# Bundle BCU Quality, Safety and Experience Committee 5 November 2026

1 PRELIMINARY MATTERS

1.1 13:00 - QS26.146 Welcome & Apologies

1.2 QS26.147 Declarations of Interest

1.3 13:01 - QS26.148 Minutes of the Previous Meeting - 3 September 2026
QS26.148 QSE Unconfirmed Public Minutes 03.09.26

1.4 13:03 - QS26.149 Action Log
QS26.149 QSE Action Log PUBLIC

1.5 13:05 - QS26.150 Patient Story Item
QS26.150 Patient Story

1.6 13:25 - QS26.151 100 Stories Project
QS26.151 100 Stories Project

2 INTEGRATED PERFORMANCE

2.1 13:40 - QS26.152 Integrated Quality Report
QS26.152 Integrated Quality Report November

2.2 14:00 - QS26.153 Integrated Performance Report
QS26.153.1 IQPR Coversheet
QS26.153.2 IQPR

3 STRATEGIC ITEMS

3.1 14:20 - QS26.154 Planned Care - Endoscopy
QS26.154 QSE planned care

3.2 14:35 - QS26.155 Urgent & Emergency Care
QS26.155 QSE UEC update

3.3 14:50 - QS26.156 Learning Disabilities
QS26.156 QSE Learning Disabilities

3.4 15:00 - QS26.157 Clinical Service Plan
QS26.157 QSE CSP Progress Report

3.5 15:10 - QS26.158 Commissioned Services - Insourcing
QS26.158.1 Quality of Commissioned Services
QS26.158.2 Internal Audit Report Q&S Follow up

4 15:20 - BREAK

5 ANNUAL REPORT

5.1 15:30 - QS26.159 Nurse Staffing Act Report
QS26.159.1 QSE Committee - Presentation of the Nurse Staffing Levels V2

QS26.159.2 Nurse Staffing QSE Presentation Oct 2026 V2

5.2 15:40 - QS26.160 HIW Annual Report 25-26
QS26.160 HIW Annual Report 2026

6 GOVERNANCE, RISK & ASSURANCE

6.1 15:45 - QS26.161 Corporate Risk Register
QS26.161.1 Corporate Risk Register Report Cover Sheet
QS26.161.2 CRR App 1-3

6.2 15:55 - QS26.162 Corporate Governance Report
QS26.162 Corporate Governance Report

7 FOR INFORMATION

7.1 QS26.163 Audit Wales - Cancer Review
QS26.163.1 Audit Wales Betsi Cadwaladr cancer services - report
QS26.163.2 Audit Wales BCUHB Cancer Review MRF

8 16:00 - CLOSING BUSINESS

8.1 QS26.164 Agree Items for Referral to Board / Other Committee

8.2 QS26.165 Review Meeting Effectiveness

8.3 QS26.166 Date of the Next Meeting - 14 January 2027

8.4 QS26.167 Resolution to Exclude the Press and Public

**Betsi Cadwaladr University Health Board (BCUHB)**
**Unconfirmed Minutes of the Quality, Safety & Experience Committee**
**held in Public on 3 September 2026**
**held in the Boardroom, Carlton Court and via Microsoft Teams**

| **Committee Members Present** | |
|---|---|
| **Name** | **Title** |
| Dr Caroline Turner | Independent Member, Chair |
| Urtha Felda | Independent Member |
| Prof Mike Larvin | Independent Member |
| **In Attendance** | |
| Dr Clara Day | Executive Medical Director |
| Dyfed Edwards | BCU Chairman (via teams) |
| Bridget Elliott | Recovery Director - UEC |
| Alison Griffiths | Director of Nursing |
| Naomi Holder | Interim Director of Nursing |
| Matt Joyes | Deputy Director of Legal Services |
| Joanne Kendrick | Head of Quality |
| Lois Lloyd | Chief Pharmacist |
| Jane Moore | Executive Director of Public Health |
| Teresa Owen | Executive Director of Allied Health Professionals & Health Sciences |
| Geoff Ryall-Harvey | Llais |
| Olivia Shorrocks | Director of Performance |
| Pam Wenger | Director of Corporate Governance (via teams) |
| Rachel Wright | Lead Patient Experience & Carers Service |
| **Committee Support** | |
| Philippa Peake-Jones | Head of Corporate Governance |
| Harriet Abbott | Secretariat |

| **PRELIMINARY MATTERS** |
|---|
| **QS26.120 Welcome and Apologies**<br><br>The Chair welcomed members to the meeting. Apologies were received from Chris Lothian-Field, Chris Lynes and Stuart Keen. |
| **QS26.121 Declarations of Interest**<br><br>No declarations of interest were received. |
| **QS26.122 Unconfirmed Minutes of the Meeting held on 2 July 2026**<br><br>Members reviewed the minutes. A number of minor phrasing and grammatical corrections were advised.<br><br>It was resolved, that the Committee: |

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- **APPROVED** the minutes of the meeting held on 2 July 2026 subject to the minor amendments.

**QS26.123 Matters Arising & Action Log**

Members reviewed the action log. Updates against the following actions were noted:

- Action QS26.10.1: it was agreed that this action was no longer required, as further information on fragile services had been received since the initial update.
- Action QS26.69.1: it was agreed to close this action, as the topic was covered at a recent board development session.

A number of actions refer to topics for a Committee Development Session, which is due to take place before the end of the calendar year. A date will be shared with members in the coming weeks.

It was resolved, that the Committee:

- **AGREED** to close all actions proposed for closure.

**QS26.124 Patient Story Item**

The Committee received a patient story focused on Emergency Departments (EDs), highlighting themes of advocacy, communication, patient experience within the Acute Medical Unit (AMU), and the impact on the patient and family.

In discussing the item, the Committee:

- Thanked the patient for sharing their experience and emphasised the importance of ensuring the patient voice is heard, and that learning from events is embedded across the organisation.
- Highlighted the importance of effective communication and discussed the importance advocacy arrangements.
- Referenced challenges associated with paper-based records and the benefits of an electronic health record system in supporting continuity of care and patient advocacy.
- Acknowledged that a number of improvement shad been made since the event outlined in the patient story, with further response expected on outstanding queries.
- Noted forthcoming work with NHS Performance & Improvement to support the embedding of learning and continuous improvement.

It was resolved, that the Committee:

- **NOTED** the update.

**INTERGRATED PERFORMANCE**

**QS26.125 Integrated Quality Report**

*[Danielle Edwards joined the meeting].*

The item was presented by the Executive Medical Director. The following points were highlighted:

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- Areas of concern remain regarding overcrowding in EDs, fragile services and endoscopy waiting list backlogs.
- Four additional Never Events occurred during the reporting period.
- There have been a number of changes to the electronic prescribing system, with work ongoing, and changes being embedded.
- The Clinical Executive Delivery Group has been established, with the first meeting scheduled for mid-September, with the aim of aiding collaboration, supporting risk management and resolution regarding quality and safety matters.

In discussing the item, the Committee:

- Reflected on the four never events, emphasising the importance of learning from events, ensuring compliance with LocSSIPS (Local Safety Standards for Invasive Procedures) and monitoring associated risks.
- Raised concern regarding the pace of implementation of the Quality Management System (QMS), with emphasis made to ensure strong embedding of quality governance arrangements across the organisation.
- Supported the introduction of the revised risk-based Tier 2 audit programme, and discussed the importance of ensuring audit recommendations are implemented, monitored and reflected in service improvements.
- Raised concerns over findings from the recent HIW inspections at Ysbyty Glan Clwyd Emergency Department. Further discussion took place during the private session.
- Noted increasing volume of incidents and complaints, including overdue incident investigations and emphasised the importance of embedding organisations learning to improve patient experience and outcomes. Members discussed potential factors that may influence complaint levels, such as increased public and media interest.
- Emphasised the importance of staff engagement regarding infection control initiatives.
- Were advised that a deep dive into endoscopy would be provided at the next Committee meeting due to ongoing concerns regarding waiting times and patient backlogs.
- Noted that no new Public Interest Reports had been received during the reporting period.

The following actions were agreed:

- **Action QS26.125.1**: a deep dive on Endoscopy to be undertaken, with update received at the next Committee meeting.

It was resolved, that the Committee:

- **NOTED** the report.

*[Bridget Elliott joined the meeting].*

**QS26.126 Integrated Performance Report**

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

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- An improved position has been seen on previous reports, with the report developing through each reporting period. Information on fragile services will be included as the report develops further.
- The number of patients waiting over 2 years has reduced significantly, down by 59% compared to this time last year. However, an increase of 61 patients has been seen since the end of March 2026. BCUHB remains outlier for Welsh Health Boards.
- A small number of 3-year waits were noted last month, but there is confidence that these will have been removed and actioned this month.
- There has been a recent allocation for Planned Care from the Welsh Government for further improvements. This does not include outsourcing or insourcing work.
- BCUHB has been asked by the Welsh Government to focus on four key targets, detailed within the report and for these to be achieved by the end of September 2026, which is expected to provide some challenge.
- Positive progress has been seen in diagnostics, with use of additional internal working and additional capacity from NHS Trusts in England. Further improvement is still required in endoscopy and ultrasound to reduce waiting times.
- An improved position regarding Cancer Services is noted. Whilst still below target, this is an improvement and above the Special Measures target set by the Welsh Government.

*[Teresa Owen left the meeting].*

In discussing the item, the Committee:

- Highlighted that maternity and neonatal metrics must remain appropriately aligned with quality reporting arrangements as the performance report develops.
- Agreed for comparative performance metrics with other Health Boards to be shared with Committee members for information and awareness.

The following actions were agreed:

- **Action QS26.126.1**: comparative metrics with other Health Boards to be shared with Committee members for awareness.

It was resolved, that the Committee:

- **NOTED** the position.

**STRATEGIC ITEMS**

**QS26.127 Planned Care**

The item was presented by the Programme Manager for Planned Care. The following points were highlighted:

- The report focused on quality aspects of planned care recovery, and the need for sustainable improvements rather than reliance on additional external capacity.
- A Recovery Director for Planned Care is now in post, with a number a speciality led reviews now completed.
- Two submissions for Welsh Government regarding Planned Care were submitted in July 2026 in two phases, with funding now allocated for the first phased focused on reducing waiting times. Work is ongoing to align the recovery plan with the approved submissions and implement the associated actions.

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- Work is underway with Digital to development a platform for validation use.
- Referenced validation of follow up pathways, along with the use of See on Symptom (SOS) and Patient Initiated Follow Up (PIFU).

In discussing the item, the Committee:

- Highlighted the impact of additional funding activity, including the impact in delays in diagnostics and follow up appointments where further review is required. Members noted that whilst the use of outsourcing and insourcing can be beneficial, depending on structure, it can generate and impact on internal waits creating further “bottle necks” in the system.
- Welcomed the inclusion of Cancer Services within the report, and discussed the importance of ensuring recovery plans address population inequalities and the needs of vulnerable groups. Members requested for the Audit Wales Cancer Review report to be included at the next Committee for consideration.

The following actions were agreed:

- **Action QS26.127.1**: Audit Wales Cancer Review Report to be included at the next Committee

It was resolved, that the Committee:

- **NOTED** the update.

**QS26.128 Urgent & Emergency Care**

The item was presented by the Recovery Director for Urgent & Emergency Care. The following points were highlighted:

- Some improvement in performance has been noted, however this has often been sporadic and not sustained for a long time period. It is acknowledged that this is a whole system approach, rather than just improvement required in Emergency Departments. The current position remains challenging.
- Work is ongoing with the Regional Partnership Board, where the Right Place, Right Time dashboard has been shared. This assists in highlighting bottle necks and areas for improvement in collaborative working.

The Executive Medical Director updated further, and highlighted:

- EICOP discussions continue biweekly. The group has created a set of metrics which are key for monitoring care in Emergency Departments.
- Following the HIW visit in May 2026, an action plan was produced, with a follow up visit from HIW undertaken at the end of August. Several areas of improvement were noted from this visit, and this will be reflected in the report published by HIW in September.
- Regarding patient experience, overall satisfaction in ED remains lower than in other service areas. The vast majority of feedback however highlights satisfaction with the care received, but notes dissatisfaction with waiting times.

In discussing the item, the Committee:

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- Emphaissed the importance of consistent targets to enable improvement with clear messaging. It was further clarified that the main focuses of reduction in 12 hour waits and reduction in ambulance handover times has been shared with teams.
- Suggested further site visits from Independent Members to EDs across the organisation and the insight this provides.

It was resolved, that the Committee:

- **NOTED** the report.

*[Bridget Elliott left the meeting and Paolo Tardivel joined the meeting].*

**QS26.129 Fragile Services, Clinical Services Plan & QMS**

The item was presented by the Interim Executive Director of Transformation & Strategic Planning. The following points were highlighted:

- Progress has been made regarding development of the Quality Management System (QMS). Due to changing priorities and leadership responsibilities associated with fragile services and the clinical service plan, it has been proposed to align these with the QMS due to overlap. This will feed into the annual planning cycle moving forward.
- Feedback so far indicates that further work is required to ensure the QMS system is practical and user friendly for services.
- Plastics and Oncology are no longer included within the formal set of “Fragile Services” due to the positive progress seen. The aim of the fragile services framework is to identify weaker areas, to provide support to enable improvement.

In discussing the item, the Committee:

- Noted the summary of fragility indicators included within the report.
- Were advised that work is progressing with Digital and performance to generate the QMS system.
- Welcomed the approach, and highlighted the need to ensure the full system is captured.
- Clarified that endoscopy is scored as red due to waiting list demand and capacity issues. A deep dive in Endoscopy is to be initiated, with an update received at the next Committee meeting.

It was resolved, that the Committee:

- **NOTED** the update.

*[Paolo Tardivel left the meeting].*

**QS26.130 Nurse Staffing Act**

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

- The report outlined the responsibility of the health board to undertake reviews to gain assurance regarding nurse staffing levels.
- The report highlighted current staffing gaps within nursing. It was noted since the review was undertaken, investment had been secured for further establishment

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through the Emergency Department business case approved by the Board in June 2026. Ongoing work continuous to address identified staffing gaps.
- The report noted concerns regarding isolated community hospital wards staffing levels overnight.
- It is expected that the Community by Design programme will impact on staffing models once implemented.

In discussing the item, the Committee:
- Raised concern regarding ongoing workforce shortages within Mental health & Learning Disabilities and Community services, together with recruitment challenges in rural areas. It was discussed whether workforce data could be utilised as an early warning indicator to identify emerging staff pressures across sites.
- Were advised that workforce planning was being considered through the People & Culture Committee.
- Emphasised the importance of care closer to home, noting the increasing correlation between inpatient admission to likelihood of discharge to care home.
- Highlighted the importance of ensuring equity of provision.
- Suggested that the board were alerted to continuing workforce shortfalls for awareness.

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

**QS26.131 Research & Development – Commercial Recovery Plan**

The item was presented by the Chief Pharmacist. The following points were highlighted:
- An Annual Review took place with Welsh Government in April 2026. Through this it was identified that improvement was needed regarding research, from which the recovery place was generated. The plan concerns clinical trials specifically.
- Dedicated capacity is required, with funding now available. Bids have been submitted for a number of areas, with BCUHB awaiting the outcome.
- A quarterly report on the recovery plan will be received at the Executive Committee going forward to monitor progress.

In discussing the item, the Committee:
- Noted the positive aspect of the work, and highlighted the importance of long-term sustainability.

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

*[Geoff Ryall-Harvey left the meeting].*

**GOVERNANCE, RISK & ASSURANCE**

**QS26.132 Board Assurance Framework**

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

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- An overall suggested assurance position has been added to the report, and will be included for the update to the Board in September.
- It is noted that several actions fall under remit of the Chief Operating Officer. Any comments regarding these actions will be taken back to Executive Committee in the interim absence of the Chief Operating Officer.

In discussing the item, the Committee:

- Raised concerns regarding limited progress the Quality Managements System and implementation noted under an action, noting a number of actions with low delivery confidence. It was clarified that this related to reduced capacity as well as the current vacancy of the Executive Director of Nursing role. This is expected to be temporary.

It was resolved, that the Committee:

- **NOTED** the report.

**QS26.133 Corporate Governance Report**

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

- The Committee self-assessment report was shared as part of the supporting papers. This has been completed for all Committee during this cycle.

In discussing the item, the Committee:

- Agreed to review the findings of the Committee self-assessment, findings from the Well Led Review and the recent Audit Wales report on quality governance within an upcoming development session. It was requested for this to be scheduled before the end of the calendar year.

The following actions were agreed:

- **Action QS26.133.1**: Development session to be held by December 2026, and to consider the committee self-assessment, well led review findings and Audit Wales Quality Governance report.

**FOR INFORMATION**

**QS26.134 Mental Health Oversight Group – AAA Report**

The Committee reviewed the report. In discussing the item, the Committee:

- Were advised that the ligature programme board is scheduled. This issue was also highlighted in the recent PPHP Committee.
- Were advised that an update on the outcome framework was reiceved at the Board meeting in July 2026. Work is progressing and an update will be given to committee at an upcomign meeting.

It was resolved, that the Committee:

- **NOTED** the report.

**CLOSING BUSINESS**

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**QS26.135 Agree Items for Referral to Board / Other Committees**

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

- There are workforce implications arising from nurse staffing reviews, with particular focus on recruitment, retention, workforce supply and the development of sustainable staffing models across Mental Health and Learning Disabilities and Community Hospital services. The Committee noted that these needed addressing within existing budgets and noted that this was also raised at Executive Committee.
- The Committee noted that a number of actions within the Quality and Safety Board Assurance Framework continue to be assessed as having low delivery confidence, reflecting capacity constraints and the need to strengthen implementation of the Quality Management System and supporting programmes of work.
- The Committee noted continuing performance risks relating to psychological therapies waiting times, CAMHS performance and cancer pathway recovery, which remain subject to enhanced oversight and recovery action.

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

- The Committee received assurance that targeted recovery plans, supported by Welsh Government investment, are driving improvements across planned care, diagnostics, cancer and urgent and emergency care pathways Whilst risks relating to emergency department overcrowding, cancer performance, follow-up backlogs, endoscopy waiting times, pre-operative assessment capacity, CAMHS and psychological therapies remain, the Committee was assured that recovery actions and enhanced oversight arrangements are in place.
- The Committee welcomed the enhanced Integrated Performance Report format, which provides improved visibility of performance trends, risks and recovery actions and supports effective scrutiny.

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

- A Deep Dive into Endoscopy will be undertaken at the next QSE Committee.
- Received a paper on Urgent and Emergency Care, noting that there is significant way to go but that improvements are evidenced. A strategic paper will be received at the Board meeting in September which will need to address leadership staffing fragility.
- The Committee agreed to hold a development session to consider the outcomes of the Committee self-assessment, Well-Led Review, Audit Wales Quality Governance Review and NHS Wales Performance & Improvement work, to inform future Committee priorities and the 2027 cycle of business.

The Committee reviewed both risks and noted ongoing mitigating actions and recovery programmes. Concerns remain regarding delivery confidence of some actions due to capacity constraints.

- The patient story highlighted communication, escalation and advocacy issues for patients with complex needs, with learning to be shared through quality improvement and governance arrangements.

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- The Committee highlighted the importance of continued promotion of hand hygiene and infection prevention and control messages to staff and the public to support improved patient safety outcomes.

- The Committee requested that the People & Culture Committee consider the workforce implications arising from nurse staffing reviews, with particular focus on recruitment, retention, workforce supply and the development of sustainable staffing models across Mental Health and Learning Disabilities and Community Hospital services.

**QS26.136 Review of Meeting Effectiveness**

Members discussed the potential use of a consent agenda format for future meetings, following a trail in Planning, Population Health and Partnership Committee, noting the ability to focus on key issues with Committees.

Members noted the importance of capturing positive items too, and emphasised the need to capture more experience focused items.

**QS26.137 Date of the Next Meeting**

**5th November 2026**

**QS26.138 Resolution to Exclude the Press and Public**

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

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# Quality, Safety and Experience Committee PUBLIC Action Log

**Updated 29.10.26**

| Open Actions | | | | | | |
|---|---|---|---|---|---|---|
| **Action No.** | **Minute Ref.** | **Date** | **Agreed Action** | **Lead** | **Time scale** | **Status** |
| **Actions to remain open** | | | | | | |
| 1 | QS26.5.1 | 15.01.26 | **Patient Story:** National Carers Report to be reviewed by PPHP and QSE Committees when received. | Exec. Director of Nursing & Midwifery. | TBC | **Remain Open**<br><br>29.10.26 – still awaiting receipt |
| 2 | QS26.38.1 | 05.03.26 | **Learning Repository**<br>A demonstration of the system to be given in a future development session | Exec Director of Nursing & Midwifery | Jan 27 | **Remain Open**<br><br>To be included at future development session. |
| 3 | QS26.64.2 | 07.05.26 | **Integrated Quality Report**<br>A Welsh language briefing to be included at a future development session. | Exec. Director of Allied Health Professionals & Health Sciences | Jan 27 | **Remain Open**<br><br>To be included at future development session. |
| 4 | QS26.64.3 | 07.05.26 | **Integrated Quality Report**<br>A demonstration on the Quality Score Card to be given at a future development session | Exec Director of Nursing & Midwifery | Jan 27 | **Remain Open**<br><br>To be included at future development session. |
| 5 | QS26.72.1 | 07.05.26 | **Mortality**<br>The next mortality report to committee to include reference | Executive Medical Director / Exec. Director of Allied Health | May 2027 | **Remain Open**<br><br>Item next due May 2027 |

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| | | | to MHLD data. | Professionals & Health Sciences | | |
| 6 | QS26.98.1 | 02.07.26 | Maternity & Neonatal Report Future maternity reports to include 12-month rolling data where appropriate. | Chief Operating Officer | Jan 2027 | **Remain Open** Next scheduled on COB for Jan 27 |
| 7 | QS26.103.1 | 02.07.26 | **Mental Health Oversight Delivery Group** An update regarding implementation of the new Mental Health Quality Statement be brought to Committee in Autumn 2026. | Exec Director of Allied Health Professionals & Health Sciences | ~~Nov 2026~~ Jan 2027 | **Remain Open** 14.09.26 - Added to Nov 26 draft agenda<br><br>16.09.26 – agreed in agenda setting to defer to next meeting |
| 8 | QS26.133.1 | 03.09.26 | **Corporate Governance Report** Development session to be held by December 2026, and to consider the committee self-assessment, well led review findings and Audit Wales Quality Governance report | Secretariat | ~~Dec 2026~~ Jan 2027 | **Remain Open** 27.10.26 – deferred to early new year due to limited availability of key attendees. |
| **Suggest Close** | | | | | | |
| 1 | QS26.105.2 | 02.07.26 | **Quality Governance Report** an update regarding quality of commissioned work to be received at the next Committee meeting. | Executive Medical Director | Nov 2026 | **Proposed for Closure** 21.07.26 – agreed to schedule for November due to number of items on Sept agenda<br><br>14.09.26 - Added to Nov 26 agenda |
| 2 | QS26.125.1 | 03.09.26 | **Integrated Quality Report** A deep dive on Endoscopy to be undertaken, with update received at the next Committee | Executive Medical Director | Nov 2026 | **Proposed for Closure** Covered through planned care item on November agenda |

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| 3 | QS26.127.1 | 03.09.26 | **Planned Care**<br>Audit Wales Cancer Review Report to be included at the next Committee | Director of Corporate Governance | Nov 2026 | **Proposed for Closure**<br>Included on November agenda for information |
| 4 | QS26.126.1 | 03.09.26 | **Integrated Performance Report**<br>Comparative metrics with other Health Boards to be shared with Committee members for awareness | Director of Performance | Sep 2026 | **Proposed for Closure**<br>28.10.26 - IQPR inclusive of the comparative position where available on each score card |
| **Closed Actions (Closed at 03.09.2026 meeting)** | | | | | | |
| **Action No.** | **Minute Ref.** | **Date** | **Agreed Action** | **Lead** | **Timescale** | **Status** |
| 1 | QS26.105.1 | 02.07.26 | **Quality Governance Report**<br>An update regarding the Quality Governance Report (Audit Wales) to be received bi-annually at committee. | Executive Medical Director | July 2026 | Closed<br>15.07.26 – added to COB |
| 2 | QS26.101.1 | 02.07.26 | **Corporate Governance Report**<br>Ensure research, development & innovation is included on the Committee COB. | Head of Corporate Governance | July 2026 | Closed<br>Item is included on COB |
| 3 | QS26.71.2 | 07.05.26 | **Adult Mental Health & Learning Disabilities**<br>Future MHLD updates to include data on number of patients with designated care coordinators, highlighting any trends | Exec. Director of Allied Health Professionals & Health Sciences | Jan 2027 | Closed<br><br>18.05.26 – next MHLD update due Jan 27 as per COB<br><br>16.07.26 – update on action to be given at Sept meeting through action log. |

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| 4 | QS26.67.1 | 07.05.26 | **Nurse Staffing Act**<br>A short paper be received at the next Committee meeting regarding Staffing ratios on the wards not covered by the Act | Exec Director of Nursing & Midwifery | ~~July 2026~~<br>Sept 2026 | Closed<br>18.05.26 – on July agenda.<br><br>02.07.26 – item deferred to next meeting due to relevant updates since paper drafted.<br><br>16.7.25 – included on Sept agenda |
| 5 | QS26.93.2 | 02.07.26 | **Integrated Quality Report**<br>Data to be added to the report going forward regarding the number of procedures undertaken in total during the reporting period to provide context | Executive Medical Director / Exec Director of Nursing & Midwifery | Sept 2026 | Closed<br>16.7.26 – to be cover in September's report |
| 6 | QS26.94.1 | 02.07.26 | **Integrated Performance Report**<br>Consistent timeframes to be included within future reports | Director of Performance | Sept 2026 | Closed<br>16.7.26 – referenced on sept agenda |
| 7 | QS26.96.1 | 02.07.26 | **Planned Care (Cancer Services)**<br>Future reports to include further detail on rates regarding different tumour sites and patterns relating to age and geography etc | Chief Operating Officer | Sept 2026 | Closed<br>16.7.26 – referenced on sept agenda |
| 8 | QS26.93.1 | 02.07.26 | **Deprivation of Liberties**<br>Summary received at Executive Committee regarding application of DoLS to be shared with members for | Secretariat | July 2026 | Closed<br>Shared with members following meeting. |

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| | | | awareness. | | | |
| 9 | QS26.10.1 | 15.01.26 | **Challenged Services**<br>Utilisation of risk registers and risk flagging to be an item for QSE development session | Executive Medical Director | Nov 26 | Closed<br><br>To be included at future development session.<br><br>03.09.26 – agreed item no longer needed. Agreed to close |
| 10 | QS26.69.1 | 07.05.26 | **Clinical Services Plan**<br>The Clinical Services Plan be included as a topic on at a future development session for further information | Executive Medical Director | Nov 26 | Closed<br><br>To be included at future development session.<br><br>03.09.26 – covered through recent board development session. Agreed to close |

# Quality Safety & Experience Committee

## The Importance of Women Advocating for Themselves

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| **Dyddiad y Cyfarfod**<br>**Date of Meeting** | 05 November 2026 |
| **Statws Cyhoeddi**<br>**Publication Status** | Open/ Public |
| | Not Applicable |
| **Enw a theitl Awdur(on) yr Adroddiad**<br>**Report Author name and title** | Eleanor Fletcher, People's Experience Officer<br><br>Rachel Wright, People's Experience Lead Manager Eleanor Fletcher, People's Experience Officer |
| **Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol**<br>**Lead Executive Team Member name and title** | Chris Lynes, Deputy Executive Director of Nursing |

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| **Pwrpas yr Adroddiad**<br>**Report Purpose** | For Noting |

**Crynodeb Gweithredol**
**Executive Summary**

This report presents a patient experience narrative describing the challenges encountered by a woman seeking support for menopause symptoms and hormone replacement therapy (HRT).

The story highlights both barriers to accessing appropriate treatment and examples of good practice within primary and secondary care services. The patient describes a four-year period of self-advocacy before receiving HRT, concerns regarding menopause knowledge and awareness, and the positive impact of more recent service developments including a dedicated Women's Health GP Lead, menopause nurse support, innovative group consultations and access to exercise referral programmes.

The story provides valuable insight into opportunities for service improvement, patient empowerment and education relating to menopause care.

Gynae Voices Story - Welsh Subtitles - Fixed.mp4

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

| **Acronyms / Glossary of Terms** | |
|---|---|
| HRT | Hormone Replacement Therapy |
| GP | General Practitioner |
| NERS | National Exercise Referral Scheme |
| WMH | Wrexham Maelor Hospital |

**The Importance of Women Advocating for Themselves**

## 1. SITUATION

1.1 A patient shared her experience of seeking treatment and support for menopausal symptoms including severe hot flushes, low mood, recurrent urinary symptoms and reduced bone density.

1.2 Despite requesting HRT, she reports being declined treatment due to her age and subsequently experienced a four-year period of self-advocacy before receiving appropriate care.

## 2. BACKGROUND

2.1 The patient sought information through independent support organisations and reliable educational resources to increase her understanding of menopause and available treatment options. Following persistent engagement with healthcare services, she was eventually prescribed HRT and vaginal treatments. Subsequent investigations undertaken at Wrexham Maelor Hospital provided further specialist support and informed decision-making regarding ongoing treatment.

2.2 The patient subsequently received a Mirena coil and reports resolution of her symptoms. She also highlights significant improvements in menopause support available through her GP practice, including dedicated women's health leadership, specialist nursing support and innovative group consultation opportunities

## 3. SPECIFIC MATTERS FOR CONSIDERATION

3.1 The importance of ensuring timely and equitable access to evidence-based menopause treatment.

3.2 The role of effective listening and shared decision-making in women's health services.

3.3 The need for greater menopause awareness and education among both patients and healthcare professionals.

3.4 The positive impact of multidisciplinary and innovative models of care.

3.5 The value of supporting women to advocate for themselves while reducing the need for persistent self-advocacy to access appropriate care.

3.6 The first Women's Health Plan for Wales has been launched, setting out an ambitious 10-year vision to improve health outcomes, access to care, and the overall healthcare experience for women across Wales. As part of Betsi Cadwaladr University Health Board's commitment to delivering the priorities outlined within the national plan, a Women's Health Hub at Llandudno General Hospital was established.

3.7 The Women's Health Hub was made up of a multi-professional team, creating a more integrated and coordinated model of care that is easier for women to access. By working collaboratively across specialties and services, the Hub aimed to improve patient experience, reduce fragmentation of care, and provide timely support for a range of women's health needs.

3.8 The Women's Health Hub at Llandudno General Hospital was established as a pathfinder service to test new ways of providing support for women with menopause, contraception and menstrual health needs in line with the NHS Wales Women's Health Plan. The pathfinder phase ended on 31 March 2026, and the Health Board is currently evaluating the service to understand its impact and identify lessons that can help shape future women's health services across North Wales.

3.9 As part of the Health Boards ongoing commitment to improving our services for women across North Wales, the Health Board is considering what women's services could look like in the future, across North Wales. This work supports the priorities set out in the Women's Health Plan for Wales, which aims to improve women's health services across Wales.

3.10 In 2023, the Health Board established a 'Menopause Matters" Steering Group, with the objective to create a 'menopause friendly culture' across the Health Board with the vision 'to have optimal menopause care accessible to all staff working within the Health Board, creating a culture where menopause can be discussed openly with colleagues and staff experiencing the menopause feel supported at work.

The Health Board offers the following support for staff:

- Monthly virtual menopause cafes with guest speakers attending from specialist services to discuss several topics including to support staff with self-management
- Staff Menopause Champions
- Menopause awareness sessions for staff on several topics including lifestyle and nutrition, men supporting women, managing menopause on a budget, mental health, neurodiversity and manager training
- Menopause Wellbeing Roadshows
- Dedicated menopause SharePoint information page for staff to access.

3.9 The Health Board has developed a menopause action plan in line with the new requirements under the Employment Rights Act 2025. The aim of the plan is to drive improvements in supporting staff experiencing symptoms of menopause and perimenopause. The actions outlined in the plan have been co-developed by staff involved in Menopause Cafes, Gender Equality Network meetings and through conversations within Wellbeing Roadshows.

## 4. KEY RISKS / MATTERS FOR ESCALATION

4.1 Potential variation in access to menopause support and treatment pathways.

4.2 Risk of delayed diagnosis and treatment affecting long-term physical and emotional wellbeing.

4.3 Potential gaps in professional education and awareness regarding menopause management.

4.4 Reputational risk if women feel their symptoms are not recognised or responded to appropriately

## 5. RECOMMENDATIONS

5.1 The Committee is asked to note the patient experience.

| ASESIAD / ASSESSMENT | |
|---|---|
| **Cysylltiad â'r Bwriadau Strategol**<br><br>**Link to Strategic Intentions** | 3. Improve Access, Outcomes and Experience<br><br>If more than one applies, please list below: |
| **Yr Egwyddorion Dylunio Design Principles** | People First<br>Equity & accessibility |
| **Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd**<br>**Corporate Risks and Board Assurance Framework** | |

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

| | | |
|---|---|---|
| | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale: | |
| **Human Rights Act**<br>*Have Human Right based concerns been addressed within WP8a* | Do/Yes: ☐ | Naddo/No: ☒ |
| | Canlyniad/Outcome:<br>The patient story is presented as an information only item. | |
| **Compliance to the Welsh Language requirements?**<br>*Have you undertaken an Impact Assessment* | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale: | Naddo/No: ☒ |
| | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale: | The patient story is presented as an information only item. All stories are bi-lingual. |
| | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale: | |
| **Compliance to giving 'Due Regard' to the principles of the Armed Forces Covenant**<br>*Have the principles of the Armed Forces Covenant been addressed within WP8a* | Do/Yes: ☐ | Naddo/No: ☒ |
| | Canlyniad/Outcome: | N/A |
| | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale: | The patient story is presented as an information only item. All stories are bi-lingual. |
| **Ansawdd**<br>*A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?*<br>**Quality**<br>*Have you undertaken a Quality Impact Assessment Screening?* | Do/Yes: ☐ | Naddo/No: ☒ |
| | Canlyniad/Outcome: | The story for information only. |
| | **Galluogwyr Ansawdd Enablers of Quality**<br>All Apply<br><br>Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:<br>If more than one applies, please list below: | |

| | | |
|---|---|---|
| **Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals** | A Healthier Wales | |
| **Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)** | Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:<br>If more than one applies, please list below: | |
| | No - Not Applicable | |
| | Os oes mwy nag un yn berthnasol, rhestrwch hynny:<br>If more than one applies, please list: | |
| **Asesiad o Effaith ar Ddiogelu Data**<br>*A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?*<br>**Data Protection Impact Assessment**<br>*Have you undertaken a Data Protection Impact Assessment Screening?* | Do/Yes: ☐ | Naddo/No: ☒ |
| | Canlyniad/Outcome: | L4 All Wales consent process followed. |
| | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale: | |
| **Asesiad o Effaith ar Atal Twyll**<br>*A ydych chi wedi ystyried yr effeithiau ar atal twyll?*<br>**Counter Fraud Impact**<br>*Have you considered the counter fraud impacts* | Do/Yes: ☐ | Naddo/No: ☒ |
| | Canlyniad/Outcome: | |
| | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale: | The patient story is presented as an information only item. All stories are bi-lingual. |
| **Cyfreithiol Legal** | There are no specific legal implications related to the activity outlined in this report. | |
| | No | |
| **Enw Da Reputational** | There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report. | |
| | No | |
| **Effaith ar Adnoddau** *(Pobl / Ariannol)*<br>**Resource Impact** *(People / Financial)* | There is no direct impact on resources as a result of the activity outlined in this report. | |
| | No – report information only. | |

**Quality Safety & Experieence Committee**

# 100 STORIES PROJECT
# LEARNING FROM YOUNG PEOPLE TO IMPROVE TRANSITION INTO ADULTHOOD

| | |
|---|---|
| **Dyddiad y Cyfarfod**<br>**Date of Meeting** | 05 November 2026 |
| **Statws Cyhoeddi**<br>**Publication Status** | Open/ Public<br>Not Applicable |
| **Enw a theitl Awdur(on) yr Adroddiad**<br>**Report Author name and title** | Christy Hoskings / Regional Patient Experience Lead (Children's Services)<br>100 Stories Project |
| **Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol**<br>**Lead Executive Team Member name and title** | Helen Stevens-Jones, Director of Partnerships, Engagement and Communications |

| | |
|---|---|
| **Pwrpas yr Adroddiad**<br>**Report Purpose** | For Assurance |

**Crynodeb Gweithredol**
**Executive Summary**

Executive Summary

***"I had literally turned 18 two days prior. How can that immediately make me a responsible adult?" — 100 Stories participant***

The 100 Stories Project explores experiences of moving from childrens to adult services, particularly for young people with neurodevelopmental conditions, learning disabilities and mental health needs. Over two years, 87 participants contributed accounts from young people, parents, carers and professionals across North Wales, with further stories continuing to be collected.

The accounts provide a rich body of qualitative evidence of fragmented pathways, loss of support and expectations that do not always reflect developmental readiness. They point to a need to explore a more graduated approach through ages 18 to 25, working across health, social care, education, employment and transport.

Storytelling has also created opportunities for participants to build confidence, relationships and influence. The paper distinguishes these reported benefits from

the service changes that now need to be evidenced and progressed.

QSE is asked to recognise the concerns, support continued involvement of young people and seek a coordinated response through relevant programmes, with an identified executive lead and a report back within an agreed period.

The project has produced a storytelling toolkit for North Wales.

The full report, stories gallery and toolkit are available through the existing link below.
https://agenda.cymru/cy/mewnwelediadau/prosiect-100-stori/

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

| **Acronymau / Rhestr Termau**<br>**Acronyms / Glossary of Terms** | |
|---|---|
| | |

**MEWNOSODWCH DEITL YR ADRODDIAD**
**100 STORIES PROJECT, TRANSITIONING TO CHANGE**

## 1. Y SEFYLLFA
## SITUATION

**HEART – THE EXPERIENCE OF MOVING INTO ADULTHOOD**

***"I had literally turned 18 two days prior. How can that immediately make me a responsible adult?" — 100 Stories participant***

1.1 This question from a participant in the project captures the gap between an age based service boundary and a young person's readiness for adult life. The 100 Stories Project.

1.2 For many young people, turning 18 means losing support rather than gaining independence. Despite more than two decades of policy guidance, national reviews and improvement programmes identifying transition as a point of significant vulnerability, young people with neurodevelopmental conditions and learning disabilities continue to encounter fragmented pathways, inconsistent support and an abrupt "cliff edge" between children's and adult services. The consequences extend far beyond healthcare, affecting wellbeing, education, employment, relationships, and future life opportunities, whilst increasing pressure on families, carers and services.

1.3 Yet while the challenge is well recognised, the voices of those living through it are often absent from the conversation. The 100 Stories Project was established to address this gap, providing a space for young people, families, carers and professionals to share their experiences and help us understand not only what is happening, but why it continues to happen. Together, these stories reveal that transition is not a single event or a transfer between services; it is a developmental journey.

1.4 People are experts in their own lives. Their accounts are a source of qualitative insight into how services are experienced. This paper brings that insight to QSE and asks how the organisation will respond.

## 2. Y CEFNDIR
## BACKGROUND

### HEAD – WHAT THE STORIES TOLD US

2.1 The 100 Stories Project was created to listen to young people, families, and professionals about their experiences of moving from children's services to adult services. Over a two-year period, 87 participants shared their stories for the report and we have continued to collect the stories of, young adults, parents, carers and professionals from across North Wales.

2.2 While every experience was unique, a common message emerged: young people do not experience transition as a single event at age 18, yet services often do. Participants described uncertainty, loss of support, and a need for systems that recognise transition as a developmental journey rather than an administrative process.

2.3 The project was founded on a simple belief: people are experts in their own lives, and their experience should help shape the services designed to support them.

### What does the system withhold?

2.4 Participants consistently described a loss of continuity and support at age 18. Support often stops rather than gradually transitions, leaving young people and families to navigate complex systems alone. Waiting lists, fragmented services, and gaps between children's and adult provision were recurring themes.

***Young people told us they often feel they must "fight" for support and that the transition process lacks coordinated guidance and continuity. "I was told you will need to fight. The fight takes its toll." (100 Stories Participant)***

### What does the system fail to understand?

2.5 The stories highlight a mismatch between chronological age and developmental readiness. Turning 18 does not automatically equip a young person with the confidence, skills or independence expected within adult services. Participants described expectations to self-advocate before they had been given opportunities to develop those skills.

2.6 Young people also spoke about the pressure to mask neurodivergent identities, difficulties accessing support without formal diagnoses, and systems that can prioritise processes over individual needs.

***"What a difference a day makes" (100 Participant)***

***"Everyone can do something. Everyone can be something, we just have to let them" (100 Stories Participants).***

**What do young people want instead?**

2.7 Participants were clear that they are not asking for dependence; they are asking for a bridge.

2.8 The strongest message emerging from the stories is the need for a more graduated and developmentally appropriate approach between ages 18 and 25. Young people want coordinated support that focuses on aspirations, employment, education, relationships and wellbeing as well as health and social care needs. They want services to work together, to listen, and to support them to thrive rather than simply manage risk.

***"When you are moving from children's services into adult services, you are not thinking, one day this will make a useful story for service improvement. You are just living it: trying to understand what is changing, who is involved, what service you fit into now, and why something that was fine before suddenly is not". (100 Stories Participant)***

2.9 The evidence suggests that the issue is not a broken service, but an absence of provision specifically designed around the developmental needs of young adults aged 18-25.

**HANDS – WHAT STORYTELLING HAS MADE POSSIBLE**

2.10 One of the most significant outcomes of the 100 Stories Project is that it did not stop at listening. Participants describe moving from isolation to influence. Through storytelling, young people developed confidence, self-advocacy skills and leadership capabilities. Individuals who initially questioned whether anyone would listen have gone on to present to Public Service Boards, Regional Partnership Boards and senior decision-makers.

2.12 The project also reports improved understanding between professionals, families and young people, and stronger relationships across organisations. It has produced a storytelling toolkit to support further use of this approach across North Wales. The Health Board can draw on its storytelling and patient experience expertise to support this work.

2.13 These are meaningful participant and relationship outcomes. Access to decision makers creates an opportunity to influence services; the next step is to show which

decisions or practices have changed and what difference this makes to young people.

## 3. From Listening to Action

3.1 The stories now ask something of us as an organisation. The proposed response as an organisation is to connect these findings to relevant existing programmes, with clear responsibility for taking the learning forward and reporting progress. This should be developed with young people and partners.

**For young people**

3.2 To design services that recognise transition as a developmental journey rather than a fixed event and ensure young people continue to have opportunities to influence decisions affecting their lives.

**For services**

3.3 To strengthen collaboration across children's and adult services and explore approaches that better support young adults through the critical 18-25 period.

**For BCUHB and system partners**

To continue embedding lived experience in service improvement, strategic planning and quality assurance processes, whilst demonstrating clearly to participants how their feedback is informing change through a visible "You Said, We Did" approach.

## 4. MATERION PENODOL I'W HYSTYRIED<br>SPECIFIC MATTERS FOR CONSIDERATION

4.1 The young people's accounts raise concerns about continuity, access and developmental readiness at transition. QSE is invited to consider the implications for quality and experience, and the assurance it requires on the organisational response.

## 5. RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO<br>KEY RISKS / MATTERS FOR ESCALATION

5.1 If the concerns remain unaddressed, young people may continue to experience interruptions in support, unmet needs and difficulty navigating services, with consequences for wellbeing, independence and pressure on families and carers.

5.2 Without an identified lead and follow up, the findings may not translate into co-ordinated improvement. Inviting people to share difficult experiences without explaining the response also risks reducing trust and willingness to participate in future work.

## 6. ARGYMHELLION RECOMMENDATIONS

The Committee/Meeting/Group is asked to:

6.1 **NOTE** the findings and recognise the quality and experience concerns described by participants during transition from children's to adult services.

6.2 **SUPPORT** continued involvement of young people in shaping the response and the use of storytelling alongside other evidence to inform improvement.

6.3 **REQUEST** that an executive lead is identified to coordinate a response through relevant existing programmes, working with services and system partners and including consideration of a graduated approach through ages 18 to 25.

6.4 **REQUEST** a report back within a period agreed by the Committee, setting out responsibilities, milestones, improvements proposed or made, how impact will be assessed, and how participants have been involved and informed.

| ASESIAD / ASSESSMENT | |
|---|---|
| **Cysylltiad â'r Bwriadau Strategol**<br><br>**Link to Strategic Intentions** | 3. Improve Access, Outcomes and Experience<br><br>If more than one applies, please list below: |
| **Yr Egwyddorion Dylunio Design Principles** | Choose an item. |
| **Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd**<br>**Corporate Risks and Board Assurance Framework** | |

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

| | | |
|---|---|---|
| | | |
| | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale: | |
| **Human Rights Act**<br>*Have Human Right based concerns been addressed within WP8a* | Do/Yes: ☐ | Naddo/No: ☐ |
| | Canlyniad/Outcome: | |
| **Compliance to the Welsh Language requirements?**<br>*Have you undertaken an Impact Assessment* | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale: | Naddo/No: ☐ |
| | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale: | |
| | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale: | |
| **Compliance to giving 'Due Regard' to the principles of the Armed Forces Covenant**<br>*Have the principles of the Armed Forces Covenant been addressed within WP8a* | Do/Yes: ☐ | Naddo/No: ☐ |
| | Canlyniad/Outcome: | |
| | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale: | |
| **Ansawdd**<br>*A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?*<br>**Quality**<br>*Have you undertaken a Quality Impact Assessment Screening?* | Do/Yes: ☐ | Naddo/No: ☐ |
| | Canlyniad/Outcome: | |
| | **Galluogwyr Ansawdd Enablers of Quality**<br>Choose an item.<br><br>Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:<br>If more than one applies, please list below: | |

| | | |
|---|---|---|
| **Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals** | Choose an item. | |
| **Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)** | Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:<br>If more than one applies, please list below: | |
| | Choose an item. | |
| | Os oes mwy nag un yn berthnasol, rhestrwch hynny:<br>If more than one applies, please list: | |
| **Asesiad o Effaith ar Ddiogelu Data**<br>*A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?*<br>**Data Protection Impact Assessment**<br>*Have you undertaken a Data Protection Impact Assessment Screening?* | Do/Yes: ☐ | Naddo/No: ☐ |
| | Canlyniad/Outcome: | |
| | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale: | |
| **Asesiad o Effaith ar Atal Twyll**<br>*A ydych chi wedi ystyried yr effeithiau ar atal twyll?*<br>**Counter Fraud Impact**<br>*Have you considered the counter fraud impacts* | Do/Yes: ☐ | Naddo/No: ☐ |
| | Canlyniad/Outcome: | |
| | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale: | |
| **Cyfreithiol**<br>**Legal** | Choose an item. | |
| | | |
| **Enw Da**<br>**Reputational** | Choose an item. | |
| | | |
| **Effaith ar Adnoddau**<br>*(Pobl / Ariannol)*<br>**Resource Impact**<br>*(People / Financial)* | Choose an item. | |
| | | |

**Quality Safety & Experience Committee**

# INTEGRATED QUALITY REPORT

| | |
|---|---|
| **Dyddiad y Cyfarfod**<br>**Date of Meeting** | 05 November 2026 |
| **Statws Cyhoeddi**<br>**Publication Status** | Open/ Public<br>Not Applicable |
| **Enw a theitl Awdur(on) yr Adroddiad**<br>**Report Author name and title** | • Patient Safety: Chris Lynes, Deputy Director of Nursing (Patient Safety) and Tracey Radcliffe, Head of Patient Safety<br>• Safeguarding and Public Protection: Michelle Denwood, Director of Safeguarding and Public Protection<br>• IPC: Deputy Director of Nursing Infection Prevention and Decontamination<br>• Patient and Carer Experience: Chris Lynes, Deputy Director of Nursing (Patient Experience) and Leon Marsh, Head of Patient Experience Clinical Effectiveness: Joanne Shillingford, Head of Clinical Effectiveness<br>• Quality Assurance: Jo Kendrick, Head of Quality, Erika Dennis, Quality Lead Manager, Sarah Musgrave Quality Learning Business Manager<br>• Healthcare Law: Matthew Joyes, Deputy Director for Legal Services and Debbie Kumwenda, Healthcare Law Lead Manager |
| **Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol**<br>**Lead Executive Team Member name and title** | • Dr Clara Day, Executive Medical Director<br>• Teresa Owen, Executive Director of AHPs and Healthcare Science<br>• Dr Jane Moore, Executive Director of Public Health |

| | |
|---|---|
| **Pwrpas yr Adroddiad**<br>**Report Purpose** | For Assurance |

**Crynodeb Gweithredol**
**Executive Summary**

This Integrated Quality Report provides the Quality, Safety & Experience Committee with an overview of the principal quality, safety and experience risks across BCUHB, together with progress on improvement activity and areas of assurance and concern. The principal corporate quality risk remains **timely access to safe and effective care**, with particular concerns relating to Emergency Department overcrowding, fragile clinical services and variation in the reliable delivery of care to agreed standards.

**Urgent and emergency care remains a significant quality and safety risk.** Emergency Department overcrowding continues to affect patient safety and experience. Improvement activity following the HIW inspection of Ysbyty Glan Clwyd Emergency Department remains under enhanced oversight, while the Quality Peer Review of Ysbyty Gwynedd Emergency Department has identified further patient safety, governance, environmental and operational issues requiring action.

**Fragility within clinical services continues to affect timely access and resilience**, with endoscopy and gastroenterology remaining areas of particular concern due to demand, workforce and infrastructure pressures. Mitigating actions and executive oversight of recovery remain in place.

**Reducing avoidable harm remains a key priority.** Fifteen Never Events were reported between October 2025 and September 2026. The Safer Surgical Procedures Improvement Programme has been established in response, including pan-BCU governance, standardised LocSSIPs and procedural checklists for high-risk procedures, strengthened audit and assurance, and work addressing human factors and safety culture. Healthcare-associated infection also requires sustained attention, particularly C. difficile and MSSA, with targeted improvement and assurance activity continuing.

**Significant pressures remain within incident management**, with a high volume of open incidents and incidents awaiting harm assessment. Improvement trajectories and targeted support are in place.

**Regulatory assurance requires continued focus**, with a number of HIW improvement plans remaining open or overdue and subject to enhanced oversight. **Patient experience** presents a mixed picture: overall experience remains positive, although waiting-time satisfaction and the volume and timeliness of complaints response continue to require attention.

There are also **areas of positive assurance**. Mortality indicators show improvement overall, although the position in relation to stroke mortality at Wrexham Maelor Hospital is undergoing structured clinical review. Nationally Reportable Incident caseload management has also improved, although overdue cases require continued focus.

**External review and assurance activity is an important part of the Health Board's quality improvement approach.** The organisation is awaiting the formal output of the NHS Wales Performance and Improvement Quality Position Statement and the independent Well-Led Review, which will complement the Audit Wales review of quality governance. The findings will inform the further development of the Health Board's Quality Plan.

**Overall, the report demonstrates significant improvement activity and strengthened clinical quality governance. However, assurance remains constrained in several important areas.** Continued executive and Committee oversight is required to ensure that improvement activity results in demonstrable and sustained reductions in patient safety risk, with external review findings providing an additional source of independent assurance.

The committee is asked to:

- **NOTE** the quality, safety and patient experience position set out within the Integrated Quality Report.
- **NOTE** the principal areas of risk requiring continued oversight, particularly urgent and emergency care, fragile clinical services, Never Events and compliance with clinical standards, incident management, healthcare-associated infection and outstanding regulatory actions.
- **RECEIVE ASSURANCE** regarding the improvement programmes and strengthened governance arrangements described within the report, whilst recognising that sustained improvement and evidence of impact remain outstanding in a number of areas.
- **NOTE** the external review and assurance activity underway and the intention to use the findings to inform the further development of the Quality Plan.
- **SUPPORT continued executive focus and escalation** where agreed improvement trajectories or required quality and safety standards are not being achieved

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

| **Acronymau / Rhestr Termau**<br>**Acronyms / Glossary of Terms** | |
|---|---|
| NRIs | National Reportable Incidents |

| | |
|---|---|
| IO | Investigating Officer |
| PST | Patient Safety Team |
| IHCs | Integrated Health Communities |
| COPD | Chronic Obstructive Pulmonary Disease |
| DoLS | Deprivation of Liberty Safeguards |
| ECHR | European Convention on Human Rights |
| HCAI | Healthcare Associated Infection |
| AWTTC | All Wales Therapeutics and Toxicology Centre |
| WHC | Welsh Health Circular |
| IPC | Infection Prevention and Control |
| FMT | Faecal Microbiota Transplant |
| PIR | Post Infection Review |
| HLD | High Level Disinfection |
| ATP | Adenosine Triphosphate |
| PSOW | Public Services Ombudsman Wales |
| PEARS | People's Enquiry and Resolution Service |
| PES | People's Experience Service |
| NICE | National Institute for Health and Care Excellence |
| CET | Clinical Effectiveness Team |
| AMaT | Audit Management and Tracking |
| SCEG | Strategic Clinical Effectiveness Group |
| BAT | Baseline Assessment Tool |
| SSNAP | Sentinel Stroke National Audit Programme |
| Sentinel Stroke National Audit Programme | Healthcare intelligence and quality improvement service |
| RAMI | Risk Adjusted Mortality index |
| HIW | Health Inspectorate Wales |
| CIW | Care Inspectorate Wales |
| CAF | Commissioning Assurance Framework |
| PET (scan) | Positron Emission Tomography Scan |
| PFD | Prevention of Future Deaths |
| LFERs | Learning from Events Reports |
| WRP | Welsh Risk Pool |

**INTEGRATED QUALITY REPORT**

## 1. Y SEFYLLFA<br>SITUATION

**1.1** For the NHS in Wales, quality is defined as continuously, reliably, and sustainably meeting the needs of the population that we serve.

**1.2** In achieving this, under the statutory Duty of Quality, Welsh Ministers and NHS bodies will need to ensure that health services are safe, timely, effective, efficient, equitable, and person-centred. Underpinning these domains are six enablers, which are leadership, workforce, culture, information, learning and research and whole-systems approach.

**1.3** These domains and enablers form the Health and Care Quality Standards for Wales introduced in April 2023 through statutory guidance.

## 2 Y CEFNDIR<br>BACKGROUND

BCUHB remains committed to delivering high-quality services across all areas of care.

Since the introduction of the Integrated Concerns Process in Sept 2024 there has been an improvement in the timeliness and quality of the processes associated with the management of concerns raised. Risks are identified locally but progress to mitigate and reduce risk can be slow. Learning from individual cases occurs but wider and consistent learning is required.

Quality governance was reviewed earlier in 2026 by Audit Wales and the organisation is currently awaiting the formal output from a Quality Position Statement from NHS Wales Performance and Improvement. This assessment forms part of the Welsh Government-commissioned, Ministerially Directed Intervention for Betsi Cadwaladr University Health Board. This intervention is structured around four independent pillars of Quality, Safety and Patient Experience; Performance and Operations; Workforce; and Financial Recovery recognising the interdependency between the pillars. The combination of the outputs of these two external reviews, along with any relevant information from the independent well led review will contribute to the design of a refined Quality Plan to be presented to the next QSE committee in January 2027.

In the meantime, focus for the organisation from the Clinical Executives has been as below

1. Simplify the governance.
    a. Build on the Integrated Concerns Policy
    b. Make multiprofessional as standard
    c. Ensure clear reporting lines, accountabilities and line of sight from ward to board

2. Identify and act on risk; building on QMS
    a. Clear diagnostics; quality planning on a page
    b. Clear actions; Rapid Quality Review methodology and link to performance and accountability framework
    c. Close the loop; make sure actions are happening and risk reducing

3. Learning strategically
    a. Back to basics; focus on multi-professional standards and audit
    b. Enhance effective use of data for quality; measure input / output / outcomes
    c. Roll out learning; test and implement what really works

A significant intervention has been the change of Corporate Quality Governance to form the Clinical Quality Executive Delivery Group. This was commenced in September and has now met twice. It is a multi-professional group bringing all clinical leadership into one meeting. It has a focus on local risks and actions ('what are your biggest quality concerns?') and the sharing of these risks and actions recognising that many are common across more than one area. It also brings all colleagues together to discuss topics relevant to all areas. In the first two meetings for instance there has been focussed discussion on Never Events and actions required, learning from implementation for the electronic prescribing system, the Thirlwall Inquiry and proposed changes in mortality review processes.

A refresh of the approach to the QMS and actions associated with a new fragile services framework is described in separate papers to QSE and within an informal board session.

Main risks have been defined and are as below. These link to both corporate risk register and BAF.

The Heath Board's main corporate quality risk is 'timely access to safe and effective care'.
Of particular concern within this risk:

- Overcrowding in Emergency Depts with risk of risk of patient harm, poor patient experience and staff burnout
- Fragile services with risk of patient harm, poor patient experience and staff burnout. There is currently a particular concern around endoscopy services
- Lack of delivery of care to known standards with risk to safe and effective care

Further information is given throughout this report on both further composition of these risks and ongoing work to both mitigate and reduce.

This report summarises BCUHB's current position regarding quality performance and identifies key actions required to strengthen outcomes and achieve sustained improvement.

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

Against the corporate risk of *timely access to safe and effective care* there are concerns relating to

- overcrowding in emergency departments,
- fragility of services particularly endoscopy
- delivery of care to known standards

This list has been compiled following the first CQ EDG. Further information is within this report and other papers to QSE.

**Emergency Department overcrowding and flow pressures** continue to present significant risks to patient safety, patient experience and staff wellbeing. Recent regulatory scrutiny, including the escalation of the Ysbyty Glan Clwyd Emergency Department to a service requiring significant improvement, reinforces the need for sustained oversight and whole-system action.

**Fragility of endoscopy and gastroenterology services** remains a significant concern due to workforce shortages, high demand, infrastructure constraints and surveillance backlogs. Delays to diagnostic and surveillance procedures continue to present risks to timely diagnosis and treatment.

**Never Events remain above an acceptable level**, with 15 incidents reported over the previous 12 months and three occurring in the current reporting period. The frequency and nature of these incidents highlight ongoing risks relating to procedural safety, compliance with established safety controls and organisational learning.

**Variation in compliance with clinical standards and quality requirements** remains a corporate concern, with risks that inconsistent implementation of evidence-based practices could adversely impact the delivery of safe and effective care.

**Workforce sustainability challenges** continue across a number of services, affecting service resilience, waiting times, continuity of care and the delivery of improvement programmes. In some areas recruitment, retention and specialist workforce shortages remain key risks.

**Infrastructure, estates and digital system limitations** continue to impact service resilience and operational effectiveness. Ageing facilities and equipment, together with the need for further digital maturity and interoperability, present ongoing risks to safe and efficient care delivery.

**Healthcare-associated infection performance** remains below trajectory in a number of key measures, particularly *C. difficile*, MSSA and bloodstream infections. Sustained improvement is being hindered by operational pressures, estate constraints and variation in compliance with infection prevention measures.

**Regulatory and quality assurance concerns** remain in several services where HIW and CIW improvement plans are overdue or remain in progress, particularly within Emergency Departments, Mental Health services and community services. Continued executive oversight is in place to ensure delivery of improvement actions and regulatory compliance.

**Ombudsman investigations, Public Interest Reports and Coroner concerns** continue to require close monitoring due to their implications for patient safety, organisational reputation and assurance regarding implementation of learning and improvement actions

**Incident management and investigation backlogs** remain significant, with high volumes of overdue incidents and outstanding harm assessments creating risks to timely learning, assurance, Duty of Candour compliance and effective organisational oversight

**Rising complaint volumes**. Sustained increases in complaints risk diverting senior operational resource away from quality improvement activity and may impact organisational responsiveness and patient confidence.

## 4 ARGYMHELLION RECOMMENDATIONS

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

- **NOTE** the quality, safety and patient experience position set out within the Integrated Quality Report.

- **NOTE** the principal areas of risk requiring continued oversight, particularly urgent and emergency care, fragile clinical services, Never Events and compliance with clinical standards, incident management, healthcare-associated infection and outstanding regulatory actions**.**

- **RECEIVE ASSURANCE** regarding the improvement programmes and strengthened governance arrangements described within the report, whilst recognising that sustained improvement and evidence of impact remain outstanding in a number of areas.

- **NOTE** the external review and assurance activity underway and the intention to use the findings to inform the further development of the Quality Plan.

- **SUPPORT** continued executive focus and escalation where agreed improvement trajectories or required quality and safety standards are not being achieved.

| ASESIAD / ASSESSMENT | |
|---|---|
| **Cysylltiad â'r Bwriadau Strategol**<br><br>**Link to Strategic Intentions** | 3. Improve Access, Outcomes and Experience<br><br>If more than one applies, please list below:<br>Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:<br>If more than one applies, please list below:<br>4. Improving quality, outcomes and experience |
| **Yr Egwyddorion Dylunio Design Principles** | Simplify, Standardise, and Adopt Best Practices<br>Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: |
| **Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd**<br>**Corporate Risks and Board Assurance Framework** | **BAF 26_03:** Failure to Improve Access, Outcomes and Experience<br><br>**BAF 26_04**: Failure to Deliver and Create a Modern, People-Centred Healthcare System that is Future Focused<br><br>**CRR25-01:** Timely access to safe and effective care<br><br>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)<br>Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR) |

| ASESIADAU O EFFAITH / IMPACT ASSESSMENTS | | |
|---|---|---|
| **Equality Act 2010 Public Sector Equality Duty:**<br>**Has BCUHB provided evidence of 'Due Regard' to compliance with the three parts of the Public Sector Equality Duty (General Duty):**<br>https://www.gov.wales/public-sector-equality-duty-htmlPublic Sector Equality Duty [HTML] \| GOV.WALES | Do/Yes: ☐ | Naddo/No: ☒ |
| | Canlyniad/Outcome: | N/A |
| | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale: | This report is purely administrative in nature and submitted for information only. |
| **Equality Act 2010 - Socio-economic Duty** | Do/Yes: ☒ | Naddo/No: ☒ |
| | Canlyniad/Outcome: | N/A |

| | | |
|---|---|---|
| *Has BCUHB provided evidence of 'Due Regard' to compliance of the Socio-economic Duty when making strategic decisions?* | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale: | This report is purely administrative in nature and submitted for information only. |
| *Have you completed an Integrated Equality Impact Assessment WP8a?*<br>*WP8a Template* | Canlyniad/Outcome:<br>Do/Yes: | Naddo/No:X |
| | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale:<br>Canlynaid/Outcome: | This report is purely administrative in nature and submitted for information only. |
| | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale: | |
| **Human Rights Act**<br>*Have Human Right based concerns been addressed within WP8a* | Do/Yes: ☐ | Naddo/No: ☒ |
| | Canlyniad/Outcome: | |
| **Compliance to the Welsh Language requirements?**<br>*Have you undertaken an Impact Assessment* | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale: | Naddo/No: ☒ |
| | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale: | This report is purely administrative in nature and submitted for information only |
| | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale: | |
| **Compliance to giving 'Due Regard' to the principles of the Armed Forces Covenant**<br>*Have the principles of the Armed Forces Covenant been addressed within WP8a* | Do/Yes: ☐ | Naddo/No: ☒ |
| | Canlyniad/Outcome: | N/A |
| | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale: | This report is purely administrative in nature and submitted for information only |
| **Ansawdd**<br>*A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?*<br>**Quality** | Do/Yes: ☐ | Naddo/No: ☒ |
| | Canlyniad/Outcome: | N/A |
| | **Galluogwyr Ansawdd Enablers of Quality**<br>All Apply | |

| | | |
|---|---|---|
| *Have you undertaken a Quality Impact Assessment Screening?* | Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:<br>If more than one applies, please list below: | |
| **Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant**<br>**Wellbeing of Future Generations Act – Wellbeing Goals** | A Healthier Wales | |
| **Effaith Amgylcheddol / Cynaliadwyedd (5Rs)**<br>**Environmental /Sustainability Impact (5Rs)** | Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:<br>If more than one applies, please list below: | |
| | No - Not Applicable | |
| | Os oes mwy nag un yn berthnasol, rhestrwch hynny:<br>If more than one applies, please list: | |
| **Asesiad o Effaith ar Ddiogelu Data**<br>*A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?*<br>**Data Protection Impact Assessment**<br>*Have you undertaken a Data Protection Impact Assessment Screening?* | Do/Yes: ☐ | Naddo/No: ☒ |
| | Canlyniad/Outcome: | N/A |
| | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale: | This report is purely administrative in nature and submitted for information only |
| **Asesiad o Effaith ar Atal Twyll**<br>*A ydych chi wedi ystyried yr effeithiau ar atal twyll?*<br>**Counter Fraud Impact**<br>*Have you considered the counter fraud impacts* | Do/Yes: ☐ | Naddo/No: ☒ |
| | Canlyniad/Outcome: | N/A |
| | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale: | This report is purely administrative in nature and submitted for information only |
| **Cyfreithiol**<br>**Legal** | Choose an item. | |
| | | |
| **Enw Da**<br>**Reputational** | Yes (Include further detail below) | |
| | Please see report for further details | |
| **Effaith ar Adnoddau**<br>*(Pobl / Ariannol)*<br>**Resource Impact**<br>*(People / Financial)* | There is no direct impact on resources as a result of the activity outlined in this report. | |
| | | |

## 5 QUALITY CONCERNS RISK OVERVIEW

The Heath Board's main corporate quality risk is 'timely access to safe and effective care'.
Of particular concern within this risk:

- Overcrowding in Emergency Depts with risk of risk of patient harm, poor patient experience and staff burnout
- Fragile services with risk of patient harm, poor patient experience and staff burnout. There is currently a particular concern around endoscopy services
- Lack of delivery of care to known standards with risk to safe and effective care

Further detail is therefore provided to the committee associated with these risks and current mitigation and improvement programmes.

In addition, with the introduction of the Clinical Quality Executive Delivery Group, the first meeting asked all areas to bring their highest quality risks for discussion. The list of risks below is collated from this meeting. Some were present in single areas but many were shared across different areas of the health board. Following this meeting, all areas are ensuring identified risks are appropriately represented locally, pan health board risks are being collated and corporate risk registers updated if required. Identified risks will then be interrogated further with linkage to operational colleagues to help prioritise actions as controls and mitigations.

Overcrowding within Emergency Departments continues to create risks of patient harm, poor patient experience and staff burnout, compounded by cultural challenges and the need for sustained whole-system transformation. Further information including actions and assurances is included within the paper relating to Urgent and Emergency Care to this committee. The Ysbyty Glan Clwyd Emergency department HIW Inspection full report was published on 10th September.

In particular to note:

- Performance in UEC pathways remains challenged as detailed within the Integrated Performance Framework. More detail on improvement work is included within separate UEC paper
- Peer review of Ysbyty Gwynedd ED identified several concerns. More detail is provided in section 11.3.
- An action plan for the HIW inspection for YGC ED is place. Further detail is in section 11.1. Oversight is via Executive led escalation meetings. Strengthening of the YGC leadership team is in progress to fill vacancies and extra support being provided to ensure action plan is progressing, along with local improvement plans.
- Emergency Department quality and safety concerns continue to be reviewed through a triangulated approach, incorporating EICOP incidents, HIW concerns, performance indicators, patient experience feedback, corporate risk register entries and HM Coroner concerns. Oversight is maintained through a fortnightly

EICOP structured review process, established following the Rapid Quality Review in November 2025. A suite of quality and safety metrics has been developed and is reporting through this group.

Fragile clinical services present risks to patient safety, service resilience and care quality due to workforce shortages and difficulties in maintaining sustainable specialist provision.

- Gastroenterology, and particularly endoscopy, continues to receive executive oversight. A “Deep Dive” has been undertaken and the reported is included within the confidential papers.
- Delayed access to planned care can also occur with service fragility. Updates on challenged services is included within paper for QSE. In addition, learning associated with the Welsh Government first appointment insourcing programme is included within the Commissioning paper.

A broader organisational risk is the variability in understanding, measuring and delivering good quality care to known standards which may lead to inconsistent practice and a failure to consistently provide safe and effective care. This includes the number of Never Events being reported. Elements of concern and actions underway relating to this risk are outlined within the Integrated Quality Reports.

A specific current risk is associated with ligature management. This is detailed further in section 5.5 below

While improvement programmes, quality reviews, strengthened governance arrangements and national support are in place, these risks require continued Board oversight and organisational focus to ensure sustainable improvements in patient safety, quality of care and patient experience. Action plans will be further developed incorporating findings and recommendations from recent external reviews when available, particularly the Quality Statement from NHS Wales P&I and the independent panel Well Led review.

**5.1 Endoscopy**

Endoscopy and gastroenterology services continue to face significant challenges due to high demand, workforce pressures and infrastructure constraints, resulting in ongoing delays for some diagnostic and surveillance procedures. While there has been sustained improvement in urgent suspected cancer and diagnostic waiting times, surveillance patients remain the most affected by delays and continue to be prioritised according to clinical risk. This is also the subject of an open Ombudsman concern.

A range of actions are underway to improve performance and reduce patient risk, including increased service capacity, validation of patient referrals as per national recommendations currently using locum cover, enhanced clinical prioritisation processes and additional clinical cover arrangements.

Risks also remain within the decontamination service due to ageing infrastructure and equipment. Plans for a new centralised facility are

progressing, with completion expected in 2027. Executive oversight continues to ensure patient safety, service resilience and delivery of recovery plans.

A deep dive by the Endoscopy Network is included in the planned care update to the committee.

## 5.2 Infrastructure, Equipment and Digital Systems

Ageing infrastructure and equipment continue to present challenges across a number of clinical services. Key areas of focus include clinical environments and specialist equipment, all of which have the potential to impact service resilience, patient safety and operational effectiveness.

Work is ongoing to address these risks through established capital investment programmes, equipment replacement plans and estates management processes.

Although significant progress has been made with introduction of clinical digital systems over the last 12 months (for instance an electronic prescribing system, a maternity clinical record and a radiology information system) or are in progress (Mental Health electronic record) the lack of a combined system-wide Electronic Health Record remains a key clinical risk. This is a national issue as agreed plan is for implementation of a Wales-wide solution. Interoperability between current systems is limited.

In addition, risks associated with multiple patient numbers remain significant. Mitigations are in place to manage but the requirement to access multiple sets of records to see a complete record and the need to ensure that digital systems use the appropriate patient identifier pose risks to patient safety. This is a national issue.

Further development of digital infrastructure and integrated patient record systems remains a priority to support safe, efficient and coordinated patient care.

## 5.3 Workforce Sustainability

Workforce sustainability continues to be a significant organisational risk, with recruitment and retention challenges affecting a number of clinical and specialist services. Workforce pressures, alongside senior leadership vacancies in some areas, have the potential to impact service resilience, waiting times, continuity of care and the delivery of improvement programmes.

Actions to mitigate these risks include targeted recruitment campaigns, workforce planning initiatives, use of temporary staffing arrangements and enhanced monitoring through divisional governance processes.

In some circumstances, solutions may need to be progressed at speed at a pan HB level to ensure safe service provision ahead of a wider clinical service plan. In addition, where services cannot be safely provided within the HB

commissioned service from partners maybe required. A review of currently commissioned services is underway to ensure clear specifications and service level agreements are in place.

Work is also ongoing to address the implications of the new Resident Doctors Contract and ensure compliance with rota requirements whilst maintaining safe and effective service delivery. The majority of rota are now compliant but a significant minority require ongoing work to address. External help is being sought and a close working with the local negotiating committee and unions is in place. A Guardian of Safe Working has been appointed to oversee compliance.

Nursing staffing is overseen as per the Nursing Staffing Act and regularly reviewed through committee structures.

## 5.4 Never Events

In NHS Wales, a Never Events are defined as:

“Serious incidents that are wholly preventable because guidance or safety recommendations are available at a national level and should have been implemented by all healthcare providers.”

In comparison to the number of times procedures are performed, these events are rare. They tend to occur when extra stressors are present. However, processes are in place that, if followed, should always prevent errors.

The table lists the Never Events by category for the last 12 months. The majority are sporadic events in different areas; where there is clustering deeper work is in progress to ensure focussed action implementation. Learning across the HB is mandated within the rapid reviews and investigations. Mechanisms are interrogated to ensure appropriate routes for learning.

Specific work programmes have been commenced to address the symptoms of reduced adherence to standards which have been observed as themes during these events. External advice is being taken as part of current NHS Wales P&I quality support.

A session at an informal executive committee meeting to discuss more broadly with incoming executives is also planned

Work programmes include:

**Focused improvement work** continues to strengthen compliance with the nurse second-checking process for medication administration, with particular emphasis on reducing incidents involving controlled drugs. This programme is aligned with the re-launch of the nursing and midwifery Quality Standards, which are currently being implemented across the Health Board and include safe medication practices and enhance quality assurance at ward level.

**Surgical Procedures Improvement Programme** established to strengthen procedural safety systems and reduce the risk of recurrent Never Events across BCUHB. This is reporting directly to the CQ EDG each month to maximise clinical leadership ownership.

- Pan-BCU governance arrangements are being established to provide consistent oversight of LocSSIPs and the WHO Safer Surgical Checklist, supported by site-based delivery groups and specialty working groups.
- Standardised LocSSIPs and procedural checklists have been developed for 10 high-risk secondary care procedures, including chest drains, central venous access, bronchoscopy, intubation, pacemaker insertion and major orthopaedic procedures. These are undergoing clinical review ahead of implementation across all sites. Structured audit is included within these
- A consistent pan-BCU approach to checklist design and presentation is being developed, incorporating psychological principles to support staff engagement and compliance.
- Human factors and safety culture are a specific programme focus, with a staff survey underway examining safety culture, teamwork and barriers to speaking up. Findings will inform subsequent improvement actions.
- Additional assurance measures have been introduced following recent incidents, including enhanced scrutiny of theatre audit findings and independent review of checklist compliance where recurring themes have been identified.
- Never Events will be an item included for all specialities in an upcoming pan BCUHB surgical governance day.

