsh Government conversation has been held, and the unofficial outcome is that additional DPIF funding scrutiny is now in place to prevent funding paying for BAU activities. This project should not fall into those criteria, but HB's will be required to validate funding request every FY. This has been built into the business planning cycle.
Risk to the delays in contracting due to complex changes made to the contract by supplier. It was originally anticipated that due to extensive pre-market contracting activities contracting would centre around key areas, however due to significant changes by the supplier a full contract ratification is required needing multiple SME's involvement. Mitigations: Contract approach has been developed to address this risk, the project has created a detailed contract tracking spreadsheet that has documented and tracks all changes. Owners are being identified by Both CTMUHB and BCUHB.

Plan To Go Forward:

Contract execution
Planning with Supplier

Milestones

High level plan to be agreed with Supplier (anticipated August 2026)
Finalisation of the contractual arrangements and contract signature (anticipated September 2026)
Commissioning of the cloud hosting environment and installation of the application (anticipated October 2026)
Development, review and approval of the detailed implementation and deployment plan jointly with the Supplier (anticipated November 2026)

Deliverables

Complete contracting phase
Commence implementation

Acute and Community EHR Programme – Local

Summary:

BCUHB has a strong strategic case for an Acute and Community EHR, but progress is paused pending national direction.

Current Position:

- National direction from Welsh Government is needed and will be instrumental in determining how the programme aligns with national priorities and funding expectations.
- BCUHB EHR Convergence Pathway: DDaT have been commissioned to produce a high-level roadmap showing how existing and planned systems can converge towards a core EHR, supported by specialist clinical systems, aligned to the National Target Architecture.

National Activities

- **Refresh of the National Digital, Data and AI Strategy:** A consultant has been appointed to develop a refreshed national strategy aligned to the 10-Year Health and Social Care Plan, creating a clear, deliverable long-term vision for digital, data and AI across Wales through engagement with NHS organisations, clinicians and key stakeholders.
- **Collaborative Once for Wales Approach:** The strategy will be co-produced across NHS Wales and the wider health and care sector to strengthen a Once for Wales model, improve consistency of delivery, maximise use of resources, and achieve better outcomes for citizens and staff, with the strategic framework due by November 2026.
- **Building on Existing Investment and Good Practice:** The work will build on the National Target Architecture, existing transformation programmes and local innovations already underway within Health Boards and trusts, ensuring a unified national approach that incorporates and scales existing good practice rather than replacing it.

Key Risks & Mitigations:

National uncertainty is delaying local progress. BCUHB is actively engaging with Welsh Government and DHCW, participating in national discussions. Welsh government Digital lead attends the EHR board to provide national updates. No action can be taken until national strategy has been developed.

Plan To Go Forward:

Maintain engagement with Welsh Government and DHCW to influence national direction.

Milestones

There are currently no milestones agreed, until a national strategy has been developed.

Deliverables

There are currently no deliverables agreed, until a national strategy has been developed.

Digital Maternity Programme Phase 2 - Local Implementation, Mandate, Procurement Framework, National Governance

Summary:

BCUHB went live with the BadgerNet digital maternity system on March 10th 2026. Outstanding work has resulted in a Phase 2 being developed, which includes a number of key integrations, some with national systems, and the implementation of national data standards. The current plan is that Phase 2 will be delivered by the end of March 2027.

Current Position:

Project Closure report for Phase 1 has been produced and is progressing through the local approval process.
A number of national workshops are being scheduled to understand scope, requirements and delivery timescales for integration with national systems.
Locally, progress is being made with integration between BadgerNet and Viewpoint 6 for ultrasound scans and integration with the cardiotocography monitors (CTGs).
A national working group is to be setup to progress national data standards. This group will comprise of Digital Midwives and Data Analysts from each health board and will report into the Clinical Design Group (CDG).
Benefit owners for each of the benefits documented in the Benefits Register have been identified.

Key Risks and Mitigations:

Recurrent funding pressure from Year 2 onward. Mitigation: A Business Case was approved by the Health Board early in March 2025 with a stated annual cost of £0.248 million
Suppliers having the capacity to support all Health Boards with integrations to other systems. Suppliers include DHCW and System C for the national systems and Philips (HNC) and System C for the Viewpoint integration. Mitigation: all suppliers will need to be aligned with the National DMC Programme
Risk relating to BCUHB having the local resources available to deliver Phase 2, in particular integration resources. Mitigation: local integration resource costs for Phase 2 have been included in the Women's BadgerNet Annual Plan for FY 26/27 and ICT have agreed to absorb using EPMA resource
Risk around inconsistent data entry in BadgerNet. Mitigation: Collaborate with BadgerNet representatives and other Welsh Health Boards to review system configuration, workflows, and data capture practices. Maintain regular monitoring through meetings with maternity informatics leads and service managers to review incidents, data quality issues, and required actions. Reinforce good documentation standards through staff communications, user guidance, targeted refresher training, and engagement with professional bodies to support accurate and consistent electronic record keeping.

Plan To Go Forward:

DHCW to schedule integration workshops, electronic document transfer (EDT) held for 23rd July.
Hold project kick off meeting with System C and Philips / HNC for the Viewpoint integration.
Obtain local financial approval for the hardware required as part of the CTG integration.
Work with benefit owners to finalise the benefit profiles, including start date, expected realisation period, and the phasing of benefit realisation over time.
Start-up of the national working group for the implementation of data standards.

Milestones

- Complete the Viewpoint and CTG integration by the end of October 2026.
- Finalise benefit profiles by the end of September 2026.
- Complete all integrations with national systems by the end of March 2027.
- Implement national data standards by the end of March 2027.

Deliverables

- Deliver all elements of Phase 2 by the end of March 2027.

ePMA Digital Programme - National Framework, Local procurement and Implementation, National Funding

Summary:

The ePMA programme has successfully delivered electronic prescribing and medicines administration across all BCUHB inpatient acute and community hospital settings, improving the safety, quality and accessibility of medicines information. The programme supports safer prescribing, reduces reliance on paper processes and provides clinicians with real-time access to patient medication records.

Current Position:

Inpatient rollout across all acute and community hospital sites was completed on 31st March 2026.
BCUHB is live with planned integrations to the national WPAS system and SMR Write for discharge medications and was the first Health Board in Wales to implement writing to the Shared Medication Record.
The programme is transitioning into Business as Usual (BAU) arrangements.
Outpatient Department (OPD) adoption continues to increase, with a planned completion date of 1st November 2026.

Key Risks & Mitigations:

The remaining programme risk relates to Patient Numbering, an existing corporate risk which continues to be managed through established corporate governance arrangements. Mitigating actions include targeted WPAS training and floorwalking support within ED and Admissions areas to improve adherence to patient numbering processes and reduce the risk of duplicate or mismatched patient records. In addition, the WPAS Manager and Assistant Director of Data are developing a revised paper for Executive Health Board consideration, outlining the current risk position and implications for ePMA and other digital initiatives.
OPD rollout remains dependent on local clinical capacity, printer availability and ICT configuration activities, which may delay full adoption in some services. This risk is being managed through the ePMA Programme Board and regular engagement with Pharmacy IHC Directors. Actions include targeted support to services with outstanding implementation requirements, ongoing ICT activity to resolve printer and configuration issues, monitoring of adoption, and consideration of a hard-stop date for OPD paper prescribing to support full transition to ePMA where operationally appropriate.
The Symphony to ePMA Mirth integration is currently dependent on a single specialist resource, creating a key-person dependency and limited resilience for support and fault resolution, particularly outside normal working hours. Failure of the integration could impact

ePMA patient registration and other downstream systems. The risk has been escalated to the Chief Technology Officer and is recorded on the DDaT Risk Register. Mitigations include strengthening the risk description to reflect ePMA impacts, documenting integration support procedures and known fixes, undertaking knowledge transfer activities, and training additional technical staff to provide increased resilience and support coverage.

Plan To Go Forward:

Complete remaining OPD implementation and transition all ePMA activities to BAU governance.
Establish benefits realisation reporting and governance arrangements.
Progress planning for the next system upgrade, including SMR Read functionality to support access to GP medication and allergy information.

Milestones:

Inpatient rollout completed – March 2026.
National WPAS and SMR Write integrations Go-Live.
Benefits reporting framework established – Q2 2026.
OPD rollout completion target – November 2026.

Deliverables

Electronic prescribing deployed across all inpatient hospital areas.
Integration with national medicines and patient administration systems.
Transition to sustainable operational governance and benefits reporting.

Digital Eye Care (OpenEyes & OPERAi) – National

Summary:

The programme is delivering two nationally mandated ophthalmology systems: OpenEyes Electronic Patient Record (EPR) and OPERAi Electronic Referral System (ERS). BCUHB was the first Health Board in Wales to implement OPERAi in Primary Care (March 2026), improving referral quality and removing postal delays. OpenEyes is live for the Glaucoma pathway at Wrexham Maelor Hospital, providing real-time digital patient records and supporting safer clinical decision-making. Together, these systems support improved information sharing, more efficient patient pathways and enhanced management of patients at risk of sight loss. Secondary care functionality within OPERAi remains under national development and is required to realise the full programme benefits. In addition, both systems have contract end dates within the next six months, and there is currently no confirmed national position regarding future arrangements.

Current Position:

OpenEyes live for the Glaucoma pathway at Wrexham Maelor Hospital.
Additional pathways (Emergency Eye Care, Cataracts, Orthoptics and Medical Retina) configured and pending clinical approval.
Pan-BCU Pathway Advisory Groups model established to support pathway standardisation, review and clinical approval.
Additional pathways (Emergency Eye Care, Cataracts, Orthoptics and Medical Retina) configured in UAT and progressing through clinical review and approval.
OPERAi live in Primary Care across North Wales, with BCUHB the first Health Board in Wales to implement the solution.

Secondary Care OPERAi functionality remains under national development, with deployment sequencing, governance and implementation arrangements awaiting national confirmation. Governance, information governance and implementation readiness arrangements are established and operating through the Digital Eye Care Programme Board.

Key Risks & Mitigations:

OpenEyes pathway approval and implementation delays: Delays in pathway review, clinical approval, hosting capacity or implementation support may delay deployment of additional OpenEyes pathways. Continued reliance on paper-based processes may delay access to clinical information and reduce the speed of referral triage, impacting patient experience and timely care. Mitigation: Pan-BCU Pathway Advisory Group model has been established to support pathway standardisation and clinical approval. BCUHB continues to work collaboratively with Cardiff and Vale University Health Board on pathway configuration, implementation planning and deployment readiness. Progress is monitored through the Digital Eye Care Programme Board.

Adoption and readiness capacity: Capacity constraints relating to training, devices, clinical engagement and specialist support may delay adoption across sites. Slower deployment may delay the patient safety, efficiency and operational benefits associated with digital patient records, including improved management of patients at risk of avoidable sight loss. Mitigation: Workforce training, infrastructure reviews, implementation readiness activities and governance arrangements are being progressed in parallel to support phased deployment across BCUHB.

National dependency for Secondary Care OPERAi: Delivery of Secondary Care OPERAi remains dependent upon national decisions regarding governance, deployment sequencing, implementation support and product development. BCUHB is unable to commit to implementation timescales for Secondary Care OPERAi until national direction is confirmed. This may delay realisation of the full benefits of digital referral management and impact delivery of planned programme outcomes. Mitigation: BCUHB continues to engage with DHCW, Welsh Government and national programme partners whilst progressing all local governance, assurance and implementation readiness activities within its control.

Future contractual and sustainability arrangements: OpenEyes and OPERAi contract arrangements require clarification beyond the current contractual periods and there is currently no confirmed national position regarding future arrangements. Uncertainty regarding future service, support and contractual arrangements may impact long-term planning, sustainability and operational continuity. Mitigation: BCUHB continues to work with Welsh Government, DHCW and partner organisations to seek clarity on future contractual, support and sustainability arrangements while maintaining delivery of current programme objectives.

Plan To Go Forward:

Continue operation and optimisation of the live OpenEyes Glaucoma pathway.
Complete pathway review, approval and standardisation through Pan-BCU Pathway Advisory Groups.
Finalise deployment plans for additional OpenEyes pathways.
Continue engagement with DHCW and Welsh Government regarding Secondary Care OPERAi deployment arrangements.
Progress workforce training, infrastructure readiness and implementation planning across all sites.
Maintain delivery readiness and secure long-term operational and support arrangements.

Milestones

Complete hardware and infrastructure readiness reviews – Q3 2026/27
Complete review and clinical approval of priority OpenEyes pathways – Q3 2026/27
Agree pathway configuration and deployment approach with Cardiff and Vale University Health Board – Q3 2026/27
Approve phased implementation and deployment plan through the Digital Eye Care Programme Board – Q3 2026/27
Commence deployment of additional OpenEyes pathways, subject to approved pathways and implementation capacity – Q3–Q4 2026/27

Deliverables

OpenEyes deployed across approved ophthalmology pathways in line with agreed phased implementation plans.
Standardised digital ophthalmology pathway governance and configuration across BCUHB.
Secondary Care OPERAi implementation readiness maintained pending national decisions and rollout arrangements.
Standardised digital referral and patient record processes supported across Ophthalmology services.

WPRS (Welsh Patient Referral Service) – National System, no funding

Summary:

This is a key project to deliver the IMTP commitment - 3B.2 A range of initiatives to support a reduction in referrals to outpatients in high-volume specialties, adopting best practice in waiting list management including the continuing roll-out of the community health pathways, to ensure better prioritisation of available capacity for the longest waiting patients with a particular focus on unwarranted variation and associated referral threshold management.

Current Position:

There are currently 10/44 BCU services live with WAP Full and 4 services are currently in progress.
Delivery delays experienced due to national resource constraints end of 2025.

Key Risks & Mitigations:

- DHCW capacity impacting rollout pace. There are no delays currently from a DHCW perspective in relation to builds / Go-Live but the resource issue is fluid so could change at any time. Mitigations: 1. Maintain positive and regular communication with DHCW to monitor upcoming resource availability issues, 2. Escalate any early signs of project deprioritisation, and 3. Have in place contingency plans should DHCW resource be temporarily removed. I.e. begin pre-engagement/mapping work for new services in readiness.

- Competing clinical priorities may affect engagement. Mitigations: Monitor each service closely from project kick off stage to ensure each site/user group is engaged and ready to onboard.

- The current project timeframe will not deliver WAP Full to all 44 BCU services by September 2027 when the Project Manager resource is currently due to end. The project is currently being reprofiled. Mitigations: In line with the IMTP the ADT Planned Care commitment to roll out this project is articulated for 2026/27 to deliver a further 8 priority services (2 per quarter). The

allocation of the B6 (uplift to B7 funded by Planned Care) is only committed by DDaT until September 2027. Planned Care have requested that this extended to complete the remaining 28/44 smaller services left over from April 2027 onwards. Project Manager currently scoping how long the remaining 28 services will take.

Plan To Go Forward:

Continue phased rollout across remaining services, dependent on sustained national support.

Milestones:

Quarter 1 2026/27 - Gynae and Vascular – Completed
Quarter 2 2026/27 – Trauma and Orthopaedics, and General Surgery – Ongoing
Quarter 3 2026/27 - Diabetes and Endocrinology – Ongoing
Quarter 4 2026/27 - Pain Management and Cardiology – Not yet started

Deliverables:

The plan is to deliver WAP Full to 2 services per quarter for the remainder of the project.

Community Dental Service PMS Replacement – Local

Summary:

This is the replacement of the Community Dental Service (CDS) Electronic Patient Management System (EPMS). The existing system is no longer supported by the supplier, which has been the case since April 2024.

Current Status:

The Executive Committee and Health Board have approved the Outline Business Case and progression to procurement and Full Business Case development, recognising that the current system is obsolete, unsupported, and presents increasing risks to service continuity, resilience, and data recovery. The proposal aligns with Welsh Government priorities to eliminate unsupported systems and will be funded from existing dental resources.

The procurement specification is approximately 80% complete and requires final sign-off from Dental and ICT stakeholders by September 2026. However, delivery risk remains high as there is currently no dedicated funding, Project Manager, or project support resource allocated, alongside no framework to procure from which may impact procurement timelines and overall project progression.

Key Risks & Mitigations:

Requirements Development Capacity: Insufficient clinical, operational and technical subject matter expertise may delay completion and validation of the requirements specification for the replacement Dental Electronic Patient Management System (EPMS). Delays to completion of the procurement process could impact the planned timetable for contract award and implementation of the new system. Mitigation: Dedicated clinical, operational and management resources from Community Dental Services have been assigned to support requirements development. Engagement with Digital and ICT Services continues to secure technical leadership and complete the technical requirements specification.

Business Case and Funding Approval: Approval of the required investment through the Health Board's business case process is required before a contract can be awarded. Any delay in

funding approval would delay procurement completion and implementation of the replacement EPMS, prolonging reliance on the current unsupported system. Mitigation: The project is progressing through the Health Board's approved business case process, with ongoing review of costs, benefits and financial requirements to support timely decision-making.

Plan To Go Forward:

Following OBC approval by the Health Board 30th July, procurement phase to begin.

Milestones:

OBC approval status:

- SRO Approved 4th June 2026
- Dental Pre-Project Board Approved 4th June 2026
- Executive Committee Approved 1st July 2026.
- The Health Board Approval, Private Session scheduled 30th July 2026

PFIG also to be updated as requested by the Executive Committee

Deliverables:

Key deliverables for the Final FBC include:

Detailed implementation plan
Supplier contract award recommendation
Financial model and affordability statement
Benefits Realisation Plan
Cyber Security and DPIA sign-off
Training and BAU adoption plan
Operational readiness assessment

The FBC can only be finalised alongside the outcome of the procurement process. Assuming a suitable framework is available from September 2026, the earliest indicative timeline would be:

Invitation to Tender (ITT) completed: 31st August 2026
Procurement and contract award: 31st October 2026
FBC completed: 31st October 2026

Therapy Management System – Local

Summary:

The Therapy Management Replacement System (Ymholi) is replacing the legacy Therapy Manager system which has been in use since 2006. The current system is end-of-life, unsupported, presents cyber-security concerns, and creates a significant risk to clinical operations if it fails.

Current Position:

Delivery of the new system started in 2025 using an Agile approach with development organised into twenty sprints. The project was paused in June 2025 following the completion of Sprint 6 of 20. There remains further development to complete the Minimum Viable Product within scope. Further discussions and agreements are in progress prior to the Project recommencing.

Key Risks & Mitigations:

The existing Therapy Manager platform remains unsupported and at risk of failure. Mitigation: Delivery of the Therapy System Replacement Project remains the primary mitigation. Until

replacement is implemented, enhanced monitoring, technical support arrangements, and proactive maintenance of the existing infrastructure will be maintained to maximise system stability and availability.
Potential loss of access to patient clinical records and therapy histories if the legacy solution fails. Mitigation: Regular backups are in place, and backup processes have been reviewed and strengthened with support from Digital Services. Business Continuity Plans are maintained to support access to critical patient information and service delivery during periods of system unavailability.
Clinical service disruption impacting referrals, Referral To Treatment (RTT) management, appointment booking, and operational reporting. Mitigation: Detailed Business Continuity Plans are in place to support continuation of essential services through manual workarounds where required. Progression of the replacement system programme remains a key mitigating action to reduce reliance on the legacy platform.
Cyber security risks associated with unsupported infrastructure. Mitigation: Cyber security controls, monitoring, and infrastructure management are being maintained as far as practicable within the constraints of the unsupported platform. Access controls, network protections, and regular risk reviews are undertaken to minimise exposure until system replacement is achieved.
Dependency on extension/support arrangements for the existing Pathway Software license while replacement work continues. Mitigation: Ongoing engagement with the supplier is being maintained to secure licence and support arrangements throughout the transition period. The Therapy System Replacement Project is actively progressing to reduce dependency on legacy contractual arrangements and associated risks.
Overall mitigation: The principal mitigation for all identified risks is the delivery of the Therapy System Replacement Project. In the interim, risks are being managed through enhanced technical support, strengthened backup arrangements, supplier engagement, cyber security controls, and established business continuity processes to maintain safe and effective service delivery.

Plan To Go Forward:

Continue working with the Organisation and Supplier to allow the Project to recommence.
Once agreement to recommence is in place, re-establish the Project Board and Working Group.
Completion of the build through the remaining development sprints.
User acceptance activities prior to deployment.
Full System Deployment followed by the eventual decommissioning of the legacy Therapy Manager platform, once stable operations are in place.
Monitor operational risks associated with the current platform and maintain support/licensing arrangements until transition is complete.

Milestones:

June 2025 – Completion of 6 out of 20 Sprints before Project pause.
Further milestones to be agreed as part of the on-going discussions.

Deliverables:

Complete system build, testing and user acceptance activities prior to deployment.

Community Health – Local Procurement and Implementation

Summary:

The procurement and implementation of an All-Age Connecting Care Community Health Record is a strategic priority for Betsi Cadwaladr University Health Board (BCUHB). Community services currently deliver over 900,000 patient contacts each year using paper-based records held across multiple locations, limiting information sharing, reducing service efficiency, and creating clinical, safeguarding and operational risks.

The programme will introduce a modern electronic health record (EHR) solution for community services, replacing paper records with a single digital platform that supports timely access to patient information, integrated multidisciplinary working and standardised care processes.

The programme aims to deliver significant benefits, including improved patient safety through real-time access to complete records, enhanced care coordination, reduced administrative burden, better quality data for reporting and service planning, and a modern digital working environment for staff. It will also strengthen safeguarding arrangements through the timely and secure sharing of critical information across health and care services.

Current Status:

The Connecting Care Community Health Outline Business Case (OBC) continues to progress successfully through the Betsi Cadwaladr University Health Board (BCUHB) governance process. Approval has now been secured from the Executive Committee, and the Planning, Finance and Information Governance Committee (PFIG), with final Health Board approval gained 30th July 2026. Alongside governance activity, the programme is progressing procurement and delivery planning activities, including development of the Invitation to Tender (ITT), high-level project plan, six-month delivery roadmap, requirements gathering, process mapping workshops, and Wi-Fi survey planning to support future-state service design and infrastructure requirements across relevant sites.

The Business Case is dependent on DPIF funding from the National Connecting Care Business Case managed by DHCW, and BCUHB awaits confirmation.

Key Risks & Mitigations:

Adequate funding for the duration of the project to facilitate procurement and implementation. Mitigation: BCUHB will seek to confirm funding from Welsh Government that covers the full lifecycle of the project. Supported by Finance, Digital Priorities Investment Fund (DPIF) funding bids will be developed and submitted in line with programme timelines. Alternative funding options will also be explored to minimise the risk of delays to procurement and implementation should primary funding sources not be secured.

Plan To Go Forward:

Health Board approval of OBC on 30th July
Continue with work to facilitate development of specifications and tender activities.
Establishment of workstreams to facilitate the development of Full Business Case

Milestones:

July 2026 – OBC approval
Qu2 26/27 – pre procurement activities and FBC development

Deliverables:

Approved OBC
Tender Specification
Tender Exercise
Full Business Case development

NHS App – National

Summary:

Digital Services for Patients and Public (DSPP) have been set up to revolutionise how people in Wales access care and manage their own health and well-being. Initially the programme will develop a gateway application (App).

Current Position:

The NHS App work is currently on hold. DHCW advised that they are not currently able to move forward as they have reduced capacity and are awaiting further direction from Welsh Government.

Key Risks & Mitigations:

This work is dependent on national direction. Risks will be considered when more information is known.

Plan To Go Forward:

Await decision from Welsh Government on funding and plans to move forward.

Milestones & Deliverables:

There are currently no milestones agreed, until DHCW are in a position to recommence activities.

Scanning Outline Business Case (OBC) – Local, No Current Funding

Summary:

This project will develop an Outline Business Case (OBC) for a Health Board-wide scanning solution to support the digitisation of paper records across Betsi Cadwaladr University Health Board (BCU). The OBC will define the strategic, financial, and operational case for investment, supporting improved access to patient information, reduced reliance on paper records, and alignment with the Health Board's digital transformation objectives.

Current Position:

The requirement for a Health Board-wide scanning solution has been identified. Initial discussions have taken place with key stakeholders; however, there is currently no approved funding for project resources to develop the Outline Business Case.

Key Risks & Mitigations:

No identified funding for project management or business analysis resources to develop the Outline Business Case (OBC). Mitigation: Escalate resource and funding requirements through the appropriate governance groups to seek approval at the earliest opportunity.

Lack of dedicated resources may delay production of the business case and subsequent implementation planning. Mitigation: Develop the OBC in phases and continue progress using existing available resources to minimise delays and maintain momentum within current capacity.

Competing organisational priorities may limit stakeholder availability and engagement. Mitigation: Prioritise stakeholder engagement and requirements gathering to ensure key information is captured and available when required.

Delays in developing the OBC may impact the timeline for securing future capital and revenue funding. Mitigation: Regularly review project timelines and dependencies to identify risks early and manage them proactively

Plan To Go Forward:

Continue to develop the Outline Business Case (OBC) utilising available resources, while recognising progress will be constrained without dedicated funding. Continue stakeholder engagement to refine requirements and define the scope, costs, benefits, and implementation approach. Subject to securing funding and the necessary project resources, complete the OBC for consideration through the Health Board's governance and approval process.

Milestones:

Quarter 2 2026/27 – Develop and complete the Outline Business Case - Underway
Quarter 3 2026/27 – Complete stakeholder engagement and requirements gathering – underway
Quarter 4 2026/27 – Submit OBC for approval and identify funding options for implementation – Not yet started.

Deliverables:

An approved Outline Business Case that sets out the strategic justification, options appraisal, costs, benefits, risks, and resource requirements for implementing a Health Board-wide scanning solution, providing the foundation for securing future funding and progressing to implementation.

Prevention Missions

Version 24.06.26

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Environment Mission

People in North Wales live in a healthy and sustainable natural environment

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HIGH IMPACT SYSTEM ACTIONS:

- We will embed consideration of carbon and nature impacts in our decision-making processes around projects, services and plans.
- We will sign up to the North Wales Healthy Travel Charter and promote sustainable and active travel across our organisations.
- Public Service Board member organisations will actively engage with the development of the Regional Climate Change Risk Assessment for Wellbeing and act on its recommendations locally, working with our communities.
- We will look for opportunities to protect, improve, and expand green spaces across existing public sector buildings and land.
- We will ensure that environmental organisations and local communities are meaningfully involved at an early stage in planning new infrastructure projects, to maximise benefits and reduce risks.
- We will include nature-based activities in community wellbeing services e.g. social prescribing, focusing on improving access for people with the greatest need.

Communities Mission

People in North Wales live in safe, supportive and resilient communities

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SUB-SECTION 1:
Giving every child the best start

HIGH IMPACT SYSTEM ACTIONS:

- We will deliver services for children and families that put their needs first, in line with the Nyth/Nest Framework.
- We will help services build the skills and confidence they need to support babies, children, and parents to flourish, focussing on the first 1000 days (pregnancy to a child's second birthday) when experiences have the greatest impact.
- We will use a place-based approach to create more inclusive indoor and outdoor spaces to increase play opportunities for children.
- We will improve how services work together so families can more easily access joined up support.
- When learning needs or disabilities are identified, we will make sure children and families quickly get high quality, coordinated support from the right services.
- We will make better use of data and shared insights across our organisations to target support for improving, and reducing inequalities in, children's development and readiness for school.

Communities Mission

People in North Wales live in safe, supportive and resilient communities

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SUB-SECTION 2:
Safe and Cohesive Communities

HIGH IMPACT SYSTEM ACTIONS:

- We will prevent and reduce violence against women and girls, including delivering approaches to promote healthy and respectful relationships.
- We will take a joined up, child centredapproach to safeguarding children and young people at risk of exploitation.
- We will strengthen partnership arrangements to share timely data and insight, enabling more targeted prevention of, and response to, serious violence.
- We will prevent serious violence in North Wales by developing a shared understanding of risk, trauma, and adverse childhood experiences, with a focus on education, youth, and youth justice settings.
- We will implement the North Wales Community Cohesion Response Strategy as part of our regional delivery of the Anti Racist Wales Action Plan.

Communities Mission

People in North Wales live in safe, supportive and resilient communities

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SUB-SECTION 3:
Welsh Language and Culture

HIGH IMPACT SYSTEM ACTIONS:

- We will embed Welsh language, heritage, and cultural identity into the design and delivery of community based wellbeing services.
- We will support strong Welsh language and cultural development in the early years through bilingual resources, workforce training, and play based learning in education and care settings.
- We will strengthen proactive support for employees to build their Welsh language skills and confidence at work.

SUB-SECTION 4:
Trauma Informed Communities

HIGH IMPACT SYSTEM ACTIONS:

- We will commit to a trauma informed approach to improve services and support staff wellbeing.
- We will use reflective practice and regional networks to share learning on trauma informed approaches.
- We will strengthen pathways so that staff and service users can access comprehensive support for trauma, building on existing partnerships and networks across the region.