BCUHB reported one Never Event in August and two in September.

These were

- Retained foreign object post procedure – retained swab following forceps birth and episiotomy
- Wrong site surgery – Procedure to eye.
- Wrong Implant/Prothesis – Incorrect component used during a knee replacement operation.

| Never Event Category | Number of Events | Relevant Months |
|---|---|---|
| Administration of medication by the wrong route | 1 | Jun 2026 |
| Misplaced Naso- or Oro-gastric tubes | 1 | July 2026 |
| Retained foreign object post procedure | 6 | Nov 2025 (1), April 2026 (1), Jun 2026 (2) Aug 2026 (1) Sept 2026 (1) |
| Wrong implant/prosthesis | 2 | Oct 2025 (1), Feb 2026 (1) |
| Wrong site surgery | 5 | Oct 2025 (1), Dec 2025 (1), Mar 2026 (2) July 2026(1) |
| **Total Never Events** | **15** | October 2025 to September 2026 |

Further learning can be found in the confidential report.

### 5.5 Ligature Management

Work continues to strengthen ligature management arrangements across the Health Board. This includes the installation of ligature-reduced assets within Tegid Ward and a programme of capital works to support further ligature reduction. The MHLD Division has adopted the All Wales Policy and Procedure, together with the associated ligature assessment documentation and ligature awareness training. A Ligature Programme Board has also been established to provide Health Board-wide oversight and assurance in relation to this work.

### 5.6 Thirlwall Inquiry

The Thirlwall Inquiry identified significant failures in recognising, escalating and responding to concerns regarding patient harm within neonatal services at the Countess of Chester Hospital. Its findings extend beyond individual accountability and highlight wider lessons regarding patient safety, safeguarding, leadership, governance, speaking up, mortality surveillance and organisational accountability. A central theme is the need for organisations to recognise emerging patterns of concern and connect intelligence from different sources at the earliest opportunity

The Inquiry makes 13 principal recommendations, supported by detailed sub-recommendations, aimed at strengthening patient safety systems, safeguarding, mortality review, speaking up arrangements, organisational accountability and Board oversight. BCUHB recognises that, while a number of recommendations are

directed towards NHS England, the wider learning is highly relevant to NHS Wales and provides an important opportunity to test the effectiveness of current Health Board arrangements. Multi-professional discussion took place at the October meeting of CQ EDG following individual professional group discussions.

BCUHB proposes an assurance-led approach, centred on the question: how would the Health Board know if a similar pattern of concern was emerging today?

Six priority areas have been identified covering patient safety and safeguarding, speaking up and psychological safety, mortality surveillance, Ward-to-Board governance and quality intelligence, investigation and organisational learning and clinical leadership and workforce governance.

Initial assessment identifies areas where further assurance is required, including escalation thresholds, professional concerns and Position of Trust processes, speaking up governance, quality intelligence triangulation, investigation quality, mortality intelligence and evidence that organisational learning is implemented and sustained. The review will also determine which actions should be addressed locally and which would benefit from regional or All-Wales consideration. At this stage no guidance has been issued from Welsh Government.

Instead of a stand-alone programme specific to Thirlwall, it is proposed that these themes are included in the Quality Plan to be developed in response to the external reviews commissioned by Welsh Government, both the Quality Statement from NHS Wales P&I and the Independent Panel Well Led review,

## 6 CLINICAL EFFECTIVENESS

### 6.1 Clinical Audit

During August and September, there were 10 Tier 1 National Clinical Audit reports, and 1 outcome review published all scheduled for responses during October and November 2026 Eleven **reports have been published in August and September, 10 included BCU identifiable data.** The table below outlines the benchmarking information:

| **Tier 1 Project reference** | **Title** | ***Performance against*** | |
|---|---|---|---|
| | | ***National Benchmark*** | ***Last BCU report*** |
| NCAORP/ 2026-27-35 | National Audit of Care at the End of Life (NACEL) - 2025 State of the Nation Report | G | G |

| | | | |
|---|---|---|---|
| NCAORP/ 2026-27-35 | National Audit of Care at the End of Life (NACEL) - Mental Health Spotlight Audit 2025 State of the Nation Report | G | N/A |
| NCAORP/ 2026-27-44 | National Maternity & Perinatal Audit (NMPA) - State of The Nation Report 2026 | A | G |
| NCAORP/ 2026-27-13 | National Oesophago-Gastric Cancer Audit (NOgCA) - State of the Nation Report 2026 | G | G |
| NCAORP/ 2026-27-17 | National Pancreatic Cancer Audit (NPaCA) - State of the Nation Report 2026 | G | G |
| NCAORP/ 2026-27-07 | National Hip Fracture Database (NHFD) - Mind the gap - Challenging inequities in hip fracture care (1st Jan - 31st Dec 25) | A | G |
| NCAORP/ 2026-27-11 | National Audit of Primary Breast Cancer (NAoPri) - State of the Nation Report 2026 | A | G |
| NCAORP/ 2026-27-12 | National Audit of Metastatic Breast Cancer (NAoMe) - State of the Nation Report 2026 | A | A |
| NCAORP/ 2026-27-47 | Mothers and Babies: Reducing risk through Audits and Confidential Enquiries across the UK (MBRRACE) - Saving lives, Improving Mother's Care (2022 - 2024)* | N/A | N/A |
| NCAORP/ 2026-27-18 | National Non-Hodgkin Lymphoma Audit (NNHLA) - State of the Nation Report 2026 (2024 Audit Period) | G | G |
| NCAORP/ 2026-27-19 | National Kidney Cancer Audit (NKCA) - State of the Nation 2026 | A | G |

| Key | ***Comparison with National Benchmark*:** | ***Comparison with Last BCUHB Report*:** |
|---|---|---|
| **R** | Where BCUHB reported performance is at or above the benchmark in fewer than 50% of KPIs | Where the previously reported BCUHB performance has deteriorated in more than 50% of Key performance indicators (KPIs) according to the latest National audit report |
| **A** | Where BCUHB reported performance is at or above the benchmark in 50% to 74% of KPIs. | Where the previously reported BCUHB performance has been maintained or improved in 50% |

| | | |
|---|---|---|
| | | to 74% of KPIs in the latest reporting period. |
| **G** | Where BCUHB reported performance is at or above the benchmark in 75% or more of KPIs. | Where BCUHB has maintained or improved in 75% or more of KPIs since the previous reporting period |

- *MBRRACE-UK is a national programme which monitors maternal, newborn, and infant outcomes to reduce mortality and improve healthcare outcomes

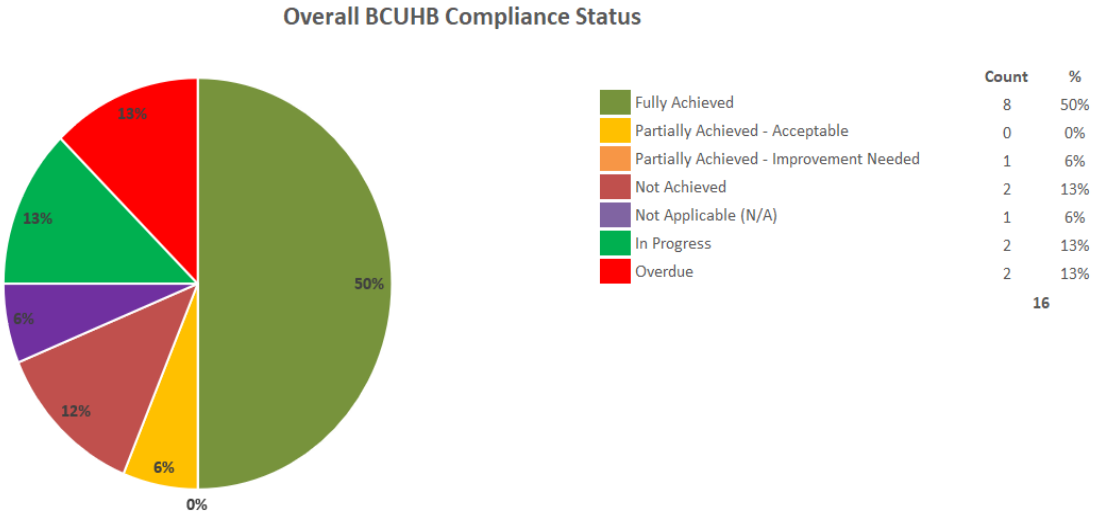
- The BCUHB MBRRACE report (2026) for perinatal mortality in BCUHB in 2024 has an overall red rating due to an increase in number of neonatal deaths (NND). Further analysis of this shows that the stillbirth rate sat within normal parameters and the outlying status related to neonatal mortality; that is mortality after a live birth. Full review of all neonatal mortality during this time period has been completed by the service. Because of small numbers and thus potential identifiable data this is described in more detail within the confidential report.

## 6.2 NICE Guidelines

BCUHB NICE compliance performance continues to be supported through ongoing engagement from both clinicians and operational management teams. This collaborative approach has strengthened the organisation's ability to implement NICE guidance effectively, providing assurance that compliance is being actively monitored and managed across the Health Board.

Overdue responses are sent escalation emails in accordance with the Escalation Process, reported monthly to the Clinical Effectiveness NICE & Audit Group (CENAG) and escalated via the CE Assurance Report for action within IHCs or Divisions. Those remaining "Overdue" following this process are then reported monthly at Executive Delivery Group - Clinical Quality (EDG-CQ).

Below is the current position for BCUHB between August 2026 and end of September 2026:




**The current compliance status for BCU**

- Overdue responses – 6 statements (2025); 12 statements (2026)
- 'Not Achieved' – NG242 Diabetic retinopathy: management and monitoring Baseline Assessment completed August 2024 by Central – review across the three sites date to be agreed.
- Partially Achieved-Improvement Needed – 112 individual responses

As part of the Internal Audit Review Action Plan, we are commencing a review of guidelines currently classified as having a compliance status of "Partially Achieved - Improvement needed". Over the coming months, the Clinical Effectiveness Team (CET) will be contacting colleagues to invite them to attend baseline assessment training.

There has been limited progress to date on the guidelines reviewed as work has been prioritised on the overdue guidelines identified as high priority - Sepsis/Pneumonia and Child Maltreatment - these are progressing well.

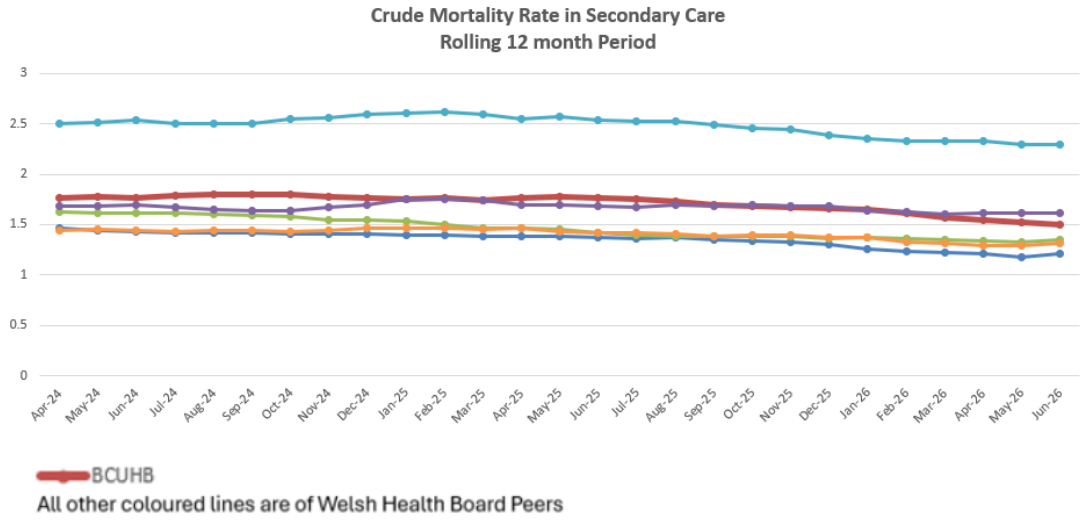
The team is working with Primary Care East to begin reviewing their *Partially Achieved – Improvement Needed* guidelines and a follow up meeting has been arranged for November with GP Clinical Leads. The team are also working with Ophthalmology regarding NG242 Diabetic Retinopathy guideline previously reviewed as Not Achieved, with a review across the sites to be carried out.

A 'Baseline Assessment How-to Guide' is in development and almost ready for circulation, then training sessions will be offered to Clinicians/Operational Management to begin the review process.

## 7 MORTALITY

### 7.1 Review of Mortality Data taken from CHKS iCompare System:

Crude Mortality Rate in Secondary Care 12-month rolling average - BCUHB vs Peers (All Other Welsh Health Boards excluding Powys):

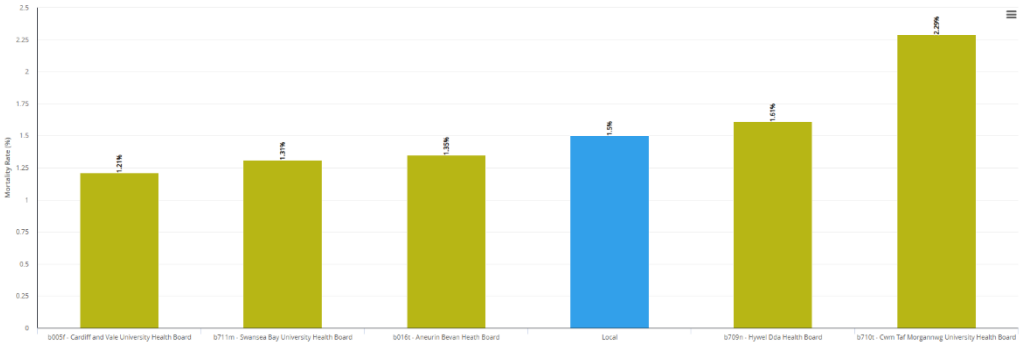



Crude mortality rate in BCUHB had been above the national average since April 2024, although the gap has reduced in recent months and as of June 2026 BCUHB crude mortality rate is equal to the Wales average. Crude mortality rates for other Welsh Health Boards are included in the graph above for comparison.

Crude mortality is not risk adjusted, and it can be affected by many factors. Population demographics including age, socioeconomic status, population health and rate of chronic disease will affect the crude mortality rate.

Crude mortality in secondary care will also be affected by the number of individuals dying outside the acute hospital setting. Capacity in community hospitals, care homes and hospices alongside availability of social care packages will affect length of stay and increase mortality in secondary care where a lack of downstream capacity prevents discharge. This will lead to variation between IHCs in the Health Board and needs to be considered when making external comparison with other Welsh Health Boards.

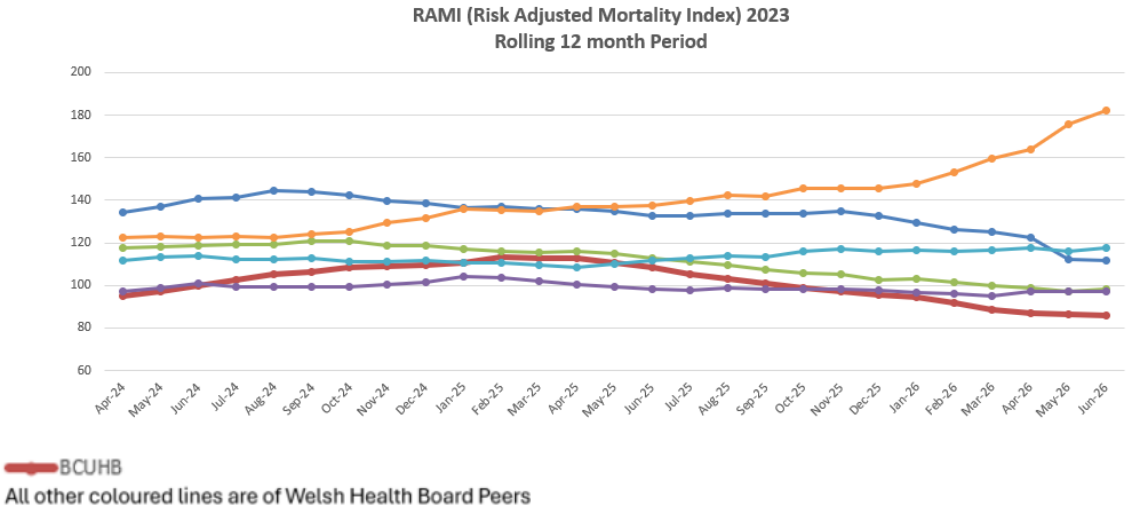
**Crude Mortality Rate Overview by Health Board – July 2025 to June 2026 (12 months)**




The overall crude mortality rate for BCU is 1.5% for the 12-month period from July 2025 to June 2026. This is a 15.25% reduction from the previous 12 months when the rate was 1.77%.

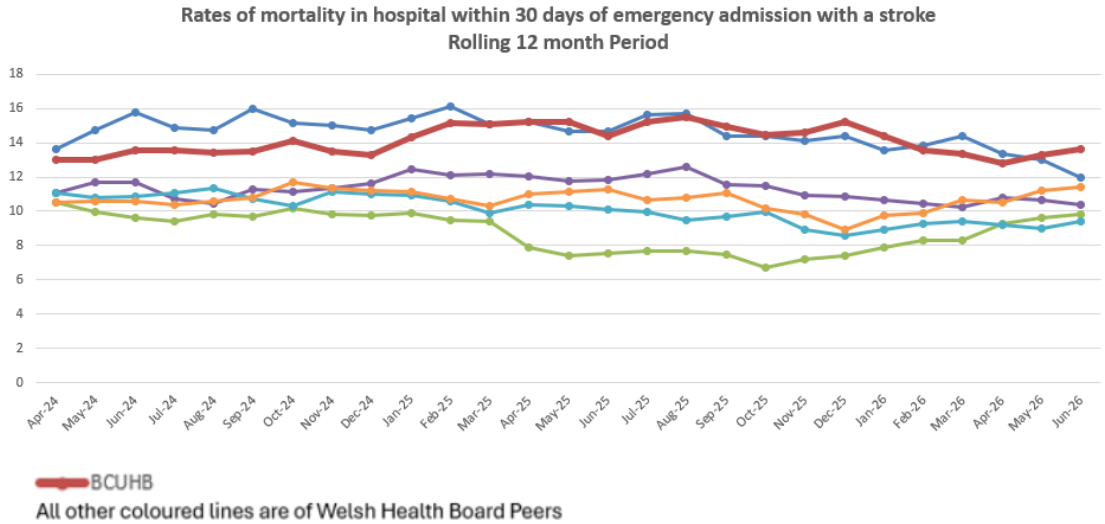
The Health Board continues to monitor risk adjusted mortality metrics. There remains to be a downward trend in RAMI in BCUHB since May 2025.

**RAMI Observed vs Expected Deaths 12-month Rolling Trend – April 2024-June 2026: BCUHB vs Peers (All Other Welsh Health Boards excluding Powys):**




The graph above compares RAMI in BCUHB with other Welsh Health Boards between April 2024 and June 2026. BCU's most recent monthly RAMI value shown in the graph above was 85.86. This number is lower than 100, which means that there were fewer observed deaths than expected deaths. For the 8 months since November 2025, BCU has had the lowest RAMI of the 6 Welsh Health Boards.

**Mortality 30 Day Post Stroke:**




Wrexham Maelor Hospital has been identified as a 'borderline outlier' for case mix-adjusted mortality within the Sentinel Stroke National Audit Programme (SSNAP), which benchmarks standardised mortality rates and other key performance indicators across stroke services in the UK. Whilst no formal

response is required from BCUHB, a detailed review of this cohort is considered appropriate.

BCUHB is undertaking a retrospective clinical review of 20 randomly selected cases using a Structured Judgement Review methodology, with the findings informing any further actions required. This approach has been adopted by other organisations to explore observed increases in mortality metrics.

The Pan-BCU Stroke Clinical Governance Group will continue to monitor mortality outcomes alongside other key performance indicators. Preliminary review of SSNAP data has identified potential issues relating to the completeness of audit data entry, which have since been addressed locally.

**7.2 Medical Examiner Service access to BCUHB Clinical Systems Update:**
The historical access issues affecting the Medical Examiner Service (MES) have now been resolved following collaborative work between the Digital, Data and Technology (DDaT), ICT, Corporate Mortality and Medical Examiner teams. MES staff are now able to access the relevant patient record systems required to undertake timely scrutiny and complete the process.

**7.3 MCCD Completion Rate Update:**

MES dashboard data indicates that BCUHB continues to perform well in comparison with other Health Boards. The current mean time to completion of a Medical Certificate of Cause of Death (MCCD) is 7.24 days, reflecting sustained performance and effective management of the certification process across the organisation.

**7.4 Falls Collaboration Work:**

Following the issuing of a Prevention of Future Deaths report relating to a fall in Llandudno hospital, the Mortality Associate Medical Directors have met with Deputy Executive Director of Nursing, to establish a collaborative programme of work between the Mortality Team, Falls Team, Patient Safety, Nursing and Medical colleagues to strengthen organisational learning from falls-related deaths and serious incidents.

The work is focused on improving alignment between falls investigations, mortality reviews and coronial processes to ensure learning is identified, shared and translated into service improvement. Opportunities to strengthen multidisciplinary involvement in post-fall reviews and enhance oversight of serious harm cases are being explored.

The Mortality Team is engaging with existing falls governance and learning processes to support a coordinated approach to patient safety, with initial areas of focus including deterioration, frailty, anticoagulation, treatment escalation planning and clinical documentation.

## 8 PATIENT SAFETY INCIDENTS

### 8.1 Incidents

Open incidents as at the end September 2026 is at 5,550, which is similar to the number open at the end of August 2026. 3490 incidents have been open greater than 30 days, again similar to last month. In the last 5 weeks, 4056 incidents were reported and 3968 were closed, resulting in a net increase in the backlog which is a consistent trend. Overall, incident submissions continue to slightly outpace closures, maintaining pressure on the open incident position.

- IHC Central – 1796 open, 1248 overdue (69.49%%),
- IHC East – 749 open, 294 overdue (39.25%)
- IHC West -597 open, 265 overdue (44.39%)
- Corporate Services – 577 open, 520 overdue (90.12%)

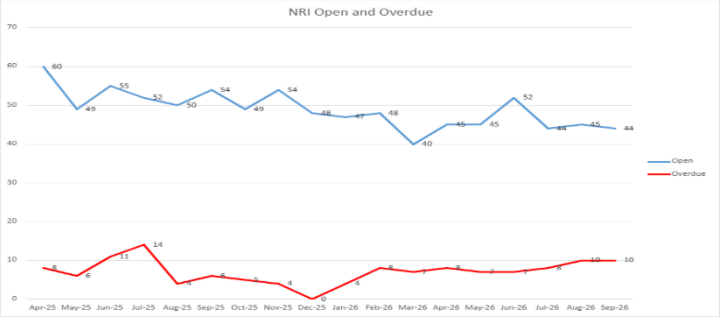
Trajectories for improvement have been set with the IHCs/Divisions. Targeted actions to Central IHC to support backlog closure is underway.

A review of incident records has identified 3699 incidents where an interim harm assessment remains outstanding. Interim harm assessments should be completed within 72 hours to support timely review, oversight and escalation where required. This is a similar position to last month when there were 3,672. This is being directly supported by the Patient Safety Team with monitoring through the PSQ and EDG. Whilst the majority of these incidents are currently recorded as None or Low Harm (2832 incidents), there are also 867 incidents recorded as Moderate, Severe or Catastrophic Harm, where timely assessment is particularly important to ensure appropriate management and consideration of any additional requirements, including Duty of Candour and National Reporting where applicable.

### 8.2 Nationally Reportable Incidents

From 01st August 2026 to 30th September 2026, there were 19 Nationally Reportable Incidents (NRIs) submitted (by incident date) compared with 17 for the previous reporting period (N.B these numbers may change due to retrospective reporting of avoidable patient pressure ulcers and patient falls that have occurred in this period.)

The number of open NRIs has shown a gradual downward trend over the past year, decreasing from the mid-50s to 44 open cases at the end of September. Overdue NRIs have remained the same as last month, currently at 10 cases, with a slight increase in recent weeks. Overall, the trend indicates improved management of the NRI caseload, with continued focus required to address outstanding overdue cases and sustain performance.




- BCUHB rate of NRIs occurring per 100,000 population is 1.59 compared to the All Wales rate of 1.33.
- The total number of NRI investigations that were open as at the end of July 2026 was 44 with 8 overdue closures.
- The proportion of NRIs that remain open for more than 365 calendar days remains at nil.
- The median working days to completion is the lowest in Wales at 107 compared to the All-Wales median of 179 days.

A total of 52 NRI outcome forms were submitted to NHS Wales Performance and Improvement for closure during June 2026 and July 2026. Further detail and learning from these closures can be found in the confidential quality report.

## 8.3 Patient Safety Alerts

Patient safety alerts are overseen in the Patient Safety Group and tracked through the relevant services by the patient safety team

**Orthopaedic Implant Alerts –** Significant programmes of work relating to Profemur Hip Replacement Components, the newly issued MHRA DSI/2026/010 Cobalt-Chrome Modular Neck Hip Replacement Alert, and Exactech Knee and Ankle Implants continue to present clinical, operational and governance risks due to the scale of affected patient cohorts, validation requirements, patient communications, diagnostic capacity requirements and ongoing long-term surveillance arrangements. Recent local review data for modular neck hip replacements have been broadly reassuring; however, continued patient identification**,** risk stratification and follow-up remain necessary in line with MHRA recommendations. This is being overseen by the newly formed Orthopaedic and Musculoskeletal Operational Delivery Group.

**PSA021 - Adult Breathing Circuits** – While progress towards compliance is positive, several outstanding actions remained prior to the August 2026 deadline, including implementation of standardised guidance, competency updates, communication arrangements and formal handover of responsibilities following the planned departure of the current Clinical Lead. A replacement is being sought.

**PSA020 - Penicillin/Penicillamine Allergy Recording** – Although system controls have been strengthened through changes to WCP and ePMA, final assurance is dependent upon completion of reviews across Primary Care, Community Pharmacy, HemoCare and Vital Data systems, alongside

confirmation of ongoing alert management and escalation arrangements. This is monitored through the Medication Safety Group.

**Medical Device and Equipment Safety Alerts** – Several complex device-related alerts, including Medical Beds, Rails and Associated Equipment and, require ongoing monitoring and assurance to ensure implementation of controls, training requirements and compliance with national safety expectations.

**Sustained Safety Alert Compliance** – Overall compliance remains high; (**95% safety alerts; 94% pharmacy recalls/notifications**) however, continued oversight is required to ensure open alerts are progressed within agreed timescales and that emerging patient safety risks are identified and mitigated promptly.

**Alarm Latching Functionality** – Compliance with WHC/2026/024 has been achieved. Ongoing monitoring is required to maintain assurance and oversight of the approved CCU exception at Ysbyty Gwynedd

A number of open safety alerts remain dependent on cross-organisational working, digital systems, clinical capacity, workforce availability and the timely implementation of agreed actions to achieve compliance.

## 9 SAFEGUARDING

Operation Embank and Operation Zirconium

Five people have been convicted of offences relating to child trafficking and sexual exploitation

North Wales Safeguarding Board has commissioned a Single Unified Safeguarding Review (SUSR) to identify learning.

North Wales Safeguarding Board; Child Practice Review - Denbighshire 2023/2

The Child Practice Review was published on the 23rd September 2026.

- BCUHB will monitor, update and complete actions aligned to BCUHB recommendations
- Developed a 7-Minute Briefing and PowerPoint presentation
- Both 7-Minute Briefing and PowerPoints will be presented at the Patient Safety Group and disseminated following the Safeguarding Reporting Framework and BCUHB Governance.

## 10. INFECTION PREVENTION AND CONTROL

Strategic Improvement Goals (2025-2027)

Strategic Improvement Goals (2025-2027) are monitored and overseen through the Strategic Infection Prevention Group, which provides governance, scrutiny, and assurance on progress against key objectives, ensuring delivery of infection prevention priorities across the Health Board.

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

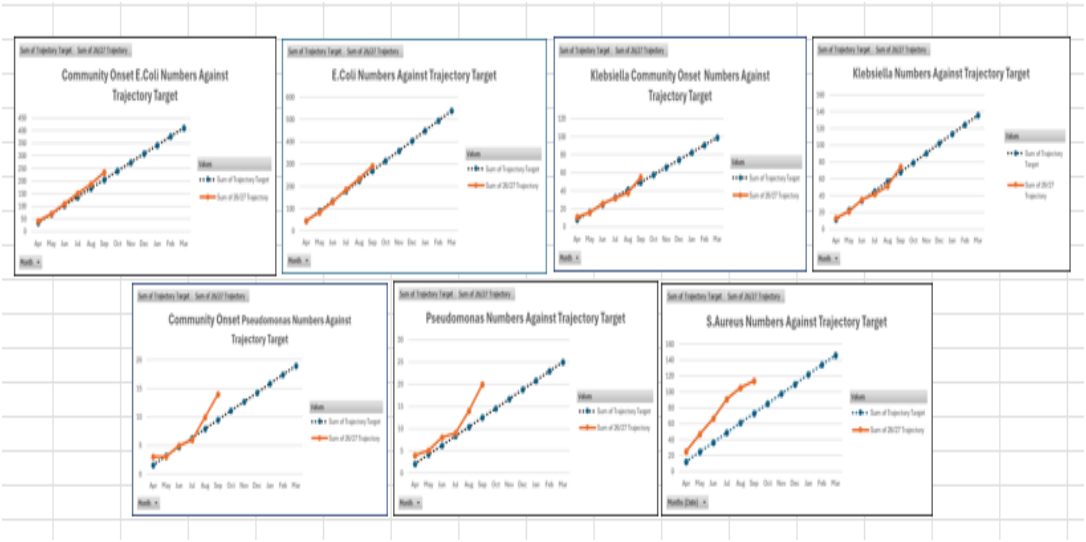
| Goal Area | Target | Current Status vs. Trajectory |
|---|---|---|
| *C. difficile* | 25% Reduction | Above trajectory (at +57 cases) |
| MRSA | < Previous Year | Above trajectory (+3 cases) |
| MSSA | 20% Reduction | Above trajectory (+37 cases) |
| *E. coli* (Hospital-onset) | 10% Reduction | Below trajectory (-1 case) |
| *Klebsiella* (Hospital-onset) | 10% Reduction | Above trajectory (+2 case) |
| *Pseudomonas* (Hospital-onset) | 10% Reduction | Above trajectory (+3case) |

The wider bloodstream infection position is also above trajectory, particularly for S. aureus (+41 cases) and E. coli, with community-onset and overall cases +24 and +22 respectively. It is important to recognise, however, that a significant proportion of Gram-negative bloodstream infections are community-onset and are not necessarily healthcare-associated. Consequently, not all cases will be preventable through healthcare-focused infection prevention interventions and increases in overall case numbers should not be interpreted solely as an indicator of healthcare-associated infection or infection prevention performance.

Overall, the position highlights two distinct challenges: reducing preventable healthcare-associated infection, particularly C. difficile and S. aureus/MSSA, whilst working across organisational and community pathways to understand and, where possible, reduce the wider burden of Gram-negative bloodstream infection.

| Goal Area | Target | Current Status vs. Trajectory |
|---|---|---|
| Klebsiella (community onset) | < Previous Year | Above trajectory (+5 case) |
| Klebsiella overall | < Previous Year | Above trajectory (+6 cases) |
| Pseudomonas (community onset) | < Previous Year | Above trajectory (+4 cases) |
| Pseudomonas overall | < Previous Year | Above trajectory (+7 cases) |
| E. coli (community-onset) | < Previous Year | Above trajectory (+24 cases) |
| E. coli overall | < Previous Year | Above trajectory (+22 cases) |
| Staphylococcus aureus | < Previous Year | Above trajectory (+41 cases) |






Additionally, a clinician-led audit on hospital-acquired pneumonia has been undertaken in Wrexham Maelor Hospital and Ysbyty Gwynedd findings submitted to Welsh Government. These including:

- Insufficient microbiology sampling – sputum and blood
- Incorrect x-ray interpretation prior to formal radiology report
- Antimicrobial treatment was guideline compliant in most cases
- “Early HAP” prescribing guidance highlighted
- IV to oral switch uptake was low in WMH
- Delayed discharge and long length of stay (LLOS) in YG. The majority of patients where discharge is delayed are Elderly Mentally Ill patients who are waiting for a residential or care home. The progress of all LLOS patients is tracked through a weekly multi-disciplinary meeting.

Outbreak activity reduced during August and September. There were 10 reported outbreaks due to C. diff (6), Covid (2) and Influenza A (2).

Impact:

- 5 full ward closures and 3 bay closures
- 120 total bed days were lost, (60 C. diff, 56 flu, 4 COVID)

**Actions to improve performance in areas above trajectory**

A targeted programme of improvement is in place, informed by enhanced surveillance, post-infection review, audit and identification of potentially avoidable infection. Whilst a range of evidence-based interventions are established, sustained improvement is dependent on their reliable and consistent implementation in operational practice.

**C. difficile**

- Continued participation in the National C. difficile Collaborative, supporting targeted behavioural and quality improvement interventions.

- Faecal Microbiota Transplant (FMT) service supporting the management of recurrent infection. The service is currently available in the West, with further work required to enable equitable access across other localities.
- Development of C. difficile cohort capacity in the East, alongside estates solutions to improve isolation capacity and reduce transmission risk.
- Environmental decontamination capability has been enhanced through the introduction of high-level disinfection technology. However, consistent delivery remains challenging due to limited decant capacity, and domestic services capacity, particularly within Central.
- Enhanced surveillance to identify trends, themes and emerging risks and enable more targeted intervention.
- Continued antimicrobial stewardship, addressing an important modifiable risk factor for C. difficile infection.
- Workforce development, audit and assurance focused on strengthening the consistent application of IPC measures.

**S. aureus bloodstream infection, including MSSA and MRSA**

- The S. aureus Post-Infection Review (PIR) process is being strengthened to provide greater scrutiny of healthcare association, avoidability, contributory factors and opportunities for learning.
- Cases where potentially avoidable infection or opportunities for prevention are identified will be considered through the East Integrated Concerns meeting, providing multidisciplinary review and medical oversight and strengthening clinical ownership and accountability for improvement actions.
- Continued focus on modifiable risk factors, including invasive device management, aseptic technique, screening through Tier 2 audits
- Enhanced surveillance and thematic review to identify recurrent themes and opportunities for prevention.
- Audit and triangulated assurance of IPC practice, including environmental cleanliness and ATP monitoring.

**Pseudomonas aeruginosa**

- Strengthened PIR and epidemiological review to improve understanding of healthcare-associated cases, contributory factors and opportunities for prevention.
- Enhanced surveillance to identify trends, clusters and risk factors.
- Continued audit and assurance of water safety and environmental controls.
- Environmental monitoring where indicated to provide additional assurance and identify potential environmental risks.

**Klebsiella species and other Gram-negative bloodstream infections**

- Enhanced surveillance and case review to improve understanding of acquisition, healthcare association and potentially modifiable risk factors.
- Continued antimicrobial stewardship to support appropriate antimicrobial use and reduce antimicrobial resistance pressures.
- Workforce development, audit and assurance to reinforce best practice in infection prevention and management.
- Increasing focus on differentiating healthcare-associated from community-onset infection to ensure improvement activity is targeted towards cases and risk factors where healthcare interventions can influence outcomes.

It is important when interpreting the overall Gram-negative bloodstream infection position to recognise that a proportion of infections are community-onset and are not attributable to healthcare delivery. Consequently, not all cases will be directly preventable through healthcare-focused IPC interventions.

**Strengthening scrutiny, learning and assurance**

The Infection Prevention Team is strengthening its scrutiny of HCAI cases, with greater focus on healthcare association, preventability, recurrent themes and identification of opportunities for intervention. This will include greater triangulation of surveillance, PIR findings, incidents, audit and assurance information.

The team will also commence use of the organisational Learning Repository to support the systematic capture and sharing of learning arising from HCAI reviews, outbreaks and infection-related incidents, enabling recurrent themes and barriers to improvement to be more readily identified, shared and escalated.

**Challenges to delivery and sustained improvement**

Despite the breadth of improvement activity, sustained reduction in HCAI remains challenging. Surveillance, PIR and assurance activity continue to identify variation in the consistent application of established infection prevention measures. Operational pressures, workforce capacity, competing clinical priorities, environmental and estate constraints, limitations in isolation and decant capacity, and variable behaviours and ownership can impact on the timely and reliable implementation of IPC requirements.

The challenge is therefore not solely the identification of further interventions, but ensuring that existing evidence-based measures are consistently embedded in everyday practice. Strengthened scrutiny and escalation will provide greater visibility of recurrent barriers and areas where additional clinical, operational or organisational support is required.

**Outbreak preparedness and organisational resilience**

The Health Board continues to strengthen outbreak preparedness through updated policies, processes and clear escalation arrangements and organisational learning. This includes preparedness for seasonal infection pressures such as influenza and norovirus, with emphasis on early identification and implementation of control measures whilst maintaining operational resilience.

**Patient and public engagement**

Work continues to strengthen patient and public involvement in IPC, including the development of educational resources and initiatives to promote effective infection prevention behaviours amongst patients and visitors.

**Overall assurance**

Collectively, these initiatives provide the framework required to support HCAI improvement. However, achieving sustained improvement requires consistent operational delivery and collective clinical, operational and organisational ownership of infection prevention measures. Current surveillance and review demonstrate that this remains variable, with operational pressures, environmental constraints and behavioural factors continuing to affect reliable implementation.

The Infection Prevention Team is therefore strengthening scrutiny, escalation and organisational learning, including enhanced PIR arrangements and use of the Learning Repository, to ensure that potentially avoidable infections, recurrent themes and barriers to improvement are identified, visible and acted upon. For bloodstream infections, particularly Gram-negative infections, continued differentiation between community-onset and healthcare-associated infection is also important, recognising that not all cases are attributable to healthcare delivery or amenable to IPC intervention.

## 11. QUALITY ASSURANCE

### 11.1 Health Inspectorate Wales

HIW inspection action plans remain in progress, with some overdue actions requiring continued monitoring.

The Quality Assurance Team continue to work with clinical areas to progress HIW action plans. Below are listed all open HIW improvement plans, with targeted plans to progress completion. Continuous monitoring via Local HIW Review Meeting, service accountability meetings and Executive Quality Delivery Group (EQDG).

**Inspection – Conwy Learning Disabilities Team, HIW/CIW Assurance Check (9th to 11th February 2026)**

- **Status**: In Progress
- **Recommendations**: 16
- **Actions**: 51 total, 47 completed (65% to 92% from last reporting period)
- **Outstanding**: 4 actions remain in progress
- **Closure Date**: 31st October 2026

The assurance check was undertaken jointly by Healthcare Inspectorate Wales (HIW)and Care Inspectorate Wales (CIW) and reviewed the statutory functions and performance of both Conwy County Borough Council's Community Learning Disability Team and Betsi Cadwaladr University Health Board's Learning Disabilities Directorate. As a result, a number of recommendations and actions are shared across the Local Authority and Health Board and require a multi-agency response. Progress is being delivered collaboratively through established partnership arrangements, with ongoing oversight through local and corporate governance structures.

**Inspection – Ablett Unit, YGC (27th to 29th April 2026)**

- **Status**: Overdue
- **Recommendations**: 16
- **Actions**: 52 total, 41 completed (46% to 79% from last reporting period)
- **Progress Status**: 11 actions remain (1 overdue,10 partially complete overdue)
- **Closure Date**: 15th November 2026

Summary of Overdue Actions

The remaining 11 actions are largely embedded within operational practice and are awaiting completion of audit cycles, sufficient data collection, or reporting through local, central and divisional governance arrangements to provide the assurance required for formal closure. Oversight of these actions is maintained through established governance processes, with progress monitored regularly to ensure delivery and capture organisational learning. Based on current progress, there is confidence that the remaining actions will be closed as the final assurance evidence becomes available.

**HIW Inspection – Nuclear Medicine Inspection, Ysbyty Gwynedd (26-27 March 2026)**

- **Status**: Overdue
- **Recommendations**: 24

- **Actions**: 26 total, 19 completed (40% to 73% from last reporting period)
- **Progress Status**:7 actions remain (3 overdue and 4 are awaiting quality assurance)
- **Closure Date**: 31st October 2026

Summary of Overdue Actions

The Professional Service Manager has confirmed that evidence demonstrating completion of the remaining actions has been collated by the service and is currently undergoing final review and quality assurance. Subject to successful validation of the evidence provided, the actions will be updated accordingly and the improvement plan is expected to achieve full compliance, with no remaining overdue actions. Progress continues to be monitored through established governance arrangements to ensure appropriate oversight and assurance.

**HIW Inspection – West End Medical Centre (21 April 2026)**

- **Status**: Overdue
- **Recommendations**:6
- **Actions**: 20 total, 8 completed (15% to 40% from last reporting period)
- **Progress Status**:12 actions remain (5 partially complete overdue, 2 overdue and 5 in progress)
- **Closure Date**: 31 January 2027

Summary of Overdue Actions

The remaining actions primarily relate to the completion of governance and assurance activities, including the implementation of patient communication initiatives, workforce benchmarking, policy and standard operating procedure development, and the collection of evidence to demonstrate sustained compliance. Progress is being monitored through established governance arrangements, with several actions awaiting final assurance, supporting documentation or completion of planned review cycles. The service has reported continued progress against the improvement plan and work remains ongoing to achieve full compliance with the HIW recommendations.

**HIW Inspection – YGC Emergency Department Immediate Improvement Plan (5 – 7 May)**

- **Status**: Overdue
- **Recommendations**:9
- **Actions**:52 total, 46 completed (87% to 88% from last reporting period)
- **Progress Status**:6 actions remain (4 partially complete overdue and 2 overdue)
- **Closure Date**: 31/12/2026

Summary of Overdue Actions

The remaining actions relate to the completion of leadership and culture development initiatives, implementation of governance arrangements for staff concerns, evaluation of improvement measures through PDSA cycles, and achievement of Level 3 Safeguarding training compliance. Progress continues across all outstanding actions, including the establishment of safeguarding

training sessions in October 2026. The majority of actions have been implemented in practice and are awaiting final assurance, supporting evidence or completion of planned review cycles before closure. Progress is monitored through established governance arrangements to ensure ongoing oversight, delivery and organisational learning.

**HIW Inspection – YGC Emergency Department Main Improvement Plan (5 – 7 May)**

- **Status**: Overdue
- Recommendations:92
- Actions:173 total, 11 completed (6%)
- **Progress Status**: 162 actions remain (52 in progress, 3 partially complete overdue, 96 overdue, 6 awaiting quality assurance and 5 rejected for further evidence)
- **Closure Date**: 31 May 2027 (this is an anticipated date and is subject to continued progress and validation of assurance evidence).

**Summary of Overdue Actions**

The service continues to progress all outstanding actions, which are subject to robust oversight through a dedicated weekly improvement meeting jointly chaired by the Integrated Health Community Director of Nursing Central and the IHC Director of Therapies. This forum brings together senior operational, medical and nursing leaders to review progress, risks and barriers to delivery. Many of the overdue actions became due during September 2026 and relate to the implementation, embedding and assurance of improvement activity, including training, governance processes, audit programmes and monitoring arrangements. Whilst a significant proportion of actions are currently reported as overdue, work is ongoing across all action areas and progress continues to be closely monitored through established local and corporate governance arrangements. This includes an executive escalation meeting with the IHC.

The dates for delivery set were consciously ambitious due to associated patient safety concerns. Whilst it was acknowledged that the actions would be challenging to fully deliver, it was necessary to place the required importance and sense of urgency to complete the actions. HIW colleagues have been kept up to date with progression of the improvement plan and actions through the regular engagement meetings.

**11.2 Concerns / Requests for Assurance (2)**

**Ablett Unit, Glan Clwyd Hospital**

HIW sought assurance regarding the use of Section 136, delays in assessment, transfer and discharge, staffing levels and skill mix, staff wellbeing and fatigue, ward management support, and governance arrangements relating to risk management decisions.

The Health Board provided a formal response to HIW on 3 September 2026, outlining actions taken and the findings of a targeted review. The response provided assurance regarding staffing arrangements, patient observation processes, governance oversight, risk management decision-making and workforce wellbeing arrangements, whilst acknowledging ongoing pressures

relating to inpatient mental health bed capacity and patient flow. No further requests for assurance have been received from HIW.

The Health Board continues to monitor the actions and assurances associated with this matter through established local and corporate governance arrangements. This provides ongoing oversight of delivery, monitoring of improvement actions and the identification and dissemination of organisational learning, where applicable.

**Nant Y Glyn Community Health Team**

HIW sought assurance regarding psychiatrist availability, the timeliness of decisions and actions taken under the relevant legal framework to manage patient risk, and communication issues affecting access to the service.

The Health Board provided a formal response to HIW on 14 September 2026, outlining the arrangements in place to ensure access to psychiatric assessment and senior clinical decision-making, together with the actions taken in response to the concerns raised. The response provided assurance regarding clinical oversight, risk management and service communication arrangements. No further requests for assurance have been received from HIW.

The Health Board continues to monitor the actions and assurances associated with this matter through established local and corporate governance arrangements. This provides ongoing oversight of delivery, monitoring of improvement actions and the identification and dissemination of organisational learning, where applicable.

**11.3 Quality Peer Reviews**

The Health Board's Quality Peer Review Programme provides an independent source of assurance and supports continuous improvement across services. The programme is aligned to HIW inspection methodology, the Duty of Quality (Wales), and the Health and Care Quality Standards. Reviews are intelligence-led and informed by a range of triangulated sources, including regulatory findings, internal governance information and the Health Board Quality Dashboard.

The frequency and focus of reviews are determined by emerging risks, quality intelligence, organisational priorities and areas where additional assurance is required, ensuring review activity remains proportionate, targeted and responsive to changing organisational risk profiles.

**Quality Peer Review of the Emergency Department, Ysbyty Gwynedd, was undertaken on 30 September 2026.**

The review identified a number of patient safety, clinical governance, environmental and operational issues requiring action.

Key themes included patient identification and safety processes, medicines management, management of paediatric patients, environmental safety, infection prevention and control, controlled drugs governance, and strengthening clinical oversight and governance arrangements.

An Immediate Improvement Plan has been issued to the service and monitored through the Health Board's established Quality Assurance and Regulatory Framework, including the AMaT system, to support ongoing monitoring, audit and executive oversight. The action plan is due to be completed by 27th October and a repeat visit planned for next few weeks. Progress is monitored with support at Quality Assurance weekly meeting forums and thereafter the Governance and Regulation Executive Delivery Group.

Findings from Quality Peer Reviews are incorporated into service improvement plans and monitored through the Health Board's Quality Assurance and Regulatory Framework. These are also tracked through accountability forums (WICOP) Learning identified through review activity is triangulated with other sources of quality intelligence, including regulatory findings, incidents, patient experience and performance information, to support organisational learning and provide assurance regarding the quality and safety of services across the Health Board.

**11.4 <u>Care Inspectorate Wales (CIW)</u>**

CIW Inspection of Enhanced Community Residential Services (ECRS) (1 July 2026)

CIW undertook an inspection of the Health Board's Enhanced Community Residential Services (ECRS) within Mental Health and Learning Disabilities on 1 July 2026.

The inspection resulted in ratings of "Requires Significant Improvement" across Wellbeing, Care & Support, and Leadership & Management, with eight Priority Action areas identified relating to safeguarding, medicines management, care planning, governance, workforce arrangements and quality assurance.

Following receipt of the draft report, the service commenced a validation exercise to review the findings against available evidence and inform consideration of the CIW review process. In parallel, a comprehensive improvement programme has been established, supported by enhanced operational and clinical oversight, strengthened governance arrangements and the establishment of an ECRS Improvement Oversight Group to monitor delivery and provide assurance regarding the implementation of improvements.

The improvement plan is now being monitored through the Health Board's established regulatory assurance arrangements, including AMaT. Key areas of focus include person-centred care and care planning, patient safety and safeguarding, medicines management, leadership and governance, quality assurance, and workforce development.

Immediate improvement actions have been implemented and progress will continue to be monitored through established governance and regulatory assurance processes to support sustainable improvement and organisational learning.

**11.5 <u>Public Services Ombudsman for Wales (PSOW)</u>**

BCUHB has recently established an Ombudsman Executive Integrated Oversight Group to provide enhanced oversight and Executive scrutiny,

strengthen organisational assurance, and ensure robust learning and implementation of Ombudsman recommendations.

BCUHB currently has 37 open Ombudsman cases, a decrease from 38 in previous reporting period.

| | |
|---|---|
| Notification of New Full Investigations | 3 |
| Awaiting Draft Report | 13 |
| Draft Report Received | 4 |
| Awaiting Final Report | 2 |
| Final Report Received and working on action plans | 2 |
| Early Resolution Proposals | 5 |
| Further Info requested during investigation | 2 |
| Enquiries | 5 |
| Further evidence requested for Sign Off | 1 |
| **Total Cases Open** | **37** |

## Public Interest Reports

The Ombudsman considers these cases to raise issues of public interest, subject to any representations from the Health Board or complainant.

## Final Public Interest Report 202404388

The Ombudsman's investigation considered aspects of the patient's care and treatment following a prostate cancer diagnosis, including delays in diagnostic investigation and treatment.

Six recommendations were issued by the Ombudsman. The Health Board has submitted a final action plan to the Ombudsman and provided evidence of compliance against the recommendations. Ongoing monitoring will continue through established governance arrangements until all actions are fully embedded.

## Final Public Interest Report 202501841

The Ombudsman's investigation considered the appropriateness of prescribed medication and whether sufficient information and support had been provided to the patient and family regarding associated safety risks.

Eight recommendations were issued by the Ombudsman. Five actions have been completed, with the remaining three actions progressing through implementation. Two of the three actions are not due until 4th December. The Audit Committee received the full report on 20th October 2026 and agreed that oversight and assurance against the report would need to be overseen by Quality Safety and Assurance Committee.

The Health Board has established an enhanced Ombudsman Executive Incident and Concerns Oversight Process (EICOP) meeting, chaired by the Executive Medical Director, to provide oversight of Ombudsman investigations, recommendations and associated improvement activity. In addition, a thematic review of Ombudsman cases is being undertaken to identify recurring themes and opportunities for organisational learning. Learning arising from

Ombudsman investigations, Public Interest Reports and recommendation compliance activity will be incorporated into wider organisational learning arrangements, including the Integrated Concerns Process and Learning Repository.

The Health Board continues to work openly and collaboratively with the Ombudsman and remains focused on ensuring timely implementation of recommendations and the dissemination of learning arising from investigations.

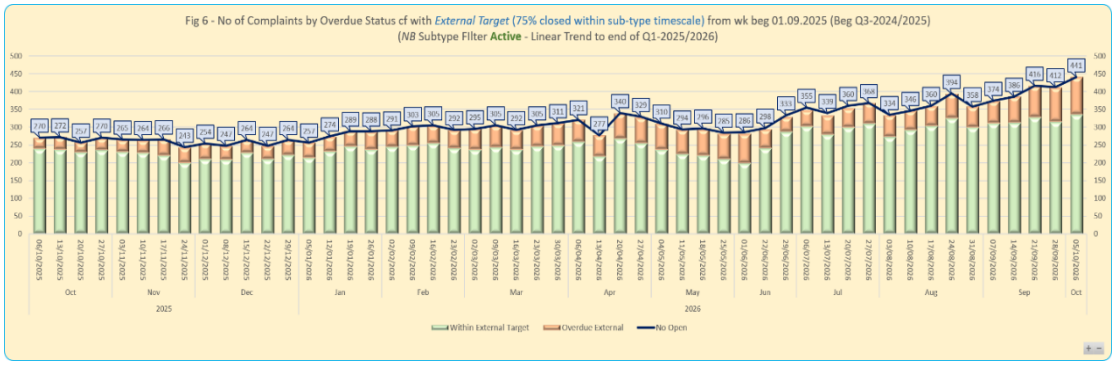
## 12 PATIENT AND CARER EXPERIENCE

### 12.1 Complaints

The current landscape in complaints has become increasingly challenged, with a significant and sustained rise in total complaints being received into the health board, creating a backlog of complaints within the corporate team, with volume exceeding capacity to respond to complaints within IHC/ Divisions, after a period of sustained improvements in performance since 2024 The upward trend in complaints remains a concern for the Health Board and is being closely monitored to identify underlying themes and implement targeted improvement actions.

From 1st April 2026 to 31st August 2026 (latest data on Beacon) the number of complaints received across Wales was 4425 which equates to 235.62 complaints per 100,000 population. In the same time period, BCUHB received 1134 (25.6% of the total of complaints received across NHS Wales), which equates to 191.77 complaints per 100,000 population. This shows that although locally our complaint numbers are high, they are below the All Wales figure.

**Total Complaints Open Trajectory**




The following table displays key complaints metrics as of 5th October 2026

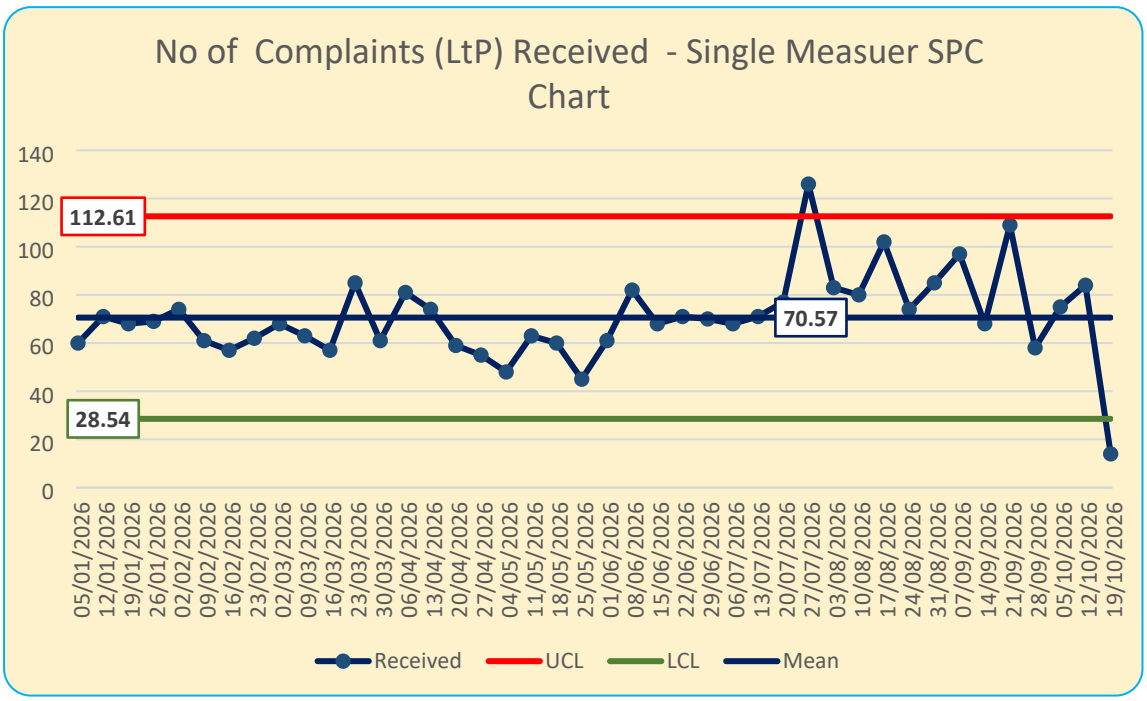
| Metric | Status | Trend |
|---|---|---|
| Total Open Complaints | 441 | Increase from 324 |
| Number Overdue | 106 | Increase from 61 |
| Overall Compliance (Target 75%) | 75.86% | Decrease from 81.17% |

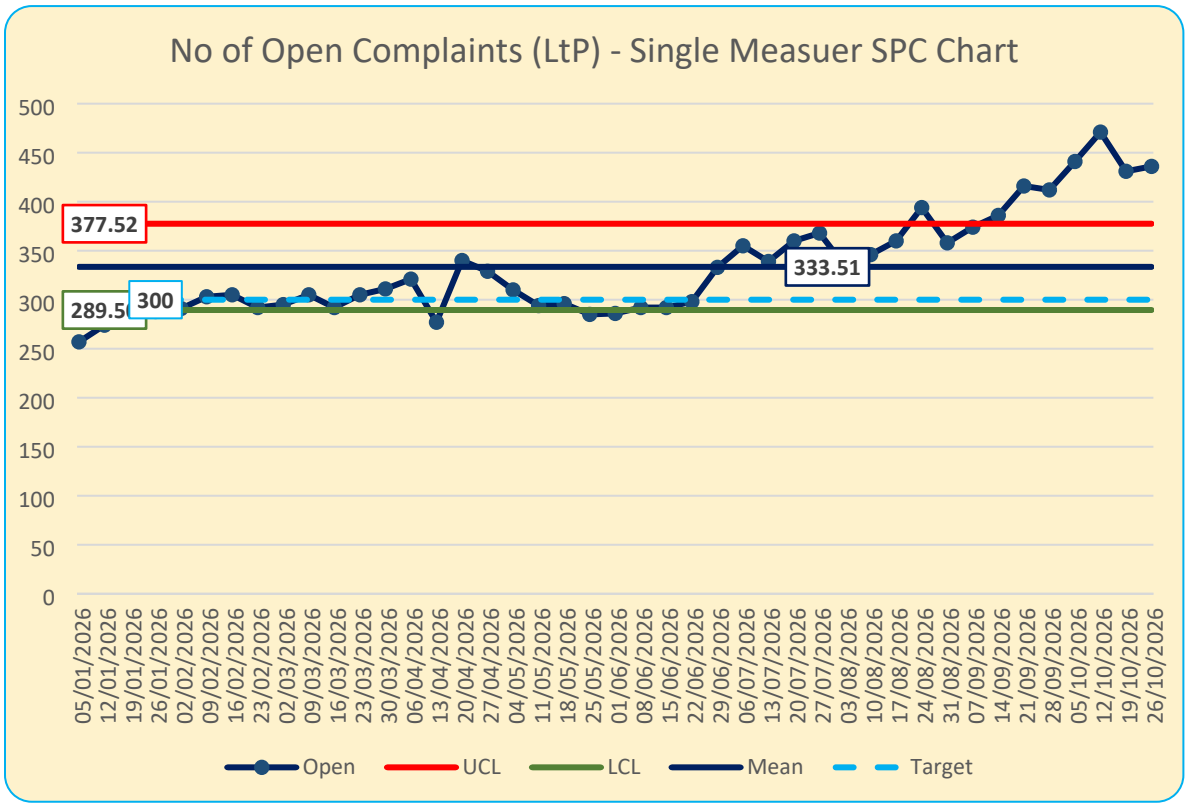
Complaints remaining open under Putting Things Right (PTR), Pre-1st April 2026 total = 4, down from 12 in the previous reporting period.

| Complaint Subtype | Total | Overdue | Compliance |
|---|---|---|---|
| Manged by PTR | 4 | 4 | 0.00% (Target 75%) |
| LTP Early Resolution | 20 | 1 | 95.24% (Target 40%) |
| LTP 30 WD | 243 | 68 | 78.14% (Target 75%) |
| LTP 60 WD | 61 | 33 | 35.11% (Target 75%) |
| LTP 90 WD | 9 | 1 | 90% (Target 75%) |
| LTP 120 WD | 2 | 1 | 66.67% (Target 75%) |

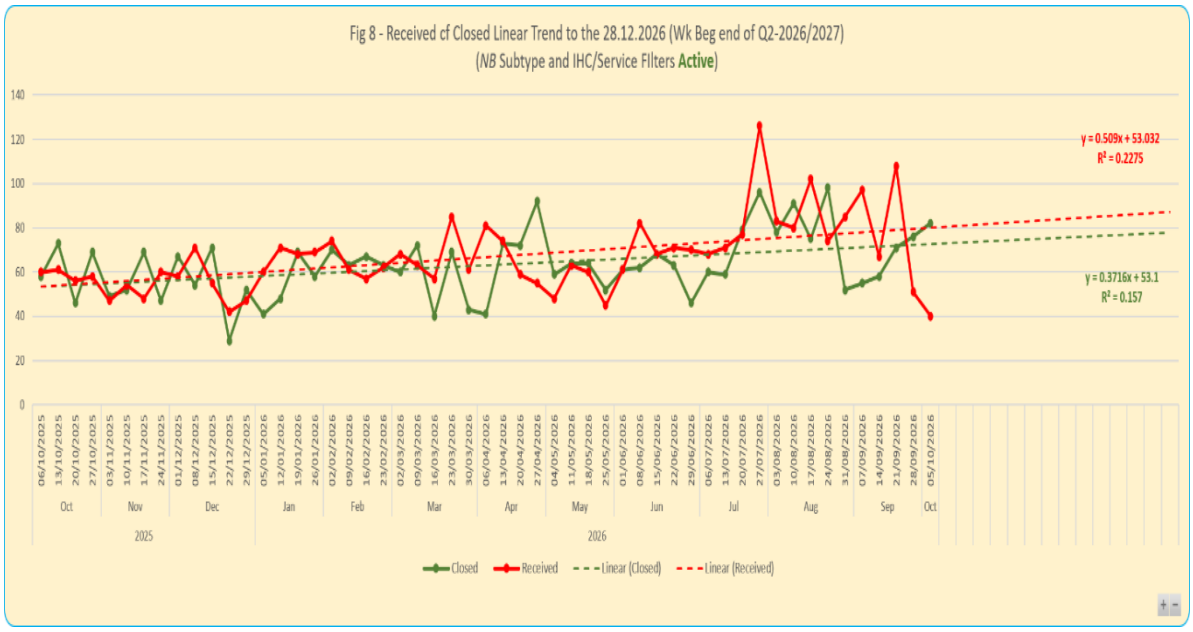
Between 3rd August and 5th October 2026, the health board received 787complaints (Average 78.7 per week) complaints and closed 736 complaints a positive variance of 51.

Complaints Received SPC chart






The chart below, shows the relationship between complaints (received Vs closed), if the red bar is higher than the green bar the Health Board has received more complaints than it has closed.



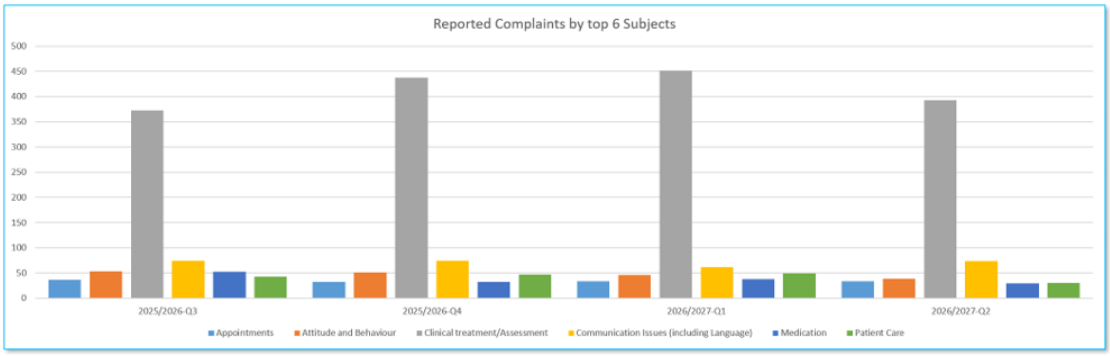

The table below shows that there has been an increase in complaints held at the point of reporting compared to the previous reporting period in July, in IHC East and IHC west, with IHC East deemed significant.

The three IHCs combined account for 287/374 (71.42%) of total complaints.

| IHC | Within target | Overdue | Total open |
|---|---|---|---|
| **Central** | 88 | 45 | **133** **(Up from 120)** |
| **East** | 89 | 7 | **115** **(Up from 64)** |
| **West** | 58 | 5 | **67** **(Up from 54)** |
| **Total** | **237** **(Up from197)** | **40** **(Down from 41)** | **315** **(Up from 238)** |

The top six main themes of complaints, are as follows, broken down by Quarter

- Delay in clinical assessment including treatment and procedure delays
- Communication issue with patient / relatives
- Staff Attitude and behaviour
- Appointments
- Medication
- Patient Care

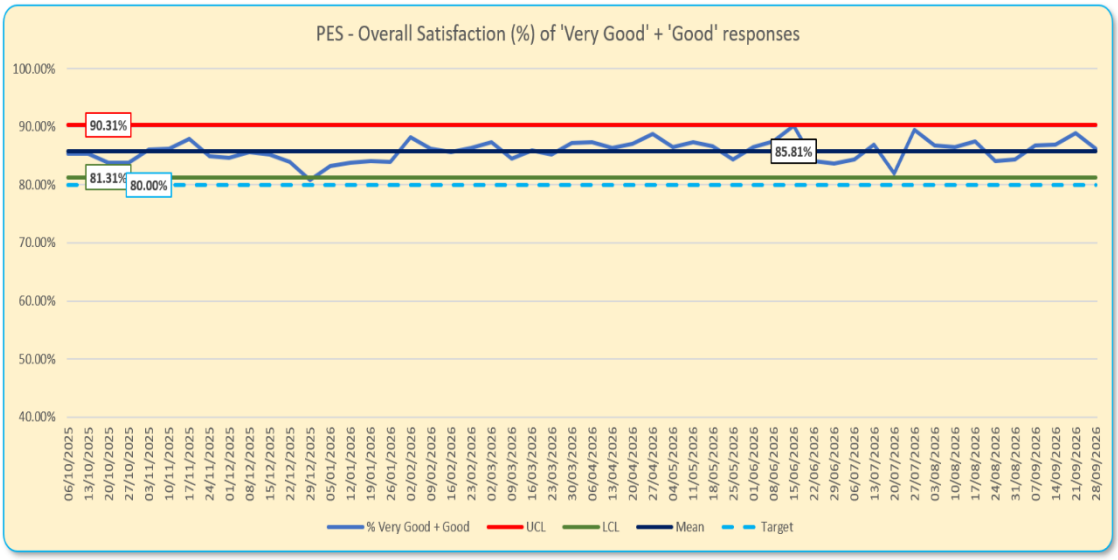



## 12.2 PATIENT EXPERIENCE

The People's Enquiry and Resolution Service (PEARS) supported the resolution of 707 enquiries between 1st August 2026 and 30th September 2026. The top 3 enquiry themes included; appointments, communication, and clinical treatment and assessment.

Within the reporting period 53 compliments were recorded. The top 3 compliment themes included; 'professional and caring staff', 'staff went the extra mile' and the 'service was beyond expectations.

Findings from the All-Wales People's Experience Survey remain highly positive. Based on 9,119 responses, 86.40% (up from 85.67%) of patients rated their overall experience as 'Good" or 'Very Good'. This exceeds the NHS Wales satisfaction benchmark of 85%




Satisfaction levels were high with people reporting they were ‘Always’ treated with dignity and respect (86.33%) and being able to communicate in a preferred language (90.87%), which exceeded the national benchmark of 85% satisfaction.

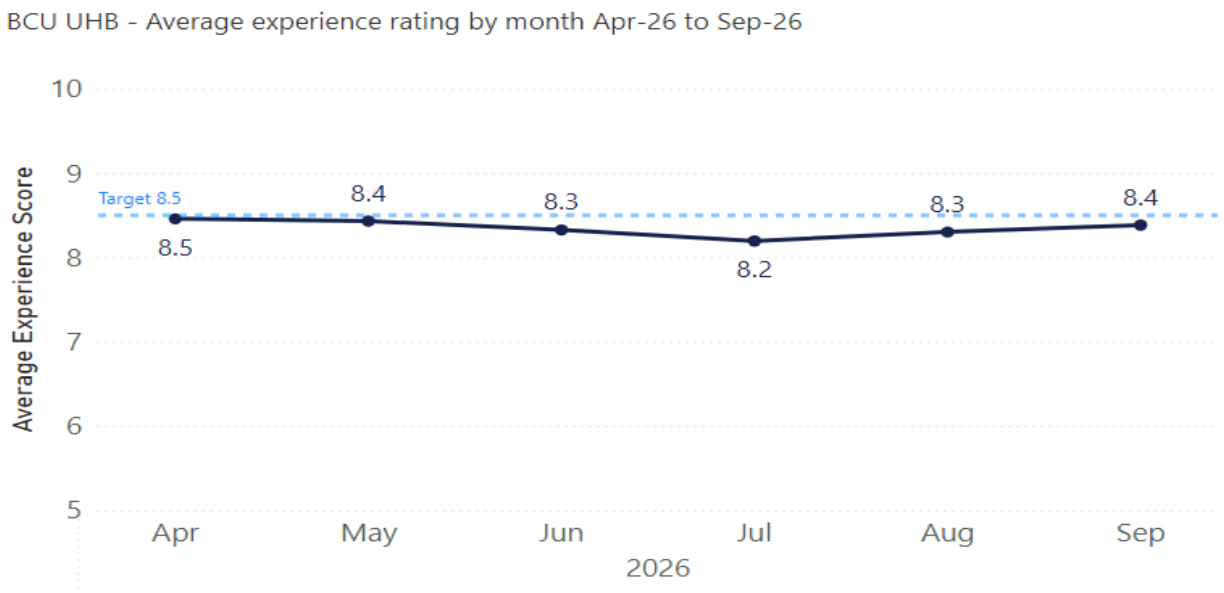
Overall waiting time satisfaction levels are below the national benchmark of 85%. In August 2026, 73.18% of respondents shared a positive experience for the time they waited (42.76% shorter than expected and 30.42% about right). In September 2026, 73.86% shared a positive experience for the time they waited (43.90% shorter than expected and 29.96% about right).

The following table displays key feedback metrics for the reporting period, which have increased slightly compared to the previous reporting period (“Always” response).

| **Survey Question** | **% of “always” response** | **Trend (vs. previous reporting period)** |
|---|---|---|
| Felt well cared for | 74.61% | Decrease from 75.09% |
| Felt listened to | 79.48% | Increased from 79.19% |
| Involved in decisions about their care | 77.41% | Increased from 76.76% |
| Explained in a way they could understand | 81.76 % | Increased from 80.79% |

Nationally the Health Board is ranked 4th in terms of best overall patient experience, with a score of 8.3 /10 (PHW = 9.2, SBU = 8.9, WAST 8.5).

On the 1st July 2026, the average experience rating was the lowest reported over the past 12 months (8.2), however this position has now improved with satisfaction ratings in September 2026 with a score of 8.4.




The Health Board received 203 Easy Read NHS Wales People's Experience Survey responses, with 83.15% of respondents sharing a positive overall experience (14.61% good and 68.54% very good).

The People's Experience Service (PES) conducted targeted work identifying services with high frequency low level concern/enquiry themes, by conducting Care 2 Share Interviews with patients to understand real-time experiences. There was a specific focus on surgical and medical service areas who had received a significant number of enquiries/concerns. In total 61 Care2Share patient interviews were undertaken across 13 healthcare settings capturing experiences and identifying opportunities for service improvement. Evidence of learning from this feedback is displayed in "You Said, We Did" posters across the service/ward areas for the public to view.

<u>Tegid Ward, Ysbyty Gwynedd:</u>

You said: "When I arrived on the ward, I felt disoriented and unsure where things were".

We did: "The ward improved signage to toilets, day rooms, exits, and nurse stations".

<u>Alaw Day Unit, Ysbyty Gwynedd:</u>

You said: "Sometimes there is a delay starting treatment due to the chemotherapy not being here on time".

We did: "Concerns regarding delays were shared with Pharmacy for their review. A poster was created to keep patients informed on the process of waiting for chemotherapy medication".

Aran Ward, Ysbyty Gwynedd:

You said: “I am unsure what the different staff uniforms mean, and which role relates to which uniform”.

We did: “The Ward will be producing an information leaflet for all admitted patients which will provide this information to you”.

In addition to routine Care2Share discovery interview activity, the team undertook targeted engagement and improvement work at several sites, including the Ablett Unit, North Wales Cancer Treatment Centre, Alaw Day Unit working directly with patients, carers and staff to better understand experiences and support local service development. Five patient stories were captured sharing experiences of patients accessing the Community High Dependency Team (West), Memory Assessment Service (West) Self-Care Team (Pan North Wales), Cancer Services (East) and Women’s Service (East). The People’s Experience Service work with services to formulate learning and opportunities for improvement from these individual experiences. Patient stories are shared across services to promote good practice, and are presented at Health Board meetings including People’s Experience Groups and Board.

The People’s Experience Service are supporting work in response to Healthcare Inspectorate Wales (HIW) actions identified within the Emergency Department at Ysbyty Glan Clwyd. Improvements have been made around waiting time experiences, including the introduction of an Emergency Department patient information leaflet, improved information and signposting in waiting areas, increasing the recognition and involvement of un-paid carers by asking the patient if they are being supported by an un-paid carer at the booking in process. This work is now being replicated across Ysbyty Gwynedd and Wrexham Maelor Emergency Departments.

The People’s Experience Service, together with the support of the Readers Panel reviewed 13 patient information leaflets. Examples include:

- Tinnitus
- Sound Therapy
- Ward 14 information leaflet
- Welcome/discharge planning leaflet

**Advocacy and Support**

The Chaplain and Spiritual Care Service responded to 161 requests for support from staff, patients, relatives, and community faith leaders in the reporting period.

This focus on the patient's experience of care is matched by an equal focus on the effectiveness of the clinical care provided.

## 13 HEALTHCARE LAW

### 13.1 Coroner and Inquests

During the reporting period, one Prevention of Future Deaths (PFD) Report was received by the Health Board. The Coroner's concerns relate to the circumstances of an unwitnessed inpatient fall at Llandudno General Hospital, including the use of the ward day room, patient observation arrangements, environmental factors within that area, and the adequacy of the subsequent organisational learning review. The Coroner noted that the Health Board's review concluded the fall was unavoidable and made no recommendations, but expressed concern that further analysis and consideration of preventative measures should have been undertaken. The Coroner did not call any witnesses from the Health Board for the inquest.

A response to the above PFD was submitted within the required timeframe, setting out the Health Board's actions and commitments. The response set out local actions to strengthen risk assessment, observation and supervision arrangements, and environmental safety within communal patient areas. Health Board-wide commitments include sharing the learning across community hospital services and relevant governance forums, and strengthening Executive-level scrutiny and assurance of incident investigations and learning reviews.

### 13.2 Liability Claims

The Health Board continues to maintain focused oversight of Learning from Events Reports (LFERs) required by the Welsh Risk Pool. A detailed thematic review of claims is planned in the coming period.

As at the end of September 2026, there were 17 overdue LFERs across claims and redress matters (slightly up from 16 at the end of July 2026 – performance is notably staled in Central and East IHCs). Overall performance remains significantly improved compared with previous years, with penalties for late submission reducing from 66 in 2024/25 to 29 in 2025/26. Three penalties have been incurred during the current financial year.

Process improvements remain in place, including earlier internal assurance deadlines ahead of Welsh Risk Pool submission dates, which are intended to improve the quality of reports, reduce deferrals and minimise the risk of financial penalties

At a national level it is noted that the overall value and complexity of claims continues to increase, including the resulting financial impact. The Welsh Risk Pool Committee continues its focus on organisational learning and assurance arising from claims and redress. There is a clear emphasis on demonstrating that learning has been embedded and translated into measurable service improvement, rather than solely identifying lessons learned. The Committee is supported by the National Learning Advisory Panel in reviewing learning arising from clinical negligence, redress and personal injury cases. LFERs are scrutinised against the actions taken, interventions implemented and evidence

of improvement, with reimbursement linked to satisfactory completion of the learning assurance process.

There are a number of WRP-led national learning and harm-prevention initiatives underway. Current programmes include PROMPT (Practical Obstetric Multi-Professional Training), MoNET (Multi-Professional Neonatal Emergency Training), wider maternity and neonatal safety work, decision-making and consent initiatives (including digital consent systems), national safety and learning networks, radiology unexpected findings reviews, venous thromboembolism prevention, and the Once for Wales concerns management system. A consistent theme was the importance of identifying learning from incidents and claims, sharing that learning across NHS Wales, and providing assurance that improvement actions have been embedded and are resulting in safer care and better outcomes for patients.

**13.3 Other Health Law Updates**

Legal Services continues to support organisational learning through the integration of claims, redress, inquests and wider governance processes. Learning identified is shared with relevant services and governance forums to support quality improvement, as well as through the national Learning from Events Report process. In addition, a six-monthly Legal Learning Report is produced to identify recurring themes and highlight emerging risks identified through legal casework.

The Health Board continues to monitor the Public Office (Accountability) Bill, commonly referred to as the “Hillsborough Law”, which has completed its passage through the House of Commons and is now progressing through the House of Lords. The Bill would introduce statutory duties of candour, transparency and frankness for public authorities and public officials, together with associated requirements concerning cooperation with inquiries and investigations, ethical conduct and accountability. If enacted, the legislation is likely to have significant implications for the Health Board’s governance, incident management, record keeping, disclosure, inquest and inquiry processes and organisational culture. Legal Services will continue to monitor the Bill’s passage and advise on the organisational preparations required.

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

# Quality, Safety and Experience Committee

## INTEGRATED QUALITY AND PERFORMANCE REPORT (IQPR)

| | |
|---|---|
| **Dyddiad y Cyfarfod<br>Date of Meeting** | 05 November 2026 |
| **Statws Cyhoeddi<br>Publication Status** | Open / Public |
| **Enw a theitl Awdur(on) yr Adroddiad<br>Report Author name and title** | Olivia Shorrocks, Director of Performance<br>Michelle Jones, Head of Financial Reporting<br>Daniel Eyre, Head of Capital Development |
| **Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol<br>Lead Executive Team Member name and title** | Alan Streets<br>Cyfarwyddwr Gweithredol Cyllid Dros Dro<br>Interim Executive Director of Finance |
| **Pwrpas yr Adroddiad<br>Report Purpose** | For noting |

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

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

# INTEGRATED PERFORMANCE AND QUALITY REPORT

## 1.0 Y SEFYLLFA / SITUATION

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

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

## 2.0 Y CEFNDIR / BACKGROUND

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

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

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

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

### 3.1 Performance and access

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## 3.2 Quality, safety and patient experience

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

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

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

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

## 3.3 Finance and Sustainability

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

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

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

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

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

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

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

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

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

3.4 **People and places**

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

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

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

## 4.0 ASSESSMENT

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

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

## 5.0 ARGYMHELLION / RECOMMENDATIONS

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

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

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

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

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

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

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

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

05 November 2026

Trugaredd
Compassion

Agored
Openness

Parch
Respect

# Betsi Cadwaladr University Health Board

# Integrated Quality and Performance Report (IQPR)

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# Introduction

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

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

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

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

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

# Executive Summary: Performance and access

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

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

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

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

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

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

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

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

# Executive Summary: Quality, safety and patient experience

**Complaints**

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

**Patient Experience**

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

**Patient Safety Incidents**

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

**Patient Safety**

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

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

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

# Executive Summary: Population health and prevention

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

**Areas to note**

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

**Meningitis B Vaccination Programme – 2026/27**

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

**Flu Programme – 2026/27**

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

**Diabetes Care**

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

# Executive Summary: People and places

**Vacancy Rate**

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

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

**Workforce Planning and Efficiency Programme**

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

**Turnover**

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

**Sickness Absence**

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

**Agency Workforce Usage**

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

**Performance Appraisal and Development Review (PADR)**

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

**Mandatory Training Compliance**

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

# Executive Summary: Finance and sustainability

**Financial Plan**

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

**Financial Position**

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

| | 2026/27 Monthly Variance | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Actual | | | | | | Forecast | | | | | | | |
| | April £m | May £m | June £m | July £m | August £m | Sept £m | Oct £m | Nov £m | Dec £m | Jan £m | Feb £m | Mar £m | Year to Date Position £m | Full Year Forecast Outturn Position £m |
| Total Monthly Surplus/ (Deficit) | (5.4) | (5.6) | (6.2) | (5.8) | (6.4) | (1.8) | (2.1) | (1.6) | (0.9) | (0.7) | (0.5) | 2.70 | (31.1) | (34.3) |

**Savings and Mitigations**

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

**Capital Programme**

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

**Key Risks & Matters for Escalation**

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

# Section 1
# Performance and access



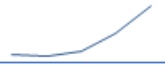
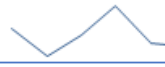
# Scorecard : Performance and access (1 of 3)

| REF | Measure Description | Target Suite | | | Wales Benchmark | Actual Performance | | | | Status |
|---|---|---|---|---|---|---|---|---|---|---|
| | | NT | SM | AP | | Jul-26 | Aug-26 | Sep-26 | 6 Month Activity | |
| LMU01 | Total number of ambulance coveyances to acute emergency departments | - | - | - | N/A | 3538 | 3437 | 3392 |  | Advise |
| 3AP02 | Percentage of ambulance handovers within 15 minutes | 80% | - | 21% | 6th of 6 (at Jun 26) | 15.8% | 17.1% | 14.7% |  | Escalate |
| 3AP01 | Number of ambulance patient handovers over 45 minutes | 0 | - | 1923 | 7th of 7 (at Jun 26) | 1549 | 1467 | 1791 |  | Escalate |
| LMU02 | Number of ambulance patient handovers over 1 hour | - | 1710 | 0 | 6th of 6 (at Apr 26) | 1233 | 1174 | 1511 |  | Escalate |
| LMU03 | Number of ambulance patient handovers over 4 hour | - | - | 0 | N/A | 243 | 237 | 436 |  | Escalate |
| LMU04 | Median emergency ambulance response time to purple: arrest category calls | 6-8 Mins | - | - | N/A | 07:37 | 08:13 | RIA |  | Advise |
| LMU05 | Median emergency ambulance response time to red: emergency category calls | 6-8 Mins | - | - | N/A | 09:25 | 08:57 | RIA |  | Advise |
| LMU06 | Total number of attendances to Minor Injury Units (MIUs) | - | - | - | N/A | 6945 | 6142 | 5841 |  | Alert |
| LMU07 | Total number of attendances to acute emergency departments | - | - | - | N/A | 16541 | 16331 | 15536 |  | Alert |
| LMU08 | Median time from arrival at an emergency department to triage by a clinician | - | 60 | - | 4th of 6 (at Mar 26) | 17.00 | 16.00 | 16.00 |  | Alert |
| 3AP04 | Median time from arrival at an emergency department to assessment by a clinical decision maker | - | - | - | 5th of 6 (at Mar 26) | 143.0 | 140.0 | 123.0 |  | Escalate |
| NPF25 | Percentage of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge | 95% | - | 0 | 7th of 7 (at Aug 26) | 59.5% | 58.9% | 58.3% |  | Escalate |
| 3AP03 | Number of patients who spend 12 hours or more in all hospital major and minor emergency care facilities from arrival until admission, transfer or discharge | 0 | 2149 | 2743 | 7th of 7 (at Aug 26) | 3842 | 3834 | 3726 |  | Escalate |
| LMU09 | Total number of patients who spent over 24 hours in the ED | - | - | 0 | N/A | 1559 | 1428 | 1677 |  | Escalate |
| LMU10 | Total number of patients who spent over 48 hours in the ED | - | - | - | N/A | 274 | 259 | 352 |  | Escalate |
| LMU11 | Number of patients who did not wait to be seen at the ED | - | - | - | N/A | 1959 | 1871 | 1710 |  | Escalate |
| LMU12 | Consistently realise 33% of discharges by midday. | - | - | 33% | N/A | 16.4% | 15.8% | 15.0% |  | Alert |
| LMU13 | Total number of unplanned returns to ED within 48 hours with the same complaint | - | - | - | N/A | 746 | 688 | 635 |  | Escalate |

# Scorecard : Performance and access (2 of 3)

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

# Scorecard : Performance and access (3 of 3)

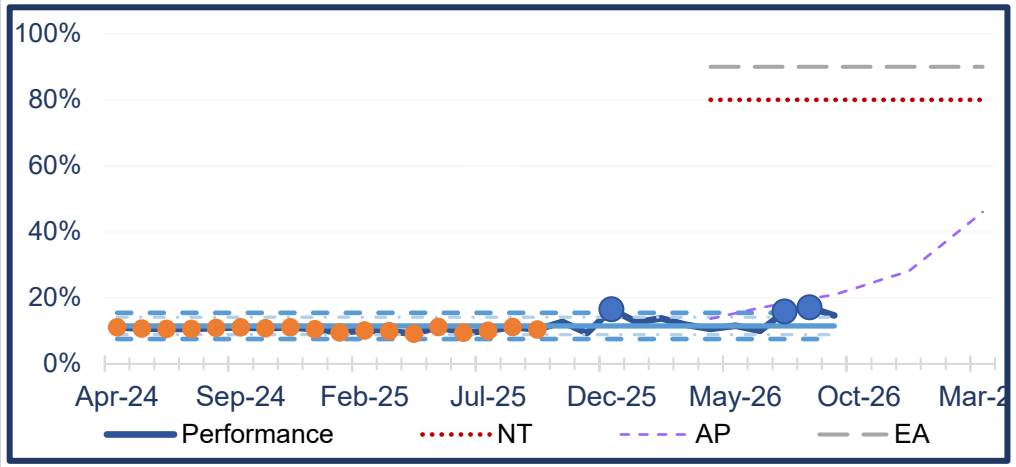
| REF | Measure Description | Target Suite | | | Wales Benchmark | Actual Performance | | | | Status |
|---|---|---|---|---|---|---|---|---|---|---|
| | | NT | SM | AP | | Jul-26 | Aug-26 | Sep-26 | 6 Month Activity | |
| LMM01 | Percentage of health board residents in receipt of secondary mental health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

# UEC: Ambulance Handover

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

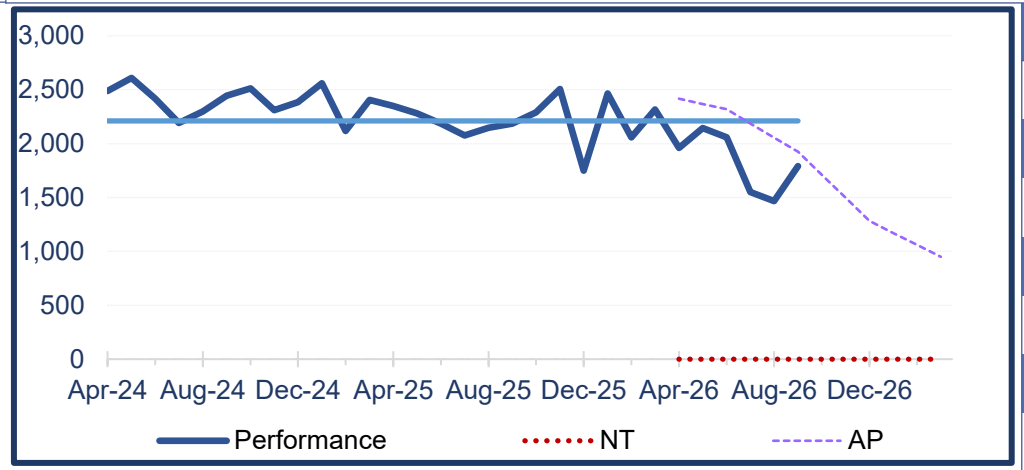
## Percentage of ambulance patient handovers within 15 minutes

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




## Number of ambulance patient handovers over 45 minutes

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




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

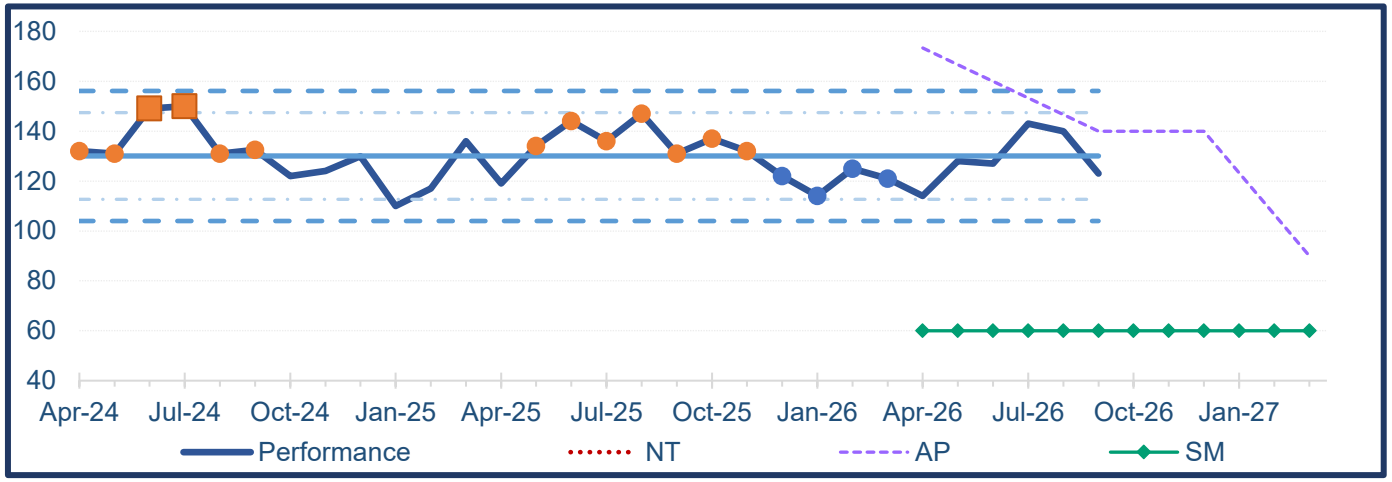
**Expected impact upon forecasted performance –**Performance against 15-minute handovers did not meet the expected quarter 2 target and presents a significant delivery risk for Quarter 4. While performance for handovers exceeding 45 minutes met the quarter 2 annual plan trajectory, substantial and sustained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

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

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

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

| Latest Month |
|---|
| September 2026 |
| **Profile** |
| 140 |
| **Actual** |
| 123 |
| **Status** |
| Escalate |




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

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

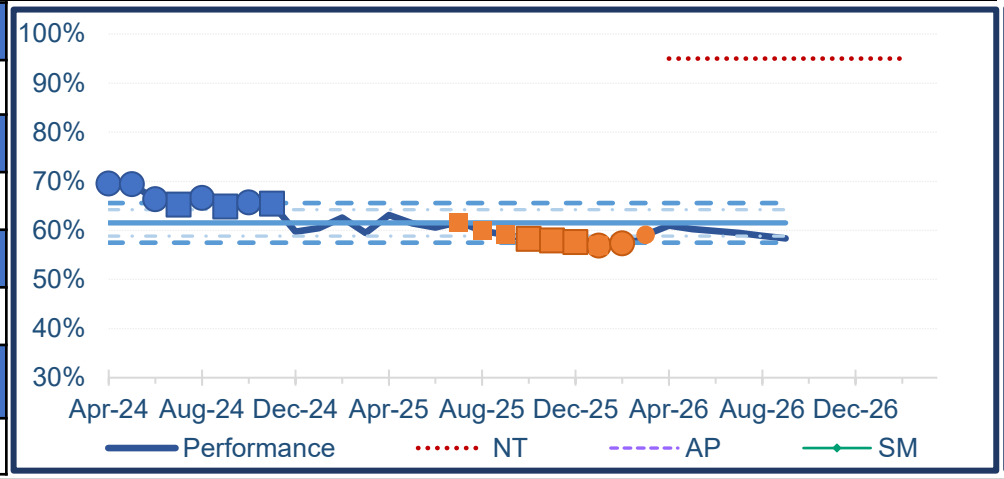
**Expected impact upon forecasted performance –** Although the median time to clinical decision maker remains aligned to the health board's internal trajectory following two months of improvement, sustained improvement will be required to deliver the March 2027 target. The workforce investment is expected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

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

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

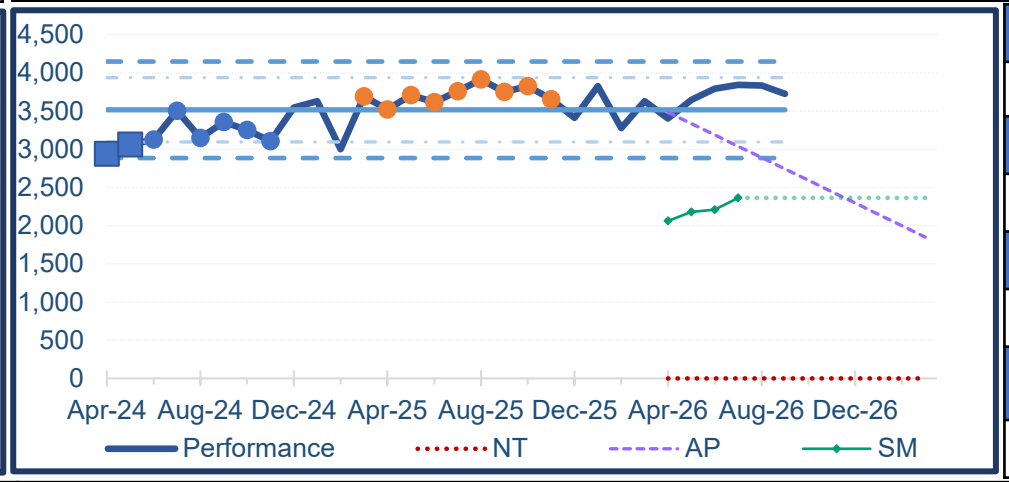
## Number of patients who spend less than 4 hours in ED & MIU

| Latest Month |
|---|
| September 2026 |
| **Profile** |
| 95% |
| **Actual** |
| 58.4% |
| **Status** |
| Escalate |




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

## Number of patients who spend 12 hours or more in ED




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

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

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

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

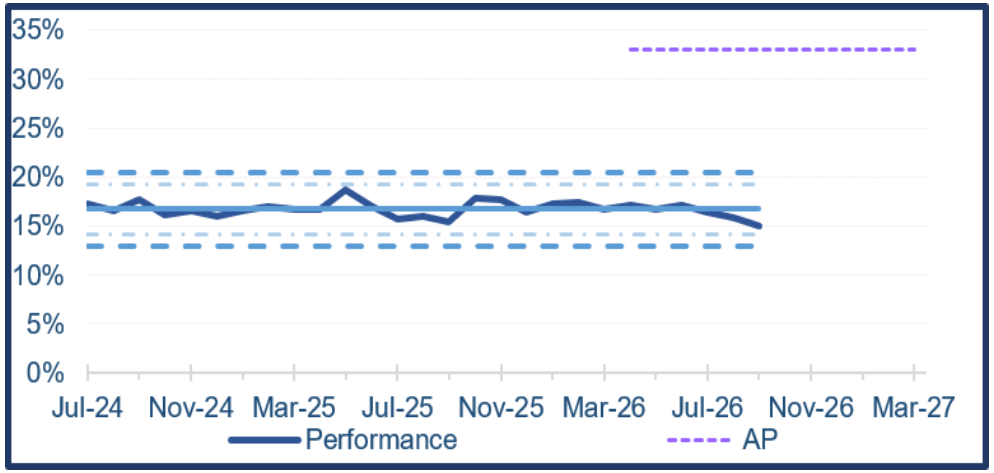
**Expected impact upon forecasted performance –** . Recovery of performance remains a key priority, with a focus on returning to the planned improvement trajectory required to achieve the 10% year-end target by March 2027. Sustained improvement is required across all three Integrated Health Communities,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

# UEC: Discharges

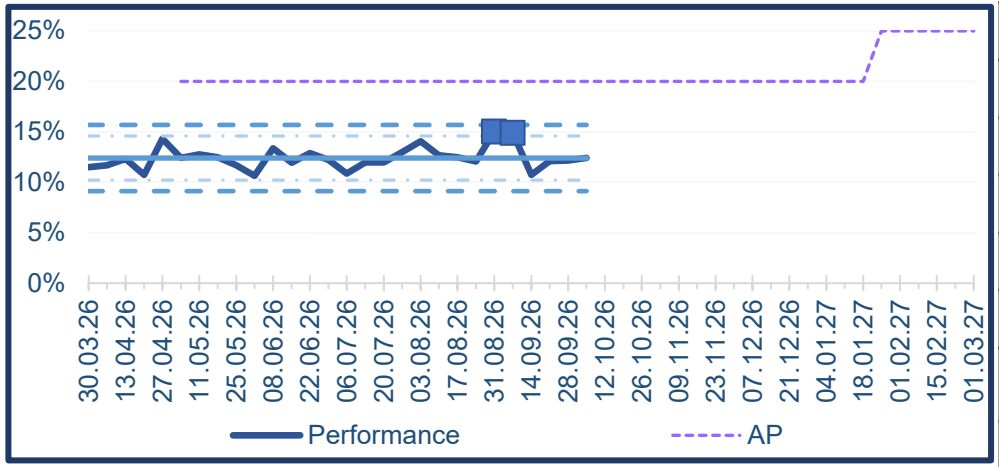
| Metric Overview | ID | Metric | SM De-escalation | Planning / Performance Framework | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|---|---|---|---|
| | TPG-28 | Discharges before midday | N/A | 33% of discharges by midday | 33% | 33% | 33% | 33% |
| | TPG- 29 | Weekend discharges | N/A | 25% by the end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

## Discharges before midday

| Latest Month |
|---|
| September 2026 |
| **Profile** |
| 33% |
| **Actual** |
| 15.0% |
| **Status** |
| Alert |




## Weekend Discharges




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

| Benchmark | N/A | N/A | Benchmark |
|---|---|---|---|

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

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

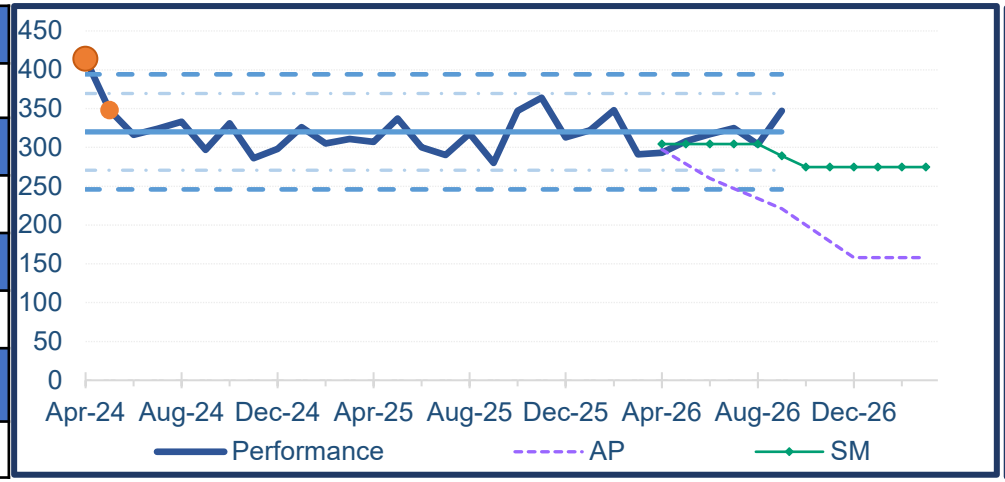
**Expected impact upon forecasted performance –** Based on current performance trends, discharge levels are not forecast to deliver on the planned trajectories.

# UEC: Pathway of Care Delays (PoCD)

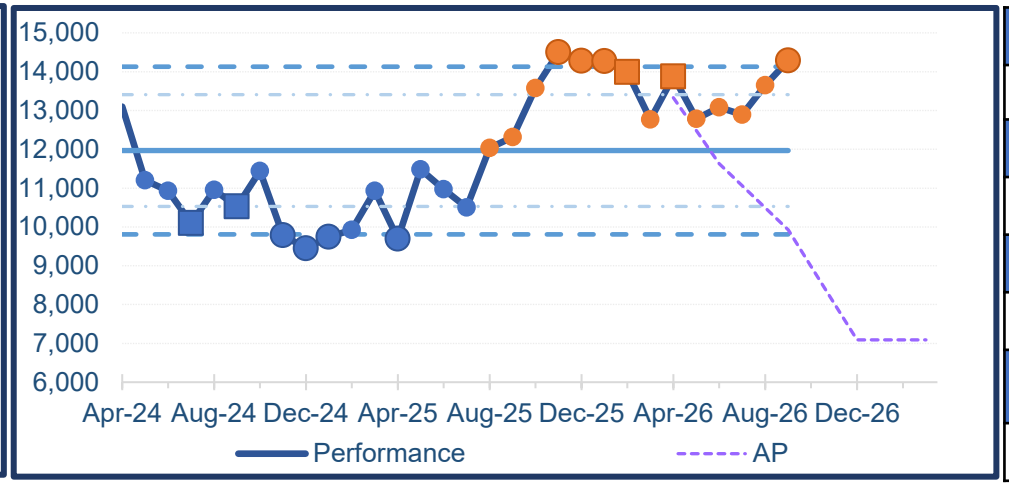
| Metric Overview | ID | Metric | SM De-escalation | Planning / Performance Framework | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|---|---|---|---|
| | 3AP05 | Number of patients on delayed pathways of care | 273 | 12-month reduction | 260 | 221 | 158 | 158 |
| | 3AP06 | Number of bed days lost to delayed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

## Number of patients on delayed pathways of care

| Latest Month |
|---|
| September 2026 |
| **Profile** |
| 158 |
| **Actual** |
| 347 |
| **Status** |
| Alert |




## Number of bed days lost to delayed pathways of care




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

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

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

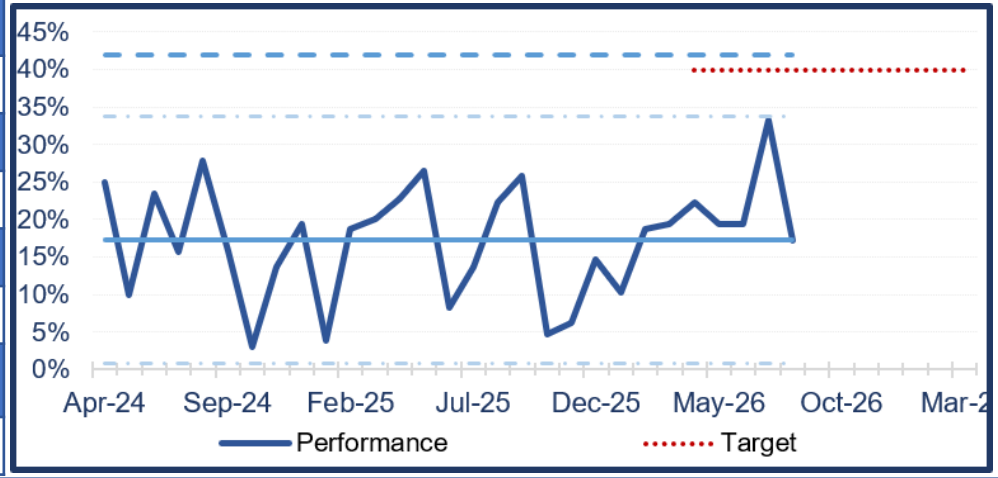
**Expected impact upon forecasted performance –** Continual improvement in reducing the number of delays is predicted but reducing the days delays will require focused actions.

# Stroke: Scan, and Thrombolysis

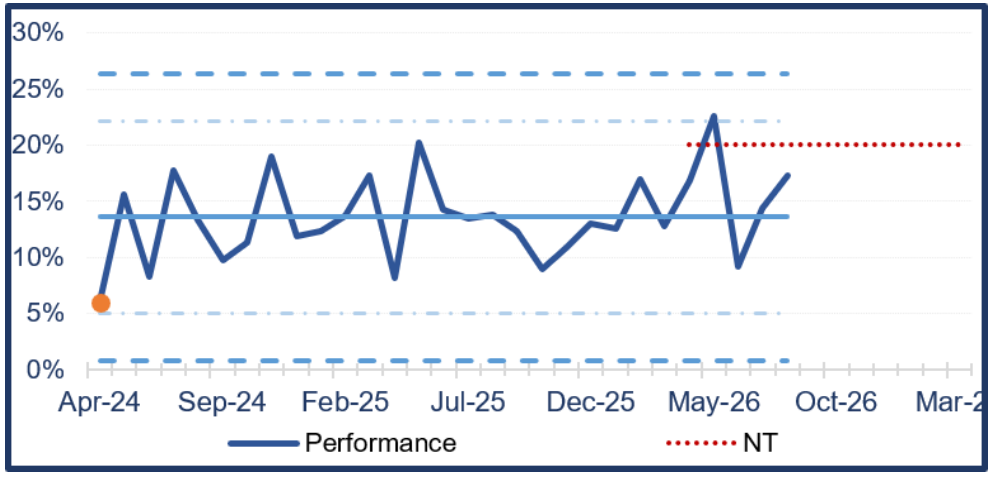
| Metric Overview | ID | Metric | SM De-escalation | Planning / Performance Framework | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|---|---|---|---|
| | LMS01 | CT scan within 20 minutes of clock start | N/A | N/A | 40% | 40% | 40% | 40% |
| | LMS02 | All patients thrombolysed | N/A | N/A | 20% | 20% |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

## CT scan within 20 minutes of clock start

| Latest Month |
|---|
| August 2026 |
| **Target** |
| 40% |
| **Actual** |
| 21.6% |
| **Status** |
| Escalate |




## Percentage of all patients thrombolysed




| Latest Month |
|---|
| August 2026 |
| **Target** |
| 20% |
| **Actual** |
| 17.2% |
| **Status** |
| Alert |

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

**Actions being taken to improve**

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

**Expected impact upon forecasted performance**

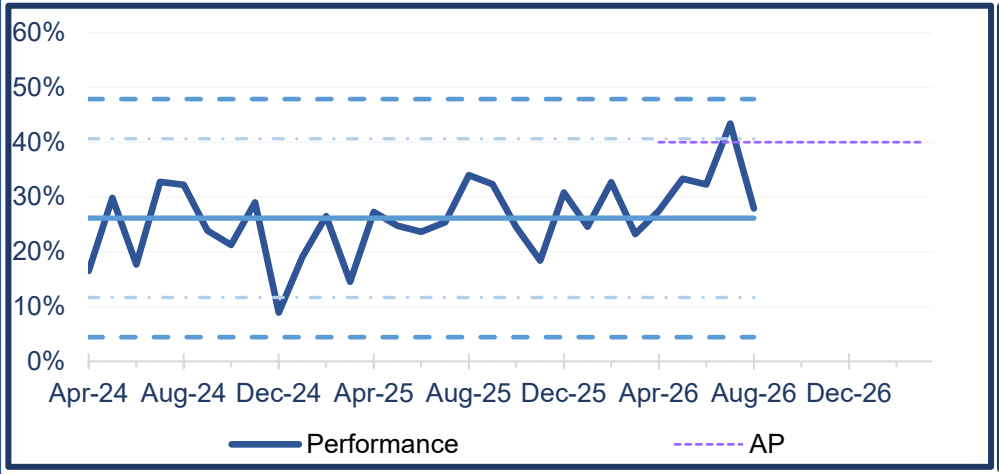
The use of PhVT is shown to have a positive impact on time to scan, which has been replicated in YGC, as it allows for patients, who are conveyed by ambulance, to be met on arrival to ED and taken straight for their CT scan. This also supports the ability to thrombolise eligible patients and supports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

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

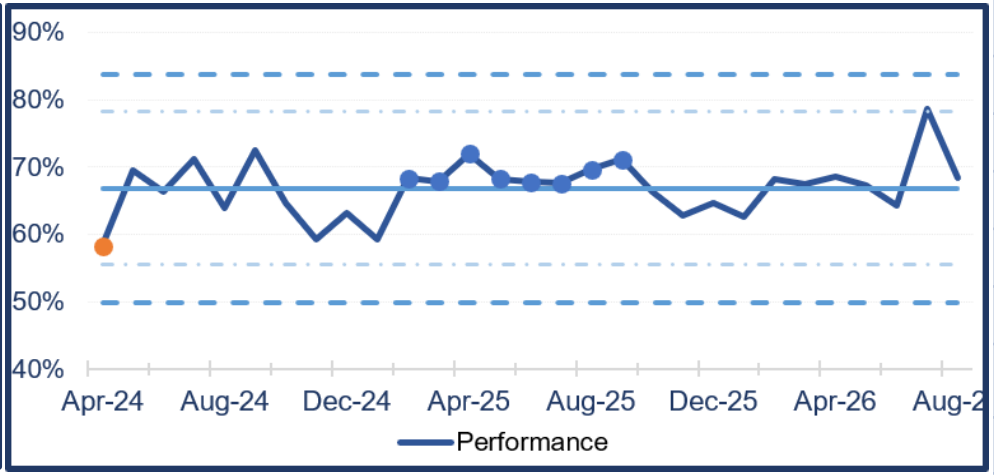
| Metric Overview | ID | Metric | SM De-escalation | Planning / Performance Framework | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|---|---|---|---|
| | LMS06 | Direct admission to the ASU within 4 hours | N/A | N/A | 40% | 40% | 40% | 40% |
| | LMS07 | Swallow screening within 4 hours of clock start |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

## Direct admission to the ASU within 4 hours

| Latest Month |
|---|
| August 2026 |
| **Profile** |
| 40% |
| **Actual** |
| 27.9% |
| **Status** |
| |




## Swallow screening within 4 hours of clock start




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

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

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

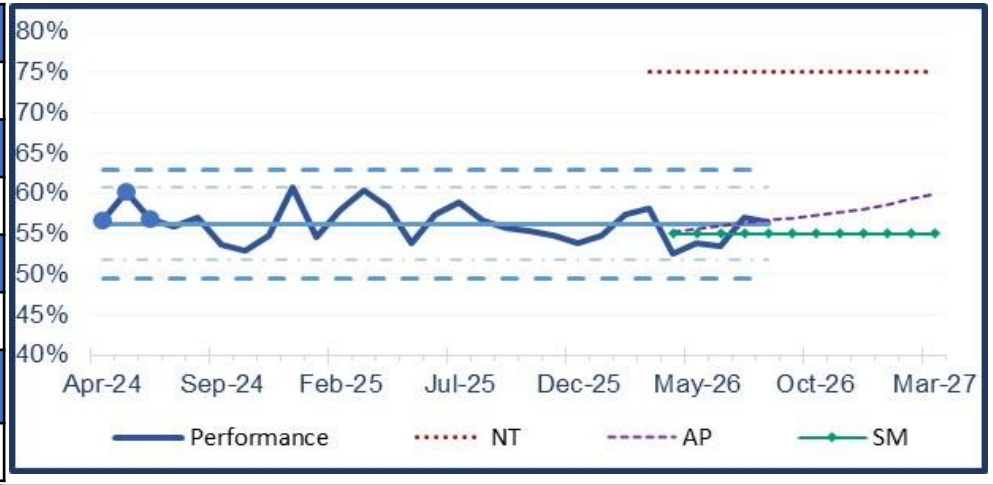
**Expected impact upon forecasted performance:** Given the work being undertaken by both the WMH and YGC teams, where they are endeavouring to ensure patients are admitted to their ASUs as soon as practicable. Site pressures and IPC issues impact on this KPI but teams work together to overcome these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

# Planned Care: Suspected Cancer Pathway

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

## Suspected cancer pathway 62 days wait

| Latest Month |
|---|
| August 2026 |
| **Profile** |
| 56.7% |
| **Actual** |
| 56.5% |
| **Status** |
| Escalate |




**Benchmark**

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

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




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

**Benchmark**

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

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

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

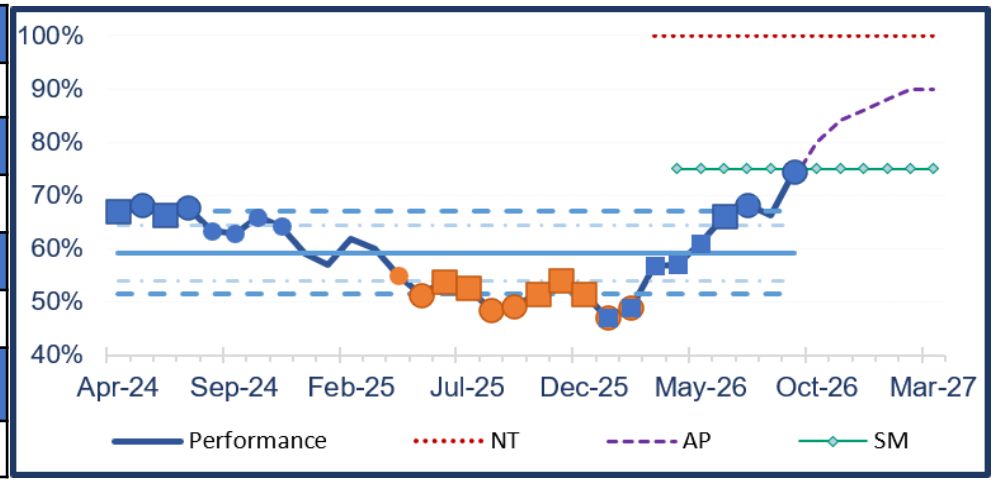
**Expected impact upon forecasted performance –** Confirmation of plan to support dermatology cohort is key to delivery. The continued increase in number of patients on an active pathways after day 62 places significant risk on delivery of targets and whilst the percentage seen within 62 days has met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

# Planned Care: 8-weeks Diagnostic Waits – Recovery Profile

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

## 8 weeks diagnostic waits

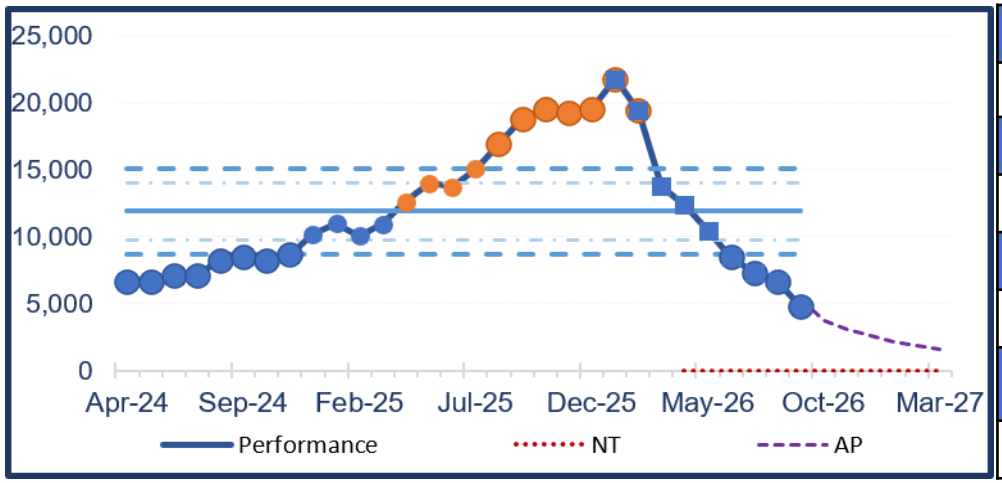
| Latest Month |
|---|
| September 2026 |
| **Profile** |
| 73.0% |
| **Actual** |
| 74.4% |
| **Status** |
| Alert |




**Benchmark**

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

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




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

**Benchmark**

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

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

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

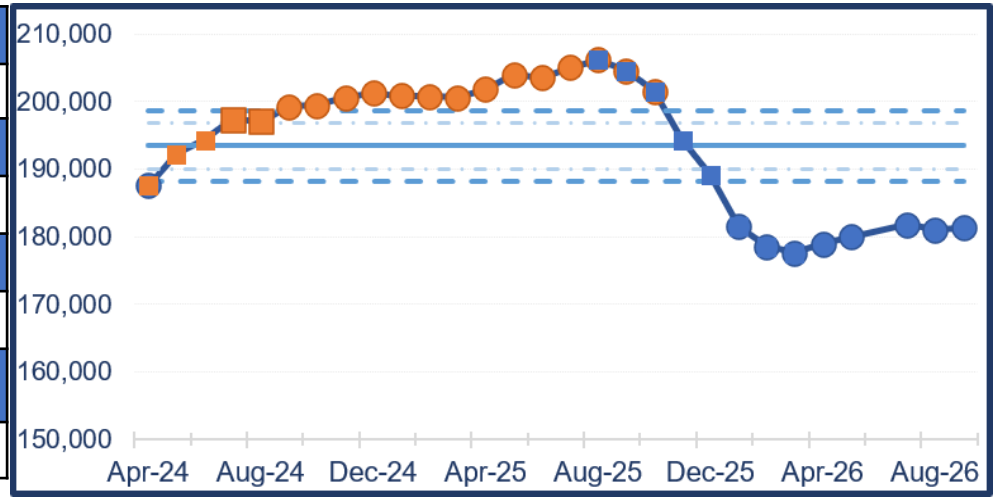
**Expected impact upon forecasted performance –** Ongoing monitoring of key pressure areas of endoscopy, non obstetric ultrasound and echocardiogram is key for continuation of improvement trajectory moving into the remaining months of the year. Sustainability remains a challenge.

# Planned Care : Referral to Treatment Metrics

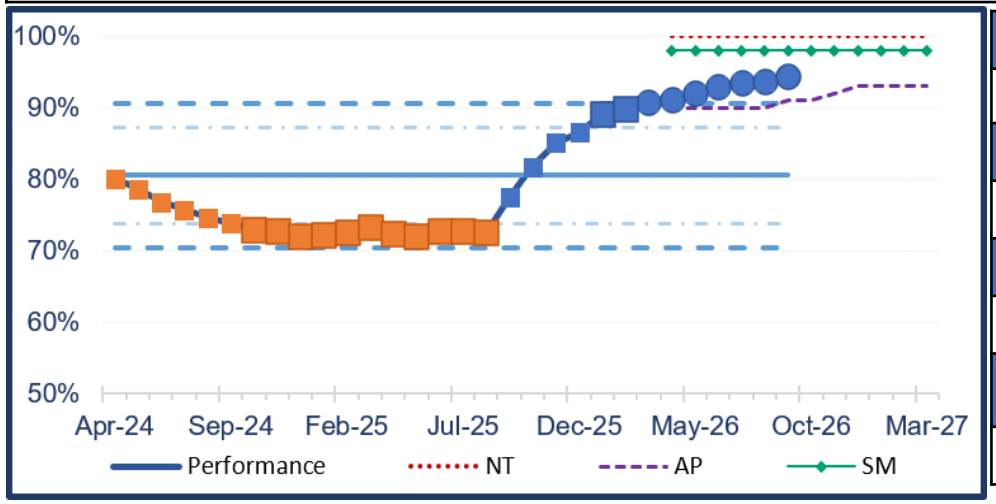
| Metric Overview | ID | Metric | SM De-escalation | Planning / Performance Framework | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|---|---|---|---|
| | Local | Total RTT Pathways | N/A | N/A | Reduction | Reduction | Reduction | Reduction |
| | 3BP02 | Open outpatient pathways waiting < 52 weeks | 98%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

## Total RTT Pathways

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




## Open outpatient pathways waiting < 52 weeks




| Latest Month |
|---|
| September 2026 |
| **Profile** |
| 90% |
| **Actual** |
| 94.3% |
| **Status** |
| Advise |

| Benchmark | March 2026 – July 2026 – all Wales waiting list increased by c43K, with increase at all health boards |
|---|---|

| BCU ranked 8th of 8 health boards as of 12/10/26 (RTT Weekly Dashboard, NHS P&I) | Benchmark |
|---|---|

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

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

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

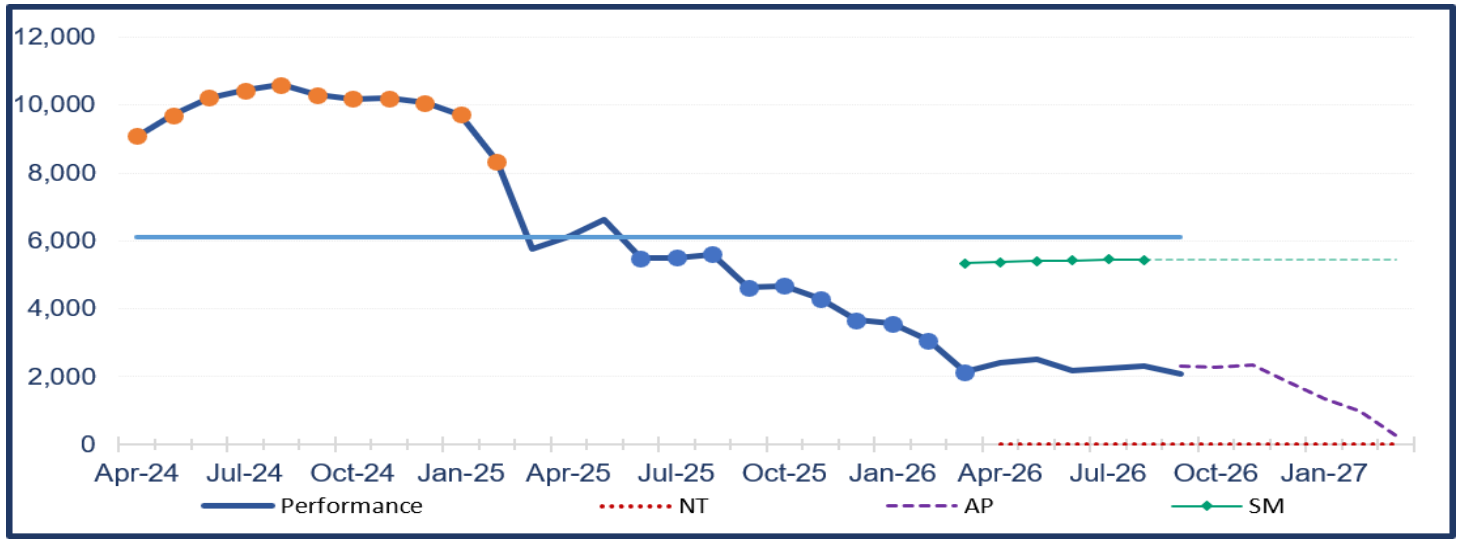
**Actions being taken to improve and expected impact upon forecasted performance –** The national insourcing outpatient programme supported a significant improvement in the first new outpatient performance during the period August 2025 – March 2026. Since then there has been continued focus on further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

# Planned Care : Referral to Treatment – 104 weeks Recovery Profile

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

## 104 weeks for referral to treatment

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




| Benchmark | BCU ranked 8th of 8 as of August 2026 |
|---|---|

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

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

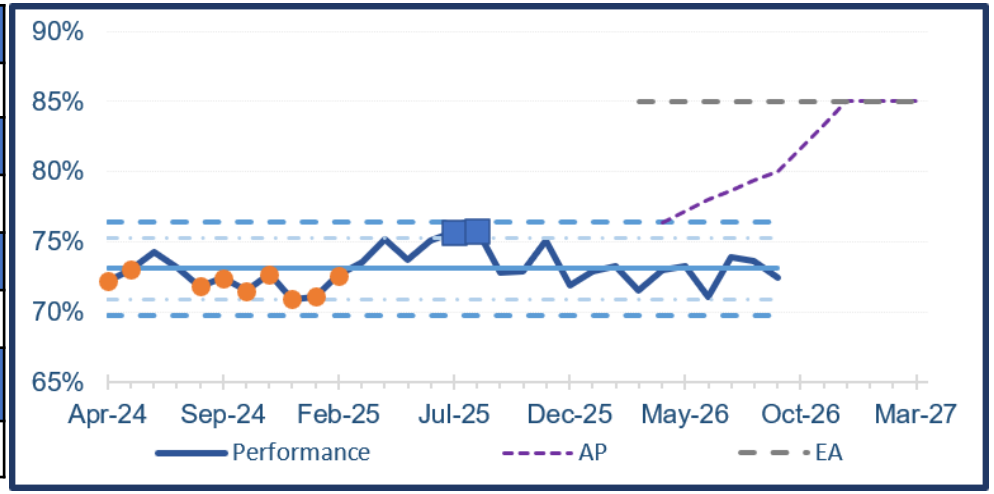
**Expected impact upon forecasted performance –** Delivery progress is monitored via single recovery plan with Director led meetings to ensure continued progress in line with agreed trajectories. At this stage there are some risks relating to specific cohorts of patients including uro-gynaecology and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

# Planned Care : Productivity / Utilisation

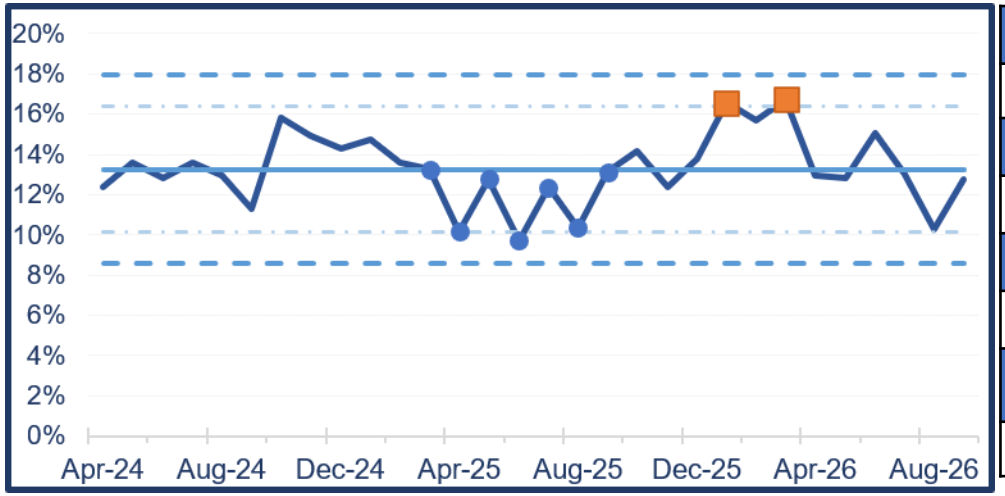
| Metric Overview | ID | Metric | SM De-escalation | Planning / Performance Framework | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|---|---|---|---|
| | 3BP13 | Theatre session overall utilisation is reported as a key KPI to underpin the GIRFT standard | N/A | 85% | 78% | 80% | 85% | 85% |
| | LMP02 | Theatre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

## Theatre Session Overall Utilisation

| Latest Month |
|---|
| September 2026 |
| **Profile** |
| 80.0% |
| **Actual** |
| 72.4% |
| **Status** |
| Alert |




## Theatre Utilisation – Short Notice Cancellations




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

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

| Area | CPS |
|---|---|
| West | 2.1 |
| Central | 2.1 |
| East | 2.2 |
| BCU | 2.1 |

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

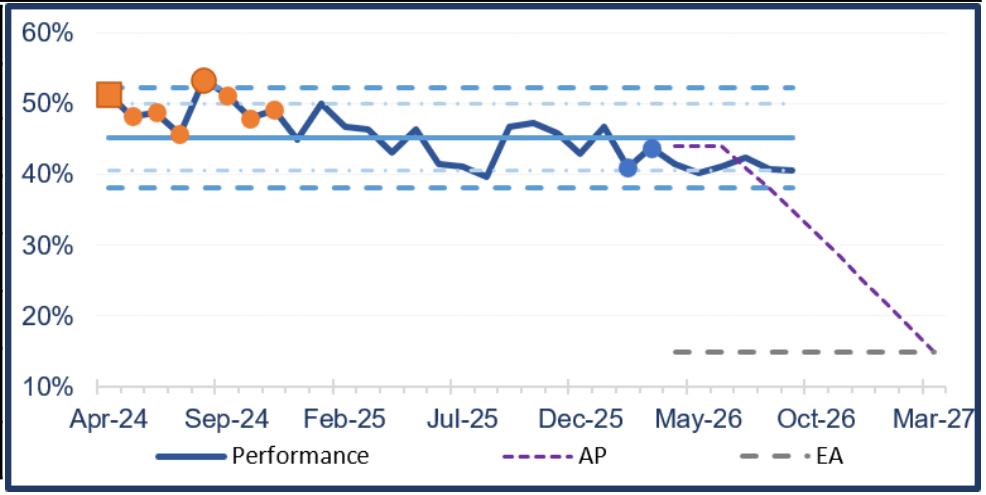
**Expected impact upon forecasted performance –** Based on current trend, overall theatre utilisation performance is not expected to deliver the step up required. With seasonal pressures resulting in increased cancellations last year UEC and Planned Care Recovery Directors will be reviewing and collaboratively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

# Planned Care : Productivity / Utilisation

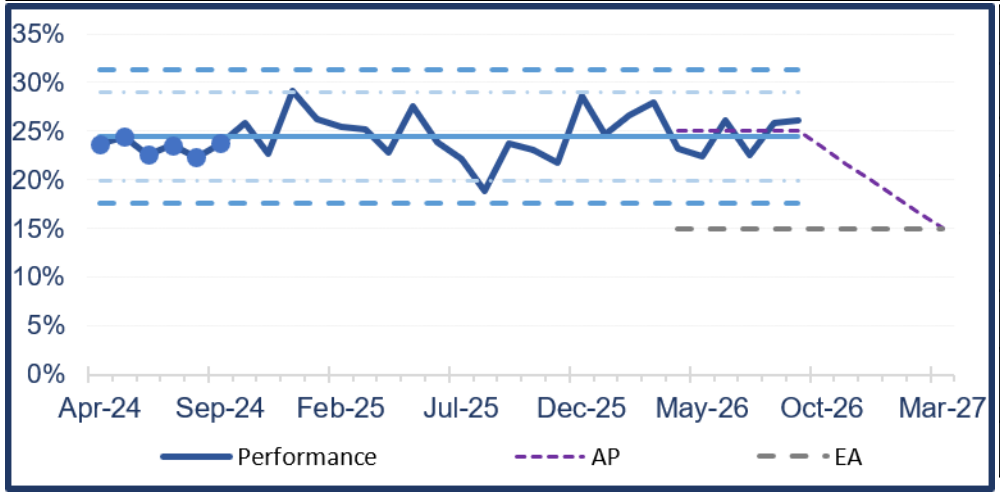
| Metric Overview | ID | Metric | SM De-escalation | Planning / Performance Framework | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|---|---|---|---|
| | 3BP11 | Theatre session utilisation is improved to achieve GIRFT standard late starts (>15 mins) | N/A | <15% | 44% | 35% | 25% | 15% |
| | 3BP11 | Theatre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

## Theatre Utilisation – Late Start

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




## Theatre Utilisation – Early Finish




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

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

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

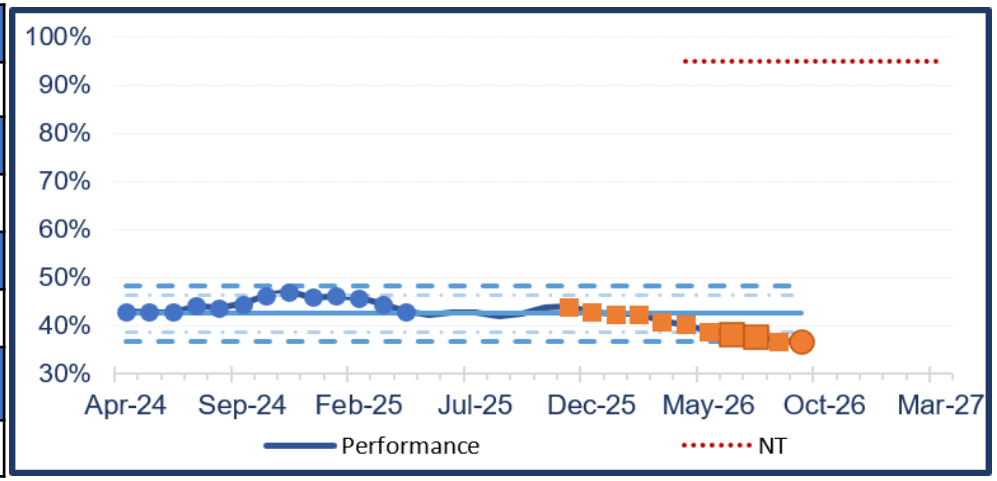
**Expected impact upon forecasted performance –** Levels of opportunity to increase theatre utilisation differ at specialty level dependent on procedure time and improvement work. Progress is overseen by the planned care recovery programme and Recovery Director remit.

# Planned Care : Outpatient Activity

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

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

| Latest Month |
|---|
| September 2026 |
| **Profile** |
| Improvement |
| **Actual** |
| 36.6% |
| **Status** |
| Escalate |



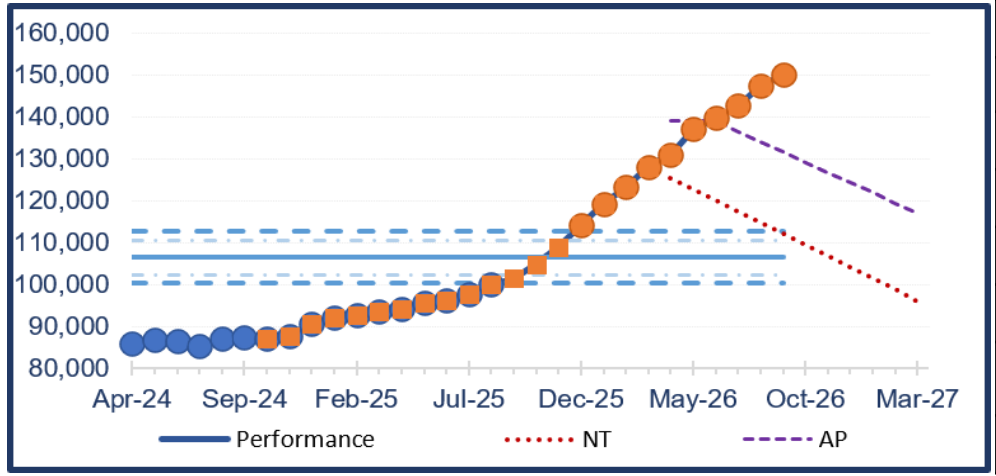

**Benchmark**

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

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

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

## Follow Up Delayed by over 100%




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

**Benchmark**

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

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

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

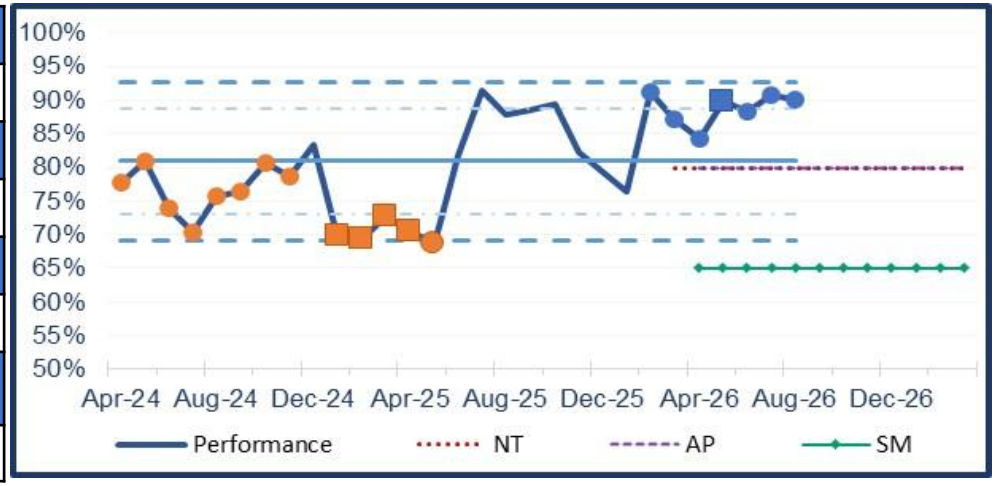
**Expected impact upon forecasted performance –** This area remains major priority. Further detail is expected regarding recent government announcement that will further inform recovery plans.

# Adult Mental Health Measures

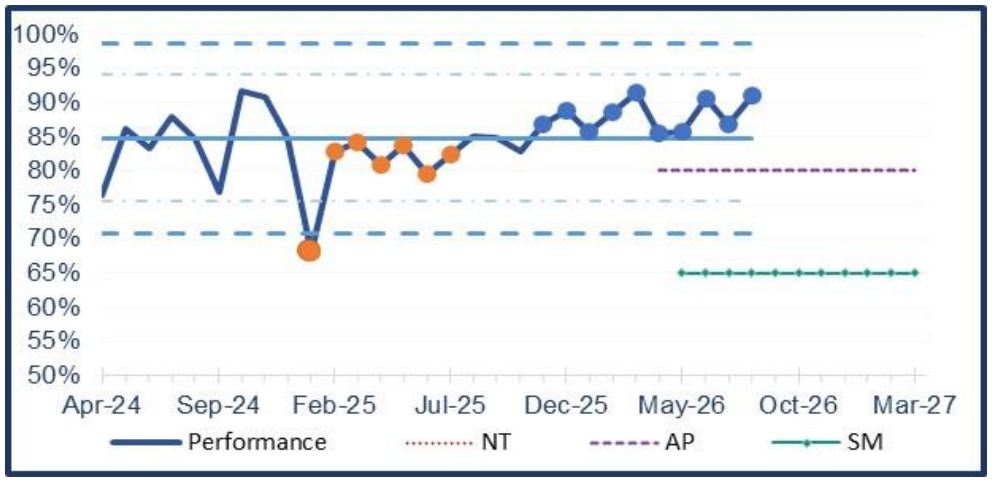
| Metric Overview | ID | Metric | SM De-escalation | Planning / Performance Framework | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|---|---|---|---|
| | 3DP01 | Percentage of Local Primary Mental Health Support Service (LPMHSS) assessments undertaken within (up to and including) 28 days from the date of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

## Mental Health Measure Part 1a - Assessments

| Latest Month |
|---|
| August 2026 |
| **Profile** |
| 80% |
| **Actual** |
| 90.2% |
| **Status** |
| Assure |




## Mental Health Measure Part 1b - 1st Intervention




| Latest Month |
|---|
| August 2026 |
| **Profile** |
| 80% |
| **Actual** |
| 91.1% |
| **Status** |
| Assure |

| Benchmark | BCU ranked 5th of 7 health boards as of August 2026 | BCU ranked 4th of 7 health boards as of August 2026 | Benchmark |
|---|---|---|---|

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

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

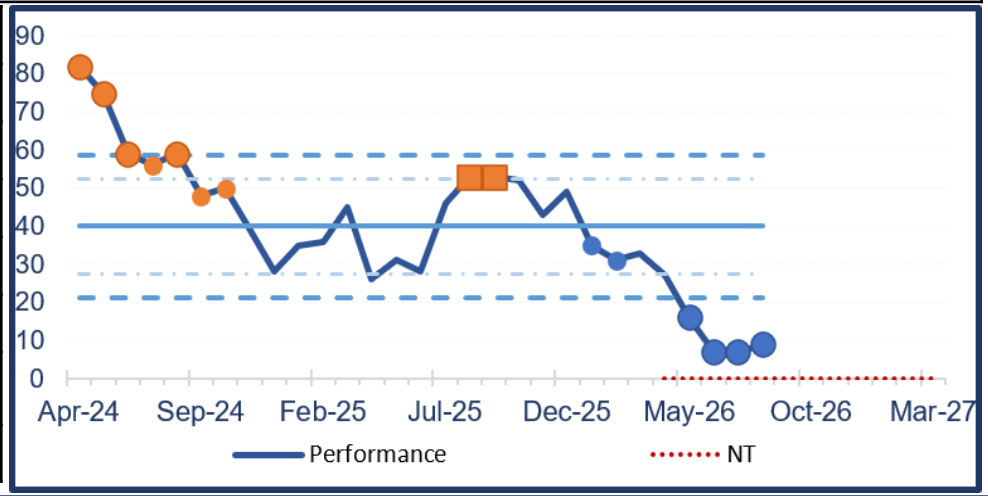
**Expected impact upon forecasted performance** The health board performance is expected to remain above the national standard, with continued focus on sustaining current performance and reducing unwarranted variation between localities and pathways.

# Adult Mental Health Measures

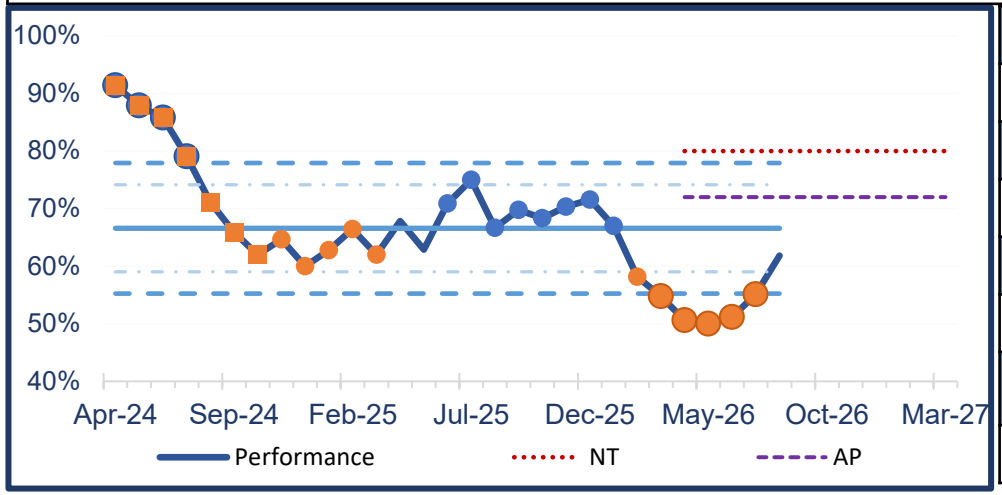
| Metric Overview | ID | Metric | SM De-escalation | Planning / Performance Framework | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|---|---|---|---|
| | 3DP06 | Material reduction in the number of adult mental health out of area placements | N/A | | | | TBC | TBC |
| | 3BP05 | Percentage of patients waiting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

## Out of Area Placements

| Latest Month |
|---|
| August 2026 |
| Profile |
| TBC |
| Actual |
| 9 |
| Status |
| Advise |




## Psychological Therapies




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

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

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

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

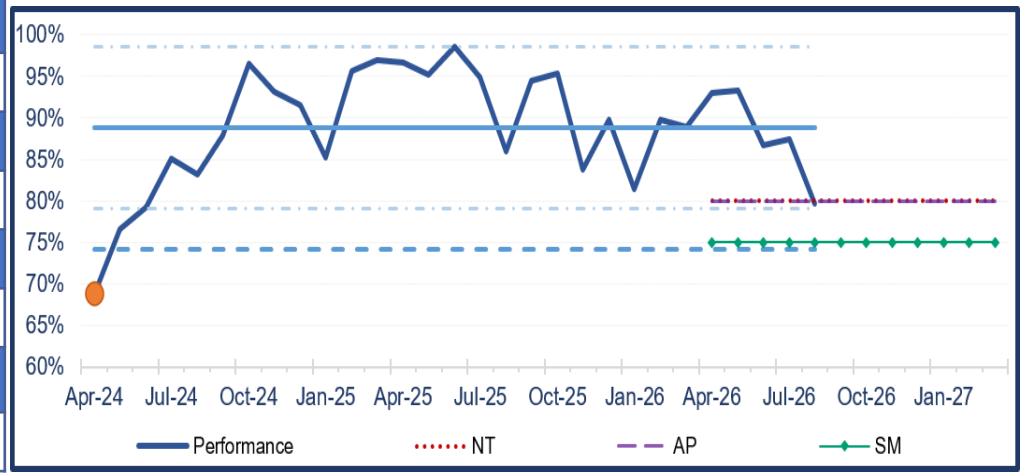
**Expected impact upon forecasted performance** Psychological therapies performance is expected to improve progressively as recovery actions take effect, although achievement of the national standard remains challenging. For out of area placements, the priority remains to sustain the significant improvement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

# Child and Adolescent Mental Health (CAMHS)

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

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

| Latest Month |
|---|
| August 2026 |
| **Profile** |
| 80% |
| Actual |
| 79.6% |
| **Status** |
| Alert |




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

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




| Latest Month |
|---|
| August 2026 |
| **Profile** |
| 80% |
| **Actual** |
| 78.84% |
| **Status** |
| Alert |

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

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

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

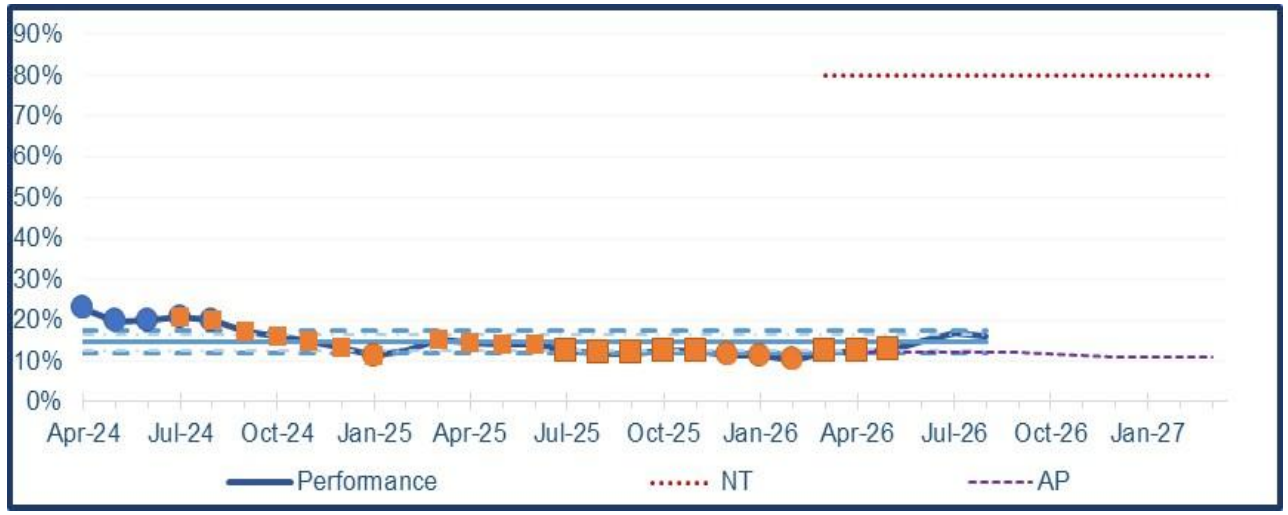
**Expected impact upon forecasted performance –** Part 1A is forecast to return to 80% compliance level from October at health board level with East locality expected to meet the 1A target by November. For Part 1B, whilst 80% target is expected to be met within West and Centre localities the recovery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

# Neurodevelopment (ND)

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

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

| Latest Month |
|---|
| August 2026 |
| **Profile** |
| 12% |
| **Actual** |
| 16.2% |
| **Status** |
| Alert |




**Waiting List Profile**

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

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

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

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

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

# Section 2
# Quality, safety and patient experience



# Scorecard: Quality, safety and patient experience

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

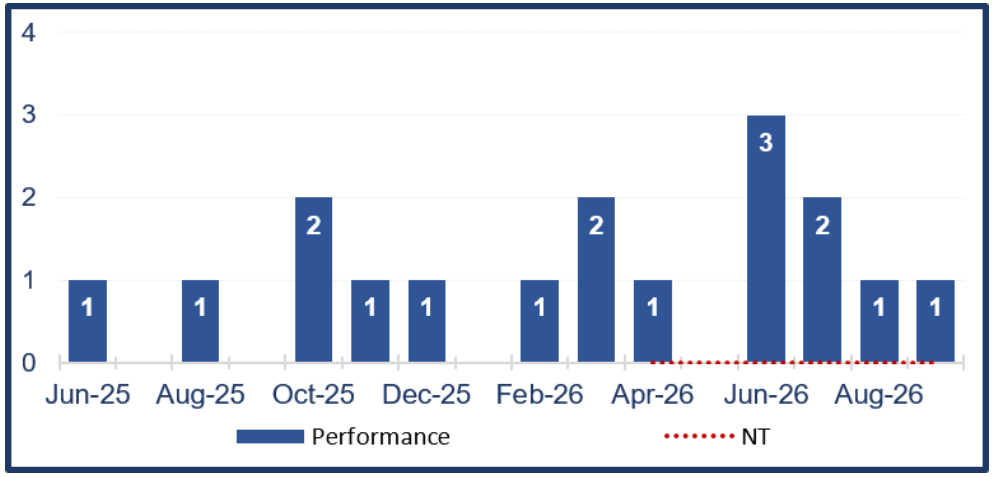
| REF | Measure Description | Target Suite | | | Wales Benchmark | Actual Performance | | | | Status |
|---|---|---|---|---|---|---|---|---|---|---|
| | | NT | SM | AP | | Q3 25/26 | Q4 25/26 | Q1 26/27 | Notes | |
| 3HP02 | Gabapentin and pregabalin (DDDs per 1,000 patients) | 10%↓ YoY | - | 1599.7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

# Never Events

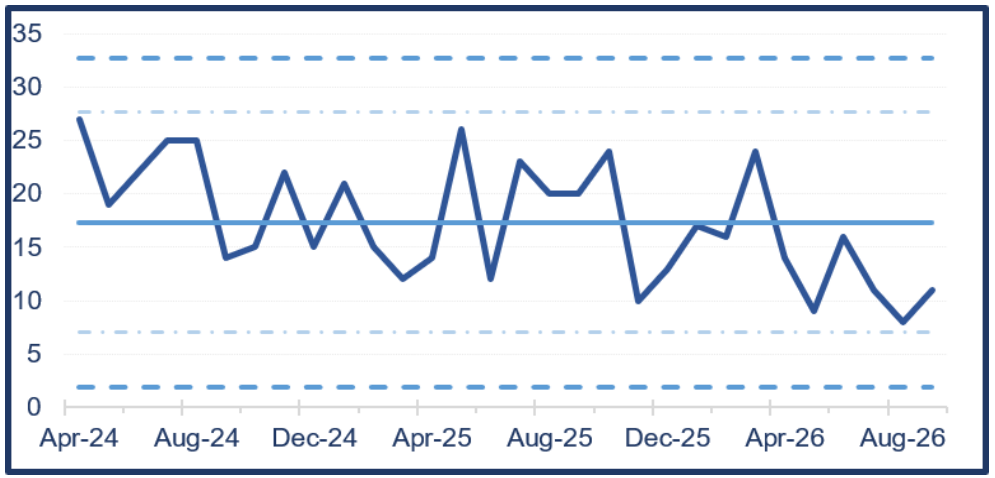
| Metric Overview | ID | Metric | SM De-escalation | Planning / Performance Framework | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|---|---|---|---|
| | NPF49 | Number of new never events | N/A | 0 | 0 | 0 | 0 | 0 |
| | LMQ04 | Number of new National Reportable Incidents (NRIs) | N/A | N/A | - | - | - |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

## Number of new never events

| Latest Month |
|---|
| September 2026 |
| **Profile** |
| 0 |
| **Actual** |
| 1 |
| **Status** |
| Alert |




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




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

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

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

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

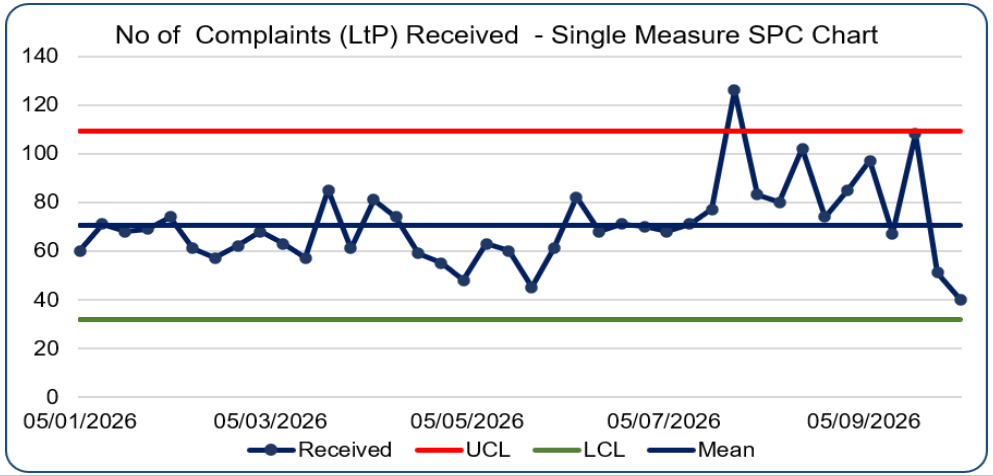
**Expected impact upon forecasted performance –** Strengthened oversight, consistent application of safety standards and continued organisational learning are intended to improve compliance and reduce the risk of recurrence.