Communities Mission

People in North Wales live in safe, supportive and resilient communities

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SUB-SECTION 5:
Transport

HIGH IMPACT SYSTEM ACTIONS:

- We will actively involve communities in the design and review of community transport services, with a focus on rural and more deprived areas.

- We will strengthen active travel and low carbon transport across North Wales through adoption of the North Wales Healthy Travel Charter and influencing spatial planning e.g. via Local Development Plans.

SUB-SECTION 6:
Vaccinations and Screening

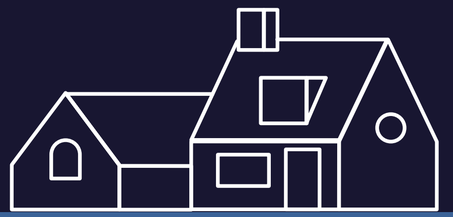
HIGH IMPACT SYSTEM ACTIONS:

- We will roll out Making Every Contact Count (MECC) and screening awareness training for frontline staff, so they can confidently promote vaccinations and screening at every appropriate opportunity.

- We will ensure frontline services provide clear, accessible information in a range of formats to support people eligible for NHS vaccination and screening programmes to make informed decisions.

Housing Mission

People in North Wales live in good quality, secure and affordable housing



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HIGH IMPACT SYSTEM ACTIONS:

- We will strengthen regional cross sector collaboration on housing, health and wellbeing, including sharing data and insights, developing shared outcome measures, and enabling joint commissioning.
- We will strengthen neighbourhood based prevention and early intervention through integrated trauma informed approaches, involving people with lived experience.
- We will embed the duty to Ask, Act and Cooperate to prevent homelessness and address housing related health issues.
- We will take a joined up approach to housing challenges across private and social sectors e.g. contributing to Local Development Plans and bringing empty or under used homes back into use with communities.

Food Mission

People in North Wales can access nutritional, affordable food

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HIGH IMPACT SYSTEM ACTIONS:

- We will take an evidence based approach to support healthier food choices, including influencing planning and strengthening local food supply chains.
- We will offer Making Every Contact Count (MECC) training to ensure frontline staff have the skills and confidence to deliver person centred support around food.
- We will use the Food for Our Future guidance and work with Local Food Partnerships to improving fair access to healthy and planet friendly food.
- We will improve access to healthy and affordable food and drink within our workplaces.

Employment Mission

People in North Wales have access to valuable and fair employment or training & development opportunities

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HIGH IMPACT SYSTEM ACTIONS:

- We will integrate employment support into health and social care pathways.
- We will secure leadership commitment to proven employment support models, including Individual Placement and Support (IPS) and the Supported Employment Quality Framework (SEQF).
- We will encourage larger organisations to share resources to enable small and medium sized enterprises (SMEs) to take part in employment support pathways.
- We will support employers to recruit and retain people from underrepresented groups, strengthening their role as Anchor Organisations within communities.
- We will embed long term social value in procurement, commissioning, and regional investment by using public spending to create fair paid jobs, apprenticeships, training, and sustainable career pathways.
- We will take a joined-up cross sector approach to employment and skills programmes such as Connect to Work, Green Skills, digital inclusion, and Trailblazer pilots.
- We will support earlier engagement with young people on career awareness and aspirations, working with education partners to promote vocational pathways and strengthen maths and language skills for employability.

Life-Long Learning Mission

People in North Wales have access to high quality education and lifelong learning opportunities

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HIGH IMPACT SYSTEM ACTIONS:

- We will provide accessible and timely support to parents and carers to help children be ready for school, with a focus on speech and language development and toilet training (as detailed in the 'Giving Every Child the Best Start' sub-section in the Communities Mission).
- We will promote lifelong learning opportunities in community-based settings.
- We will increase digital, language, and maths skills through strengthening adult learning opportunities.
- We will work with communities to address transport barriers that limit access to lifelong learning opportunities.
- We will develop a regional inclusion initiative for underrepresented groups to reduce participation gaps in further and higher education.
- We will strengthen shared employer engagement and skills partnerships aligned to regional economic priorities.
- We will ensure that tackling inequality is directly connected to economic opportunity.

Active Lifestyles Mission

People in North Wales are engaged in physical activity and opportunities for creativity

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HIGH IMPACT SYSTEM ACTIONS:

- We will invest long term in local cross sector partnerships, including Active Locality Partnership Groups, to support communities to design, lead, and sustain local physical activity opportunities.
- We will develop the knowledge, skills, and confidence of frontline staff, volunteers, and community organisations to work in an asset based and inclusive ways through accessing Making Every Contact Count (MECC) training and sharing learning from Asset Based Community Development (ABCD) approaches.
- We will shape and invest in our built and natural environments so that being active and playing is part of everyday life across homes, workplaces, services, and communities.
- We will share data, evidence, and lived experience insights through Active Locality Partnerships to understand impact, scale what works well, and stop what does not.

Creative Lifestyles Mission

People in North Wales are engaged in physical activity and opportunities for creativity

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REGIONAL PARTNERSHIP BOARD

HIGH IMPACT SYSTEM ACTIONS:

- We will enable fair access to creative approaches to wellbeing in community buildings and green spaces, including in rural areas.
- We will build the knowledge and skills of frontline staff to embed creative wellbeing activities within existing pathways e.g. through accessing the existing training offer via the Welsh Arts, Health and Wellbeing Network (WAHWN), and short courses such as Creative Approaches to Wellbeing available via Wrexham University.
- We will co design workplace creative wellbeing programmes with leadership support.
- We will develop and deliver a trauma informed framework for Arts in Health, promoting safe and inclusive creative spaces aligned with national standards.
- We will use creative approaches to wellbeing to support people with lived experience to share their stories, to inform service improvement and support evaluation.
- We will strengthen the evidence base for creative approaches to wellbeing to support sustainable funding models, including wellbeing outcomes and social return on investment.

North Wales Anchor Charter

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REGIONAL PARTNERSHIP BOARD

1.	**WORKFORCE, EMPLOYMENT AND SKILLS**
1.1	We will seek to pay the real living wage and ensure fair terms and conditions, reducing insecure contracts and supporting staff wellbeing and financial security.
1.2	We will create opportunities for people furthest from the labour market to access training, apprenticeships, and employment within our organisation, and promote progression and training opportunities for our staff.
1.3	We will support staff health and wellbeing through a strong prevention focused offer, including opportunities to be physically active at work and access to healthy food and drink.
1.4	We will strengthen the health impact of our workforce by promoting access to Making Every Contact Count (MECC) training, helping staff and service users make healthier and more sustainable choices.
1.5	We will work with education providers and Anchor Organisations to respond to future workforce skills needs and improve accessible employment pathways.
1.6	We will promote the Welsh language by supporting staff to learn and use Welsh, particularly in public facing roles, contributing to the Cymraeg 2050 ambition.
2.	**BUILDINGS AND LAND**
2.1	We will explore and review our use of existing buildings and land to proactively identify potential future opportunities for community and voluntary use.
2.2	We will involve communities at an early stage in planning new developments.
3.	**ENVIRONMENTAL IMPACTS**
3.1	We will commit to sustainable and active travel by adopting the Healthy Travel Charter and sharing learning across North Wales.
3.2	We will work with regional partners to reduce carbon emissions, cut waste, enhance green infrastructure and biodiversity, and adapt to climate change.
4.	**COMMUNITY INVOLVEMENT**
4.1	We will address inequalities by adopting the Mission Actions.
4.2	We will embed Asset Based Community Development (ABCD) approaches to strategy development, planning and service delivery.
4.3	We will encourage and enable staff to take part in community and voluntary activity.
4.4	We will support fair access to arts, heritage, and cultural wellbeing opportunities for our staff and local communities.
5.	**PROCUREMENT AND SPEND**
5.1	We will procure locally where possible, using social partnerships to support local growth, employment, social value, and environmental benefit.
5.2	We will work with other public bodies to identify opportunities for joint procurement where this delivers better outcomes.

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

DRAFT 03/09/26

Health Improvement Menu of Interventions

Produced by the:

Betsi Cadwaladr University Health Board

Public Health Directorate

Population Health Service

2026

First iteration:

September 2026

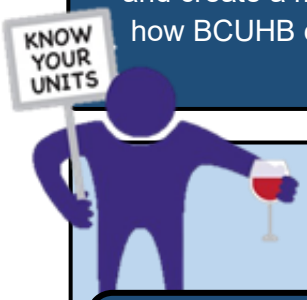
Content

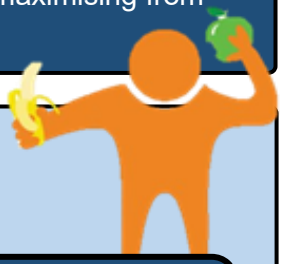
Out of scope is vaccinations, immunisations, infection prevention and control.

1. Executive Summary

Prevention Must Matter

The case for preventive health improvement interventions has never been stronger. Almost half of adults in Wales are living with a long-term condition, while major diseases account for most NHS activity. At the same time, people in the most deprived communities experience up to 17 fewer healthy years of life, driving inequalities and increasing pressure on health and care services, communities and the economy. In the context of rising demand and constrained resources, prevention offers one of the greatest opportunities to improve population health, reduce inequalities and create a more sustainable future for health and care in North Wales. This framework sets out how BCUHB can strengthen prevention with a focus on health improvement by maximising from every pound invested.





Strategic Opportunity

Evidence shows that prevention delivers greater value with public health interventions estimated to be around 3.5 times more cost-effective than healthcare treatment, while also improving outcomes and reducing inequalities

The question is not whether we can afford to invest in prevention, it is whether we can afford not to?

Prevention is not about creating new programmes alone; it is about embedding prevention into the way services are designed, pathways are developed, resources are invested and partnerships are strengthened

The Menu of Interventions

A practical resource that provides the Health Board with its first consolidated, evidence-based menu of recommended health improvement interventions designed to strengthen prevention and early intervention at scale. It will be underpinned by a 'Making Change Happen' toolkit with a range of levels of evidence and approaches that can be used proportionately within services.

The scope of health improvement is complex, and this Menu of Interventions as a new resource will be based on a test bed of Mobilisation and iterative learning.

Topic areas with associated menu of interventions included within this document are:

- Tobacco/ Vaping Cessation
- Healthy Weight
- Drugs & Alcohol
- Physical Activity
- Mental Wellbeing

Primary and Community Care

2. Introduction

This Menu of Interventions is a resource intended to be used by the Health Board, supported by the Public Health Directorate and other enabling functions to consider opportunities to strengthen preventative health improvement both strategically and operationally. It will be underpinned by a 'Making Change Happen' toolkit with a range of levels of evidence and approaches that can be used proportionately within services. The scope of health improvement is complex, and this Menu of Interventions as a new resource will be based on a test bed of mobilisation and iterative learning.

2.1 Case for Change

The Health Board will continue to face a range of challenges but now is the time to mitigate as much as possible what those challenges could present moving into the future. By prioritising funding into preventative health improvement programmes with a long-term commitment to realise the impact, it can reduce the cost of ill health burden resulting in better outcomes for our population.

Targeting socio-economic inequalities, the major drivers of poor health in Wales could decrease demand on health services, increase economic productivity, and shorten long-term inequalities. It is essential that the focus needs to include reprofiling of funding to benefit our communities who are most deprived through programmes that deliver high impact, scalable potential.

- People in Wales live **13-17 fewer healthy years** in deprived areas.
- **7.2 million days** in Wales are lost each year through sickness absence.
- Deaths rates attributable to smoking are **three times higher** in the most deprived communities compared to the least deprived.
- The Wales employment rate in 2025 for ages 16–64 is **3.7% lower than the UK** rate of 75.1%.
- Average monthly earnings in Wales in 2025 are around **5% below** the UK figure of £2,526.

The preventative health improvement topics within this document include:

The impact that these health improvement programmes can have on health services in Wales is significant where demand is outstripping capacity and finances are increasingly fragile.

- **17,000 hospital admissions** each year on average in Wales are **smoking related.**
- Obesity costs the NHS Wales £73 million annually **estimated rise to £465 million by 2050.**
- **12,236 hospital admissions** in Wales in 2023 were **alcohol-specific** related.
- NHS Wales **spent £35m in 2015** on diseases caused by **lack of physical activity**.
- NHS Wales spends **~£810 million per year** on mental health (≈11% of total NHS spend).

What our population think:

Recent Health Board engagement focusing on prevention was undertaken to explore how we can work together with communities to try to shift from treating illness to preventing or reducing the risks of illness before it starts. Overwhelming, people agreed that prevention matters, with many people believing preventing illness is important and could ease pressure on the Health Board, they told us:

"Prevention has got to be a priority the hospitals are swamped"

"Focusing on prevention helps people stay well for longer, improves quality of life, and reduces pressure on NHS services. Strong partnerships between health services, local authorities, and organisations like Citizens Advice are key to making this work."

Some people however, fear that prevention could be used as an excuse to avoid fixing current failures such as, long waits for GP appointments, emergency departments and specialist services.

The following captures the % response to some key prevention/health improvement questions asked of our public:

How important do you think it is for the NHS to focus more on preventing illness rather than only treating sickness, e.g. helping people to stay well, improve their wellbeing, and quality of life?

		Response Percent
1	Not Important	3.15%
2	Slightly Important	3.85%
3	Moderately Important	18.88%
4	Very Important	32.17%
5	Extremely Important	41.96%

Do you feel you currently have enough access to services and prevention support, e.g. this might be help and advice on living a healthy lifestyle, weight management, stop smoking services, access to vaccinations and screening?

		Response Percent
1	Yes	22.61%
2	No	62.19%
3	Not Sure	15.19%

Public feedback is key in providing direct evidence of what matters to local people. These survey responses will inform this work by increasing understanding of our population's awareness of prevention, how important they feel it is, how available and accessible prevention services are, and to understand the barriers that perhaps prevent our population from adopting healthier behaviours.

Major diseases:

It is a testament to the Health Board that people in our population are living longer. Increasingly however, this longevity is accompanied by chronic and often long-term multiple conditions where 48% of adults are estimated to be living with a long-term condition. This results in rising demand on services and shifts in demographics and morbidity that impact how care is delivered.

The Welsh Government have highlighted six conditions within their major diseases programme that drive the highest levels of mortality, morbidity and health service use where they account for **70% of all NHS activity**:

Health-related behaviours play a major role in these major diseases, with tobacco use having the greatest impact (10%), followed by poor diet (8%). Additionally, high body mass index (BMI) accounts for a further 8%.

The preventative areas included within this document focus on strengthened prevention and early intervention health improvement approaches and seek to address the major diseases within our population by preventing ill health, reducing risk factors and improving quality of life.

Major disease projections:

An examination of the projected impact of long-term conditions in Wales was conducted in September 2023 via the Welsh Governments Science Evidence Advice – NHS in 10+ Years. This highlighted the importance of a collective, system-wide shift towards prevention and health improvement in Wales. Strengthening approaches that support positive changes in health-related behaviours can play a crucial role in reducing future impact and demand. The following are the projections from the Welsh Governments Science Evidence Advice report:

Welsh adults who have had a stroke are expected to **increase by 33% from 2015 to 2035.** Projected UK costs directly attributable with stroke incidence show future **costs will rise to £75.2bn in 2035.**

Musculoskeletal (MSK) conditions affect an estimated **974,000 people in Wales of whom 440,000 have long term MSK conditions**.

Considering all-ages rates, **Hypertension, COPD, Heart Failure and Asthma** are just some of the conditions projected to have **2038 diagnosis rates at least 10% above those of 2021.**

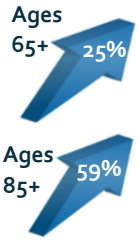
If current trends continue the number of people in Wales diagnosed with cancer in Wales will **rise from the 19,800 diagnosed per year in 2017-2019, to 24,800 in 2040.**

It is estimated that by 2030 the number of people living with dementia in the UK would increase to 1,233,400, this equates to **64,200 people living with dementia in Wales by 2030.**

The cost to the Welsh Economy from cardiovascular disease is **£800 million**, dementia is **£700 million** and mental health problems is **£4.8 billion** per annum.

2.2 Setting the Scene in North Wales

North Wales Population:



The North Wales population is projected to grow from 691,990 in 2025 to 703,040 by 2040 which will place additional demand on our health services. North Wales has one of the oldest population profiles in Wales and will continue to rise where by 2040:

North Wales Health-Related Behaviours – Inequalities and Life Expectancy:

The Health Board has a key role in reducing health inequalities by delivering equitable access, experience and care across all communities and groups in North Wales. The gap in life expectancy remains substantial where women live 6 years less and men 7 years less in most deprived communities as than those in least deprived communities. The health-related behaviours that can lead to non-communicable diseases are more common in deprived communities:

Public Health Wales (PHOF) using National Survey for Wales, 2022/23 (WG).	BCUHB	Wales	Wales Least Deprived	Wales Most Deprived
Tobacco Smoking %	10.6	12.8	7.5	21.8
Drinking alcohol above guidelines %	16	17.2	21.3	14.6
Working age adults of healthy weight %	37.4	36.1	39.5	33.7
Meeting physical activity guidelines %	45.8	55.4	61.4	47.7

North Wales Health-Related Behaviours – Activity:

In North Wales, the health-related behaviours data across the life course on smoking, alcohol use, poor diet and physical inactivity and poor mental wellbeing remain largely similar to the Wales average but on a locality level where they may be rural, coastal or deprived urban areas there are pockets of poorer health and higher demand.

- **Smoking:** 16% of mothers report smoking at birth. 8% of 11–16-year-olds have tried e-cigarettes at least weekly. 3% of 11–16-year-olds smoke tobacco at least weekly. 11% of adults are current smokers.
- **Healthy Weight:** 28% of children aged 4-5 are overweight or obese. 13% of children aged 4-5 are obese. 63% of adults are overweight or obese. 59% of over 65's are not of a healthy weight. 38% of babies are breastfed at 10 days.
- **Physical Activity:** 18% of 11–16-year-olds are physically active for 60 minutes a day. 46% of working age adults do not meet physical activity guidelines.
- **Mental Wellbeing:** 79% of 11–16-year-olds reported feeling satisfied with their life. 15% of 11–16-year-olds report being problematic social media users.
- **Substance Use:** 37% of 11–16-year-olds report drinking alcohol. 16% of adults drink more than the guidelines advise. In 2023, 16.3% of 11–16-year-olds reported being offered cannabis in the last 12 months.

Data source: BCUHB Health and Wellbeing Infographic

3. Menu of Interventions

This is an area where the Health Board can best serve our population by supporting and enabling our frontline staff to maximise opportunities including through preventative messaging and action. Making every contact count through healthy conversations and signposting to onward help where even small changes can lead to significant improvements at a population level.

Prevention is already a core part of primary, community and secondary care, and many of the interventions highlighted in this document are likely to be in progress. However, there remains value in reviewing current approaches. For example, are we reaching the most appropriate population groups? Do some interventions need to be adapted to better meet the needs of specific communities? Where initiatives are working well, can they be expanded or replicated elsewhere? Are interventions fully maximised to achieve their intended outcomes?

The recommended interventions presented within this section have been prioritised from a BCUHB public health evidence review of effective and cost-effective interventions in a Health Board setting. They are purposefully high level but have detailed technical documents to underpin them, including the range of other interventions which were not prioritised. Many of the interventions and high-level actions have interdependencies and as such are intended for whole system consideration where stakeholders must be involved, supporting local decisions and providing local expertise.

This document is the very first attempt to set a direction by consolidating an evidence base of what the Health Board could be doing to strengthen the shift to prevention. Recognising the complexity of health improvement, it will evolve, adopting an iterative approach through ongoing evaluation, collaboration and learning. Any comments or feedback are therefore welcomed.

The menu of interventions is presented on a health-related topic basis with a separate section on primary and community care. Major diseases will be added in the second iteration in December 2026.

3.1 Tobacco, Vaping and Nicotine Products

Overview

Smoking is the largest single preventable cause of ill health and death in Wales

Smoking remains a significant public health issue in Wales, despite sustained progress over the past decade. Smoking prevalence among people aged 16 and over has declined from 23% in 2010 to 13% in 2024; however, tobacco use continues to be a major cause of ill health. More than one in ten deaths among people aged 35 and over in Wales are still attributable to smoking.

Cost: Smoking has a significant impact on Welsh society costing over £790 million a year.
Demand: 17,000 hospital admissions in Wales were attributable to smoking during 2022.
Major Diseases: Smoking causes illness and major diseases including cancer in addition to being a risk factor for a wide range of long-term conditions, including cardiovascular disease and dementia and therefore continues to place substantial demand on health and care services.
Inequalities: 28.9% of adults were reported to smoke in the most deprived areas in Wales compared to 6.6% in the least deprived areas in the 2021 Census.

The increasing use of vapes and other nicotine products, many of which contain nicotine, is worrying, particularly amongst children and young people and those who have never smoked in Wales. Selling nicotine vapes to people under the age of 18 is illegal and the 2024 data tells us that 7% of young people aged 11 to 16 use vapes weekly which is in increase from 5.4% in 2021.

What difference could health improvement interventions make?

SHORT TERM OUTCOMES:

Improved mood and wellbeing **within ~6 weeks.** Lung function improves by **up to 10% by 3-9 months**. 95% of ex-smokers report **positive changes within ~2 weeks** including better breathing, energy and overall health.

MEDIUM/LONG TERM OUTCOMES:

The risk of **coronary heart disease halves after 1 year** of smoking cessation. Better surgical outcomes, wound healing and reduced complications. Reductions commence in reducing demand for acute care where **17,000 hospital admissions in Wales** were attributable to smoking during 2022.

Recommendations – Health Improvement Interventions

The following five recommended interventions have been prioritised from the Public Health Directorate evidence review and are intended for all key stakeholders to consider their collective contribution (further details can be viewed in Appendix 5.1).

Every recommendation in this document should be planned, designed, delivered and evaluated with the needs of all population groups in mind, applying the BCUHB Health Equity Maturity Matrix and making reasonable adjustments so that access, experience and outcomes are equitable. This includes, but is not limited to, people experiencing socioeconomic deprivation, people with a protected characteristic and inclusion health groups.

1. Deliver targeted smoking cessation support for women during pregnancy

Smoking in pregnancy remains a major cause of poor maternal and infant outcomes and contributes significantly to health inequalities. Strengthening maternity pathways through routine carbon monoxide monitoring, improved Help Me Quit referral uptake, support for partners and households, and postnatal relapse prevention will improve outcomes for both mothers and babies.

2. Promote and increase public uptake of Help Me Quit services

Effective behavioural communications are essential for increasing readiness to quit and encouraging engagement with cessation services. Targeted promotion of Help Me Quit across healthcare, community and workplace settings and inclusive and accessible to people who share any of the protected characteristics should reinforce Ask Advise Act as the standard response whenever smoking is identified and ensure clear signposting to support.

3. Strengthen nicotine dependence treatment in secondary care

Hospital admissions and planned surgical pathways provide valuable opportunities to support smoking cessation. Embedding routine smoking status identification, providing rapid access to nicotine replacement therapy, strengthening opt-out referrals to Help Me Quit, and improving integration between clinical services and cessation support will improve patient outcomes while reducing complications, hospital stays and costs.

4. Improve prevention and management of vaping and nicotine addiction

As vaping and alternative nicotine products become increasingly common, consistent and evidence-based messaging is required to support smoking cessation while preventing misinformation. Staff should align advice with Public Health Wales guidance, implement emerging national recommendations, and maintain awareness of developments in vaping, harm reduction and nicotine dependency service models.

5. Create Nicotine-Free Communities and Prevent Uptake Among Children and Young People

Preventing nicotine addiction among children and young people is a critical long-term tobacco control priority. Support should focus on smoke-free and vape-free schools and community environments, targeted interventions informed by School Health Research Network (SHRN) data, collaboration with national prevention programmes, and coordinated communications with local authority partners to maximise reach and impact.

3.2 Alcohol and Drugs

Overview

In BCUHB the rate of alcohol specific conditions has decreased however hospital admissions related to illicit drugs are higher than the Wales average

The use of drugs and alcohol remains a significant and complex public health concern contributing to a range of negative outcomes including increased hospital admissions, premature mortality, social inequalities, and the disruption of families and communities. It has a marked impact on vulnerable groups, including those living in deprived areas. In 2023 in North Wales there were 3120 children aged over 10 receiving care and support due to parental substance use or alcohol use, an increase of 7% since 2022.

Cost: Alcohol and drugs misuse costs the UK society around £40-£45 billion a year (proportionate estimate of £2-£2.5 billion in Wales.
Demand: There is over 12,000 alcohol-related hospital admissions annually in Wales. BCUHB has the highest rate per 100,000 in Wales for hospital admissions related to illicit drugs between 2023/4 (169.6 per 100,000 population)
Major Diseases: Alcohol and drugs misuse is a central risk factor that causes illness and major diseases including liver related disease, cancers and mental health disorders.
Inequalities: Those in deprived areas of Wales are 2.8 times more likely to be admitted for alcohol related conditions

What difference could health improvement interventions make?

SHORT TERM OUTCOMES:

One month of abstinence reduces insulin resistance which can lead to high blood sugar by 25%. Blood pressure also reduces by 6% and cancer-related growth factors declines, lowering the risk of cancer.

MEDIUM/LONG TERM OUTCOMES:

The risk of alcohol-related cancer drops by 4%, even for light drinkers who quit. Reducing from heavy to moderate drinking reduces alcohol-related cancer risk by 9%.

Recommendations – Health Improvement Interventions

The following four recommended interventions have been prioritised from the Public Health Wales Drug & Alcohol Health Needs Assessment intended for all key stakeholders to consider their collective contribution.

Every recommendation in this document should be planned, designed, delivered and evaluated with the needs of all population groups in mind, applying the BCUHB Health Equity Maturity Matrix and making reasonable adjustments so that access, experience and outcomes are equitable. This includes, but is not limited to, people experiencing socioeconomic deprivation, people with a protected characteristic and inclusion health groups.

1. Alcohol and Drugs in Preconception and Pregnancy

Reducing alcohol and drug use before, during and after pregnancy is critical to improving outcomes for mothers and babies and supporting the ambition of giving every child the best start in life. Priorities include routine alcohol and drug use screening throughout pregnancy, timely referral to multidisciplinary services, continued support for the Specialist Substance Misuse Midwife role, integrating alcohol and drug awareness into preconception delivery plan, using lived experience to inform services, and delivering Making Every Contact Count (MECC) and Alcohol Brief Intervention (ABI) approaches.

2. Identification, Screening and Brief Intervention for substance use

Early identification and brief intervention are among the most effective and cost-efficient approaches to preventing drug and alcohol harm. Priorities should include; a consistent approach to promote MECC and ABI training, support workforce development through Area Planning Board programmes, strengthen recording and monitoring of activity, and maximise opportunities within primary care, emergency departments and hospital settings to refer individuals to Substance Misuse Service, iCAN, DAN 24/7, Adferiad.

3. Reduce Harm to Children from Parental Substance Use

Parental substance use is a major risk factor to adverse childhood experiences and poorer long-term health and wellbeing outcomes. Priorities should focus on early intervention with vulnerable families within policy and practice, expanding access to evidence based parenting programmes including Building Early Attuned Relationships (BEAR), embedding trauma informed and Adverse Childhood Experience awareness practice to address co-occurring challenges, increasing awareness of the impact of substance use on children and improve parent's health literacy, and strengthening partnership working across health, local authority and third sector services.

4. Strengthen Resilience and Mental Wellbeing in Children and Young People

Drug and Alcohol use among children and young people is often linked to poor mental wellbeing. Prevention efforts should focus on building resilience through the Whole School Approach to Mental Health, targeted education for vulnerable young people, involvement of people with lived experience, support for hard-to-reach groups, including those who share protected characteristics and face additional barriers, and partnership working to identify and respond to emerging risks.

3.3 Healthy Weight

Overview

Unhealthy weight affects 60% of adults and 25% of children in Wales driving preventable disease, widening inequalities and increasing pressure on NHS services

Being a healthy weight has become one of the most effective ways to reduce the risk of long term health conditions such as diabetes, heart disease and cancers. We are increasingly less active as a nation where prioritising convenience over health when making choices regarding food.

Cost: Unhealthy weight has a significant impact on Welsh society costing around £5.2 billion a year.
Demand: Obesity contributed to over 1.2 million hospital admissions in 2022/23 in England.
Major Diseases: Unhealthy weight is a central risk factor that causes illness and major diseases including cardiovascular disease, type 2 diabetes and at least 13 types of cancer amongst other diseases making it one of the leading drivers of preventable ill health.
Inequalities: 15.6% of children were reported to have obesity in the most deprived areas in Wales compared to 8.9% in the least deprived areas.

What difference could health improvement interventions make?