# Complaints

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

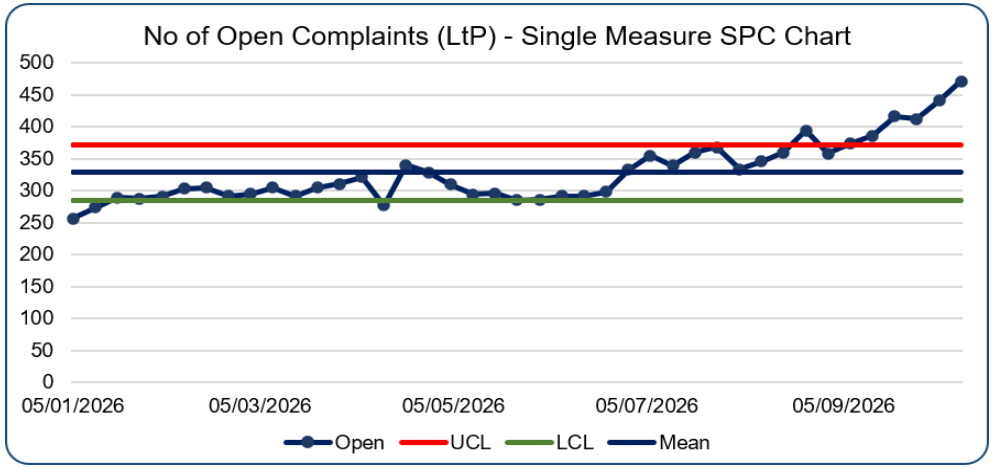
## Number of complaints received (weekly)

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




| Benchmark |
|---|
| N/A |

## Number of open complaints (weekly)




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

| Benchmark |
|---|
| N/A |

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

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

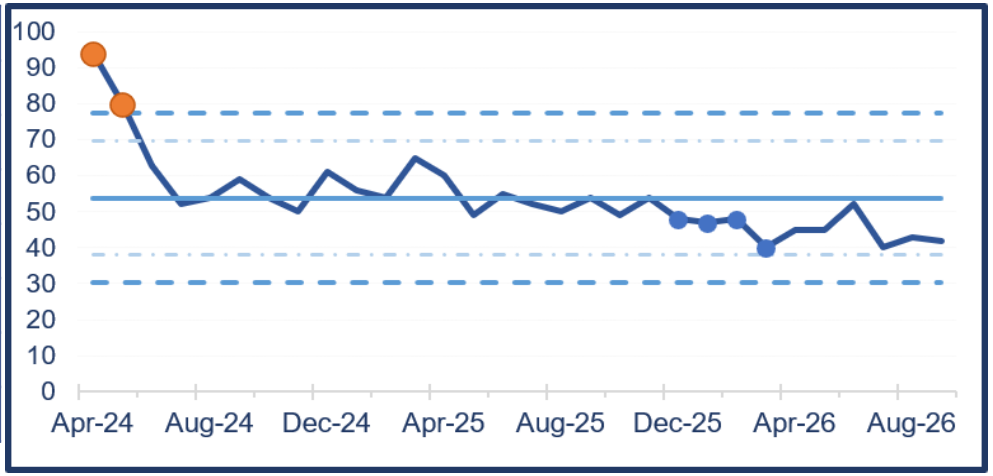
**Expected impact upon forecasted performance** – The improvement programme is intended to increase the timely resolution of concerns, reduce the overall number of open and overdue complaints and improve compliance.

# Quality: Patient Experience and Regulation 28 notices

## All open NRIs

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

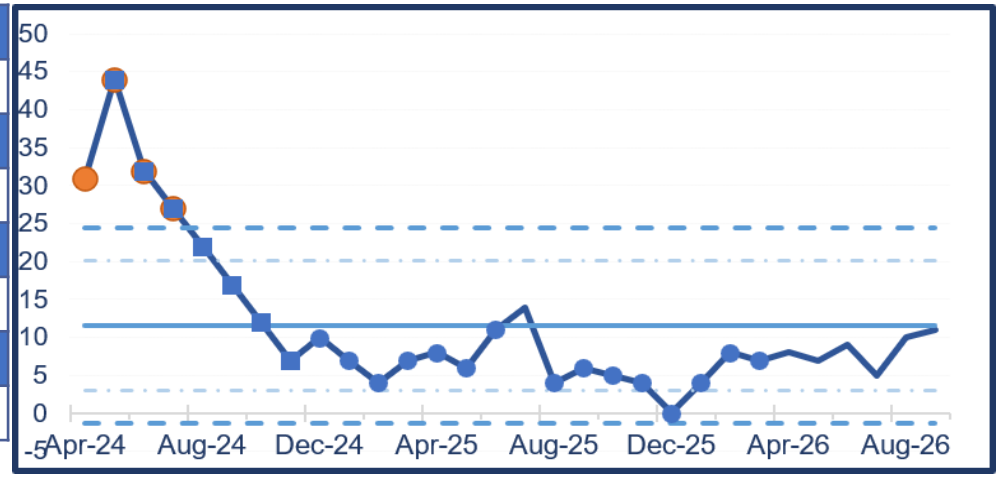
| Latest Month |
|---|
| September 2026 |
| **Profile** |
| N/A |
| **Actual** |
| 42 |
| **Status** |
| Advise |




## All overdue NRIs

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

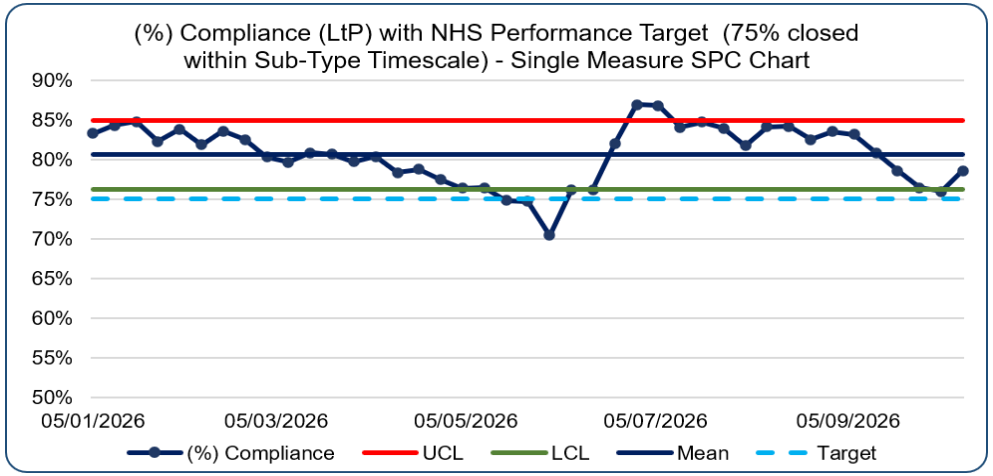
| Latest Month |
|---|
| September 2026 |
| **Profile** |
| N/A |
| **Actual** |
| 11 |
| **Status** |
| Advise |




## Percentage of complaints closed within agreed timescales

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

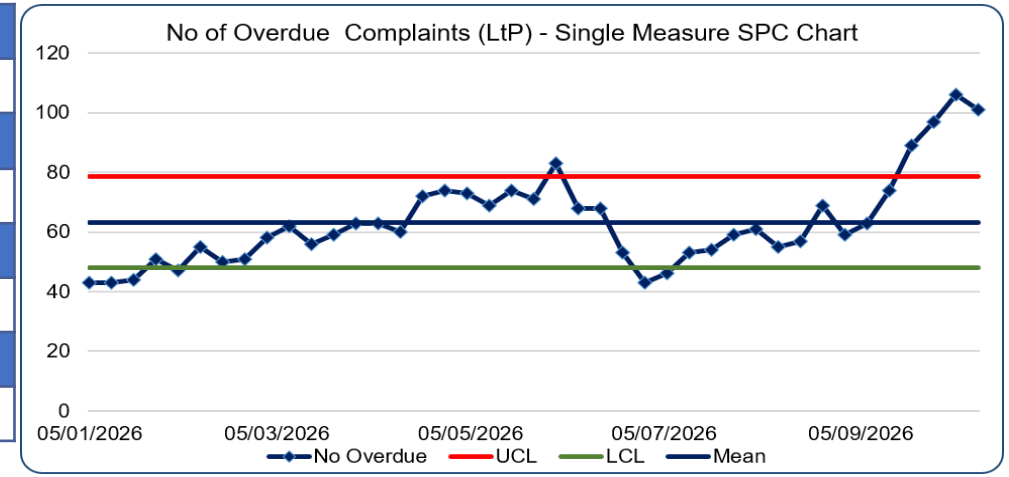
| Latest Position |
|---|
| w/c 12 October |
| **Profile** |
| N/A |
| **Actual** |
| 78.6% |
| **Status** |
| Assure |




## Number of overdue complaints

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

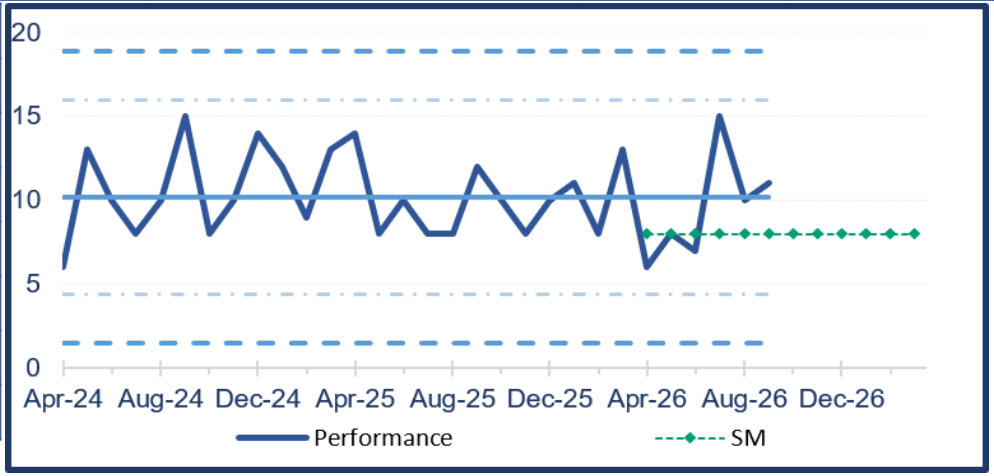
| Latest Position |
|---|
| w/c 12 October |
| **Profile** |
| N/A |
| **Actual** |
| 101 |
| **Status** |
| Assure |



## Number of hospital onset E-coli BSI cases

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

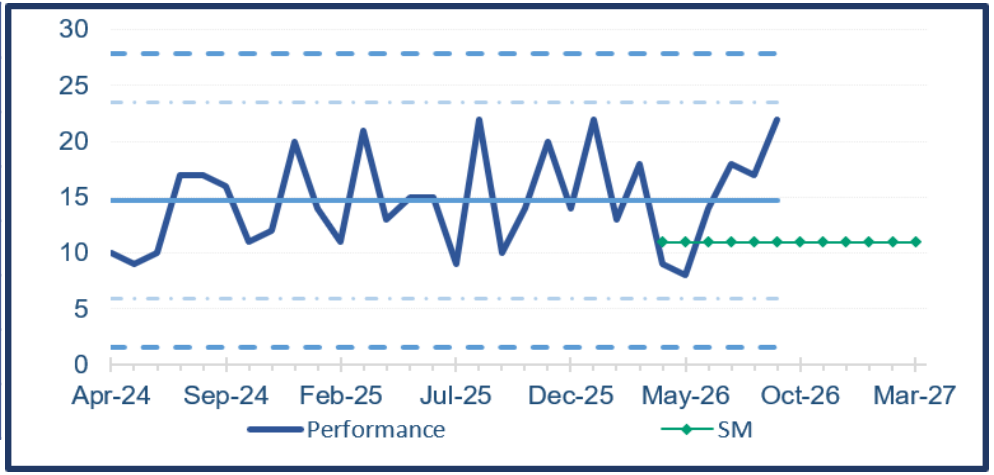
| Latest Month |
|---|
| September 2026 |
| **Profile** |
| N/A |
| **Actual** |
| 11 |
| **Status** |
| Advise |




## Number of hospital onset C-Diff cases

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

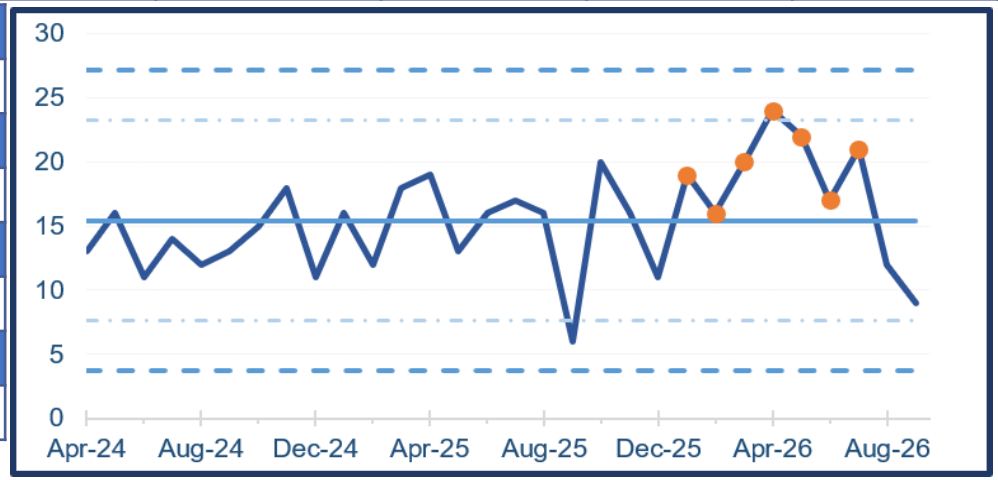
| Latest Month |
|---|
| September 2026 |
| **Profile** |
| N/A |
| **Actual** |
| 22 |
| **Status** |
| Advise |




## Number of MSSA cases

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

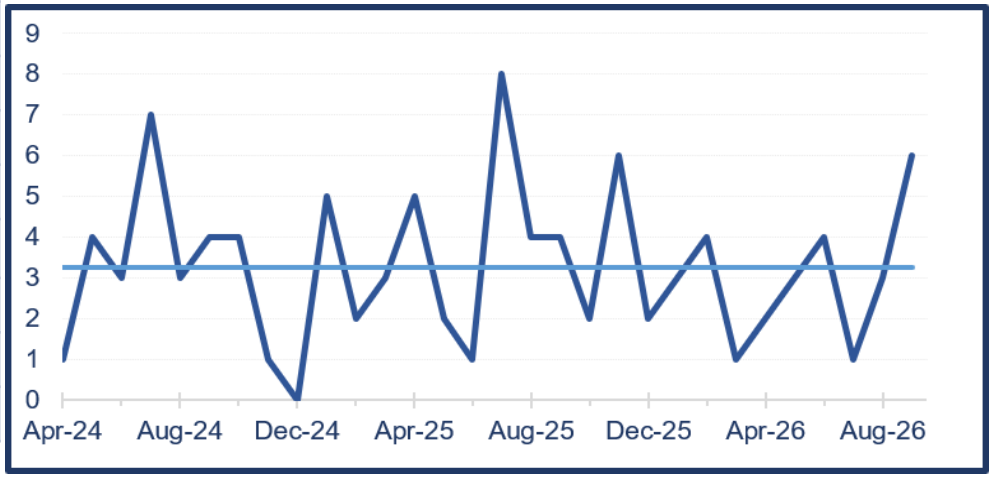
| Latest Month |
|---|
| September 2026 |
| **Profile** |
| N/A |
| **Actual** |
| 9 |
| **Status** |
| Advise |




## Number of hospital onset Klebsiella spp BSI cases

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

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

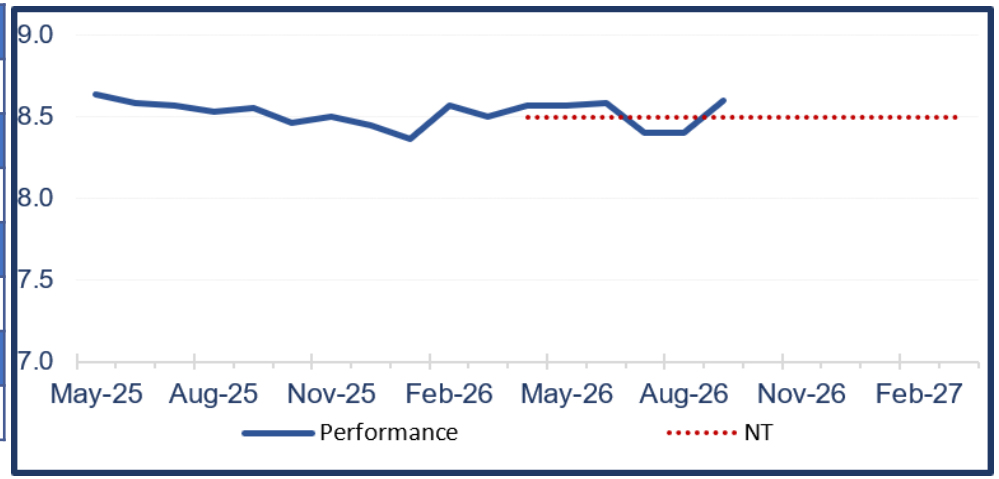


# Quality: Patient Experience and Regulation 28 notices

## Overall health board patient experience score

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

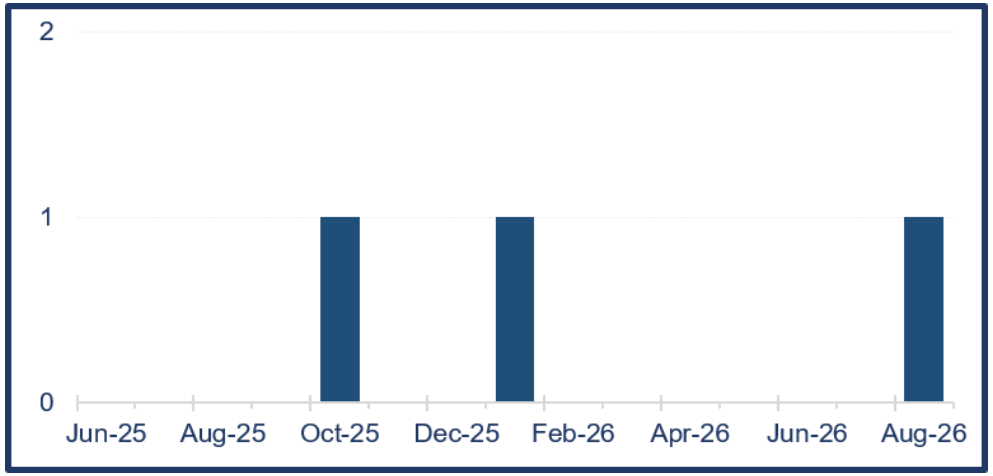
| Latest Month |
|---|
| September 2026 |
| **Profile** |
| N/A |
| **Actual** |
| 8.6 |
| **Status** |
| Advise |




## Regulation 28 notices (Prevention of Future Deaths reports)

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

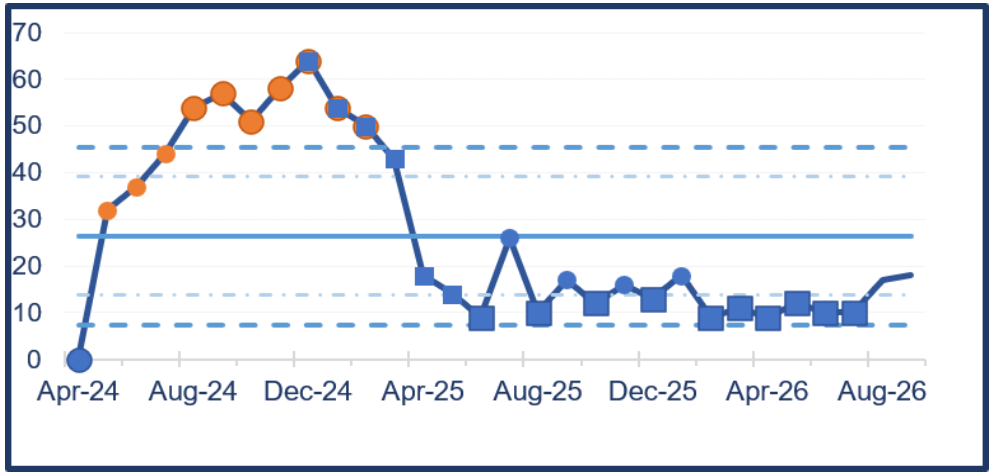
| Latest Month |
|---|
| August 2026 |
| **Profile** |
| N/A |
| **Actual** |
| 0 |
| **Status** |
| Advise |




## Number of overdue Learning from Event Reports (LFERs)

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

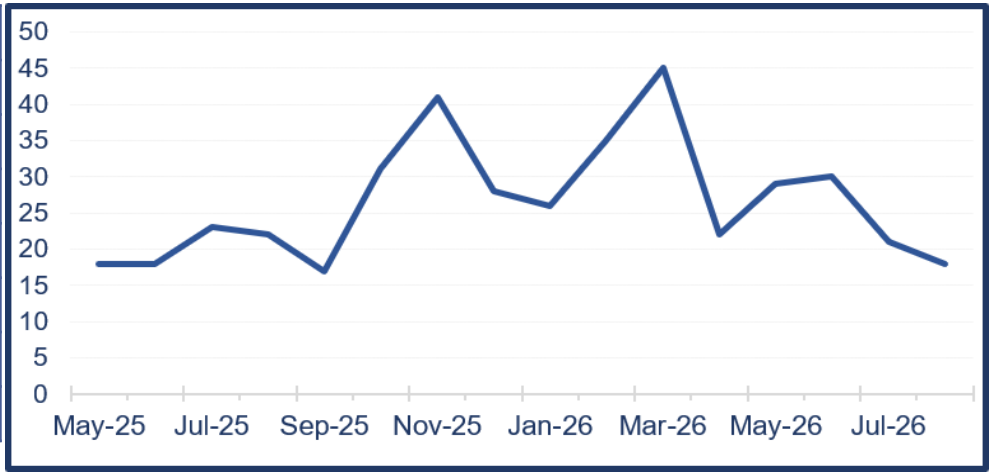
| Latest Month |
|---|
| September 2026 |
| **Profile** |
| N/A |
| **Actual** |
| 18 |
| **Status** |
| Assure |




## Number of new Ombudsman contacts

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

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



# Section 3
# Population health and prevention



# Scorecard: Population health and prevention

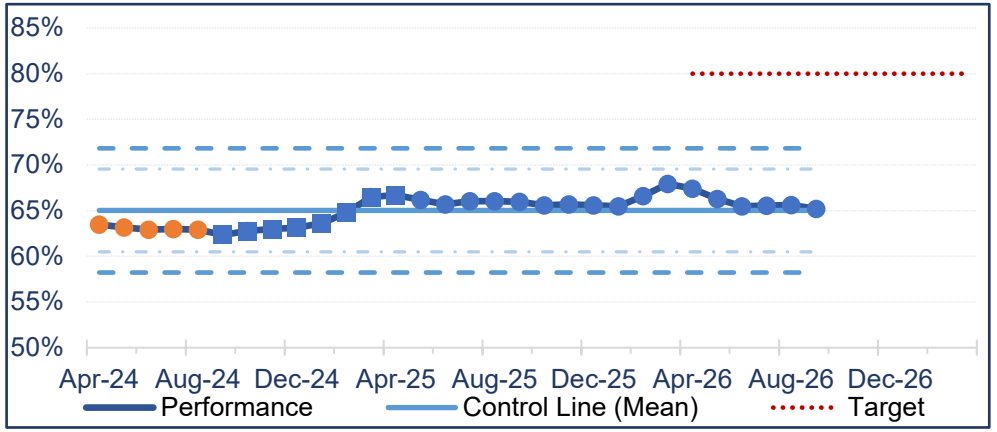
| REF | Measure Description | Target Suite | | | Wales Benchmark | Actual Performance | | | | Status |
|---|---|---|---|---|---|---|---|---|---|---|
| | | NT | SM | AP | | Q4 25/26 | Q1 26/27 | Q2 26/27 | Notes | |
| 1AP01 | Percentage of adult smokers who make a quit attempt via smoking cessation services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

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

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

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

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

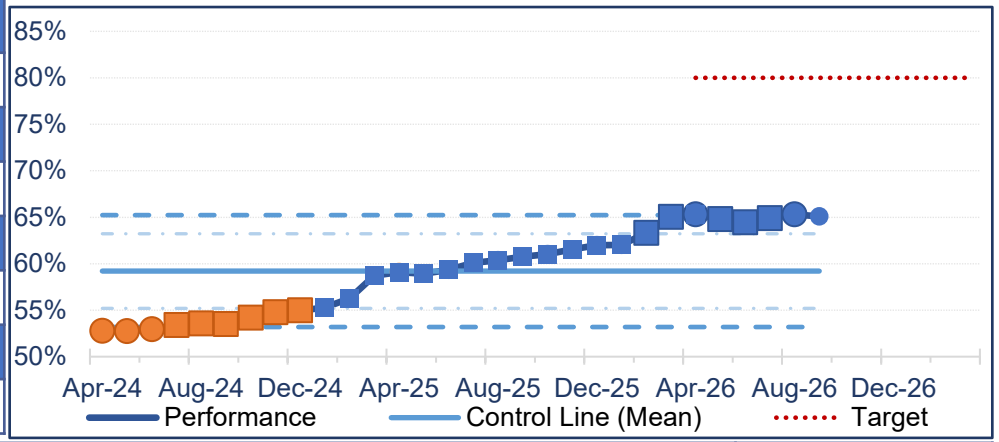



**Benchmark** BCU ranked 5th of 7 at September 2026

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

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

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




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

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

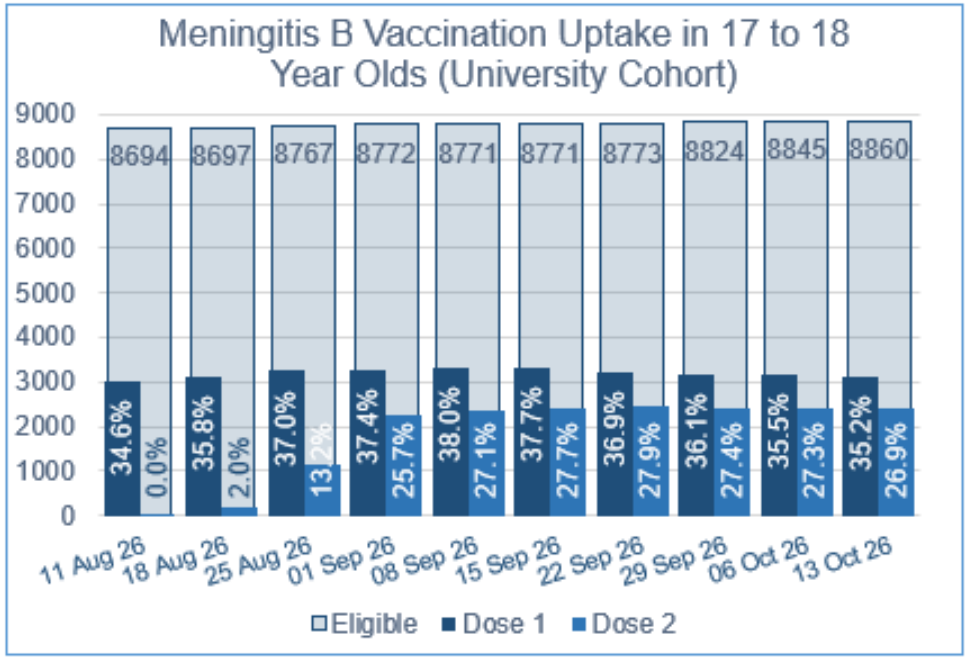
**What does the data tell us?** Foot surveillance (FS) and urine albumin (UA) continue to be the lowest recorded of the eight NICE recommended care processes for diabetes. UA has seen a comparative month on month increase and at Sep 26 was 2.7% higher than Sep 25. FS, although improved from 2024/25,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

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

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

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

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




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

| **Benchmark** | 13th October 2026<br>Dose 1: BCU ranked 7th of 7 Health Boards<br>Dose 2: BCU ranked 7th of 7 Health Boards |
|---|---|

**What does the data tell us?**

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

**Actions being taken to improve**

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

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

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

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

**Expected impact upon forecasted performance**

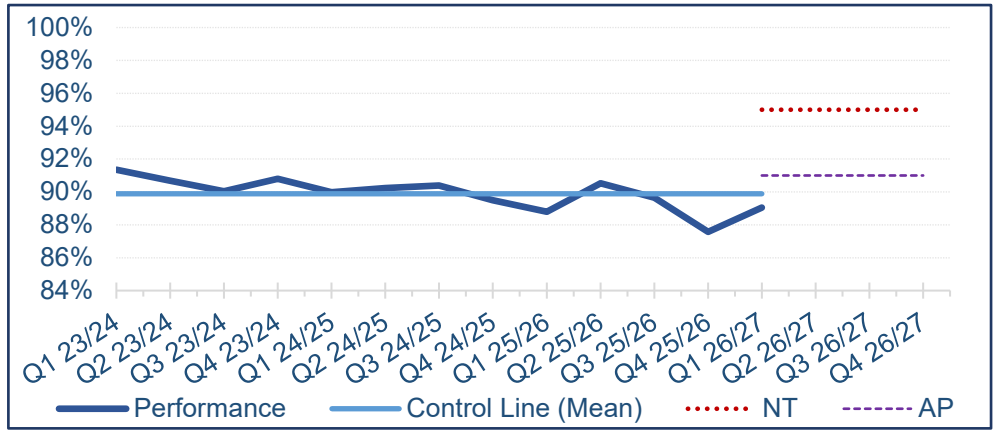
Targeted follow-up of individuals who have not yet attended and continued clinic delivery are expected to improve first-dose uptake. The routine scheduling of second-dose appointments should support sustained growth in course completion rates, while delivery through education settings will provide additional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

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

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

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

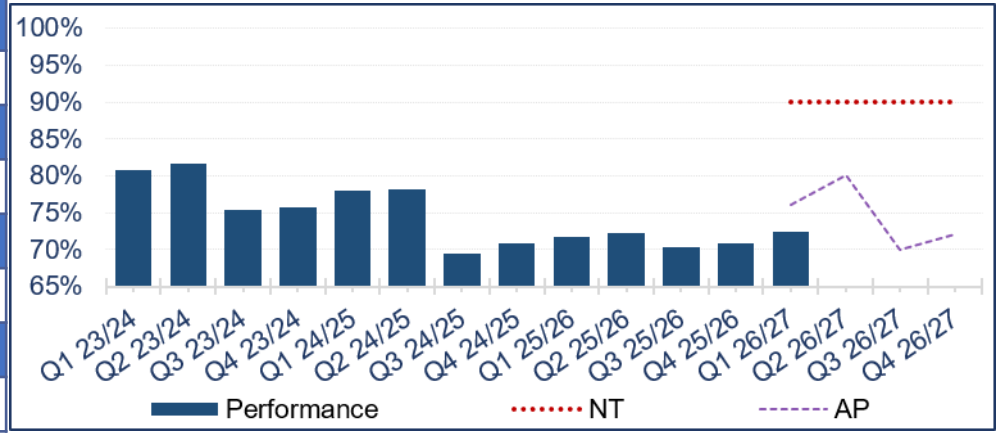
| Latest Month | Profile | Actual | Status |
|---|---|---|---|
| Q1 2026/27 | N/A | 89.0% | Advise |




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

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

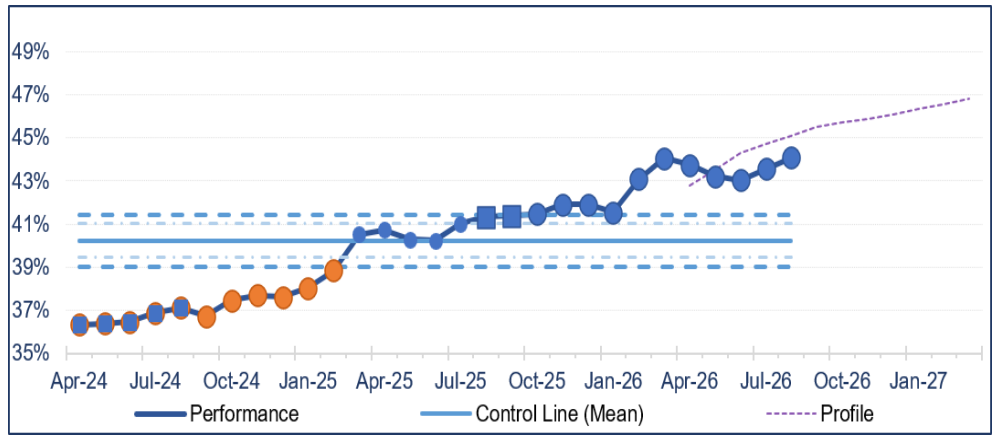
| Latest Month | Profile | Actual | Status |
|---|---|---|---|
| Q1 2026/27 | N/A | 70.8% | Advise |




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

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

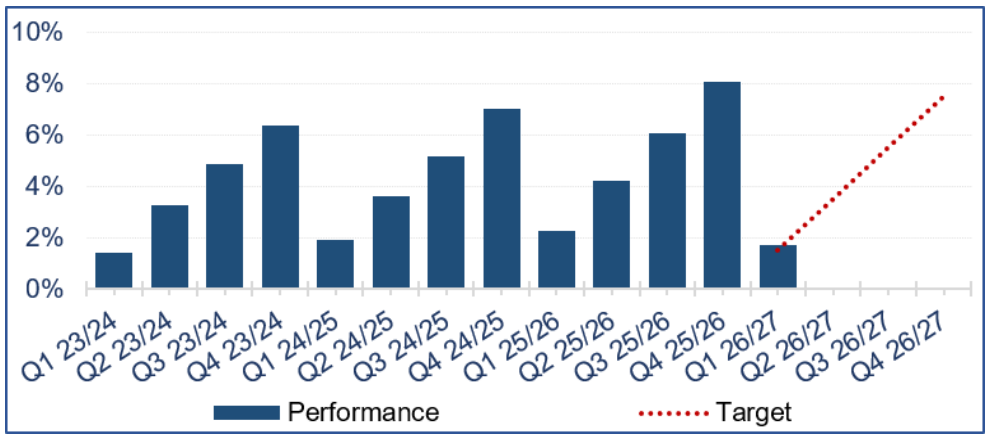
| Latest Month | Profile | Actual | Status |
|---|---|---|---|
| September 2026 | 45.5% | 44.1% | Alert |




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

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

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



# Section 4
# People and places



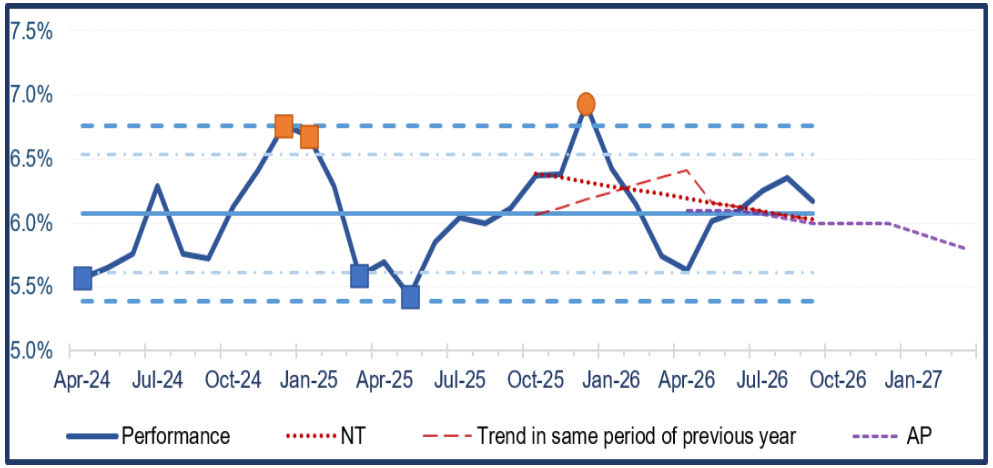
# Scorecard: People and places

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

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

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

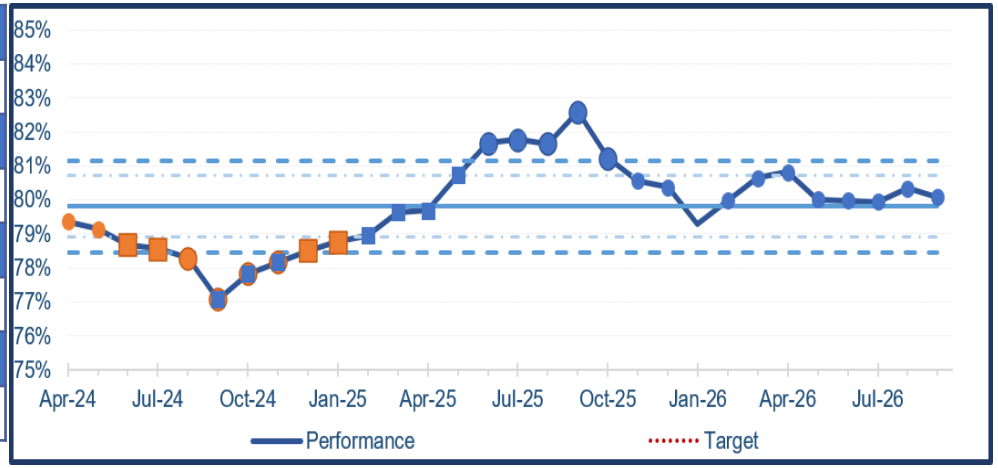
| Latest Month |
|---|
| Sept 2026 |
| **Profile** |
| 6.1% |
| **Actual** |
| 6.1% |
| **Status** |
| Alert |




## Percentage of Performance Appraisal Development Reviews (PADRs) undertaken

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

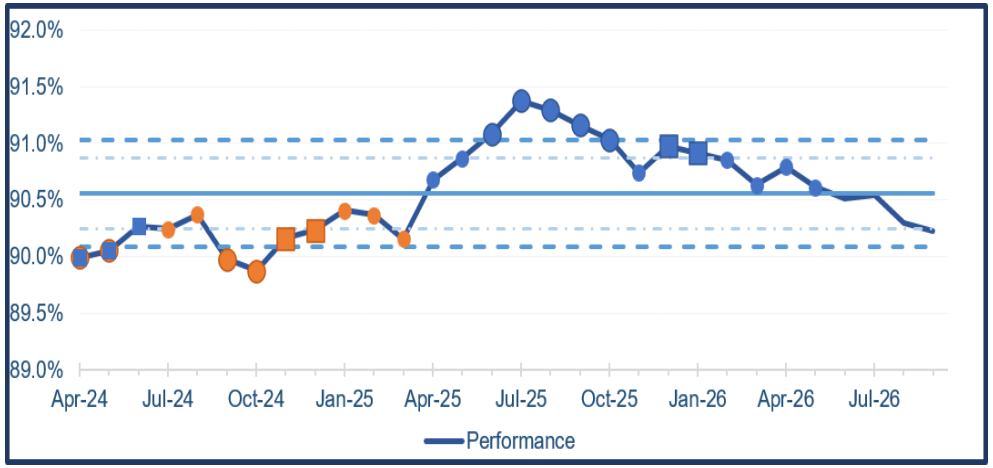
| Latest Month |
|---|
| Sept 26 |
| **Profile** |
| N/A |
| **Actual** |
| 80.1% |
| **Status** |
| Advise |




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

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

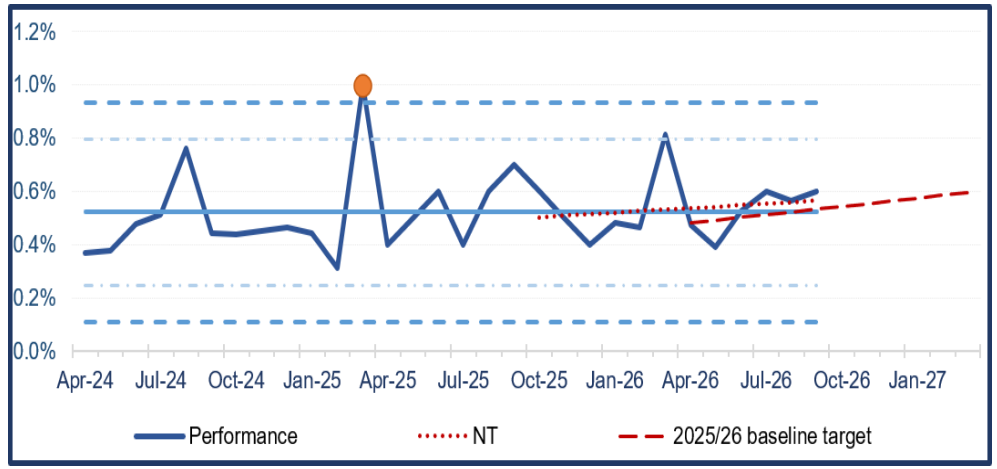
| Latest Month |
|---|
| Sept 26 |
| **Profile** |
| N/A |
| **Actual** |
| 90.2% |
| **Status** |
| Advise |




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

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

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



# Section 5
# Finance and sustainability



# Scorecard: Finance and sustainability (1 of 2)

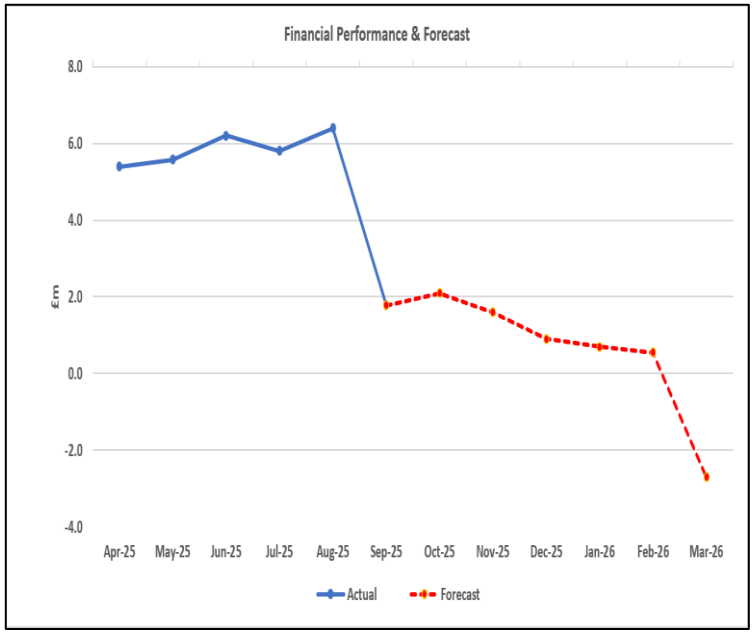
| REF | Measure Description | Target Suite | | | Wales Benchmark | Actual Performance | | | | Status |
|---|---|---|---|---|---|---|---|---|---|---|
| | | NT | SM | AP | | Jul-26 | Aug-26 | Sep-26 | 6 Month Activity | |
| LMF01 | In-month revenue position (expenditure over planned deficit of £3.6m per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

# Scorecard: Finance and sustainability (2 of 2)

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

# Revenue Position

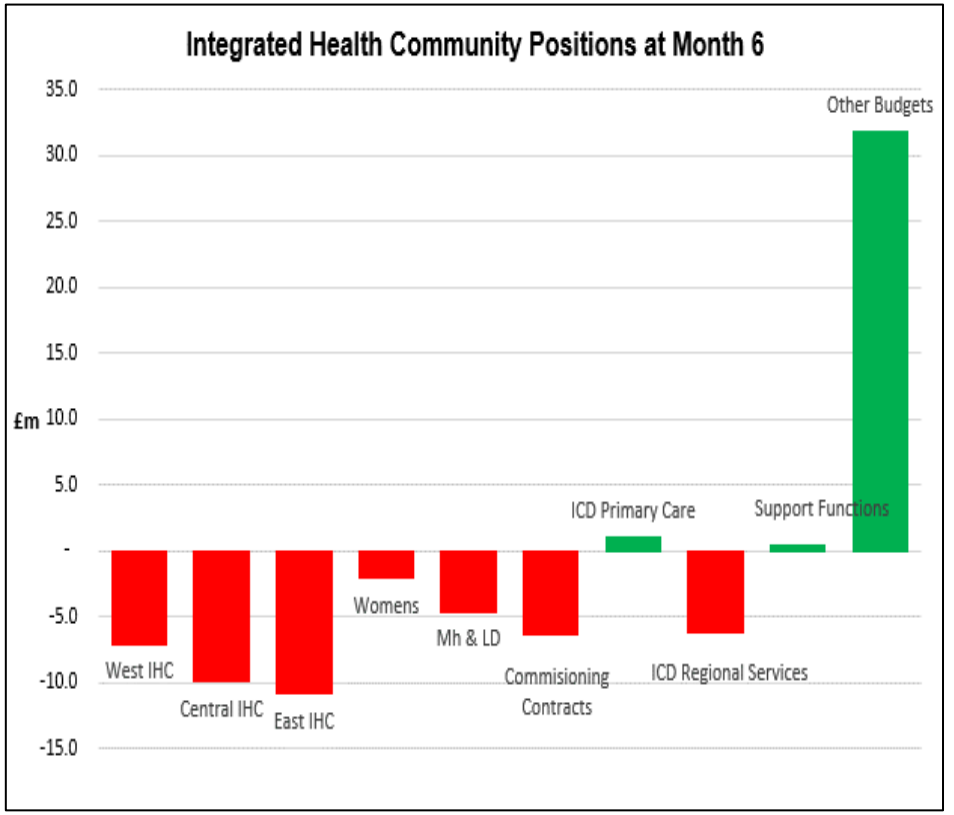
| | Actual | | | | | | Forecast | | | | | | 2026/27 Cumulative against Plan | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | M01 | M02 | M03 | M04 | M05 | M06 | M07 | M08 | M09 | M10 | M11 | M12 | Budget | Actual | Variance | Variance |
| | £m | £m | £m | £m | £m | £m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




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

# Divisional Positions

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




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

# Expenditure – Pay & Non-Pay

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

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

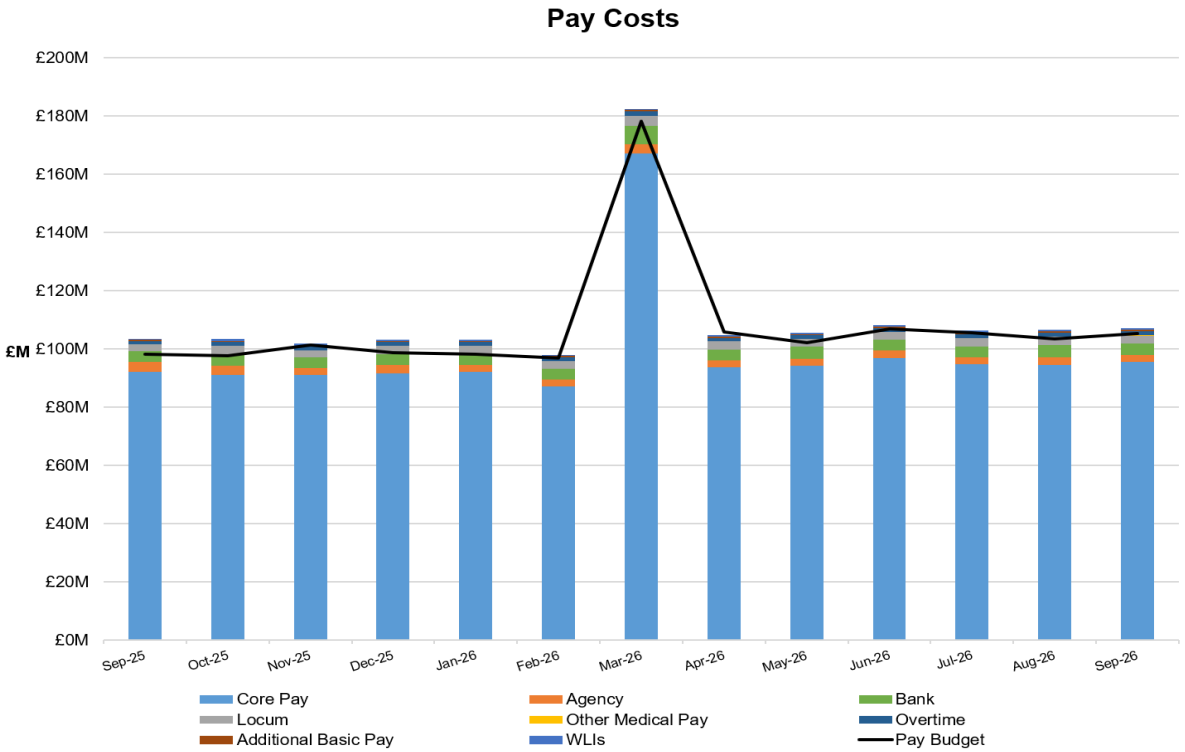
## Health Board Pay:

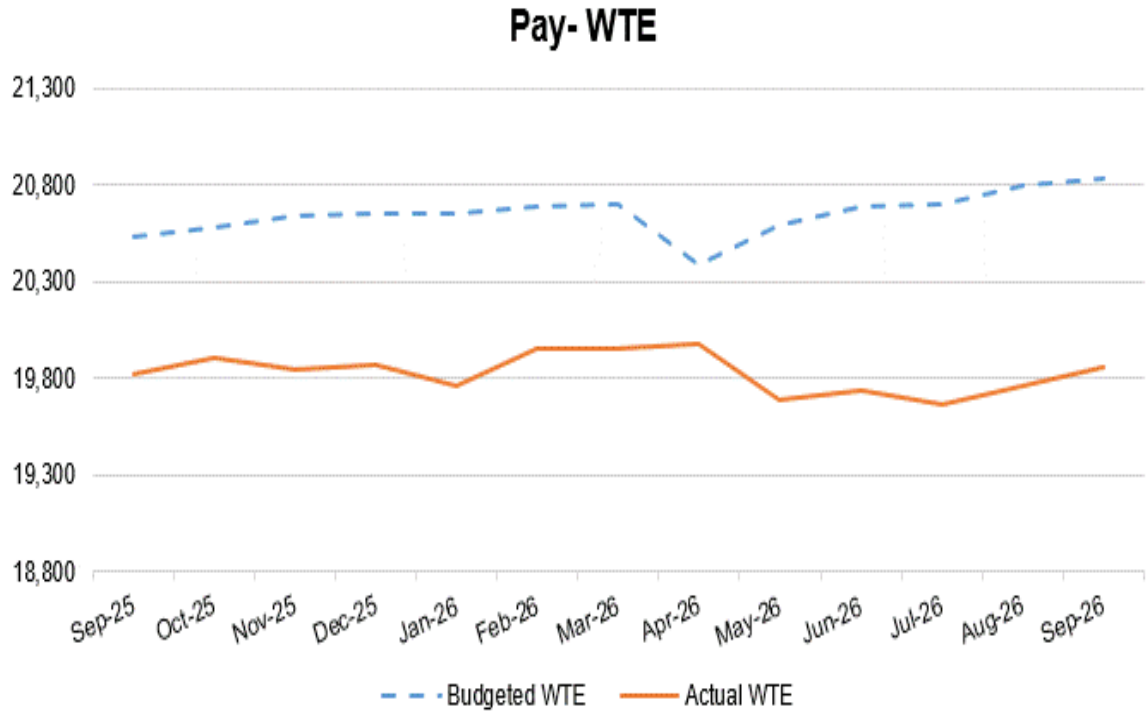
- Month 6 Provider Services Pay increased by £0.3m (0.3%) from previous month with the increase being predominantly reported in core pay.
- Variable Pay totals £11.4m for September, a reduction of £0.5m from previous month driven by reductions of £0.2m Agency, £0.2m Bank and £0.2m Locum, offset by an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

## Non-Pay Expenditure (excluding Depreciation):

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

# Expenditure - Pay




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

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

# Pay - WTE

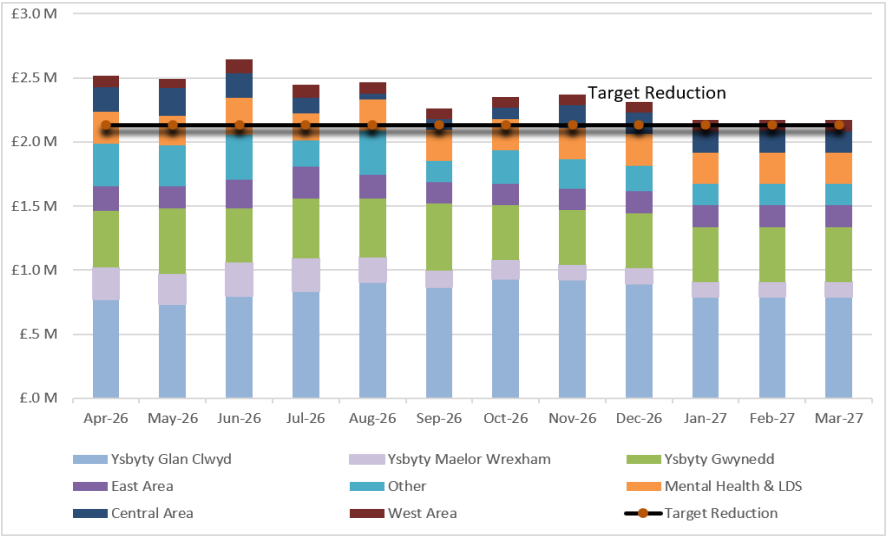
| | 2025/26 | | | | | | 2026/27 | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 | Apr-26 | May-26 | Jun-26 | Jul-26 | Aug-26 | Sep-26 | Movement M4 V M3 |
| Budgeted WTE | 20,575 | 20,637 | 20,649 | 20,656 | 20,693 | 20,705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

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

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

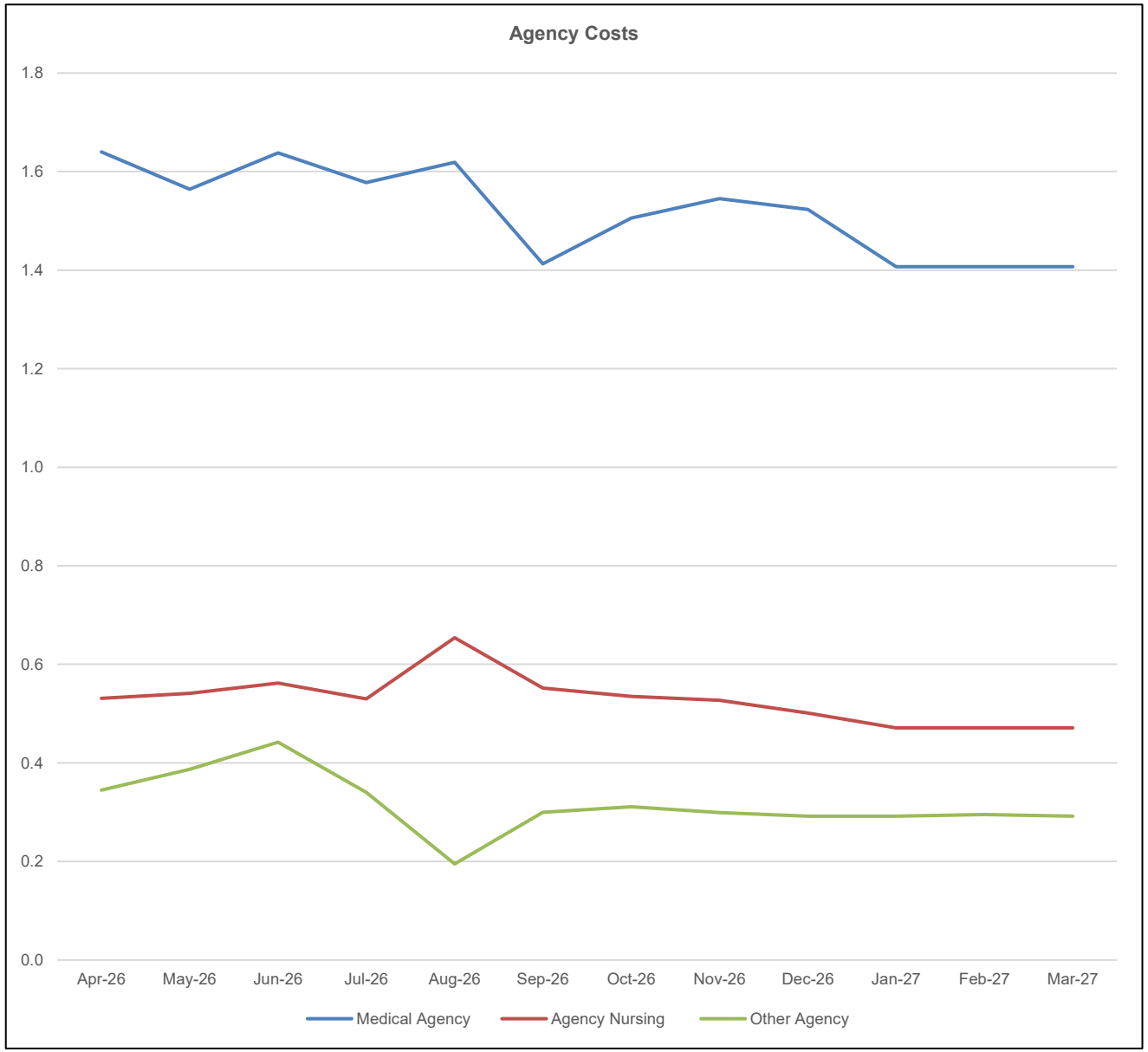
# Pay Costs - Agency

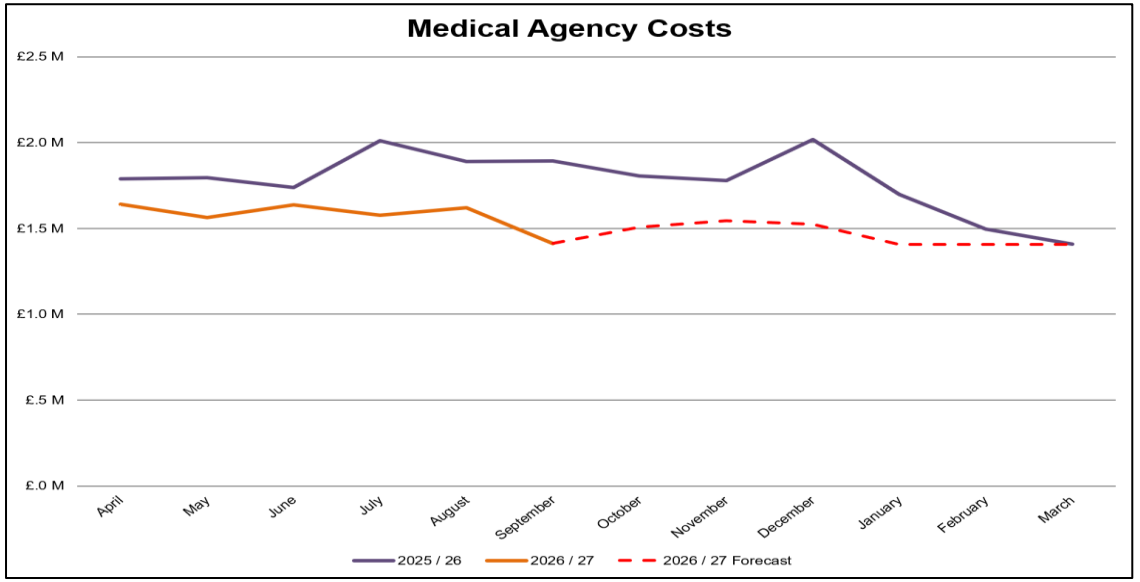
| | 2026-27 Agency Spend £m | | | | | | | | | | | | YTD Expenditure £m | 2026/27 Forecast £m |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Actual | | | | | | Forecast | | | | | | | |
| | Apr-26 | May-26 | Jun-26 | Jul-26 | Aug-26 | Sep-26 | Oct-26 | Nov-26 | Dec-26 | Jan-27 | Feb-27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

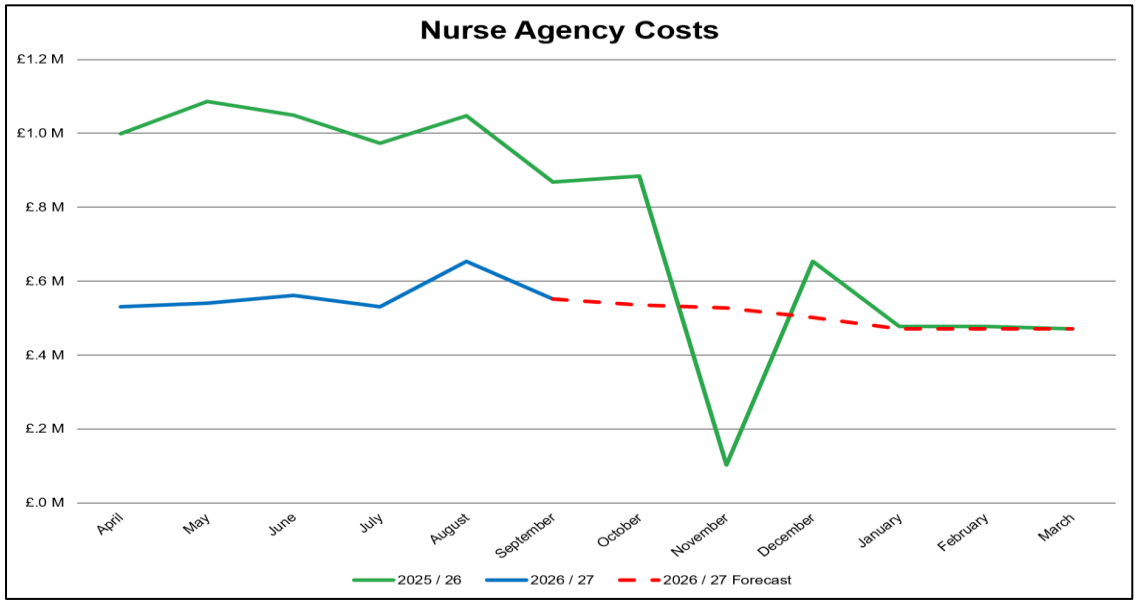



- Agency expenditure for September (Month 6) is £2.3m (2.1% of total pay). In-month spend is reporting a £0.2m reduction from previous month and is £0.8m less compared to the 2025/26 monthly average of £3.0m. 2026/27 Full year Agency forecast outturn is £28.4m (2.3% of total pay), a £0.3m increase from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

# Pay Costs - Agency



# Expenditure – Non-Pay

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

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

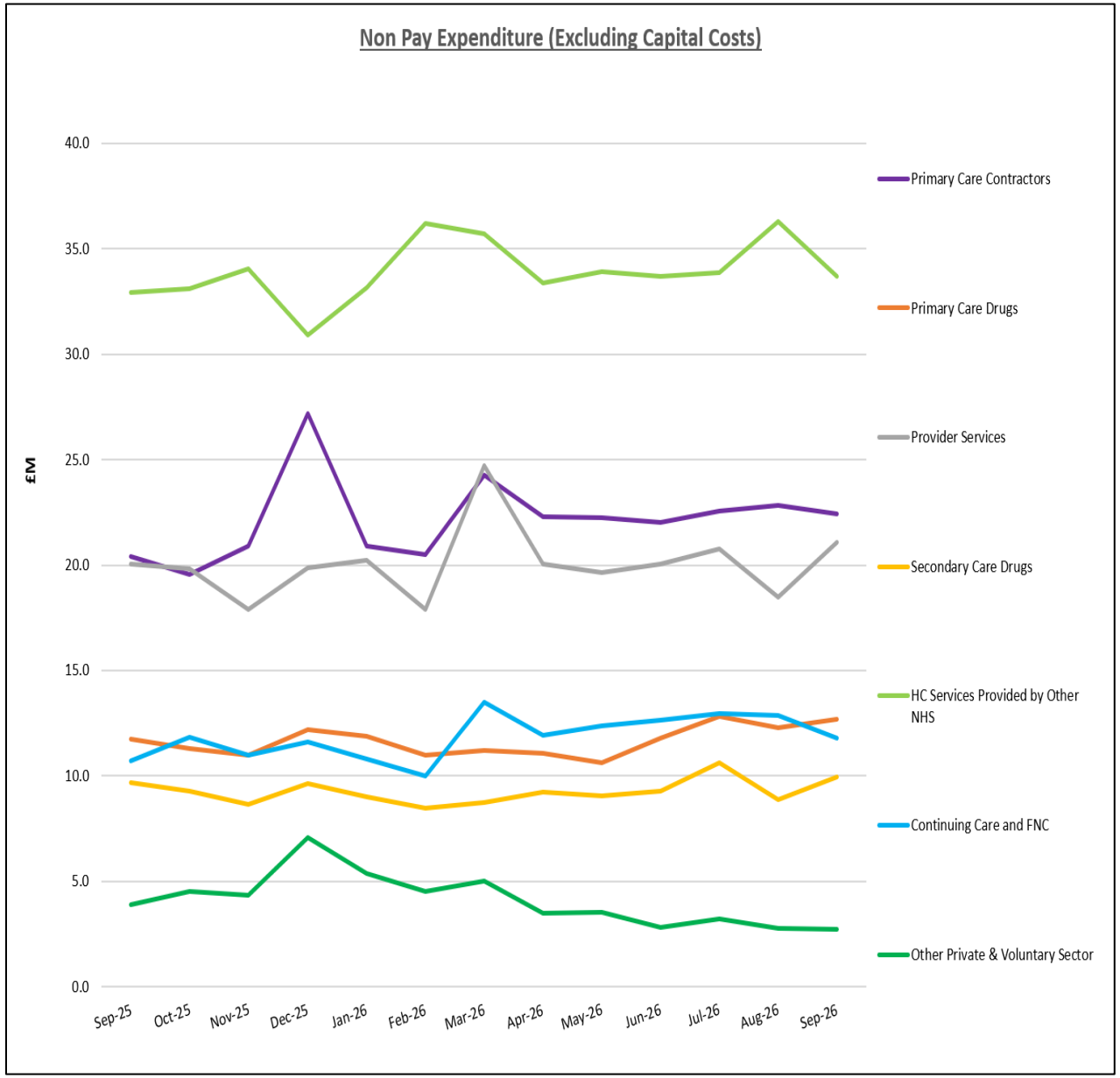
- **Provider Services Non-Pay:** Provider Services Non-Pay spend increased by £2.6m (14.0%) in-month, of which £1.4m is increase in Clinical Services & Supplies spend, 0.4m increase in General Services & Supplies and £0.4m increase in Premises and Fixed Plant expenditure.

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

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

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

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



# Risks

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

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

# Balance Sheet & Cash

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

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

# Capital

| BUDGET 2026/27 | | |
|---|---|---|
| **Capital Resource Limit 2026/27** | **£m** | Brief Overview / Update The purpose of this dashboard is to brief the committee on the delivery of the approved capital programme to enable appropriate monitoring and scrutiny. The report provides an update, by exception, on the status and progress of the major capital projects and the agreed capital programmes. The report also provides a summary on the progress of expenditure against the capital resources allocated to the Heath Board by the Welsh Government through the Capital Resource Limit (CRL). |
| WG Discretionary Capital | 14.1 | |
| All Wales Scheme | 43.9 | |
| **CRL** | **58.0** | |

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

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

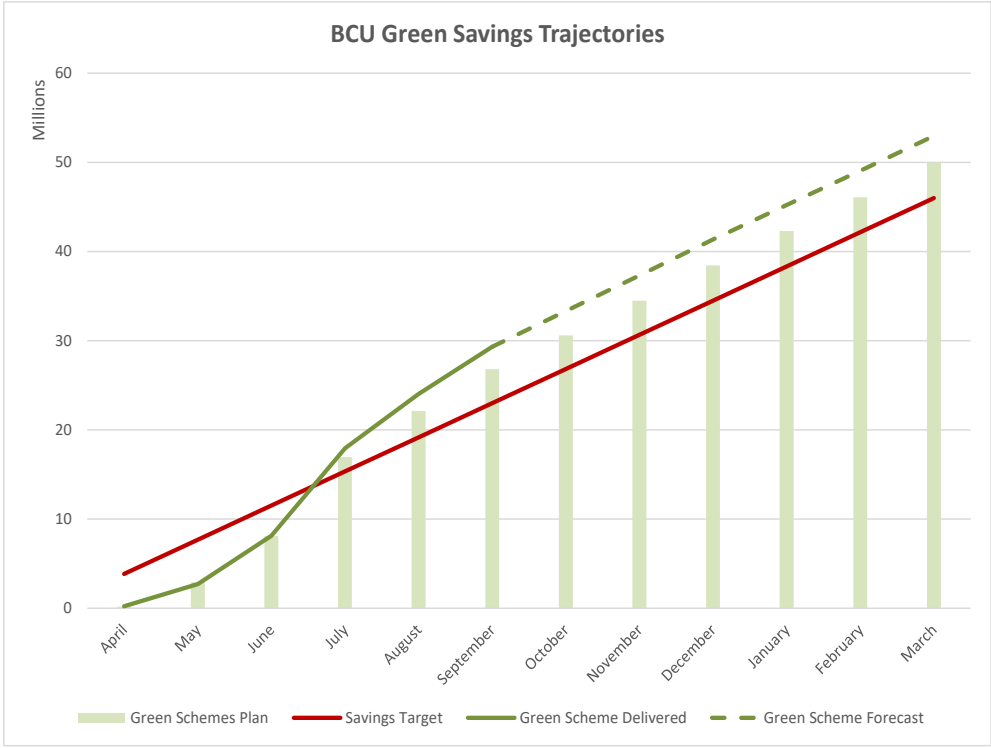
# Capital

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

# Savings Performance against Target

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

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



# Appendices

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



# Interpreting Statistical Process Control (SPC) Charts

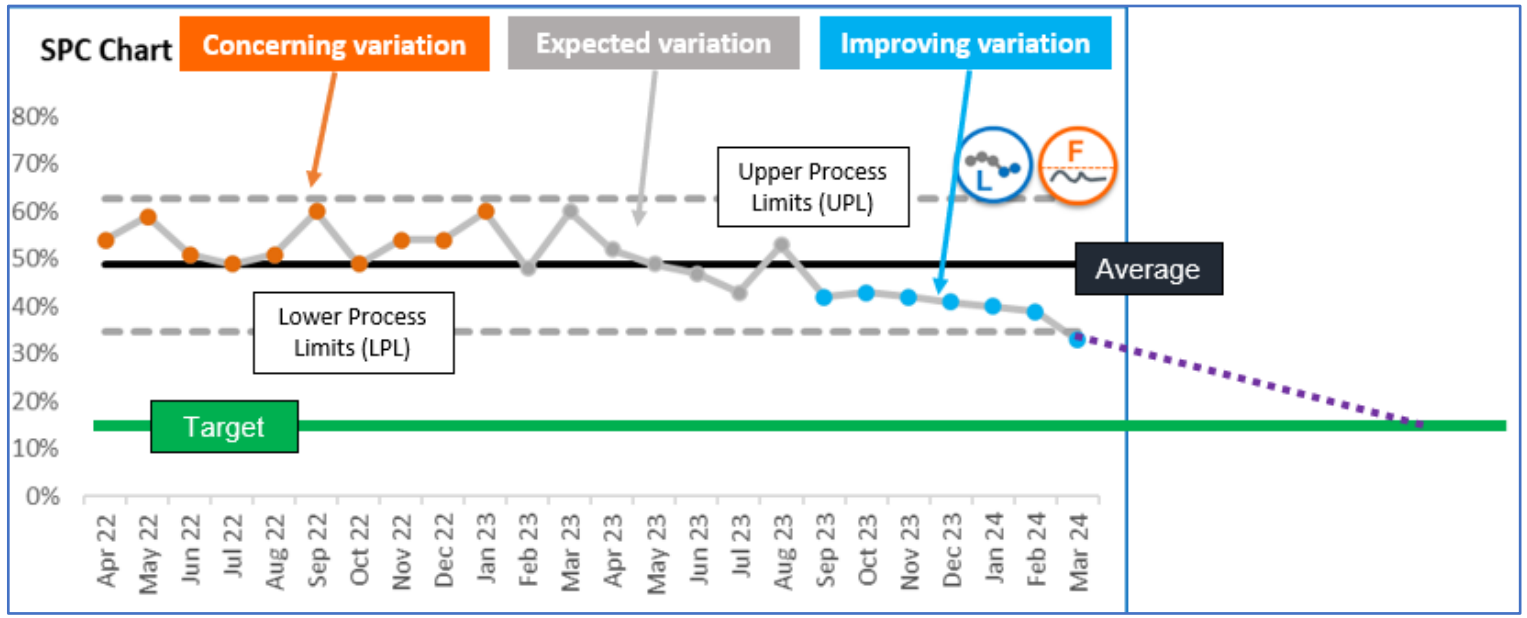
A statistical process control (SPC) chart is a useful tool to help distinguish between signals (which should be reacted to) and noise (which should not as it is occurring randomly).

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

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

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

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




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

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

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

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

# Key

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

# How to interpret the Integrated Performance Scorecard

Diagram and description of Scorecard elements

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

**Actual Performance Window**

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

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

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

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

Full Measure Description

Benchmark of Performance compared to rest of Wales

BCUHB position compared to other Welsh NHS Organisations

# Abbreviations

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

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

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

# Additional Information

## Integrated Quality and Performance Report
## Betsi Cadwaladr University Health Board

Information on our performance can be found online at:

Our website www.bcu.wales.nhs.uk

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

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

follow @bcuhb

http://www.facebook.com/bcuhealthboard

# Quality Safety & Experience Committee

## PLANNED CARE – FOCUS ON ENDOSCOPY DEEP DIVE

| | |
|---|---|
| **Dyddiad y Cyfarfod<br>Date of Meeting** | 05 November 2026 |
| **Statws Cyhoeddi<br>Publication Status** | Open/ Public |
| | Not Applicable |
| **Enw a theitl Awdur(on) yr Adroddiad<br>Report Author name and title** | Rachel Hayward – Endoscopy Network Manager |
| **Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol<br>Lead Executive Team Member name and title** | Matt Powls Chief Operating Officer |

| | |
|---|---|
| **Pwrpas yr Adroddiad<br>Report Purpose** | For Assurance |

**Crynodeb Gweithredol<br>Executive Summary**

BCUHB Endoscopy Services have made significant progress in improving diagnostic access and reducing long waits during 2025/26. Waiting-list recovery is evident across urgent and routine cohorts, and over-8-week breaches have reduced substantially from the position at September 2025. This has been supported by improved waiting-list validation and clinical vetting, additional capacity, transfers of care between sites, insourcing and outsourcing, alongside active engagement with the National Endoscopy Programme and national improvement initiatives.

Despite this improvement, the service remains under significant operational and clinical pressure. Demand continues to increase, while 2,125 surveillance patients are overdue their planned procedure. Upper and lower GI cancer pathway performance remains below the stated 75% target, and physical estate constraints continue to restrict opportunities to increase capacity. The absence of a fully progressed Endoscopy Workforce and Capacity Business Case remains a significant strategic risk, with continued reliance on insourcing, waiting-list initiatives and temporary workforce solutions to maintain service delivery.

Quality, safety and service resilience therefore remain central to the recovery programme. The service continues to monitor adverse events, patient experience and performance, has strengthened assurance arrangements for non-JAG accredited and internationally recruited endoscopists, and is working towards JAG standards. However, important risks remain in relation to workforce fragility, specialist procedures including ERCP, the absence of a sustainable internally delivered out-of-hours upper GI bleed service, ageing equipment and decontamination infrastructure. A Regulation 28 Report to Prevent Future Deaths has also identified areas requiring improvement, including staffing, infrastructure, waiting-time performance, development of a networked service and risk management.

The overall position is therefore one of demonstrable recovery but continuing vulnerability. Recent improvements remain dependent on a range of temporary mitigations and will require sustainable workforce and capacity solutions, investment in equipment and digital infrastructure, continued strengthening of governance and progress towards JAG accreditation. QSE is asked to take assurance from the progress made and the governance arrangements in place, while recognising the significant residual risks to sustainable performance, quality and patient safety that require continued executive oversight and monitoring

The Committee is asked to:

- NOTE the progress achieved,
- SEEK ASSURANCE regarding the management of the outstanding quality and safety risks
- SUPPORT the recommendations set out within the paper

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

| **Acronymau / Rhestr Termau**<br>**Acronyms / Glossary of Terms** | |
|---|---|
| JAG | Joint Advisory Group (Gastrointestinal Endoscopy) |
| GI | Gastro Intestinal |
| WLI | Waiting List Initiative |
| OGD | Oesophago-Gastro Duodenoscopy |
| ERCP | Endoscopic Tetrograde Cholangiopancreatography |

## PLANNED CARE – FOCUS ON ENDOSCOPY DEEP DIVE

### 1. Y SEFYLLFA / SITUATION

1.1. BCUHB Endoscopy Services provide diagnostic and therapeutic gastrointestinal endoscopy across the East, Central and West areas of North Wales

1.2. The service has demonstrated sustained improvement in access and waiting time performance during 2025/26, including:

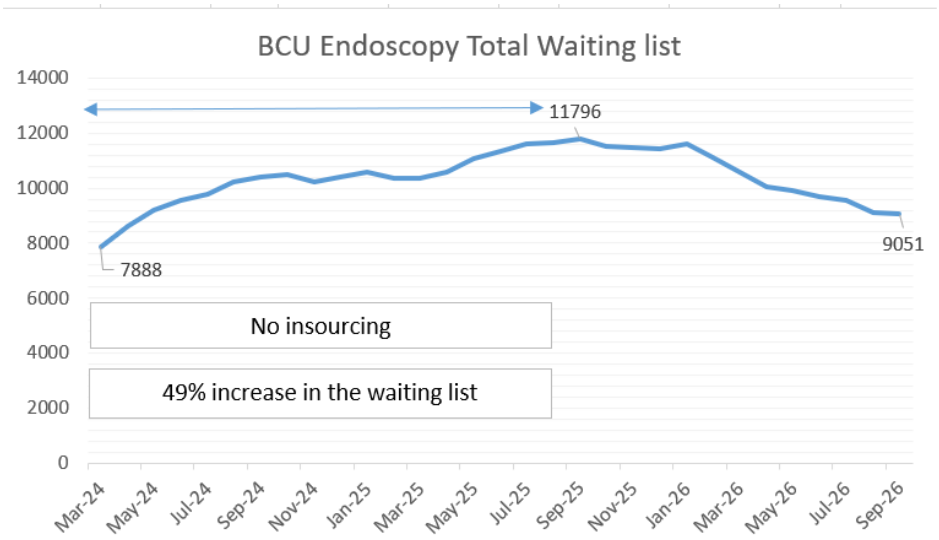
1.2.1. Continued reduction in diagnostic waiting lists and long wait backlogs.
1.2.2. Ongoing support for urgent suspected cancer pathways.
1.2.3. Increased focus on workforce development and competency assurance.
1.2.4. Active participation in the National Endoscopy programme, adoption of national guidance and documentation.
1.2.5. Engagement in the Bowel Screening Improvement Collaborative to support pathway improvement and performance
1.2.6. Despite these improvements, demand remains greater than historical levels and continues to create operational pressure across all sites.

1.3. Alongside operational pressures, the service continues to manage a number of governance, quality and patient safety challenges. Endoscopy services are operating within an environment of heightened scrutiny relating to incident reporting, equipment reliability, workforce sustainability, estate constraints and compliance with national standards. A number of ongoing incidents and service risks remain under active management through established governance processes, requiring continued executive oversight, timely escalation and robust mitigation to minimise impact on patient safety, service delivery and performance.

### 2. Y CEFNDIR / BACKGROUND

2.1. Since 2021, Endoscopy Services have been operating against a workforce business case that remains only partially approved. While a small number of posts were authorised and recruited to, the substantive remainder of the business case, despite receiving executive approval, has yet to be fully progressed. This has delayed the development of a sustainable workforce model and has resulted in a continued reliance on insourcing arrangements and Waiting List Initiative (WLI) activity to maintain service delivery and support waiting list recovery. It should also be recognised that, even when the outstanding business case is approved in full, there will be a considerable lead-in period before benefits are realised, as recruitment, onboarding, training and competency development for endoscopy staff can take several years before individuals are able to work independently within their full scope of practice.

2.2. In addition, the decision to not procure a replacement insourcing contract prior to the expiry of the existing arrangement resulted in a six-month period during which no insourcing activity could be undertaken. This had a significant adverse effect on service capacity and waiting list performance, with our patient waiting list increasing by 49% during this period as shown in the graph below.




2.3. The table below provides a detailed breakdown of the increase within each patient cohort during the period when no insourcing contract was in place. The final column shows the current waiting list position for each cohort as at 30 September 2026.

| **Cohort** | **March 24** | **Sept 25** | ***Increase of*** | **Sept 26 *current** |
|---|---|---|---|---|
| USC | 401 | 863 | *462* | 566 |
| Urgent | 992 | 2854 | *1862* | 1468 |
| Routine | 1319 | 2464 | *1145* | 882 |
| Surveillance | 5176 | 5615 | *439* | 6047 |
| Over 8-week breaches | 1470 | 4484 | *3014* | 1439 |

2.4. Recovery actions have been implemented, but services continue to manage the impact of this deterioration, and waiting list recovery remains a significant operational challenge across the Endoscopy service. Whilst cohort volumes, with the exception of the surveillance group, have improved it's also important to note the number of weeks waited has significantly improved.

2.5. Endoscopy services nationally continue to experience increasing demand associated with:

2.5.1. Increased cancer pathway activity.

2.5.2. Expansion of bowel cancer screening programmes.
2.5.3. Increased surveillance requirements.
2.5.4. Ageing population and rising prevalence of gastrointestinal disease.
2.5.5. Workforce shortages across medical, nursing and administrative groups.

2.6. Within BCUHB, significant work has been undertaken to improve productivity, maximise available capacity and reduce waiting times. This has included validation of waiting lists, optimisation of clinical capacity, utilisation of insourcing and outsourcing where required, and implementation of standardised operational processes across sites. Weekly 6-4-2 performance meetings, incorporating retrospective review of the previous week to capture learning, share good practice, and inform future actions. These are also supported by monthly cancellation review meetings, this provides oversight of activity, utilisation, waiting times and key performance indicators reviews. These forums review performance trends, identify recurring themes, risks and capacity constraints, monitor delivery against agreed trajectories, and ensure actions are agreed and tracked to support service improvement, recovery and sustainable performance.

2.7. The service maintains strong engagement with the National Endoscopy Programme, ensuring implementation of national guidance, standards and clinical documentation where appropriate. Representatives attend national meetings and contribute to collaborative improvement initiatives across Wales. BCUHB Endoscopy Services are also actively engaged in the Bowel Screening Improvement Collaborative workstreams, supporting service improvement, pathway optimisation and performance within the bowel screening programme.

2.8. As part of the recovery programme, interim solutions have been implemented to maximise available capacity and improve patient access. These include additional endoscopy capacity within the West area and outsourcing arrangements with the Countess of Chester Hospital to support diagnostic backlog reduction and waiting time recovery.

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

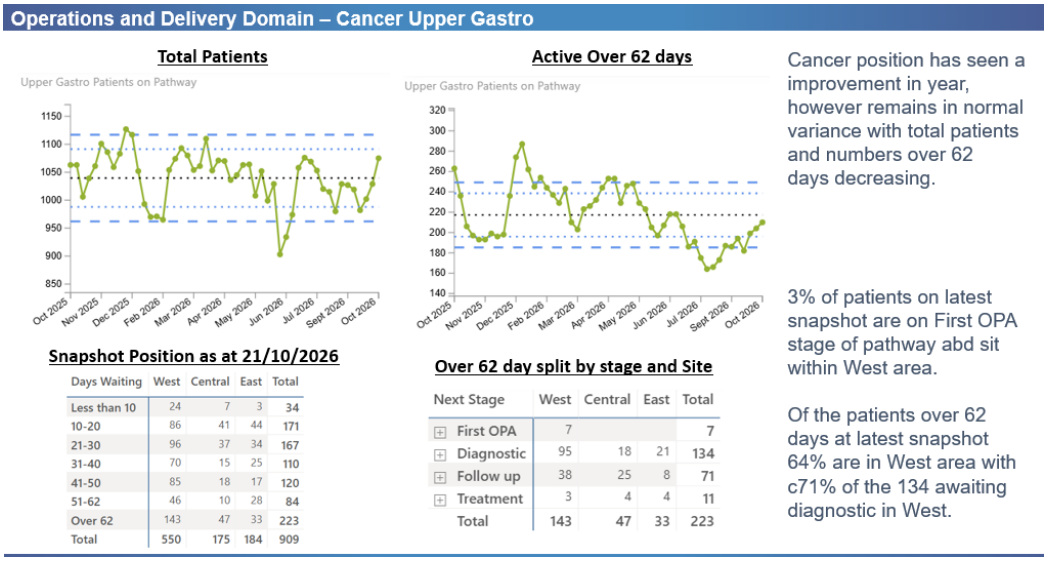
3.1. Performance
3.1.1. Diagnostic waiting list performance has improved significantly over the last 12 months with further improvement required to meet zero over 8-week breaches by March 2027. (See picture 1)
3.1.2. Cancer performance remains a priority to ensure in line with requirements to support the 62-day pathway.
3.1.3. Demand continues to exceed pre-pandemic levels.
3.1.4. Surveillance backlog remains a concern with little capacity in the system to support due to competing cohort priority.

3.1.5. Improved clinical vetting and validation processes in place following National guidance.

3.1.6. A review of low-yield endoscopy activity is underway to ensure procedures remain clinically appropriate and capacity is utilised effectively.

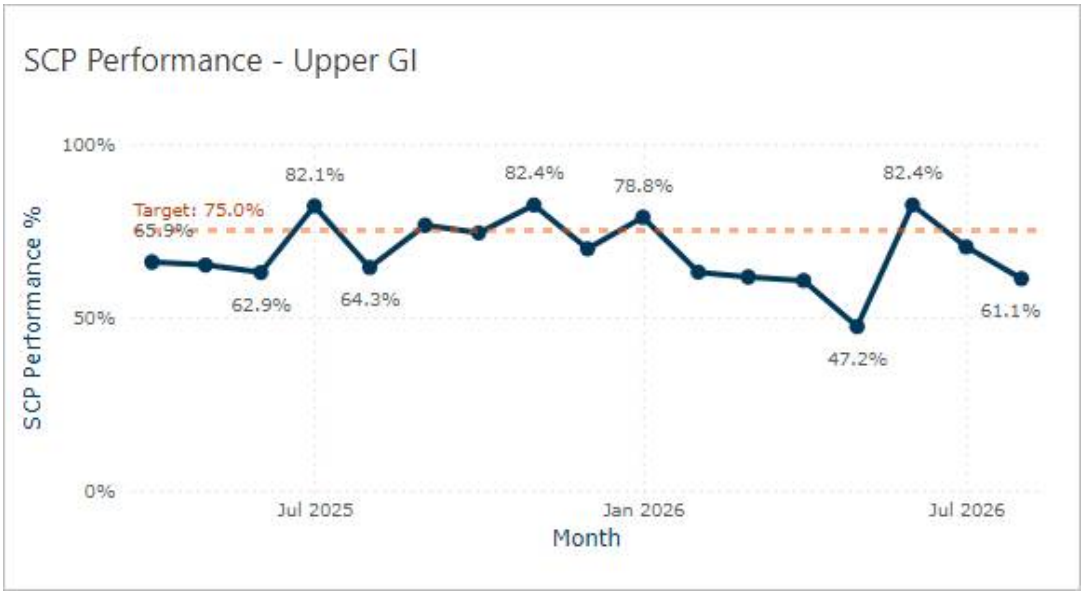
3.1.7. Transfers of care between Central and East to equalise waiting lists and improve equity of access.

*Picture 1*




3.1.8. Highlighted in the following graphs are upper GI and lower GI:

Upper GI – the data highlights that we are below trajectory with performance sat at 61%



Lower GI – the data highlights that we have not achieved the target and continue to find extremely challenging.




3.1.9. The quantity of surveillance patients that are overdue their planned admission date is 2125 patients of which 485 are upper procedures (OGD), 1517 lower (colonoscopy), 121 lower (flexible sigmoidoscopy), 2 ERCP.

3.2. Capacity

3.2.1. Physical estate limitations continue to impact service expansion opportunities.
3.2.2. Variation exists across sites in available rooms, recovery space and support infrastructure.
3.2.3. Increasing surveillance demand is placing pressure on future capacity requirements.
3.2.4. Opportunities to expand our capsule services are currently being reviewed to increase diagnostic capacity and provide an alternative pathway.

3.3. Workforce

3.3.1. The Endoscopy Business Case remains awaiting approval, limiting progress toward the development of a sustainable workforce model and reduction in reliance on insourcing arrangements.
3.3.2. Recruitment and retention challenges remain across several staff groups.
3.3.3. Staffing requirements in the business case not only account for the weekend working (replacement of insourcing), it also allows for staffing to ensure alternative pathways can be put into place robustly for example Capsule services and Transnasal endoscopy. It also allows

for support for the out of hours GI bleed rota, vetting and validation and additional administrative support.

3.3.4. Opportunities for training must be balanced against operational pressures.

3.3.5. Continued focus is required on governance, JAG compliance and succession planning.

3.3.6. Working closely with workforce colleagues to ensure workforce plan development.

3.4. Quality and Governance

3.4.1. Ongoing monitoring of key performance indicators, adverse events, patient experience and National Endoscopy Database submissions continues.

3.4.2. Governance arrangements for non-JAG accredited and internationally recruited endoscopists have been strengthened through formal competency and assurance processes.

3.4.3. JAG accreditation standards remain a priority. JAG accreditation would provide independent assurance that BCUHB endoscopy services meet recognised standards for clinical quality and safety, patient experience, workforce competence and service governance. This is a structured quality-improvement framework, supporting consistent standards across services, identification of gaps and sustained improvement. It would also align BCUHB with the wider NHS Wales ambition for endoscopy units to achieve and sustain JAG accreditation.

3.5. Digital Infrastructure

3.5.1. Continued reliance on ageing hardware and equipment in some areas creates operational risk
3.5.2. Digital consent pilot to commence in East.
3.5.3. Electronic test requesting pilot to commence.

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

4.1. The most significant strategic risk facing the Endoscopy Network is the absence of an approved Endoscopy Workforce and Capacity Business Case. Without agreement on a sustainable long-term workforce model, the service remains heavily reliant on temporary mitigation measures to maintain performance, support waiting time recovery and meet increasing demand. This limits the Health Board's ability to develop internal capacity, reduce dependency on insourcing arrangements and establish a resilient service for the future

4.2. These risks were further highlighted through the Health Board's receipt of a Regulation 28 Report to Prevent Future Deaths, which identified key areas requiring improvement, including staffing, infrastructure, waiting time performance, development of a fully networked service and robust risk management arrangements

4.3. The continued reliance on insourcing remains a major operational and financial challenge. Across the three endoscopy sites, insourcing currently delivers 28 lists per week in addition to providing midweek backfill to sustain core service capacity. Whilst this approach has enabled progress against waiting times, it is not a sustainable long-term solution. The current contract expires in September 2027, at which point a full procurement exercise will be required. Sustainable workforce solutions are therefore essential to reduce this dependency and support alternative models of care. This is detailed in risk register entry ID 4252, 3419, 4963.

4.4. Workforce fragility continues to impact service resilience across the network. Recruitment and retention challenges, sickness absence and ongoing vacancies reduce available clinical capacity and increase reliance on temporary staffing solutions. In the Central Area, dependence on agency consultant support remains substantial, whilst recruitment of substantive BCUHB consultants remains a priority across all sites. Nursing insourcing arrangements continue to be required to deliver core weekday capacity. Furthermore, only three of the seven funded Clinical Endoscopist posts are substantively filled, limiting internal capacity and resulting in continued reliance on waiting list initiatives and insourcing support to ensure lists can proceed. This is detailed in risk register entry ID 4963, 5877.

4.5. The service also faces significant risk in relation to specialist procedure provision. Endoscopic Retrograde Cholangiopancreatography (ERCP) services remain particularly vulnerable, with only three endoscopists currently able to perform the procedure, two of whom are not substantive BCUHB consultants. Any reduction in this workforce could have a significant impact on service continuity and patient access. This is detailed in risk register entry ID 2946, 4015, 4963.

4.6. Demand for endoscopy continues to increase and may outstrip available capacity if further sustainable solutions are not implemented. In addition to growing diagnostic demand, surveillance activity is increasing, including a backlog of patients who are overdue their planned surveillance procedures. Harm associated with this delay is subject of a current Ombudsman case. Continued growth in surveillance requirements risks reducing available capacity for timely diagnostic investigations, potentially impacting waiting time performance and service recovery trajectories. This is detailed in risk register entry 4963, 4252, 3419.

4.7. Additional pressure is anticipated through the ongoing retrospective Barrett's surveillance review within the Bangor service. The impact on capacity and waiting time recovery plans will require continued monitoring. This is detailed in risk entry 5784.

4.8. Access to complex procedures remains another area of concern. Limited Propofol and General Anaesthetic capacity means some patients are waiting longer than clinically desirable for their procedures. Similarly, there remains no sustainable internally delivered out-of-hours Upper Gastrointestinal Bleed rota across BCUHB. A weekend therapeutic endoscopy provision was introduced in May 26 but continues to rely heavily on insourcing support to maintain patient safety and access. Whilst effective in the short term, this model is not sustainable, and development of sufficient internal workforce capacity remains essential to establish a resilient Health Board-led service. This is detailed in risk entry 4963, 4252.

4.9. Infrastructure and operational resilience present further risks. The Endoscopy Decontamination Unit within the Central Area remains a significant concern pending the planned transfer of activity to Sterile Services in April 2027. The current decontamination model is increasingly fragile, with resilience challenged on a week-by-week basis by ageing equipment and the risk of washer-disinfector failures. Any loss of decontamination capacity would have an immediate impact on endoscopy activity and could significantly affect waiting time performance and recovery plans. Regular operational meetings and interim infection prevention audits continue to monitor compliance, safety and operational risks whilst long-term solutions are progressed. This is detailed in risk register entry ID 3820, 5908.

4.10. Across the network, delays in replacing endoscopy equipment, digital systems and supporting infrastructure also present a risk to operational resilience and service continuity. The ability to maintain safe and effective services is increasingly dependent on investment in modern equipment and facilities. This is detailed in risk register entry ID 5905, 5908, 5501

4.11. Alongside these operational challenges, financial pressures may limit the ability to secure the additional workforce and capacity required to sustain current performance levels. Failure to invest in sustainable solutions risks undermining recent improvements in waiting times and increasing reliance on costly temporary arrangements.

4.12. Finally, maintaining compliance with Joint Advisory Group (JAG) standards remains a key priority. Failure to achieve or sustain JAG standards could adversely affect service quality, accreditation status, patient experience and clinical outcomes.

4.13. To detail the incidents raised via Datix between 1 April and 30 September 2026 totalled 132, comprising 66 incidents in the West, 41 in the Centre, and 25 in the East. The table below categorises these incidents by theme and shows the number recorded against each category. All incidents are managed through the appropriate governance processes and reporting routes within their respective Integrated Health Communities (IHCs). A summary is provided at the monthly Regional operational group (ROG).

| **Categories** | **No** |
|---|---|
| Treatment or procedure issues | 37 |
| Access to service/admission delayed | 21 |
| Medical equipment | 15 |
| Delay in clinical assessment | 15 |
| Admin error | 8 |
| Communication issues | 5 |
| Slip, trip or fall | 5 |
| Documentation | 5 |
| Prescribing issues | 3 |
| Pathology testing | 3 |
| Ward / Inpatient issues | 3 |
| Environment issue | 2 |
| Inappropriate behaviour | 2 |
| Breach of confidentiality | 2 |
| Unplanned admission | 2 |
| Allergic reaction / adverse reaction | 1 |
| Pressure ulcer on admission | 1 |
| Consent process | 1 |

4.14. Taken together, these challenges show our Endoscopy service has achieved significant improvements through considerable effort and the extensive use of temporary mitigations, but which remains vulnerable without longer-term investment and strategic support. Increasing demand, workforce shortages, ageing infrastructure, specialist service fragility and ongoing reliance on insourcing collectively threaten the ability to sustain performance improvements and deliver further reductions in waiting times. Continued executive oversight, organisational support and timely investment will be critical to maintaining service resilience and securing the long-term sustainability of endoscopy services across BCUHB.

## 5. ARGYMHELLION / RECOMMENDATIONS

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

- **NOTE** the significant improvement in endoscopy waiting-list performance, alongside the continuing risks relating to surveillance backlog, increasing demand, workforce fragility, specialist capacity, infrastructure and reliance on insourcing.
- **SEEK ASSURANCE** that recovery plans remain focused on quality and patient safety and clinical prioritisation, particularly the 2,125 patients overdue for surveillance, cancer pathways and patients requiring complex procedures or access to Propofol/General Anaesthetic capacity.
- **ENDORSE** progression of a sustainable workforce and capacity model, including the outstanding Endoscopy Workforce and Capacity Business Case, to reduce reliance on insourcing, agency staffing and Waiting List Initiatives and support development of alternative pathways.
- **SEEK ASSURANCE** that the actions arising from the Regulation 28 Report to Prevent Future Deaths, including those relating to staffing, infrastructure, waiting times, networked service provision and risk management, are being appropriately progressed and monitored.
- **ENDORSE** continued participation in national improvement programmes and development towards JAG accreditation, alongside strengthened clinical governance, workforce competency assurance, incident learning and greater consistency across the three endoscopy sites.
- **REQUEST** continued QSE oversight of the principal quality and safety risks, with a six-monthly update on waiting-list and surveillance recovery, workforce sustainability, significant service risks, Regulation 28 actions and progress towards JAG accreditation.

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

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

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

| | | |
|---|---|---|
| | Os oes mwy nag un yn berthnasol, rhestrwch hynny:<br>If more than one applies, please list: | |
| **Asesiad o Effaith ar Ddiogelu Data**<br>*A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?*<br>**Data Protection Impact Assessment**<br>*Have you undertaken a Data Protection Impact Assessment Screening?* | Do/Yes: ☐ | Naddo/No: ☒ |
| | Canlyniad/Outcome: | |
| | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale: | |
| **Asesiad o Effaith ar Atal Twyll**<br>*A ydych chi wedi ystyried yr effeithiau ar atal twyll?*<br>**Counter Fraud Impact**<br>*Have you considered the counter fraud impacts* | Do/Yes: ☐ | Naddo/No: ☒ |
| | Canlyniad/Outcome: | |
| | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale: | |
| **Cyfreithiol**<br>**Legal** | There are no specific legal implications related to the activity outlined in this report. | |
| | | |
| **Enw Da**<br>**Reputational** | There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report. | |
| | | |
| **Effaith ar Adnoddau**<br>*(Pobl / Ariannol)*<br>**Resource Impact**<br>*(People / Financial)* | Yes (Include further detail below) | |
| | The absence of an approved Endoscopy Workforce and Capacity Business Case represents the most significant strategic risk to maintaining waiting time recovery and reducing dependency on insourcing arrangements. Continued investment in workforce, equipment and digital infrastructure will be required to support sustainable service delivery and future demand. | |

## Quality Safety & Experience Committee

# URGENT & EMERGENCY CARE – UPDATE ON HEALTH BOARD RESPONSE TO HIW INSPECTION AT YGC

| | |
|---|---|
| **Dyddiad y Cyfarfod<br>Date of Meeting** | 05 November 2026 |
| **Statws Cyhoeddi<br>Publication Status** | Open/ Public |
| | Not Applicable |
| **Enw a theitl Awdur(on) yr Adroddiad<br>Report Author name and title** | Bridget Elliott, Recovery Director Urgent & Emergency Care |
| **Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol<br>Lead Executive Team Member name and title** | Matt Powls, Interim Chief Operating Officer |

| | |
|---|---|
| **Pwrpas yr Adroddiad<br>Report Purpose** | For Assurance |

**Crynodeb Gweithredol<br>Executive Summary**

This report provides assurance on the Health Board's response to the Healthcare Inspectorate Wales (HIW) inspection of the Emergency Department at Ysbyty Glan Clwyd (YGC), which resulted in a designation of Significant Improvement and an Immediate Assurance and Improvement Plan. Since the inspection, the Health Board has implemented a series of immediate actions to address identified risks, including strengthened executive oversight, enhanced quality monitoring, additional workforce capacity, improved patient flow processes and the introduction of standard operating procedures to support safer care delivery.

Recognising that the issues identified by HIW also reflect the broader systemic challenges across urgent and emergency care, the Health Board has been clear that the response to the HIW findings should not be managed as a standalone regulatory action plan.

At the Health Board meeting on 24th September, the Board received and approved the UEC improvement plan, which has been developed as a single framework for delivering UEC improvement across North Wales and aligns WG priorities, local Integrated Health Community (IHC) plans, and actions arising from the HIW inspection to ensure sustainable and organisation-wide improvement.

Progress has also been made in establishing enhanced governance arrangements, implementing Board-approved investment, developing a comprehensive UEC Improvement Plan and strengthening operational delivery arrangements across all Integrated Health Communities.

Whilst significant challenges remain in relation to patient flow, ambulance handovers, discharge delays and emergency department performance, the actions taken to date provide a strengthened framework for recovery. This report outlines progress against the HIW improvement requirements, the arrangements in place to monitor compliance and assurance, and the next steps required to embed sustainable improvements in the quality, safety and effectiveness of urgent and emergency care services across North Wales.

This report which encompasses the wider overarching UEC improvement plan should be read in conjunction with any other separate updates provided to committees specifically on the response to HIW inspection report.

The Committee is asked to:

- Note the progress made against the HIW Improvement Plan and wider UEC Improvement Programme.
- Receive assurance regarding the strengthened governance and delivery arrangements now in place.
- Note that improvement will continue to be monitored against key indicators, including patient flow, ambulance handover performance, 12-hour waits, discharge timeliness and compliance with HIW requirements.

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

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

# URGENT & EMERGENCY CARE – UPDATE ON HEALTH BOARD RESPONSE TO HIW INSPECTION AT YSBYTY GLAN CLWYD

## 1. Y SEFYLLFA / SITUATION

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

1.2 This report provides an update on the Health Board's response to the Healthcare Inspectorate Wales (HIW) inspection at Ysbyty Glan Clwyd, progress in implementing the Board-approved investment to support improvement, development of the UEC Improvement Plan, and proposals to strengthen governance arrangements to support sustainable delivery and improvements for patients accessing urgent and emergency care.

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

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

## 2 Y CEFNDIR / BACKGROUND

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

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

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

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

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

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

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

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

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

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

3.3 The Improvement Plan provides a comprehensive account of:

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

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

**Major Change Programmes and Operational Delivery**

3.5 During development of the UEC Improvement Plan, it became evident that current governance arrangements did provide a dedicated forum for co-ordinating and overseeing the operational development of urgent and emergency care across the Health Board.

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

3.7 To address these issues, the current governance structure is strengthened through the establishment of a fortnightly IHC UEC 90 Day reviews with the attendance of UEC Recovery Director, 3 Pillars Programme Director, and Head of Performance. This group provides operational grip, coordination and oversight across urgent and emergency care services and supports development of a future BCUHB UEC Operating Model.

3.8 This refreshed approach to UEC Improvement is aimed at establishing a common organisational framework for urgent and emergency care across

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

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

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

**UEC Recovery and BCUHB Priorities**

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

**UEC Improvement Strategic Priorities**

3.12 Immediate priorities are:

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

3.13 Medium term priorities are:

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

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

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

**Frailty and Same Day Emergency Care**

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

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

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

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

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

**Discharge to Recover and Assess (D2RA)**

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

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

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

**Clinical Engagement**

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

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

3.25 Several initiatives are supporting this objective:

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

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

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

**Single Point of Access (SPOA)**

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

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

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

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

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

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

## 5 ARGYMHELLION / RECOMMENDATIONS

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

- Note the progress made against the HIW Improvement Plan and wider UEC Improvement Programme.
- Receive assurance regarding the strengthened governance and delivery arrangements now in place.
- Note that improvement will continue to be monitored against key indicators, including patient flow, ambulance handover performance, 12-hour waits, discharge timeliness and compliance with HIW requirements.

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

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

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

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

**Quality Safety & Experience Committee**

# Learning Disability Services Strategic Quality, Safety and Experience Assurance Report

| | |
|---|---|
| Dyddiad y cyfarfod<br>Date of meeting | 05 November 2026 |
| Statws cyhoeddi<br>Publication status | Open/ Public |
| | Not applicable |
| Enw a theitl awdur(on) yr adroddiad<br>Report author name and title | Zoe Prince Director of Nursing, Mental Health and Learning Disabilty Division<br><br>Carole Evanson Director of Operations, Mental Health and Learning Disabilty Division<br><br>Nichaela Jones Head of Operations Regional Support Services Mental Health and Learning Disability Division |
| Enw a theitl aelod arweiniol o'r tîm gweithredol<br>Lead executive team member name and title | Teresa Owen Executive Director of Allied Health Professionals and Health Science |

| | |
|---|---|
| Pwrpas yr adroddiad<br>Report purpose | For Assurance |

| Crynodeb gweithredol<br>Executive summary |
|---|
| This paper provides the Quality, Safety and Experience Committee with an overview of the strategic direction of Learning Disability Services, including progress against key priorities, current performance and areas requiring continued focus.<br><br>Strong partnership working across health, social care, housing, advocacy and third-sector organisations remains central to the delivery of safe, effective and person-centred services, supporting improved outcomes for people with learning disabilities<br><br>The paper is presented in two parts. Part One outlines the strategic priorities for Learning Disability Services and progress against national, regional and organisational objectives, including reducing health inequalities, strengthening |

community-based support and promoting greater independence through integrated partnership working.

Part Two provides an update on quality, safety and experience, including progress following the recent HIW/CIW inspection of Conwy Community Learning Disability Services.

Overall, learning disability services continue to demonstrate positive progress against strategic priorities, underpinned by strong partnership working, a clear transformation programme and findings from the recent HIW/CIW inspection. Significant achievements include achievement of the highest Health Equality Framework performance in Wales, continued development of community alternatives to admission, and implementation of regional approaches to reducing health inequalities. Whilst the available evidence indicates positive progress and continued effective support, key challenges remain in relation to delayed discharge, accommodation availability, out-of-area placements, workforce sustainability and achievement of annual health check targets.

| Ymgysylltu (mewnol/allanol) yr ymgymerwyd ag ef hyd yma (gan gynnwys derbyn/ystyried yn y pwyllgor/grŵp)<br>Engagement (internal/external) undertaken to date (including receipt/consideration at committee/group) | | |
|---|---|---|
| Pwyllgor / grŵp / unigolion<br>Committee / group / individuals | Dyddiad<br>date | Canlyniad, tystiolaeth a data<br>Outcome, evidence and data |
| Not applicable for this report | | |

| Acronymau / rhestr termau<br>Acronyms / glossary of terms | |
|---|---|
| MHLD | Mental Health & Learning Disabilities |
| CLDT | Community Learning Disability Teams |
| WG | Welsh Government |
| IT | Information Technology |
| CIW | Care Inspectorate Wales |
| HIW | Health Inspectorate Wales |
| HEF | Health Equalities Framework |
| LD | Learning Disabilities |
| ATU | Assessment and Treatment services |
| BCUHB | Betsi Cadwaladr University Health Board |
| WG | Welsh Government |
| QNLD | Quality Network Learning Disability |
| NCEPOD | National Confidential Enquiry into Patient Outcome and Death |

# Learning Disability Services Strategic Quality, Safety and Experience Assurance Report

## 1. Part 1 Situation

1.1 The strategic direction for learning disability services is informed by both national and regional priorities. The Welsh Government's Learning Disability Strategic Action plan and subsequent Learning Disability Transformation Programme 2026-2029 focus on improving health and social care, advocacy and self-advocacy, education and support for children and young people, employment and skills, housing and accommodation, transport, and wider wellbeing, inclusion and partnership working. The refreshed North Wales Learning Disability Strategy 2026-2036 builds upon these priorities and the achievements of the previous 2018-2023 ( extended to 2026) strategy, setting out fifteen strategic priorities for the region: reaching potential; feeling safe and supported; lifespan and wellbeing; prevention and early intervention; voice, choice and control through self-advocacy; children and young people; transition support; access to transport; positive relationships; community and leisure opportunities; support for people with severe, profound and multiple learning disabilities; employment, lifelong learning and day opportunities; having a home; workforce development; and commissioning. Collectively, these priorities provide a comprehensive framework for improving quality, safety and experience through partnership working, early intervention, community-based support and improved outcomes for people with learning disabilities across North Wales.

1.2 Learning Disability services within the Mental Health and Learning Disability Division continue to deliver these priorities through partnerships with local authorities, housing, advocacy and third-sector organisations. However, progress against key ambitions, including community capacity, accommodation pathways, care closer to home and the wider transformation of learning disability services, will require continued partnership working, effective system leadership and sustained focus on delivering agreed service improvements. There is also a risk that assurance arrangements focus more on activity and compliance than on the outcomes that matter most to people with learning disabilities and their families.

1.3 Notwithstanding these challenges, the joint Healthcare Inspectorate Wales (HIW) and Care Inspectorate Wales (CIW) inspection of the Conwy Community Learning Disability Team (CLDT), completed in February 2026, identified evidence of effective practice, positive partnership working and person-centred care. The inspection also highlighted areas for improvement, which have informed ongoing service development and quality improvement activity across learning disability services in North Wales.

## 2. Background

2.1 North Wales has been at the forefront of learning disability service transformation for a number of years. Prior to the introduction of a national learning disability improvement framework, partners across health, social care, housing, advocacy and the third sector established a shared regional vision to improve outcomes and reduce inequalities for people with learning disabilities. This collaborative approach culminated in the development of the original North Wales learning disability strategy, developed during 2017-18 and formally adopted in 2019.

2.2 The strategy was co-produced with people with learning disabilities, families, carers, providers and professionals from across North Wales and led to the establishment of the North Wales together programme, creating a regional mechanism to drive transformation, innovation and service improvement across organisational boundaries.

2.3 Since 2019, the learning disability regional partnership has delivered significant progress against the original strategy, supported by mature governance arrangements and strong partnership working across health, local authorities, people with lived experience, families and carers. The Learning Disability Regional Partnership Group provides strategic oversight and delivery monitoring of the programme and reports through the Regional Learning Disability Board, with onward assurance and escalation to the Regional Partnership Board. Within BCUHB, progress, risks and transformation priorities are aligned through Mental Health and Learning Disabilities Divisional governance arrangements and the Health Board's Transformation Programme, ensuring clear accountability, organisational oversight and strategic alignment.

2.4 A strong co-production approach has underpinned delivery of the strategy, with people with lived experience, families and carers actively represented through established engagement mechanisms, including the North Wales Flyers self-advocacy group. This has created a robust feedback loop through which stakeholder views directly inform strategic priorities, service redesign and quality improvement initiatives. Key achievements include strengthened self-advocacy, improvements in annual health check delivery, development of supported employment pathways, advancement of accommodation planning, increased adoption of technology-enabled care, and enhanced transition and community inclusion pathways. The North Wales Together Programme has been a key enabler of this progress, providing strategic leadership and driving transformation through co-production, innovation and collaboration across North Wales.

2.5 While significant progress has been made, some of the more complex transformation ambitions have yet to be fully realised, particularly the development of pooled budget arrangements between health and Ynys Môn social care and the establishment of a regional crisis and intermediate care

model. These priorities remain central to the refreshed North Wales Learning Disability Strategy 2026-2036 and are critical to strengthening integration, improving community-based support, enhancing system resilience and reducing reliance on inpatient and out-of-area placements. Continued focus on these areas will support people with learning disabilities to access timely, person-centred care closer to home.

2.6 Current reporting provides oversight of quality, safety, performance and key metrics, including admissions, discharges, delayed discharges, out-of-area placements and health inequality measures. The planned National Learning Disability Quality Dashboard will strengthen assurance by incorporating quality, workforce, experience and outcome measures, with greater emphasis on outcomes identified by people with learning disabilities, including independence, choice, community inclusion, housing stability, access to healthcare and quality of life. This will further align reporting with co-production principles, the North Wales Learning Disability Strategy and the Health Board's commitment to person-centred care.

**3. Strategic Priorities and Next Steps**

3.1 Looking ahead, learning disability services will focus on improving outcomes, strengthening organisational assurance and supporting sustainable service delivery. Key priorities include supporting Health Board compliance with the mandatory National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Learning Together audit, improving access to annual health checks, embedding evidence-based care bundles and enhancing support for people with complex physical health needs. Whilst specialist learning disability services provide expert advice and support, responsibility for delivering safe, equitable and accessible healthcare for people with learning disabilities rests with all Integrated Health Communities (IHCs). IHCs must ensure reasonable adjustments are consistently implemented, Learning Disability care pathways are embedded, staff are appropriately skilled, and services meet the needs of people with learning disabilities in line with national standards. There are 108 Learning Disability Champions who support this work, but accountability for delivery sits within mainstream services. Strengthening this approach is essential if the Health Board is to reduce health inequalities, improve life expectancy, enhance quality of life and achieve its ambition of delivering high-quality care closer to home for people with learning disabilities.

3.2 Learning Disability services will also continue to strengthen community-based support to reduce avoidable admissions and ensure that individuals receive care as close to home as possible. This aligns with wider Health Board ambitions regarding prevention, early intervention, and the delivery of care within community settings. In support of this ambition, North Wales was formally notified on 14 October 2026 that its Regional Partnership Board bid for the development of a multi-agency crisis model for adults with a learning

disability had been successful, providing an important opportunity to further develop sustainable community alternatives to hospital admission, strengthen crisis prevention and response, and improve outcomes for people with learning disabilities across the region. The proposal was recognised as one of the strongest submissions nationally, reflecting the maturity of partnership working and commitment to long-term service transformation.

3.3 A further priority will be the continued development of quality governance arrangements. This includes improving the use of quality indicators, strengthening performance reporting, and enhancing the ability of leaders to identify and respond to emerging risks. The development of more sophisticated IT quality dashboards will support greater transparency and accountability.

3.4 Workforce sustainability remains a key priority, as of September 2026, the service has an establishment of 333.5 whole time equivalent (WTE), with 296.7 WTE in post, representing a vacancy rate of 11%. With 36.8 WTE substantive vacancies being supported at various stages of recruitment.

3.5 The joint HIW/CIW inspection of the Conwy Community Learning Disability Team identified a range of strengths within the service, while also highlighting areas for further development. These findings provide important insight to inform ongoing improvement activity; however, wider strategic challenges remain. Demand for learning disability services continues to increase, with growing complexity of need requiring effective multidisciplinary and multi-agency responses. At the same time, services must continue to support the strategic ambition of providing care closer to home, reducing avoidable admissions and improving equitable access to high-quality community-based support

3.6 Improving outcomes for people with learning disabilities also remains a priority, particularly in relation to annual health check outcomes, reducing health inequalities, improving access to specialist primary and secondary health board services, and strengthening the measurement of patient and carer experience. The service continues to embed learning from the inspection across all community learning disability teams to ensure consistent standards of quality, safety, governance, and patient experience across North Wales.

### 3.7 Strategic Risks

The principal strategic risks facing Learning Disability Services relate to:

- Persistent health inequalities for people with learning disabilities.
- Failure to achieve Annual Health Check targets.
- Workforce recruitment and retention challenges.
- Limited community accommodation and specialist support provision.

- Delayed discharges and prolonged inpatient stays.
- Continued reliance on high-cost CHC out-of-area placements.
- Capital constraints impacting development of future inpatient and community infrastructure.
- Reliance on partner organisations to deliver accommodation, social care and community support solutions.

These risks are actively managed through divisional governance arrangements, the Learning Disability Strategy programme and regional partnership structures.

## 4. Part 2: Quality, Safety and Experience

### 4.1 Quality

4.1.1 Learning disability services continue to deliver a range of positive outcomes for people who use services, supported by multidisciplinary working, effective partnership arrangements and a commitment to person-centred care. Recent inspection activity provided evidence of good practice and effective partnership working across health, social care and third-sector organisations, while also identifying areas where further improvement is required. These findings continue to inform service development and quality improvement priorities. Strategic oversight is provided through the Learning Disability Regional Partnership Group, reporting via the Regional Learning Disability Board to the Regional Partnership Board. Within BCUHB, delivery, performance, risks and transformation priorities are monitored through established divisional governance arrangements and the Health Board's Transformation Programme, ensuring accountability and alignment with regional and national priorities

4.1.2 The joint HIW/CIW inspection of the Conwy Community Learning Disability Team identified a range of strengths in service delivery, including person-centred and strengths-based practice, effective advocacy arrangements, accessible communication approaches, positive behaviour support pathways and strong partnership working across health, social care and third-sector organisations. The inspection also highlighted opportunities to strengthen aspects of care planning, documentation, governance, workforce capacity and service-user engagement. The Health Board and Local Authority have accepted the findings and are implementing a coordinated improvement plan through established governance and partnership arrangements. Three actions remain open, relating to evidencing the sustainability of improvements and implementation of the Mental Health Act policy. Progress continues to be monitored through existing quality, safety and performance frameworks to provide assurance that improvements are embedded and lead to better outcomes and experiences for people with learning disabilities.

4.1.3 Since the inspection, progress has been made in strengthening quality governance arrangements through enhanced audit programmes, improved managerial oversight, strengthened review processes, implementation of transition guidance and increased scrutiny of clinical documentation and care planning. Learning arising from inspection findings has been shared across Community Learning Disability Teams to support greater consistency, continuous improvement and the dissemination of good practice across North Wales.

4.1.4 The service continues to strengthen its approach to outcome measurement through the enhanced use of the Health Equalities Framework (HEF), with BCUHB consistently achieving compliance levels exceeding 80%. This approach supports a greater understanding of outcomes relating to health, independence, wellbeing and quality of life, whilst helping to identify and address unmet need and health inequalities. Co-production arrangements have also continued to develop, with increased emphasis on ensuring that the voice of individuals and their families is reflected within assessment, care planning and review processes. Collectively, these developments support more personalised, outcome-focused care and contribute to the delivery of the principles set out within the Integrated Quality Statement for People with a Learning Disability and the North Wales Learning Disability Strategy 2026-2036.

4.1.5 Quality indicators continue to demonstrate safe and person-centred care, supported by effective partnership working across health, social care, housing and third-sector organisations. However, significant strategic challenges remain. Increasing complexity of need, delayed discharges and limited availability of appropriate community accommodation continue to impact on the ability to support people to live within their local communities. More than 2,900 delayed bed days, equivalent to approximately £1.79 million, and annual out-of-area Continuing Healthcare expenditure exceeding £4.2 million reflect ongoing pressures within accommodation pathways and community support provision. Whilst partners remain committed to delivering the ambitions set out within regional and national strategies, continued progress will require sustained partnership working across health, social care, housing and the third sector to expand local capacity and strengthen community-based alternatives to hospital admission and out-of-area placements. Delayed discharge and reliance on out-of-area placements therefore remain the most significant strategic quality and system risks for Learning Disability Services, with ongoing regional work focused on improving outcomes and enabling more people to receive care closer to home

## 4.2 Assurance

Positive assurance is provided through HIW/CIW inspection findings, strong Health Equalities Framework compliance, embedded audit arrangements and progress against the inspection improvement plan. Further assurance is provided through effective partnership working across health, social care,

housing, advocacy and third-sector organisations, supporting delivery of the North Wales Learning Disability Strategy and Welsh Government Learning Disability Transformation Programme. Areas requiring continued oversight relate to annual health check uptake, delayed discharge, community accommodation provision and reducing reliance on out-of-area placements.

### 4.3 Safety

4.3.1 The safety and wellbeing of people accessing LD services remains the highest priority. Robust safeguarding arrangements continue to operate across all service areas and were recognised during inspection activity as a particular area of strength. Inspectors identified effective safeguarding practice, strong partnership working and appropriate arrangements to support individuals safely whilst promoting independence, choice and least restrictive practice.

4.3.2 Significant progress has been made in strengthening governance, compliance and assurance arrangements. Focus has been placed on documentation standards, statutory compliance, clinical oversight and systematic learning from incidents, audits and reviews. These developments continue to support a positive safety culture and increased organisational assurance.

4.3.3 LD services continue to support individuals with increasingly complex presentations, often involving combinations of learning disability, physical health needs, mental health conditions, behavioural support requirements and social care challenges. While services continue to respond effectively, increasing complexity places additional pressure on workforce capacity, community services and system resilience.

4.3.4 A key safety priority remains reducing reliance on inpatient and out-of-area care by strengthening community pathways and improving system responsiveness. Delays in housing provision, care package development and integrated discharge planning can result in extended admissions and increased care costs. These challenges are reflected within both the LD transformation programme 2026-2029 and the refreshed North Wales LD strategy 2026-2036, which identify integrated community care, crisis prevention and accommodation support as critical areas for improvement.

4.3.5 Continued focus within the wider Health Board is also being placed on implementation of the Paul Ridd learning disability education framework, learning disability Care Bundles, reasonable adjustments and improved identification of people with learning disabilities within mainstream healthcare services. These initiatives support safer care, reduce diagnostic overshadowing and contribute to reducing avoidable health inequalities and preventable harm.

4.3.6 The sustainability and suitability of learning disability inpatient environments remain a significant strategic consideration. WG commissioned the *improving environments; improving lives* review of LD inpatient services across Wales, highlighting the importance of modern, therapeutic environments that promote safety, dignity and positive outcomes. Locally, the Bryn y Neuadd feasibility study undertaken in 2023 has informed ongoing development of the health board's learning disability accommodation strategy, including future consideration of assessment and treatment unit (ATU) provision and the wider accommodation needs of people with learning disabilities. Whilst plans are being expedited to develop an enhanced intensive care suite that would support the repatriation and management of individuals with highly complex needs currently placed outside North Wales, this represents only one element of the broader strategic challenge. The wider requirement remains the development of a sustainable accommodation and community support model capable of meeting increasing levels of complexity, reducing reliance on out-of-area provision and supporting care closer to home. Progress is further constrained by the limited availability of capital funding, which remains a significant risk to delivering the long-term ambitions outlined within the North Wales LD strategy 2026-2036 and the WG LD transformation programme 2026-2029.

4.3.7 Compliance with safeguarding, mental capacity act, deprivation of liberty safeguards, mental health act and statutory review processes continues to be monitored through established governance arrangements, with no systemic concerns identified through recent inspection activity.

## 4.4 Experience

4.4.1 People's experiences of learning disability services are informed by a continued focus on person-centred care, co-production and multidisciplinary working. Recent inspection activity identified positive examples of partnership working, advocacy and approaches that support individuals to achieve meaningful outcomes. The inspection also highlighted opportunities to strengthen the accessibility and use of feedback mechanisms, ensuring that feedback from individuals and families is routinely captured, analysed and responded to. In addition, accessibility challenges associated with the Health Board's CIVICA system has been identified for some people with learning disabilities. These findings have informed ongoing improvement activity aimed at strengthening engagement, ensuring accessibility and further embedding the voice of people with learning disabilities and their carers within service development and delivery

4.4.2 The positive findings referenced relate specifically to the recent HIW/CIW inspection of the Conwy Community Learning Disability Team. Whilst equivalent inspections have not been undertaken recently within the other

five counties, the same operating model, governance arrangements, co-production principles, advocacy processes and person-centred approaches are implemented across Learning Disability services throughout North Wales. Assurance is further supported through routine quality, safety and experience monitoring, service user feedback, engagement activity and regional governance arrangements.

4.4.3 Improving access to annual health checks (AHCs) remains a key priority in addressing health inequalities for people with learning disabilities. Uptake across BCUHB reduced from 59% in 2024–25 to 38% in 2025–26 following changes to the general medical services contract. As of September 2026, 1,742 individuals on the GP learning disability register had received an annual health check, representing 46.5% uptake. Whilst this reflects improvement on the previous year, performance remains below the WG target of 75%.

4.4.4 Improving uptake remains a priority through collaboration with primary care, supported by the primary care contracting team through targeted engagement, performance monitoring and improvement initiatives. Learning disability champions, proactive invitation processes and care bundles continue to improve access and reduce health inequalities. Learning disability contractual requirements are being reinforced through the contract assurance framework (CAF), with practices required to demonstrate that annual health checks have been offered to all individuals on the learning disability register and to implement improvement actions where gaps are identified. Whilst challenges remain regarding the accuracy of register data, performance information continues to inform targeted support and drive improvements in uptake and quality of care across North Wales.

4.4.5 The dashboard below provides a high-level summary of the current quality, safety and experience position across learning disability services and supports organisational oversight of areas requiring continued focus. Indicators are routinely reviewed through divisional governance arrangements, with improvement plans in place where performance is below the required standard. The dashboard demonstrates positive assurance in a number of key areas, whilst also highlighting ongoing challenges associated with delayed discharges, out-of-area placements, workforce pressures and annual health check uptake.

### 4.4.6 Divisional Quality Safety Experience Dashboard

| Domain | Indicator | Position | Assurance |
|---|---|---|---|
| Quality | Inspection Recommendations | 10 completed / six in progress | □ |
| Quality | Clinical Audit Programme | Embedded | □ |
| Quality | Documentation Standards | Improving | □ |
| Quality | HEF Compliance | >80% (Highest in Wales) | □ |
| Quality | Delayed Discharge Bed Days | >2,900 | ● |
| Safety | Safeguarding Arrangements | Strong assurance | □ |
| Safety | Workforce Sustainability | Recruitment pressures remain | □ |
| Safety | Out-of-Area Placements | Ongoing reliance | ● |
| Safety | Care Closer to Home | Progress continues in strengthening community pathways and local support arrangements; however, delays in accommodation, discharge pathways and bespoke community packages continue to contribute to out-of-area placements and increased Continuing Healthcare expenditure. | □ |
| Safety | MHA & WARRN Compliance | Improvement programme in place | □ |
| Experience | Service User Feedback | Positive | □ |
| Experience | Person-Centred Care | Embedded | □ |
| Experience | Annual Health Check Uptake | 46.5% against 75% WG target | ● |
| Experience | Advocacy Access | Embedded | □ |

## 5. SPECIFIC MATTERS FOR CONSIDERATION

**5.1 Quality, Safety and Experience**

The report demonstrates positive assurance across a number of quality and experience measures, including completion of inspection recommendations, safeguarding arrangements, person-centred care and advocacy access. However, continued focus is required in relation to documentation standards, Mental Health Act compliance and the timely discharge of individuals from inpatient care.

**5.2 Workforce**

Whilst staffing levels remain sufficient to maintain safe services, recruitment and retention challenges continue across a number of professional groups. Ongoing workforce pressures have the potential to impact service resilience and will require continued oversight through divisional governance arrangements.

**5.3 Strategic and System Dependencies**

Achievement of strategic objectives, including reducing out-of-area placements and improving care closer to home, is dependent upon effective partnership working with local authorities, housing providers and regional partners. Delays in accommodation and community support provision continue to impact patient flow and increase system costs.

**5.4 Health Inequalities**

Whilst performance in relation to annual health checks continues to improve, uptake remains below the Welsh Government target. Continued collaborative working with primary care is required to reduce health inequalities and improve access to preventative healthcare for people with learning disabilities.

**5.5 Sustainability and Future Development**

The successful Regional Partnership Board investment in a regional crisis service presents a significant opportunity to strengthen community-based support, reduce avoidable admissions and improve outcomes for people with learning disabilities across North Wales

## 6. Recommendations

6.1.1 The committee/meeting/group is asked to:

- Take assurance from the information contained within the report regarding the quality, safety and experience of Learning Disability Services.
- Note the progress made against strategic priorities and inspection recommendations.
- Note the ongoing risks relating to delayed discharges, out-of-area placements, workforce sustainability and annual health check uptake.

| Asesiad / assessment | |
|---|---|
| Cyswllt â'r blaenoriaethau strategol<br>Link to strategic priorities | <br>3. Creating compassionate culture, leadership and engagment3. Creating compassionate culture, leadership and engagment |
| | |
| | 3.creating compassionate leadership and culture<br>4.improving quality outcomes and experience |
| Yr egwyddorion dylunio<br>Design principles | People First<br>Inclusive design |
| Fframwaith risgiau corfforaethol a sicrwydd y bwrdd<br>Corporate risks and board assurance framework | This report links to corporate risks relating to service quality, workforce sustainability, governance, health inequalities, service accessibility and regulatory compliance. Failure to deliver the improvement plan may result in increased operational, governance and reputational risk. Actions are monitored through the mh&ld governance structure and service quality delivery group. |
| deddf llesiant cenedlaethau'r dyfodol - nodau llesiant wellbeing of future generations act – wellbeing goals | A resilient Wales |
| | If more than one applies, please list below:<br>• ✓ a healthier Wales<br>✓ a more equal Wales<br>✓ a Wales of cohesive communities<br>✓ a Wales of vibrant culture and thriving Welsh language |

| Asesiadau o effaith / impact assessments | | |
|---|---|---|
| Cydraddoldeb<br>*A ydych chi wedi cynnal prawf sgrinio o'r asesiad o'r effaith ar gydraddoldeb (sy'n cynnwys gofynion safonau'r gymraeg)*<br>Equality<br>*Have you undertaken an equality impact assessment screening (which includes the requirements of the welsh language standards)* | Do/yes: ☐ | Naddo/no: ☒ |
| | Canlyniad/outcome: | |
| | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale: | *This report provides assurance regarding the findings of a regulatory inspection and the associated improvement plan. It does not introduce a new policy, service change or decision which directly impacts protected* |

| | | |
|---|---|---|
| | | *groups. Equality considerations form part of several improvement actions, including reasonable adjustments, access to services and accessible feedback mechanisms* |
| Asesiad o'r effaith economaidd-gymdeithasol<br>*A ydych chi wedi cynnal asesiad o'r effaith economaidd-gymdeithasol?*<br>Socio-economic impact assessment<br>*Have you undertaken a socio-economic impact assessment* | Do/yes: ☐ | Naddo/no: ☒ |
| | Canlyniad/outcome: | |
| | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale: | *This report is presented for assurance and does not propose any service redesign, commissioning decision or resource allocation that would require a socio-economic impact assessment. The improvement actions will be delivered through existing service governance arrangements.* |
| ansawdd<br>*A ydych chi wedi ymgymryd â phrawf sgrinio o'r asesiad o'r effaith ar ansawdd?*<br>quality<br>*Have you undertaken a quality impact assessment screening?* | Galluogwyr ansawdd<br>Enablers of quality all apply | Meysydd ansawdd<br>Domains of quality all apply |
| | Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:<br>If more than one applies, please list below: | Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:<br>If more than one applies, please list below: □ |
| | | |
| Effaith amgylcheddol / cynaliadwyedd (5rs)<br>Environmental /sustainability impact (5rs) | Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:<br>If more than one applies, please list below:<br>No significant impact<br>The report relates to assurance and governance arrangements and does not introduce any significant environmental or sustainability implications. | |
| | No - Not Applicable | |

| | | |
|---|---|---|
| | Os oes mwy nag un yn berthnasol, rhestrwch hynny:<br>If more than one applies, please list: | |
| Dyletswydd sylw dyladwy cyfamod y lluoedd arfog<br>A ydych chi wedi ystyried dyletswydd sylw dyladwy cyfamod y lluoedd arfog:<br>Armed forces covenant due regard duty<br>Have you considered the armed forces covenant due regard duty? | Do/yes: ☐ | Naddo/no: ☒ |
| | Canlyniad/outcome: | |
| | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale: | The report concerns service assurance and quality improvement within learning disability services and has no direct impact on armed forces personnel, families, or veterans. |
| Asesiad o effaith ar ddiogelu data<br>*A ydych chi wedi cynnal prawf sgrinio o'r asesiad o effaith ar ddiogelu data?*<br>Data protection impact assessment<br>*Have you undertaken a data protection impact assessment screening?* | Do/yes: ☐ | Naddo/no: ☒ |
| | Canlyniad/outcome: | |
| | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale: | The report does not involve new information systems, changes to information processing arrangements or new uses of personal data. Existing organisational information governance arrangements remain applicable. |
| Asesiad o effaith ar atal twyll<br>*A ydych chi wedi ystyried yr effeithiau ar atal twyll?*<br>Counter fraud impact assessment<br>*Have you considered the counter fraud impacts* | Do/yes: ☐ | Naddo/no: ☒ |
| | Canlyniad/outcome: | |
| | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale: | The report is for assurance purposes and does not introduce new financial processes, procurement arrangements or areas of identified fraud risk. |
| Cyfreithiol<br>Legal | Yes (Include further detail below)Yes (Include further detail below) | |
| | The inspection and improvement plan relate to statutory duties and regulatory requirements | |

| | |
|---|---|
| | including the social services and well-being (wales) act 2014, health and social care (quality and engagement) (wales) act 2020, health and care quality standards 2023, mental capacity act 2005, and mental health act 1983. The improvement plan supports continued compliance with these requirements. |
| Enw da<br>Reputational | Yes (Include further detail below)Yes (Include further detail below) |
| | Failure to deliver the agreed improvement actions could adversely impact organisational reputation and regulatory assurance. Successful delivery of the improvement plan will demonstrate responsiveness to inspection findings and commitment to continuous improvement. |
| Effaith ar adnoddau *(pobl / ariannol)*<br>Resource impact *(people / financial)* | Yes (Include further detail below)Yes (Include further detail below) |
| | The improvement plan is expected to be delivered primarily through existing resources and governance structures. Some actions relate to workforce pressures and service development and will continue to be managed through existing operational and workforce planning arrangements. |

## Quality Safety & Experience Committee

# CLINICAL SERVICES PLANNING (CSP) PROGRAMME PROGRESS REPORT

| | |
|---|---|
| **Dyddiad y Cyfarfod**<br>**Date of Meeting** | 05 November 2026 |
| **Statws Cyhoeddi**<br>**Publication Status** | Open/ Public |
| | Not Applicable |
| **Enw a theitl Awdur(on) yr Adroddiad**<br>**Report Author name and title** | Kamala Williams, Interim Assistant Director of Strategy<br>Julie Ward-Jones, Head of Service Improvement<br>Samantha Pritchard, Interim Programme Manager – CSP Programme |
| **Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol**<br>**Lead Executive Team Member name and title** | Clara Day, Executive Medical Director |

| | |
|---|---|
| **Pwrpas yr Adroddiad**<br>**Report Purpose** | For Noting |

**Crynodeb Gweithredol**
**Executive Summary**

The Clinical Services Planning (CSP) Programme is a key enabler of the emerging Ten-Year Strategy, providing a structured, evidence-informed and multidisciplinary framework for future clinical service planning across North Wales.

The programme will deliver three interconnected outputs: a Future Clinical Services Model (FCSM) for North Wales, a Clinical Services Planning (CSP) Framework, and a suite of clinical service plans aligned to the organisational strategy and the FCSM.

Initial mobilisation activity has included clinical engagement, development of governance arrangements, appointment of a Programme Manager and establishment of programme infrastructure. The inaugural CSP Programme Board is scheduled to meet in November 2026.

Annual Delivery Plan (ADP) milestones scheduled for the first half of 2026/27 have not been achieved, reflecting the scale and complexity of the programme, competing organisational priorities and limited programme capacity. An updated programme

plan, including revised milestones and timescales, is being developed.

Findings from the Health Board's Fragile Services work have reinforced the need for a more systematic approach to service planning and transformation. Going forward, Quality Management System (QMS) principles and indicators, alongside wider organisational intelligence, will be used to identify and prioritise services requiring support and to inform CSP priorities, service assessments and future planning activity.

Subject to CSP Programme Board approval, delivery during the remainder of 2026/27 will focus on a small number of priority fragile services. This will provide an opportunity to test and refine the CSP Framework, strengthen programme methodology and inform future phases of delivery.

The report outlines progress to date, the proposed delivery approach, key programme risks and priorities for the next quarter.

**Ymgysylltu (mewnol/allanol) yr ymgymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp)**
**Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)**

| **Pwyllgor / Grŵp / Unigolion**<br>**Committee / Group / Individuals** | **Dyddiad**<br>**Date** | **Canlyniad, Tystiolaeth a Data**<br>**Outcome, Evidence and Data** |
|---|---|---|
| Strategic Planning and Service Change Group | 23rd April 2026 | Initial progress report considered and programme approach supported. |
| Clinical leadership event | 5th May 2026 | Initial clinical engagement to consider programme direction, principles, and priorities. |
| Strategic Planning and Service Change Group | 4th June 2026 | Further progress update received and progress noted |
| Virtual focus groups | June 2026 | To test and refine outputs from leadership event |
| Strategic Planning and Service Change Group | 24th June 2026 | Leadership event Output Report approved for onward circulation |
| Strategic Planning Programme Board | 8th October 2026 | Development of proposed CSP approach for remainder of 2026/27 |

| **Acronymau / Rhestr Termau**<br>**Acronyms / Glossary of Terms** | |
|---|---|
| ADP | Annual Delivery Plan |
| CSP | Clinical Services Plan |
| FCSM | Future Clinical Services Model |
| IMTP | Integrated Medium Term Plan |
| NCP | National Clinical Plan |
| QMS | Quality Management System |

# MEWNOSODWCH DEITL YR ADRODDIAD

# CLINICAL SERVICES PLANNING (CSP) PROGRAMME PROGRESS REPORT

## 1. Y SEFYLLFA
## SITUATION

1.1 The Clinical Services Planning (CSP) Programme is a key enabler of the Health Board's emerging Ten-Year Strategy, providing a structured, evidence-informed and multidisciplinary approach to planning sustainable clinical services across North Wales.



1.2 Initial programme mobilisation activity has included a clinical engagement event, the development of governance arrangements, establishment of supporting programme infrastructure and appointment of a Programme Manager. The inaugural CSP Programme Board is scheduled to meet on the 10th November 2026.

1.3 Annual Delivery Plan (ADP) milestones scheduled for the first half of 2026/27 have not been achieved. This reflects the scale and complexity of the programme, competing organisational priorities and limited programme capacity. Work is therefore underway to develop an updated programme plan, including revised milestones and timescales, which will be presented to the CSP Programme Board for approval.

1.4 Subject to Programme Board approval, delivery during the remainder of 2026/27 will focus on a small number of fragile services, to be agreed. These will be selected where a pan-BCUHB approach can be progressed at pace and where future service models are less dependent on completion of the wider Future Clinical Services Model (FCSM).

## 2. Y CEFNDIR / BACKGROUND

2.1 The CSP Programme has been established in response to increasing demand, workforce pressures, financial constraints, service sustainability challenges, and the need to improve quality, outcomes and patient experience. It also supports the Health Board's response to national expectations for planned and sustainable service transformation, including the direction set out through the emerging NHS Wales National Clinical Plan (NCP).

2.2 Findings from the Health Board's Fragile Services programme have reinforced the need for this approach, highlighting recurring sustainability, workforce and resilience challenges across a number of services. Whilst immediate actions can help mitigate operational risks, sustainable solutions will require longer-term service planning and transformation through the CSP Programme.

2.3 The purpose of the CSP Programme is therefore to:

- Deliver multidisciplinary, evidence-informed service redesign.
- Improve quality, safety, patient experience and outcomes.
- Support integrated, whole-system models of care.
- Embed prevention and population health approaches.
- Align long-term strategic ambitions with three-year plan delivery requirements, ensuring consistency with the NCP and wider national policy direction.
- Provide a credible basis for organisational, regulatory and public assurance regarding future service configuration.

2.4 The programme will deliver three interconnected outputs:

- A Future Clinical Services Model (FCSM) for North Wales, setting out the long-term vision, principles and strategic direction for how clinical services should be organised and delivered to meet future population needs.
- A Clinical Services Planning (CSP) Framework, providing a consistent methodology for assessing services, evaluating options and developing evidence-informed service plans
- A suite of clinical service plans developed through application of the CSP Framework and aligned to both the organisational strategy and the FCSM.

## 3. MATERION PENODOL I'W HYSTYRIED<br>SPECIFIC MATTERS FOR CONSIDERATION

### 3.1 Delivery Approach

3.1.1 The Fragile Services programme will help identify and prioritise services experiencing significant sustainability, workforce, quality or resilience challenges. These insights will inform priorities for the CSP Programme and the selection of services for inclusion within future planning activity

3.1.2 The CSP Programme will provide a structured framework for the development of sustainable service solutions. Clinical service area plans will be developed through application of the CSP Framework and aligned to the emerging organisational strategy and the FCSM, ensuring consistency between individual service developments and the Health Board's longer-term strategic direction.

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3.1.3 Quality Management System (QMS) indicators and other relevant intelligence will be used to inform service prioritisation, establish baseline assessments, and guide both immediate improvement activity and longer-term service planning and transformation.

3.1.4 Early implementation through a small number of priority services will provide an opportunity to test and refine the CSP Framework, strengthen programme methodology, and generate learning to inform future phases of delivery and the ongoing development of the FCSM.

### 3.2 Progress to Date

3.2.1 The programme is transitioning from mobilisation into the Design stage, with governance, leadership and delivery arrangements continuing to be developed. Progress to date includes

- Establishment of programme governance, reporting and oversight arrangements, including the inaugural CSP Programme Board scheduled for November 2026.
- Commencement of stakeholder mapping and engagement activity to support appropriate clinical, operational and corporate involvement.
- Development of a proposed delivery approach for the remainder of 2026/27, including an initial focus on a small number of fragile services to test and refine the CSP Framework, subject to Programme Board approval.
- Appointment of an interim Programme Manager to coordinate programme development and delivery.
- Work has commenced to secure specialist expert external consultancy support for development of the FCSM, CSP Framework and associated analytical and service redesign requirements. Funding has not yet been identified and this remains a critical dependency for programme delivery. Without additional specialist capacity, progress will be significantly constrained and development timescales are likely to be extended.

## 3.3 Programme and Fragile Services Development

3.31 Work is progressing to establish a standardised methodology for service assessment, quality planning and redesign. The methodology will provide a consistent route from identification of risk and service fragility through baseline assessment, option development, appraisal and implementation. It will ensure that proposals are developed through a structured, multidisciplinary and evidence-informed process, with explicit assessment of quality, safety, outcomes, access, workforce, finance and long-term sustainability.

3.3.2 Development of the Fragile Services Framework has continued, building on learning from the former Challenged Services programme and phase 1 of the CSP. Fragility indicators have been developed and incorporated into a draft assessment methodology that brings together workforce, quality, performance, service delivery, external assurance and financial intelligence. The methodology is being testing through the Urology specialty as the first pilot service, enabling refinement of the approach and improving understanding of how service fragility intelligence can inform improvement, planning and transformational activity.