SHORT TERM OUTCOMES:

Losing up to 10% of total body weight can lower blood pressure and cholesterol, cut the risk of type 2 diabetes, and improve joint pain. Reductions commence in reducing use of GP services where 32% of obese adults are more likely to see their GP.

MEDIUM/LONG TERM OUTCOMES:

9 out of 10 people with type 2 diabetes in a DiRECT trial study achieved remission with a return blood glucose to non-diabetic range from losing more than 15kg of body weight. Reductions commence in reducing demand for acute care where obesity was a factor in 1.2 million hospital admissions in England during 2023/23.

Recommendations – Health Improvement Interventions

Given the breadth and complexity of the healthy weight agenda spanning the full life course, multiple care settings and a wide range of evidence-based interventions the interventions are presented in two sections: 1. Healthy Weight and Early Years Prevention 2. Adult Healthy Weight.

The following eight recommended interventions have been prioritised from the Public Health Directorate evidence review and are intended for all key stakeholders to consider their collective contribution.

Children's Healthy Weight and Early Years Prevention

Every recommendation in this document should be planned, designed, delivered and evaluated with the needs of all population groups in mind, applying the BCUHB Health Equity Maturity Matrix and making reasonable adjustments so that access, experience and outcomes are equitable. This includes, but is not limited to, people experiencing socioeconomic deprivation, people with a protected characteristic and inclusion health groups.

1. Deliver a universal healthy weight offer for children and families

Develop a consistent North Wales-wide prevention pathway by reviewing existing provision, and co-developing a standardised universal offer across early years, schools and communities, and using Child Measurement Programme (CMP) and deprivation data to target support where need is highest. Consistent, evidence-based and non-stigmatising messaging, referral routes and follow-up processes should be implemented across all settings.

2. Develop a Tier 2 Community Pathway for Children and Young People

Introduce a community-based, NHS supported Tier 2 service to bridge the gap between universal prevention and specialist Tier 3 services. The pathway should provide family-based support focused on nutrition, physical activity and behaviour change through a hybrid model combining digital and face-to-face delivery, with clear referral criteria and progression routes. Consideration should be given to building partnerships with Flying Start, schools and Actif North Wales to maximise reach.

3. Promote healthy weight during pregnancy

Build on the existing pregnancy weight management service by establishing a multidisciplinary maternity team involving dietetics, psychology, physiotherapy and obstetrics. Referral criteria should be expanded to prioritise co-morbidities and higher-risk women, while strengthening referral pathways and aligning delivery with the emerging All Wales Pregnancy Weight Management Pathway. Continued promotion of evidence-based resources and personalised support will help improve outcomes for mothers and babies, with a strong focus therapeutic rapport and personalised, non-stigmatising support.

4. Strengthen infant feeding, weaning and early years nutrition support

Refresh and co-develop the Infant Feeding Action Plan (2026–2029) to improve breastfeeding rates and reduce inequalities. Use the Breastfeeding Dashboard to monitor outcomes, drive improvement and target action to support partnership working across maternity, health visiting, community and third-sector services. Priorities should also consider focused efforts to support healthy food provision in childcare settings and accessible public information on infant feeding and nutrition.

5. Embed healthy eating and healthy weight approaches in schools

Use the Healthy Child Wales Programme 2 (HCWP2) as the principal mechanism for delivering school-based healthy weight interventions. School-level health needs assessments and CMP data should inform targeted support, particularly in areas of higher deprivation. Schools should be supported to implement healthy eating initiatives, referral pathways, weight-related resources and Whole School Food Policy approaches to strengthen prevention and early identification.

Adult Healthy Weight

Every recommendation in this document should be planned, designed, delivered and evaluated with the needs of all population groups in mind, applying the BCUHB Health Equity Maturity Matrix and making reasonable adjustments so that access, experience and outcomes are equitable. This includes, but is not limited to, people experiencing socioeconomic deprivation, people with a protected characteristic and inclusion health groups.

1. Strengthen workforce skills in healthy weight support

Healthcare professionals are a key driver of obesity prevention and management, yet awareness of available services and confidence in delivering weight-related conversations remains inconsistent across North Wales. Strengthening workforce capability and public awareness is essential to improve referral rates and service uptake. This should include delivering a regional communications strategy, promoting the BCUHB Help with my Weight website as the main Level 1 resource, improving awareness of referral pathways among primary and secondary care professionals, embedding brief advice and Making Every Contact Count (MECC) approaches, providing training on sensitive weight conversations and weight bias, scaling successful Short Message Service (SMS) texting engagement initiatives, standardising advice and messaging across settings, and embedding trauma-informed and digitally inclusive practice.

2. Improve access through modern referral and monitoring systems

Current referral, triage and monitoring arrangements are fragmented and largely manual, limiting efficiency and reducing the ability to monitor outcomes, identify inequalities and evaluate service performance. A strengthened digital infrastructure will improve access, streamline pathways and support more effective service planning. This should include implementing a standardised digital referral form, establishing a single point of access for all referrals including self-referral routes, introducing automated triage processes based on agreed clinical criteria, improving referral quality through digital prompts and professional engagement, and developing a unified dashboard to monitor referrals, outcomes, inequalities and service performance while supporting continuous improvement and future benchmarking.

3. Deliver equitable, person-centred weight management support

Obesity is strongly associated with deprivation and wider social determinants of health, and many individuals who would benefit from support are not currently accessing services. A greater focus on reducing inequalities and improving accessibility is therefore required. This should include targeted outreach through primary care, pharmacies and community settings, ensuring all communications are culturally appropriate and free from weight stigma, making reasonable adjustments so support is inclusive of people who share any protected characteristic, embedding trauma-informed approaches across service delivery, providing non-digital access routes for those experiencing digital exclusion, and using routine data to identify and address inequalities in referral, engagement and completion rates so that support is targeted towards communities with the greatest need.

3.4 Mental Wellbeing of Babies, Children, Young People, Adults and Older People

Overview

Poor mental wellbeing in Wales is increasing across the life course, with rates among children doubling in a generation and over one in four adults now affected.

Mental wellbeing in Wales has declined steadily in recent years and evidence shows worsening trends following the pandemic. This places considerable pressure on NHS services, with thousands waiting for treatment and increasing demand for both primary and specialist care. In BCUHB nearly a quarter of 11–16-year-olds report average mental wellbeing scores.

Cost: Mental ill health costs around £300 billion per year in England and Wales combined comprising of economic; human and health and care (proportionate estimate for Wales ~£12-£15 billion per year).
Demand: Local Primary Mental Health Support Service referrals across all Health Boards in March 2025 were 1,179 for under 18 years and 6,369 for age 18 and over.
Major Diseases: Poor mental health has a significant contribution on developing and worsening poor physical health across the life course relating to diseases such as cardiovascular disease, respiratory disease, diabetes and cancer.
Inequalities: 26% of adults were reported to have a mental health problem in the most deprived areas in England compared to 16% in the least deprived areas (no Wales data).

What difference could health improvement interventions make?

SHORT TERM OUTCOMES:

Improved mood and emotional resilience, reduced stress/anxiety symptoms. Reduced GP appointments where evidence suggests 20% of people go to their GP for social problems which can be linked to mental wellbeing.

MEDIUM/LONG TERM OUTCOMES:

Fewer crisis presentations at emergency departments. Reduction in referrals for mental health services where around 27% of adults in Wales have poor mental health.

Recommendations – Health Improvement Interventions

Due to the breadth and complexity of the mental wellbeing agenda spanning the full life course, multiple care settings and a wide range of evidence-based interventions the interventions are presented in two sections; 1. Babies, Children and Young People. 2. Adults and Older People.

The following twelve recommended interventions have been prioritised from the Public Health Directorate evidence review and are intended for all key stakeholders to consider their collective contribution.

Babies, Children and Young People's Mental Health and Wellbeing

Every recommendation in this document should be planned, designed, delivered and evaluated with the needs of all population groups in mind, applying the BCUHB Health Equity Maturity Matrix and making reasonable adjustments so that access, experience and outcomes are equitable. This includes, but is not limited to, people experiencing socioeconomic deprivation, people with a protected characteristic and inclusion health groups.

1. Protect and Promote Infant Mental Health

The first 1,000 days are critical for child development and lifelong wellbeing. Priorities include strengthening parent infant relationships through workforce development, community support, secure attachment approaches, the BCUHB Preconception Delivery Plan, and wider use of Making Every Contact Count (MECC).

2. Continue Supporting the 'Emotional Health, Wellbeing and Resilience Document' (EHWBF)

Focus should be on strengthening collaboration through the Children's Regional Partnership Board and embedding the document across organisations.

3. Develop Social Prescribing approaches for Families, Children and Young People

Social prescribing helps connect people with community activities, services and support networks that improve wellbeing. Working with partners and the third sector can strengthen resilience, wellbeing and community connections.

4. Signpost children, young people and families to information and resources to protect and promote good mental wellbeing and have the 'best start in life'

Accessible information helps children, young people and families support their mental wellbeing and find help when needed. This includes promoting the Best Start Hub and Children and Adolescent Mental health Services (CAMHS) resources, presented in inclusive and accessible formats for all children, young people and families to access, involving families in service design, and using MECC approaches to encourage wellbeing.

5. Prevention and early intervention with weighting towards those groups at higher risk of poor mental health

Poverty, inequality and adverse experiences increase the risk of poor mental health. Priorities include strengthening community pathways, using population health approaches to reduce inequalities, and applying Health Impact Assessments to support decision making.

6. Support Young People Transitioning from CAMHS to Adult Services

Effective transitions are essential for continuity of care and positive outcomes. Services should strengthen transition arrangements and ensure support is person centred, needs led and not determined solely by age.

Adult and Older People's Mental Health and Wellbeing:

Every recommendation in this document should be planned, designed, delivered and evaluated with the needs of all population groups in mind, applying the BCUHB Health Equity Maturity Matrix and making reasonable adjustments so that access, experience and outcomes are equitable. This includes, but is not limited to, people experiencing socioeconomic deprivation, people with a protected characteristic and inclusion health groups.

1. Promoting Mental Wellbeing through Early Identification and Timely Intervention

Early identification and brief intervention are among the most effective and cost-efficient approaches to improving mental wellbeing underpinning the One at a Time (OAAT) approach. A consistent Making Every Contact Count (MECC) approach should be embedded across primary and community care, including the routine use of identification tools for high-risk groups, improved signposting to support services, which should be inclusive and accessible to people who share any protected characteristic, promotion of digital self-help resources, dementia prevention messaging, and a trained workforce delivering trauma informed, recovery focused interventions.

1. Strengthen Community Wellbeing and Social Prescribing

Community based support and social prescribing can improve wellbeing, build resilience and reduce pressure on specialist services. Development of an integrated community wellbeing offer should include social prescribing, early help services, digital self-help resources, the emerging recovery college model, and strong partnerships with third sector and community organisations to ensure equitable access across North Wales.

3. Support perinatal and paternal mental wellbeing

The perinatal period is a critical time for both parental and infant mental health, with long-term impacts on family wellbeing and child development. Support should include routine wellbeing conversations across maternity and early years services, accessible referral pathways for both parents and co-parents, promotion of the BCUHB Best Start Hub, strengthened parent infant relationship support, integrated perinatal mental health and substance use pathways, and continued involvement of those with lived experience in service design and delivery.

4. Deliver person-centred support and wellbeing for complex mental health needs

People with complex mental health needs require strengths-based support that recognises both physical and mental health and wellbeing needs. Priorities include embedding person centred and trauma informed approaches, improving care coordination, strengthening crisis and recovery pathways, supporting unpaid carers, improving transitions between services, and further integrating physical and mental health care for those with severe mental illness.

5. Embed trauma informed and recovery-focussed approaches

Trauma informed approaches are central to improving mental health outcomes and supporting recovery. Key actions include developing sustainable recovery college provision, improving access to psychological therapies, embedding the Trauma Recovery Model within community services, maintaining Motivational Interviewing and Alcohol Brief Intervention programmes, and strengthening workforce training, supervision and wellbeing support.

6. Improve mental wellbeing for people with learning disabilities

People with learning disabilities experience poorer mental health outcomes and barriers to accessing care. Priorities include adopting a holistic approach to health and wellbeing, extending learning disability awareness training, ensuring responsive crisis support, maximising annual health check uptake, improving reasonable adjustments and communication support, and recognising carers as key partners through access to appropriate support and assessment.

3.5 Physical Activity

Overview

Physical inactivity in Wales is a major public health challenge where around 40% of adults reporting no recent participation in physical activity.

Nearly a million people in Wales were not taking part in any sport or physical activity in 2022/23 contributing significantly to rising levels of obesity, chronic disease, poor mental wellbeing, and widening health inequalities which places substantial and increasing pressure on NHS services and the wider economy.

Cost: Poor health and ill-health related inactivity (which physical inactivity contributes to) costs around £19.4 billion per year in Wales.
Demand: Physical inactivity contributes to major long-term conditions (e.g. cardiovascular disease, type 2 diabetes, some cancers and poor mental health), which are among the largest drivers of NHS demand.
Major Diseases: Physical Activity can prevent and manage over 20 chronic conditions and diseases, including some cancers, heart disease, type 2 diabetes and depression. Physical inactivity is one of the leading risk factors for non-communicable diseases and death worldwide.
Inequalities: Physical inactivity disproportionately affects people in deprived communities, women, disabled people, and underrepresented groups in Wales

What difference could health improvement interventions make?

SHORT TERM OUTCOMES:

Reduced excess weight and blood pressure through improved fitness, strength and mobility. Even small increases in activity begin to deliver measurable mental and physical benefits.

MEDIUM/LONG TERM OUTCOMES:

Reduces risk of many types of cancer by 8–28%; heart disease and stroke by 19%; diabetes by 17%, depression and dementia by 28–32%.

Recommendations: – Health Improvement Interventions

The following six recommended interventions have been prioritised from the Public Health Directorate evidence review and are intended for all key stakeholders to consider their collective contribution.

Every recommendation in this document should be planned, designed, delivered and evaluated with the needs of all population groups in mind, applying the BCUHB Health Equity Maturity Matrix and making reasonable adjustments so that access, experience and outcomes are equitable. This includes, but is not limited to, people experiencing socioeconomic deprivation, people with a protected characteristic and inclusion health groups.

1. Increase physical activity among children and young people

Physical activity levels among children and young people remain low, particularly among girls, deprived communities and those facing additional barriers. Action should focus on family-based approaches, partnership working with Actif North Wales and schools, targeted support for priority groups, promotion of active travel, and maximising school facilities as community assets to increase participation.

2. Embed physical activity conversations and signposting

Brief advice is a cost-effective way to promote physical activity and can be delivered by all staff. A consistent MECC based approach should be embedded across primary, secondary and community care, supported by workforce training, use of the Actif North Wales Activity Finder, stronger links with community activity providers, and improved monitoring of interventions and outcomes.

3. Strengthen Physical Activity Referral and Pathway Navigation

Physical activity is an effective intervention for preventing and managing long-term conditions, reducing frailty and supporting healthy ageing. Priorities include increasing visibility of physical activity within clinical pathways, strengthening referral routes to National Exercise Referral Service (NERS) and community programmes, ensuring these are accessible and inclusive for people who share any protected characteristic, improving pathway consistency, supporting falls prevention, and enhancing data collection to understand need and impact.

4. Integrate physical activity into health programmes

Physical activity is most effective when integrated within wider behaviour change and rehabilitation programmes. A more consistent approach should be developed across weight management, cardiac, respiratory, musculoskeletal and rehabilitation services, including goal setting, follow-up support and clear onward pathways to help people remain active after completing programmes.

5. Optimise Physical Activity Before and After Surgery

Supporting physical activity before and after surgery can improve outcomes, reduce complications and aid recovery. This should include pre-surgical activity pathways, information and support for patients on waiting lists, alignment with existing programmes such as KindEating and NERS, strengthened community-based options, and continued support during recovery.

6. Promote Physical Activity During and After Pregnancy

Regular physical activity during pregnancy improves maternal health, reduces complications and supports postnatal recovery. Priorities include developing pregnancy safe resources and classes, embedding physical activity advice within maternity and weight management services, supporting postnatal activity, providing referral routes to community opportunities, and ensuring support is compassionate, trauma-informed and inclusive.

3.6 Primary and Community Care

Overview

Primary and community care are central to preventing poor health and providing the foundation for early intervention.

Primary and community care services in Wales provide a substantial volume of patient contact each year and are the main entry point to healthcare. Community pharmacies deliver around 650,000–700,000 clinical consultations annually, including over 460,000 through the Common Ailments Service, while optometry and dentistry contribute activity at a similar scale. Alongside significant community and secondary care activity, and around 1.6 million GP contacts each month, there is a clear opportunity to improve health outcomes by embedding prevention, supporting self-care, and addressing wider determinants at every contact. This section re-emphasises the importance of health improvement within the Clinical Services Plan and aligns with Community by Design, recognising primary and community care as key stakeholders. Delivering this requires strong partnership working across sectors, including the Voluntary, Community, Faith and Social Enterprise partners, with social prescribing in Wales offering a key opportunity to support coordinated, place-based approaches, reduce variation, improve equity, and maximise value while enabling timely care closer to home.

Cost: Rising prescribing costs over £700 million annually in Wales, including £180 million in our Health Board, alongside avoidable missed appointment costs (£30 per GP and £160 per hospital appointment) make clear that shifting focus to prevention and health improvement is essential to sustain services and maximise value.

Demand: Almost 48% of people in Wales have a long-term condition and primary care is where most long-term conditions are: diagnosed, monitored and treated.

Major Diseases: Primary care provides a critical first point of contact, where there is significant opportunity to prevent poor health from developing into major diseases.

Inequalities: Persistent health inequalities, the Inverse Care Law, and strong public support for action (80%) underline the need for the *Teg i Bawb – Fair for All* approach, embedding equity led prevention and targeted resource allocation across primary care to improve outcomes for those most in need.

What difference could health improvement interventions make?

SHORT TERM OUTCOMES:

Improved prevention delivery, patient engagement, and identification of unmet need, while strengthening partnership working and use of existing capacity.

MEDIUM/LONG TERM OUTCOMES:

Sustained delivery leads to reduced avoidable demand, improved equity and outcomes for high-need populations, and more efficient, value-based use of Health Board resources.

Recommendations – Health Improvement Interventions

The following seven recommended interventions have been prioritised from the Public Health Directorate evidence review and are intended for all key stakeholders to consider their collective contribution.

Every recommendation in this document should be planned, designed, delivered and evaluated with the needs of all population groups in mind, applying the BCUHB Health Equity Maturity Matrix and making reasonable adjustments so that access, experience and outcomes are equitable. This includes, but is not limited to, people experiencing socioeconomic deprivation, people with a protected characteristic and inclusion health groups.

1. Embed Prevention in Everyday Primary and Community Care

Primary care is often the first point of contact with health services and provides a significant opportunity to support prevention and early intervention. Recommended priorities include embedding prevention within routine contacts, care pathways and discharge planning, strengthening multidisciplinary and cluster-based approaches, supporting team-based care planning for people with long-term conditions and frailty, and developing locally tailored approaches that proactively address people living in socio-economic deprivation areas, those with protected characteristics and inclusion health groups.

2. Implement preventive conversations through MECC

Making Every Contact Count (MECC) provides a simple and effective way to embed prevention into routine interactions across health and care services. Recommended action includes focused efforts on integrating MECC into workforce development, job roles and professional development, promoting the digital training offer, using simple prompts to support conversations, and utilising data and staff insights to improve delivery and consistency.

3. Strengthen Place-Based Prevention

Health inequalities and preventable ill health are often concentrated within specific communities, requiring targeted local solutions. Recommended priorities include using population health data to identify areas of greatest need, strengthening cluster-based prevention models, co-producing solutions with communities and voluntary sector partners, expanding community-based screening and case finding, and sharing learning across local areas to scale effective approaches.

4. Deliver Equity Led Health Improvement

A consistent focus on equity is essential to ensure prevention activity reduces rather than widens inequalities. Recommended priorities include embedding health equity checklist within planning and commissioning, developing a core equity dataset, using population health management approaches to identify those with protected characteristics, inclusion health groups and those living in areas of socio-economic deprivation, improving uptake of screening and prevention programmes, and strengthening workforce capability to address health inequalities.

5. Strengthen Partnership and Community-Based Outcomes

Improving population health requires strong partnerships across health, local government and the voluntary and community sector. Recommended priorities include aligning investment towards prevention, scaling effective community led programmes, developing shared outcomes documents,

embedding evaluation into routine practice, and strengthening collaboration with Public Service Boards, community organisations and wider system partners.

6. Improve inclusive and equitable access

As services continue to evolve, accessibility and inclusion must be built into service design from the outset. Recommended priorities include maintaining multiple access routes, improving communication and health literacy approaches, monitoring access and experience across population groups, strengthening digital inclusion support, and co-designing services with underserved communities to reduce barriers and improve equity.

7. Expand social prescribing and community assets

Social prescribing helps address the wider determinants of health by connecting people to community-based support and activities. Recommended priorities include embedding social prescribing within routine care and prevention pathways, strengthening referral processes and personalised care planning, improving tracking of outcomes and referrals, developing shared outcomes documents, and enhancing collaboration between primary care, local authorities, community organisations and the voluntary sector.

4. Conclusion

In summary, this document is a building block for the organisation to work from. It is the very first attempt to provide a practical resource which sets a direction to strengthen the shift to prevention by consolidating an evidence base of what the Health Board could be doing. Recognising the complexity of health improvement, it will need to evolve, adopting an iterative approach through ongoing evaluation, collaboration and learning.

The next steps should include the following which are high level but will allow the Health Board to consider the local infrastructure to drive this agenda forward aligned with and integrated into the agreed governance structures at both a strategic and operational level.

- Develop the practical approach in how the Health Board can use this work iteratively from Quarter 4 2026/27
- Establish operational governance with efficient reporting mechanisms
- Consider integration with current structures and alignment with emerging major change programmes
- Instigate recommended approaches within this framework commencing with key principles
- Develop maximising health improvement delivery plans integrated into operational delivery
- Deliver change, measure and evidence impact

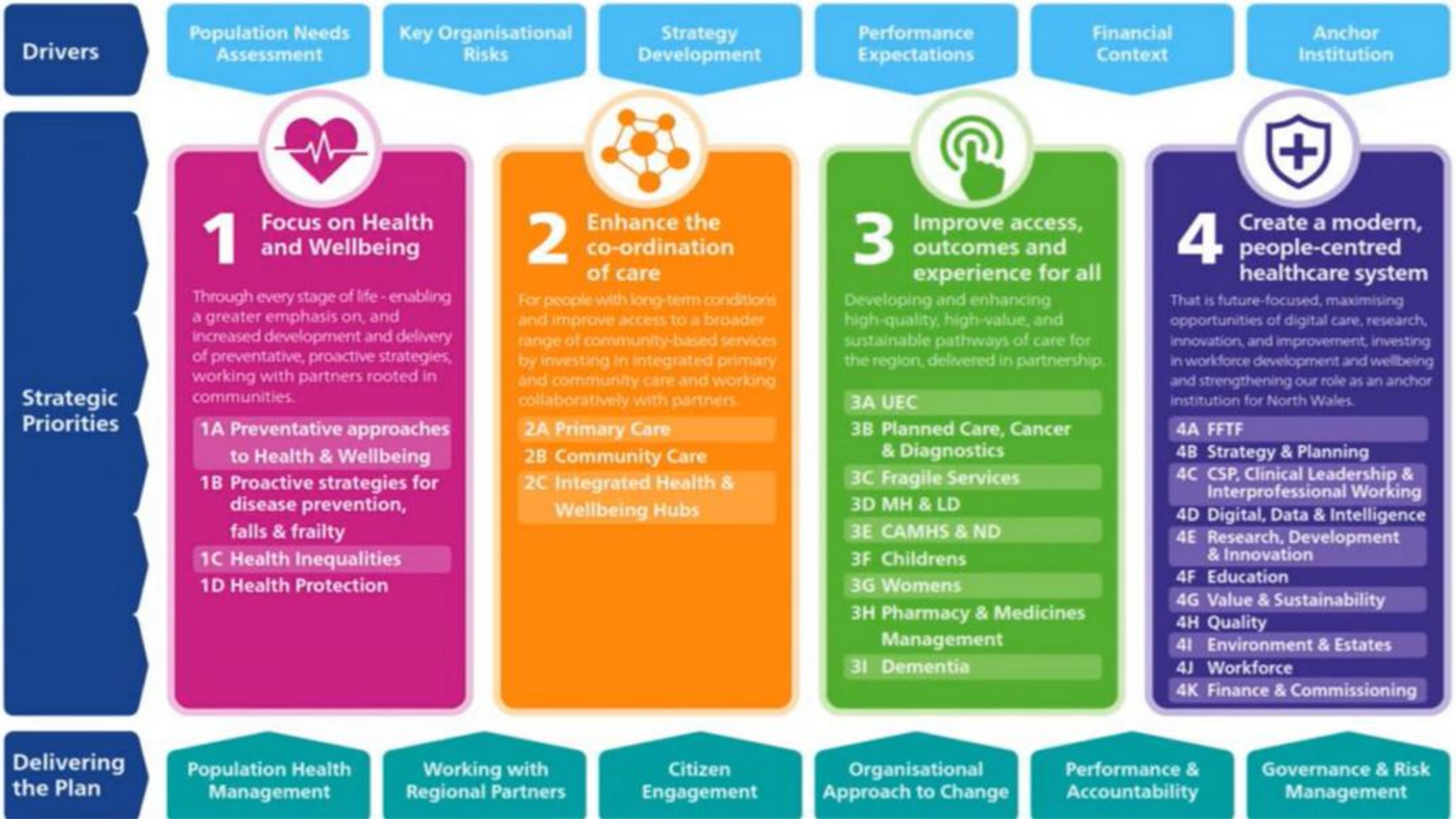
5. Appendices

This is an example table of interventions which demonstrates the level of supportive public health evidence-based work underpinning the high-level summaries within this document designed to drive this forward more practically.

Tobacco, Vaping and Nicotine Products

Intervention:	Why is it a recommended intervention:	High-level recommended actions:
1. Supporting women to quit in pregnancy	• Strongly linked to stillbirth, low birthweight, & health inequalities. • Clear BCUHB accountability with strong return on investment. • Aligns with Saving Babies' Lives, PHW national programme & NICE NG209.	• Routine CO testing at all antenatal contacts • Review HMQ referral-to-treated conversion • Support partners & household members • Postnatal relapse prevention as standard
2. Increase Public Engagement to Help Me Quit Services	• Behavioural communications are a core system enabler for tobacco control, increasing readiness to quit and driving engagement with stop-smoking services. • This priority reinforces Ask Advise Act as the minimum standard response when smoking is identified. • Aligns with NICE NG209, Making Every Contact Count (MECC) and BCUHB health inequalities objectives.	• Amplify Help Me Quit campaigns across hospital, community & workforce settings, targeting key motivational moments. • Reinforce Ask Advise Act as the minimum standard; all communications clearly signpost to Help Me Quit.
3. Strengthen Clinical Management of Nicotine Withdrawal in Secondary Care	• Smoking cessation in the context of surgery and hospital admission is one of the most effective clinical prevention interventions available, reducing post-operative complications, length of stay, and costs. • This is an area where the Health Board has clear accountability and established delivery mechanisms with strong evidence of return on investment. • Aligns with Optimisation for Surgery and Planned Care, PHW Help Me Quit in Hospital Programme, NICE NG209 and value-based healthcare.	• Embed routine smoking status identification and Ask Advise Act within all pre-operative, planned care, and acute admission pathways. • Support rapid access to cessation support and pharmacotherapy; NRT offered within 4 hours of admission and discharge. • Finalise & implement the revised NRT Protocol for Adult Inpatients • Strengthen opt-out referral to Help Me Quit and progress automated WNCR referral with PHW national team. • Improve integration and feedback between clinical teams and HMQ.
4. Improve Understanding & Management of Vaping & Nicotine Addiction	• Vaping is increasingly prevalent across adult and young populations. Significant uncertainty remains in the public and in our workforce about risk and its relationship to smoking cessation. • Consistent, evidence-based messaging is essential to avoid confusion that can undermine quit attempts.	• All staff advising on vaping to work in line with PHW Vapes Position Statement (2025) • Implement PHW practice note on vaping advice once published • Ensure Smoke Free Policy is visible and accessible to all staff • Monitor national HMQ Service Review vaping, harm reduction and future nicotine dependency service.
5. Create Nicotine-Free Communities& Prevent Uptake Among Children & Young People	• Preventing nicotine addiction among children and young people is a critical long-term tobacco control priority, aligning with the recently passed Tobacco and Vapes Act which brings smoking, vaping and nicotine together in legislation. Evidence shows that early experimentation is strongly associated with continued use into adulthood. • Aligns with A Healthier Wales, Wellbeing of Future Generations Act and the Tobacco and Vapes Act.	• Support smoke-free and vape-free schools and community environments; support school nursing, healthy school coordinators & JustB Smokefree. • Use SHRN data to identify highest-prevalence areas and target support accordingly. • Engage with national prevention strategy across Tobacco, Vaping & Nicotine Advisory Partnership. • Seek mutual amplification of messages with Local Authorities, no duplication, and maximum reach.


GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board
Board Assurance Framework 2026-29


Drivers
Population Needs Assessment
Key Organisational Risks
Strategy Development
Performance Expectations
Financial Context
Anchor Institution
Strategic Priorities
1 Focus on Health and Wellbeing
Through every stage of life - enabling a greater emphasis on, and increased development and delivery of preventative, proactive strategies, working with partners rooted in communities.
1A Preventative approaches to Health & Wellbeing
1B Proactive strategies for disease prevention, falls & frailty
1C Health Inequalities
1D Health Protection
2 Enhance the co-ordination of care
For people with long-term conditions and improve access to a broader range of community-based services by investing in integrated primary and community care and working collaboratively with partners.
2A Primary Care
2B Community Care
2C Integrated Health & Wellbeing Hubs
3 Improve access, outcomes and experience for all
Developing and enhancing high-quality, high-value, and sustainable pathways of care for the region, delivered in partnership.
3A UEC
3B Planned Care, Cancer & Diagnostics
3C Fragile Services
3D MH & LD
3E CAMHS & ND
3F Childrens
3G Womens
3H Pharmacy & Medicines Management
3I Dementia
4 Create a modern, people-centred healthcare system
That is future-focused, maximising opportunities of digital care, research, innovation, and improvement, investing in workforce development and wellbeing and strengthening our role as an anchor institution for North Wales.
4A FFTF
4B Strategy & Planning
4C CSP, Clinical Leadership & Interprofessional Working
4D Digital, Data & Intelligence
4E Research, Development & Innovation
4F Education
4G Value & Sustainability
4H Quality
4I Environment & Estates
4J Workforce
4K Finance & Commissioning
Delivering the Plan
Population Health Management
Working with Regional Partners
Citizen Engagement
Organisational Approach to Change
Performance & Accountability
Governance & Risk Management

Board Assurance Framework

**The Board Assurance Framework (BAF) provides a single view of the organisation's principal risks, how they are being managed, and the level of assurance available to the Board.
It brings together strategic risks, controls, actions and assurance sources to support effective oversight and decision-making.**

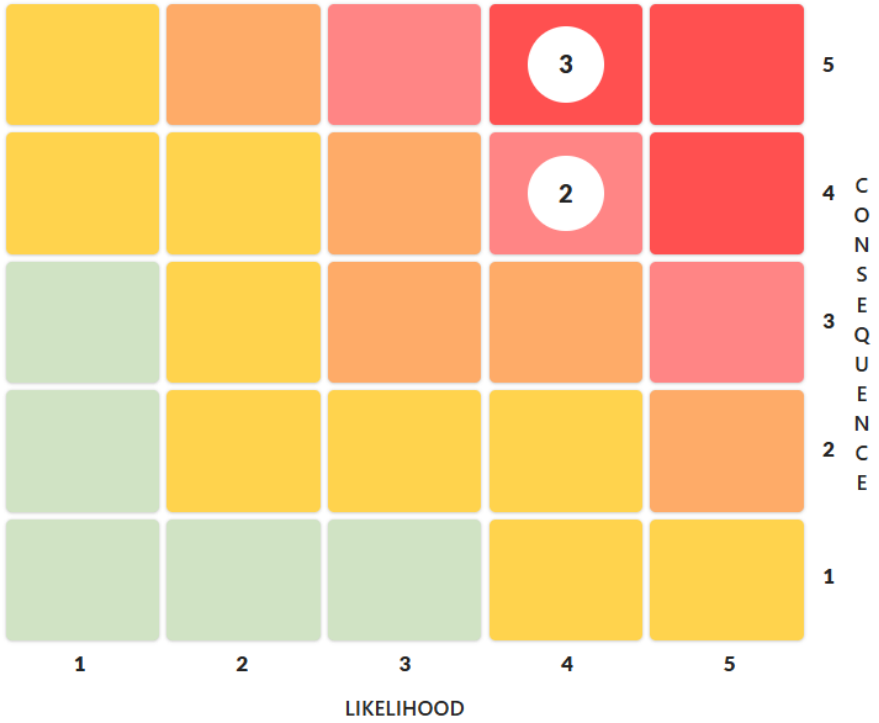
Pending Action

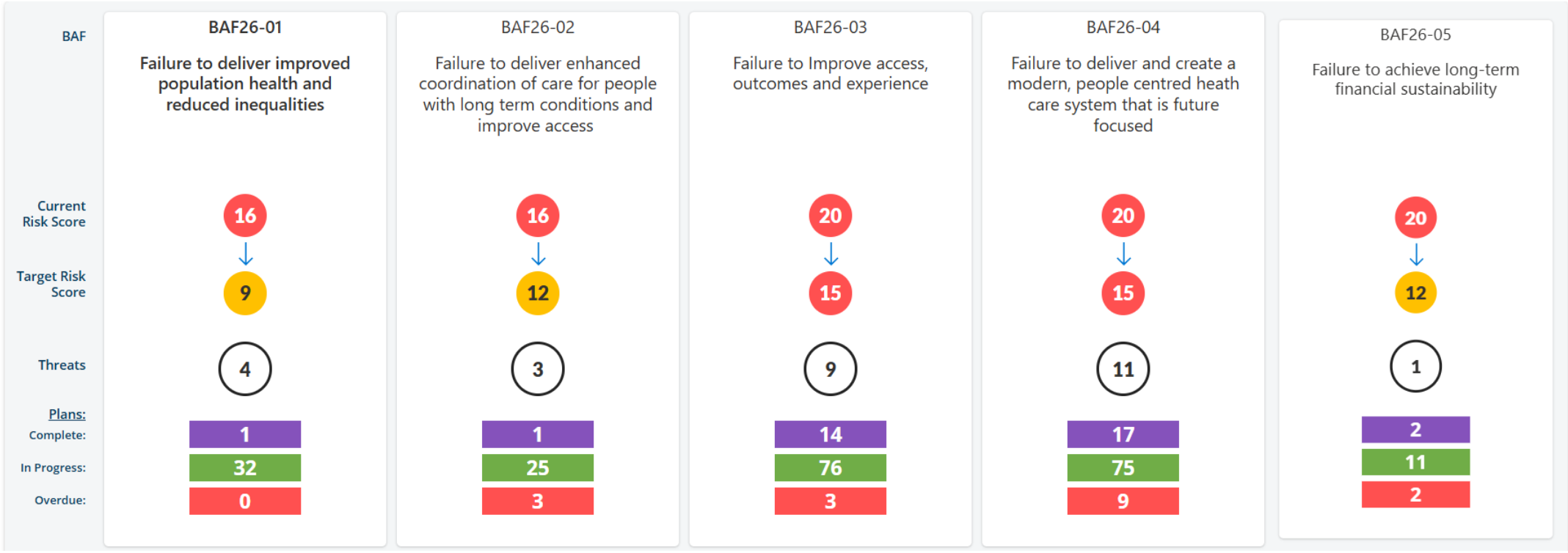
20	0	0
Plans Pending Update	Threats Pending Update	BAF Risks Pending Update

All Risks

Reset All Risks

Risk Title	Current Score
BAF26-03 - Failure to Improve access, outcomes and experience	20
BAF26-05 - Failure to achieve long-term financial sustainability	20
BAF26-04 - Failure to deliver and create a modern, people centred heath care system that is future focused	20
BAF26-01 - Failure to deliver improved population health and reduced inequalities	16
BAF26-02 - Failure to deliver enhanced coordination of care for people with long term conditions and improve access	16




BAF
BAF26-01
Failure to deliver improved population health and reduced inequalities
BAF26-02
Failure to deliver enhanced coordination of care for people with long term conditions and improve access
BAF26-03
Failure to Improve access, outcomes and experience
BAF26-04
Failure to deliver and create a modern, people centred heath care system that is future focused
BAF26-05
Failure to achieve long-term financial sustainability
Current Risk Score
16
16
20
20
20
Target Risk Score
9
12
15
15
12
Threats
4
3
9
11
1
Plans:
Complete:
1
1
14
17
2
In Progress:
32
25
76
75
11
Overdue:
0
3
3
9
2

Key to lead committee assurance ratings:

 **Substantial Assurance**	The Committee is satisfied that there is reliable evidence supporting the effectiveness of the current risk treatment strategy in mitigating the threat, with minimal gaps in control. While the majority of actions have been addressed, some minor actions may still require completion before the risk score is reduced. However, the Committee has good assurance regarding action progress. Likelihood of risk materialising: Low.
 **Reasonable Assurance**	The Committee has seen sufficient evidence that the most significant actions to reduce the risk have been completed. There is assurance that the planned actions within the current risk treatment strategy are appropriate, with the majority of control and assurance gaps having been addressed. Likelihood of risk materialising: Low to moderate.
 **Limited Assurance**	The Committee does not have sufficient evidence for assurance that the current risk treatment strategy is effectively mitigating the threat. There remains to be some key gaps in controls that require management attention, and further external validation is needed. Until further controls are in place, there remains a number of actions to reduce the score. Likelihood of risk materialising: Moderate.
 **Unsatisfactory Assurance**	The Committee has no/little evidence for assurance that the current risk treatment strategy is effectively managing the threat. There remains to be several key gaps in controls that require management attention, and further external validation is needed. Until further controls are in place, there remains a number of actions to reduce the score. Likelihood of risk materialising: High

Principal risk (What could prevent us achieving this strategic objective)	**BAF 26 01 - Failure to deliver improved population health and reduced inequalities** There is a risk that the Health Board fails to improve population health and reduce inequalities, due to insufficient progress in prevention and early intervention, leading to increased demand, widening inequalities, and pressure on acute services.		
Lead Commitee	Planning, Population Health & Partnerships Committee	**Risk Type**	Quality
Risk Lead	Executive Director of Public Health	**Risk Appetite**	<15
Related Corporate Risks:	CRR25-01 – Timely Patient Access to Safe and Effective Care, CRR25-02 – Future Demand & Sustainable Workforce, CRR25-03 – Population Needs, CRR25-05 – Strategic Change Impacting Care and Staff Delivery, CRR25-06 – Delivery of the 2026/27 Financial Plan and Financial Sustainability		

Risk Rating			**Review Dates**	
	Current Exposure	**Target**		
Consequence	4	3	**Initial assessment**	July 2026
Likelihood	4	3	**Last Committee review**	
Risk Rating	16	9	**Last Executive Review**	July 2026

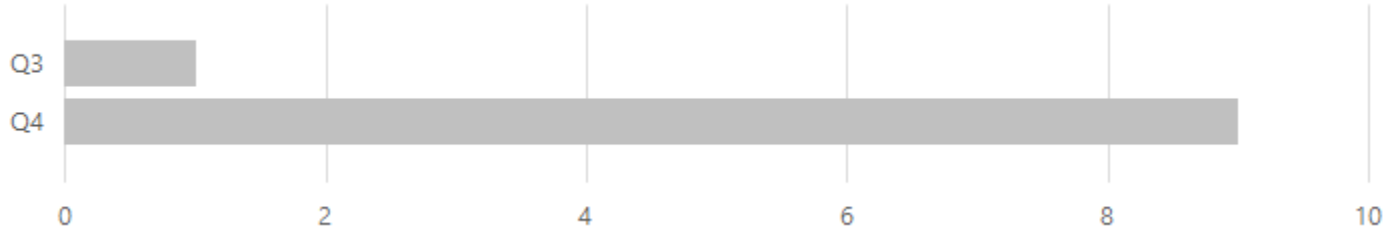
Priority:	1A Preventative approaches to Health & Wellbeing

Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to improve population health and wellbeing due to increasing prevalence of preventable long term conditions, insufficient uptake of preventative interventions, and limited impact of early intervention programmes, leading to increased demand on acute and community services and widening health inequalities.

Accountable:	Executive Director of Public Health

Primary risk controls:	Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating
• Delivery of Healthy Weight programmes (children and adults) • Implementation of Weight Management Review recommendations • Delivery of grant funded prevention programmes • Development of Health Improvement offer across the system • Delivery of early years and school-based prevention interventions • Embedding Making Every Contact Count (MECC) training • Partnership working with: - Public Service Boards - PSBs) - Local Authorities - Third Sector	G1: Limited scale and impact of preventative interventions across the population G2: Workforce capability and capacity to plan for and deliver prevention consistently (e.g. MECC undertaken by patient facing staff) G3: Increasing prevalence of obesity and lifestyle-related conditions G4: Limited intelligence to fully target prevention activity G5: Population Health improvement is dependent on whole system approach	**Management Assurance** IMTP monitoring of 1A.1–1A.10 deliverables Performance metrics: • Smoking cessation targets • Access to weight management services and healthy weight • Improved Breastfeeding rates • Number of staff completing MECC training Programme governance (Health Improvement / Public Health programmes) **Risk & Compliance Assurance** Alignment to: • National Public Health strategies • Weight Management Review recommendations • National Mental Health & Wellbeing Strategy • Internal programme reviews **Independent Assurance** • Welsh Government oversight • Public Health Wales reporting (grants) • Public Health Outcomes Framework • Regional Partnership Board reporting	A1: Limited assurance of long-term behaviour change outcomes A2: Limited independent validation of impact of prevention programmes A3: Data limitations on prevention and early intervention impact A4: Limited real-time evidence linking interventions to reduced demand A5: Limited assurance on reduction of inequalities at pace A6: Limited assurance on workforce consistency and capability	

Plans to improve control :



Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
1A.1	Develop a proposal to support referrals to appropriate support following participation in Child Measurement Programme (e.g. to CAMHS, Children's, Dietetics, Weight Management).	G1 G3 G4	A1 A4	Executive Director of Public Health	**Q3 (No Update provided during this reporting cycle)**
1A.2	Implementation of the recommendations in the Weight Management Review, increasing activity in Level 2 Adult weight services.	G1 G3 G4	A1 A5	Executive Director of Public Health	**Q4 (Moderate Delivery Confidence)**
1A.3	Deliver approved Grant funded Programmes of work (Prevention and Early Years, Whole School Approach, Whole System approach to Healthy Weight)	G1 G5	A4 A5	Executive Director of Public Health	**Q4 High Delivery Confidence**
1A.4	Provide education and targeted approaches to healthy choices through supporting schools, early years environments and families through Dietetics - early years programmes (Come & Cook, Tiny Tums).	G1 G3	A1 A5	Executive Director of Public Health	**Q4 High Delivery Confidence**
1A.5	Act on the conditions that influence risk factors for ill-health (e.g. environmental, social or economic interventions), including promoting a state of good mental and physical health through assessment of impact including: 1) influence planning applications 2) work with the Alcohol Partnership Board and Public Service Boards (PSBs) to implement their plans 3) contribute to developing the environment through	G3 G5	A4 A5	Executive Director of Public Health	**Q4 High Delivery Confidence**

	local development plans and Actif North Wales to consider green and blue spaces.				
1A.6	Agree and commence a phased implementation of an enhanced Health Improvement offer within the Health Board and with partners across the health system that increases access to evidence-based opportunities to improve health and wellbeing outcomes.	G1 G5	A1 A4 A5	Executive Director of Public Health	**Q4 High Delivery Confidence**
1A.7	Produce gap analysis and opportunities from the potential and current state to shape the enhanced Health Improvement offer for services.	G4	A3 A4	Executive Director of Public Health	**Q4 High Delivery Confidence**
1A.8	Embed Health Improvement into the following areas: 1) delivery planning to support Statement 2 & 4 of the National Mental Health & Wellbeing Strategy (led by Mental Health Services / Public Health Wales), 2) refresh the Preconception Strategic Plan, 3) response plan developed from the weight management review recommendations.	G1 G2	A1 A6	Executive Director of Public Health	**Q4 High Delivery Confidence**
1A.9	Healthy Travel Charter – increase the number of participating organisations each quarter, supporting Public Service Boards (PSBs) and wider partners to register organisational commitment at a regional and national level.	G5	A5	Executive Director of Public Health	**Q4 High Delivery Confidence**
1A.10	Embed Making Every Contact Count (MECC) brief intervention training into organisational processes to increase numbers of trained staff.	G2	A6	Executive Director of Public Health	**Q4 (Moderate Delivery Confidence)**

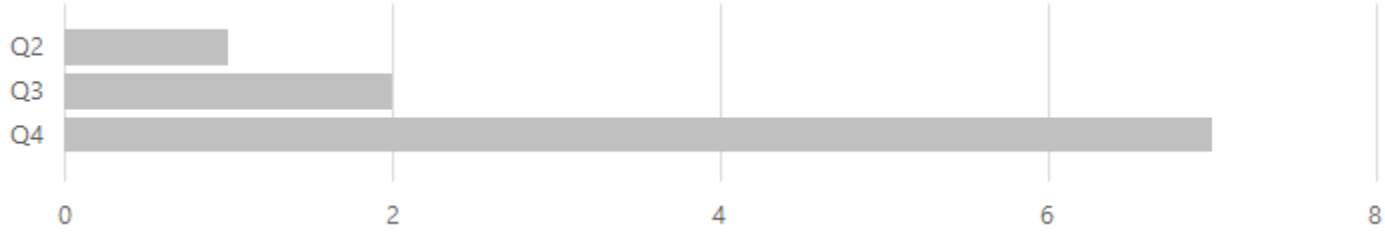
Priority:	**1B Proactive strategies for disease prevention, falls & frailty**

Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to reduce the prevalence and impact of disease, falls and frailty due to increasing demand from an ageing population, variation in clinical outcomes (e.g. diabetes), insufficient uptake of screening programmes, and limited use of population health intelligence, leading to avoidable deterioration in health outcomes, increased service demand, and widening health inequalities.

Accountable:	Executive Director of Public Health

Primary risk controls:	**Gaps in control:**	**Sources of assurance:**	**Gaps in assurance:**	**Assurance Rating**
• Delivery of Diabetes High Value High Impact pathway (1B.4) • Development and implementation of Population Health Management (PHM) programme (1B.1–1B.3) • Delivery of screening improvement plans and uptake initiatives (1B.8–1B.10) • Improvement programmes to reduce variation in diabetes care processes (1B.6–1B.7) • Place-based care models through Primary and Community Care (1B.5) • Partnership working with Public Health Wales and national screening programmes • Performance monitoring against diabetes and screening indicators	G1: Limited maturity and implementation of Population Health Management (PHM) approach G2: Variation in clinical performance and outcomes (e.g. diabetes care processes) G3: Insufficient uptake and variation in screening programmes G4: Limited early identification and targeting of at-risk populations G5: Increasing demand from ageing population (frailty and long-term conditions) G6: Limited integration of data across systems to support proactive care	**Management Assurance** IMTP monitoring of 1B deliverables (1B.1–1B.10) - Performance indicators: Diabetes care processes and screening metrics - Programme governance arrangements **Risk & Compliance Assurance** - Alignment to national diabetes and screening standards - Internal reviews and compliance checks **Independent Assurance** - Welsh Government oversight - Public Health Outcomes Framework	A1: Limited assurance of long-term impact of disease prevention and frailty reduction A2: Limited independent validation of effectiveness of PHM interventions A3: Data limitations impacting ability to track outcomes at population level A4: Limited real-time linkage between preventative action and reduced demand A5: Limited assurance on reduction of variation in clinical outcomes A6: Limited evidence of sustained improvement in screening uptake	

Plans to improve control :



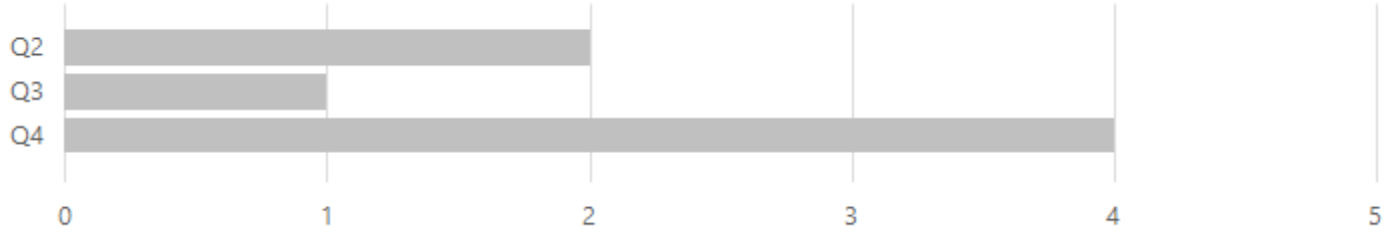
Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
1B.1	Develop and agree a comprehensive road map that outlines priorities, roles, data requirements and phased delivery actions to support the development of the Population Health Management (PHM) Programme.	G1 G2 G3 G4 G5 G6	A1 A2 A3 A4 A5	Executive Director of Public Health	**Q3 High Delivery Confidence**
1B.2	Develop and launch a suite of health intelligence resources that support improved, evidence-based decision-making in service planning and help identify and reduce inequalities.	G1 G2 G3 G4 G5 G6	A1 A2 A3 A4 A5	Executive Director of Public Health	**Q2 High Delivery Confidence**
1B.3	Establish a Population Health Management (PHM) programme with the Digital Team (DDAT) through development of a comprehensive road map, that will facilitate sustainable healthcare transformation in future years by targeting interventions that prevent ill health, improve care and support for people with ongoing health conditions, and reduce inequalities in health outcomes.	G1 G2 G3 G4 G5 G6	A1 A2 A3 A4 A5	Executive Director of Public Health	**Q4 High Delivery Confidence**
1B.4	Complete implementation of the focused Diabetes High Value High Impact pathway.	G2 G4 G5	A5	Executive Director of Public Health	**Q4 High Delivery Confidence**
1B.5	Identify place-based approaches within Primary and Community care and develop options which respond to population need and deliver holistic patient centred care for people living with diabetes.	G2 G4 G5	A1 A5	Executive Director of Public Health	**Q4 High Delivery Confidence**
1B.6	Support improvement and reduce variation in performance and compliance in relation to Diabetes priorities including: 8 Care Processes and reducing variation.	G2 G4 G5 G6	A5	Executive Director of Public Health	**Q4 High Delivery Confidence**
1B.7	Implement appropriate best practice within the national Quality Statement for Diabetes.	G2	A5	Executive Director of Public Health	**Q4**

					High Delivery Confidence
1B.8	Support the introduction of the National Lung Screening Programme (commence 2027).	G3 G4 G5	A6	Executive Director of Public Health	**Q4 High Delivery Confidence**
1B.9	Create a plan together with Public Health Wales to support delivery of the National screening uptake targets and improvement against National performance indicators and to reduce variation.	G3 G4	A5 A6	Executive Director of Public Health	**Q4 High Delivery Confidence**
1B.10	Produce local plans to support new National Public Health Wales Human Papillomavirus (HPV) self-sampling programme.	G3	A6	Executive Director of Public Health	**Q3 (Moderate Delivery Confidence)**

Priority:	**1C Health Inequalities**			
Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to reduce health inequalities due to insufficient partner commitment to the Prevention, Anchor and Wellbeing Framework, and continued variation between the most and least deprived populations in access, uptake and outcomes. This may lead to widening health inequalities, poorer health outcomes for vulnerable and inclusion groups, and increased demand on health and care services.				
Accountable:	Executive Director of Public Health			
Primary risk controls:	**Gaps in control:**	**Sources of assurance:**	**Gaps in assurance:**	**Assurance Rating**
• Implementation of targeted plans to reduce inequity in uptake of vaccination, screening and diabetes prevention and care (1C.1) • Development and delivery of Regional Vaccine Equity Plan and Screening Equity Plan (1C.2–1C.3) • Partnership working with Primary Care to reduce variation in uptake (1C.4) • Development of jointly commissioned social prescribing services with Local Authorities and Third Sector (1C.5) • Implementation of Marmot / Anchor framework and system-wide prevention approaches (1C.6) • Development of inclusion health offer for vulnerable groups (1C.7)	G1: Limited system-wide adoption and prioritisation of Prevention / Anchor Wellbeing Framework across partners G2: Continued variation in access, uptake and outcomes between most and least deprived areas/groups G3: Insufficient targeting of interventions for inclusion health groups and vulnerable populations G4: Limited integration of population health intelligence to inform inequality reduction strategies G5: Requirement for whole system approach to tackle health inequalities and	**Management Assurance** IMTP monitoring of 1C deliverables (1C.1–1C.7) Performance monitoring: Vaccination uptake across deprivation quintiles Screening uptake and variation Diabetes care process delivery by cluster Programme governance (Public Health, Inequalities, Prevention programmes) **Risk & Compliance Assurance**	A1: Limited assurance of sustained reduction in health inequalities over time A2: Limited validation of impact of health inequality and prevention programmes A3: Data limitations affecting measurement of outcomes across deprivation and inclusion groups A4: Limited real-time	

• Use of population health intelligence to target interventions in deprived and inclusion groups	wider determinants of health G6: Unable to implement at scale actions to address health inequalities	Alignment with: Wellbeing of Future Generations (Wales) Act Equality Act 2010 and Socio-economic Duty National Public Health and Equity strategies Internal reviews of equity plans and targeted programmes **Independent Assurance** Welsh Government oversight Regional Partnership Board reporting External benchmarking of inequality and equity measures	evidence linking interventions to improved access and outcomes A5: Limited assurance of whole system approach to reducing health inequalities A6: Limited evidence of scale and spread of effective interventions which reduce health inequalities	

Plans to improve control :



Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
1C.1	Implement plans which reduce inequity in the uptake in the most and least deprived areas in preventing ill-health, especially in relation to vaccination, screening and diabetes prevention and care. By utilising population health intelligence and evidence, target approaches to reduce variation and health inequalities within inclusion health groups and areas of deprivation.	G4	A1 A4 A6	Executive Director of Public Health	**Q4 High Delivery Confidence**

1C.2	Regional Vaccine Equity Plan co-developed and launched.	G2 G3 G4	A1 A3 A4 A5 A6	Executive Director of Public Health	**Q2 High Delivery Confidence**
1C.3	Regional Screening Equity Plan co-developed and launched.	G2 G3 G4	A3 A4 A5 A6	Executive Director of Public Health	**Q4 High Delivery Confidence**
1C.4	Work with primary care partners to reduce variation in vaccine uptake between primary care clusters.	G2 G3 G4 G5	A1 A2 A3 A4 A5 A6	Executive Director of Public Health	**Q4 High Delivery Confidence**
1C.5	Work with Local Authorities to secure jointly commissioned social prescribing services and expand creative offers with the Third Sector across North Wales.	G1 G5	A1 A2 A3 A4 A5 A6	Executive Director of Public Health	**Q2 (Moderate Delivery Confidence)**
1C.6	Supporting Marmot principles work towards a whole system shift to prevention and addressing inequalities by increasing the number of organisations/partnerships committing to, and evidencing early delivery against, the missions and Anchor Charter in the Regional Wellbeing, Prevention and Anchor Framework (missions: Environment, Communities, Housing, Food, Employment, Life-Long Learning, Active Lifestyles, Creative Lifestyles)	G1 G5	A5 A6	Executive Director of Public Health	**Q4 High Delivery Confidence**
1C.7	Based on the work in 2025/26 on the homelessness assessment, to comply with the new Homelessness and Social Housing Allocation (Wales) legislation and needs assessments on other inclusion groups, develop a comprehensive inclusion health offer for people in North Wales.	G2 G5	A1 A2 A3 A4 A5 A6	Executive Director of Public Health	**Q3 High Delivery Confidence**

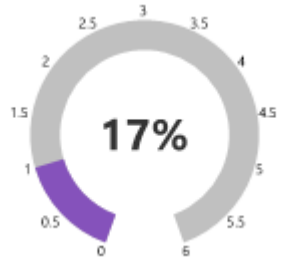
Priority:	1D Health Protection

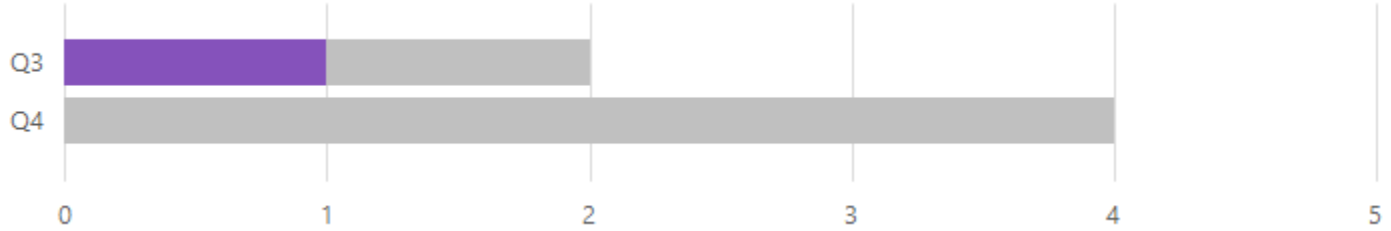
Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to protect the population from communicable disease and other health protection threats due to suboptimal vaccination uptake, increasing vaccine hesitancy, and ineffective management of environmental and societal risks. This may lead to increased spread of infectious disease, higher demand on services, and adverse population health outcomes.

Accountable:	Executive Director of Public Health

Primary risk controls:	Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating
•Delivery of vaccination and immunisation programmes aligned to National Immunisation Framework (1D.1–1D.3) •Implementation of Vaccine Equity Plan and targeted uptake initiatives •Development of GP and IVS collaborative to improve uptake (1D.2) •Delivery of Health Protection Plan and establishment of Local Authority partnerships (1D.4) •Delivery of disease prevention, screening and elimination programmes (1D.5) •Infection prevention and control interventions across high-risk settings (1D.6) •Partnership working with Public Health Wales and Local Authorities	G1: Suboptimal vaccination uptake, particularly due to opt-out consent models G2: Increasing vaccine hesitancy driven by misinformation and lack of trust G3: Variation in vaccine uptake across communities and population groups G4: Limited targeting of high-risk and underserved populations G5: Requirement for Partner organisations to strengthen key aspects of health protection G6: Limited system-wide coordination of environmental and societal risk management	**Management Assurance** IMTP monitoring of 1D deliverables (1D.1–1D.6) Performance indicators: Childhood vaccination uptake HPV vaccination uptake Flu and RSV vaccination uptake Programme governance (Immunisation, Health Protection programmes) **Risk & Compliance Assurance** Alignment with: National Immunisation Framework Health Protection Framework (Wales) IPC standards and guidance Internal compliance reviews **Independent Assurance** Welsh Government oversight Public Health Wales monitoring of transmissible disease External benchmarking of vaccination uptake and disease control	A1: Limited assurance of achieving sustained herd immunity levels A2: Limited independent validation of vaccine uptake improvement interventions A3: Data limitations affecting targeting and monitoring of vaccination uptake A4: Limited real-time visibility of emerging health protection risks A5: Limited assurance of consistency in delivery across partners and communities A6: Limited evidence of long-term reduction in disease transmission and outbreaks	

Plans to improve control :





Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
1D.1	Through targeted programmes of work for each vaccine / immunisation, implement the vaccine equity plan and work with partners (e.g. schools) to deliver the National Immunisation Framework targets to improve take up rates.	G1 G2 G3 G4	A1 A3 A5	Executive Director of Public Health	**Q4 High Delivery Confidence**
1D.2	Develop the GP and Identified Validated Sample (IVS) collaborative to improve uptake in the RSV 75 plus cohort.	G2 G3 G4 G5	A1 A5	Executive Director of Public Health	**Q4 High Delivery Confidence**
1D.3	Implementation of phase 2 Childhood Immunisation Schedule recognising changes to the immunisation schedule for 2026, protecting children across a range of disease and illness.	G1 G2 G3	A1 A2 A3 A4 A5	Executive Director of Public Health	**Q3 (Complete)**
1D.4	Deliver the funded Health Protection plan including establishing a Health Protection partnership with a	G5 G6	A4 A5	Executive Director of Public Health	**Q3 High Delivery Confidence**

	Service Level Agreement in place with the 6 North Wales Local Authorities.				
1D.5	Enhance the delivery of health board services to protect people in North Wales against existing, new and emerging health protection threats and hazards by supporting screening and vaccination programmes, and disease elimination activities (Hepatitis B and C, and TB).	G4 G5 G6	A4 A6	Executive Director of Public Health	**Q4 High Delivery Confidence**
1D.6	Deliver evidence-based approaches to protecting and preventing ill health within specific sectors and settings e.g. delivery of infection prevention control interventions in residential Care Homes.	G5 G6	A1 A6	Executive Director of Public Health	**Q4 High Delivery Confidence**

Principal risk (What could prevent us achieving this strategic objective)	**BAF 26 02 - Failure to deliver enhanced coordination of care for people with long term conditions & improve access** There is a risk that the Health Board fails to improve coordination of care and access to integrated primary and community services for people with long-term conditions. This may lead to fragmented pathways, reduced community support, widening health inequalities, increased pressure on acute services, and poorer patient outcomes.		
Lead Commitee	Partnership Finance and Information Governance Committee/ Planning, Population Health & Partnerships Committee	**Risk Type**	Quality
Risk Lead	Chief Operating Officer	**Risk Appetite**	<15
Related Corporate Risks:	CRR25-01 – Timely Patient Access to Safe and Effective Care, CRR25-02 – Future Demand & Sustainable Workforce CRR25-04 – Modernising Digital Infrastructure to Enable Safe, Integrated Care, CRR25-05 – Strategic Change Impacting Care and Staff Delivery, CRR25-06 – Delivery of the 2026/27 Financial Plan and Financial Sustainability		

Risk Rating			**Review Dates**	
	Current Exposure	**Target**		
Consequence	4	4	**Initial assessment**	July 2026
Likelihood	4	3	**Last Committee review**	
Risk Rating	16	12	**Last Executive Review**	July 2026

Priority:	2A Primary Care

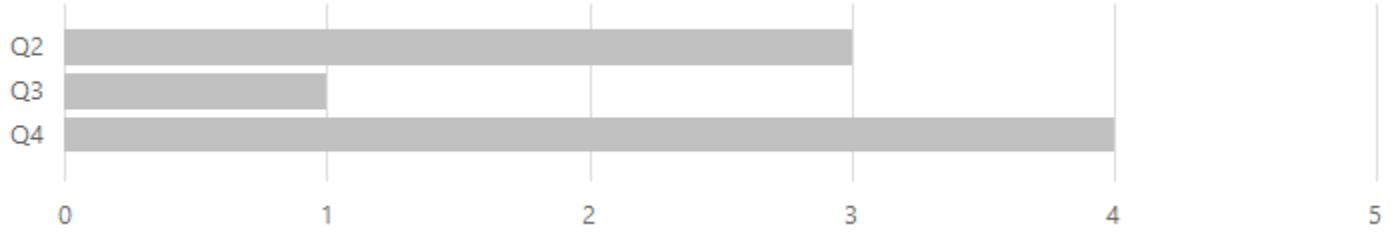
Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to deliver enhanced coordination of care for people with long-term conditions and improve access to primary and community-based services due to workforce challenges, service capacity constraints, contractual limitations, and the early maturity of transformation programmes. This may lead to reduced access to services, increased variation in care, poorer patient outcomes, and increased demand on acute services

Accountable:	Chief Operating Officer

Primary risk controls:	Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating
Implementation and embedding of new GDS contract and dental service commissioning (2A.1–2A.2) Digital transformation of Community Dental Services (2A.3) Delivery of Primary Care Workforce Strategy (2A.4) Implementation of Community by Design programme (2A.5) Development of frailty model and proactive care approaches (2A.6–2A.7) Roll-out and promotion of NHS Wales App to improve access (2A.8) Performance monitoring of access, activity and outcomes	G1: Workforce capacity and sustainability challenges across primary care services G2: Variation in access to primary care services (e.g. dental, frailty care, chronic conditions) G3: Early maturity of Community by Design programme limiting delivery at scale G4: Limited contractual levers to drive change and improvement in primary care G5: Limited digital maturity and patient uptake of digital access solutions G6: Insufficient proactive management of long-term conditions within community settings	**Management Assurance** IMTP monitoring of 2A deliverables (2A.1–2A.8) Performance indicators: Dental access rates (P01–P02) Frailty management metrics (P03) Diabetes care processes (P05–P08) NHS App uptake (P09) Programme governance (Primary Care, Community by Design) **Risk & Compliance Assurance** Alignment with: National Primary Care Model for Wales Strategic Workforce Plan Contractual frameworks (GDS, GP services) Internal reviews and compliance monitoring **Independent Assurance** Welsh Government oversight External benchmarking of primary	A1: Limited assurance of sustained improvement in access to primary care services A2: Limited independent validation of impact of Community by Design programme A3: Limited data integration across primary and community care systems A4: Limited evidence linking primary care interventions to reduced acute demand A5: Limited assurance on reduction of variation across clusters and regions A6: Limited assurance on workforce sustainability and long-term capacity	

		care access and outcomes Audit and regulatory review		

Plans to improve control :



Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
2A.1	Ensure the new General Dental Service (GDS) contract is in place and embedded, with a clear plan for the procurement of new services including commissioning of tier 2 dental services where appropriate.	G2 G2 G4	A5	Chief Operating Officer	**Q2 High Delivery Confidence**
2A.2	Undertake a review of primary care dental services to assess current capacity, patient access, and service utilisation. Work with commissioned providers and system partners to identify opportunities to increase access for patients.	G2	A1	Chief Operating Officer	**Q2 (Moderate Delivery Confidence)**
2A.3	Procure a robust digital system within the Community Dental Service (CDS) to support the management of patient records, and replace the current outdated system.	G5	A3	Chief Operating Officer	**Q2 (Moderate Delivery Confidence)**
2A.4	Continue to deliver the Strategic Programme for Primary Care (SPPC) national 'Strategic Workforce Plan for Primary Care in Wales', with the aim of developing a sustainable, skilled workforce to meet the evolving healthcare needs of the population of North Wales over the next five years. Fully utilise the	G1	A6	Chief Operating Officer	**Q4 High Delivery Confidence**

	Work Based Learning Funding allocated to Primary Care to support delivery.				
2A.5	The Health Board will strengthen the model of integrated primary and community care across North Wales by designing and delivering strategic priorities that align with the national Community by Design Transformation Programme. The key areas of focus will include urgent and same day care, management of chronic conditions in the community and prevention and population health management.	G3 G6	A3 A4	Chief Operating Officer	**Q4 High Delivery Confidence**
2A.6	Develop a costed primary care-led frailty model to enable proactive, coordinated care closer to home, as part of the Community By Design work. Identify the impact that current initiatives are having on maintaining patients at home.	G6	A4 A5	Chief Operating Officer	**Q3 (No Update provided during this reporting cycle)**
2A.7	Finalise a proposal to increase the use of the Audit Plus Frailty Tool in the community to ensure that patients receive proactive care in line with their agreed care plans.	G6	A4	Chief Operating Officer	**Q4 High Delivery Confidence**
2A.8	Support the implementation and roll-out of the NHS Wales app in primary and community care services by developing and implementing an action plan to promote the NHS app including patient education, staff training and monitoring of uptake.	G5	A1 A3	Chief Operating Officer	**Q4 (Moderate Delivery Confidence)**

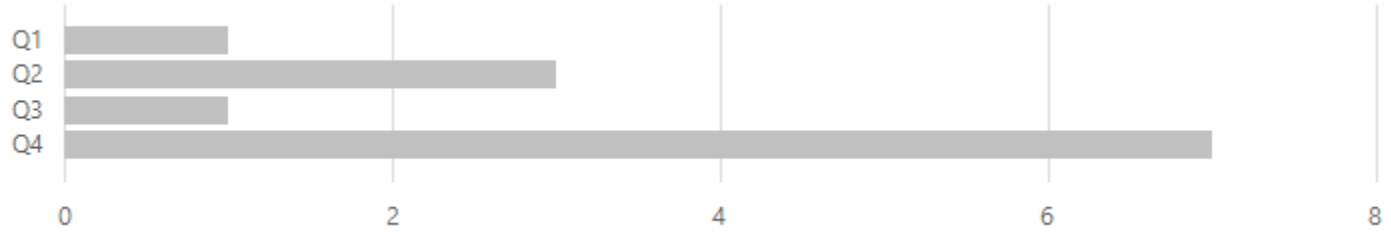
Priority:	**2B Community Care**

Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to deliver coordinated, accessible, and high-quality community-based care for people with long-term conditions due to insufficient strategic planning, workforce and resource constraints, and lack of an agreed system-wide frailty and community care model. This may result in fragmented service delivery, increased variation in care, reduced access to services, increased demand on acute settings, and poorer patient outcomes

Accountable:	Chief Operating Officer

Primary risk controls:	**Gaps in control:**	**Sources of assurance:**	**Gaps in assurance:**	**Assurance Rating**
Development and delivery of Community by Design programme (2B.1) Demand and capacity review of community nursing services (2B.2) Mapping and redesign of Enhanced Community Care services (2B.3) Development of community investment fund with partners (2B.4) Strategic delivery plan for Palliative and End of Life Care (2B.5–2B.7) Review and optimisation of urgent community-based care services (2B.8) Delivery of coordinated care model for long-term conditions (2B.9) Implementation of frailty model and best practice standards (2B.10) Development of community diagnostic and breathlessness hubs (2B.11–2B.12)	G1: Lack of a fully agreed and embedded system-wide strategic plan for community care G2: Workforce and capacity constraints across community and primary care services G3: Early maturity of Community by Design programme limiting impact at scale G4: Variation in access and service provision across localities G5: Reliance on partner organisations and external providers G6: Limited integration and coordination of care for frailty and long-term conditions	**Management Assurance** IMTP monitoring of 2B deliverables (2B.1–2B.12) Performance metrics: Frailty pathway delivery Community nursing capacity Reduced hospital admissions and conveyance Programme governance (Community by Design, Frailty, Palliative Care) **Risk & Compliance Assurance** Alignment with: National Quality Statements (Frailty, End of Life Care) Community Care and Primary Care Models Internal service reviews and programme oversight **Independent Assurance** Welsh Government oversight External benchmarking of community services Regional partnership and system oversight	A1: Limited assurance of consistent delivery and access across all localities A2: Limited independent validation of Community by Design programme impact A3: Limited data integration and benchmarking of community services A4: Limited real-time evidence linking community interventions to reduced hospital demand A5: Limited assurance of consistent implementation of national standards A6: Limited evidence of sustainability of workforce and service models	

Plans to improve control :



Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
2B.1	Develop Community by Design as a Major Change programme, working with partners to ensure it reflects national priorities and local needs.	G1 G3 G5	A2 A5	Chief Operating Officer	**Q4 (Moderate Delivery Confidence)**
2B.2	Undertake a demand and capacity review to understand the levels of community nursing that are required across the Health Board, including weekend working.	G2 G4	A1 A6	Chief Operating Officer	**Q2 (No Update provided during this reporting cycle)**
2B.3	Map current Enhanced Community Care services across North Wales, identifying where services are located and the differences. Develop a proposal that offers recommendations as to how to further reduce unnecessary hospital conveyance and admissions.	G4 G6	A4 A5	Chief Operating Officer	**Q4 (No Update provided during this reporting cycle)**
2B.4	Develop a proposal for creating an investment fund for community groups and third sector organisations to work with the Health Board on community based solutions to some of the largest challenges facing the system.	G3 G5	A1 A5	Chief Operating Officer	**Q1 (Low Delivery Confidence)**
2B.5	Develop a strategic delivery plan for Palliative, End of Life and Bereavement Care (PEoLBC) in line with the All Wales Service Specification for the delivery of Palliative and End of Life care in Wales and All Wales Competency Framework. This will include consideration of how to increase weekend capacity for specialist palliative care nursing.	G1 G6	A1 A5	Chief Operating Officer	**Q4 (Moderate Delivery Confidence)**

2B.6	Agree an approved Quality Improvement Plan for End-of-Life Care Decision Making	G6	A1 A5	Chief Operating Officer	**Q4 (Moderate Delivery Confidence)**
2B.7	Implement appropriate best practice within the national Quality Statement for Palliative and End of Life Care.	G6	A5	Chief Operating Officer	**Q4 (Moderate Delivery Confidence)**
2B.8	Undertake a review of urgent care services available in the community including general practice, optometry, dental and pharmacy. Identify how services may be optimised and expanded.	G2 G4	A1 A4	Chief Operating Officer	**Q2 (No Update provided during this reporting cycle)**
2B.9	The Health Board will enhance the coordination of care for people with long term conditions and improve access to a broader range of community-based services, investing in integrated primary and community care.	G1 G3 G6	A2 A4 A6	Chief Operating Officer	**Q4 (Moderate Delivery Confidence)**
2B.10	Implement appropriate best practice within the national Quality Statement for Older people and people living with frailty.	G6	A1 A5	Chief Operating Officer	**Q4 (Moderate Delivery Confidence)**
2B.11	Develop a proposal to establish local breathlessness hubs to provide specialised support and care for people experiencing chronic breathlessness.	G2 G6	A1 A4	Chief Operating Officer	**Q3 High Delivery Confidence**
2B.12	Diagnostic Provision in the Community will be reviewed including undertaking a needs assessment for diagnostics and working with current providers to review and agree the most efficient delivery mechanism.			Chief Operating Officer	**Q2 High Delivery Confidence**

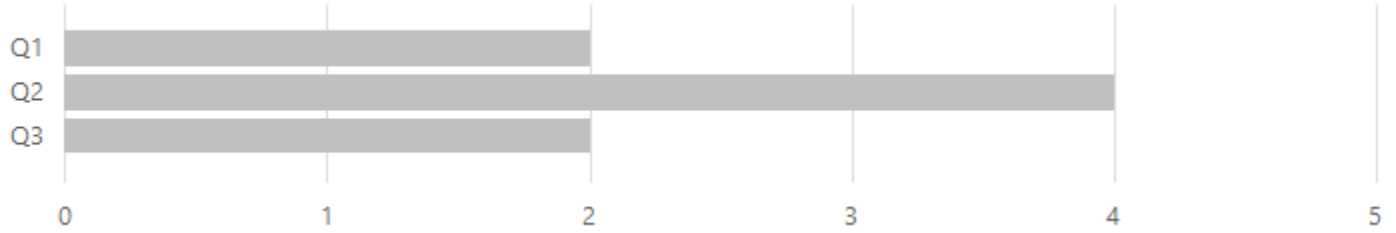
Priority:	**2C Integrated Health & Well-being Hubs**

Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to deliver Integrated Health & Well-being Hubs at pace and scale due to insufficient funding, workforce capacity constraints, and changing system priorities. This may result in delays to implementation, reduced access to integrated community-based services, missed opportunities to improve coordination of care, and continued pressure on acute services.

Accountable:	Chief Operating Officer

Primary risk controls:	**Gaps in control:**	**Sources of assurance:**	**Gaps in assurance:**	**Assurance Rating**
Delivery of Integrated Health & Well-being Hub programme across multiple sites (2C.1–2C.8) Strategic partnership working with Local Authorities, housing associations and third sector Development and approval of business cases and programme plans for hubs Governance through programme and capital planning frameworks Prioritisation through Integrated Rebalancing Capital Fund (IRCF) (2C.9) Alignment with Community by Design and wider strategic intent	G1: Funding constraints impacting pace and scale of hub development G2: Workforce capacity and contractor engagement challenges G3: Dependency on multi-agency partners and external decision-making G4: Risk of changing political or strategic priorities affecting delivery G5: Early stage of programme maturity across multiple sites G6: Limited capacity to scale integrated models consistently across North Wales	**Management Assurance** IMTP monitoring of 2C deliverables (2C.1–2C.9) Programme governance (Integrated Hubs Programme) Monitoring against programme milestones and timelines **Risk & Compliance Assurance** Alignment with: Health Board Strategy and Capital Programme National "A Healthier Wales" policy direction Internal programme and financial governance **Independent Assurance** Welsh Government oversight of capital and transformation programmes External scrutiny of business cases and funding approvals Partner organisation governance and reporting	A1: Limited assurance of delivery at pace across all hub developments A2: Limited independent validation of long-term impact of integrated hub model A3: Limited visibility of real-time progress across multiple programmes A4: Limited evidence linking hub delivery to improved outcomes and reduced demand A5: Limited assurance of consistent partner commitment across all sites A6: Limited assurance of sustainability of funding and workforce models	

Plans to improve control :



Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
2C.1	Bangor Integrated Health & Well-being Centre – work with partners on a strategic outline case	G1 G3 G5	A1 A3	Chief Operating Officer	**Q2 High Delivery Confidence**
2C.2	Waunfawr Integrated Health & Well-being Centre – sign heads of terms to secure purchase of a site, progress the parallel elements of the programme plan.	G1 G3	A1 A3	Chief Operating Officer	**Q1 (Moderate Delivery Confidence)**
2C.3	Penygroes Integrated Health & Well-being Centre – develop an outline business case, progress the parallel elements of the programme plan.	G1 G5	A1 A3	Chief Operating Officer	**Q3 (Moderate Delivery Confidence)**
2C.4	Porthmadog Integrated Health & Well-being Centre – revise options appraisal for location, progress the parallel elements of the programme plan.	G1 G4	A1 A3	Chief Operating Officer	**Q2 (Moderate Delivery Confidence)**
2C.5	Conwy West Integrated Health & Well-being Centre – finalise site location, progress the parallel elements of the programme plan.	G1 G5	A1 A3	Chief Operating Officer	**Q2 (Low Delivery Confidence)**
2C.6	Denbigh (Caledfryn) Integrated Health & Well-being Centre – finalise funding strategy, thereafter progress the programme plan.	G1 G2 G5	A1 A6	Chief Operating Officer	**Q2 (Low Delivery Confidence)**
2C.7	Holyhead Integrated Health & Well-being Centre – agree memorandum of understanding with Local Authority, thereafter progress the programme plan.	G3 G5	A5	Chief Operating Officer	**Q1 (Moderate Delivery Confidence)**

2C.9	Finalise Integrated Rebalancing Capital Fund (IRCF) prioritisation.	G1 G4	A1 A3	Chief Operating Officer	**Q3 (Low Delivery Confidence)**

4 **Create a modern, people-centred healthcare system that is future-focused**, maximising opportunities of digital care, research, innovation, and improvement, investing in workforce development and wellbeing and strengthening our role as an anchor institution for North Wales.

Principal risk (What could prevent us achieving this strategic objective)	**BAF 26 04 - Failure to deliver and create a modern, people centred heath care system that is future focused** There is a risk that the Health Board is unable to deliver a modern, people-centred and future-focused healthcare system due to capacity constraints, workforce pressures, financial and infrastructure limitations, dependency on national programmes and funding, and the scale and complexity of transformation required across digital, estates, workforce, planning, quality &governance. Failure to modernise the system risks unwarranted variation in care, reduced workforce sustainability and resilience, loss of public confidence, increased scrutiny, and delayed Special Measures de-escalation.		
Lead Commitee	Planning, & Population Health and Partnerships Committee Performance, Finance & Information Governance Committee Quality, Safety & Experience Committee	**Risk Type**	**Innovation**
Risk Lead	Executive Director of People Services & OD, Executive Director of Nursing , Executive Director of Transformation and Strategic Planning, Executive Medical Director, Chief Digital & Information Officer, Director of Corporate Governance, Director of Partnerships, Executive Director of Finance and Director of Estates	**Risk Appetite**	**<20**
Related Corporate Risks:	CRR25-02 – Future Demand & Sustainable Workforce, CRR25-04 – Modernising Digital Infrastructure to Enable Safe, Integrated Care, CRR25-05 – Strategic Change Impacting Care and Staff Delivery, CRR25-06 – Delivery of the 2026/27 Financial Plan & Financial Sustainability, CRR25-07 – Leadership and Operating Model, CRR25-08 – Non-Compliance with Regulatory & Legislative Requirements, CRR25-09 – Safe Environment, CRR25-10 – Health & Safety, CRR25-11 – ICT Failure & Cyber		

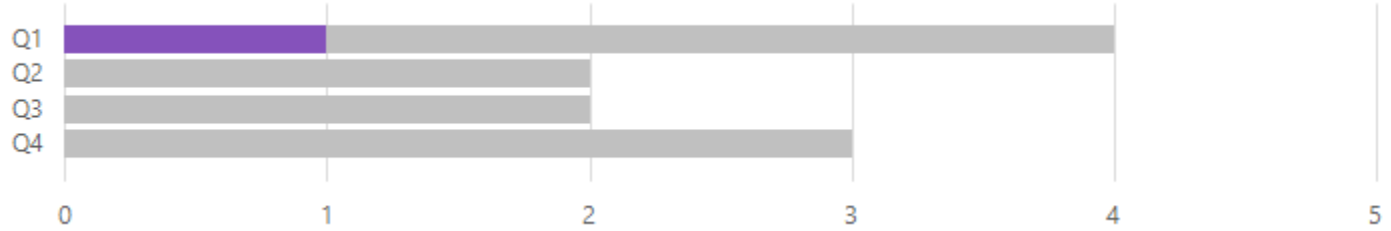
Risk Rating			**Review Dates**	
	Current Exposure	**Target**		
Consequence	**5**	**5**	**Initial assessment**	**July 2026**
Likelihood	**4**	**3**	**Last Committee review**	
Risk Rating	**20**	**15**	**Last Executive Review**	**July - Aug 2026**

Priority:	4B Strategy and Planning
Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to develop, align and deliver a robust long-term strategy and integrated planning framework due to operational pressures, limited stakeholder engagement, and external uncertainty. This may result in lack of strategic clarity, poor alignment between plans and resources, reduced organisational ownership, and inability to deliver sustainable transformation and improved outcomes.	
Accountable:	Executive Director of Transformation

Primary risk controls:	Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating
Delivery of 10-Year Strategy development (discovery, design and delivery phases) (4B.1–4B.3) Structured stakeholder engagement across organisation and partners Development of partnership frameworks (e.g. Third Sector collaboration) (4B.4) Implementation of improved planning and modelling capability (4B.5, 4B.7–4B.9) Establishment of annual reflection and learning cycles (4B.6) Strengthened IMTP delivery monitoring and reporting (4B.11) Development of integrated planning and decommissioning approaches (4B.8, 4B.10)	G1: Long-term strategic direction not yet agreed, and therefore not yet fully embedded and understood across the organisation. G2: Inconsistent alignment between strategic priorities, operational plans and resource allocation. G3: Insufficient engagement and shared ownership across clinical, operational and partner organisations G4: Integrated planning processes not fully mature or consistently applied across all services. G5: Limited organisational capability in strategic modelling, forecasting and scenario planning. G5: Variable ownership and accountability for delivery of strategic objectives. G6: Limited ability to systematically de-	**Management Assurance** - Board-approved 10-Year Strategy and associated strategic objectives. - Approved Integrated Medium Term Plan (IMTP) and annual planning cycle. - Integrated Planning Framework and planning guidance. - Strategy & Planning Programme governance and reporting arrangements. - Quarterly performance reports demonstrating delivery against strategic priorities and IMTP commitments. - Executive performance reviews and accountability arrangements. - Strategic planning milestones and delivery monitoring. - Resource allocation and investment decision making processes aligned to strategic priorities **Risk & Compliance Assurance**	A1: Limited assurance that strategic priorities are consistently understood, owned and translated into operational delivery across all parts of the organisation. A2: Limited independent assurance regarding the effectiveness and impact of the Health Board's strategic planning framework and decision-making processes.A3: Limited real-time visibility of alignment between strategy, plans, resources and delivery at organisational level A4: Limited evidence demonstrating a clear link between strategic objectives, investment decisions and improved organisational or population outcomes. A5: Limited assurance regarding the consistency	

	prioritise activity and redirect resources to agreed strategic priorities.	- Assessment against NHS Wales Planning Framework requirements. - Planning Maturity Matrix self-assessment and improvement programme. - Internal reviews of planning, prioritisation and governance processes. - Compliance with Well-being of Future Generations duties and organisational planning requirements. - Monitoring of alignment between strategic, workforce, financial, digital and estate plans. **Independent Assurance** - Welsh Government review and oversight of Strategy and IMTP submissions. - Internal Audit reviews of planning, governance and strategic decision-making processes. - Audit Wales reviews relating to planning, governance and organisational resilience. - NHS Performance & Improvement reviews - External benchmarking of planning maturity and organisational performance. - Stakeholder and partner feedback regarding strategic engagement and alignment.	and maturity of planning practices across services, directorates and programmes. A6: Limited assurance that resource allocation, prioritisation and de-prioritisation decisions are systematically aligned to strategic priorities and long-term sustainability.	