3.3.3 The Framework has been mapped to the four QMS domains of Quality Planning, Quality Control, Quality Improvement and Quality Assurance. Links with the ADP and wider processes are also being strengthened so that service sustainability risks are considered more systematically within organisational planning and prioritisation. This will provide a structured evidence base to inform CSP priorities, workforce planning and FCSM development.

### 3.4 Priorities for Next Quarter

3.4.1 Over the next three months the programme will translate the revised approach into delivery through the following priorities:

- Implement governance, reporting, escalation and accountability arrangements across the combined CSP and Fragile Services work alignment
- Embed risk management, benefits realisation and quality assurance processes so that delivery, outcomes and unintended consequences can be consistently monitored
- Identify and agree the priority services using transparent criteria informed by service fragility, quality and safety intelligence, population need, deliverability and dependency on the FCSM.
- Commence structured baseline assessments for the agreed priority services and progress option development through clinically led, evidence-based and quality-assured processes
- Maintain clinical engagement and strengthen clinical leadership arrangements through establishment of a Clinical Reference Group, ensuring clinicians contribute from initial assessment through option development and decision-making, alongside wider stakeholder input to support balanced, evidence-informed decision-making and sustainable service design.
- Align CSP and Fragile services with the IMTP planning process and wider organisational programmes to reduce duplication, manage dependencies and provide a clear route from strategy to delivery
- Progress work to identify a funding solution to support procurement of external expert consultancy support

Delivery against these priorities will be monitored through the CSP Programme Board using agreed milestones, risks, dependencies and quality measures. Progress reporting will distinguish between the immediate response to fragile services and the development of longer-term sustainable service models, while maintaining a single integrated view of programme delivery.

## 4. RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO<br>KEY RISKS / MATTERS FOR ESCALATION

### 4.1 Clinical Engagement and Capacity

4.1.1 The success of the CSP is dependent upon sustained clinical engagement. Competing operational pressures and workforce capacity constraints may reduce the ability of clinicians to participate fully in service redesign activity.

4.1.2 Mitigation includes maintaining visible clinical leadership, targeted engagement activity, and ensuring participants receive feedback demonstrating how their contributions influence programme outputs.

## 4.2 Organisational Capacity and Alignment

4.2.1 The Health Board is currently managing multiple transformation programmes and competing organisational priorities. Internal programme, analytical and clinical redesign capacity is insufficient to deliver the full ambition of the CSP Programme at the pace originally envisaged. There is a risk that, without funding for specialist external consultancy support, development of the FCSM, CSP Framework and associated service planning activity will be significantly delayed.

4.2.2 Mitigation includes strengthened governance arrangements, executive oversight, prioritisation of critical deliverables and closer integration with IMTP development processes. Work is underway to identify funding to secure specialist external consultancy support, recognising that this is a key requirement for delivery of the FCSM, CSP Framework and priority service plans.

## 4.3 Balancing Pace and Quality

4.3.1 There is a risk that pressure to deliver rapid progress could compromise the robustness of service assessments and future decision-making.

4.3.2 Mitigation includes implementation of a structured methodology, phased programme delivery, quality management processes, and enhanced analytical support.

## 4.4 Future Decisions and Approvals Required

4.4.1 As the programme progresses from mobilisation to the Design Stage, a number of matters will require Committee and Board consideration, including:

- Confirmation of the initial priority service areas and endorsement of the service assessment, quality planning and redesign methodology.
- Agreement of the clinical leadership, analytical modelling, improvement and programme capacity required to deliver the agreed priorities, including identification of a funding solution for specialist external consultancy support.
- Agreement of the governance and accountability arrangements needed to align the CSP and the Fragile Services work with the IMTP, annual planning process and wider organisational change portfolio

## 5. ARGYMHELLION RECOMMENDATIONS

The Committee is asked to:

- **NOTE** progress
- **COMMENT** on the proposed delivery approach and priorities.
- **ENDORSE** continued programme development and alignment with wider organisational planning.

| **ASSESSMENT** | |
|---|---|
| **Link to Strategic Priorities** | <br>2. Developing strategy and long-lasting change<br>*If more than one applies, please list below:* |
| **Design Principles** | Choose an item.<br>All apply |
| **Corporate Risks and Board Assurance Framework** | *N/A* |
| **Wellbeing of Future Generations Act – Wellbeing Goals** | A Healthier Wales<br>*If more than one applies, please list below:*<br>• *A More Equal Wales*<br>• *A Prosperous Wales*<br>• *A Resilient Wales* |

| **IMPACT ASSESSMENTS** | | |
|---|---|---|
| **Equality Act 2010 Public Sector Equality Duty: Has BCUHB provided evidence of 'Due Regard' to compliance with the three parts of the Public Sector Equality Duty (General Duty):** Public Sector Equality Duty [HTML] \| GOV.WALES | Yes: ☐ | No: ☒ |
| | Outcome: | Provide details of the findings following the review |
| | If no, please include rationale: | An Integrated Equality Impact Assessment has not been completed at this stage as the report does |

| IMPACT ASSESSMENTS | | |
|---|---|---|
| | | not seek approval for service change, policy change or resource reallocation. The paper outlines progress in developing the Clinical Services Planning (CSP) Programme and associated frameworks.<br><br>Equality considerations will be embedded within the CSP methodology and will form a core component of future service assessment, option appraisal and decision-making processes. Equality impacts will be assessed as part of the development of individual clinical service plans and any resulting service change proposals. |
| **Equality Act 2010 - Socio-economic Duty**<br>*Has BCUHB provided evidence of 'Due Regard' to compliance of ther Socio-economic Duty when making strategic decisions?* | Yes: ☐ | No: ☒ |
| | Outcome: | Provide details of the findings following the review |
| | If no, please include rationale: | The report does not include any specific proposals that would directly impact individuals or communities. As the programme develops, socio-economic considerations, including access to services and health inequalities, will be incorporated into service assessments, option appraisal and future service planning activity. |

| IMPACT ASSESSMENTS | | |
|---|---|---|
| *Have you completed an Integrated Equality Impact Assessment WP8a?* *WP8a Template* | Canlyniad/Outcome: Do/Yes: | Naddo/No: |
| | Os naddo, dylech gynnwys y rheswm: If no, please include rationale: Canlyniad/Outcome: | |
| | Os naddo, dylech gynnwys y rheswm: If no, please include rationale: | A WP8a assessment has not been completed as the paper is reporting programme progress rather than seeking approval for a policy, service or organisational change. Impact assessments will be completed where required as specific service planning proposals are developed. |
| **Human Rights Act** *Have Human Right based concerns been addressed within WP8a* | Do/Yes: ☐ | Naddo/No: ☒ |
| | Canlyniad/Outcome: | No specific human rights impacts have been identified at this stage. Human rights considerations will be incorporated into future service planning, option appraisal and service change processes where relevant. |
| **Compliance to the Welsh Language requirements?** *Have you undertaken an Impact Assessment* | Os naddo, dylech gynnwys y rheswm: If no, please include rationale: | Naddo/No: ☒ |
| | Os naddo, dylech gynnwys y rheswm: If no, please include rationale: | The report does not propose any service changes that would impact Welsh language provision. Welsh language considerations will be incorporated into future service planning and redesign activity in line |

| IMPACT ASSESSMENTS | | |
|---|---|---|
| | | with statutory requirements and Health Board standards. |
| **Compliance to giving 'Due Regard' to the principles of the Armed Forces Covenant** *Have the principles of the Armed Forces Covenant been addressed within WP8a* | Do/Yes: ☐ | Naddo/No: ☒ |
| | Canlyniad/Outcome: | |
| | Os naddo, dylech gynnwys y rheswm: If no, please include rationale: | The report does not introduce any changes that would directly affect members of the Armed Forces community. Relevant considerations will be addressed through future impact assessment processes where applicable. |
| **Quality** *Have you undertaken a Quality Impact Assessment Screening?* | **Enablers of Quality** All Apply | **Domains of Quality** All Apply |
| | If more than one applies, please list below: | If more than one applies, please list below:<br><br>Quality is a central consideration within both the CSP Programme and Fragile Services Framework. The proposed methodology incorporates assessment of quality, safety, outcomes, patient experience and sustainability. Quality considerations will be formally evaluated as part of future service assessments, option appraisals and service planning activity. |
| | *Please list other Enablers of Quality in here* | *Please list other Domains of Quality in here* |
| **Wellbeing of Future Generations Act – Wellbeing Goals** | A Healthier Wales | |
| | All apply<br><br>The CSP Programme supports the long-term | |

| IMPACT ASSESSMENTS | | |
|---|---|---|
| | planning and transformation of services to improve health outcomes, reduce unwarranted variation, address service sustainability challenges and support delivery of the Health Board's strategic ambitions. | |
| **Environmental /Sustainability Impact (5Rs)** | No - Not Applicable | |
| | If more than one applies, please list: | |
| | If no, please include rationale: | This report does not propose specific service changes and therefore no environmental impact assessment has been undertaken. Sustainability considerations will form part of future service planning and option appraisal processes. |
| **Data Protection Impact Assessment**<br>*Have you undertaken a Data Protection Impact Assessment Screening?* | Yes: ☐ | No: ☒ |
| | Outcome: | Provide details of the findings following the review |
| | If no, please include rationale: | The report does not involve the introduction of new personal data processing activities, systems or information-sharing arrangements. No DPIA is required at this stage. |
| **Counter Fraud Impact Assessment**<br>*Have you considered the counter fraud impacts* | Yes: ☐ | No: ☒ |
| | Outcome: | Provide details of the findings following the review |
| | If no, please include rationale: | The report does not propose changes to financial controls, procurement arrangements or resource allocation that would require a counter fraud assessment. |

| IMPACT ASSESSMENTS | | |
|---|---|---|
| | | |
| **Legal** | There are no specific legal implications related to the activity outlined in this report. | |
| | *If yes, include further details in here* | |
| **Reputational** | Yes (Include further detail below) | |
| | Delivery of the CSP Programme is important to demonstrating a clear, evidence-informed and sustainable approach to future service planning. Failure to establish a credible programme, agree priorities or maintain progress could undermine confidence among Welsh Government, regulators, partners, staff and the public, and may impact the Health Board's ability to demonstrate strategic oversight and long-term planning. | |
| **Resource Impact** *(People / Financial)* | Yes (Include further detail below) | |
| | Delivery of the programme is dependent upon appropriate programme, clinical, analytical and improvement capacity. Work is underway to identify the resources required to support development of the FCSM, CSP Framework and priority service plans, including potential requirements for external expert specialist support. Any future resource implications will be considered through the Health Board's governance and planning processes. | |

# Quality Safety & Experience Committee

## QUALITY OF COMMISSIONED SERVICES

| | |
|---|---|
| **Dyddiad y Cyfarfod**<br>**Date of Meeting** | 05/11/26 |
| **Statws Cyhoeddi**<br>**Publication Status** | Open/ Public |
| | Not Applicable |
| **Enw a theitl Awdur(on) yr Adroddiad**<br>**Report Author name and title** | Pam Wenger, Director of Corporate Governance;<br>Dr Clara Day, Executive Medical Director |
| **Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol**<br>**Lead Executive Team Member name and title** | Clara Day- Executive Medical Director<br>Alan Streets, Interim Director of Finance |

| | |
|---|---|
| **Pwrpas yr Adroddiad**<br>**Report Purpose** | For Assurance |

**Crynodeb Gweithredol**
**Executive Summary**

This report to the Quality, Safety and Experience Committee provides assurance on the quality, safety and governance of services commissioned by BCUHB. The April 2023 Internal Audit review concluded No Assurance, identifying the absence of an overarching assurance framework, unclear responsibilities and escalation, inconsistent review of provider quality information and insufficient routine assurance to the Board and its Committees. The April 2025 follow-up found that none of the four high-priority recommendations had been implemented; all four remained open with limited assurance at 26 October 2026.

In response, the Health Board has developed a Commissioning Assurance Framework and established a Contract and Commissioning Executive Delivery Group. These arrangements are intended to provide proportionate, risk-based and multidisciplinary oversight, clearer ownership, standard monitoring and provider assurance, defined escalation and regular reporting through Executive and Committee routes. QSE will receive quarterly assurance on the quality, safety and patient experience of commissioned services.

The National Outpatient Insourcing Programme demonstrates the need for these strengthened arrangements.

**Members are asked to:**
• **NOTE** the Commissioning Quality Services report and the key issues and learning identified;
• **NOTE** the position in terms of the quality and safety of commissioned services and the actions being taken to address identified risks; and
• **SUPPORT** the continued development of quality assurance arrangements for commissioned services.

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

| **Acronymau / Rhestr Termau**<br>**Acronyms / Glossary of Terms** | |
|---|---|
| BCUHB | Betsi Cadwaladr University Health Board |
| SOPs | Standard Operating Procedure |
| EPRO | Clinical IT System |
| CITO | Clinical IT System |

# QUALITY OF COMMISSIONED SERVICES

## 1. Y SEFYLLFA/SITUATION

BCUHB relies upon commissioned services from external providers. This can be to ensure provision of service for the population that are not provided within BCUHB itself, or as an addition to standard service provision to help reduce waits for care.

Internal Audit has identified significant weaknesses in the Health Board's arrangements for assuring the quality, safety and governance of commissioned services. The original review in April 2023 concluded No Assurance, and the subsequent follow-up in April 2025 found that the four high-priority recommendations remained outstanding. This establishes the context for strengthening commissioning oversight across BCUHB.

In response, the Health Board has developed a Commissioning Assurance Framework and established a Contract and Commissioning Executive Delivery Group to provide clearer ownership, multidisciplinary oversight, escalation and reporting.

The experience of the National Outpatient Insourcing Programme delivered through ID Medical is then considered as a practical case study, demonstrating why these strengthened arrangements are required and informing the actions for future commissioned services.

## 2. INTERNAL AUDIT AND CURRENT ASSURANCE POSITION

The original Internal Audit review of contracted patient services in April 2023 concluded No Assurance. It identified the absence of an overarching commissioning assurance framework, unclear roles and escalation, inconsistent receipt and review of provider quality information, insufficient scrutiny of quality data, and no routine assurance to the Board or its Committees. The recommendations covered process management, contractual obligations, quality measures and Board assurance.

The April 2025 follow-up found that none of the four high-priority recommendations had been implemented. A sample of six NHS England providers found all six rated Requires Improvement by the Care Quality Commission. Regular contract meetings were evidenced for only one provider in the sample, and the agendas reviewed focused on finance and performance rather than quality and safety. The follow-up also reported contractual approval and delegation concerns in relation to the Health Board's commissioned services.

The open-actions tracker dated 26 October 2026 records that the four high-priority recommendations remain open with limited assurance. It also records progress in establishing governance groups to support the assurance process, an initial pilot

focused on significant NHS contracts, and a first commissioning Executive Delivery Group meeting with Terms of Reference and roles being developed.

The Committee is referred to the Internal Audit review of contracted patient services and subsequent follow-up work, which were most recently reported to Audit Committee in October 2026. Audit Committee noted that the four high-priority recommendations remained open and that a programme of work was underway to strengthen commissioning governance and assurance arrangements. The Commissioning Assurance Framework and Contract and Commissioning Executive Delivery Group described in this paper form part of the Health Board's response to those findings. The Internal Audit report is attached at Appendix 1.

The Actions agreed are as follows:

| | |
|---|---|
| **Commissioning Assurance Framework and Governance**<br>Establish a comprehensive commissioning assurance framework and supporting procedures, with clear accountability, roles, responsibilities and escalation arrangements for the oversight of commissioned services. | **Completed approved by the Board** |
| **Provider Oversight and Contract Management**<br>Strengthen arrangements to ensure commissioned providers are monitored against contractual requirements and subject to appropriate quality, performance and governance oversight. | In Progress |
| **Quality Assurance and Escalation**<br>Review and strengthen contractual quality measures and establish effective arrangements for identifying, managing and escalating quality concerns associated with commissioned services. In progress | |
| **Board and Committee Assurance**<br>Establish governance and reporting arrangements that provide the Board and its Committees with regular oversight and scrutiny of the quality and performance of commissioned services. | In Progress |

## 3. COMMISSIONING ASSURANCE FRAMEWORK

The Commissioning Assurance Framework establishes a continuous, proportionate and risk-based approach to the oversight of externally commissioned healthcare, recognising that BCUHB retains accountability for assuring the quality and safety of services delivered on its behalf. It brings together assurance across access, quality and safety, activity and finance, patient experience, governance and strategic change.

The framework introduces a structured approach to multidisciplinary contract monitoring and provider review, supported by standard monitoring requirements and provider assurance ratings. It also provides a clear escalation route where concerns arise, from routine monitoring through to enhanced and Executive-level intervention.

For QSE, the framework provides a strengthened and consistent mechanism for oversight of the quality, safety and patient experience of commissioned services**,** with quarterly assurance reporting through the Quality Lead. This will enable the Committee to maintain oversight of significant quality concerns, actions and escalation, while wider performance and financial assurance is reported through the appropriate Executive and Committee routes.

## 4. CONTRACT AND COMMISSIONING EXECUTIVE DELIVERY GROUP

The Contract and Commissioning Executive Delivery Group has now ben established as the executive forum for oversight of commissioning and significant contracts. Accountable to the Executive Committee, it is intended to provide clear ownership, effective monitoring and timely action. Its remit includes significant clinical and non-clinical contracts, service-level and long-term agreements, grants, partnerships and outsourced services.

The group will oversee implementation of the Commissioning Assurance Framework and assurance that significant contracts have named owners, are recorded on an up-to-date register, follow the correct approval route and are monitored across quality, patient safety, outcomes, cost, activity, performance, risk and value for money. It may require further assurance, challenge performance, commission proportionate reviews, seek professional advice, agree corrective actions and escalate matters, while formal approvals remain with the authorised officer or body.

The EDG is expected to meet monthly and report regularly to the Executive Committee on significant risks, exceptions, emerging concerns and progress. It will also contribute assurance to relevant Board Committees.

## 5. OUTPATIENT INSOURCING PROGRAMME

A detailed review of the National Outpatient Programme, including patient safety, clinical oversight, patient experience, provider assurance, contractual matters, lessons learned and proposed actions, is presented in the accompanying private report due to the commercially sensitive nature of the contractual and provider-performance information.

## 8. ARGYMHELLION / RECOMMENDATIONS

- **NOTE** the Commissioning Quality Services report and the key issues and learning identified;

- **NOTE** the position in terms of the quality and safety of commissioned services and the actions being taken to address identified risks; and
- **SUPPORT** the continued development of quality assurance arrangements for commissioned services.

| **ASESIAD / ASSESSMENT** | |
|---|---|
| **Cyswllt â'r Blaenoriaethau Strategol**<br>**Link to Strategic Priorities** | <br>4. Improving quality, outcomes and experience |
| | |
| | Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:<br>If more than one applies, please list below: |
| **Yr Egwyddorion Dylunio**<br>**Design Principles** | People First<br>Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:<br>If more than one applies, please list below: |
| **Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd**<br>**Corporate Risks and Board Assurance Framework** | • **BAF 26_03: Failure to improve access, outcomes and experience..**<br>• **CRR25-01: Timely Patient Access to Safe and Effective Care.** |
| **Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals** | Not Applicable |
| | Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:<br>If more than one applies, please list below: |

| **ASESIADAU O EFFAITH / IMPACT ASSESSMENTS** | | |
|---|---|---|
| **Cydraddoldeb**<br>*A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)*<br>**Equality**<br>*Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)* | Do/Yes: ☐ | Naddo/No: ☒ |
| | Canlyniad/Outcome: | |
| | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale: | This report is purely administrative in nature and submitted for information only. |

| | | |
|---|---|---|
| **Asesiad o'r Effaith Economaidd-gymdeithasol**<br>*A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?*<br>**Socio-Economic Impact Assessment**<br>*Have you undertaken a Socio-Economic Impact Assessment* | Do/Yes: ☐ | Naddo/No: ☒ |
| | Canlyniad/Outcome: | |
| | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale: | This report is purely administrative in nature and submitted for information only. |
| **Ansawdd**<br>*A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?*<br>**Quality**<br>*Have you undertaken a Quality Impact Assessment Screening?* | **Galluogwyr Ansawdd**<br>**Enablers of Quality**<br>All Apply | **Meysydd Ansawdd**<br>**Domains of Quality** All Apply |
| | Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:<br>If more than one applies, please list below: | Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:<br>If more than one applies, please list below: |
| | | |
| **Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant**<br>**Wellbeing of Future Generations Act – Wellbeing Goals** | Not Applicable | |

| | | |
|---|---|---|
| **Effaith Amgylcheddol / Cynaliadwyedd (5Rs)**<br>**Environmental /Sustainability Impact (5Rs)** | Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:<br>If more than one applies, please list below: | |
| | No - Not Applicable | |
| | Os oes mwy nag un yn berthnasol, rhestrwch hynny:<br>If more than one applies, please list: | |
| **Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog**<br>A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog:<br>**Armed Forces Covenant Due Regard Duty** | Do/Yes: ☐ | Naddo/No: ☒ |
| | Canlyniad/Outcome: | |
| | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale: | This report is purely administrative in nature and submitted for information only. |

| | | |
|---|---|---|
| Have you considered the Armed Forces Covenant Due Regard Duty? | | |
| **Asesiad o Effaith ar Ddiogelu Data**<br>*A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?*<br>**Data Protection Impact Assessment**<br>*Have you undertaken a Data Protection Impact Assessment Screening?* | Do/Yes: ☐ | Naddo/No: ☒ |
| | Canlyniad/Outcome: | |
| | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale: | |
| **Asesiad o Effaith ar Atal Twyll**<br>*A ydych chi wedi ystyried yr effeithiau ar atal twyll?*<br>**Counter Fraud Impact Assessment**<br>*Have you considered the counter fraud impacts* | Do/Yes: ☐ | Naddo/No: ☒ |
| | Canlyniad/Outcome: | |
| | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale: | This report is purely administrative in nature and submitted for information only. |
| **Cyfreithiol**<br>**Legal** | There are no specific legal implications related to the activity outlined in this report. | |
| | | |
| **Enw Da**<br>**Reputational** | There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report. | |
| | Internal information sharing. | |
| **Effaith ar Adnoddau**<br>*(Pobl / Ariannol)*<br>**Resource Impact**<br>*(People / Financial)* | There is no direct impact on resources as a result of the activity outlined in this report. | |
| | | |

# Follow-up: Contracted Patient Services: Quality and Safety Arrangements

# Final Internal Audit Report

## 2024/25

## Betsi Cadwaladr University Health Board

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| | |
|---|---|
| **Review Reference** | BCU-2425-24 |
| **Fieldwork** | March 2025 |
| **Executive Sign Off** | 15 April 2025 |
| **Audit Committee** | April 2025 |
| **Executive Lead** | Stephen Powell, Director of Performance and Commissioning |
| **Audit Team** | Dave Harries, Head of Internal Audit<br>Nicola Jones, Deputy Head of Internal Audit |


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

# Executive Summary

## Purpose

This audit originates from the 2024/25 internal audit plan, agreed with management, and approved by the Audit Committee. The overall objective of this audit is to review implementation that the agreed management action has been applied to address risks identified and reported in the 2022/23 *Contracted Patient Services: Quality and Safety Arrangements (BCU-2223-19)* audit report which concluded unsatisfactory (no) assurance

## Overview

None of the agreed actions have been closed as per table below:

| | High | Medium | Low | **Total** |
|---|---|---|---|---|
| Closed | - | - | - | **-** |
| Partially Implemented | - | - | - | **-** |
| Outstanding | 4 | - | - | **4** |
| **Total** | **4** | **-** | **-** | **4** |

Further details on each recommendation are provided below.

Our follow-up review has identified that both posts responsible for implementation of all the agreed actions are no longer present.

On 28 February 2025, we were advised that executive leadership for this review had transferred to the Director of Performance and Commissioning, however it must be noted that all agreed actions had implementation dates pre-dating the appointment of the Director and should, in our view, already have progressed.

In identifying a sample of contracts for review, of the fourteen NHS England providers the Health Board commissions services from directly, totalling £78,988,225 (excluding those services facilitated by the NHS Wales Joint Commissioning Committee) we were advised that seven (50%) had been signed by the provider and the Chief Executive/Director of Finance.

The delegation for signing all healthcare contracts is set out in the Scheme of Reservation and Delegation (SoRD) whereby the Health Board under the *Contracts between NHS Bodies (annual value)* delegation value states it must receive the *"Initial contract schedule approved via annual budget approval process. New contracts /variations £1m+ to be retrospectively reported with £10m+ approved in advance"*. We have found no evidence the initial contract schedule has been presented to the Health Board in 2024/25 as part of the annual budget approval process or any subsequent presentation of this information for the Board to consider – consequently there is no delegated approval for Executive officers to sign and agree contracts on behalf of the Health Board.

We note the SoRD is subject to review as clarity is required surrounding *Delegated Matter 13a Primary Care Patient Services/ Healthcare Agreements* that state *Contract negotiation and provision of service agreements* is operationally delegated to *System Oversight* – we are unclear to what post(s) *System Oversight* refers.

# Status of Previously Agreed Recommendation

| Ref | Recommendation | Original Responsibility & Timescale | Priority Rating | Status, Updated Responsibility and Timescale |
|---|---|---|---|---|
| **1. Process Management** | | | | |
| 1.1 | Management establish robust overarching Commissioning Assurance Framework, Policy, or relevant Standard Operating Procedure (SOP) to support the healthcare commissioning / contracting process. This should ensure that lines of escalation, roles, responsibilities, and requirements regarding the management and oversight of the quality aspect of services provided are clearly defined. | Associate Director of Healthcare Contracting.<br>Deputy Director of Quality.<br>31 August 2023 | **High** | **Not Implemented**<br>**Finding**<br>We received a copy of a draft Commissioning Assurance Framework (CAF), dated July 2024, which was prepared by Healthcare Contracting leads, however this has not been progressed within the Health Board. This was due to the pending start date of a newly appointed Director of Performance and Commissioning.<br>We met with officers from the Healthcare Contracting Team and Director of Performance and Commissioning (DP&C) on the 18 March 2025 and were advised that:<br>The DP&C acknowledged receipt of the draft CAF from Healthcare contracting but had agreed that the focus in the immediate term was on planned care and whilst the review area was a risk for the Health Board, the long waits for patients was deemed a higher risk and priority.<br>The DP&C does not believe the development of the CAF is now the correct tool for the Health Board and contracted services should be subject to the same rigour as the Health Board's own services.<br>The DP&C stated that the intention is to amend the current Integrated Performance and Quality Framework and include a specific section on the expected standards and assurance for commissioned services. This will ensure that all contracted services will be subject to the same rigour and process as in-house provide care. |

| Ref | Recommendation | Original Responsibility & Timescale | Priority Rating | Status, Updated Responsibility and Timescale |
|---|---|---|---|---|
| | | | | **Revised Action, Responsibility and Timescale**<br><br>Recommendation accepted. The Director of Performance and Commissioning will ensure this is completed during Quarter 1 of 2025/26. |
| **2. Contractual Obligations** | | | | |
| 2.1 | Management establish controls to ensure that all commissioned providers adhere to agreed contractual agreements and assess current contract review meeting arrangements to ensure appropriate levels of oversight and engagement. | Associate Director of Healthcare Contracting.<br><br>Deputy Director of Quality.<br><br>31 August 2023 | **High** | **Not Implemented**<br><br>**Finding**<br><br>We selected a sample of six NHS England providers with which the Health Board has contracts in place. A review of the Care Quality Commission (CQC) website has identified all six providers as amber rated *Requires Improvement.*<br><br>We received evidence of regular meetings being held between the Health Board and the Countess of Chester NHS Foundation Trust (CoCH) but no evidence for the remaining five in our sample. Agenda items with the CoCH focus on finance and performance; we found no evidence that quality and safety issues were being shared by the CoCH or anyone with a quality remit attending from the Health Board.<br><br>Through reviewing recent Board papers for the NHS England providers, we have noted matters relating to patient safety/quality being reported and are unsighted whether any of these relate to Health Board patients.<br><br>**Revised Action, Responsibility and Timescale**<br><br>Recommendation accepted. The Director of Performance and Commissioning will ensure this is completed during Quarter 1 of 2025/26. |
| **3. Quality Measures** | | | | |

| Ref | Recommendation | Original Responsibility & Timescale | Priority Rating | Status, Updated Responsibility and Timescale |
|---|---|---|---|---|
| 3.1 | Management to review contractual quality measures to ensure they are robust, effective, and appropriate. | Associate Director of Healthcare Contracting.<br>31 March 2024 | High | **Not Implemented**<br>As noted in 2.1 above, a Commissioning Assurance Framework has not been implemented, and quality measures of contracts have not been reviewed.<br>**Revised Action, Responsibility and Timescale**<br>Recommendation accepted. The Director of Performance and Commissioning will ensure this is completed during Quarter 1 of 2025/26. |
| 3.2 | Management to ensure procedures have provision for addressing and escalating quality issues that fall outside the agreed measures. | Associate Director of Healthcare Contracting.<br>Deputy Director of Quality.<br>31 October 2023 | High | **Not Implemented**<br>As noted in 2.1 above, a Commissioning Assurance Framework has not been implemented and procedures for addressing and escalating issues have not been developed (beyond those already in place during our previous review).<br>**Revised Action, Responsibility and Timescale**<br>Recommendation accepted. The Director of Performance and Commissioning will ensure this is completed during Quarter 1 of 2025/26. |
| **4. Board Assurance** | | | | |
| 4.1 | Management to review governance and reporting arrangements to ensure English NHS provider quality and performance data is subject to Health Board review and scrutiny. | Associate Director of Healthcare Contracting.<br>Deputy Director of Quality.<br>31 October 2023 | High | **Not Implemented**<br>We can find no evidence that a six-monthly report has been provided to the Quality, Safety and Experience Committee (QSE) as detailed within the agreed management response.<br>We have found no reference to contracted services within the standard agenda item titled *Integrated Quality Report* presented by the Executive Director of Nursing and Midwifery to QSE. |

| Ref | Recommendation | Original Responsibility & Timescale | Priority Rating | Status, Updated Responsibility and Timescale |
|---|---|---|---|---|
| | | | | **Revised Action, Responsibility and Timescale**<br><br>Recommendation accepted. The Director of Performance and Commissioning will ensure this is completed during Quarter 1 of 2025/26. |

# Appendix A

## Assurance Opinion

| | |
|---|---|
|  **Substantial** | Few matters require attention and are compliance or advisory in nature.<br>**Low impact** on residual risk exposure. |
|  **Reasonable** | Some matters require management attention in control design or compliance.<br>**Low to moderate impact** on residual risk exposure until resolved. |
|  **Limited** | More significant matters require management attention.<br>**Moderate impact** on residual risk exposure until resolved. |
|  **Unsatisfactory** | Action is required to address the whole control framework in this area.<br>**High impact** on residual risk exposure until resolved. |
|  **Advisory** | Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate.<br>These reviews are still relevant to the evidence base upon which the overall opinion is formed. |

## Prioritisation of Findings

| Priority | Explanation |
|---|---|
| **High** | Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance. |
| **Medium** | Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance. |

## Disclaimer

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Cwm Taf Morgannwg University Health Board, and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of the Cwm Taf Morgannwg University Health Board Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

## Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership]

# Quality Safety & Experience Committee

## PRESENTATION OF THE NURSE STAFFING LEVELS – AUTUMN 2026

| | |
|---|---|
| **Dyddiad y Cyfarfod**<br>**Date of Meeting** | 05 November 2026 |
| **Statws Cyhoeddi**<br>**Publication Status** | Open/ Public |
| | Not Applicable |
| **Enw a theitl Awdur(on) yr Adroddiad**<br>**Report Author name and title** | Alison Griffiths Director of Nursing Workforce, Staffing & Professional Standards<br>Joanna Brown Nurse Staffing Programme Lead |
| **Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol**<br>**Lead Executive Team Member name and title** | Chris Lynes Deputy Executive Director of Nursing & Midwifery<br>Naomi Holder Deputy Executive Director of Nursing & Midwifery |

| | |
|---|---|
| **Pwrpas yr Adroddiad**<br>**Report Purpose** | Endorse for Board Approval |

**Crynodeb Gweithredol**
**Executive Summary**

This paper provides the Quality, Safety and Experience (QSE) Committee with assurance on compliance with the Nurse Staffing Levels (Wales) Act 2016, following completion of the autumn 2026 bi-annual nurse staffing calculations for all wards within the scope of Section 25B of the Act.

The calculations have been undertaken in accordance with statutory guidance and approved by the designated person. Within Welsh Health Boards, the designated person is the Executive Director of Nursing, acting on behalf of the Chief Executive Officer.

In line with the statutory nurse staffing review cycle, and as the Executive Director of Nursing and Midwifery post was vacant at the time the reviews were undertaken, the reviews were approved on this occasion by the Deputy Executive Directors of Nursing in accordance with delegated authority.

The accompanying Nurse Staffing QSE Presentation demonstrates that Betsi Cadwaladr University Health Board (BCUHB) has discharged its statutory duty to calculate nurse staffing levels and continues to take all reasonable steps to maintain those levels across all applicable wards.

The paper also highlights material risks that limit full and unqualified assurance, including unfunded approved establishments and sustained reliance on unfunded escalation bed capacity. These issues present ongoing operational, workforce, financial, and regulatory risk, requiring continued Board oversight and timely decision-making.

The annual report to the Board on compliance with the Nurse Staffing Levels (Wales) Act 2016, including nurse staffing levels calculations and the steps taken maintain those levels during the period 1 October 2025 to 30 September 2026, will be presented to the Board in November 2026.

| **Ymgysylltu (mewnol/allanol) yr ymgymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp)**<br>**Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)** | | |
|---|---|---|
| **Pwyllgor / Grŵp / Unigolion**<br>**Committee / Group / Individuals** | **Dyddiad**<br>**Date** | **Canlyniad, Tystiolaeth a Data**<br>**Outcome, Evidence and Data** |
| Local reviews: Ward Managers, Associate Directors of Nursing (IHC ADON/ IHC Directors of Nursing (DON), people services, finance officers.<br><br>Read across reviews: DON Nursing Workforce, Staffing & Professional Standards, Nurse Staffing Programme Lead, IHC ADON/DON, people services, finance officers.<br><br>Executive reviews: Executive Director of People Services & Organisational Development, Deputy Executive Directors of Nursing, Director of Commissioning and Financial Planning, DON Workforce, Staffing & Professional Standards, Nurse Staffing Programme Lead, IHC ADON/DON | August - October 2026 | Completion of statutory nurse staffing level calculations for all applicable wards, using a triangulated methodology, with review and approval by the designated person or delegated nominee in accordance with the Nurse Staffing Levels (Wales) Act 2016. |

| **Acronymau / Rhestr Termau**<br>**Acronyms / Glossary of Terms** | |
|---|---|
| | |

# PRESENTATION OF THE NURSE STAFFING LEVELS – AUTUMN 2026

## 1. Y SEFYLLFA
## SITUATION

1.1 The statutory guidance supporting the Nurse Staffing Levels (Wales) Act 2016, requires Health Boards to provide annual assurance to the Board on nurse staffing levels in all wards within the scope of Section 25B of the Act.

1.2 This assurance is provided through:

**1.2.1** An annual presentation by the designated person setting out the calculated nurse staffing levels for each ward to which Section 25B of the Act applies; and

**1.2.2** An annual assurance report to the Board on compliance with the Nurse Staffing Levels (Wales) Act 2016, structured to support the statutory triennial submission to Welsh Government.

1.3 In line with these requirements, bi-annual nurse staffing calculations are undertaken in spring and autumn using the nationally mandated triangulated methodology. The autumn 2026 nurse staffing level calculations underpin the assurance provided to the Committee within this paper.

1.4 Due to national reporting timelines, the full annual Nurse Staffing Levels Report is not yet available. This paper therefore presents a summary position, supported by the Nurse Staffing QSE Presentation (Appendix 1), to enable the Committee to receive assurance regarding compliance with the Nurse Staffing Levels (Wales) Act 2016 and to note the risks that currently limit full and unqualified assurance.

## 2 Y CEFNDIR
## BACKGROUND

2.1 Under the Nurse Staffing Levels (Wales) Act 2016, nurse staffing calculations must be approved by a designated person authorised to act on behalf of the Chief Executive Officer. The designated person should also be a person of sufficient seniority within the organisation, such as the Executive Director of Nursing and Midwifery.

2.2 At the time of the autumn 2026 nurse staffing level calculations, the Executive Director of Nursing and Midwifery post was vacant. In accordance with the Health Board's governance and accountability arrangements, the Deputy Executive Directors of Nursing assumed the role of Designated Persons and discharged the statutory responsibilities associated with the review and approval of the nurse staffing level calculations. Appropriate

governance, oversight and assurance arrangements were maintained throughout the calculation, review and approval process.

2.3 The approved calculation establishes the nurse staffing level for each ward, expressed as the required establishment to support a planned roster that enables nurses to provide care that is sensitive to the needs of patients.

2.4 In accordance with the Nurse Staffing Levels (Wales) Act 2016, the Health Board is required to take all reasonable steps to maintain these staffing levels, supported through the revenue allocation and the substantive staffing costs associated with the funded establishment.

## 3 MATERION PENODOL I'W HYSTYRIED<br>SPECIFIC MATTERS FOR CONSIDERATION

3.1 The committee is asked to note the following matters, which support the Health Board's strategic objective of improving access, outcomes and experience, and provide assurance regarding compliance with the Nurse Staffing Levels (Wales) Act 2016 and arrangements for maintaining safe and effective nursing care:

**3.1.1** Nurse staffing levels for all wards within the scope of Section 25B of the Act have been calculated in line with statutory requirements, using the nationally mandated triangulated methodology and have been approved by the designated person.

**3.1.2** Existing governance arrangements will continue to provide oversight of the maintenance of the Health Board's duty to take all reasonable steps to maintain approved nurse staffing levels, including the review and escalation of any material changes in service delivery, patient acuity and dependency, workforce profile or ward configuration.

3.2 The HCSW Skill Set Assessment process, undertaken in accordance with the NHS Wales Collective Agreement Framework, is nearing completion. Once finalised, the findings will require detailed analysis to determine the implications for future workforce configuration, including the optimal Band 2 / Band 3 skill mix. This may influence future nurse staffing calculations and workforce models.

## 4 RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO<br>KEY RISKS / MATTERS FOR ESCALATION

4.1 The risks outlined below impact the Health Board's ability to provide full and unqualified assurance regarding compliance with the Nurse Staffing Levels

(Wales) Act 2016, workforce sustainability and the delivery of safe and effective care, and therefore require continued Board oversight:

4.2 Outstanding Funding Requirements:
*Health Boards and Trusts must take all reasonable steps to maintain nurse staffing levels, funded through their revenue allocations*.

4.3 Nurse staffing reviews undertaken between autumn 2024 and spring 2026 identified increases in nurse staffing requirements within Hebog, Prysor and Morris wards. The resulting establishment changes were subsequently approved by the Board, however, the associated recurrent funding has not yet been secured. As a result, there is an ongoing misalignment between Board-approved nurse staffing establishments and funded budgets.

4.4 Whilst the nurse staffing levels have been calculated and approved in accordance with statutory requirements, the absence of corresponding budget uplifts presents a risk to the Health Board's ability to fully maintain the approved nurse staffing levels and consequently limits the assurance that can be provided regarding ongoing compliance with the Act.

4.5 Unfunded Escalation Bed Capacity:
Sustained system pressures continue to necessitate the routine use of unfunded escalation bed capacity, with an average of 147 unfunded escalation beds in operation at any given time, 54 of which are located within Section 25B wards. Whilst a proportion of this activity can be absorbed within existing establishments, a significant proportion requires additional staffing to maintain safe and effective care.

4.6 The continued reliance on unfunded escalation bed capacity presents a material risk to compliance with statutory nurse staffing requirements, quality standards, and financial control. The requirement to staff escalation capacity beyond approved establishments limits the assurance that can be provided regarding the Health Board's ability to maintain approved nurse staffing levels and increases exposure to workforce, patient safety and financial risks.

4.7 The workforce establishment required to support the current unfunded escalation bed capacity has been identified, however, a strategic decision is required regarding the long-term position of these beds, including whether this capacity can be safely de-escalated or requires recurrent funding to support continued operation. Until a sustainable solution is agreed, the Health Board will continue to carry elevated operational, quality, workforce and regulatory risk.

## 5 ARGYMHELLION RECOMMENDATIONS

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

- Receive the Nurse Staffing QSE Presentation and take assurance that Betsi Cadwaladr University Health Board (BCUHB) has undertaken its statutory duty to calculate nurse staffing levels and continues to take all reasonable steps to maintain those levels in wards within the scope of Section 25B of the Nurse Staffing Levels (Wales) Act 2016, whilst noting the risks and limitations to full and unqualified assurance outlined in this report.
- Note the material risks outlined in this paper relating to unfunded approved nurse staffing establishments and the sustained reliance on unfunded escalation bed capacity, and support continued Board oversight until sustainable mitigations are implemented.
- Support the following actions to address identified nurse staffing, operational and financial risks:
    - Continue to monitor the impact of nurse staffing levels within clinical areas through workforce, quality and patient outcome metrics.
    - Continue to focus on recruitment, retention and innovation to support workforce sustainability and utilisation, aligned to the BCUHB People Strategy & Plan, the All-Wales National Workforce Implementation Plan, the All-Wales Nurse Retention Plan and the All-Wales Strategic Nursing Workforce Plan.
    - Undertake a Health Board review of unfunded escalation bed capacity to determine whether this capacity can be safely de-escalated or requires recurrent funding and workforce provision to support continued operation.
- Note the following actions, to be progressed under the authority of the Deputy Executive Director of Nursing & Midwifery acting as the Designated Person:
    - Consider the recurrent funding requirements associated with previously approved nurse staffing establishments to support compliance with the Health Board's duty to maintain nurse staffing levels.
    - Amend planned roster templates within e-Rostering to reflect approved nurse staffing levels.
    - Ensure recruitment is undertaken in line with approved nurse staffing establishments.
    - Ensure public-facing ward information boards display approved nurse staffing levels.
- Note that the Annual Nurse Staffing Levels Report, providing assurance on compliance with the Nurse Staffing Levels (Wales) Act 2016 for the period 1 October 2025 to 30 September 2026, will be presented to the Board in November 2026.

| ASESIAD / ASSESSMENT | |
|---|---|
| **Cysylltiad â'r Bwriadau Strategol**<br><br>**Link to Strategic Intentions** | 3. Improve Access, Outcomes and Experience<br><br>If more than one applies, please list below: |
| **Yr Egwyddorion Dylunio Design Principles** | Wise Spending |
| **Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd**<br>**Corporate Risks and Board Assurance Framework** | There are several risks associated with the subject and scope of this paper, including workforce, financial and operational risks related to unfunded establishments, unfunded escalation bed capacity, and the need for timely decisions on nurse staffing establishments. |

| ASESIADAU O EFFAITH / IMPACT ASSESSMENTS | | |
|---|---|---|
| **Equality Act 2010 Public Sector Equality Duty:**<br>**Has BCUHB provided evidence of 'Due Regard' to compliance with the three parts of the Public Sector Equality Duty (General Duty):**<br>https://www.gov.wales/public-sector-equality-duty-htmlPublic Sector Equality Duty [HTML] \| GOV.WALES | Do/Yes: ☐ | Naddo/No: ☒ |
| | Canlyniad/Outcome: | N/A |
| | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale: | The report concerns internal workforce establishment decisions.<br>There is no impact on protected groups identified within the report, and the associated public sector equality duties are not engaged (there are no associated impacts on any of the protected groups). |
| **Equality Act 2010 - Socio-economic Duty**<br>*Has BCUHB provided evidence of 'Due Regard' to compliance of ther Socio-economic Duty when making strategic decisions?* | Do/Yes: ☐ | Naddo/No: ☒ |
| | Canlyniad/Outcome: | N/A |
| | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale: | The report does not introduce decisions that would disproportionately affect individuals or communities experiencing |

| | | |
|---|---|---|
| | | socio-economic disadvantage. |
| *Have you completed an Integrated Equality Impact Assessment WP8a?* *WP8a Template* | Do/Yes: ☐ | Naddo/No: ☒ |
| | Canlyniad/Outcome: | N/A |
| | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale: | The report concerns internal workforce establishment decisions.<br>There is no impact in terms of equality. |
| **Human Rights Act**<br>*Have Human Right based concerns been addressed within WP8a* | Do/Yes: ☐ | Naddo/No: ☒ |
| | Canlyniad/Outcome: | N/A |
| | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale: | The proposal does not alter patient rights, service entitlements, privacy, liberty, or care pathways.<br>It is an internal workforce establishment decision rather than one affecting individual rights. |
| **Compliance to the Welsh Language requirements?**<br>*Have you undertaken an Impact Assessment* | Do/Yes: ☐ | Naddo/No: ☒ |
| | Canlyniad/Outcome: | N/A |
| | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale: | The changes proposed do not affect the delivery of bilingual clinical services, communication with the public, or access to information in Welsh. |
| **Compliance to giving 'Due Regard' to the principles of the Armed Forces Covenant**<br>*Have the principles of the Armed Forces Covenant been addressed within WP8a* | Do/Yes: ☐ | Naddo/No: ☒ |
| | Canlyniad/Outcome: | N/A |
| | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale: | There is no evidence that the proposed workforce establishment impacts members of the Armed Forces community differently from other staff or service users.<br>The proposal does not create or remove access to services that |

| | | |
|---|---|---|
| | | specifically affect veterans, serving personnel, or their families. |
| **Ansawdd**<br>*A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?*<br>**Quality**<br>*Have you undertaken a Quality Impact Assessment Screening?* | Do/Yes: ☐ | Naddo/No: ☒ |
| | Canlyniad/Outcome: | N/A |
| | **Galluogwyr Ansawdd Enablers of Quality**<br>Choose an item.<br><br>Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:<br>If more than one applies, please list below: | The report concerns internal workforce establishment decisions.<br>Whilst the report itself does not introduce changes to clinical services, nurse staffing levels are recognised as a contributor to care quality and patient outcomes. |
| **Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals** | Not Applicable | |
| **Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)** | Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:<br>If more than one applies, please list below: | |
| | No - Not Applicable | |
| | Os oes mwy nag un yn berthnasol, rhestrwch hynny:<br>If more than one applies, please list: | |
| **Asesiad o Effaith ar Ddiogelu Data**<br>*A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?*<br>**Data Protection Impact Assessment**<br>*Have you undertaken a Data Protection Impact Assessment Screening?* | Do/Yes: ☐ | Naddo/No: ☒ |
| | Canlyniad/Outcome: | N/A |
| | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale: | The report concerns internal workforce establishment decisions.<br><br>There is no impact in terms of data protection. |
| | Do/Yes: ☐ | Naddo/No: ☒ |

| | | |
|---|---|---|
| **Asesiad o Effaith ar Atal Twyll**<br>*A ydych chi wedi ystyried yr effeithiau ar atal twyll?*<br>**Counter Fraud Impact**<br>*Have you considered the counter fraud impacts* | Canlyniad/Outcome: | N/A |
| | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale: | The report concerns internal workforce establishment decisions.<br>There is no impact in terms of counter fraud. |
| **Cyfreithiol**<br>**Legal** | Yes (Include further detail below) | |
| | The Nurse Staffing Levels (Wales) Act 2016 places a statutory duty on Health Boards to have *"regard to the importance of providing sufficient nurses to allow the nurses time to care for patients sensitively*" and within 25B areas to "*calculate and take all reasonable steps to maintain nurse staffing levels".* | |
| **Enw Da**<br>**Reputational** | Yes (Include further detail below) | |
| | There is potential reputational impact should quality, financial performance, or operational delivery deteriorate as a result of unresolved staffing and budgetary risks outlined in this report. Failure to maintain safe staffing levels, particularly within 25B areas and Emergency Departments, may attract scrutiny from regulators, the public, and Welsh Government. | |
| **Effaith ar Adnoddau**<br>*(Pobl / Ariannol)*<br>**Resource Impact**<br>*(People / Financial)* | Yes (Include further detail below) | |
| | Premium agency costs will remain unless staffing gaps are addressed, including those associated with the unfunded escalation bed capacity. Failure to reduce agency spend will attract ongoing scrutiny. | |

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# Presentation of the Nurse Staffing Levels Reporting Period: Autumn 2026

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# Introduction / Background

Section 25B of the **Nurse Staffing Levels (Wales) Act 2016** applies to adult acute medical inpatients wards; adult acute surgical inpatient wards; and paediatric inpatient wards.

The Act has two key requirements:

1. **A duty to calculate and take all reasonable steps to maintain nurse staffing levels**[1]
2. **A duty to calculate the nurse staffing level using the prescribed triangulated methodology, incorporating professional judgement, patient acuity and dependency, and quality indicators.**

In line with the Act, nurse staffing calculations are to be approved by a designated person who is authorised to undertake this calculation on behalf of the Chief Executive Officer. The designated person should be registered with the Nursing and Midwifery Council and have an understanding of the complexities of setting a nurse staffing level in the clinical environment. The designated person should be a person of sufficient seniority within the organisation, such as the Executive Director of Nursing or the Deputy Executive Director of Nursing.

"*The calculation undertaken by the designated person must result in the nurse staffing level for the ward area. In practice, the nurse staffing level will be the required establishment and the planned roster*"[2].

[1] Statutory calculations of nurse staffing levels across wards pertaining to Section 25B take place between March/April (reporting to Board in May) and August/September (reporting to Board in November).

[2] Nurse Staffing Levels (Wales) Act 2016: Statutory Guidance

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# Section 25C: method of calculation

Section 25C of the Act describes the triangulated method of calculation that must be used for calculating the nurse staffing levels. The triangulated methodology involves collecting, reviewing and interpreting data relating to:

- **Professional Judgement** - applying knowledge, skills and experience in a way that is informed by professional standards, law and ethical principles to develop a decision on the factors that influence clinical decision making

- **Patient Acuity** - an estimate of the amount of care a patient requires based on the intensity, complexity and unpredictability of their holistic needs. In Wales the Welsh Levels of Care is the tool used to assist nurses in measuring the acuity and dependency of their patients.

- **Quality Indicators** – a measure of factors that relate to the delivery of nursing care and are used to demonstrate whether the department delivers good outcomes for patients and staff.




During the process of calculating the nurse staffing levels using the triangulated approach there is no pre-determined hierarchy in terms of the evidence with equal weighting given to all the information that informs this process. The designated person will make the determination of the nurse staffing levels based on an analysis of all the information collected about the ward and the contributions of those staff involved in the process.

# Nurse Staffing Levels Calculations Process

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## Local Reviews
## Data Collection & Review

Ward Manager presentations to Associate Director of Nursing/Director of Nursing; people services and finance officers, outlining ward acuity/care quality indicators/and applied professional judgement.

Discussion takes place regarding current workforce issues/temporary staffing usage/future workforce needs/staff development & innovation.

## Health Board Wide Read Across Reviews

Health Board wide read across reviews (multi-site, service specific) are led by the Director of Nursing Workforce, Staffing & Professional Standards to ensure a consistent approach, share good practice/lessons learned/opportunity to improve patient care pathways.

Autumn 2026 reviews were undertaken during the week commencing 14th September.

## Review & Approval by Designated Person

Formal presentations by the were made to the Deputy Executive Directors of Nursing and Midwifery on 01/10/2026. In attendance was the Executive Director of People Services & the Deputy Director of Finance.

Agreed Nurse Staffing Level calculations will be formally presented to the Board on 26/11/2026.

# Acuity Data

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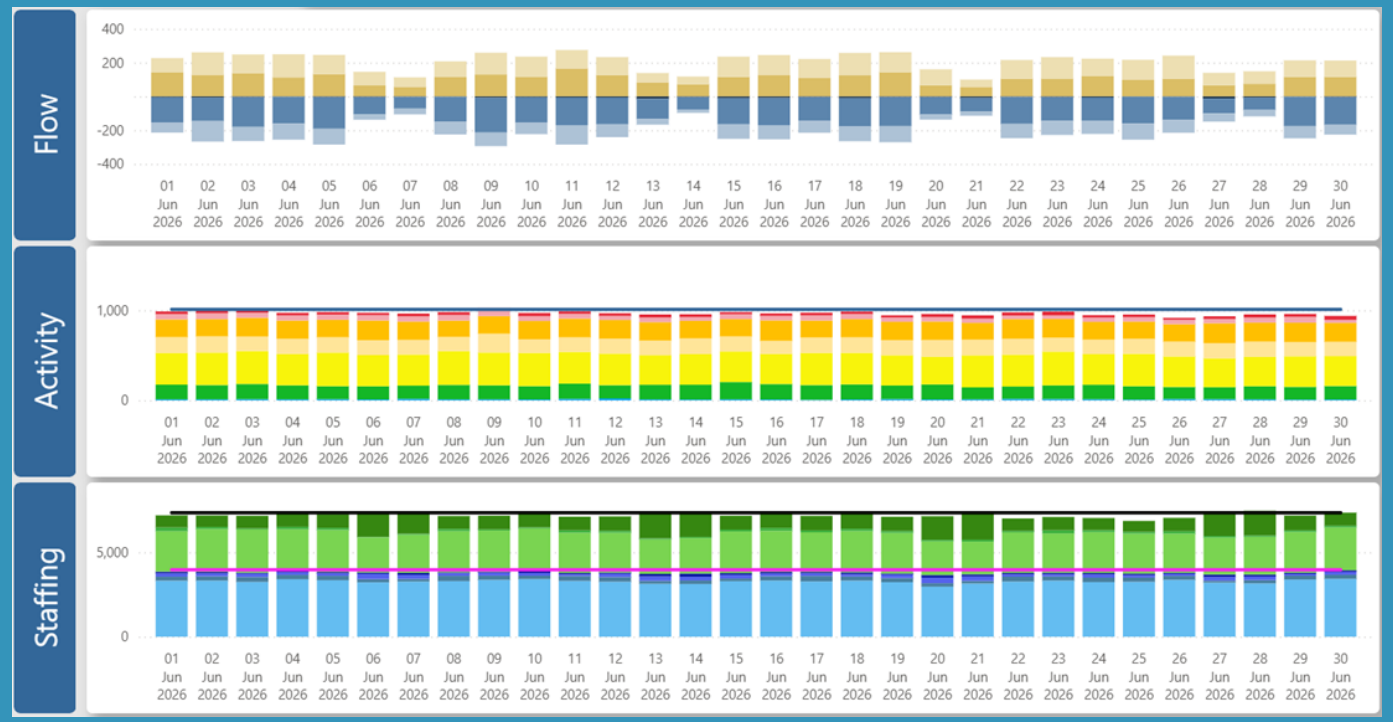
**Acuity data**

Patient acuity is assessed using the Welsh Levels of Care evidence-based workforce planning tool. This measure of patients levels of acuity indicates how much care is required in order to determine the nurse staffing level that is required to meet reasonable requirements of care.

This information when used as part of a triangulated approach alongside the use of quality indicators and professional judgement will determine the nurse staffing level for the ward.

Individual BCU ward acuity details can be viewed here

## BCUHB Section 25B Wards June 2026 Acuity data




**Welsh Levels of Care**

The Welsh Levels of Care are summarised opposite, further detailed information can be found here

| | |
|---|---|
| Level 5 | **One to One Care** - the patient requires at least one to one continuous nursing supervision and observation for 24 hours a day |
| Level 4 | **Urgent Care** - The patient is in a highly unstable and unpredictable condition either related to their primary problem or an exacerbation of other related factors. |
| Level 3 | **Complex Care** - The patient may have a number of identified problems, some of which interact, making it more difficult to predict the outcome of any individual treatment |
| Level 2 | **Care Pathways** - The patient has a clearly defined problem but there may be a small number of additional factors that affect how treatment is provided. |
| Level 1 | **Routine Care** - The patient has a clearly identified problem, with minimal other complicating factors. |

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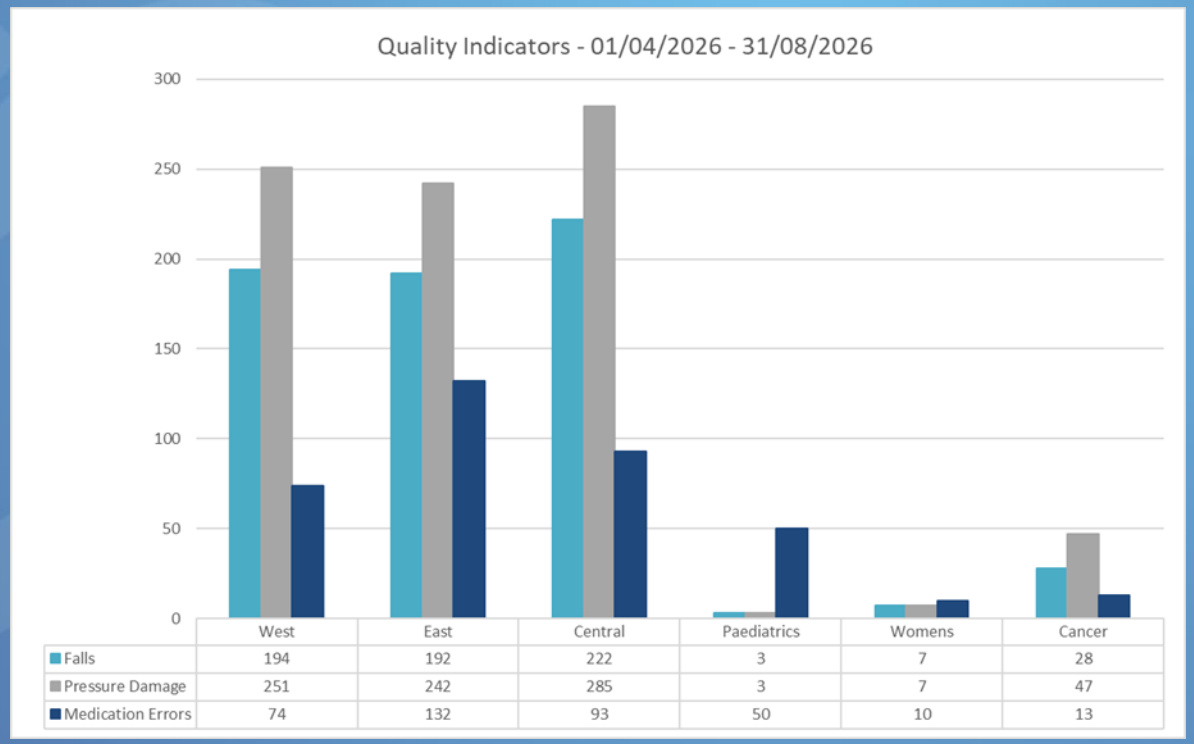
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# Quality Indicators

When calculating the nurse staffing level the quality indicators that are particularly sensitive to care provided by a nurse must be considered. These include patient falls, pressure damage, medication errors and complaints.

The below chart details the total number of patient falls; pressure damage and medication errors that have occurred across BCUHB Section 25B wards, and as recorded within the DATIX system for the period 01/04/2026 – 31/08/2026.




| | West | East | Central | Paediatrics | Womens | Cancer |
|---|---|---|---|---|---|---|
| Falls | 194 | 192 | 222 | 3 | 7 | 28 |
| Pressure Damage | 251 | 242 | 285 | 3 | 7 | 47 |
| Medication Errors | 74 | 132 | 93 | 50 | 10 | 13 |

Data Source: DATIX system as at 23.09.2026

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# Approved Nurse Staffing Levels – Autumn 2026 (Summary)

The nurse staffing level calculations undertaken during this reporting period (spring 2026 – autumn 2026) identified a number of wards who have proposed a change to their establishments, with the overall proposed FTE changes summarised in the table below.

| Integrated Health Community | Number of Act Wards | Funded Bed Numbers | Required Establishment at the start of the reporting period (October 25) | | Required Establishment at the end of the reporting period (September 2026)* | | Staffing FTE changes during reporting period 2025 - 2026* | | Funded** Establishment (as at September 2026) | | FTE Variance between current funded and required (September 2026) | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | RN | HCA | RN | HCA | RN | HCA | RN | HCA | RN | HCA |
| YMW | 15 | 334 | 279.17 | 229.45 | 301.92 | 255.04 | 22.75 | 25.59 | 301.92 | 252.2 | 0 | 2.84 |
| YGC | 13 | 313 | 263.46 | 254.99 | 263.46 | 254.99 | 0 | 0 | 263.46 | 254.99 | 0 | 0 |
| YG | 10 | 239 | 214.61 | 206.65 | 211.77 | 206.65 | -2.84 | 0 | 211.87 | 202.39 | -0.1 | 4.26 |
| Womens Gynaecological | 2 | 34 | 34.11 | 21.94 | 34.11 | 21.94 | 0 | 0 | 34.11 | 21.94 | 0 | 0 |
| Oncology & Haematology | 3 | 38 | 37.56 | 34.11 | 37.56 | 34.11 | 0 | 0 | 37.57 | 34.11 | -0.01 | 0 |
| Paediatric Inpatient Wards | 3 | 64 | 85.29 | 28.43 | 85.29 | 28.43 | 0 | 0 | 85.29 | 28.43 | 0 | 0 |
| **BCUHB Total** | **46** | **1022** | **914.2** | **775.57** | **934.11** | **801.16** | **19.91** | **25.59** | **934.22** | **794.06** | **-0.11** | **7.1** |

Funding changes between February and July 2025 resulted in the funded bed base fluctuating across 4 wards within YMW (Arrivals, Pantomime, Prince of Wales & Morris), with their escalated beds moving in and out of funded status. In January 2026, funding was permanently restored from central HB reserves, establishing a fully funded bed base across these 4 wards.

*Funded establishment sourced from Finance Ledger

Note: The required and funded establishment figures exclude any additional staffing requirements needed to support the unfunded escalation bed capacity, and also exclude the supernumerary ward manager and ward support staff i.e. housekeepers, dementia support workers etc.

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# Section 25B wards requesting a change to nurse staffing levels

During the autumn 2026 reporting period two statutory calculations of nurse staffing levels have taken place, these being spring 2026 (reported to Board in May 2026) and autumn 2026 (to be reported to Board in November 2026).

Across both calculation periods 9 wards have requested changes to their establishments. The changes proposed (identified in red) and those approved following review by the Designated Person (identified in green) are summarised in the table below.

| Review Period | IHC | Ward | Roster Period | Bed Numbers (actual excluding unfunded) | Current staffing (at time of review) | | | | | | | | Proposed staffing (submitted by IHCs for Designated Persons Consideration) | | | | | | | | Supported staffing (following review by Designated Person) | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Early | | Late | | Twilight | | Night | | Early | | Late | | Twilight | | Night | | Early | | Late | | Twilight | | Night | |
| | | | | | RN | HCA | RN | HCA | RN | HCA | RN | HCA | RN | HCA | RN | HCA | RN | HCA | RN | HCA | RN | HCA | RN | HCA | RN | HCA | RN | HCA |
| Spring 2026 | East | Arrivals | 7 Days | 26 | 3 | 2 | 3 | 2 | 0 | 0 | 2 | 2 | 5 | 3 | 5 | 3 | 0 | 0 | 3 | 3 | 5 | 3 | 5 | 3 | 0 | 0 | 3 | 3 |
| Spring 2026 | East | Morris | 7 Days | 27 | 4 | 4 | 4 | 3 | 0 | 0 | 2 | 4 | 4 | 5 | 4 | 4 | 0 | 0 | 3 | 5 | 4 | 5 | 4 | 4 | 0 | 0 | 3 | 4 |
| Spring 2026 | East | Pantomime | 7 Days | 27 | 4 | 3 | 3 | 3 | 0 | 1 | 2 | 2 | 5 | 4 | 4 | 4 | 0 | 0 | 3 | 3 | 5 | 4 | 4 | 4 | 0 | 0 | 3 | 3 |
| Spring 2026 | East | Prince of Wales | 7 Days | 27 | 3 | 3 | 3 | 3 | 0 | 0 | 2 | 2 | 4 | 4 | 4 | 4 | 0 | 0 | 3 | 3 | 4 | 4 | 4 | 4 | 0 | 0 | 3 | 3 |
| Autumn 2026 | West | Hebog | 7 Days | 27 | 5 | 5 | 5 | 5 | 0 | 0 | 3 | 4 | 5 | 5 | 5 | 5 | 0 | 0 | 4 | 4 | 5 | 5 | 5 | 5 | 0 | 0 | 3 | 4 |
| Autumn 2026 | West | Moelwyn | 7 Days | 28 | 6 | 4 | 6 | 4 | 0 | 0 | 4 | 4 | 6 | 4 | 6 | 4 | 0 | 0 | 5 | 4 | 6 | 4 | 6 | 4 | 0 | 0 | 4 | 4 |
| Autumn 2026 | West | Tegid | 7 Days | 28 | 5 | 4 | 5 | 4 | 0 | 0 | 4 | 3 | 5 | 5 | 5 | 5 | 0 | 0 | 4 | 3 | 5 | 4 | 5 | 4 | 0 | 0 | 4 | 3 |
| Autumn 2026 | Central | Ward 3 | 7 Days | 23 | 4 | 4 | 4 | 4 | 0 | 0 | 4 | 4 | 5 | 4 | 5 | 4 | 0 | 0 | 3 | 4 | 5 | 4 | 5 | 4 | 0 | 0 | 3 | 4 |
| Autumn 2026 | East | Pantomime | 7 Days | 27 | 5 | 4 | 4 | 4 | 0 | 0 | 3 | 3 | 5 | 4 | 5 | 4 | 0 | 0 | 3 | 3 | 5 | 4 | 4 | 4 | 0 | 0 | 3 | 3 |
| Autumn 2026 | East | Mason | 7 Days | 26 | 4 | 6 | 4 | 5 | 0 | 0 | 3 | 3 | 5 | 4 | 5 | 4 | 0 | 0 | 3 | 3 | 4 | 6 | 4 | 5 | 0 | 0 | 3 | 3 |

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# Section 25B wards requiring a change to nurse staffing levels

Two statutory nurse staffing level calculations have taken place during this reporting cycle (spring 2026, reported to Board in May 2026; autumn 2026, to be reported to Board in November 2026). Across both calculation periods 9 wards have requested changes to their establishments. The changes approved and the rationale for these, are summarised in the table below.

| Integrated Health Community | Number of Act Wards | Number of Wards Requesting Adjustments | Adjustments Approved by Exec DoN | Comments | Funding Received |
|---|---|---|---|---|---|
| YWM | 15 | 6 | 4 | Arrivals - funding changes between February and July 2025 resulted in the funded bed base fluctuating between 16 and 26 beds, with 10 escalated beds moving in and out of funded status. In January 2026, funding was permanently restored from central HB reserves, establishing a funded bed base of 26. | Yes |
| | | | | Morris - funding changes between February and July 2025 resulted in the funded bed base fluctuating between 21 and 27 beds, with 6 escalated beds moving in and out of funded status. In January 2026, funding was permanently restored from central HB reserves, establishing a funded bed base of 26.<br><br>Whilst the funding for 27 beds was reinstated in January 2026, the associated night-shift staffing requirement—specifically the 5th HCA—remains unfunded. IHC requests funding for this post, supported by the ward staffing data and patient harm profile. | Partially - requirement of 2.84 HCSW remains outstanding |
| | | | | Pantomime - funding changes between February and July 2025 resulted in the funded bed base fluctuating between 21 and 27 beds, with 6 escalated beds moving in and out of funded status. In January 2026, funding was permanently restored from central HB reserves, establishing a funded bed base of 26. | Yes |
| | | | | Prince of Wales - funding changes between February and July 2025 resulted in the funded bed base fluctuating between 21 and 27 beds, with 6 escalated beds moving in and out of funded status. In January 2026, funding was permanently restored from central HB reserves, establishing a funded bed base of 26. | Yes |
| YGC | 13 | 1 | 1 | Ward 3 - RN staffing adjusted due to patient acuity and speciality care requirements. | Yes - no change in funded requirements |
| YG | 10 | 3 | 1 | Moelwyn - RN staffing adjusted at night following a review of the utilisation of NIV beds. | Yes - no change in funded requirements. RN night staffing had previously been unfunded. |
| | | | | | |
| | | | | | |
| Oncology & Haematology | 2 | 0 | - | - | - |
| Womens Gynaecological | 3 | 0 | - | - | - |
| Paediatric Inpatients Wards | 3 | 0 | - | - | - |
| **BCUHB Total** | **46** | **10** | **6** | **-** | **-** |

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# Section 25B wards maintaining the nurse staffing level

The **Act** requires LHBs and Trusts to take all reasonable steps to maintain the nurse staffing level. "*Maintaining means having the number of registered nurses the required establishment and its planned roster require. The maintenance of the nurse staffing level should be funded from the LHB's (or Trust's) revenue allocation, taking into account the actual salary points of staff employed on its wards*"[1]

Approved nurse staffing establishment increases for Hebog and Prysor were identified through reviews undertaken between autumn 2024 and spring 2026, with Morris identified in spring 2026. Recommendations were subsequently supported by Board; however, the associated recurrent funding has not yet been implemented. The table below details the required budgetary uplifts to meet approved staffing levels.

| Integrated Health Community | Ward | Required Establishment Autumn 2026 RN | Required Establishment Autumn 2026 HCA | Current Funded RN | Current Funded HCA | FTE Variance between current funded (Sept 26) and required (autumn 26 reviews) RN | FTE Variance between current funded (Sept 26) and required (autumn 26 reviews) HCA | Date Presented to Board |
|---|---|---|---|---|---|---|---|---|
| YG | Hebog | 22.74 | 25.58 | 22.75 | 22.74 | -0.01 | 2.84 | November 2024; May 2025; November 2025 & May 2026 |
| YG | Prysor | 12.79 | 12.37 | 12.87 | 10.95 | -0.08 | 1.42 | November 2024; May 2025; November 2025 & May 2026 |
| YMW | Morris | 19.9 | 27 | 19.9 | 24.16 | 0 | 2.84 | May 2026 |

[1] Nurse Staffing Levels (Wales) Act 2016: Statutory Guidance

# Recommendations

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Support the following actions, to address identified nurse staffing, operational, and financial risks:

- Continue to monitor the impact of nurse staffing levels within the clinical areas, through workforce, quality and patient outcome metrics.
- Continue to focus on recruitment, retention and innovation to support workforce sustainability and utilisation, aligned to **BCUHB People Strategy & Plan;** the **All Wales National Workforce Implementation Plan**; the **All Wales Nurse Retention Plan** and the **All Wales Strategic Nursing Workforce Plan**.
- Undertake a Health Board review of unfunded escalation bed capacity to determine whether this capacity can be safely de-escalated or requires recurrent funding and workforce provision to support continued operation.

Note the following actions, to be progressed under the authority of the Deputy Executive Director of Nursing & Midwifery acting as the Designated Person:

- Consider the recurrent funding requirements associated with previously approved nurse staffing establishments to support compliance with the Health Board's duty to maintain nurse staffing levels.
- Amend planned roster templates within e-Rostering to reflect approved nurse staffing levels.
- Ensure recruitment is undertaken in line with approved nurse staffing establishments.
- Ensure public-facing ward information boards display approved nurse staffing levels.

Note that the Annual Nurse Staffing Levels Report, providing assurance on compliance with the Nurse Staffing Levels (Wales) Act 2016 for the period 1 October 2025 to 30 September 2026, will be presented to the Board in November 2026.



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# Diolch / Thank you
# Any questions?

GIG CYMRU NHS WALES

Addysg a Gwella Iechyd Cymru (AaGIC)
Health Education and Improvement Wales (HEIW)

# Annual Report And Accounts 2025/2026



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# Welcome from our Chair and Chief Executive

This year has been one of continued pressure and change across the health and care system in Wales.

Services are responding to a complex combination of financial constraint, changing population need, workforce availability and evolving models of care. In that context, the importance of a skilled, sustainable and supported workforce has never been clearer. As part of NHS Wales, Health Education and Improvement Wales (HEIW) plays a national role in addressing workforce challenges and supporting change across the system. Our focus is not only on meeting current workforce needs, but on enabling the longer-term transformation required to deliver care differently in the future. During 2025-26, we have worked closely with partners across NHS Wales, Welsh Government, education providers and professional bodies to strengthen workforce supply, improve capability and support change across the system.

This report highlights progress against our Integrated Medium-Term Plan (IMTP) 2025-28, including:

- Strong and sustained delivery against our IMTP, with 89% of development objectives achieved, 96% of operational objectives delivered and all enabling objectives achieved.
- Delivery of the All-Wales National Retention Programme, contributing towards sustained reductions in workforce turnover and voluntary resignations and improving workforce stability across NHS Wales.
- Sustained national investment in education and training, alongside a clear shift towards transformation and innovation to better align workforce supply with future service models and population need.
- Strengthened national workforce intelligence and planning capability, improving data quality, modelling and accessibility to support more consistent, evidence led decision making across NHS Wales.

Alongside this progress, we are clear that challenges remain. These include the alignment between workforce supply and employment opportunities, the pace of system transformation, and the need to continue improving data, capacity and consistency across NHS Wales.

We have approached these challenges through collaboration, transparency and a focus on practical solutions, working with partners to respond to immediate pressures while maintaining a clear view of long-term sustainability.

At the heart of all of this work are people, patients, learners and staff. The workforce is the foundation of safe, high quality care, and supporting that workforce remains fundamental to what we do.

We would like to thank our staff and partners for their continued commitment, professionalism and willingness to work together to address shared challenges. As we look ahead, our focus remains on working as a trusted partner to the system, bringing together insight, planning and action to support a sustainable workforce for Wales.



**Dr Chris Jones**
Chair
24 June 2026



**Alex Howells**
Chief Executive Officer
24 June 2026



# **Performance** Report 2025/2026



# Performance Report Overview

## 1. Chief Executive's Foreword

The past year has reinforced the scale and complexity of the workforce challenge facing NHS Wales.