Plans to improve control :



Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
4B.1	Complete the Discovery Phase of the new 10-year Health Board Strategy by finalising evidence gathering, synthesising insights from key stakeholders, and undertaking structured engagement across the organisation and wider partners. This will culminate in an agreed Discovery Report, to inform the subsequent Design Phase of the Strategy. This work will also cover some specific requirements within the NHS Wales Planning Guidance:• A review of the organisation's Well-being objectives and how they fit within the Health Board's overarching strategic objectives. Provide clarity on the full suite of underpinning strategic plans (such as the Clinical Services Plan, Estates Strategic Plan and Digital Strategic Plan) and timelines for their development. Incorporate the Health Board's ambitions relating to Advanced Therapies and Genomics.	G1 G2 G4	A1 A3	Executive Director of Transformation & Strategic Planning	**Q1 (Low Delivery Confidence)**
4B.2	Complete the full strategy design phase by translating the insights from the discovery phase into a validated strategic framework, including defined goals, strategic priorities, delivery roadmaps, and governance model, culminating in a final Strategy ready for Board approval. This will include structured engagement with key stakeholders throughout the design process to test assumptions, refine options,	G1 G6	A1 A4	Executive Director of Transformation & Strategic Planning	**Q3 (Moderate Delivery Confidence)**

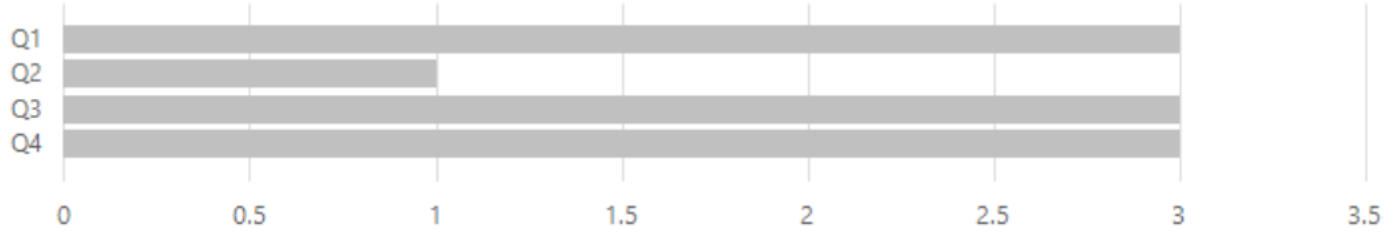
	and build organisational alignment, ensuring aspects such as the Marmot principles (relating to early childhood, education, employment, preventing ill-health, housing and community well-being) are covered within the scope.				
4B.3	Implementation of the strategy will be via key underpinning quality impact assessed strategic plans (e.g. Clinical Services Plan) and their key deliverables falling within the 2027-30 IMTP.	G4 G6	A4 A6	Executive Director of Transformation & Strategic Planning	**Q4 (Moderate Delivery Confidence)**
4B.4	Co-create a Third Sector Partnership Working Framework with Third Sector Partners to move to more proactive and strategic collaborative approach.	G1 G3	A1 A5	Executive Director of Transformation & Strategic Planning	**Q1 (Moderate Delivery Confidence)**
4B.5	Draw on support from NHS Performance and Improvement (NHS P&I) colleagues to develop proposals on an improved approach to a unified modelling across demand, capacity, skills mix, activity, performance, finance and workforce, incorporating benchmarking against other Health Boards – to be utilised in the 2027-30 IMTP planning cycle.	G5	A3 A6	Executive Director of Transformation & Strategic Planning	**Q1 (Low Delivery Confidence)**
4B.6	Undertake an annual reflection and learning exercise in relation to the annual planning cycle, incorporating the planning maturity matrix self-assessment tool and involving internal and external stakeholders.	G4 G5	A2 A5	Executive Director of Transformation & Strategic Planning	**Q1 (Complete)**
4B.7	Deliver improvements in the organisation's approach to planning through delivery of the planning capability action plan that is informed by feedback from key stakeholders, annual learning cycles and contains actions from the planning maturity matrix self-assessment. Aiming to progress to level 3 and above across all areas.	G4 G5	A5	Executive Director of Transformation & Strategic Planning	**Q4 High Delivery Confidence**
4B.8	Update the BCUHB Integrated Planning Framework and associated more detailed planning guidance in light of annual reflection and learning exercise,	G4 G6	A3 A5	Executive Director of Transformation & Strategic Planning	**Q2 High Delivery Confidence**

	emphasising the importance of clinical leadership, Community by Design principles and patient feedback in service planning.				
4B.9	Contribute to the broader organisational capability development work, specifically in relation to development of skills in planning.	G5	A6	Executive Director of Transformation & Strategic Planning	**Q2 High Delivery Confidence**
4B.10	Develop an organisational approach to de-prioritisation and de-commissioning for teams to utilise in reaching and implementing decisions of this nature, ensuring the full range of clinical and operational perspectives are central to the approach.	G6	A4 A6	Executive Director of Transformation & Strategic Planning	**Q3 High Delivery Confidence**
4B.11	Support delivery of commitments set out in the IMTP through monthly monitoring and timely escalation of any risks to delivery as well as quarterly reporting of delivery against the IMTP and Special Measures de-escalation framework.	G2 G4	A3 A4	Executive Director of Transformation & Strategic Planning	**Q4 High Delivery Confidence**

Priority:	**4C Clinical Services Planning, Leadership and Interprofessional Working**			
Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to effectively develop and deliver the Clinical Services Plan (CSP), alongside strong clinical leadership and interprofessional working, due to organisational change, insufficient resources, external uncertainty, and limited clinical engagement in leadership roles. This may result in delayed or ineffective service transformation, lack of clinical ownership, inconsistent leadership capacity, and an inability to deliver sustainable, high-quality, person-centred care aligned to strategic objectives and population needs.				
Accountable:	Executive Medical Director / Executive Director of Transformation			
Primary risk controls:	**Gaps in control:**	**Sources of assurance:**	**Gaps in assurance:**	**Assurance Rating**
• Establishment of CSP Programme governance, delivery plans and reporting structures (4C.1–4C.2) • Delivery of CSP assessment process including evidence gathering, population health intelligence and option appraisal (4C.3) • Development and approval of CSP service change proposals (4C.4) • Implementation of clinical leadership roles, job	G1: CSP programme at early stage of development and not fully embedded across all services G2: Variable engagement across clinical, operational and partner stakeholders G3: Limited clinical leadership pipeline and capacity across services G4: Insufficient prioritisation of resources (time and funding) to support CSP	**Management Assurance** • IMTP monitoring of 4C deliverables (4C.1–4C.10) • CSP Programme governance and reporting arrangements • Evidence of completed CSP assessments and approved service change proposals • Workforce metrics including	A1: Limited assurance of consistent engagement and ownership across all services and partners A2: Limited independent validation of CSP effectiveness and decision-making outcomes A3: Limited real-time visibility of	

descriptions and remuneration models (4C.5) • Delivery of clinical leadership training and development programmes (4C.6–4C.7) • Development of clinical leadership career pathways (4C.8) • Strengthening interprofessional working through clear roles, responsibilities and OD support (4C.9–4C.10)	delivery G5: Dependencies on operating model changes affecting programme coordination and engagement G6: Interprofessional working arrangements not consistently embedded across teams	clinical leadership vacancies and training uptake • Staff engagement and organisational development feedback **Risk & Compliance Assurance** • Alignment with Clinical Services Plan requirements, IMTP and 10-year strategy • Internal governance and performance reporting frameworks • Oversight of workforce and leadership development programmes **Independent Assurance** • Welsh Government oversight of IMTP delivery and service transformation • External benchmarking and learning from other Health Boards • Stakeholder and partner feedback on CSP engagement and proposals	CSP delivery progress and alignment with strategy A4: Limited evidence linking CSP delivery to improved population and service outcomes A5: Limited assurance of leadership capacity and capability development impact A6: Limited assurance of sustainability of delivery within available resources	

Plans to improve control :



Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
4C.1	Agree the CSP methodology and first tranche of areas to be prioritised and establish the CSP Programme by developing the programme structure, governance, and delivery approach, supported by targeted internal engagement and awareness raising activities to build understanding and organisational buy in. Success will be demonstrated through formal approval of the methodology, confirmation of programme governance, and evidence of staff awareness and engagement across key teams including the first major engagement event held.	G1 G2 G5	A1 A3	Executive Medical Director	**Q1 (Low Delivery Confidence)**
4C.2	Operationalise the CSP Programme by finalising detailed delivery plans for the process (pertaining to the first tranche of areas), establishing programme reporting and risk management processes, and initiating structured engagement with leads to prepare for CSP assessments. Success will be demonstrated through approved delivery plans, active reporting cycles, and evidence of areas' readiness to enter the CSP process in Q3.	G1 G4	A3	Executive Medical Director	**Q2 (Moderate Delivery Confidence)**
4C.3	Deliver the full CSP assessment process for the first tranche of priority services, including evidence gathering (including use of key population level intelligence, assessment workshops, option development and prioritisation. This will be supported by structured engagement with leads and clinical and operational teams from the full set of professional groups to ensure clarity, collaboration and high-quality outputs. Success will be demonstrated through completed CSP assessment documentation and agreed prioritisation outcomes for all first tranche areas that	G1 G2	A3 A4	Executive Medical Director	**Q3 (Moderate Delivery Confidence)**

	demonstrates Community by Design principles, maximise pathway redesign and strengthened joint working between primary and secondary care and partners.				
4C.4	Finalise and submit the first tranche of CSP service change proposals for formal approval by the CSP Programme Board. This will include refining proposals based on feedback, completing required documentation, and ensuring alignment with strategic, operational and financial considerations. Success will be demonstrated through Programme Board approval of all first tranche service change proposals and confirmation of readiness for wider Health Board governance approvals and implementation planning.	G1 G6	A4	Executive Medical Director	**Q4 (Moderate Delivery Confidence)**
4C.5	Job descriptions with roles with responsibilities and appropriate remuneration in place for all clinical leadership posts with Foundations for the Future organisation structure, across primary, community and secondary care.	G3	A5	Executive Medical Director	**Q1 (Low Delivery Confidence)**
4C.6	Commence implementation of a menu of formal training programmes informed by training and development needs analysis for all within clinical leadership positions, across primary, community and secondary care.	G3	A5	Executive Medical Director	**Q3 (Low Delivery Confidence)**
4C.7	Generalised upskilling related to modern NHS needs via Clinical Services Plan programme to include strategic planning, value-based health care, population health management etc, across primary, community and secondary care.	G3	A5	Executive Medical Director	**Q4 (Low Delivery Confidence)**
4C.8	Develop a clear and attractive career path and development package for those in or aspiring to Clinical Leadership position, drawing on internal and external expertise and support including NHS P&I and CMO. Across primary, community and secondary care.	G3	A5	Executive Medical Director	**Q4 (Low Delivery Confidence)**

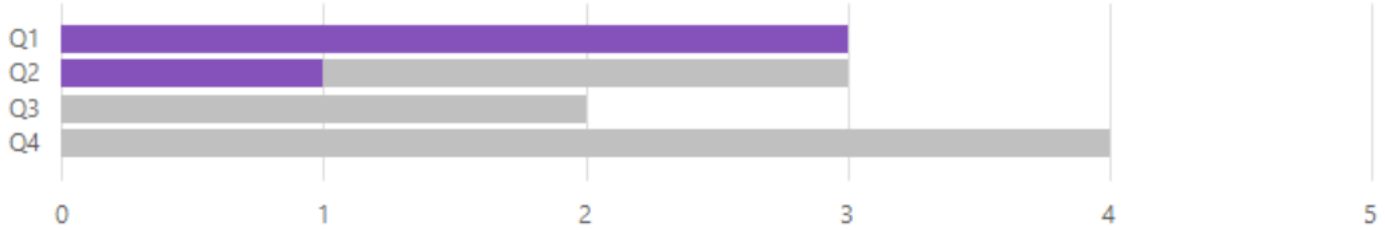
4C.9	Provide clarity over best practice clinical and operational multi-professional working, in line with the new operating model structures roll out, both roles and responsibilities and effective team working. Across primary, community and secondary care.	G6	A1	Executive Medical Director	**Q1 (Low Delivery Confidence)**
4C.10	Provide organisation development support to ensure newly formed teams are working effectively together across clinical and operational inter-professional disciplines. Across primary, community and secondary care.	G2 G6	A1	Executive Medical Director	**Q3 (Low Delivery Confidence)**

Priority:	**4D Digital, Data and Intelligence**
Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to deliver a robust, integrated digital, data and intelligence capability due to insufficient funding prioritisation, dependencies on internal and external partners, and limited clinical and operational capacity. This may result in delayed digital transformation, poor data quality and intelligence, reduced ability to support decision-making, and an inability to deliver safe, efficient and modern technology-enabled healthcare	
Accountable:	**Chief Digital & Information Officer**

Primary risk controls:	**Gaps in control:**	**Sources of assurance:**	**Gaps in assurance:**	**Assurance Rating**
Development and implementation of demand and capacity planning tools (4D.1) • Rollout of data quality kite mark and data governance programme (4D.2–4D.4) • Development of data governance audits and frameworks to improve data accuracy and accountability (4D.3–4D.4) • Implementation of clinical coding quality dashboards and improvement initiatives (4D.6–4D.8) • Development of population health intelligence and analytics capabilities (4D.11–4D.12) • Implementation of digital skills assessment and training programmes (4D.13–4D.14) • Programme of decommissioning legacy systems and reducing technical debt (4D.15) • Development of AI governance framework and	G1: Funding not consistently prioritised across digital and data initiatives G2: Dependencies on national programmes, partners and internal transformation limiting delivery G3: Limited clinical and operational capacity to support digital transformation G4: Variable data quality and governance maturity across organisation G5: Digital and analytical capability not fully embedded across services G6: Legacy systems and infrastructure impacting efficiency and integration	**Management Assurance** • IMTP monitoring of 4D deliverables (4D.1–4D.20) • Digital programme governance and reporting arrangements • Data quality kite mark assessments and data governance audits • Clinical coding performance dashboards and reporting • Digital skills training uptake and workforce development metrics **Risk & Compliance Assurance** • Compliance with Cyber Assessment Framework (CAF) requirements	A1: Limited assurance that digital investment decisions are prioritised and deliver expected benefits A2: Limited visibility and control over dependencies impacting delivery timelines A3: Limited assurance of clinical engagement and capacity to support digital implementation A4: Limited confidence in consistency and quality of data across organisation A5: Limited evidence of impact of digital transformation on service outcomes	

digital roadmap aligned to CSP and strategy (4D.18–4D.19) • Strengthening cyber security and compliance through Cyber Assessment Framework gap analysis (4D.17)		• Information governance and data quality frameworks • Oversight of digital clinical safety and cyber risks at Board level (4D.20) **Independent Assurance** • Welsh Government oversight of digital transformation and IMTP delivery • External benchmarking and national digital programmes • Audit and review of data governance, cyber security and system performance	A6: Limited assurance over full integration and sustainability of digital systems	

Plans to improve control :



Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
4D.1	Identify and commence implementation of best practice and tools available to support improved organisation wide demand and capacity planning.	G3 G5	A3 A5	Director of Digital, Data & Intelligence	**Q2 (Moderate Delivery Confidence)**
4D.2	Further development and roll out throughout the year of the data quality kite mark to provide assurance on data quality and accuracy.	G4	A4	Director of Digital, Data & Intelligence	**Q4 (Moderate Delivery Confidence)**

4D.3	Develop and commence implementation a programme of data governance audits to provide assurance on data processing and reporting accuracy.	G4	A4	Director of Digital, Data & Intelligence	**Q1 (Complete)**
4D.4	Develop a data quality framework that makes clear the responsibilities and accountability associated with the collection and management of data across the health board.	G4 G5	A4	Director of Digital, Data & Intelligence	**Q3 High Delivery Confidence**
4D.6	Develop and implement a Clinical Coding quality dashboard to facilitate improved clinical coding error detection and correction.	G4	A4	Director of Digital, Data & Intelligence	**Q1 (Complete)**
4D.11	Further enhance existing information products to introduce elements of Population Health Management (PHM) e.g. deprivation analysis, further identification of patient cohorts for targeted interventions.(Shared objectives with Public Health Team on PHM).	G5	A5	Director of Digital, Data & Intelligence	**Q3 High Delivery Confidence**
4D.13	Implement a comprehensive Digital Skills Assessment and publish Training Needs Analysis and Academy plan on LMS landing page.	G3 G5	A3	Director of Digital, Data & Intelligence	**Q1 (Complete)**
4D.15	Progressively and systematically decommission and archive unsupported systems and devices in line with available resources, while maximising the efficient use of current supported systems to reduce technical debt, support costs, and safety risk.	G6	A6	Director of Digital, Data & Intelligence	**Q4 (Moderate Delivery Confidence)**
4D.17	Completion of a gap analysis against the requirements of the newly released Cyber Assessment Framework (CAF) version 4 – this will be the tool used by our regulators to measure compliance.	G2	A2	Director of Digital, Data & Intelligence	**Q2 (Complete)**
4D.18	Create and establish a robust AI framework to ensure the appropriate processes, people and governance arrangements are in place. This will provide assurance that the approval/review process in place provides structure for the appropriate and safe use of AI tools which considers all 7 AI principles, covering safety,	G2 G5	A2 A6	Director of Digital, Data & Intelligence	**Q2 (No Update provided during this reporting cycle)**

	confidentiality, research, evaluation, partnership, ethics, transparency, and data quality.				
4D.19	To review the organisational wide Digital Roadmap to take into account the 10 year strategy and Clinical Service Plan.	G1 G2	A1 A2	Director of Digital, Data & Intelligence	**Q4 (No Update provided during this reporting cycle)**
4D.20	Ensure that digital clinical safety, cyber security and information governance risks in relation to digital are considered by the board, and undertake regular board development sessions to develop digital and data competence.	G2 G3	A2 A3 A6	Director of Digital, Data & Intelligence	**Q4 (No Update provided during this reporting cycle)**

Priority:	**4I Environment and Estates**

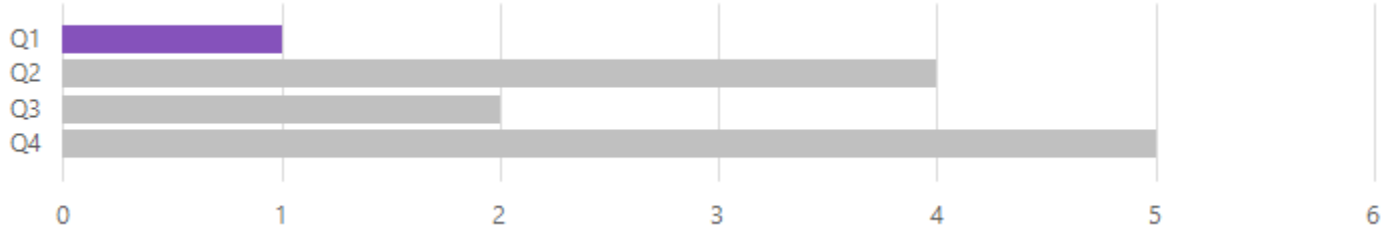
Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to deliver a safe, efficient and sustainable estate and environment due to external uncertainty, competing priorities and limited resources to deliver climate adaptation and estate transformation programmes. This may result in deterioration of estate quality, reduced service resilience, inability to support service transformation, and failure to meet environmental and decarbonisation targets.

Accountable:	Director of Environment & Estates

Primary risk controls:	**Gaps in control:**	**Sources of assurance:**	**Gaps in assurance:**	**Assurance Rating**
Development of long-term estate plans for major infrastructure and business continuity schemes (4I.1) • Progression of key capital projects and estate developments (4I.2–4I.3) • Implementation of safety improvement programmes (e.g. anti-ligature) (4I.4) • Development of revised Estates Strategic Plan aligned to 10-year strategy and CSP (4I.5) • Engagement on future estate redevelopment and planning (4I.6) • Programmes to improve estate efficiency and utilisation (4I.7–4I.9) • Development and implementation of climate adaptation and decarbonisation plans (4I.10–4I.12)	G1: Dependence on external strategic direction (e.g. Welsh Government/Senedd decisions) G2: Limited capacity and prioritisation to deliver climate adaptation and decarbonisation programmes G3: Ageing estate and backlog maintenance challenges G4: Limited availability of capital funding and competing investment priorities G5: Incomplete alignment between estate strategy and service transformation plans G6: Variable estate utilisation and efficiency across sites	**Management Assurance** • IMTP monitoring of 4I deliverables (4I.1–4I.12) • Estates Programme governance and reporting • Capital programme monitoring and delivery reporting • Estate performance metrics (utilisation, maintenance backlog, efficiency) **Risk & Compliance Assurance** • Compliance with estate safety standards and statutory requirements • Monitoring against NHS Wales	A1: Limited assurance over impact of external strategic changes on estate planning A2: Limited visibility of delivery progress of climate adaptation and decarbonisation plans A3: Limited assurance of long-term sustainability of estate within funding constraints A4: Limited evidence linking estate improvements to service outcomes A5: Limited assurance that estate strategy is fully	

		Decarbonisation Strategic Delivery Plan • Oversight of capital planning and prioritisation processes **Independent Assurance** • Welsh Government oversight of capital programmes and estate strategy • External audit and inspection (e.g. estates, safety compliance) • Benchmarking against NHS Wales estate performance and sustainability metrics	aligned to service transformation plans	

Plans to improve control :



Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
4I.1	Develop long-term plans for the delivery of the key estates projects including 1) Business continuity scheme for Ysbyty Gwynedd, 2) Electrical infrastructure replacement scheme for Ysbyty Glan Clwyd, 3) Business Continuity scheme for Wrexham Maelor Hospital, 4) Replacement helipads at Ysbyty Gwynedd and Ysbyty Glan Clwyd.	G3 G4	A3	Director of Environment & Estates	**Q4 High Delivery Confidence**
4I.2	Royal Alexandra Hospital (Rhyl) Phase 2 – Complete the schedule of accommodation and strategic outline case	G4	A3	Director of Environment & Estates	**Q4 (Low Delivery Confidence)**

4I.3	Plas Gororau (Wrexham) Phase 2 - Commence construction.	G4	A3	Director of Environment & Estates	**Q1 (Complete)**
4I.4	Develop and commence implementation of an organisation wide anti-ligature programme.	G3	A4	Director of Environment & Estates	**Q2 (Low Delivery Confidence)**
4I.5	Agree the approach to developing a revised Estates Strategic Plan, in line with the Health Board's 10-year Strategy and Clinical Services Plan.	G5	A5	Director of Environment & Estates	**Q4 (Moderate Delivery Confidence)**
4I.6	Commence engagement regarding the potential future redevelopment of the Wrexham Maelor Hospital site.	G1 G5	A1 A5	Director of Environment & Estates	**Q3 (Moderate Delivery Confidence)**
4I.7	Ensure strengthened actions are taken to improve estate utilisation including the appropriate repurposing & disposal of under-utilised estate and the reduction in the number of leases.	G6	A4	Director of Environment & Estates	**Q2 (Moderate Delivery Confidence)**
4I.8	Implement a computer aided facilities management system to support the management of the estate and the implementation of AI based energy management applications.	G2 G6	A2	Director of Environment & Estates	**Q2 High Delivery Confidence**
4I.9	Development of a pan-BCU approach to managing car parking for staff and patients.	G6	A4	Director of Environment & Estates	**Q2 (Moderate Delivery Confidence)**
4I.10	Develop a BCUHB Climate Adaptation plan aligned with the NHS Wales Decarbonisation Plan and in parallel implement estate decarbonisation programmes.	G2	A2	Director of Environment & Estates	**Q4 (Low Delivery Confidence)**
4I.11	Maximising the access to grant funding through the Refit Framework to deliver a programme of works to support carbon reduction.	G4	A3	Director of Environment & Estates	**Q3 (Moderate Delivery Confidence)**

4I.12	Commence construction of the photo-voltaic array at Ysbyty Gwynedd as part of adopting renewable energy technologies.	G2	A2	Director of Environment & Estates	**Q4 (Low Delivery Confidence)**

BAF Risk	Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range	Status of Actions at mapping	Strategic intent Priority	Mapped deliverable	BAF 26_01 – Failure to deliver improved population health and reduced inequalities	BAF 26_02 – Failure to deliver enhanced coordination of care for people with long term conditions and improve access	BAF 26_03 – Failure to Improve access, outcomes and experience	BAF 26_04 Failure to deliver and create a modern, people centred heath care system that is future focused
BAF24-02: Not Delivering Strategic Development and Digital Transformation	Senior Posts for reviewing Digital architecture and EHR. Funding for Architecture and EHR Teams is temporary and has been sourced from various non-recurrent budgets. Teams likely to have to stand down from April 2025 onwards and therefore progress halted (subject to budget setting process). NB. This is a 3-to-5-year piece of work. Activity which is required by 31st March 2025 will be completed. Senior Architecture posts in place but funded non-recurrently. These are resolving clinical system integration, which will also halt on the 31/03/2026 should recurrent funding not be secured.	Overdue	4D – Digital, Data & Intelligence 4C – Clinical Services Planning	• 4D.19 Review and update Digital Roadmap • 4D.15 Decommission legacy unsupported systems • 4D.16 Strategic Outline Case for digitisation of patient records • 4C.1–4C.4 CSP methodology & alignment of digital requirements				X
BAF24-02: Not Delivering Strategic Development and Digital Transformation	Roll-out of key priority EHR transformation projects. No funding from April 2025 onwards, to progress EHR Programme and other augmentation projects to improve the current digital environment. NB. This is a 3-to-5-year piece of work. The Electronic Health Record (EHR) – Acute and Community, Outline Business Case (OBC) first draft was handed over from the external consultants in March 25, the OBC has been updated following engagement with legal, finance, procurement and DDaT. Currently, there is no funding to progress this further, and Welsh Government have asked all Health Boards to pause while they agree a national approach. The Mental Health EHR is progressing with the procurement evaluation complete. Once assurance activities have been completed the next step will be to finalise the Full Business Case (FBC) and award contract following board approval. A strategic outline case for the scanning plan is being prepared, with anticipated submission for formal approval in April 2026 via the appropriate governance board.	Progressing	4D – Digital, Data & Intelligence 3D – Mental Health & Learning Disabilities	• 4D.19 Digital Roadmap alignment to 10-year Strategy & CSP • 4D.11–4D.12 Population Health Management datasets • 3D.9 Mental Health EHR transformation			X	X
BAF24-02: Not Delivering Strategic Development and Digital Transformation	Transformation of the DDaT Operating Model. Proposals for 2025/26 onwards are being progressed for consideration. Due to significant digital inflation, plans have been put forward and are currently being considered in line with other inflationary pressures. Bids for growth are being revised to align with IMTP Planning processes Anticipated position and due date will be 30th April 2026	Delayed	4D – Digital, Data & Intelligence 4A – Foundations for the Future	• 4D.1 Demand & capacity tools for digital • 4D.19 Digital Roadmap alignment • 4A.1–4A.7 Foundations for the Future: new operating model design				X
BAF24-02: Not Delivering Strategic Development and Digital Transformation	Proposals, (repeated from previous years) for 2025/26 onwards are being progressed for consideration. Cost Pressures and Growth proposals submitted to Executive Team for consideration. Only RIGA 1 additional funding resource received which doesn't take into consideration the required cost pressures or growth initiatives. Will continue to review funding gaps and available schemes.	Overdue	4K – Finance & Commissioning 4G – Value & Sustainability	4K.1 Financial control measures • 4K.2 Accountability agreements • 4G.12 Recurrent savings realisation • 4G.3 Address clinical variation & resource efficiency				X
BAF24-02: Not Delivering Strategic Development and Digital Transformation	Expand the implementation of the Digital Training Academy enhancing the skills and understanding of clinical and non-clinical systems and O365 tools.	Progressing	4D – Digital, Data & Intelligence	• 4D.13 Digital Skills Assessment • 4D.14 Data literacy & "Making Data Count" training offer				X
BAF24-02: Not Delivering Strategic Development and Digital Transformation	Implement and ensure Executive Decision and oversight of the Digital Prioritisation of projects and programmes in line with IMTP and Funding Arrangements.	Progressing	4D – Digital, Data & Intelligence 4B – Strategy & Planning	4D.19 Roadmap integration with Strategy & CSP • 4B.1–4B.3 Strategy Discovery & Design phases				X
BAF24-02: Not Delivering Strategic Development and Digital Transformation	Develop phase 2 of the Clinical Services Plan for implementation - a blueprint for services across North Wales	Progressing	4B – Strategy and Planning 4C - Clinical Services Planning	4B1, 2, 3 & 4B5 – 11 4C1, 2, 3, 4				X
BAF24-03: Not Achieving Long Term Financial Sustainability	Decarbonisation reporting of key objectives through to Committee (PPHP) completed, articulating goals and objectives through to Health Board. Revised NHS Wales decarb plan was published in 2025 and is currently under review. Health Board then to draft plan and an action plan.	Delayed	4I – Environment & Estates	• 4I.10 Development of BCUHB Climate Adaptation Plan • 4I.11 REFIT / carbon-reduction grant funding access • 4I.12 Renewable energy implementation (e.g., PV array) 4I.7 4I.5				X
BAF24-03: Not Achieving Long Term Financial Sustainability	Ongoing development of Estates strategy to be informed by completion of a reduced facet survey (to reflect unallocated budget), a register of assets and most importantly clinical strategies (this review of estates is likely to take 12 months) and will be used to drive estate utilisation and rationalisation. At present, this is delayed pending clinical service plans.	Delayed	4I – Environment & Estates 4C – Clinical Services Planning	• 4I.5 Revised Estates Strategic Plan aligned to 10-year Strategy & CSP • 4I.7 Estate utilisation & rationalisation improvements • 4C.1–4C.4 Clinical Services Plan methodology, prioritisation & alignment				X
BAF24-04: Not Establishing a Compassionate Culture, Leadership, Engagement and workforce capacity and capability	Prioritise implementing the workforce planning framework across the Health Board, with initial prioritisation for 'challenged services'. This action is on-going as services become familiar with the templates and the governance arrangements for the framework are embedded throughout 2026/27.	Overdue	4J – Workforce 4F – Education Partnerships	• 4J.7 Strategic Workforce Planning implementation • 4J.1–4J.4 Workforce productivity, job planning & sickness absence reduction • 4F.9–4F.10 Governance alignment of education & workforce planning				X