Across the system, organisations are balancing immediate service pressures with longer term transformation within a constrained financial environment. Workforce planning sits at the centre of this, requiring decisions made years in advance to align with a system that continues to evolve.

Within this context, HEIW continues to play a key role in supporting the system response, bringing together workforce planning, education, development and intelligence at a national level.

During 2025-26, we delivered strong progress against our Integrated Medium-Term Plan (IMTP) 2025-28, with the majority of objectives achieved and performance remaining robust despite a challenging delivery environment.

Our focus has been on delivering practical impact across the workforce lifecycle. Workforce solutions have focused on priority areas, including planned care, diagnostics, urgent and emergency care, mental health and primary care. This has been supported through national resources, expanded training and learning opportunities, and better workforce intelligence informing planning and service delivery.

Investment in education and training has been sustained at scale, alongside a clear shift towards transformation and innovation. This includes the first stage of the development of a longer-term education strategy, expansion of digital learning through Y Tŷ Dysgu, and the creation of a Primary Care Deanery focused on the expansion and development of the primary care workforce. There has also been measurable progress in workforce stability. Delivery of the All-Wales National Retention Programme has contributed to sustained reductions in turnover and voluntary resignations, improving continuity and reducing reliance on temporary staffing.

In parallel, leadership and management development resources and programmes have continued to strengthen across NHS Wales in response to need, recognising their critical role in developing compassionate cultures that enable our people to provide the best care.

We have also enhanced the system's ability to plan for the future. Improved workforce intelligence, modelling and the development of national workforce plans are supporting more consistent, evidence led decision making across Wales.

However, significant challenges remain. These include the alignment between education output and employment opportunities in some professions, the pace and complexity of workforce transformation, and capacity constraints in key areas such as digital and data delivery.

Our response has been grounded in partnership and coordination, including the establishment of national forums such as the Workforce Supply Oversight Group to support a more joined up approach across the system.

Throughout the year, we have maintained strong governance and financial discipline, delivered a balanced financial position, and continued to operate within routine oversight arrangements. We have been building on these sound foundations to review and refresh our Target Operating Model which will conclude in Quarter 1 2026/27.

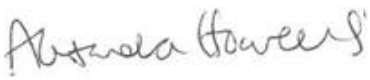
What remains consistent is our role as a partner to the system.

We are not separate from the challenges facing NHS Wales. We are part of the collective response. Our role is to bring together insight, planning and delivery in a way that supports the system to make informed decisions and take coordinated action.

Above all, our work is about people.

The workforce is the foundation of safe, effective and compassionate care. Supporting that workforce through education, development, leadership and planning is how we contribute to improving care for people and communities across Wales. As we move into the next year of our IMTP, our focus remains on delivering impact, strengthening partnerships and supporting the system to navigate both immediate pressures and longer-term change.





**Alex Howells**
Chief Executive Officer
24 June 2026

## 2. Purpose of the Performance Report Overview

The performance report overview provides a summary of HEIW's performance during the year. It provides an understanding of HEIW's role within NHS Wales, our purpose and priorities, the progress we have made against our plans and the key challenges and risks that have been faced throughout the year.

## 3. Who we are

HEIW is the statutory education and strategic workforce organisation for NHS Wales.

We are a Special Health Authority with an all-Wales remit, and we work with partners across health, education regulatory and professional bodies and government.




### 3.1 Our Vision, Purpose and Values

Our vision is to transform the workforce for a Healthier Wales.

As part of the NHS, our purpose is to work with partners to develop a skilled and sustainable workforce that improves care and population health.

We strive to create a compassionate, inclusive, and collaborative culture with high levels of staff engagement, and a focus on our values and behaviours that have been developed with our staff:




The principles of quality, equality, diversity, and sustainability are embedded across our activities as an organisation, recognising the breadth of impact we can have on the whole workforce.

## 3.2 HEIW's Key Facts

- HEIW is a Special Health Authority with an All-Wales remit.
- £384.5m annual revenue budget, of which about 85% is invested in education and training.
- 671 staff employed (as at 31 March 2026) including both core and sessional staff.
- 4,789 medical, pharmacy, optometry and dental trainers and supervisors supporting the workforce.
- National reach across all NHS Wales organisations.

The scale of HEIW's work, and the impact it delivers across NHS Wales, is reflected in the figures below.



# 4. What we do

HEIW brings together a range of national functions that support our vision of transforming the workforce for a Healthier Wales.



## 4.1 Our Functions

### Planning, commissioning and delivering education and training

HEIW is responsible for the planning, commissioning, quality management and in some cases the delivery of education and training across a wide range of health professionals. Our responsibilities encompass undergraduate and postgraduate education and training, post-registration development, and work-based learning. We provide a significant volume of Continuing Professional Development (CPD) for several professions, supported by our digital learning platform, Y Ty Dysgu.

We are responsible for producing an annual HEIW Education and Training Plan (ETP). This makes strategic recommendations to the Welsh Government based on input and advice from NHS organisations and other partners, to inform the volume of training places that need to be commissioned.

Our Integrated Medium-Term Plan (IMTP) and ETP are interdependent; each is crucial to the delivery of the other, and together they encapsulate the full scope of HEIW's activities.

### Leadership, Culture and Succession Planning

HEIW plays a key role in designing and delivering national leadership development programmes to NHS Wales, with a view to improving talent management, supporting succession planning, and creating compassionate and collaborative cultures. Our Gwella Portal serves as a central hub for leadership development and hosts range of evidenced-based culture and leadership tools, including a supervision hub to support staff at all levels.

### Workforce Strategy, Planning and Intelligence

HEIW plays a critical role in ensuring that NHS Wales undertakes robust workforce planning at both local and national levels. We provide strategic leadership and resources; we have developed national systems that provide workforce data and intelligence; and we collaborate with other NHS Wales organisations to improve the capture of the data required to generate accurate and accessible workforce intelligence and insights.

We also develop and implement national strategic workforce plans for key professions and services (including nursing, mental health, and genomics) in line with national priorities.

## Workforce development and transformation

We play a critical role in developing new workforce solutions to address service challenges and workforce pressures. We work across various health professions and as part of NHS Wales National Programmes. We design and support delivery of the annual NHS Wales Staff Survey and develop programmes that meet national needs such as retention. We design new and enhanced roles, support multi-disciplinary working, encourage staff to work at the 'top of their licence', and support skills development, continuous professional development and career pathway development. This work is key to optimising the workforce and supporting productivity.

## Attraction, careers and widening access

HEIW leads the strategic framework for health careers in Wales, designed to attract new talent into the NHS and to strengthen the reputation of Wales as a place to train and work. We support the entire career journey, from recruitment into training to ongoing professional development, and provide platforms and frameworks to support professional growth.

We are committed to reducing barriers for underrepresented groups and to ensuring that the workforce comprises a diverse range of skills and experiences.

## Professional support for the People Profession

HEIW has a statutory duty to support the development of the People profession within NHS Wales. We use resources creatively to support systematic and structured approaches to the development and professionalisation of the People Profession, and we have created frameworks, career pathways, and training to build sustainable, inclusive, and skilled People teams.

## Revalidation

HEIW manages the appraisal and revalidation process for doctors in Wales through its Revalidation Support Unit (RSU). We support General Practitioner (GP) revalidation and the quality management of appraisals, and we provide online systems like the Medical Appraisal Revalidation System (MARS). We also facilitate the collection of Continuous Professional Development, patient/colleague feedback, and support trainee revalidation by capturing significant event information and ensuring revalidation requirements are met at the point of Certificate of Completion of Training (CCT).

## 4.2 Our Structure

HEIW is a statutory body governed by a Board that provides leadership, oversight and assurance for the organisation.

The Board is made up of the Chair, the Chief Executive, six Independent Members and four Executive Directors. In addition, HEIW has two Director roles, the Director of Digital, Data and Engagement and the Director of Education Strategy and Transformation.

Further information about the Board, including its membership, roles and responsibilities, is set out in the Annual Governance Statement.

HEIW is organised across seven directorates:

| | |
|---|---|
| 1 | Digital, Data and Engagement |
| 2 | Education Strategy and Transformation |
| 3 | Nursing, Health Professionals and Quality |
| 4 | Finance, Planning and Performance |
| 5 | Workforce and Organisational |
| 6 | Medical |
| 7 | Executive Office |

## 4.3 The value we add

We add value to the health and care system in Wales by:

- Strengthening workforce sustainability through national workforce planning, education commissioning and coordinated action to improve recruitment, development and retention.
- Building the workforce pipeline for the future, accelerating workforce readiness in priority and shortage areas through targeted education and training programmes.
- Supporting workforce transformation, enabling new roles, new skills and new models of care that help services adapt to changing population needs.

- Providing trusted workforce intelligence, improving the availability and accessibility of workforce data and insight to support better decision making across NHS Wales.

- Future proofing workforce capability, developing the digital, clinical and professional skills needed for modern healthcare through digital learning, simulation, AI and innovative education models.

- Strengthening leadership and culture, embedding compassionate leadership and inclusive practice across the NHS Wales workforce.

Through our national role in workforce planning, education and development, HEIW helps ensure NHS Wales has the workforce needed to deliver safe, high-quality care for the people of Wales.

Working with partners across health, social care, education and government, we support the workforce at every stage, from attracting people into health careers, to educating and developing staff, to planning for the future.

## 5. Legal and Policy Context for NHS Wales

HEIW operates within a strong legislative and policy framework that shapes how services are planned, delivered and improved.

Wellbeing of Future Generations (Wales) Act 2015: The act provides a common and comprehensive framework to support sustainable development. Our role in education and training places us in an excellent position to contribute to its implementation. The five ways of working are already aligned with our strategic aims, objectives and deliverables within our IMTP 2025-28.

As an organisation, we do not have a direct population health responsibility. However, we collaborate across the system to scenario plan and forecast the workforce demand which informs the commissioning in the annual Education and Training Plan, pivotal to widen access to NHS careers. This significantly contributes to preventing social deprivation, poverty, long-term health, and socio-economic issues in Wales.

Work over the last year has focused on embedding the organisational Wellbeing Objectives that were agreed in March 2025. Through extensive social partnership, and alignment with our strategic aims, the organisation agreed to the following objectives:

- A flexible and adaptable workforce.
- Embedding compassionate leadership.
- A culture that supports well-being.

Realising these objectives are HEIW's contribution to the Wellbeing of Future Generations Act and covers both our externally facing work as well as our internal enabling work. Progress against the objectives will be reported in line with the Annual Wellbeing of Future Generations Act Report, produced later in 2026.

Moreover, the Future Generations Commissioner in May 2025 outlined a number of recommendations to public bodies who come under the act. HEIW has largely adopted and embedded the Commissioner's recommendations within its corporate and strategic framework, with implementation focused on integration, prevention, and workforce-led system transformation.

### Embedding the Act in core business:

The Act is now integrated into corporate governance, planning, and performance arrangements, including the co-creation of wellbeing objectives and the introduction of an Integrated Impact Assessment to systematically consider long-term impacts across all programmes, policies, and Board-level decisions.

### Capability and culture:

The Act is being operationalised through organisational processes and staff engagement, strengthening understanding and consistency of application across HEIW's corporate functions.

### Engagement and collaboration:

HEIW engages with stakeholders including NHS Wales organisations, trade unions and partners to support delivery of workforce and education plans.

### Prevention as a strategic driver:

Prevention is fully embedded as a core strategic priority within the IMTP, with a clear shift towards primary, community, and place-based care. This is being delivered through workforce transformation, education reform, and partnership with Public Health Wales to build a prevention-focused workforce and system resilience.

### Health and wellbeing impact:

HEIW is contributing to long-term improvements in population health outcomes through targeted workforce planning, addressing inequalities and supporting sustainable service models.

### Environmental responsibility:

Actions are in place to support climate awareness, sustainability, and environmental management, including regulatory compliance, education initiatives, and local environmental activities.

### Welsh language and culture:

HEIW has committed to strengthening the use of Welsh internally, supporting a more bilingual organisational culture.

### Scope and applicability:

A small number of recommendations are not applicable due to HEIW's organisational role (e.g. estate management, Public Services Board led assessments), but alignment is maintained where relevant through partnerships and system working.

Further information in relation to the Wellbeing of Future Generations (Wales) Act can be found in the Accountability report.

**Social Partnership Duty:** During 2025-26, HEIW has embedded the requirements of the Social Partnership Duty, working in active social partnership with our trade union partners to shape and agree its wellbeing objectives and strategic workforce priorities. Through established partnership structures, including the Local Partnership Forum, HEIW sought consensus and compromise on the development of wellbeing objectives.

Awareness of the Social Partnership Duty was further strengthened through national guidance engagement and the roll out of dedicated learning resources.

**10-year Workforce Strategy for Health and Social Care:** The 10-year Workforce Strategy for Health and Social Care was published on 22 October 2020 and remains extant. The Strategy's seven themes, and fundamental principles of wellbeing, inclusion and the Welsh Language, have informed our strategic approach via our IMTP, as we move closer to the 2030 ambition 'to have a motivated, engaged and valued Health and Social Care workforce with the capacity, competence and confidence to meet the needs of the people of Wales.'

**The Social Services and Wellbeing (Wales) Act 2014:** This act places a duty on local authorities and health boards to promote the wellbeing of those who need care and support, or carers who need support, and to put in place measures that support a preventative approach and reduce the need to escalate care. Our ongoing work with Social Care Wales includes delivery of the mental health workforce plan, which is reported through our performance reporting.

**A Healthier Wales:** The long-term plan for Health and Social Care embraces the prudent healthcare principles and sets out an ambitious plan for a whole system revolution and provides essential context for all NHS plans going forward. In addition to the Workforce Strategy referred to above, it challenges HEIW, along with other NHS organisations, to develop sustainable plans and actions to deliver care close to home, through strengthening primary and community services, and refocusing on prevention.

## 6. HEIW's Integrated Medium Term Plan (IMTP) 2025-2028

HEIW operates within a strong legislative and policy framework that shapes how services are planned, delivered and improved.

The Integrated Medium Term Plan (IMTP) 2025-2028 is HEIW's operational plan and sets out HEIW's vision, purpose, and functions in the context of our Workforce Strategy for Health and Social Care, the Ministerial Priorities, and the Wellbeing Goals through the delivery of our eight strategic priorities:

| | | |
|---|---|---|
| 1 | **National workforce solutions that support quality and productivity** | Addressing key workforce shortages aligned with national service priorities. |

| | | |
|---|---|---|
| 2 | Workforce transformation to support preventative and place-based healthcare | Supporting system shifts by educating, training and developing an expanded, integrated primary and community workforce and supporting the shift to preventative healthcare. |
| 3 | Excellent education and training | Developing a long term education strategy to create a more agile and adaptable workforce to support the shift to community-based care and respond to technological teams. |
| 4 | Role evolution and multi-professional working | Redesigning team models and embedding new skills and roles effectively into multi-professional teams. |
| 5 | A digital and technology ready workforce | Enhancing digital and data skills within the workforce optimise new care models. |
| 6 | Compassionate cultures and effective leadership | Continued focus on compassionate leadership, high quality management and fostering compassionate cultures. |
| 7 | Future focussed workforce plans | Providing expertise, support and workforce intelligence that improve the quality of workforce planning in NHS Wales. |
| 8 | Supporting the implementation of Welsh Government policy decisions | Influencing and implementing workforce policy initiatives. |

To support delivery of the strategic priorities, HEIW identified 33 development objectives, 21 operational delivery objectives and 8 enabling objectives. Key achievements and challenges in relation to these objectives can be found in the delivery and performance analysis.

## 7. Delivery against our Integrated Medium-Term Plan (IMTP) 2025-28

Progress against the IMTP has been monitored across the development, operational and enabling objectives, using a refreshed integrated performance framework. Despite a challenging political, financial and delivery climate, HEIW has delivered on the vast majority of its commitments as set out in the IMTP 2025-28.

## How many development objectives have been met




### Development Objectives

31 of the 35

Development Objectives achieved a Green status (assessed as completed), with the remaining 4 in Red (not completed) status. 1 objective related to registered nurse associates was closed in-year due to external dependencies not being in place.




### Delivery Objectives

23 of the 24

Delivery Objectives achieved a Green status.




### Enabling Objectives

All 7

Enabling Objectives achieved a Green status.

## 7.1 Key Achievements (Performance Overview by Strategic Priority)

| | | |
|---|---|---|
| 1 | **Strategic Priority** | National Workforce Solutions that support quality and productivity |

Workforce capability and system readiness have improved across key priority areas, including planned care, end of life care, cancer services, diagnostics and emergency care. This has been supported through national frameworks, stronger workforce intelligence, and consistent 'Once for Wales' education resources.

Key development included the All-Wales End of Life Care Competency Framework, perioperative workforce planning tools and urgent care learning initiatives engaging over 400 staff.

Together, these improvements are supporting more timely, effective delivery of care across NHS Wales.

| | | |
|---|---|---|
| 2 | **Strategic Priority** | Workforce Transformation to Support Preventative and Place-Based Healthcare |

Strengthening the workforce in primary and community settings is critical to delivering care closer to home and supporting prevention. A national data-gathering and engagement phase to strengthen Enhanced, Advanced and Consultant (EAC) roles was completed. This confirmed that EAC roles improve continuity, retention and service efficiency.

Delivery also progressed across key national workforce plans for pharmacy, primary care, dental services and prevention. HEIW enabled 156 pharmacists to undertake independent prescribing helping expand community and primary care provision. Over 60% of Year 2 actions in the Primary Care Workforce Plan were progressed. In dentistry, Year 2 actions increased training capacity by 60% for hygienists and therapists, introduced longitudinal training posts and piloted rural fellowships. Work with Public Health Wales also identified priority actions to embed prevention through a more standardised national approach.

This is strengthening workforce sustainability providing care closer to home.

| 3 | **Strategic Priority** | Excellent Education and Training |
|---|---|---|

High quality education and training is central to developing a workforce that can respond to changing service needs and future models of care. Investment in education and training has been sustained at scale, with over 85% of the annual budget committed to this area, alongside a clear shift towards transformation and innovation.

Progress includes the initial stages in the development of a long-term education strategy and establishment of a national medical education reform programme. The Endoscopy Academy of Wales delivered 16 courses to 118 NHS staff, strengthening workforce capacity and supporting diagnostic services.

Digital platforms continue to scale, with Y Ty Dysgu now reaching over 38,000 users, providing access to more than 400 learning modules and 200 live events.

This is expanding access to learning and supporting more flexible and modern approaches to education and training.

| 4 | **Strategic Priority** | Role Evolution and Multi-Professional Working |
|---|---|---|

Progress on supporting new role evolution has been limited due to legislative issues and UK reviews outside our direct control. However, we have continued to work with partners in particular WG to support these programmes of work. We have also continued to support the implementation of the enhanced, advanced and consultant framework and focused on Multi-Disciplinary Training approaches through our strategic workforce plans.

| 5 | Strategic Priority | A Digital and Technology Ready Workforce |
|---|---|---|

Building digital capability across the workforce is essential to supporting modern healthcare delivery and improving productivity. Progress against the Genomics Workforce Plan has strengthened workforce capability and established a foundation for future workforce sustainability.

The Digital Capability Framework has expanded system readiness, with over 2,500 self-assessments completed. AI capability has also increased through the introduction of the AI mentor and foundation module, supporting workforce understanding and adoption of new technologies.

These developments are supporting NHS Wales to deliver safer more efficient care by enabling staff to use digital and data tools to improve decision making and patient experience.

| 6 | Strategic Priority | Compassionate Cultures and Effective Leadership |
|---|---|---|

Strong leadership and positive workplace cultures are critical to workforce sustainability and performance. Delivery of the All-Wales Retention Programme has contributed to sustained improvements in workforce stability. Staff turnover reduced from 8.1% to 7.0% and voluntary resignations from 4.1% to 3.8% between April and December 2025.

A national approach to operational management development for Band 6 to 8A operational managers has been piloted in line with MAG recommendations laying the foundations for a future NHS Wales Operations Academy. Leadership diversity and governance capability have also been strengthened through the Stepping into Senior Leadership pilot and a national Board development programme.

This is improving workforce stability, strengthening leadership and supporting more consistent delivery of care across NHS Wales.

| 7 | Strategic Priority | Future Focussed Workforce Plans |
|---|---|---|

Effective workforce planning is essential to ensuring the NHS Wales workforce remains sustainable and responsive to future demand. The Workforce Planning Hub has improved access to tools, guidance and intelligence with training completions rising by 137% since its launch June 2025 (from 46 to 109).

Delivery of the Strategic Nursing Workforce Plan has strengthened workforce supply, capability and retention, including contributing to reduced nursing turnover from 7.2% in December 2023 to 5.8% in November 2025.

HEIW has improved workforce data by developing national workforce intelligence tools such as the Hub, making dashboards and guidance more available. This is improving the quality and consistency of workforce planning and supporting better long term decision making across NHS Wales.

| 8 | Strategic Priority | Supporting the Implementation of Welsh Government Policy Decisions |
|---|---|---|

Supporting delivery of national policy priorities is essential to ensuring workforce planning aligns with wider system direction.

The Train, Work, Live campaign has delivered strong recruitment outcomes, including 96% GP trainee fill rates, 100% core psychiatry recruitment and dental recruitment exceeding the UK average.

Progress on a number of Welsh Government policy decisions required continued joint working with Welsh Government; these areas are being progressed further and have been included as objectives in our 2026–27 remit letter.

Improved national coordination has strengthened workforce sustainability and supported delivery of NHS Wales priorities, contributing to long term value and system stability.

## 7.2 Key Issues and Risks Affecting Delivery

Delivery during 2025-26 has taken place within a complex and changing system, with a number of key risks and challenges affecting progress across HEIW's priorities.

A key challenge has been the alignment between workforce supply and employment opportunities in some professions. Financial constraints across NHS Wales, changing service models, alternative recruitment, improved retention of staff together with a workforce planning lag, have limited the availability of graduate roles in areas such as adult nursing and paramedics. In response, HEIW established the Workforce Supply Oversight Group in February 2026, bringing together partners across NHS Wales to improve alignment, support timely decision making and share best practice.

A further challenge has been the decision by Cardiff University to reduce the number of places on its nursing undergraduate course. This had the potential to reduce supply of graduate nurses into the workforce pipeline and increased pressure on other education providers in south-east Wales. In response HEIW, following consultation with Welsh government and higher education institutions, is undertaking a tender to commission additional undergraduate nursing places to protect the workforce pipeline for the region.

The environment continues to present challenges for Medical Associate Professions (MAPs) (physician and anaesthesia associates in Wales). For Physician Associates, only one post was identified for graduates in 2025 and so far, none for 2026. This has directly impacted on the commissioning of Physician Associate training places in Wales, with none commissioned for the 2026-2027 academic year. The future strategic direction for MAPs, following the introduction of regulation by the General Medical Council in 2024 and the publication of the Leng review in 2025, will be determined by the Leng Review Implementation Oversight Board.

Embedding the Clinical Associates in Applied Psychology (CAAP) role in Wales has presented challenges for HEIW, particularly around role clarity within multidisciplinary teams, limited supervisory capacity from practitioner psychologists, and variability in placement availability across Health Boards. HEIW is addressing these issues through close partnership working with Health Boards.

The introduction of the Medical Training (Prioritisation) Act 2026 created uncertainty around recruitment timelines and fill rate impact for August 2026 starters. For 2026 the act required prioritisation for both foundation and speciality training to take place at the allocation/ offer stage (rather than at application). Further work is required around the possible inclusion of further regulations as part of the Act for 2027 and beyond.

Delivery of major digital programmes has also presented challenges. Following the initial launch of CODI in March 2025, data quality and functionality issues required a temporary return to legacy systems. A revised approach, including external assurance and strengthened programme governance, supported a successful relaunch in December 2025. This has improved system stability, although recovery activity has impacted delivery timelines for future phases. Capacity constraints in digital and data functions have also affected delivery in some areas, requiring reprioritisation to focus on the most critical programmes.

In addition, delivery of some workforce transformation initiatives has been dependent on external factors, including legislative change and wider system decisions. This includes the introduction of the Registered Nursing Associate role, which remains subject to amendment of the Nursing and Midwifery Order 2001.

HEIW continues to manage these risks through established governance and risk management arrangements. Corporate risks are overseen by the Board and Executive Team, with clear ownership, mitigation and monitoring in place. A focus on partnership working, transparency and early intervention has supported a proactive approach to managing delivery risk throughout the year.

Details of risk managed through the Corporate Risk Register, are set out in the Risk Management Section of the Accountability Report.

# Delivery and Performance Analysis

## 8. Purpose of the Delivery and Performance Analysis

The Delivery and Performance Analysis provides an explanation of how we have performed during the year in respect of our 2025-28 IMTP and how this performance has been measured, monitored and improved. It brings together information to provide a clear and coherent picture of delivery against our priorities, plans and resources. delivery.

## 9. HEIW Integrated Medium Term Plan (IMTP) 2025-28 Development, Approval and Reporting

The structure of our 2025-28 IMTP has enabled us to effectively monitor not only the delivery of our IMTP, but also to ascertain its impact and benefits.

Our IMTP was developed through engagement with NHS partners, Welsh Government and staff, ensuring alignment with system priorities and delivery requirements. It was, for the first time, informed by specific Welsh Government guidance to HEIW in the form of a Remit Letter. This supplemented the NHS Planning Framework that the Cabinet Secretary issued to all NHS Wales organisations and identified the priorities that the Welsh Government asked us to focus on during 2025-26. These priorities were reflected in HEIW's own IMTP strategic priorities and their underpinning objectives, and their delivery is reflected in our reporting.

We have also been cognisant of the need for HEIW to contribute to the delivery of 'Improving Performance Together: Priority Delivery Actions for Better Health and Care 2025/26', which described the Cabinet Secretary's priorities to improve care, services and performance over the course of 2025-26, and the outcomes of the 'Ministerial Advisory Group (MAG) NHS Performance and Productivity', which was published in April 2025. Our contribution to these priorities and recommendations is evident across the breadth of our IMTP objectives and has been reflected in the IMTP's delivery.

The Board approved the IMTP 2025-2028 in March 2025 and the plan was subsequently submitted to Welsh Government.

For 2025-26, IMTP Key Performance Indicators have been used to measure progress against our priorities and those of the Remit Letter, and to identify areas where delivery may be at risk. The implementation of the IMTP has been reviewed by the Board through integrated bi monthly performance reporting; our contributions to the delivery of 'Improving Performance Together' and the MAG report recommendations have been identified and monitored; and additional area specific reporting has been issued where required. This has enabled the Board to monitor performance, risk and uncertainty.

This has enabled the Board to monitor performance, risk and uncertainty. Where performance is off track or uncertainty has arisen, it has been reflected in our risk management arrangements and considered through the Corporate Risk Register and Board Assurance Framework. Further detail on how performance is monitored and reported is set out in the performance framework section of this report.

Our IMTP does not, however, represent the full scope of our activities. A significant portion of our remit is encompassed by the Education and Training Plan. This is produced on an annual basis, linked to academic cycles and identifies our investment and recommendations for NHS Wales workforce training. Given the duration of the programmes that we commission, the ETP requires us to understand our long-term (5 year) financial commitments and is therefore interdependent with the IMTP.

## 10. Strategic Priority 1: National Workforce Solutions that Support Quality and Productivity

HEIW has supported the delivery of timely access to care and treatment with a specific focus on Planned Care and the implementation of the perioperative workforce/theatre project and the completion of the palliative and end of life care competence project: As part of the perioperative transformation workforce project, a workforce analysis was undertaken to support future workforce planning. A digitalised workforce guide, including a multi-professional career development framework spanning registered and non-registered roles, is in the final stages of development and will be launched Spring 2026. As part of the education offer, 54 staff across all bands attended a bespoke in-person leadership training course. Palliative and End of Life Care education progressed through the development of the All-Wales Competency Framework (launched October 25), aligned to 2024/25 national priorities with the framework being embedded, receiving positive feedback and national recognition.

### Completion of the Cancer Nurse Specialist Project:

The Cancer Specialist Nursing workforce review was completed, with recommendations to introduce the Aspirant Cancer Career and Education Development (ACCEND) framework. This will be due for publication in Spring 2026, establishing a national competency framework for cancer services. Progress beyond preparatory activity was paused due to delays in governance sign-off at national programme level. Ongoing engagement with NHS Performance and Improvement and the Cancer Network, internal readiness work, and planned follow up discussions are in place to mitigate delays and clarify HEIW's role in future delivery. It is envisaged the programme of work will be agreed in 2026/27 Quarter 2.

### Implementation of the priorities from the Diagnostic Workforce Plan:

Although the Diagnostics Workforce Plan concluded in March 24, of the 57 actions, 23 were completed, 7 closed and 27 were either completed in 2025/26 or became business as usual. One key action was the establishment of the virtual Pathology Academy which was launched in November 2025 on Y Ty Dysgu. To date, 82 individuals have registered and engaging with this educational offer.

### Progression of actions relating to Urgent and Emergency Care:

Programme delivery progressed with key outputs achieved. These included advancement of the Urgent Care Practitioner evaluation, establishment of baseline equality and diversity workforce data, improving awareness of frailty (including L3 Agored Diploma) and preventing deconditioning, and launch of the Optimising Hospital Patient Flow network (1,200 views since February) on y Ty Dysgu. To support winter pressures, lunchtime webinars to support timely discharge engaged over 400 participants. However, capacity, system pressures and changing priorities caused delays in activity across Welsh Emergency Care Data Set eLearning, elements of Acute Frailty and no progress to date on the Discharge Quality Statement.

### Completion of a review of the education and training requirements to support the Women's Health Plan:

Mapping of existing education and training was completed, enabling development of 10 bite-sized foundational learning modules to address the clinical priority areas of the Women's Health Plan. The centralised Women's Health Education Hub was launched on International Women's Day (8 March) housing all Women's Health related educational offer on the Y Ty Dysgu learning platform. Each module had an engagement of approximately 500 times in the first month.

### Completion of the final phase of implementation of the Healthcare Science Framework:

The Healthcare Science Career Framework was published, with career pathways developed for 94% of the 32 professions, and both promoted across all health boards and UK professional bodies. Workforce data quality improved to 90% ESR accuracy, supporting improved planning. Impact of the programme are anticipated to include a science centre exhibit reaching 60,000 visitors annually, delivery of a further 9 professional fellowships, and a 47% reduction in healthcare science workforce turnover 2024-25.

### Improvement in the workforce intelligence and insights relating to the Psychological Therapy Workforce in Wales:

The Psychological Therapies Coding Manual for Wales was completed, with a first draft produced and all 2025/26 objectives met, establishing a bilingual national framework to support data cleanse activity from 2026/27. Stakeholder liaison will continue into 2026/27 Quarter 1. The HEIW Matrics webpage was finalised, supporting service delivery, recruitment, and evidence based psychological interventions.

## 11. Strategic Priority 2: Workforce Transformation to Support Preventative and Place-Based Healthcare

### Targeted development of Enhanced, Advanced and Consultant (EAC) Practice in Primary and Community Settings:

A national data gathering and engagement phase to strengthen EAC roles was completed, confirming EAC roles improving continuity, retention and service efficiency, supported by an average of 356 community modules funded annually over the past five years. As of December 2025, the advanced practice workforce totalled 923. However, fragmented employment models and limited training capacity means system impact has varied from plan. HEIW is focusing on coordinating a national approach through data clarity, succession planning and equitable EAC workforce development across Wales.

### Implementation of the year 2 actions from the Strategic Pharmacy Workforce Plan:

Key achievements include enabling 156 pharmacists to undertake the independent prescribing (IP) qualification. 5,651 e-learning modules have been completed by pharmacy professionals, including 150 new completions of Sore Throat Test and Treat and 195 new completions of Urinary Tract Infection service modules, contributing to an increase in common ailment scheme appointments being undertaken for patients. Workforce impact is demonstrated through an increase in community and primary care from 20 to 26, and a 95% fill rate for managed sector (38 learners) for 2025-26. The Foundation Pharmacist programme achieved a 97% start rate and has formally embedded IP. There is increased engagement in credentialling through the Royal College of Pharmacy with increasing first time pass rates for post-registration pharmacy technicians by approximately 30%.

### Implementation of the year 2 actions from the Primary Care Workforce Plan and refining as new models emerge:

Over 60% of actions in the Primary Care Workforce Plan were progressed, strengthening leadership, retention, prevention and mental health capability while reducing health inequalities. Delivery of Allied Health Professional (AHP) Framework priorities engaged 426 delegates, contributing to a 40% increase in AHP registrations, a 55% rise in Clinical Leadership Training Fellow scheme applications and a 192% increase to the Advanced Clinical Leadership Programme, with no significant deviations from plan.

### Implementation of the year 2 actions from the Dental Workforce Plan:

A range of year two actions in the Dental Workforce Plan were delivered yielding increased training capacity of the dental workforce. Undergraduate hygienist and therapist training places were increased in North and South Wales by 60%. In addition, two longitudinal Dental Foundation Training (DFT)/ Dental Core Training (DCT) posts (running September 2025 - August 2027) have been implemented and expansion planned through three new longitudinal DCT posts starting in September 2026. Innovative training models included development of two fully funded West Wales Rural Dental Fellow posts in partnership with Hywel Dda University Health Board. These actions are strengthening dental training continuity, supporting smoother early careers transition, and improving retention beyond initial delivery expectations.

### Implementation of the priorities within the Allied Health Professional (AHP) Framework in support of community and neighbourhood care models:

Key achievements included national learning activity reaching 426+ delegates, a multi professional Supervision Hub engaging 2,000+ users (6,600 visits), and development of national networks and resources. The impact included a 40% increase in AHP registrations, improved wellbeing, retention and workforce capability, and strengthened supply through clearer registration pathways and expanded learning opportunities. Leadership development exceeded expectations, with 55% and 192% increases in applications to national leadership programmes, while workforce intelligence, planning workshops and 1,000+ stakeholder engagements supported more consistent, skills based workforce design across Wales.

### Working together with Public Health Wales to assess the actions to embed prevention in our workforce:

Direct engagement with over 60 individual leads, helped identify priority actions for a defined national approach to workforce health and wellbeing across NHS Wales. Shifting from fragmented local activity to prevention focused, system wide action. A national discovery phase and establishment of a joint HEIW-Public Health Wales governance group delivered a clear evidence base and case for change. The Building Blocks for Better Workplace Health aligned existing provision and addressed key drivers of sickness absence. Identified variation and inequity in access shaped the next phase, focussing on standardised national offers, data led wellbeing campaigns and strengthened leadership accountability.

## 12. Strategic Priority 3: Excellent Education and Training

### Begin the development of the Education Strategy for HEIW to transform experience and outcomes for students and trainees:

Engagement with learners, educators and stakeholders was undertaken to inform the long-term strategic development of education and training. The strategy remains on track for Board approval by the end of 2026. The positive engagement to date helped to raise awareness of the work of HEIW and expand the range of stakeholders engaged in the process.

### Reform Medical Education in line with developments across the UK (phase 1):

Governance and a strengthened evidence base was established during 2025/26. Key outputs included early pilots to improve support for locally employed doctors, research informed transition work, and recommendations to strengthen trainer capacity and consistency. A pilot project was commenced to support Locally Employed Doctors to gain access to Internal Medicine Training competencies in Hywel Dda University Health Board. A research project examining attitudes to medical school attitudes around foundation training is in progress and findings will inform Phase 2 work. A review of school structures and educational support structures was progressed and will be taken forward into Phase 2.

### Introduction of the NHS Wales accelerated Clinical Skills Training Model to support timely access to care and treatment (Endoscopy phase 1):

A Phase 2 Academy proposal was submitted to Welsh Government in December 2025 and awaiting prioritisation and funding, constraining planned delivery. It proposed a regional training network, national faculty and accelerated pathways enabling up to 45% faster progression. In 2025-26 the Academy delivered 16 Joint Advisory Group accredited courses to 118 NHS staff (average rating 6.5/7), reinstated training in North Wales, and secured funding to introduce Endoscopic Retrograde Cholangiopancreatography (ERCP) and Endoscopic Ultrasound (EUS) training at Aneurin Beaven University Health Board in 2026-27.

### Work with MEDR to continue to develop opportunities to Widening Access to Careers in Health through Apprenticeship routes and development of a plan to identify how degree apprenticeships could be developed in Wales:

HEIW progressed solutions by co designing new work based learning and apprenticeship pathways. The organisation also jointly maintained 13 all Wales health apprenticeship frameworks covering 43 qualifications, supporting transferable progression aligned to NHS service needs. The workforce report was finalised mid March 2026 and approved for Executive sign off, with submission to Welsh Government deferred to June 2026 due to the pre election period.

### Continue to implement the roll out of CODI, the new integrated digital system designed to streamline and enhance the management of Resident Doctors and Postgraduate Professionals across NHS Wales:

Codi was launched to over 10,000 users in December 2025 replacing the outdated post, placement and programme administration system. Codi improved efficiency, modernised processes, and enhanced data quality for residents, administrators and qualified professionals and delivered significant financial savings which were reinvested to support HEIW's Digital First ambitions. Codi will continue to evolve, integrating further systems and expanding benefits across NHS Wales.

### Continue the implementation of the roll out of Y Ty Dysgu:

Y Ty Dysgu has supported 38,000+ users with sustained 3-4% month on month growth, hosting 400+ learning modules and 200 live events. Key impacts included delivery of priority learning areas and completion of mandatory National Clinical Services Accreditation (NCSA) training by over 7,000 community pharmacy users. Improvements focused on usability, data integration and rollout of a reporting dashboard to strengthen insight and evidence value-for-money. A formal external evaluation by Tritech Institute will inform continuous improvement activity ahead of the new contract term.

### The Launch of the Continuous Professional Development Strategic Framework (CPD):

A draft CPD Strategic Framework for NHS Wales has continued to be developed through stakeholder engagement, supported by a HEIW working group and academic input. Refinement through a stakeholder event, consultation and a 2025-26 deep dive review shaped its definition, principles and roles. The Framework is due to be approved and launched by the end of June 2026.

## 13. Strategic Priority 4: Role Evolution and Multi-Professional Working

HEIW has worked with partners to progress and support the following areas:

### The implementation of the agreed actions for Band 4 Registered Nursing Associate (RNA) Role:

Introduction of the role in Wales is dependent on the approval of legislation enabling RNAs to practise in Wales and to register with the Nursing and Midwifery Council. Work remains in abeyance, pending confirmation of the timeline for this legislative change. Foundational activity has been completed to enable introduction of the role, for example, development of an educational specification, engagement with education institutions and consideration of education provision options.

### Providing support and resources to facilitate safe and effective integration of Medical Associate Professions (MAPs) into the workforce post regulation phase:

National engagement and supervisor support was improved, with workforce intelligence enhanced through employer toolkits, a national Physician Associates (PA) heat map and survey. Key deviation included ongoing recruitment capacity constraints which led to cancellation of the 2025 streamlining round and escalation to Welsh Government. As of April 2026, Wales has 216 PAs and 6 Anaesthetic Associates registered with the General Medical Council. Nevertheless, the overall position remains challenging as considered in the Key Issues and Risk section above.

### Providing support and resources to facilitate the safe and effective integration of the Clinical Associates in Applied Psychology (CAAP) workforce into service models:

Although CAAPs were not commissioned in the 2026-27 Education and Training Plan and the executive paper on next steps has been postponed pending the appointment of a new Associate Director, the objective achieved its intended impact. Six new CAAPs commenced training at Cardiff University and joined the NHS Wales workforce, delivering service and population health benefits despite uncertainty created by a fallow training year. See the Key Issues and Risk Section above in respect of the challenges for this role.

## 14. Strategic Priority 5: A Digital and Technology Ready Workforce

### Implementation of the priorities from the Genomics Workforce Plan:

The first year of implementation of the Genomics Strategic Workforce Plan was completed with 25 of the 44 actions progressed. The Genomics Capability Framework, first to be delivered across the UK, and supported by Genomics (wider) Workforce Education Navigator (GWEN), the next iteration of the HEIW Artificial Intelligence mentors, will be officially launched mid-May. Genomics e learning delivered 20,000 views and 1,200 completions, alongside expansion of the funded MSc offer to up to four modules per learner. The Advanced Therapies webpage was launched, with ongoing module development and national engagement activity underway.

### Development of an Artificial Intelligence (AI) Education Framework:

HEIW exceeded expectations on AI education, where over 1,000 users engaged with the AI Foundation Module and HALI (Healthcare AI Learning Interface - AI Mentor) on Y Tŷ Dysgu. Development of the Genomics AI Mentor neared completion. Healthcare People Management Association's (HPMA) award nominations positioned HEIW as a four-nations leader in AI workforce capability, with a scalable model ready to expand, funding permitting. This has established a national baseline for AI literacy, shifting learning from static training to on-demand, AI-enabled capability development, supporting faster knowledge acquisition and application in practice.

### Expansion of the Digital Capability Framework (DCF):

Uptake of the Digital Capability Framework (DCF) continued to grow, with 2,500+ self assessments. In 2025/26, HEIW launched a DCF hub on Y Tŷ Dysgu, published domain guidance, strengthened four nations collaboration, and progressed DCF aligned e-learning (Levels 1–2) alongside an external review to refresh the framework.

## 15. Strategic Priority 6: Compassionate Cultures and Effective Leadership

### Implementation of the All Wales Retention Programme:

The National Retention Programme, through sustained collective efforts across NHS Wales, continued to drive measurable system wide improvements. Between April 2025 and November 2025, sustained reductions in staff turnover and voluntary resignation rates were observed across NHS Wales. Overall staff turnover decreased from 8.1% to 7.5%, representing a 0.6% reduction (7.4% relative decrease), while voluntary resignation rates reduced from 4.1% to 3.8% (0.3 percentage point reduction; 7.9% relative decrease). Statistical process control analysis has indicated these reductions are sustained and consistent with special cause variation rather than normal fluctuation, with a clear shift in the underlying trend.

(Calculations exclude Digital Health and Care Wales and NHS Wales Shared Services Partnership. Turnover calculated by leavers during rolling 12-month period divided by average headcount over same period. Bank, honorary and locum staff excluded from calculations. Leavers defined as those leaving NHS Wales service and does not include movement between organisations.)

### Increasing leadership and management development for Operational NHS managers:

A pilot leadership programme was delivered to 27 participants with equal representation across the health boards and clinical pathways. Evaluation showed strong impact, with relevance rated at 4.35/5 and 9.6/10 participants recommending the programme. The programme was co-designed by Silvermaple and subject matter experts from across the system, resulting in a finalised education offer for the system accompanied by a full suite of resources and educational material. Findings informed approval of a scaled regional rollout, with procurement underway to reach approximately 1,200 operational managers over two years. Impact was further extended through a national Operational Managers Conference (March 2026), engaging approximately 300 colleagues and generating system-wide insights to refine the future offer.

### Implementation of a national leadership and management code of practice and competency framework in line with developments across the UK:

HEIW played a leading role in shaping a UK-wide national Framework to be adopted across all four nations. In response to delays to the national launch, HEIW developed a self assessment tool to maintain delivery momentum and reduce implementation risk. HEIW shared this solution nationally which informed the approach taken by NHS England, providing external validation and demonstrating HEIW's system leadership. This external dependency is being actively managed, and assurance will be maintained once the Framework is confirmed.

### Expansion of diversity in leadership pipelines through new programmes and resources:

In 2025-26, HEIW strengthened diverse leadership pipelines across NHS Wales, delivering the Stepping into Senior Leadership programme at scale to support minority ethnic colleagues into senior roles. Strong engagement demonstrated increased confidence and application of learning, alongside delivery of the Expert Leadership Series to approximately 300 Board level leaders, with positive feedback received on inclusive leadership.

### Establishment of a national induction programme and continuous professional development (CPD) offer for NHS Wales Board Members, building on the initial pilot:

The national induction and CPD offer for NHS Wales Board Members was established, with 50 members inducted since March 2025 and 50 participants in the Expert Leadership Series. Impact has been evidenced by high satisfaction scores (4–5/5), strengthened board capability and unitary working. The architecture for a national CPD framework has been developed on Gwella, covering core governance, leadership and compassionate leadership themes.

# 16. Strategic Priority 7: Future Focussed Workforce Plans

## Building capacity within the NHS in Wales to deliver workforce planning skills and all Wales methodologies based on best practice:

HEIW established the foundations for the Development of workforce data and insights to support NHS Wales. The Workforce Planning Hub was launched. Regular promotion has led to increased utilisation, and evaluation has led to targeted content and navigation improvements. The Hub has received an estimate of 2,000 unique weekly users and access to online training led to 137% increase in completions of the Introduction to Workforce Planning training. The most popular resource has been the toolkit, which experienced a 91% increase in views since last year. 88% would recommend the training which has been rated 4.3/5 for its value.

## Implementation of year 3 actions from the Mental Health Workforce Plan for health and social care (in partnership with Social Care Wales):

HEIW and Social Care Wales delivered the Strategic Mental Health Workforce Plan, achieving a net increase of 240 mental health staff over two years and significant reductions in turnover for key professions such as consultant psychiatrists (14.7% to 8.6%) and mental health nurses (10.5% to 6.7%). Impact included training 20 Approved Mental Health Practitioners annually, enrolling 5,000+ staff in education programmes and 1,500 trained in psychological therapies. Early improvements were reflected in the NHS Wales Staff Survey, informing next phase delivery aligned to Mental Health and Wellbeing.

## Implementation of year 1 actions from the Strategic Nursing Workforce Plan:

Year 1 of the Strategic Nursing Workforce Plan focused on transformation. Over 600 professionals completed High Performing Teams train the trainer, achieving a mean rating of 4.76/5 and reporting improvements in psychological safety, communication, kindness and empathy (with evidence linking this to 20–25% performance gains). New Motivational Interviewing interactive resources have exceeded 11,000 views on Y Ty Dysgu, supporting behaviour change and person centred care. Workforce planning was also strengthened through enhanced supply demand modelling and completion of a national Nursing Career Framework, supporting clearer progression, retention and team effectiveness.

## Conclusion of the development of the Strategic Perinatal Workforce Plan and the commencement of implementation:

The Plan was published in June 2025, with Year 1 delivery including a multi-professional workforce compendium, a perinatal workforce dashboard, an evaluation of the model of Midwifery supervision, funding 10 Clinical Supervisors of Midwives for the Professional Advocate programme. The new Neonatal Qualified in Specialty Education Standards was published. Also, a Level 7 Enhanced Maternity Care module was commissioned, a Level 3 Maternity Support Worker Diploma was developed, and working collaboratively with Swansea Bay University Health Board, a pilot Perinatal Leadership Programme was undertaken focused on compassionate leadership and team working.

## 17. Strategic Priority 8: Supporting the Implementation of Welsh Government Policy Decisions

HEIW has worked with Welsh Government to support Train, Work, Live, the National Workforce Operational Delivery Group, Bursary Policy Development, Compassionate Cultures, the Workforce Delivery Function within NHS Executive, Value and Sustainability Work Programme, and the Long-Term Workforce Plan.

HEIW is responsible for national attraction campaigns that enable NHS organisations to recruit and employ staff locally. HEIW has continued to utilise Train Work Live (TWL) as a national strategic marketing and recruitment campaign targeted at priority areas. Whilst recognising there are multiple factors affecting recruitment, the estimated contribution of these campaigns is summarised below:

### GP Training:

To address longstanding shortages in GP trainee recruitment the medical campaign has contributed to sustained high fill rates with the current GP trainee fill rate at 96%.

### Medical Core Psychiatry:

To address 33% fill rates in 2017, the targeted TWL psychiatry campaign is associated with a dramatic improvement in recruitment outcomes, with year on year increases (79% in 2018) and currently at 100%.

### Dental:

Dental Foundation Training (DFT) and Dental Core Training (DCT) campaigns have been delivered to tackle known recruitment gaps, including the 15 unfilled DFT posts in 2022. The 2024/25 DFT fill rate was 100% and a DCT fill rate at 96%, outperforming the UK average of 89%.

### Undergraduate Nursing and Allied Health Professionals:

TWL support wider actions to increase participation in undergraduate programmes such as the Get into Nursing (GiN) attraction campaign. Early evaluation demonstrates material influence on applicants with 91% of surveyed students reporting that the GiN influenced their decision to apply.

Welsh Government are currently evaluating the effectiveness of TWL and associated incentives, and we acknowledge the importance of maintaining an agile approach that delivers value for money.

# 18. HEIW's 2025/26 Operational Delivery Objectives

## 18.1 Education and Training

### 18.1.1 Education and Training Plan

The annual Education and Training Plan, developed by HEIW, sets out the education and training to be commissioned for the NHS Wales health professional workforce, alongside the supporting workforce planning evidence. Investment in education and training remains central to sustaining the workforce pipeline, ensuring services have the capacity and capability to deliver safe, high-quality, person-centred care across Wales.

HEIW developed and submitted the Annual Education and Training Plan (2026–27) to Welsh Government, following engagement with stakeholders and a strengthened, evidence-led approach.

The Plan set out a range of options to support decision making in the context of financial constraints and changing workforce dynamics. The Education and Training Plan agreed by Welsh Government in March was based on a flat cash position requiring HEIW to prioritise investment within the available allocation. In responding to this position, several key factors have been considered in prioritising commissioning decisions:

- Alignment to service demand and workforce need.
- Employment opportunities and ability to translate training into roles.
- System capacity, including placement and supervision constraints.
- Emerging risks in workforce supply and deployment.
- Maintaining commitments to existing learners and training pathways.

This approach ensures that available investment is targeted to areas of greatest impact, while recognising the constraints of the current financial position.

Further details on our planning approach can be found in the Annual Governance Statement.

### 18.1.2 Education to Employment

During 2025, there were some specific areas of mismatch between demand and supply, namely adult nursing in the Swansea area and paramedics. We recognise that the Education and Training Plan is planning 3 to 4 years ahead, and local and national drivers can change during this time. In this case, the issues were resolved through collaborative work with NHS colleagues to find innovative solutions. Steps undertaken by HEIW included the establishment of a Workforce Supply Oversight Group as outlined in the section above on key issues and risks affecting delivery (6.2).

## 18.1.3 Education and Training Commissioning and Programmes

### Implementation of agreed 2025/26 commissioning recommendations for undergraduate and postgraduate/post registration education and training

Nurse graduate employment commissioning numbers reduced in 2024/25 and 2025/26 to 2400 places per year.

In Autumn 2025, a total of 3,038 pre-registration health care professional places were commissioned across all nursing, midwifery, Allied Health Professionals and Healthcare science courses with a fill rate of 85.3%.

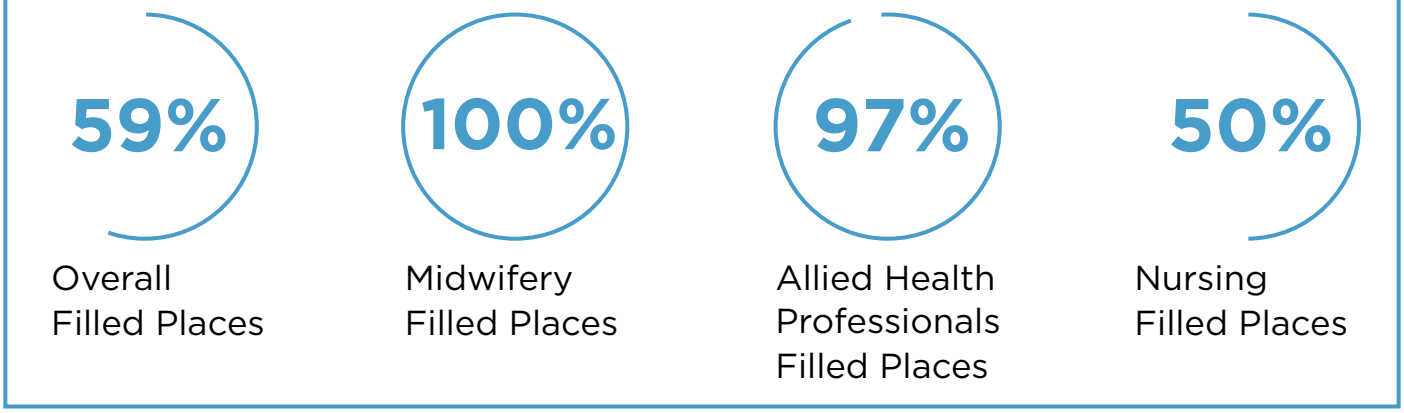
The below table reflects the fill rates for commissioned numbers for Autumn 2025 only. Another 2025/26 academic year intake took place in March 2026, with further cohorts of Adult and Mental Health Nursing, Midwifery and Physiotherapy.

| Professions | Commissioning No Autumn 2025 | Recruited Position (Fill Rate) | % |
|---|---|---|---|
| Allied Health Professional | 628 | 607 | 97% |
| Dental | 66 | 66 | 100% |
| Healthcare Science | 325 | 323 | 99% |
| Midwifery | 173 | 171 | 99% |
| Nursing | 1798 | 1372 | 76% |
| **Grand Total** | **3038** | **2572** | 84% |

The recruitment data for Autumn 2025 across allied health professional education programmes shows strong alignment with commissioned targets, where most roles achieved near or full recruitment. Healthcare Science presents a mixed picture, with notable under-recruitment in Audiology.

Spring 2026 recruitment was challenging. Of the 804 commissioned places only 59% were filled. Midwifery (100%) and Allied Health Professionals (97%) spring fill rates remain strong, with Nursing only filling 50%.

**Spring 2026 recruitment by sector**



## The review and recommissioning of education and training underpinned by contractual arrangements working with higher and further education.

Post registration education continues to play a vital role in strengthening the NHS Wales workforce. Over 2,100 health professionals accessed funded learning during the year, completing a wide range of advanced and specialist modules that directly enhance clinical capability, service quality and patient outcomes.

High demand areas such as Critical Care saw significant year on year growth in learner numbers, reflecting ongoing system need and the value placed on specialist development. 2,153 learners completed 2,638 modules across 787 courses.

Post registration education enables staff to develop advanced competencies, take on enhanced responsibilities and deliver greater impact for patients. It is also a proven retention tool, with staff reporting that being supported and funded to develop makes them feel valued and more likely to remain within their organisations. Developing our own workforce through structured progression provides a tangible opportunity to reduce reliance on agency staffing across the system.

## Supporting an infrastructure to support high quality and effective learning for Nursing and Healthcare Professional Education Educational Placements.

In 2025/26, we further expanded training opportunities and student placements. 100% of healthcare students were allocated placements aligned with HEIW placement plans. HEIW's focus on placements in primary care has expanded student capacity from an initial baseline figure of 18 placement locations to 97 placements that are either fully approved or in the process of development. 259 students have had a full General Practice Nursing placement of 6 weeks or longer.

## Supporting the Delivery of Apprenticeships with NHS Wales, working with MEDR and in line with the Government Strategy and Health Board Requirements.

HEIW hosts two all-Wales groups, (the all-Wales Apprenticeships Steering group and the all-Wales Apprenticeships Leads group), health-based apprenticeship frameworks in Wales. This in turn increases accessibility and one-voice collaboration with strategic stakeholders such as Medr, education professional regulators and health-based professional bodies.

We continue to work very closely with Social Care Wales, aligning learning and educational resources where relevant, such as the medications management education packages.

## Supporting an infrastructure to support high quality and effective learning

HEIW has implemented a comprehensive Quality Management System, reflective of the Duty of Quality. This systematic approach underpins high-quality, multi-professional education and training across all healthcare disciplines. As part of our statutory duty, HEIW remains focused on driving continuous improvements in education and training quality.

Universities play a vital role as key partners of the NHS, providing essential education and training pathways for health professionals at both undergraduate and postgraduate levels. Through robust contract management processes, HEIW ensures that the education and training commissioned and delivered in Wales meet the highest academic and vocational standards. These processes also support widening access, promoting the Welsh language, and strengthening local education routes.

As part of this quality assurance framework, HEIW conducts quality reviews with each education partner. These reviews, built on collaborative engagement, drive continuous improvement into each university's internal quality processes. This approach is embedded within HEIW's Quality Performance Framework, ensuring ongoing development in healthcare education.

The Performance Quality Framework also outlines a staged escalation process. This mechanism ensures that any performance-related issues linked to key contractual requirements with Universities are addressed efficiently.

## HEIW Quality Improvement Skills Training (QIST) Programme

The Programme provides healthcare professionals with the knowledge and skills to make changes that can continually enhance health services and improve patient experience and outcomes. In 2025-26, 471 people completed QIST training. The programme continues to receive outstanding feedback. In addition, QIST hosted the HEIW National Learning Event in February 2026, which saw an opportunity to share learning, innovation and experience in Quality Improvement from across Wales. Through its quality improvement and national engagement work, QIST continues to build leadership and improvement capability across the workforce.

## Simulation Practice

HEIW has maintained a strong national simulation education and faculty development offer across Wales, delivering sustained activity throughout 2025/26. Over the year, 1 conference, 7 Simulation Faculty Development courses and 2 webinars were delivered, engaging around 360 participants, with 91–100% rating activities as useful and relevant. The Simulation Faculty Development programme has now supported 314 practitioners since launch, strengthening the simulation workforce.

There have been reflected delays within the Immersive Technologies project, driven by complexity and resourcing gaps, resulting in a reset of scope and timelines. Mitigating actions, including strengthened leadership and governance, were implemented while wider programme delivery and impact remained strong.

## Primary and Community Care Education and Training Academies

In addition to encouraging local uptake of national programmes, each academy has developed a multi-professional offer to meet local learning needs. Over 2000 clinical, managerial, administrative and support staff across Wales have attended academy-led learning events, supporting new skills and increased confidence in patient care. Academies are supporting the delivery of General Medical Services Practice Time for Learning across health boards to over 2000 learners. 29 nurses new to general practice have been trained in essential skills to deliver effective long-term condition and preventative care through the GP Nurse Foundation Programme.

Those new to primary care are being supported through induction and essential skills training for their role. Early collaboration supporting community and interprofessional settings is improving training reach and supporting local service models aligned to population health and Community by Design.

Progress has continued across the educational offer, but delivery has been slower in some areas due to system capacity. This has been managed through prioritisation and phased delivery.

The development of the Primary Care Deanery represents an important step in strengthening a more unified and coherent approach to developing and communicating the HEIW offer to the primary and community care workforce.

## 18.1.4 Medical

Supporting an infrastructure to support high quality and effective learning for postgraduate medical training/ Managing recruitment of high-quality postgraduate education and training for resident doctors.




### Foundation Programme 2025

434 of 450 posts

At the start of the Foundation Programme 2025, 434 of 450 Foundation Year 1 posts were filled (96%), with 16 vacancies in total.




### General Practitioner (GP) Training Programmes

144 of 160 trainees

160 trainees were recruited over the two recruitment rounds (starting August 2025 and February 2026) for General Practitioner (GP) training programmes. 144 trainees are currently being supported through HEIWs Welcome to Wales programme and the Programme of Additional and Specialised Support. The programmes aim to support trainees who may encounter difficulties during their training and improve trainee outcomes.




### Secondary Care Medical Training

380 of 398 posts

A recruitment rate of 95% (380 of 398 posts advertised) was achieved, for Secondary Care Medical Training posts which commenced in August 2025. Of the 380 doctors accepting posts, 370 commenced on the programme start date, with 10 trainees requesting deferrals for statutory reasons. Some specialties (Clinical Oncology, Geriatric Medicine and Genitourinary Medicine) remain challenging to fill, and this is reflected across the UK. The highest fill rates in recent years were achieved for both Higher Psychiatry, with 13 of 14 posts filled, and Obstetrics and Gynaecology Specialty Training (ST1).

HEIW assures the high-quality of medical education and training across Wales through its Quality Management System, which provides a consistent approach to continuous improvement aligned to the Duty of Quality. By using learner and trainer feedback alongside workforce intelligence, HEIW works with NHS Wales organisations to identify variation early and continuously improve learning environments, supporting high quality training and safe patient care across Wales.

Quality management uses a proportionate, four staged approach (initial enquiry, local management, direct quality unity intervention and enhanced monitoring) to address concerns regarding training quality.

Enhanced monitoring status is applied by the General Medical Council to those sites which they consider require an additional level of support. As at 31 March 2026, departments in five areas in Wales were under enhanced monitoring. Each has clear action plans and scheduled review points in place to support improvement and confirm progress:

| | | |
|---|---|---|
| 1 | **Internal Medicine** | All sites \| Aneurin Bevan University Health Board |
| 2 | **Emergency Medicine** | Prince Charles Hospital \| Cwm Taf Morgannwg University Health Board |
| 3 | **Cardiology** | University Hospital of Wales \| Cardiff and Vale University Health Board |
| 4 | **Cardiothoracic Surgery** | University Hospital of Wales \| Cardiff and Vale University Health Board |
| 5 | **Medicine** | Glangwili Hospital \| Hywel Dda University Health Board (added Jan 2026) |

HEIW achieved strong response rates in the 2025 General Medical Council (GMC) National Training Surveys, with Wales again recording the highest completion levels in the UK. Reporting Systems scores continued to rise, reflecting HEIW's sustained work to strengthen speaking-up culture through Speaking Up Safely and HEIW Open. Many programmes also demonstrated continued excellent practice.

Where the survey highlighted concerns, workload, induction, regional teaching, and the impact of increasing less than full time (LTFT) working, HEIW has intensified collaboration with health boards. This has included supporting rota planning for LTFT trainees and reinforcing induction guidance. Burnout remains a national issue, but fewer Wales trainees reported high burnout risk compared with the 2023 peak. HEIW continues joint work with health boards to promote wellbeing and support the workforce.

Trainer survey findings mirrored UK trends. Pressures on educational time persist, though the proportion of trainers with job-planned time remains comparable nationally. HEIW continues to work with health boards to ensure trainers are supported and resourced to deliver high quality supervision and education.

HEIW's transparent use of data, proactive engagement, and continuous improvement through its Quality Management System continue to give the GMC assurance that Wales meets its responsibilities under Promoting Excellence.

### Development of Specialist and Associate Specialist doctors within the Workforce

Over recent years, we have strengthened our education and development offer and increased opportunities for engagement with SAS doctors. Our Associate Dean for SAS doctors, leads a team of SAS tutors across all health boards in Wales, who act as the primary point of contact for education and training opportunities. During 2025-2026, HEIW delivered approximately 21 educational courses with around 450 attendees. The SAS conference was successful, with 88 delegates. We support the educational component of a pilot portfolio pathway development programme in anaesthetics in South Wales.

### Supporting an infrastructure to support high quality and effective learning.

Each year, HEIW undertakes Education and Training Commissioning and Quality meetings with NHS Wales Local Education Providers (LEPs), to review the delivery of postgraduate medical education and ensure alignment with GMC standards. A core theme of the 2025 meeting cycle was the relationship between education quality, learning environments, and workforce sustainability. Improvements were reported in induction processes, expansion of feedback mechanisms, and within strengthened psychological safety for resident doctors and trainers. The meetings also showcased innovation, with LEPs engaging in simulation-based education, digital and artificial intelligence enabled approaches, and wider multiprofessional workforce developments.

## 18.1.5 Pharmacy

### Supporting an infrastructure to support high quality and effective learning for pharmacy/ Managing recruitment of high-quality postgraduate education and training of pharmacy professionals.

114 pre-registration pharmacy technicians, are currently completing an Apprenticeship level 4 training programme. Our “Access To” programmes provide the opportunity for existing employees to achieve the qualifications to meet the entry criteria for the HEIW Pre-registration Pharmacy Technician training programme. 29 learners are completing 43 qualifications, and 9 learners have progressed to the HEIW pre-registration training programme.

A 97% fill rate (114 trainees) was achieved for the 2025/26 Foundation Training Programme which commenced in July 2025. 2026/27 recruitment achieved a 100% fill rate (132 posts), the highest in the UK, with 89 trainees from Welsh Schools of Pharmacies.

In the 2025/26 academic year, approximately 2330 MPharm funded clinical placement weeks took place, compared with approximately 1776 placement weeks in 2024/25. The increase includes the first-year students at the newly opened Bangor School of Pharmacy.

The post registration foundation (PRF) programme supports new/early career pharmacist registrants across all sectors of practice. Four active cohorts are working through the programme which enables participants to achieve independent prescriber status and the Royal Pharmaceutical Society (RPS) Post-Registration Foundation (PRF) credential. Programme completion rate is 93% for the 2023/24 cohorts.

RPS credential submissions has improved from 38% for the September 2022 cohort to 58% for the September 2023 cohort. January 2024 cohort has a high number of deferrals with 32% of cohort submitting with a 46% first time submission and credential award percentage.

**RPS Credential submissions by year**




A particular focus has been placed on upskilling the existing workforce with the enhanced skills of Independent Prescribing and the skills of the community pharmacy workforce to deliver the requirements of Presgripsiwn Newydd - New Prescription. Since the launch on 26 June 2020, over 490,973 consultations have been recorded. 96.4% of patients said they would have visited another healthcare provider had the service not been available in the pharmacy.

Under the common ailments scheme (CAS), educational support has been provided to upskill the pharmacist workforce to manage sore throats and urinary tract infections. Since the launch of the management of urinary tract infections under CAS in June 2024, 41,307 consultations have taken place. Since the launch of the management of sore throats under CAS in November 2018, 185,876 consultations have taken place.

Provision of both CAS and Pharmacist Independent Prescriber Services (PIPS) in community pharmacy is underpinned by workforce accreditation to administer basic life support (BLS) in an emergency. In 2025/26, 1,279 pharmacy professionals have been assessed to provide BLS, and 173 pharmacy professionals accredited to administer influenza vaccines.

Our multi-sector foundation pharmacist training programme has been accredited by the General Pharmaceutical Council (GPhC) against the Initial Education and Training Standards for Pharmacists. We are now successfully delivering the new Initial Education and Training Programme (IETP), with the first cohort of foundation trainee pharmacists on track to complete training in summer 2026, graduating with independent prescribing annotation at the point of registration.

### 18.1.6 Dental

Supporting an infrastructure to ensure high quality and effective dental training and recruitment for dental professionals.

Dental Foundation Training (DTF) posts were recruited through a combination of national recruitment (NR) and an incentivised local recruitment initiative (DFT Welsh Enhanced Recruitment Offer (WERO), established to protect training posts in rural areas of Wales. The 2025/26 cohort achieved a 100% fill rate (57 posts filled via NT, 15 posts filled through DFT WERO). Dental Core Training (DCT) achieved a 94% fill rate in Wales.

Dental Speciality Training posts achieved an 88% fill rate, with 28 posts filled and recruitment to vacant posts taking place in 2026.

Nine out of 16 Dental Therapy Foundation training posts were filled for the September 2025 start date, representing a stronger position than elsewhere in the UK. This position was influenced by a smaller number of dental therapists graduating from Cardiff Dental School this year, the mixed economy of dentistry and working in the private sector. This reflects ongoing challenges with expanding skill mix in dentistry, particularly in the context of lucrative earnings in the private sector and NHS contracts only being available to dentists who then must either employ or sub-contract therapists.

In 2022, HEIW commenced delivery of a pre-registration Dental Nurse (DN) training programme, (accredited by the National Examining Board for Dental Nurses). The short-term arrangement was put in place due to training providers ceasing in South-East Wales and insufficient training places being available. Recruitment to a second cohort, which was due to start in September 2025, did not yield sufficient applications to make the course viable, therefore the course did not run. The Dental Strategic Workforce Plan included an action to review and scope the DN training offer and provision in Wales. The report has been completed, and the review indicates that there are sufficient training places available in Wales and apprenticeship places have increased. However, it is also clear that retention of the workforce is a greater challenge. Work has commenced on developing retention plans for the DN workforce. A mentoring programme to support newly qualified DNs in the workforce has been introduced and is being piloted.

Recruitment to undergraduate dental hygiene and dental therapist training courses has consistently been highly competitive, reflecting strong interest in these professions. Nine months after graduation, employment within Wales remains high, showing the courses' effectiveness in preparing candidates for the workforce.

### Dental Speciality Training in 2026




Dental Speciality Training posts achieved




No of posts filled and recruitment to vacant posts

**Table:** Recruitment into Dental based positions.

| Programme | Duration of course | Number of places | Number of applicants per place 2025 | Employment in Wales<br><br>9 months after Graduation (data as at 1/5/25) |
|---|---|---|---|---|
| Cardiff DIPHE Dental Hygiene | 2 years | 18 | 438 | 2022 cohort 63% |
| Cardiff BSc Dental Therapy | 3 years | 24 in 2025 | 786 | 2021 cohort 90% |
| Bangor DIPHE Dental Hygiene | 2 years | 12 | 312 | 2022 cohort 80% |
| Bangor BSc Dental Therapy for Dental Hygienists | 1 year | 12 | 40 | N/A |

HEIW continues to support the knowledge, skills and competencies of the existing dental workforce with courses, conferences and resources delivered face to face where appropriate and through the Y Ty Dysgu platform for a blended learning experience. In March 2026, there were 6,119 dental professionals in Wales registered on this learning platform. The Infection Prevention and Control e-learning module was launched in November 2025, providing dental professionals with learning to ensure patients, staff and the wider community are protected. To date, 325 professionals have engaged with the learning.

### 18.1.7 Optometry

Supporting an infrastructure to support high quality and effective postgraduate optometry and supporting the delivery of enhanced eye care services.

HEIW Optometry commissions higher qualifications that enable Optometrists in Wales to provide extended eye care services to patients so that they can manage more patients in optometry practices and prevent patients from being referred to secondary care.

**Table:** Number of qualifications commissioned from HEIW this year.

| Qualification | April 2025 - March 2026 |
|---|---|
| Independent Prescribing | 20 |
| Prof Cert Medical Retina | 30 |
| High Cert Medical Retina | 8 |
| Prof Cert Low Vision | 21 |

| | |
|---|---|
| Prof Cert Glaucoma | 13 |
| High Cert Glaucoma | 14 |
| **Total** | **106** |

Commissioning by HEIW for the higher qualifications has increased the number of practices able to perform extended eye care services in line with the Welsh General Ophthalmic Services (WGOS) Optometry Contract. A 100% fill rate has been achieved for all courses commissioned this year.

HEIW introduced a mixed model placement providing Independent Prescribing (IP) clinical sessions across a combination of HEIW advanced training practices and Hospital Eye Service settings. Through this approach, HEIW has centrally coordinated IP placements for 62 optometrists, funding 389 Advanced Training Practice (ATP) sessions, eliminating waiting times, and clearing the trainee backlog. Trainee feedback averages 91% satisfaction across our 22 ATPs in Wales with supervisor training ranked at 100%.

HEIW provide continuing professional development both as part of the WGOS contract and for further development. HEIW have delivered contract mandatory training through our online platform, Y Ty Dysgu to 3,254 users; 891 Optometrists, 176 dvispensing opticians, 56 Contact Lens Opticians, 12,033 practice staff. HEIW have delivered 38 evening sessions in 12 months, attended by 69 newly qualified Independent Prescribers. Forums boosted confidence from 25% to 100%, highlighting its transformative effect.

**Y Ty Dysgu Optometry sector based training breakdown**



**891**
Optometrists

**176**
Dispensing Optometrists

**56**
Contact Lens Opticians

### 18.1.8 Professional Support Unit

Delivery of effective additional support for resident doctors, pharmacists and dentists who need access to the Professional Support Unit (PSU).

The PSU delivers a comprehensive programme of support for resident doctors, dentists and trainee pharmacists across Wales. Its core focus remains on maximising progression, promoting wellbeing, and strengthening the wider training environment through early intervention, tailored support, and stakeholder development. During 2025/26, demand for PSU services remained consistently high:

- 544 new referrals were received.
- An average monthly active caseload of over 590 residents/trainees was managed.

- Dyslexia and neurodiversity referrals continued throughout the year (34 dyslexia referrals), highlighting the PSU's critical role in supporting inclusive training and addressing differential attainment.
- An expanded learning and development offer was delivered (68 workshops delivered to nearly 2,700 attendees). These sessions supported both residents/ trainees and educators, covering areas such as wellbeing, communication, exam preparation, and supporting neurodivergent learners.
- Exam support outcomes indicate that 69% of residents passed following targeted intervention, with others demonstrating improved performance and continuing engagement toward future success.
- Over 400 healthcare professionals were supported through the Wales Asylum Seeking and Refugee Doctors initiative, with further individuals successfully entering the NHS workforce.

### 8.1.9 Revalidation Support Unit

Effective support for revalidation, appraisal and continuous professional development through the Revalidation Support Unit (RSU).

HEIW supports and improves professional standards through revalidation and appraisal in line with the requirements of the regulators. The RSU continues to provide and manage the GP appraisal process for approximately 2,800 GPs in Wales. In 2025/26, the RSU completed 2,616 GP appraisals.

**RSU Proccessed GP Appraisals**



**2,616** RSU completed GP appraaisals

**184** RSU uncompleted GP appraisals

Total GPs **2,800**

Over the course of the year, the RSU has worked closely with the Chief Medical Officer (CMO), Medical Directors, General Medical Council (GMC) and appraisal leads across the four nations, to ensure that the future model of medical appraisal is robust and remains wellbeing focussed. As part of an action plan for Wales, the CMO as Chair of the Wales Revalidation Oversight Group (WROG) tasked the RSU with undertaking a programme of Revalidation Quality Assurance Review Visits to all Designated Bodies (DBs) in Wales. An evaluation report detailing best practice, areas of challenge and recommendations for improvement will be drafted once all visits are complete.

## 18.1.10 Regulators

HEIW works with professional regulators in the development of our education and training programmes.

### The General Medical Council (GMC)

The General Medical Council (GMC) serves as the independent regulator ensuring high standards and quality assurance in medical education and practice. HEIW functions as an 'Education Organiser,' aligning its postgraduate medical training programmes with GMC standards to ensure high-quality education and training in Wales. HEIW also provides, via the Quality Management System (QMS), a quality management function to monitor adherence to standards providing the GMC with assurance. In the context of medical workforce regulation in Wales, the GMC sets the overarching standards for medical practice, including revalidation. HEIW plays a key role in supporting doctors through the revalidation process by providing governance, appraisal frameworks, and professional development opportunities to ensure compliance with GMC requirements.