BAF24-04: Not Establishing a Compassionate Culture, Leadership, Engagement and workforce capacity and capability	Support the implementation of measures to aid reducing agency usage and improve value and sustainability of workforce. Progress has been made in some staff groups and now a particular focus on M&D agency is needed throughout 2026/27. The action end date will need to be extended to the end of Q4 (from 31/03/2026).	Delayed	4G – Value & Sustainability 4J – Workforce	• 4G.1–4G.12 Value & Sustainability (clinical variation, workforce efficiencies) • 4J.2–4J.3 Reduce agency spend & improve workforce sustainability • 4J.7 Strategic Workforce Planning implementation				X
BAF24-04: Not Establishing a Compassionate Culture, Leadership, Engagement and workforce capacity and capability	Implementing Values and Behaviours Framework. The V&B framework has been implemented, additional actions will be agreed to further embed and enhance its adoption, these will be added to the BAF in the coming weeks.	Overdue	4A – Foundations for the Future 4J – Workforce 4C – Clinical Leadership	• 4A.1 Culture, Leadership & Engagement programme • 4J.5–4J.6 Culture, engagement & behavioural improvement actions • 4C.9–4C.10 Interprofessional team working & leadership behaviours				X
BAF24-04: Not Establishing a Compassionate Culture, Leadership, Engagement and workforce capacity and capability	Embedding Integrated Leadership Development Framework. Three of the four programmes have already been written and launched. The remaining program pilot will be developed by the end of Q2 and the expected launch will be Q426/27. The ILDF framework will be reviewed by the Executive Committee in Q1 2026/27 to ensure it remains strategically aligned to the IMPT. The end date for action will be extended to end of September 2026 (from 31/03/2026).	Delayed	4C – Clinical Services Planning & Leadership 4A – Foundations for the Future 4J – Workforce	• 4C.5–4C.8 Clinical leadership roles, training & capability • 4A.1 Leadership culture & organisational development • 4J.5 Leadership & engagement improvement programme				X
BAF24-04: Not Establishing a Compassionate Culture, Leadership, Engagement and workforce capacity and capability	Developing Anchor Institute Framework – ongoing, draft Anchor Charter developed with partners and being formally discussed at regional wellbeing and anchor charter event on 19.03.26.	Overdue	1C – Health Inequalities / Anchor Institute Partnership & Regional Collaboration	• 1C.6 Anchor principles & missions implementation (Environment, Communities, Housing, Employment, Food, Learning, Creative & Active Lifestyles) • Section 5 – Working with Partners: strengthening regional collaboration & social value frameworks	X			
BAF24-04: Not Establishing a Compassionate Culture, Leadership, Engagement and workforce capacity and capability	Citizen Engagement Plan being reviewed – the draft principles and framework developed – Co-production, Engagement and Consultation Toolkit developed, Principles and Framework to be discussed at Executive Group Meeting before end of April 2026.	Progressing	3B – Citizen Engagement 4A – Foundations for the Future 4B – Strategy & Planning	• 4A.12 Partner engagement in operating model • 4B.1–4B.4 Embedding engagement into IMTP & Strategy processes			X	X
BAF24-04: Not Establishing a Compassionate Culture, Leadership, Engagement and workforce capacity and capability	Communications and engagement plan November 2025 to post Senedd election 2026 addressing progress to date and areas of Board focus in the months ahead – plan in development, overseen by the Chief Executive Officer.	Progressing	3B – Citizen Engagement 4A – Foundations for the Future 4B – Strategy & Planning	• 4B.2–4B.3 Strategic design & delivery – embedding public voice 4B.4, 4B7			X	X
BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Learning Repository Development – A Project Group oversees governance, strategic alignment, and accountability for the wider rollout by 31st April 2026. (Delayed from 31/11/2025)	Delayed	4H – Quality	• 4H.13 Implementation of learning repository & embedding organisational learning				X
BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Harms review process to be approved for planned care activity.	Overdue	3B – Planned Care 4H – Quality 4C – Clinical Services Planning	• 4H.1–4H.3 Quality Management System & governance framework development			X	X
BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Diabetes Pathway Programme – completion of case for change and next steps agreed - delay in appointing Clinical Lead however this has now gone out for expressions of interest. There have been some revisions to the plan as a result and also in keeping with wider priority programmes including Primary Care. Completion of the Diabetes Pathway Programme case for change has been completed however the overall implementation of the programme has been delayed in 25.26 due to dependencies, including the appointment of a Clinical Lead. The plan has been revised to align with wider priorities, and the completion date has moved from July 2025 to December 2026.	Delayed	1B – Disease Prevention 2A Primary Care 2B Community by Design 4G – Value & Sustainability 4C – Clinical Services Plan 4D – Population Health Management	• 1B.4–1B.7 Diabetes pathway (care processes, variation reduction, best practice) 2A.5 integrated primary & Community care 2B.1 -4 Community by Design (mapping, planning, delivery) • 4G.2 High Value/High Impact Diabetes Pathway • 4C.1-4 CSP alignment with disease pathways 4D.11-12 Population health intelligence	X	X		X
BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Deliver Primary Care based approaches to improving the compliance with NICE guidance. Awaiting update and revised date from Primary Care leads.	Overdue	2A – Primary Care 2B – Community by Design 1B – Disease Prevention 4H – Quality 4C – Clinical Services Plan	Incomplete improvement in NICE compliance; requires strengthened primary-community-secondary integration and clearer pathways.	X	X		X
BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Prevention embedded in Board Major Programmes.	Overdue	1A–1D – Prevention & Inequalities 4B – Strategy & Planning 4C – Clinical Services Plan 4G – Value Based Healthcare	• 1A–1D Prevention, Health improvement, Health Inequalities, Health Protection • 4B.1–4B.3 Strategy & IMTP alignment • 4C.1 CSP methodology – embedding prevention & PHM 4G.10 Respond to key population health intelligence	X			X

BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Development of Clinical Services Plan and Health Board Strategy recognises prevention as component part. Development of the Clinical Services Plan and Health Board Strategy, which incorporates prevention as a key component, has been delayed due to dependencies on preceding work. The completion date has moved from March 2025 to December 2026.	Delayed	1A-D Prevention & inequalities 4C – Clinical Services Planning 4B – Strategy & Planning 4D – Population Health Management 4I – Environment & Estates	1A-D Prevention, Health improvement, Health Inequalities, Health Protection • 4C.1–4C.4 Clinical Services Plan development & prioritisation • 4B.1–4B.3 10-year Strategy Discovery/Design/Delivery 4D.11-12 Population health intelligence • 4I.5 Estates Strategy alignment to CSP	X			X
BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Increased pathways with Primary care. Primary Care Service Transformation Delivery group has progressed with work completed outlining system challenges to inform next steps. On track but will be ongoing.	Delayed	3D MHLD 2A – Primary Care 4C – Clinical Leadership	• 3D.3 - Agree and develop with partners • 2A.5 Integrated primary & community pathways • 4C.9–4C.10 Interprofessional working		X	X	X
BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Electronic Health Record programme with MHLD as early adopter. Procurement concluded - assurance activity underway for award of contract. Implementation will be impacted by contract award timescales; this may impact the control completion date, but measures are being into place to mitigate this.	Overdue	4D – Digital, Data & Intelligence 3D – Mental Health & LD	• 4D.19 Digital Roadmap • 4D.6–4D.8 Coding, AI & data quality improvements • 3D.9 MHLD EHR programme rollout			X	X
BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Enhanced Savings plans. OOA/ CHC remain the well documented risks here for delivery, but plans are progressing well.	Overdue	3D MHLD 4G – Value & Sustainability 4K – Finance & Commissioning	3D.5 - Deliver a material reduction 4G.1–4G.12 Value & Sustainability Programme 4K.1–4K.3 Financial control & commissioning improvements			X	X
BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Capping OOA bed utilisation	Overdue	3D – Mental Health & LD 4G – Value & Sustainability	3D.5 Reduction in out-of-area placements • 4G.12 Financial sustainability & reducing unwarranted cost variation			X	X
BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Continued implementation of waiting list protocol to ensure patients are supported whilst waiting.	Progressing	3D MHLD	3D.3 agree & develop with partners a phrased open access MH service model			X	
BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Alignment with Learning Disabilities national programme- Improving Care Improving lives review.□ The LD transformation programme covers ECRS, Inpatient and Community Services and is fully aligned to the NHS P&I National improvement works. Improvements are project managed through service and divisional governance as well as the national programme. Progress to date includes successful roll out and uptake of Paul Ridd disability awareness training across BCU (not just LD services), introduction of the Health Equalities Framework (HEF) outcomes measure to support identifying health inequalities for people with a learning disability.	Overdue	3D – Mental Health & Learning Disabilities 4C – Clinical Services Planning & Interprofessional Leadership	3D.6–3D.7 MHLD improvement actions including health inequalities reduction, crisis response, • 4C.1–4C.4 CSP methodology & redesign of challenged services			X	X
BAF24-07: Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk	Use of data analytics to identify high-risk populations (completed) and optimise resource allocation, as a part of workstream one, needs aligning to enhanced community care Priorities agreed for primary and community transformation led by DPH, EMD and COO.	Overdue	4D – Digital, Data & Intelligence 1B – Proactive Strategies for Prevention	• 4D.1 Demand & capacity modelling tools • 4D.11–4D.12 Population Health Management intelligence • 1B.1–1B.3 Population health & prevention roadmap	X			X
BAF24-07: Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk	Deployment of live dashboards for real-time monitoring (complete) of performance and governance metrics. Standardise data collection and reporting processes to reduce variability in decision-making. Review of various dashboards to align input criteria and date. Data quality and alignment to data dictionary review ongoing. Dashboard designs work ongoing. Design phase to be complete by 31/07/2025. Once designed, build and deployment to take place with timescale tbc. Dashboard completed and information now used in UEC programme management, further work to continue moving forward as we develop SPoA This is on track. Due date extended to 30/09/2026 from June 2026.	Progressing	4D – Digital, Data & Intelligence	4D.13–4D.14 Digital & data skills improvement 4D.6–4D.8 Coding & data quality improvements 4D.19 Digital Roadmap alignment				X
BAF24-07: Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk	Strengthen digital capabilities to support service teams (such as e-triage, further roll out of home adaptations particularly rural areas, single patient tracking lists). Align digital plan to UEC plans. Alignment of plans consistent with revised prioritisation. Work underway to improve digital interface with UEC. WECDS has just been updated to enhance the data collection for ED's.	Overdue	4D – Digital, Data & Intelligence	4D.19 Digital Roadmap • 4D.15–4D.16 Legacy system reduction & digital records • 4D.5 RPA & automation opportunities				X
BAF24-07: Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk	Standardising care pathways across the Health Board. Current mapping exercise. Sits within clinical service strategy, community health pathways being rolled out for development in elective care. SPoA 'operational 'phase is commencing in Q1. There are clear performance metrics and expectations assigned to the developments into 2026/27	Overdue	3A – Urgent & Emergency Care 3B – Planned Care 4C – Clinical Services Planning	3A.4–3A.12 UEC care pathway redesign • 4C.1–4C.4 CSP methodology & service redesign 3B.2 Planned care 3B.5 Planned care			X	X

BAF24-07: Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk	Re-enforce specialty level planning cycle through service line demand and capacity plan across the Health Board. Reinforced with services, complete. To be evidenced in April 2026 through Plans. Demand & capacity (D&C) planning session held in April to review core demand and capacity planning across specialties within Q1 to confirm the position for 2026/27. A further session is scheduled in May with a specific focus on Cancer and Diagnostics to enable more detailed discussions on demand and capacity for 26/27. This will be supported by a 'planned care sprint' to improve booking of long waiters into core capacity and transfers of care to appropriate services	Overdue	Outstanding for update as at 22/05/2026	Outstanding for update as at 22/05/2026				
BAF24-07: Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk	Strengthened workforce planning for key areas linked to challenged services.	Overdue	4J – Workforce 4A – Foundations for the Future	• 4J.7 Strategic workforce planning • 4J.1–4J.4 Workforce productivity controls • 4A.1 Leadership, culture & engagement improvement				X
BAF24-07: Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk	Telehealth care to strengthen out of hospital care including home systems and video facilitated care forms workstream 1 or 4 for UEC.	Overdue	2A – Primary Care 1B – Prevention 4D – Digital, Data & Intelligence	2A.8 Digital innovation in primary care (NHS app, virtual care) • 1B.3 Preventive digital interventions • 4D.19 Digital Roadmap	X	X		X
BAF24-07: Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk	Continued efforts to further strengthen collaboration with local authorities and voluntary sectors for integrated care delivery models. Milestones to be reported. Operational workshop to be held in May with health & Social care partners to discuss development of a 12 month plan for implementation	Overdue		Outstanding for update as at 22/05/2026				
BAF24-07: Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk	Incorporate public health needs analysis to service planning (such as deprivation links to access for UEC, Planned Care, CAMHS and Womens services).	Overdue	1B.1–1B.3 PHM intelligence • 4B.1–4B.3 Strategy Discovery/Design/Delivery • 3A.1–3A.3 UEC prevention & falls pathways 4C.1-4C.4	• 1B – Population Health 4B – Strategy & Planning 4C Clinical Services Plan 3A – UEC	X		X	X
BAF24-07: Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk	Regional improvement approach for Child and Adolescent Mental Health (CAMHS)and Childrens Neurodevelopmental Services. CAMHS Improvement Plan revised for 2026/27 to sustain delivery of the Mental Health Measure access targets which the HB achieved in 2026/27 for assessment and intervention. The Childrens ND 3-year improvement plan has been agreed with RPB to implement a needs-led Childrens ND delivery model across health, social care and education. Confirmation of WG funding allocation (£2m) 26-27 for ND assessments, received in April. Approval from Exec Committee & PFIG subsequently confirmed for the continued use and extension of the private provider contract for children's ND assessments to support delivery against WG expectations for 2026/27.	Overdue	3E – CAMHS & ND 3D – MHLD 4C – Clinical Leadership & CSP 1A - Preventative Approaches to Health & Wellbeing 4B - Strategy & Planning	3E.1–3E.6 CAMHS & ND redesign • 3D.9 EHR for MHLD • 4C.3 CSP alignment with challenged services 1A.3 Deliver approved Grant Funded Programmes of work (WSA) 4B.5 Draw on support for NHS P&I colleagues	X		X	X
BAF24-08: Not Implementing Evidenced Based Improvement and Innovation	Develop a model for Cancer Referrals and activity for single modality. Work is continuing with cancer services looking at breast pathways. Stage 1 demand for all tumour sites has been assessed against ringfenced capacity to incorporate into Referral to Treatment demand and capacity work, linked to workstream 6 of the Planned Care Programme. Due to operational challenges and the complexity of cancer pathways and associated data, current focus is on short term operational forecasting and we will with colleagues from NHS Performance & Improvement to develop longer term (annual and beyond) forecasting tools for the cancer pathways. Revised due date 30/06/2026 from 30/11/2025)	Delayed	3B – Planned Care, Cancer & Diagnostics 4D – Digital, Data & Intelligence	• 3B.7–3B.15 Cancer pathway optimisation & diagnostics modernisation • 4D.1 Demand & capacity modelling • 4D.10 Transition to cloud analytics			X	X
BAF24-08: Not Implementing Evidenced Based Improvement and Innovation	Strengthen collaborative research projects with university partners. Draft 'Research Strategy on a Page' developed with Bangor University for consideration by the BU & BCUHB Strategic Steering Group which is due to meet on 8th May 2026. Action delayed from 31/03/2025 to 31/05/2026	Delayed	4E – Research, Development & Innovation	• 4E.1–4E.5 Research, Development & Innovation strategic plan, joint appointments & academic partnerships				X
BAF24-08: Not Implementing Evidenced Based Improvement and Innovation	Strengthen academic career pathways with universities Academic Careers Community of Interest Working Group has been established and draft framework developed. The community of Interest is to be established during 2026/27. The development of this is to be supported by focus groups and workshops approach. A paper for the consideration of Executive Committee was considered on 4th March 2026 and agreement reached regarding support pending a further paper with a business case approach describing anticipated benefits and costs. Delayed from 31/03/2025 to 31/05/2026.	Delayed	4F – Education Partnerships & Academic Careers	• 4F.7–4F.11 Academic careers framework; governance for strategic education planning; HEI partnerships				X

BAF24-08: Not Implementing Evidenced Based Improvement and Innovation	Strengthen collaboration with Higher and Further Education partners across North Wales Memoranda of Understanding have been developed with Bangor and Wrexham Universities as well as Group Llandrillo Menai and College Cambria. Signing is complete apart from CC which is expected to take place in April/May. Strategic Steering Groups are in place with Bangor, Wrexham and GLIM with arrangements to follow with CC in April/May. The collaborative partnerships will progress and mature during the course of 2026/27.	Progressing	4F – Education Partnerships & Academic Careers	• 4F.1–4F.6 HE/FE partnerships; Medical School & Dental School collaboration; MoU implementation				X
BAF24-08: Not Implementing Evidenced Based Improvement and Innovation	Increase R&D collaboration with industry and academic institutions. MoUs have been developed as described above. Collaborations with industry have resulted in a number of joint bid applications to i4i, Contracts for Innovation and NIHR. BCU staff have presented nationally at events such as BioWales London, Cancer innovation.	Overdue	• 4E.2–4E.5 Innovation Centre development; external funding; research activity expansion	4E – Research, Development & Innovation				X
BAF24-08: Not Implementing Evidenced Based Improvement and Innovation	Secure additional funding for healthcare innovation projects. A number of grant applications are being developed or are awaiting decision from funders. To date funding has been secured from Welsh Government Innovation and from Contracts for Innovation.	Overdue	• 4E.2 Innovation Centre & funding model • 4E.4 Growth of research studies and income	4E – Research, Development & Innovation				X
BAF24-08: Not Implementing Evidenced Based Improvement and Innovation	Increase the number of joint appointments between the Health Board and academic institutions. A number of honorary appointments have been awarded, and a joint research fellow post has been appointed to. A joint research fellow post in cardiology is in progress. We are awaiting decision regarding readvertising the joint post in cancer services.	Overdue	• 4F.7–4F.11 Academic careers pathways & joint roles • 4E.3–4E.5 Embedding research into clinical roles	4F – Academic Careers 4E – Research, Development & Innovation				X

Planning, Population Health & Partnerships Committee – Non-Routine Committee Business Workplan

(1 April 2026 – 31 March 2027)

This forward plan is only to be used for one-off Adhoc items that do not require inclusion as routine business on the Annual Committee Cycle of Business.

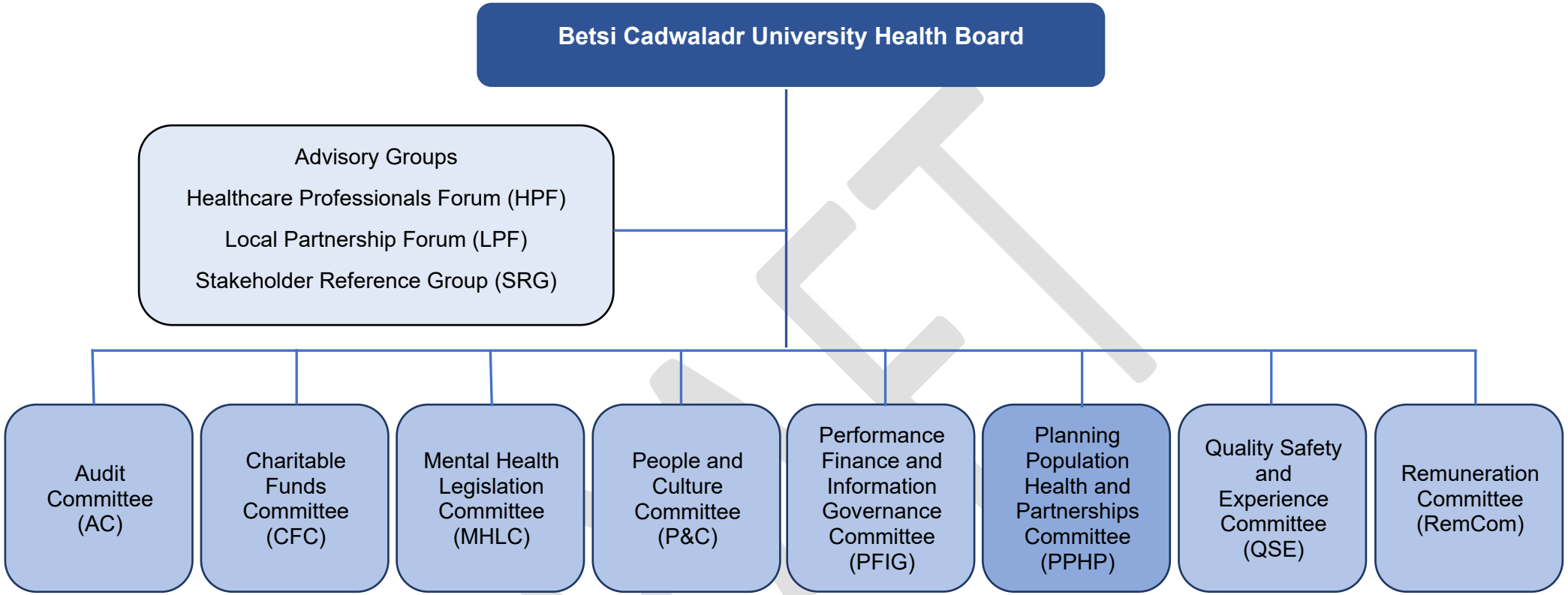
Date of Request	Origin of Request	Requestor	Item Summary / Title	Nature of Request	Lead Officer	Executive Lead	Intended Meeting Date	Status
08.04.26	Email request from Clare Budden	Clare Budden following visit to Pharmacy	Pharmacy Service (aligned with the Pharmaceutical Needs Assessment)	Presentation or Report describing current service offerings / plans for the future. Opportunities and any risks / challenges to achieving BCU's longer term strategic intention. Where we focus much more on well-being / maintaining good health and more community based models of delivery.	Adam Mackridge Lois Lloyd	Tehmeena Ajmal	~~September 26~~ November 26	Agreed at agenda setting to put forward for November meeting
05.03.26	Action PP26.42.1 from Committee	Action from Private PPHP Committee	Third Sector Contracts and Grants	Third Sector Contracts and Grants to report back to the Committee in November 2026 to provide an update on progress in this area (confirm whether this need to report back in private session).	Russell Caldicott	Russell Caldicott	November 26	
27.11.25	Action 25.209.1 from Board	Board and email from Philippa	Healthy Travel Charter	Update to PPHP Committee following sign up by the Board. Links to action 25.209.1 from the Board: Healthy Travel Charter: Progress against the Healthy Travel Charter to report back to the Board in May 2026.	Jane Moore	Stuart Keen	November 26	This is being taken forward by Stuart and will report to the Nov PPHP Committee.
16.03.26	Email trail from Pam and Lois Lloyd	Lois Lloyd and Pharmacy Team	Pharmaceutical Needs Assessment	Paper setting out the oversight arrangements	Adam Mackridge Lois Lloyd	Tehmeena Ajmal	September 26	This is included on the agenda for the September meeting
18.03.26	Email request from Clare Budden	Clare Budden (with agreement from Jane Moore)	Denbighshire County and Marmot	Report to focus on what role BCU will have and how partnership working is developing to support this. How it will be measured and what success will look like. How does it tie in with Community By Design and the Wellbeing, Prevention and Anchor framework work. Provide assurance on how everything fits together and contributes to the Ten-Year Strategic plan and Strategic Intent statements. Including a focus on how they deliver change building on the work already done to test ways of moving from plans and strategies to delivery.	Jane Moore	Jane Moore	September 26	This will be covered at the September meeting as part of the Wellbeing Prevention and Anchor Framework Report

PLANNING, POPULATION HEALTH AND PARTNERSHIPS COMMITTEE

Terms of Reference & Operating Arrangements

(Schedule 3.5 of the Standing Orders)

Date approved by Health Board:



Version Control

Version	Issued to	Date	Comments
V0.01	Planning, Population Health & Partnerships Committee	01.05.25	Endorsed for approval at the May Board
V1.0	Board	29.05.25	Approved
V1.01	Planning, Population Health & Partnerships Committee	03.09.26	Seek endorsement for submission to the Board

TERMS OF REFERENCE

1 INTRODUCTION

1.1 The Betsi Cadwaladr University Health Board (BCUHB) Standing Orders provide that "The Board may and, where directed by the Welsh Government must, appoint Committees of the Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees

1.2 In accordance with Standing Orders (and the BCUHB scheme of delegation), the Board shall nominate annually a committee to be known as the Planning, Population health and Partnerships Committee. The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set in this document.

2 PURPOSE

The purpose of the Committee is to act on behalf of the Board to:

2.1 Provide advice and assurance to the Board with regard to the development and oversight of the Health Board's long term planning, Integrated Medium Term Plan and Annual Operating Plan ensuring that enabling strategies are aligned to these plans.

2.2 Ensure effective partnership arrangements are in place to improve Population Health (i.e primary care, public health and the social determinants of health) and reduce health inequalities.

2.3 Provide oversight, delivery and monitoring (by exception) of Population Health improvement and health inequalities strategies, policies and performance informed through Population Need's Assessment.

2.4 Seek assurance on the management of principal risks within the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) allocated to the Committee and provide assurance to the Board that risks are being managed effectively and report any areas of significant concern.

3 DELEGATED POWERS

With regard to its role in acting on behalf of the Board, and in providing advice and assurance to the Board, the Planning, Population health and Partnerships Committee will comment specifically upon:

3.1 Providing advice, assurance and support to the Board on compliance with legislation, guidance and best practice relevant to the Planning, Population Health and Partnerships agenda, learning from work undertaken nationally

and internationally, ensuring the Health Board can continually improve the quality of healthcare for the population.

3.2 Providing advice and insight to the Board on the implementation of the strategies related to the Committee's remit and assurance that it is consistent with the Board's overall strategic direction and with any requirements and standards set for NHS bodies in Wales.

3.3 Providing advice, assurance and insight to the Board on the organisation's ability to create and manage strong planning, population health and partnership arrangements, including through a robust data strategy.

3.4 Providing the Board with advice and insight on the development of the Health Board's Integrated Medium Term Plan (IMTP), and long term planning based on robust business intelligence and modelling, and assuring the development of delivery plans within the scope of the Committee including their alignment to the Population Health Needs assessment. Seeking assurances on all outstanding plans in relation to the National Networks and Joint Committees including commitments agreed with partner organisations.

3.5 Receiving assurance through any update reports (that may be in existence or developed) and other management group reports that risks relating to their areas are being effectively managed across the whole of the Health Board's activities (including for hosted services and through partnerships and Joint Committees as appropriate).

3.6 Oversee the development of the Health Board's strategies and plans for maintaining the trust of patients and public through its arrangements for handling and using information, including personal information, safely and securely, consistent with the Board's overall strategic direction and any requirements and standards set for NHS bodies in Wales.

3.7 Oversee the direction and delivery of the Health Board's information governance strategies to drive change and transformation in line with the Health Board's integrated medium term plan that will support modernisation using information and technology.

3.8 Consider the information governance implications arising from the development of the Health Board's corporate strategies and plans or those of its stakeholders and partners.

3.9 Consider the information governance implications for the Health Board of internal and external reviews and reports.

3.10 Oversee the development and implementation of a culture and process for data protection by design and default (including Privacy Impact Assessments) in line with legislation (e.g. General Data Protection Regulation).

3.11 Oversee the direction and delivery of the Health Board's Cyber security policy (details of which will be taken in private session of the committee)

3.12 Oversee the direction and delivery of the Health Board's Patient records management.

3.13 Oversee the direction and delivery of the Health Board's National systems and programmes.

3.14 ~~Receiving assurance on the development of plans for Digital and Information Management noting that operational assurance of Information Governance requirements is under the remit of the Health Board's Performance, Finance and Information Governance Committee.~~

3.15 Seeking insights and relevant information from Committee Advisory Groups where relevant to the remit of this agenda.

3.16 Assuring the Board in relation to its compliance with relevant national practice, mandatory guidance, healthcare standards and duties, including Duty of Quality, Duty of Candour, Quality Standards, Quality Management and the Civil Contingencies Act ensuring the Board is supported to make strategic decisions from a quality perspective.

4 AUTHORITY

4.1 The Committee may investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any:

- Employee - and all employees are directed to cooperate with any legitimate request made by the Committee; and
- Other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

4.2 It may also obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

5 SUB-COMMITTEES

5.4 The Committee may, subject to the approval of the Health Board, establish sub-committees or task and finish groups to perform specific aspects of Committee business.

6 MEMBERSHIP

6.1 Formal membership of the Committee shall comprise of the following:

MEMBERS
Independent Member (Chair)
2 x Independent Members (one of whom will be designated as Vice Chair)

6.2 The following should attend Committee meetings:

IN ATTENDANCE
Executive Director of Transformation, Strategic Planning and Commissioning (Executive Lead)
Executive Director of Public Health
Director of Partnerships, Engagement and Communications
Chief Digital and Information Officer
Chief Operating Officer

6.3 The attendance of the Committee shall be determined by the Board, based on the recommendation of the Health Board Chair, taking into account the balance of skills and expertise necessary to deliver the Committee's remit, and subject to any specific requirements or directions made by the Welsh Government.

6.4 Other Directors/Officers will attend as required by the Committee Chair, as well as any others from within or outside the organisation whom the Committee considers should attend, taking into account the matters under consideration at each meeting.

5. COMMITTEE MEETINGS

5.1 Quorum

- A quorum shall consist of no less than two of the membership, and must include as a minimum the Chair or Vice Chair of the Committee.

5.2 Frequency of meetings

- The Committee will meet bi-monthly and an annual schedule of meetings will be determined by the corporate calendar.

- Any additional meetings will be arranged under exceptional circumstance and shall be determined by the Chair of the Committee in discussion with the Executive Lead.

5.2 Withdrawal of individuals in attendance

- The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

5.3 Meeting arrangements

- The agenda and papers will be distributed/published seven days in advance of the meeting.

- The Director of Corporate Governance is to hold an agenda setting meeting with the Chair and/or Vice Chair and the Executive Director Transformation, Strategic Planning and Commissioning at least six weeks before the meeting date.

- The agenda will be based on the Committee work plan, identified risks, matters arising from previous meetings, issues emerging throughout the year, and requests from Committee members.

6. REPORTING AND ASSURANCE ARRANGEMENTS

The Committee, through its Chair and members, shall work closely with the other Committees to provide advice and assurance to the Board through joint planning and co-ordination of Board and Committee business including sharing information.

6.1 The Committee Chair, supported by the Committee Secretary, shall:

- Report formally, regularly and on a timely basis to the Board on the Committee's activities;
- Bring to the Board's specific attention any significant matter under consideration by the Committee; and
- Ensure appropriate escalation arrangements are in place to alert the Health Board's Chair, Chief Executive and/or Chairs of other relevant Committee, of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

6.2 The Committee will undertake an annual review on the effectiveness of its arrangements and responsibilities. The Director of Corporate Governance will oversee this review.

7. RELATIONSHIP WITH THE BOARD AND ITS COMMITTEES/GROUPS

Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these Terms of Reference, it retains overall responsibility and accountability for these matters.

7.1 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference.

7.2 The Committee, through its Chair and members, shall work closely with the Board's other committees, including joint (sub) committees and groups to provide advice and assurance to the Board through the:

~ Joint planning and co-ordination of Board and Committee business and
~ Sharing of information

In doing so, it will contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

7.3 The Committee will consider the assurance provided through the work of the Board's other committees and sub groups to meet its responsibilities for advising the Board on the adequacy of the Health Board's overall system of assurance.

7.4 The Committee shall embed the Health Board's corporate standards, priorities and requirements, e.g. equality and human rights through the conduct of its business.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in the Health Board's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

9. REVIEW

These Terms of Reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board.

10. CHAIR'S ACTION ON URGENT MATTERS

10.1 There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Board – after first consulting with **all** Members of the Committee. The Secretariat must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

10.2 Chair's action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

PLANNING, POPULATION HEALTH AND PARTNERSHIPS COMMITTEE

Annual Report 2025-26

FOREWORD

I am pleased to present the 2025-26 Annual Report of the Planning, Population Health and Partnerships Committee.

During the year, the Committee discharged its delegated responsibilities on behalf of the Board by providing oversight, scrutiny and assurance in relation to strategic planning, population health improvement, partnership working, service transformation and the delivery of the Health Board's long-term objectives.

The Committee received regular reports on the development and delivery of strategic plans, population health and health inequalities, regional and local partnership arrangements, service planning, performance against key objectives and other matters within its delegated remit.

Through its work, the Committee was able to provide assurance to the Board in a number of key areas whilst identifying matters that require continued scrutiny and oversight during 2026-27. These include delivery of the Health Board's strategic objectives, reducing health inequalities, strengthening partnership arrangements, ensuring effective planning and transformation arrangements, and maintaining a clear focus on population health outcomes.

The remainder of this report summarises the assurance received, the challenge provided by Committee members and the key areas requiring continued attention

Clare Budden
Chair of the Planning, Population Health and Partnerships Committee

Annual Report 2025 - 2026

1. Introduction

1.1 This report provides the Board with an annual summary of the assurance received by the Planning, Population Health and Partnerships Committee during 2025-26. It describes how the Committee discharged its delegated responsibilities on behalf of the Board and identifies the key areas of oversight, assurance and ongoing focus for 2026-27.

1.2 The Committee's work during the year was guided by its Terms of Reference and Cycle of Business, which supported the systematic consideration of key matters within its remit. The Committee considered reports and updates relating to strategic planning and delivery, population health improvement, prevention and health inequalities, partnership working, public engagement, digital transformation, public health programmes and the management of associated strategic risks.

1.3 Through its work, the Committee sought assurance that appropriate arrangements were in place to support delivery of the Health Board's strategic priorities relating to long-term planning, improving population health outcomes, reducing health inequalities, strengthening partnership arrangements, enhancing citizen engagement and supporting sustainable service transformation.

2. Role and Responsibilities

2.1 The primary purpose of the Committee is to act on behalf of the Board to:

2.1.1 provide advice and assurance to the Board with regard to the development and oversight of the Health Board's long term planning, Integrated Medium Term Plan and Annual Operating Plan ensuring that enabling strategies are aligned to these plans.

2.1.2 ensure effective partnership arrangements are in place to improve Population Health (i.e., primary care, public health and the social determinants of health) and reduce health inequalities.

2.1.3 provide oversight, delivery and monitoring (by exception) of Population Health improvement and health inequalities strategies, policies and performance informed through Population Need's Assessment.

2.1.4 seek assurance on the management of principal risks within the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) allocated to the Committee and provide assurance to the Board that risks are being managed effectively and report any areas of significant concern.

3. Agenda Planning Process

3.1 The Chair of the Committee, in conjunction with the Executive Lead and Corporate Governance Directorate develop the final agenda for the Committee meetings.

3.2 The venue, location and other administrative arrangements are organised a year in advance where possible.

3.3 The secretariat for the meeting is provided by Laura Jones.

3.4 The agenda and papers are disseminated to Committee members prior to the date of the meeting. Where appropriate all papers are accompanied by a cover sheet which provides an executive summary and guidance to the Committee on the action required.

4. Operating Arrangements

4.1 The Committee reviewed its Terms of Reference and operating arrangements during the year. A minor amendment was made to ensure the Committee's remit remained clear, current and aligned to the Board's assurance requirements.

4.2 The Committee also reviewed its Cycle of Business, which provided a structured framework for ensuring that key matters within the Committee's remit were scheduled for consideration during the year. The agenda remained sufficiently flexible to allow the Committee to consider emerging issues and areas requiring additional scrutiny.

5. Membership, Frequency and Attendance

5.1 The Terms of Reference state that the Committee should consist of a minimum of three members of the Board.

5.2 During the year the Committee met on six occasions with member attendance as follows:

Name	Attendance
Clare Budden, Committee Chair	Six out of six meetings
Gareth Williams, Committee Vice Chair	Four out of six meetings
Caroline Turner	Five out of six meetings
Williams Nichols, Trade Union Representative	Six out of six meetings

5.3 The Committee requires the attendance of other Health Board Officers for advice, support and information routinely at meetings. It may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

6. Committee Activity

During 2025-26, the Committee considered a wide range of reports and updates aligned to its delegated remit. The Committee's business can be summarised under the following assurance themes:

6.1 Strategic Planning and Delivery

The Committee maintained oversight of the Health Board's strategic planning framework throughout 2025-26. This included consideration of the Integrated Medium Term Plan, Annual Delivery Plan, Health Board Strategic Intentions and associated planning reports. The Committee sought assurance that planning arrangements remained aligned to Welsh Government requirements, population need and organisational priorities, and that progress against key milestones was regularly monitored and reported.

6.2 Population Health and Prevention
The Committee received regular updates regarding population health improvement, prevention and reducing health inequalities. This included scrutiny of the Outline Prevention Plan 2025-28, Diabetes Transformation Programme, Health Protection Service, substance misuse initiatives, homelessness reduction activity and wider population health programmes. Through consideration of these reports, the Committee sought assurance that programmes were supporting improved health outcomes and addressing areas of greatest need across North Wales.

6.3 Partnerships, Engagement and Citizen Experience
The Committee considered reports relating to citizen engagement, communications and partnership working. It received assurance regarding activity to strengthen engagement with citizens, communities and partners and sought evidence that collaborative approaches were informing service planning, delivery and strategic decision-making. The Committee recognised the importance of effective partnerships in supporting population health improvement and sustainable service development.

6.4 Enabling Strategies and Organisational Development
The Committee maintained oversight of a range of enabling strategies and programmes, including Digital, Data and Technology, decarbonisation, workforce wellbeing and emergency preparedness arrangements. The Committee sought assurance that these programmes were progressing appropriately and supporting delivery of the Health Board's longer-term strategic ambitions.

6.5 Public Health, Resilience and System Leadership
The Committee received the Director of Public Health Annual Report together with reports relating to winter resilience, civil contingencies and emergency preparedness. The Committee sought assurance regarding the Health Board's readiness to respond to emerging challenges and its ability to work effectively with partner organisations to support the health and wellbeing of the population it serves.

7. Key Achievements/Benefits:

7.1 During 2025-26, the Committee continued to provide oversight and assurance across a broad range of strategic planning, population health and partnership-related matters. Key areas of focus and achievement included:

- Providing oversight of the development, delivery and monitoring of the Health Board's Integrated Medium Term Plan and Annual Delivery Plan, ensuring alignment with strategic priorities and Welsh Government expectations.
- Strengthening Board visibility of population health priorities, prevention initiatives and programmes aimed at reducing health inequalities across North Wales.
- Receiving assurance regarding the effectiveness of partnership working and stakeholder engagement, including opportunities to hear directly from partner organisations and strengthen collaborative approaches to improving outcomes for the population served.
- Monitoring progress in relation to Digital, Data and Technology programmes, recognising the importance of digital transformation as an enabler of service improvement and organisational sustainability.
- Providing oversight of key public health, resilience and prevention programmes, including winter planning, health protection, substance misuse and homelessness initiatives, supporting a proactive and preventative approach to improving health and wellbeing

8. Key Challenges and Areas of Focus

8.1 During 2026-27, the Committee will continue to develop its role in providing strategic assurance to the Board across planning, population health and partnership arrangements. Particular focus will be placed on monitoring delivery of the Health Board's strategic plans, assessing the impact of prevention and population health interventions, and ensuring that partnership arrangements continue to support delivery of improved outcomes and reduced inequalities.

8.2 The Committee recognises the continuing challenges associated with improving population health outcomes, addressing health inequalities, delivering sustainable services within available resources and responding to increasing system-wide demand. The Committee will continue to provide scrutiny, challenge and assurance in these areas and support the identification of opportunities for innovation, collaboration and service transformation.

9. Committee Effectiveness & Performance

9.1 The Committee regularly reviews its own performance by completing this report on an annual basis, reviewing the cycle of business which provides the Committee with the basis on which it will monitor its progress during the year and also provide clarity for all of those who contribute to the agenda as to the expectations of them.

9.2 A Committee effectiveness questionnaire will be issued in July 2026, the outcome of which will be reported to the Committee in respect of recommendations and subsequent actions in response to areas identified for improvement.

10. Overall Assurance Opinion

10.1 During 2025-26, the Committee discharged its responsibilities in accordance with its Terms of Reference and approved Cycle of Business. Through the reports, presentations and discussions received throughout the year, the Committee was able to provide the Board with assurance that appropriate arrangements were in place in relation to strategic planning, population health improvement, partnership working and service transformation within its remit.

10.2 Whilst assurance has been received regarding the effectiveness of governance, planning and partnership arrangements, the Committee recognises that a number of areas require continued focus and oversight during 2026-27. These include delivery of the Health Board's strategic objectives, reducing health inequalities, sustaining progress in population health improvement, strengthening partnership effectiveness, and ensuring that transformation and service planning arrangements continue to deliver measurable benefits and improved outcomes for the population of North Wales.

11. Conclusion and way forward

11.1 The Committee is very grateful to all those involved in the work of the Committee for their support over the past 12 months, and for the constructive and positive way in which they have contributed to the activity.

11.2 The Committee will continue to ensure that it conducts its business in accordance with legislation and best practice.

11.3 It will provide the assurance that the Committee has in place the appropriate governance arrangements and resources to ensure success in achieving its objectives.

12. Further Information

Please visit the Health Board's websites for further information as outlined below:
Committees and Advisory Groups - Betsi Cadwaladr University Health Board

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PLANNING, POPULATION HEALTH & PARTNERSHIPS COMMITTEE SELF ASSESSMENT

2025-2026 Results Summary

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Planning, Population Health & Partnerships Committee Self Assessment 2025-26: Headline Feedback

- Overall feedback is broadly positive, with responses agreeing or strongly agreeing across most areas
- Terms of reference, annual review arrangements, cycle of business, meeting culture, chairing and secretariat support show clear strengths
- Areas to clarify include awareness of annual reporting, internal assurance visibility, quality of papers and audit action monitoring
- Responses indicate the Committee is operating positively, with targeted opportunities to further strengthen assurance arrangements

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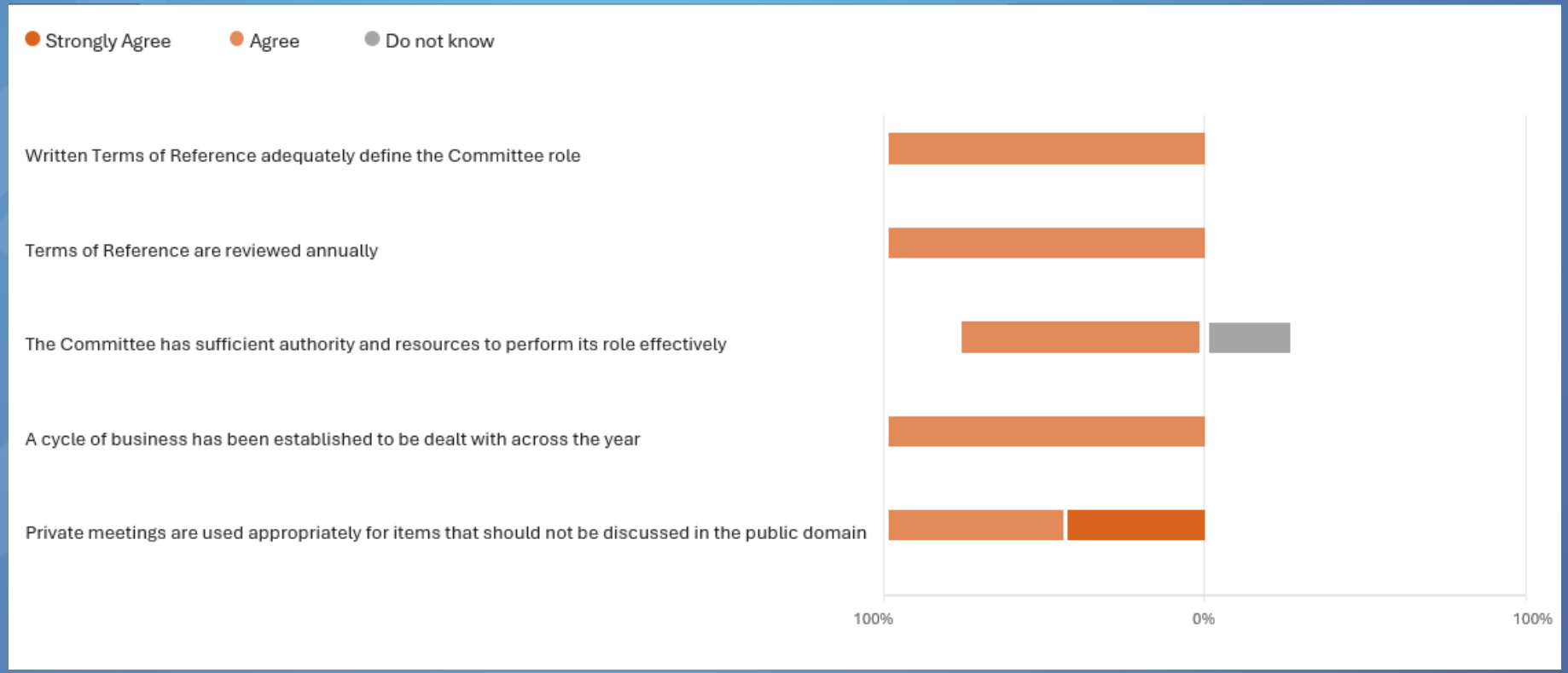
Composition, Establishment and Duties

- There is clear recognition of written Terms of Reference, annual review arrangements and the established Cycle of Business
- Awareness of the Annual Report could be strengthened, with mixed responses recorded



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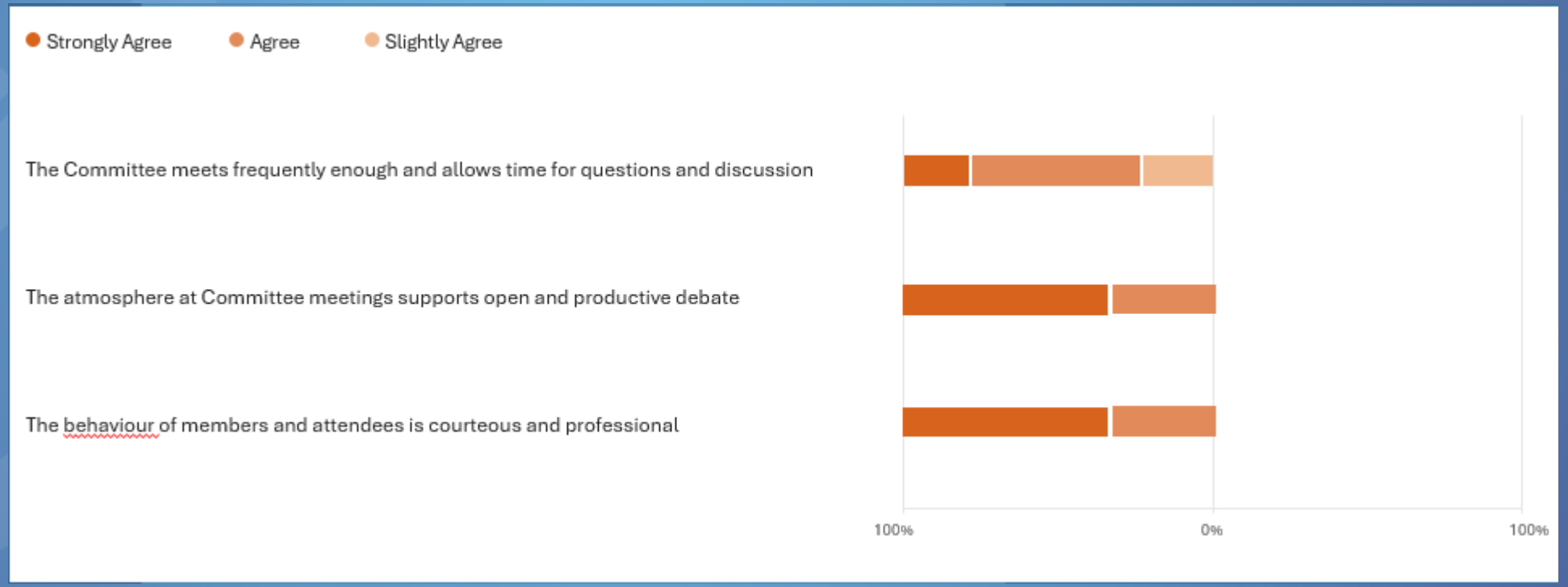
Meeting Culture and Effectiveness

- Meeting frequency and time for discussion were generally rated positively
- Meeting atmosphere and open and productive debate received a high level of agreement
- Members attendee behaviour was rated positively as courteous and professional



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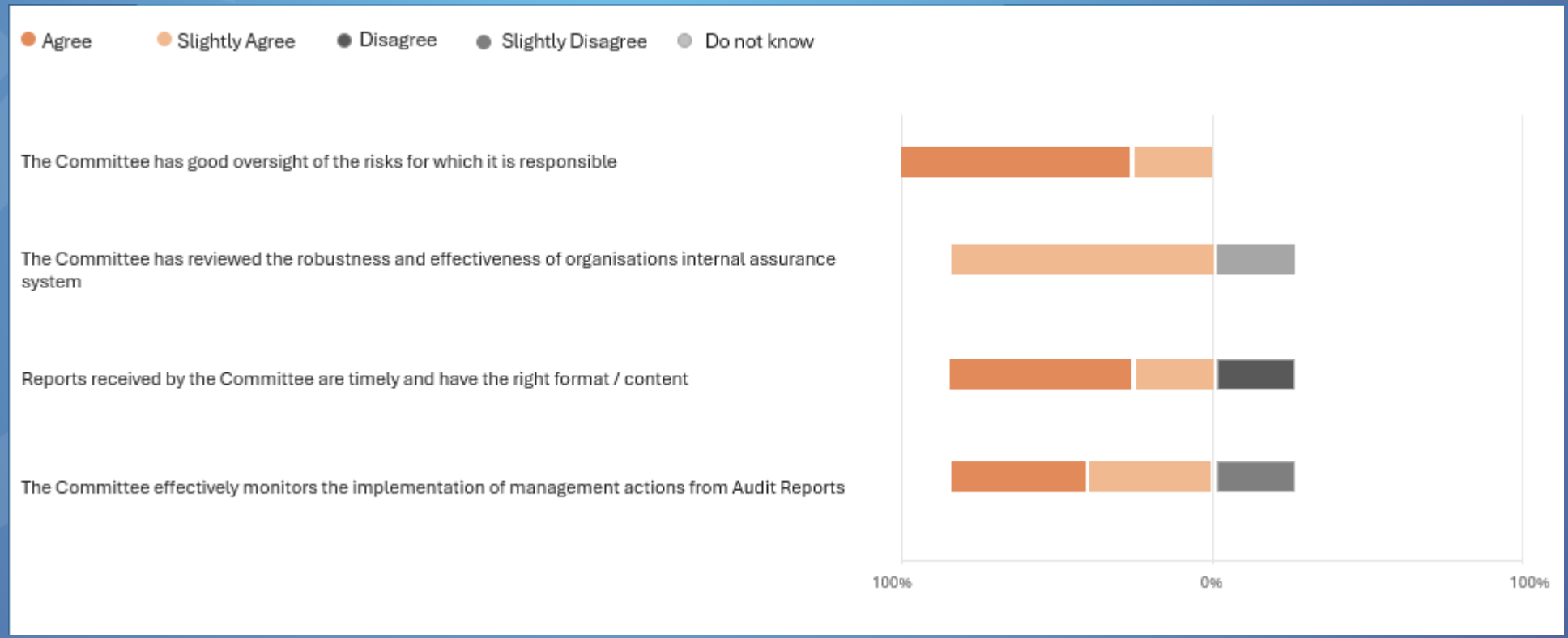
Internal Controls, Risk Management and Assurance

- Risk oversight was rated positively, with most respondents agreeing good oversight of relevant risks
- Responses indicate opportunities to strengthen assurance visibility, report quality and audit action monitoring
- One comment raised concerns regarding the quality of papers



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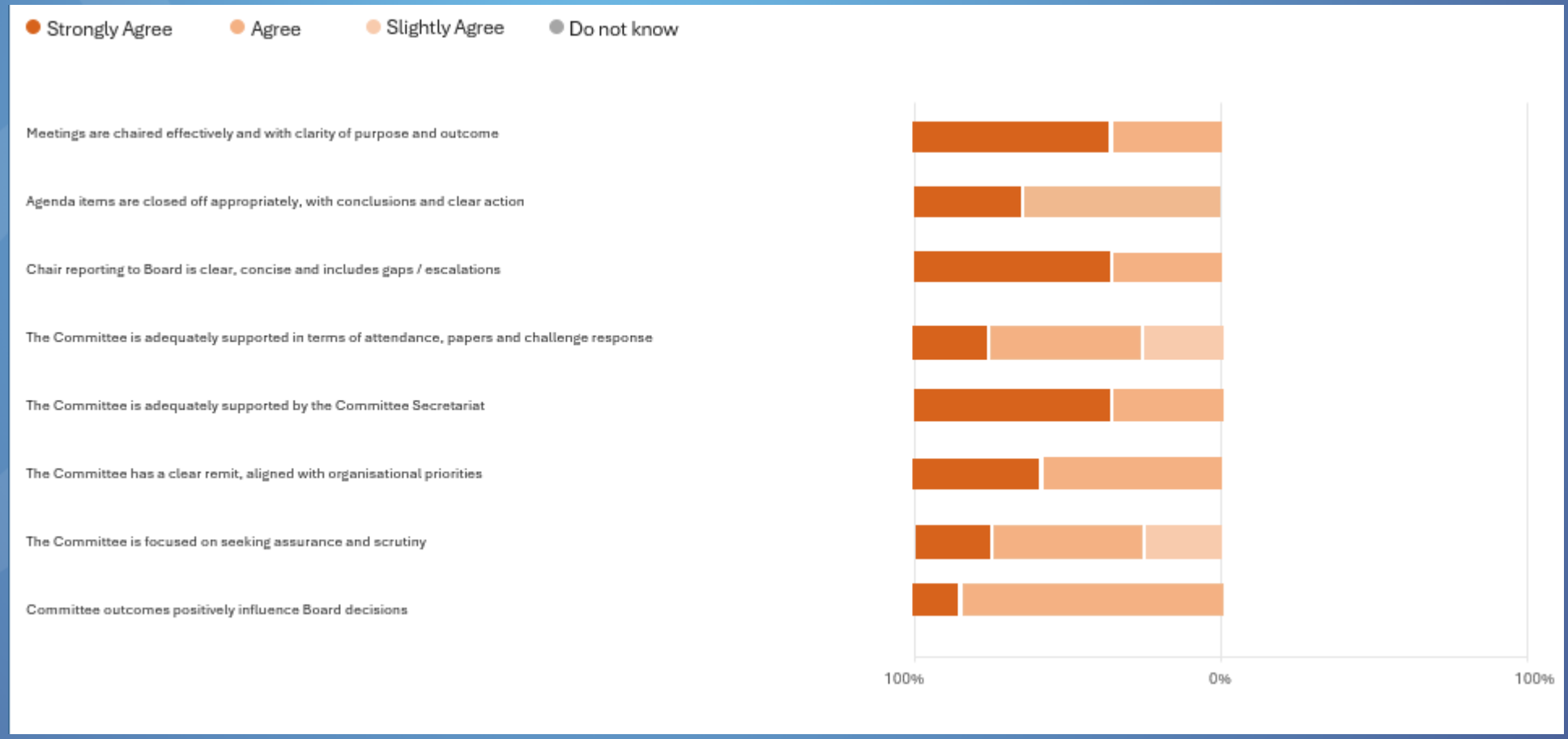
Committee Leadership and Support

- Chairing, clarity of outcomes, secretariat support and Board reporting were rated positively
- Responses suggest continued focus on Executive Director support and maintaining a clear assurance and scrutiny remit



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Overall Summary

Overall Position:

- Clear Terms of reference, annual review arrangements and cycle of business
- Positive meeting culture, professional behaviour and constructive Committee atmosphere
- Strong chairing, clear closure of agenda items and effective secretariat support
- Positive evidence that Committee outcomes influence Board decisions
- The Committee is operating positively, with targeted opportunities to strengthen assurance visibility, paper quality and awareness of annual reporting

Key areas for improvement:

- Strengthen awareness of the Committee Annual Report and its purpose
- Continue to improve the quality, format and timeliness of reports received by the Committee
- Clarify visibility of Board Assurance Framework review and internal assurance arrangements
- Strengthen monitoring and reporting of audit management actions within the Committee work programme
- Maintain focus on Executive Director support and assurance-based scrutiny