### The General Pharmaceutical Council (GPhC)

The General Pharmaceutical Council (GPhC) is the independent regulator responsible for setting the standards for the initial education and training (IET) of pharmacy professionals. In 2021, the GPhC introduced revised IET standards for pharmacists, structured around a new set of learning outcomes. These changes have strengthened and evolved our relationship with the GPhC, particularly in relation to the quality management and assurance of the foundation training year. In parallel, the GPhC is progressing wider reforms across the pharmacy education landscape. This includes consultation on the initial education and training of pharmacy technicians, as well as a forthcoming consultation on the international route to registration.



### The General Dental Council (GDC)

The General Dental Council (GDC) is the UK-wide statutory regulator of members of the dental team. As regulator the GDC assesses, approves, monitors and inspects education providers for programmes leading to registration with the GDC. HEIW commissions undergraduate dental hygiene and dental therapy training in Wales. All these programmes meet the requirements set out by the GDC.



The GDC is also responsible for the quality assurance of dental specialty training and approving all curricula for education and training in specialty dentistry. Revised curricula have been developed by the Specialty Advisory Committees (SACs) for each specialty and approved by the GDC for use from September 2024. These are in use for the postgraduate dental specialty training programmes delivered in Wales.

## The General Optical Council (GOC)

The General Optical Council (GOC) is the regulator for Optometrists (including student Optometrists), dispensing opticians and optical businesses. HEIW commission postgraduate qualifications for Optometrists. The GOC approve the Higher Education Institutions for the postgraduate qualifications. HEIW provides a mechanism for postgraduate placements in Optometry practices in Wales as part of the independent prescribing qualification and HEIW has a quality planning role. We work with the GOC to ensure postgraduate qualification placements in Optometry practices are suitable. The quality assurance role for the placements sits with the HEIs as part of the qualification.



## 18.2 Leadership Development and Compassionate Cultures

HEIW continued to deliver key leadership programmes and resources that support the creation of compassionate cultures in NHS Wales. ShiftWorks supported leadership development, with 378 active licences and ongoing engagement, providing a cost effective, consistent learning resource. The Advanced Clinical Leadership Programme engaged approximately 50 participants with 100% retention, strengthening clinical leadership capability. The Wales Clinical Leadership Fellowship improved governance and project quality through a revised operating model, while targeted compassionate leadership programmes for resident doctors and Primary Care leaders strengthened teamworking, wellbeing and safer care.

### Compassionate leadership has continued to be embedded across NHS Wales.



Betsi Cadwaladr University Health Board

HEIW enabled Betsi Cadwaladr University Health Board to implement an evidence based compassionate leadership approach at scale, moving from ad hoc activity to a planned, measurable model and creating national assets to support sustained culture change across NHS Wales.

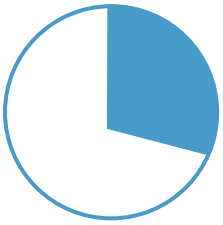
There are 9,991 register users on Gwella, with 37,000 page views per month. National impact was further strengthened through the Institute of Health and Social Care Management Wales Hub, expanding access to leadership development, with relaunch planned to align to national leadership standards. Strengthened assurance and access to leading practice through active involvement in international compassionate leadership networks such as the Swartz Centre USA.

HEIW delivered key leadership programmes and resources to support the creation of compassionate cultures in NHS Wales. In 2025/26 the General Management Graduate Programme supported 44 trainees. Cohort 2 completed in August 2025 with 100% of individuals retained in NHS Wales. Approval was secured to move from an MSc to an Institute of Leadership and Management Level 7 Extended Diploma, shifting to more applied, work based learning and faster organisational return. A redesigned national recruitment model is in development.

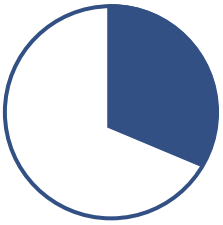
In relation to senior leadership succession planning and talent management, Executive Development Centres supported 10 Executive Directors, strengthening reflective appraisal and readiness for Chief Executive roles. The Aspiring Executive Director Talent Pool engaged 35 participants, with ~33% progressing into executive roles, evidencing a strengthened executive pipeline. However, revision of the Aspiring Chief Executive 2026-27 offer prompted a shift to a scoping phase to reassess future leadership capacity needs, priorities and options developed to inform proposals for the Culture Leadership Succession Board and delivery in 2026-27.

The 2025 NHS Wales Staff Survey was delivered as planned, achieving a 30% response rate, representing an 8.12% increase on 2024, and 9,836 additional responses. Increased participation has strengthened the representativeness and credibility of national and local staff experience data, providing a more robust evidence base to support targeted action on staff experience, engagement and retention.

**NHS Staff Survey Results**



**21.88%**
2024 Survey Response



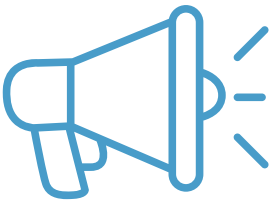
**30%**
2025 Survey Response

HEIW has continued to implement the Welsh Language Standards. HEIW operates under the Welsh Language Act 1993, through an approved Welsh Language Scheme, authorised by the Welsh Language Commissioner. Preparatory work was undertaken for transition to the Welsh Language Standards under the Welsh Language (Wales) Measure 2011. HEIW has continued this year to prioritise delivery against the Scheme, focusing on access to Welsh language services and strengthening staff Welsh language skills and confidence. During 2025–26, translation volumes increased to 5.3 million words, and interpretation was provided for 98 events, up from 45 in 2024–25. Recording of Welsh language skills has improved, with 89% of core staff now completing language information and 12% identifying as proficient Welsh speakers.

**Welsh Language Translation Delivery and Support**

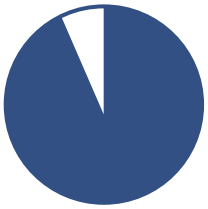


**5.3 Million Words**
2025–26, translated volumes

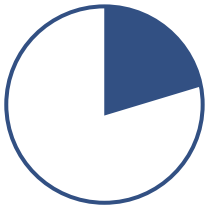


**98 Events**
Supported translation wise (2025 - 2026)

**45 Events**
Supported translation wise (2024 - 2025)



**89%**
Core staff now completing language information



**12%**
Identify as proficient Welsh speakers

### More Than Just Words (MTJW)

More Than Just Words (MTJW), the Welsh Government initiative to improve the provision of NHS services through the Welsh language, continues to be a key focus for HEIW. HEIW established and launched a national More Than Just Words (MTJW) network, engaging 77 delegates at launch. Feedback informed targeted follow up seminars and the first national MTJW event, co led with Welsh Government and attended by 100+ delegates. HEIW is now established as a key delivery partner for the Welsh Government Welsh Language Policy team, strengthening collaboration, particularly around developing a bespoke 'Leading in a Bilingual Wales' Programme for NHS Wales.

## 18.3 Workforce Strategy, Planning and Intelligence

HEIW achieved its objective to support NHS Wales with workforce intelligence and deliver digital systems that support the efficient and effective delivery of working, education and training functions (including Workforce Race Equality Standards (WRES) and Workforce Equality Standard (WES) requirements).

Standards (WRES) and Workforce Equality Standard (WES) requirements). The workforce intelligence and digital system services at HEIW encompass a wide range of internal and national analytical functions. This has played a central role in strengthening workforce intelligence across NHS Wales. HEIW delivered key workforce intelligence and digital infrastructure improvements, strengthening system-wide planning, decision-making and service resilience.

### National Data and Analytics Portal

HEIW established a national Data and Analytics Portal (HEIW Data and Analytics Portal - Home) consolidating interactive workforce dashboards, education pipeline intelligence and planning insights into a single, accessible platform.

### Education and Training Plan Commissioning Dashboard

The Education and Training Plan Commissioning Dashboard was implemented, and a new workforce supply pipeline dashboard is planned for launching in May 2026. These will, act as key enablers for Workforce Supply Oversight Group decision-making, supporting streamlining, recruitment alignment and workforce supply decisions across NHS Wales and Welsh Government. Digital service continuity was maintained during the Codi pause, enabling successful system launch, alongside efficiency gains through a single point of contact model and network upgrades.

HEIW also led the national Infrastructure Adoption Model (INFRAAM) assessment, with NHS Wales achieving Stage 4 (of 7), demonstrating strong digital maturity relative to peers and the global average. Overall, this has strengthened national workforce intelligence and digital capability to support sustainable workforce planning and service transformation.

## 18.4 Attraction, Careers and Widening Access

Following its launch in April 2024, HEIW has continued to implement the Strategic Framework for NHS Wales Careers. Active engagement with a wide range of stakeholders has resulted in the delivery of an "Advise the Advisor" programme. This has informed all Welsh Department of Work and Pensions offices on careers within NHS Wales as part of their "Focus Fortnight", in person careers fayres and mock interviews at schools and colleges across Wales. HEIW has also hosted specific profession based career webinars, developed Post 16 years resources for educators, parents, students and advisors. Attendance at high profile Welsh language events such as the Urdd and National Eisteddfods and Royal Welsh has positioned NHS Wales Careers as the go to primary and trustworthy source for all careers information for NHS Wales Careers. HEIW has continued to implement NHS attraction campaigns and information in relation to our Train, Work, Live programme can be found in strategic priority 8.

## 18.5 Professional Support for Workforce and Organisational Development

Through a "Once for Wales" approach, the development of a programme to support the People Profession in Wales is strengthening the capability, consistency and strategic influence of the people profession, directly supporting workforce sustainability, compassionate leadership and improved workforce experience.

A key milestone was the Chartered Institute of Personnel and Development (CIPD) endorsement and national launch of the People Profession Map, establishing for the first time, a consistent, system-wide framework for career development and workforce planning. National delivery improved strategic confidence, collaboration and wellbeing, while investment in digital, AI and workforce planning tools strengthened the people profession's contribution to workforce sustainability, leadership and organisational performance.

# 19. HEIW's 2025/26 Enabling Objectives

Our eight enabling objectives, detailed below, strengthen the impact of our work by ensuring that the essential functions within HEIW provide the foundations to deliver high quality, customer focused services across NHS Wales.

## 19.1 Enabling Objective 1:

| 1 | Enabling Objective | HEIW Internal Workforce Plan 2026-2031 |
|---|---|---|
| HEIW developed its 2026-2031 Internal Workforce Plan, which was approved in March 2026. The plan aims to ensure the organisation remains resilient, skilled and sustainable in the face of increasing national expectations and financial constraint. The Plan is evidence-led and recognises that HEIW's future challenge is not workforce growth, but ensuring the right skills, leadership, succession and flexibility within a stable establishment. The plan will be implemented during 2026/27. | | |

## 19.2 Enabling Objective 2:

| 2 | Enabling Objective | HEIW Ways of Working (Operating Model) |
|---|---|---|

HEIW's remit has expanded and our contribution to NHS Wales continues to grow in scope, ambition and impact.

The review of our Operating Model has made good progress, with discovery completed and a clear case for change established as HEIW's work has continued to evolve in scale and complexity. Emerging themes have informed a prototype future model focused on stronger cross-functional working, clearer decision-making, end-to-end delivery of priorities, and digital and data as core enablers. In addition is has also highlighted improvements to ways of working such as three horizons planning and hybrid working. The programme is now moving into design and testing through co-design. A phased plan will support delivery of both structural and behavioural change through 2026/27, embedding a more effective and future-ready organisation.

## 19.3 Enabling Objective 3:

| 3 | Enabling Objective | Strategic Equality Plan |
|---|---|---|

Our Strategic Equality Plan (SEP) sets out our commitment and direction of travel over four years in the way we attract, recruit, retain and develop our HEIW Workforce. Our SEP includes objectives related to our wider functions and system impact, including increasing diversity in senior leadership pools and addressing differential attainment in education and training programmes. The SEP is a core enabler of HEIW's Integrated Medium-Term Plans (IMTP), impacting how services are designed and delivered to be inclusive, equitable, safe and diverse. Governance and reporting mechanisms are in place to monitor progress and meet internal and external reporting requirements, with oversight provided through the HEIW Equality, Diversity and Inclusion (EDI) Steering Group, chaired by HEIW's Chief Executive and Director of Workforce and Organisational Development.

## 19.4 Enabling Objective 4:

| 4 | Enabling Objective | Speaking Up Safely |
|---|---|---|

We have continued to implement our Speaking Up Safely (SUS) Plan. Key developments included the launch of the HEIW SUS Hub, revised processes and the implementation of the 'Work in Confidence' platform, addressing key barriers such as anonymity, clarity and timeliness. These improvements also enabled better insight into staff experience through enhanced data and triangulation with wider workforce intelligence. The internal audit report into HEIW's arrangements for implementing our SUS Plan provided an assessment of Substantial assurance.

HEIW strengthened its approach to learner and trainee voice through an ongoing programme of work designed to enhance the consistency, visibility and impact of student and trainee feedback. This included organisation-wide scoping, a strengthened focus on equity and anti-racist practice, and engagement with external partners such as NHS Education Scotland to inform future development.

The Wales Health Student Forum (WHSF) is an innovative group of over 250 pre-registration healthcare students from across all of HEIW's commissioned healthcare courses. The forum is divided into different groups of special interest to students and met on a quarterly basis to discuss Global Majority and Welsh Language perspectives, challenges and opportunities.

As part of the pre-registration commissioning, the student voice was heard through programme-specific focus group sessions between January and April for each commissioned Higher Education Institution (HEI) across their different programmes. This enabled the pre-registration team to triangulate this information, alongside data from Practice Educator sessions and Annual Return data from HEIs discussed at contract meetings with each HEI to ensure regular conversation regarding programme quality.

HEIW's bespoke Complaints Handling Policy reflects our role as the national body for workforce planning, education, training and leadership. It sets out how we respond to concerns and complaints, with a focus on the swift resolution of issues where possible. During 2025/26, we received 25 complaints, of which, 21 were stage two complaints. The complaints received covered a variety of issues and three themes were identified:

- Six complaints received were in relation to graduate role opportunities including physician associates, genetic counsellors and nursing.
- Five complaints received were in relation to funding allocations and processes including expenses and traveling funds.
- Three complaints received were in relation to the implementation of CODI.



Several valuable lessons emerged from the complaints received during the year. Clear, timely and consistent communication remains essential, particularly where trainees and students rely on accurate information about employment opportunities, placement, funding, sponsorship arrangements and policy requirements.

Across multiple cases, a need for better visibility and transparency around training opportunities was highlighted. Several complaints emphasised the need for stronger pastoral support, whether through mediation, clearer accessibility pathways, or improved guidance for learners.

During 2025/26, processes were strengthened in relation to tracking the implementation of actions and lessons identified from complaints.




In relation to Counter Fraud, the 2025/26 Counter Fraud Annual Workplan received approval from the Audit and Assurance Committee on 10 April 2025. The plan outlined how the NHS Counter Fraud requirements including bribery and corruption would be fulfilled throughout the year. Updates on delivering against the work plan were provided to the Audit and Assurance Committee during 2025/26.

A separate report was received by the closed session of Audit and Assurance Committee in respect of 'The Failure to Prevent Fraud Offence under the Economic Crime and Corporate Transparency Act 2023 (ECCTA)'. This set out the background and recommendations to address the requirements of the Act.

HEIW has a Counter Fraud Policy and Response Plan that was approved by the Audit and Assurance Committee in October 2023 and was subsequently updated in February 2026 in response to the ECCTA. The plan sets out the roles and responsibilities of all staff in relation to counter fraud and the relevant laws and regulations, including the Fraud Act 2006 and the Bribery Act 2010.

During the 2025/26 financial year, 138 HEIW staff received Counter Fraud training to publicise and support understanding of the policy throughout the organisation. Presentations will continue in 2026/27 and on a rolling basis as required.

## 19.5 Enabling Objective 5:

| 5 | **Enabling Objective** | Communications and Engagement Plan |
|---|---|---|

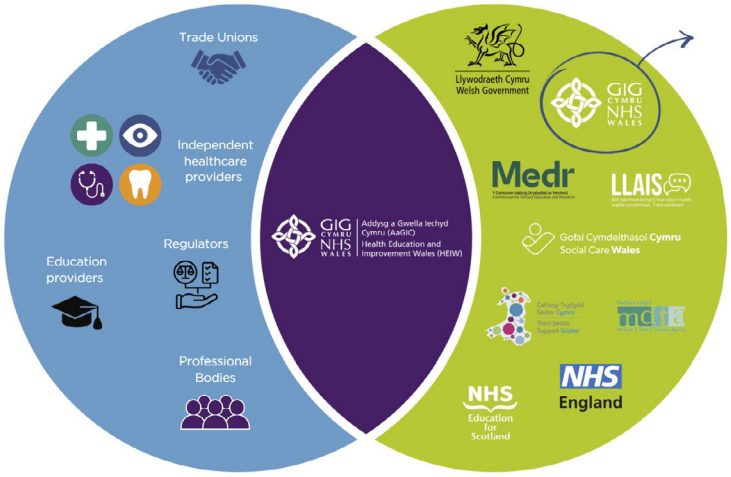
In March 2025, the Board approved the HEIW Communications and Engagement Strategic Framework. This established an organisation wide approach to embedding communication and engagement more consistently across HEIW's work, making it a shared responsibility across the organisation.

The Communications and Engagement Plan has progressed well, with strong foundations in place including improved governance, stakeholder mapping and use of tools such as Tractivity to support more coordinated and insight-led engagement. Early outcomes show improved reach, consistency and visibility of HEIW's role across the system.

The next phase will focus on embedding these approaches and strengthening the organisational narrative to support a more consistent and strategically aligned approach to communication and engagement.

HEIW's broader approach to stakeholder and partner engagement is set out in more detail in the Stakeholder and Partner section of the Annual Governance Statement.

## HEIW and our partners




**NHS Wales partners**

Aneurin Bevan University Health Board
Betsi Cadwaladr University Health Board
Cardiff and Vale University Health Board
Cwm Taf Morgannwg University Health Board
Hywel Dda University Health Board
Powys Teaching Health Board
Swansea Bay University Health Board

Public Health Wales NHS Trust
Velindre University NHS Trust
Welsh Ambulance Services University NHS Trust

Digital Health and Care Wales
NHS Wales Shared Services Partnership

NHS Wales Performance and Improvement

## 19.6 Enabling Objective 6:

| 6 | Enabling Objective | Data and Digital Strategy 2023-2028 |
|---|---|---|

In 2025/26, delivery of the Digital and Data Strategy has focused on progressing the strategy's five missions. Delivery has included modernising business processes through Codi and Microsoft 365, expanding digital and Artificial Intelligence (AI) capability through the Digital Capability Framework, Foundations in AI learning module and launch of Healthcare AI Learning Interface (HALI), and growing the national reach and usability of Y Tŷ Dysgu. Workforce intelligence was strengthened through new dashboards and modelling, alongside improvements in cyber security and information governance resilience. Growing demand for digital and data support amid capacity challenges highlighted the need for a digital first approach. Supported by the HEIW workforce plan, the capability shift required across the organisation will be taken forward as part of a two-year action plan to grow HEIW's internal digital and data maturity.

## 19.7 Enabling Objective 7:

| 7 | Enabling Objective | Quality Plan (Duty of Quality and Quality Management system) |
|---|---|---|

HEIW has undertaken a comprehensive range of activity to embed the Duty of Quality principles across the organisation. Key achievements included Internal Audit providing substantial assurance on arrangements to embed the Duty of Quality, with further work underway to increase uptake of awareness training. HEIW continues to work closely with NHS Performance and Improvement and contributes to national quality programmes.

HEIW participated in the Quality Management System (QMS) Learning and Delivery Network and begun implementing a QMS within education and training commissioning and delivery. Progress continues in relation to the National Quality Outcomes Framework (QOF), which will form a key element of future Annual Quality Reports.

Further information in relation to quality can be found within Strategic Priorities 1, 2, 3, 4, 7, the Education and Training Plan Operational Delivery Objective and the learner and trainee voice sections of this report.

### 19.8 Enabling Objective 8:

| 8 | Enabling Objective | Performance Framework |
|---|---|---|

In 2025, the Performance Framework was refreshed to strengthen assurance, improve information flow and increase focus on impact and benefits. An Assure, Advise and Alert mechanism was introduced to support Board focus on under performance and Welsh Government priorities, alongside a shift to a monthly performance cycle aligned with NHS Wales practice. Given the specific nature of our role as a strategic organisation and the demands placed on us by the UK regulators, we largely measure and monitor a different set of performance indicators to the rest of NHS Wales. Our reporting cycle is also different, with a greater focus on academic cycles, annual and quarterly timescales rather than the daily, weekly, and monthly beat of other NHS organisations.

## 20. The HEIW Workforce

Our workforce consists of both core staff (for whom HEIW is the main employer) and sessional staff (who work three or fewer sessions for HEIW and work elsewhere within the NHS). HEIW's core workforce provides the permanent organisational capacity required to deliver our statutory functions and national remit. Core staff are employed across a range of NHS-recognised professional groups. In addition to outward-facing delivery teams, this workforce includes finance, people and organisational development, digital, governance, communications and corporate services). Collectively, they contribute to the smooth operational and strategic development of HEIW.

The sessional workforce is a key component of HEIW's education and training model. These professionals are predominately medical and dental staff who work in health boards, trusts or general or dental practice. Their contributions to HEIW are invaluable, particularly in education and training roles such as heads of training schools for resident doctors or as GP appraisers. This sessional model provides essential flexibility, strengthening the relevance, quality and impact of educational provision.

The headcount for directly employed staff, those on permanent and fixed term contracts was 671 (499.34 Full Time Equivalent (FTE)), on 31 March 2026. This figure has remained stable through the year and reflects a core headcount of 538 (475.9 FTE) and Sessional headcount 133 (23.44 FTE).

**Staff on fixed term contracts and in full time employment**




**671**
Permanent and fixed term contracts

Full Time Equivalent (31 March 2026)

**538**
Core headcount

**475**
Full Time Equivalent (FTE)

**133**
Seasonal headcount

When HEIW was established in 2018, several staff members transitioned from Cardiff University under TUPE arrangements, retaining their original terms and conditions of service. This number has continued to reduce as individuals have pursued new opportunities within HEIW or moved on to external roles. For our core workforce is 7.5% of the total core staff.

Beyond our directly employed staff, we also welcome a number of secondees each year from across within NHS Wales. These individuals bring valuable expertise to HEIW, contributing to specific projects before returning to their original roles, enriched by the knowledge and skill acquired during their time with us.

For the period 1 April 2025 to 31 March 2026, the turnover rate was 13.77%, a small increase from 12.59% in the previous year. This figure is slightly inflated due to the inclusion of interns and graduate trainees who are employed for fixed periods. During the year there were 94 new starters and 94 leavers.

We take a targeted and well-governed approach to recruitment, to ensure each role is essential, clearly defined and attracts the right skills and capability for HEIW. Alongside standard NHS recruitment platforms (including NHS Jobs and Trac Jobs), we have broadened our approach through Diversity Jobsite

and Ffair Jobs Compact initiative to strengthen our reach into the wider community and support access to a more diverse candidate pool including from public and private sectors. To support inclusive recruitment, we offer guaranteed interviews to eligible applicants and members of the armed forces community who meet the minimum role requirements and provide reasonable adjustments to ensure the interview process is accessible and supportive for disabled candidates.

Our recruitment and selection activity is underpinned by a values-based recruitment and selection policy, supported by toolkits and training resources for hiring managers. This includes specialist training covering effective appointment decisions, the candidate experience and the management of unconscious bias. Training is evaluated to understand application in practice and sustained impact.

Feedback indicates that the training supports best practice approaches and strengthens confidence in making appointments aligned to role requirements. Newly appointed staff have also reported a positive candidate experience. A wider survey to unsuccessful candidates is being reviewed to provide a more comprehensive view of the end-to-end recruitment experience, with findings expected in 2026/27.

We regularly review our recruitment and selection processes to ensure they remain efficient, consistent and aligned to our organisation's values. We participate in the NHS Wales Recruitment Modernisation Programme, working closely with Recruitment Services within NHS Wales Shared Services Partnership to support continuous improvement and adoption of emerging best practice. To strengthen governance and assurance, we routinely monitor recruitment activity and outcomes, including equality and diversity data, to identify and address any unintended barriers. Our agency spend (NHS Wales Performance Framework 2025/26 Delivery Measure 38) for 2025/26 was 1.1% (as a percentage of the total pay bill).

In accordance with our Remit Letter, we are currently undertaking a baseline review during Quarter 1 of 2026/27, including a requirement to identify any additional savings. In parallel with this, Welsh Government required us to implement a recruitment freeze in line with the completion of the baseline review.

HEIW's rolling 12-month sickness rate was 2.94% remaining stable and below the NHS Wales target of 4.1% (NHS Wales Performance Framework 2025/26 Delivery Measure 36). The NHS Wales rolling 12-month sickness rate was 6.3% (February 2025 – January 2026). Most HEIW sickness absence relates to long term cases, with anxiety and stress being the most common reason, accounting for around half of all sickness absence.

**Sickness Rate**

| HEIW's rolling 12-month sickness rate | NHS Wales rolling 12-month sickness rate | NHS Wales target |
|---|---|---|
| 2.94% | 6.3% | 4.1% |

Welsh Government sets a minimum compliance target of 85% for the 10 UK Core Skills Framework for NHS Staff (mandatory and statutory training). At the end of March 2026, HEIW's compliance rate for core staff was 90.10%, exceeding the national target. Sessional staff are not included in this figure, as their primary employment is elsewhere within the NHS. These staff can provide confirmation of having undertaken the relevant training with their primary employer and have their competency confirmed within ESR. The compliance rate for sessional staff was 67.68%. The combined compliance rate for HEIW was 86.25%.

**Compliance Rate for 10 UK Core Skills**

| Welsh Government minimum compliance target | HEIW's compliance rate for core staff |
|---|---|
| 85% | 90.10% |

| Compliance rate for sessional staff | Combined compliance rate for HEIW |
|---|---|
| 67.68% | 86.25% |

At the end of March 2026, the HEIW performance appraisal (PADR) compliance rate for core staff was 77.13% (NHS Wales Performance Framework 2025/26 Delivery Measure 39). Sessional staff are not included in this figure and are required to undertake a lighter version of appraisal with HEIW, to review performance and objectives and to identify relevant training needs. At the end of March 2026, the compliance rate for these staff was 87.97%. The combined compliance rate for HEIW was 79.48% (Welsh Government target 85%).

**Performance appraisal (PADR) compliance rate**

| HEIW performance appraisal (PADR) compliance rate for core staff sickness rate | Compliance rate for staff (End of March 2026) | HEIW Combined compliance rate | Welsh Government target |
|---|---|---|---|
| 77.13% | 87.97% | 79.48% | 85% |

We remain broadly representative of the overall NHS workforce in terms of the gender profile of the organisation, with 71% of the workforce being female, and this includes our senior leaders as represented by the HEIW Board. Across Wales, 6.2% of the population identify themselves as from a minority ethnic background, within our local areas of Cardiff and Rhondda Cynon Taff this is 16% and 4% respectively. From those who have declared their ethnicity, those from a minority ethnic background make up 5.08% of our total workforce. Although this remains less than the overall NHS Wales profile of 10.6%, our work on the delivery of the workforce race equality standard (WRES) focuses on us identifying and understanding any barriers within our local recruitment practices and encouraging new and existing staff to update their ethnicity to enable us to have a better understanding of the diversity of our workforce.

**Gender Profile**

| Male | Female |
|---|---|
| 29% | 71% |

**Percentage of minority groups in Wales and the Healthcare workforces**




Wales National Average - Minority Ethnic background




HEIW Workforce - Minority Ethnic background




NHS Wales Workforce - Minority Ethnic background

We are committed to eliminating discrimination and promoting diversity and inclusion through equality of opportunity and through everything that we do. As such, we are fully committed to meeting duties set out in the Public Sector Equality Duties Act (2011), the Anti-Racist Wales Action Plan 2022, the LGBTQ+ Action Plan 2023 and the Workforce Race Equality Standard (WRES).

As a workforce-focused organisation, our aspiration continues to be a great place to work. Our aim to be an exemplar employer, where our workforce is happy, healthy, and engaged and where wellbeing, equality, diversity, inclusion and bilingualism are valued, promoted and celebrated. We continue to embed our values and behaviours into our policies, practices, and processes, and take every opportunity to be a role model for the national work we are leading on compassionate and collective leadership.

We continue to promote our vocational-based learning offer. We have also taken steps to ensure that all those involved in recruitment undertake unconscious bias sessions.

We are committed to providing safe, welcoming and supportive working environments, both at home and at our headquarters in Ty Dysgu. Through 2025/26, we have made improvements to the building and grounds, alongside a proactive approach to health and safety. We provide guidance, risk assessments and appropriate equipment to support safe home working. We continue to operate a hybrid working arrangements, with a baseline of 2 days in the office and 3 days working from home. Teams manage attendance locally, with many now using 'anchor days' when whole teams come into the office on specific days to support collaboration and connection.

## 21. Financial Performance

The HEIW Board approved its draft Annual Plan at its meeting on 27 March 2025. The plan set a revenue funding requirement for the year of £364.27m. This has subsequently been revised to an in-year funding requirement of £384.503m by year-end. HEIW reported an underspend of £0.530m for the year, meeting its financial duty to break even against the Revenue Resource Limit (RRL).

The underspend during the year came from several sources including from within pay budgets due to vacancies across a number of directorates and from within commissioning due to under recruitment in healthcare professional courses, dental foundation and pharmacy undergraduate clinical placements.

The draft annual accounts were submitted to Welsh Government by the deadline of 1 May 2026.

Expenditure on the two main commissioning areas is shown in the table below. Operating costs of £56.0m relate to non-commissioning expenditure (including staff and director costs £38.5m), premises and related items (£3.2m), establishment costs (£4.6m), supplies and services (£5.4m) and other expenditure (£4.3m).

| Health Professional Medical Training & Education | £'m |
|---|---|
| Student Training Fees (Universities) | 78.5 |
| Funding for Healthcare Education Fees (Health Boards & Trusts) | 5.8 |
| Student Bursaries Reimbursement (Universities) | 19.0 |
| Student Salaries Reimbursement (Health Boards & Trusts) | 33.0 |
| Advanced Practice Training fees | 2.2 |
| Healthcare Support Working Training | 2.3 |
| Non-medical Prescribing | 0.4 |
| Training related Travel and Subsistence | 6.8 |
| Disability Support Allowance | 1.6 |
| Mental Health Workforce Plan Commissioning | 1.5 |
| **Total** | **151.1** |

| Postgraduate Medical, Dental & Pharmacy Education | £'m |
|---|---|
| Training Grade Salaries | 87.9 |
| Postgraduate Centre and Study Leave | 5.0 |
| GP Registrars | 51.3 |
| Dental Foundation Trainees | 11.7 |
| Pharmacy Training | 14.3 |
| Induction & Refresher | 0.1 |
| Welsh Clinical Academic Training | 1.8 |
| GP Continues Professional Development and Appraisal Costs | 1.2 |
| Trainee Relocation Expenses | 2.4 |
| Primary Care | 1.6 |
| Optometry | 0.4 |
| Other | 1.1 |
| **Total** | **178.8** |

HEIW received a strategic capital allocation of £1.185m during the year to fund the development of Codi. This is a new integrated digital system designed to streamline and enhance the management of Resident Doctors and Postgraduate Professionals across NHS Wales. The first phase of Codi received funding of £2.365m over three financial years from 2023/24 to 2025/26 and an additional £0.914m was awarded in the year.

**Codi Funding Analysis**

| £1.185m | £2.36m | £0.96m |
|---|---|---|
| Capital strategic allocation amount received | Amount received for First phase of Codi over 3 years (2023 - 26) | Additional amount awarded in year |

A further strategic allocation of £0.218m was received to support the phased refresh of digital assets operated by HEIW including laptops, telephony and network infrastructure.

End of Year capital funding of £0.176m was awarded to fund several projects including the purchase of endoscopy training equipment and for the development of further intangible fixed assets.

A discretionary capital allocation of £0.100m was allocated to support other digital initiatives and minor works required at Ty Dysgu.

Capital expenditure during the year totalled £1.640m against the total Capital Resource Limit (CRL) of £1.698m, resulting in an underspend of £0.058m for the 2025/26 financial year.

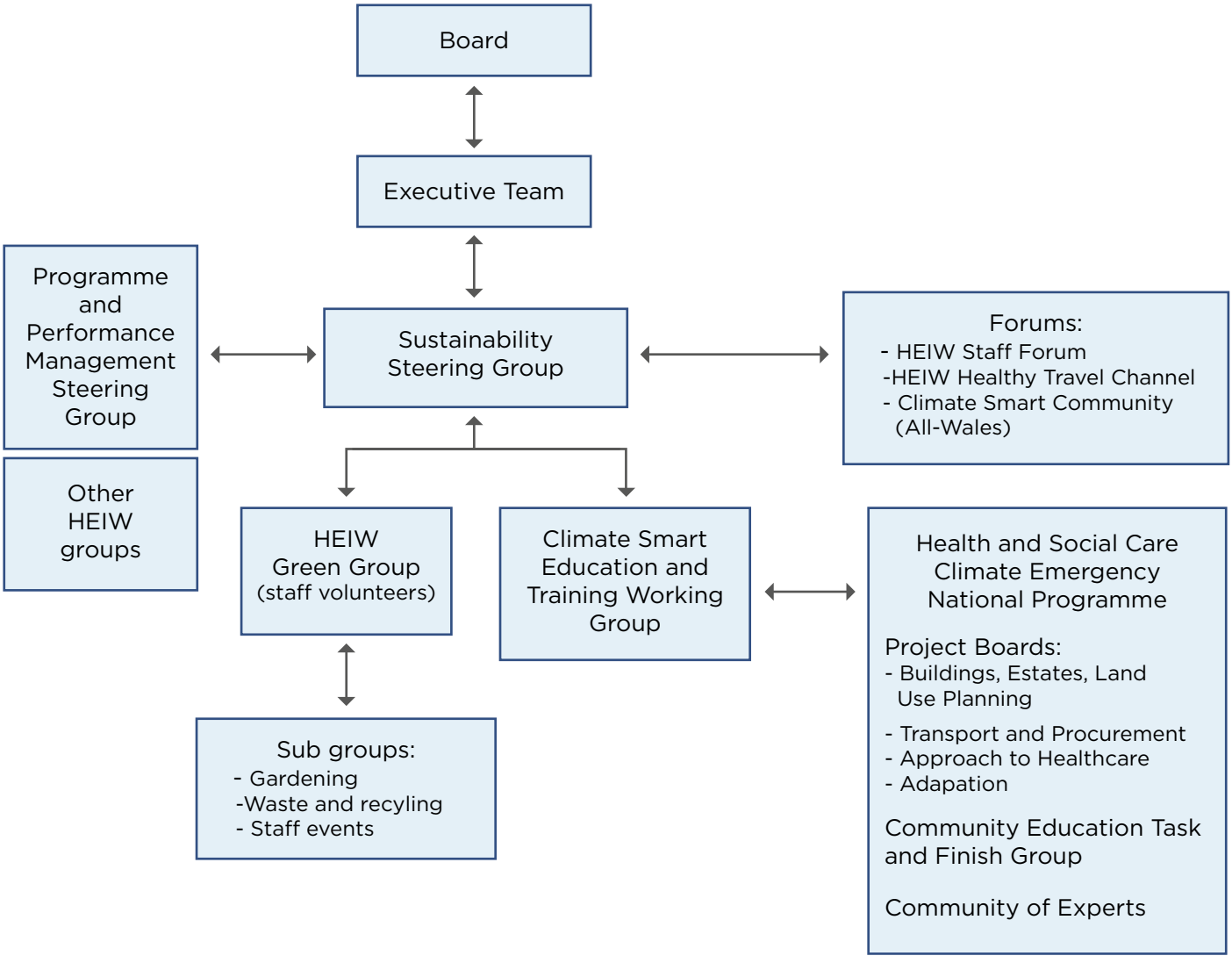
The financial statements of HEIW have been prepared on the going concern basis. This assumes that HEIW will continue to operate and meet its statutory responsibilities for the foreseeable future, being a period of at least twelve months from the date of approval of the financial statements.

## 22. Sustainability Report

HEIW is committed to action on climate change through the reduction of emissions and planning for climate adaptation. This is being achieved via the organisation's Biodiversity and Climate Change Strategy 2021-24 (under review in 2026) and Sustainability Action Plan (SAP) 2023-25. In 2025/26, public sector organisations in Wales have been requested to provide a climate related financial disclosures Compliance Statement (TFCD) and the recommended disclosures for: Governance; and Metrics and Targets, only where available from existing reporting processes. The following statements fulfil this requirement.

In relation to governance arrangements, HEIW's executive lead for Sustainability is the Deputy Chief Executive and Director of Finance, Planning and Performance. HEIW's Senior Responsible Officer (SRO) for Sustainability, which includes climate related work, is the Assistant Director of Planning and Performance. The core group overseeing work on sustainability is the Sustainability Steering Group, chaired by the SRO for Sustainability.

The governance structure is shown below, whereby the Sustainability Steering Group reports directly to the HEIW's Executive Team and information is shared internally and externally via existing forums inside and outside of the National Programme governance structure, as required. The SAP is led by the Sustainability team and overseen by the Sustainability Steering Group, which has representation from across the organisation.



In 2025/26, we have continued to take a proactive approach to the biodiversity and decarbonisation agenda, as well as progressing new and key work to develop HEIW's climate adaptation plan to build the organisation's resilience to existing and expected impacts of climate change. This work has been underpinned and supported by system-wide collaboration to develop an all-Wales approach where appropriate. We have continued to raise awareness of sustainable healthcare internally and externally and delivered further funded training opportunities across the system to promote action to implement sustainable healthcare in practice. We have continued to implement the Climate Smart Education and Training Action Plan, to embed sustainable healthcare in programmes in HEIW's remit and to ensure consistency.

HEIW worked with the All-Wales Climate Smart Education Task and Finish Group and the secondees to develop the new Climate Education Hub on Y Ty Dysgu, to be launched in April 2026. This will provide access to climate education to the entire NHS Wales workforce. The Sustainability Steering Group and Green Group have continued to deliver the priorities in the HEIW Biodiversity and Decarbonisation Strategy.

At our office, Ty Dysgu in Nantgarw, we have continued to maintain limited outdoor space to protect existing biodiversity, undertaking new planting to encourage additional bird and insect species. HEIW has continued to lead monthly litter picks and collected a total of 9 full bags of rubbish from our grounds and the surrounding area this year. We have streamlined set point temperature parameters to improve energy usage in our building.

HEIW is piloting a scheme to install all-season window film to the windows on one floor. The film is expected to reduce heat loss in winter and solar heat gain in summer, helping to lower heating and cooling demand and smooth internal temperatures. The organisation has continued to promote cycling as a sustainable mode of transport for staff commuting, providing up to £3,000 for cycling equipment via salary sacrifice, on-site showers and a digital Healthy Travel communications channel for staff. HEIW also achieved level 1 of the Wales Healthy Travel Charter.

We have trained a further 30 NHS Wales staff as Climate Smart Champions, bringing the total trained to over 200.

**Climate Smart Champions Training Analysis**



**30** Additional NHS Wales staff trained to be Climate Smart Champions

**200** Total number of staff trained

Further information regarding climate action can be found on our website: Climate action - HEIW.

We monitor emissions and waste creation on an ongoing basis, taking account of our commitment under the Environment (Wales) Act 2016. As a Special Health Authority of NHS Wales, our emissions differ considerably to other NHS Wales organisations.

The latest public sector net zero emissions estimations available are for 2024/25, where HEIW's total emissions are estimated to be 28.70 ktCO2e. This is a considerable increase compared to estimations for 2023/24, which was 12.50 kt CO2e. This is mainly due to increases in supply chain, homeworking and business travel emissions, but there were also reductions in emissions related to buildings and organisational waste. Official estimations of public sector emissions for 2025/26 will be available in late 2026/27, following collation and analysis of all public sector data.

Table 2 shows that utility consumption rose in line with increased on-site activity, while overall energy costs reduced due to lower unit prices. Electricity consumption increased to 338,912 kWh (+7.7% vs 2024/25). EV charging demand rose significantly, with chargers consuming 11,799 kWh (+137% year-on-year) and accounting for around half of the net increase in electricity use.

Due to the current metering set-up (no sub-metering), it is not possible to attribute the increase to individual areas or systems; however, the rise is consistent with higher staff attendance and external visitor volumes, more on-site meetings and events, weekend working and longer operating hours for ventilation, heating/cooling and small power loads on peak days.

Gas consumption also increased to 357,860 kWh (+10.7% vs 2024/25), reflecting higher occupancy and building use, alongside operational factors including fan coil unit repairs which increased run time. Water and sewerage consumption reduced to 4,963 m3 (20.6% vs 2024/25). Waste increased to 10.7 tonnes (+33.1%), with 5.0 tonnes recorded as general waste and 5.7 tonnes as recycling (glass, paper/cardboard, metals/plastics and food, ad hoc recycling boxes), resulting in an overall recycling rate of 53%. All waste is diverted from landfill.

**Table 1:** Utilities – Units and Costs 2025/2026

| 2025/26 | Electricity (kWh) | Gas (kWh) | Water & Sewerage m3 | Waste (Tonnes) |
|---|---|---|---|---|
| Q1 | 82,053 | 58,722 | 1195 | 2.7 |
| Q2 | 91,248 | 44,636 | 1209 | 2.8 |
| Q3 | 79,444 | 106,329 | 1465 | 2.8 |
| Q4T | 86,167 | 148,173 | 1094 | 2.4 |
| **Total Units** | **338,912** | **357,860** | **4,963** | **10.7** |
| **Total cost ex Vat(£)** | **92,916** | **19,927** | **12,069** | **5,312** |

**Table 2:** Utilities and waste comparison 2024/25 and 2025/26

| | Electricity (KWh) 24/25 | Electricity (KWh) 25/26 | Gas (KWh) 24/25 | Gas (KWh) 25/26 | Water & sewerage (m3) 24/25 | Water & sewerage (m3) 25/26 | Waste (Tonnes) 24/25 | Waste (Tonnes) 25/26 |
|---|---|---|---|---|---|---|---|---|
| Total Units | 314,776 | 338,912 | 323, 259 | 357, 860 | 6,251 | 4,963 | 8.0 | 10.7 |
| Cost (£) | £99,256 | £92,916 | £20, 622 | £19, 927 | £11,650 | £12,069 | £4,160 | £5,132 |
| Difference in units | 24,136 | | 34,601 | | -1,288 | | 2.7 | |
| Difference (%) | 7.7% | | 10.7% | | -20.6% | | 33.1% | |
| Difference (£) | -£6,340.00 | | -£694.87 | | £419.00 | | £972.00 | |
| Difference £ (%) | -6.4% | | -3.4% | | 3.6% | | 23.4% | |

# Appendix 1.1 Trends in Education & Training Commissioning

| Specialty | August 2025 post numbers | Changes August 2025 | Changes August 2024 | Changes August 2023 | Changes August 2022 | Changes August 2021 | Changes August 2020 | Changes August 2019 | Changes August 2018 | Changes August 2017 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Anaesthetics/ICM** | | | | | | | | | | |
| Core Anaesthetics Training/ACCS Anaesthetics | 131 | | | | +10 | | | | | |
| Higher Anaesthetics | 149 | | | +6 | +3 | +3 | +3 | | | |
| ACCS Intensive Care | 14 | | | | | | | | | |
| Higher Intensive Care Medicine | 38 | | | +3 | +4 | +4 | +4 | +2 | | +4 |
| **Emergency Medicine** | | | | | | | | | | |
| Acute Care Common Stem - Emergency Medicine | 34 | | +3 | +4 | +4 | +2 | | | | +4 |
| Emergency Medicine (includes PEM & PHEM) | 64 | +2 | +4 | +4 | | +5 | +7 | +4 | | +2 |
| **Medicine** | | | | | | | | | | |
| Internal Medicine Training/ACCS Acute Medicine | 283 | | | +12 | +12 | +15 | +13 | | | |
| Acute Internal Medicine | 14 | | | | | +2 | | | | |
| Audio vestibular medicine | 1 | | | | | | | | | |

| Specialty | August 2025 post numbers | Changes August 2025 | Changes August 2024 | Changes August 2023 | Changes August 2022 | Changes August 2021 | Changes August 2020 | Changes August 2019 | Changes August 2018 | Changes August 2017 |
|---|---|---|---|---|---|---|---|---|---|---|
| Cardiology | 40 | | | | | | | | | |
| Clinical Genetics | 7 | | | | +2 | | | | | |
| Clinical Neurophysiology | 2 | | | +1 | | | | | | |
| Clinical Oncology | 28 | | | +4 | +4 | +4 | | | | |
| Clinical Pharmacology and Therapeutics | 3 | | | +1 | | | | | | |
| Dermatology | 19 | | | +3 | | | +3 | | | |
| Endocrinology & Diabetes | 24 | | | +1 | | | | | | |
| Gastroenterology | 27 | | | | +1 | +2 | | | | |
| Genito-urinary Medicine | 4 | | | | | | | | | |
| Geriatric medicine | 57 | | | +5 | | | | | | +3 |
| Haematology | 18 | | | | | | | | | |
| Immunology | 1 | | | | | | | | | |
| Medical Oncology | 15 | | | +3 | +3 | +3 | | | | |
| Neurology | 20 | | | +3 | | | | | | |
| Palliative Medicine | 17 | | | +2 | +2 | | | | | |
| Rehabilitation Medicine | 2 | | | | | | +1 | | | |
| Renal medicine | 17 | | | | | | | | | |

| Specialty | August 2025 post numbers | Changes August 2025 | Changes August 2024 | Changes August 2023 | Changes August 2022 | Changes August 2021 | Changes August 2020 | Changes August 2019 | Changes August 2018 | Changes August 2017 |
|---|---|---|---|---|---|---|---|---|---|---|
| Respiratory Medicine | 31 | | | | | +2 | | | | |
| Rheumatology | 14 | | | +2 | +2 | | | | | |
| **Surgery** | | | | | | | | | | |
| Core Surgical Training | 92 | | | | | | | | | |
| Cardio-thoracic surgery | 7 | | | | | | | | | |
| General surgery | 65 | | | +7 | | +4 | | | | |
| Neurosurgery | 7 | | | | | -1 | | | | |
| Ophthalmology | 40 | | | | | | | | +4 | |
| Oral and Maxillo-facial Surgery | 11 | | | | +2 | | | | | |
| Otolaryngology | 18 | | | | | | | | | |
| Paediatric surgery | 2 | | | | | | | | | |
| Plastic surgery | 15 | | | | | +2 | | | | |
| Trauma & Orthopaedic surgery | 50 | | | +5 | | | | +4 | | |
| Urology | 20 | | | | | +4 | | | | |
| Vascular surgery | 10 | | | | | +1 | | | | |
| **Pathology** | | | | | | | | | | |
| Chemical pathology | 4 | | | | | | | | | |

| Specialty | August 2025 post numbers | Changes August 2025 | Changes August 2024 | Changes August 2023 | Changes August 2022 | Changes August 2021 | Changes August 2020 | Changes August 2019 | Changes August 2018 | Changes August 2017 |
|---|---|---|---|---|---|---|---|---|---|---|
| Histopathology | 21 | | | | +1 | | | | | +2 |
| Infectious diseases | 2 | | | | | | | | | |
| Medical Microbiology and Infectious Diseases | 22 | | | +3 | +3 | +3 | +3 | | | |
| Paediatric & Perinatal pathology | 1 | | | | -1 | | | | | +1 |
| **Psychiatry** | | | | | | | | | | |
| Core Psychiatry Training | 109 | | +8 | +8 | +8 | | | | | |
| Child and Adolescent Psychiatry (run through) | 2 | | +2 | | | | | | | |
| Child and Adolescent Psychiatry | 18 | | | +2 | +4 | | | | | |
| Forensic Psychiatry | 7 | | | +1 | | | | | | |
| Old Age Psychiatry | 15 | | | +2 | +2 | | +2 | +2 | | |
| General Psychiatry | 31 | | | +2 | | | | | | |
| Psychiatry of Learning Disability | 5 | | | | | | | | | |
| **Imaging and Radiology** | | | | | | | | | | |
| Clinical Radiology | 112 | | | +5 | +15 | +10 | +10 | +4 | +7 | +11 |

| Specialty | August 2025 post numbers | Changes August 2025 | Changes August 2024 | Changes August 2023 | Changes August 2022 | Changes August 2021 | Changes August 2020 | Changes August 2019 | Changes August 2018 | Changes August 2017 |
|---|---|---|---|---|---|---|---|---|---|---|
| Interventional Neuro Radiology | 1 | | | | +1 | | | | | |
| Nuclear medicine | 1 | | | | | | | | | |
| **Women's Health** | | | | | | | | | | |
| Obstetrics and gynaecology | 95 | | | | | +2 | | | | |
| Community Sexual & Reproductive Health | 4 | | | | +2 | | | | | |
| Paediatrics | 170 | | +4 | | +4 | +6 | +4 | | | |
| Public Health Medicine | 22 | | | +3 | +2 | | | | | |
| | 1937 | +2 | | | +90 | +73 | +50 | +14 | | |
| | | | | | | | | | | |
| Foundation Training | | | | | | | | | | |
| Foundation Year 1 | 450 | | | +39 | +30 | +30 | +12 | | | |
| Foundation Year 2 | 450 | | +39 | +30 | +30 | +12 | | | | |

## Appendix 1.2 Health Professional Commissioning Trends

The trends in commissioning and training numbers for health professional in Wales from 2017 to 2025 are detailed below.

| Staff Group | 2025 | 2024 | 2023 | 2022 | 2021 | 2020 | 2019 | 2018 | 2017 |
|---|---|---|---|---|---|---|---|---|---|
| Pre Registration Nursing | 2031 (Adult 1714 / Child 200 / MH 530 / LD 87) | 2400 (Adult 1892 / Child 211 / MH 557 / LD 87) | 2701 | 2202 | 2202 | 1,987 | 1,911 | 1,911 | 1,750 |
| Midwifery | 224 | 224 | 190 | 185 | 185 | 161 | 134 | 134 | 134 |
| District Nurses | 85 (p/t) | 80 | 80 | 80 | 80 | 80 | 80 | 80 | 80 |
| DN (Modules) | 95 | 123 | 123 | 123 | 123 | 123 | 123 | 123 | 123 |
| Health Visitors | 95 (f/t) + 31 (p/t) | 92 | 92 | 92 | 92 | 92 | 92 | 90 | 82 |
| Health Visitors (Modules) | 20 | 30 | 30 | 30 | 30 | 30 | 30 | 30 | 40 |
| CPNs | 10 (p/t) | 30 | 30 | 30 | 30 | 30 | 30 | 30 | 39 |
| CPN (Modules) | 12 | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 40 |
| CLDNs | 14 (p/t) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| CLDNs (Modules) | 12 | 10 | 10 | 10 | 10 | 0 | 10 | 10 | 10 |
| School nurse | 28 (f/t) + 15 (p/t) | 30 | 30 | 30 | 30 | 19 | 19 | 19 | 19 |
| School nurse (modules) | 0 | 0 | 0 | 0 | 0 | 3 | 3 | 3 | 3 |
| Practice nurses | 20 (p/t) | 30 | 30 | 30 | 30 | 20 | 20 | 20 | 20 |
| PN (Modules) | 60 | 50 | 50 | 50 | 50 | 29 | 29 | 29 | 29 |
| CCN (p/t) | 12 | 0 | 0 | 0 | 4 | 0 | 0 | 0 | 0 |
| Paediatric nurses | 0 | 0 | 0 | 0 | 0 | 7 | 0 | 0 | 16 |
| Paed. nurses (Modules) | 11 | 0 | 24 | 24 | 24 | 10 | 24 | 24 | 24 |

| Staff Group | 2025 | 2024 | 2023 | 2022 | 2021 | 2020 | 2019 | 2018 | 2017 |
|---|---|---|---|---|---|---|---|---|---|
| Occupational Therapists | 213 | 197 | 197 | 179 | 179 | 163 | 133 | 133 | 121 |
| Physiotherapists | 180 | 189 | 180 | 174 | 174 | 164 | 147 | 147 | 134 |
| Speech & Language Therapy | 58 | 53 | 49 | 49 | 49 | 49 | 44 | 44 | 0 |
| Dietetics | 75 | 82 | 60 | 40 | 40 | 40 | 30 | 30 | 30 |
| Post grad. Dietetics | 54 | 44 | 22 | 20 | 20 | 20 | 12 | 12 | 12 |
| Podiatry | 27 | 27 | 27 | 27 | 27 | 24 | 24 | 24 | 24 |
| Orthoptics | 0 | 0 | 0 | 0 | 0 | 5 | 5 | 5 | 5 |
| Medical Photography | 9 | 11 | 0 | 0 | 7 | 5 | 5 | 5 | 5 |
| ODPs | 74 | 69 | 62 | 49 | 49 | 49 | 49 | 49 | 49 |
| Surgical Care Pracs | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Physicians Associate | 42 | 57 | 57 | 54 | 61 | 60 | 42 | 32 | 32 |
| Clinical Psychologists | 54 | 44 | 40 | 36 | 32 | 29 | 27 | 27 | 27 |
| Pharmacists - Pre Reg. | 116 | 122 |  |  | 160 | 40 | 50 | 41 | 41 |
| Pharmacists Dip & Techs | 100 | 100 |  |  | 77 | 99 | 85 | 75 | 75 |
| Dental Hygienists | 30 | 30 | 30 | 33 | 18 | 18 | 18 | 18 | 18 |
| Dental Therapists | 24 | 24 | 15 | 13 | 13 | 13 | 13 | 13 | 13 |
| Ambulance Paramedics | 139 | 131 | 120 | 116 | 105 | 115 | 85 | 76 | 86 |

| Staff Group | 2025 | 2024 | 2023 | 2022 | 2021 | 2020 | 2019 | 2018 | 2017 |
|---|---|---|---|---|---|---|---|---|---|
| Diagnostic Radiographers | 131 | 139 | 140 | 140 | 166 | 140 | 112 | 112 | 112 |
| Therapeutic Radiographers | 20 | 20 | 20 | 26 | 26 | 22 | 20 | 20 | 20 |
| Asst Practitioners Radiography | 10 | 10 | 10 | 12 | 12 | 12 | 12 | 12 | 12 |
| PTP | | | | | | | | | |
| BMS - Blood/ Infection/Cellular/ Genetics | 59 | 44 | 26 | 25 | 25 | 24 | 21 | 21 | 21 |
| HE Cert in Audiological Practice | 11 | 8 | 10 | 15 | 13 | 15 | | | |
| Clinical Physiologists - Cardiac Physiology/ Audiology/ Respiratory and Sleep Science | 18 / 20 / 11 | 23 / 31 / 13 | 48 | 44 | 44 | 39 | 45 | 47 | 47 |
| Neuro Physiology | 7 | 4 | 4 | 3 | 3 | 4 | 3 | 3 | 3 |
| Medical Radiation Techs - Nuclear Medicine & Radiotherapy Physics | 6 | 69 | 62 | 49 | 49 | 49 | 49 | 49 | 49 |
| Clinical Engineering in Rehab | 8 | 10 | 6 | 4 | 4 | 2 | 3 | 3 | 2 |
| Medical Engineering | 6 | 4 | 0 | 4 | 4 | 0 | 0 | 0 | 0 |
| STP | | | | | | | | | |

| Staff Group | 2025 | 2024 | 2023 | 2022 | 2021 | 2020 | 2019 | 2018 | 2017 |
|---|---|---|---|---|---|---|---|---|---|
| Audiological Scientists/ Neurosensory Sciences | 11 | 13 | 5 | 5 | 5 | 6 | 6 | 3 | 3 |
| Neurophysiology | 7 | 4 | 2 | 2 | 2 | 0 | 2 | 2 | |
| Respiratory and sleep science | 11 | 13 | 6 | 2 | 2 | 1 | 3 | | |
| Reconstructive Science | 0 | 0 | 1 | 1 | 0 | 0 | 1 | | |
| Cardiac Physiology | 18 | 23 | 9 | 7 | 7 | 3 | 1 | 3 | |
| Haematology and Transfusion Science | 15 | 15 | 1 | 0 | 0 | 1 | | | |
| Biochemists/Blood Sciences | 15 | 15 | 1 | 1 | 0 | 4 | 2 | 0 | 3 |
| Cytogeneticists | 5 | 5 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Medical Physics/ Radiotherapy Physics/INIR/IIR | 3 + 131 | 3 + 139 | 11 | 8 | 11 | 7 | 3 | 3 | 4 |
| Molecular Geneticist/ Genomics/ | 6 | 6 | 1 | 2 | 1 | 1 | 1 | 1 | 1 |
| Cancer Genomics | 2 | 2 | 1 | 1 | 1 | 1 | 1 | 1 | |
| Genomic Counselling | 2 | 2 | 1 | 0 | 1 | 2 | | | |
| Bioinformatics | 2 | 2 | 5 | 2 | 1 | 1 | 1 | 2 | 1 |
| Tissue Typing/ Immunology/ Histocompatibility | 5 | 5 | 0 | 1 | 0 | 0 | 0 | 0 | 0 |

| Staff Group | 2025 | 2024 | 2023 | 2022 | 2021 | 2020 | 2019 | 2018 | 2017 |
|---|---|---|---|---|---|---|---|---|---|
| Clinical Engineering/ DRMG | 8 | 10 | 5 | 4 | 3 | 2 | 1 | 2 | 4 |
| Cellular Science/ Embryology/ Andrology | 5 | 5 | 2 | 0 | 1 | 1 | 2 | 0 | 0 |
| Infection Science - Clinical Microbiology | 5 | 5 | 0 | 0 | 0 | 2 | 0 | 3 | 3 |
| Clinical Pharmaceutical Science | 0 | 0 | 2 | 3 | | | | | |
| HSST | | | | | | | | | |
| Life Sciences - Genetics/Genomics | 11 | 20 | | | 0 | 0 | 0 | 0 | 1 |
| Microbiology/ infection | 2 | 2 | 1 | 1 | 2 | 1 | 0 | 1 | |
| Life Sciences - Molecular Pathology of acquired disease | 1 | 1 | | | 0 | 0 | 0 | 1 | 0 |
| Life Sciences - Clinical Biochemistry | 11 | 20 | 1 | 1 | | | | | |
| Physical Sciences and Biomedical Engineering - Medical Physics (Radiotherapy/ radiation protection) | 3 | 3 | 1 | 1 | 2 | 1 | 1 | 1 | 1 |
| Physical Sciences and Biomedical Engineering - Clinical Biomedical Engineering | 8 | 10 | | | 0 | 0 | 1 | 0 | 1 |

| Staff Group | 2025 | 2024 | 2023 | 2022 | 2021 | 2020 | 2019 | 2018 | 2017 |
|---|---|---|---|---|---|---|---|---|---|
| Bioinformatics | 1 | 1 | | 1 | 2 | 0 | 1 | | |
| Physiological Science (Audiology/ Vascular/Cardiac) | 11 | 13 | 1 | 5 | 0 | 1 | 0 | 0 | 1 |
| Histocompatability & Immunology | 2 | 2 | 1 | | 0 | 3 | 1 | 0 | 1 |
| Clinical Biochemistry | 11 | 20 | 1 | | | | | | |
| Transfusion Science/ Haematology | 15 | 15 | 1 | 1 | 0 | 0 | 0 | 1 | |



# **Accountability** Report 2025/2026



# Corporate Governance Report

## Governance Statement (for the Period Ended 31 March 2026)

The Corporate Governance Report provides an overview of the governance arrangements and structures in place across Health Education and Improvement Wales (HEIW) during 2025/26. It includes:

### The Governance Statement

The Governance Statement sets out the governance arrangements and structures and brings together how the organisation manages governance, risk and control.

View The Governance Statement

### The Statement of Accountable Officers' Responsibilities and Statement of Directors' Responsibilities

The Accountable Officer, Chairman and Executive Director of Finance confirm their responsibilities in preparing the financial statements and that the Annual Report and Accounts as a whole, is fair, balanced and understandable.

View The Statement of Accountable Officers' Responsibilities and Statement of Directors' Responsibilities

### The Directors' Report

The Directors' Report provides details of the Board who have authority or responsibility for directing and controlling the major activities of HEIW during the year. Some of the information which would normally be shown here is provided in other parts of the Annual Report and Accounts and this is highlighted where appropriate.

View The Director's Report

# 1. Scope of Responsibility

The Board of HEIW is accountable for governance, risk management, and internal control. The Chief Executive Officer (CEO) has responsibility for maintaining appropriate governance structures and procedures, as well as a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives, whilst safeguarding the public funds and the organisation's assets for which the CEO is personally responsible. These are carried out in accordance with the responsibilities assigned to the CEO as Accountable Officer by the Chief Executive of NHS Wales.

The Annual Report outlines the different ways the organisation has worked both internally and with partners in response to the unprecedented pressure in planning and providing services. HEIW recognises the continued risks which have faced higher education institutions in Wales including those of financial sustainability, student enrolment, reduction in funding and the challenges in international recruitment. HEIW also acknowledges the wider financial pressures across NHS Wales and the impact these constraints have on the system's ability to plan, train and sustain the workforce.

The Annual Report explains the arrangements for ensuring standards of governance are maintained, risks are identified and mitigated, and assurance has been sought and provided.

Where necessary, additional information is provided in the Governance Statement, however, the intention has been to reduce duplication where possible. It is therefore necessary to review other sections in the Annual Report alongside this Governance Statement.

The background to HEIW, its functions and the Integrated Medium-Term Plan (IMTP) 2025/28 is set out in the Performance Report.

This Governance Statement explains the composition and organisation of HEIW's governance structures and how they support the achievement of our objectives.

During 2025/26, work has commenced to reshape our operating model. Further information regarding our Ways of Working Programme can be found in the Performance Report.

We have also continued to further develop our system of governance and assurance. During the year we have reviewed HEIW's Strategic and Corporate Risks. Our Board Assurance Framework is outlined in the Purpose of the System of Internal Control section and it will continue to evolve in 2026/27.

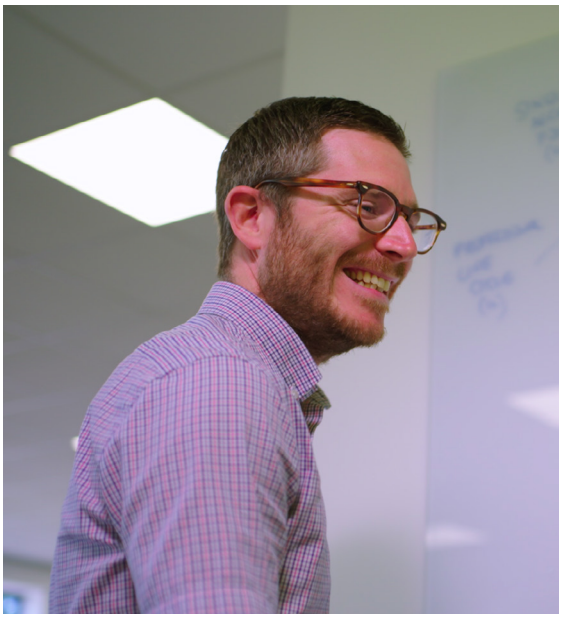
The Board sits at the top of our governance and assurance system. It sets strategic aims, monitors progress, agrees actions to achieve these objectives and ensures appropriate controls are in place and working properly. The Board also takes assurance from its committees, assessments, against professional standards and regulatory frameworks.

In accordance with the Public Bodies (Admissions to Meetings) Act 1960, the organisation is required to meet in public. All Board and Committee meetings are held face-to-face at Ty Dysgu. Members of the public have been able to register and observe Board and Committee meetings online which has increased the number of people viewing these meetings.

## Reporting period

The reporting period for this Governance Statement is primarily focussed on the financial year from 1 April 2025 to 31 March 2026. However, it also includes reporting on material issues that have taken place between 31 March 2026 and the date that the Governance Statement was approved by the HEIW Board on 25 June 2026.

# 2. Our Governance Framework



Our vision is...

**"transforming the workforce for a Healthier Wales".**

Our purpose is...

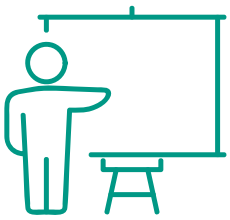
**"as part of the NHS, to work with partners to develop a skilled and sustainable workforce that improves care and population health".**

As a workforce-focused organisation, our culture and the way we do business are very important to us, and together with our staff we have developed our organisational values. This provides the internal operating context for delivering our planned activity. The organisation has worked hard to embed quality, equality, diversity, and inclusion in all that we deliver. Our Values and Behaviour Framework is on our website at https://heiw.nhs.wales/about-us.

| Respect for all | Together as a team | Ideas that improve |
|---|---|---|
| in every interaction | Working collaboratively across NHS Wales and with partners | Embracing creativity, innovation and continuous learning |

As a Special Health Authority our unique contribution or "added value" is to address strategic and specialist workforce opportunities and risks that affect workforce demand and supply through our statutory functions.

HEIW's statutory functions include:



Planning, commissioning and delivering education and training



Leadership, culture and succession planning



Workforce strategy, planning and intelligence



Workforce development and transformation



Attraction, careers and widening access



Professional support for workforce and organisational development

HEIW, in line with all Health Boards and Trusts in Wales, has agreed standing orders for the regulation of proceedings and business of the organisation. These are designed to translate the statutory requirements set out in the HEIW (Establishment and Constitution) Order 2017 into day-to-day operating practice. Together with the adoption of a scheme of matters reserved to the Board; a scheme of delegation to officers and others; and standing financial instructions, they provide the regulatory framework for the business conduct of HEIW and define its 'ways of working'. These documents, together with the range of corporate policies set by the Board, make up the Governance and Assurance Framework. These documents can be found on our website at https://heiw.nhs.wales/about-us/key-documents/.

Our Standards of Behaviour Policy was approved by the Board on 26 March 2026. Work has continued during 2025/26 in respect of communication and to ensure that declarations are up to date to proactively manage any conflicts of interest that might arise for our Board members and staff. Information on Declaration of Interest can be found in the Directors Report.

## 2.1 The Role of the Board

The Board has been constituted to comply with the Health Education and Improvement Wales Regulations 2017. In addition to responsibilities and accountabilities set out in terms and conditions of appointment, Independent Members also fulfil a number of Champion roles where they act as ambassadors (see Appendix 1 Board and committee membership and attendance).

The Board is made up of independent members and executive directors.

There have been a number of changes to the Executive Team during 2025/26 due to departures and changes in portfolios. Tom Lawson was appointed as Medical Director on 1 September 2025 after undertaking the role on an acting basis since 31 May 2024.

Glyn Jones' (Director of Finance, Planning and Performance) appointment as Deputy Chief Executive alongside his statutory role was extended for a one-year term starting 1 July 2025. Subsequently, Glyn Jones resigned as Director of Finance, Planning and Performance/ Deputy CEO and left HEIW on 30 June 2026.

Lisa Llewelyn, Executive Director of Nursing, Health Professions and Quality left HEIW on 3 March 2026 and Samantha Donohue was appointed to the role on 2 March 2026. The Welsh Language Team was transferred to the Director of Education Strategy and Transformation on 1 February 2026. The National Programmes portfolio was transferred to the Executive Director of Nursing, Health Professions and Quality on 1 April 2026.

The Director of Digital, Data and Engagement, the Director of Education Strategy and Transformation, together with the executive directors and the Board Secretary, are members of the Executive Team. In addition, the Director of Digital, Data and Engagement and the Director of Education Strategy and Transformation have a standing invitation to Board meetings where they can contribute to discussions, but do not have voting rights.

Alun Lloyd commenced his term as an Independent Member on 1 April 2025 following a successful public recruitment process. John Gammon resigned as Vice-Chair of HEIW's Board on 31 July 2025. Subsequently, Donna Macarthur was appointed into the position of Vice-Chair on 1 August 2025. Jayne Sadgrove resigned as Independent Member and left HEIW on 31 January 2026.

Elizabeth Treasure was appointed as an Independent Member on 1 April 2026 following a successful recruitment process in February 2026.

During 2025/26 several Board Development Sessions were undertaken which included a focus on the following elements of governance:

- Board's self-assessment of its own effectiveness
- Development of the IMTP
- Strategic development and use of the 3 Horizons Model
- Approach to Board Development Sessions
- Welsh Government's Public Accountability Meeting
- Pre-election and post-election actions

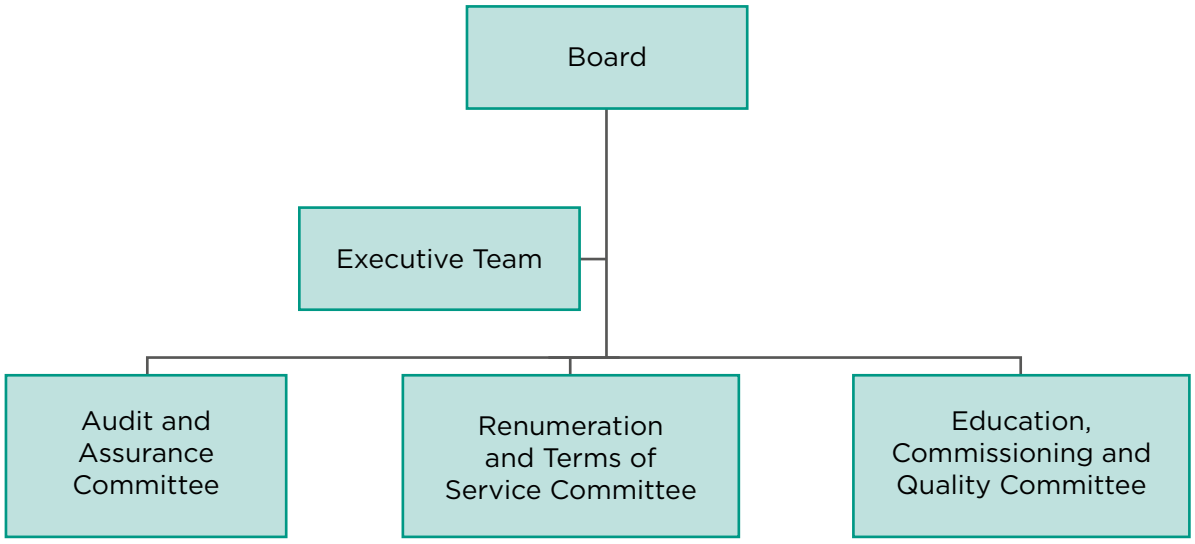
Welsh Government held the HEIW Public Accountability Meeting on 12 February 2026. The meeting focused on in year delivery and formed part of the arrangements through which Welsh Ministers receive assurance on HEIW's progress against its priorities. The evidence pack provided in advance of the meeting, alongside the meeting recording can be viewed on the Welsh Government website. Following the meeting, the Cabinet Secretary for Health and Social Care identified three consistent themes which underpinned the discussions. Firstly, the need for HEIW to develop an agile, real time workforce planning model to better anticipate emerging challenges. Secondly for the organisation to deepen its understanding of the relationship between digital transformation and workforce planning, moving beyond just numbers. Thirdly to evaluate the contribution of leadership training to system-wide improvement, aiming for clearer evidence of its impact. HEIW will take these themes forward during 2026/27, using them to inform the further development of our workforce planning, digital maturity and leadership offer.

As our Welsh Government Remit Letter was not received until March, therefore our Risk Appetite, Risk Tolerance and Strategic Risks were not considered until the April 2026 Board Development Session and May 2026 Board.

In addition, during 2025/26 four briefing meetings were convened for the Board to consider the following areas:

- Cardiff University Consultation
- The Performance Framework 2025-26
- The draft Education and Training Plan 2026-27
- The Integrated Medium-Term Plan 2026-29

The full membership of the Board, their lead roles and committee responsibilities are outlined in Appendix 1 (Board and Committee membership and attendance). Below is a summary of the Board and committee structure:



The Board provides leadership and direction to the organisation and has a key role in ensuring the organisation has sound governance arrangements in place. The Board also seeks to ensure the organisation has an open culture and high standards when conducting its work. Together, Board members share corporate responsibility for all decisions and play a key role in monitoring the performance of the organisation. All the meetings of the Board during 2025/26 were deemed, when held, to be appropriately constituted with a quorum. The key business and risk matters considered by the Board during 2025/26 are outlined in this statement and further information can be obtained from meeting papers available on our website: https://heiw.nhs.wales/about-us/board-and-committee-meetings/.

## 2.2 Committees of the Board

The Board has established three committees, the Audit and Assurance Committee, the Remuneration and Terms of Service Committee, and the Education Commissioning and Quality Committee. These committees are chaired by the Chair of the Board or independent members and have key roles in relation to the system of governance and assurance, supporting decision making, scrutiny and in assessing current risks. The committees provide assurance and key issue reports to the Board to contribute to the Board's assessment of assurance and to provide scrutiny on the delivery of objectives.

1. The Audit and Assurance Committee
2. The Remuneration and Terms of Service Committee
3. The Education Commissioning and Quality Committee

The Board is responsible for keeping the committee structure under review and reviews its standing orders on an annual basis. The Board will consider whether any changes are needed during 2026/27 in line with the Board's governance framework and priorities of the Integrated Medium-Term Plan 2026/29.

HEIW is committed to openness and transparency with regard to the way in which it conducts its committee business. The HEIW Board and its committees aim to undertake the minimum of its business in closed sessions and ensure business wherever possible is considered in public with open session papers published on HEIW's website: https://heiw.nhs.wales/about-us/board-and-committee-meetings/.

The closed session elements of Board and committee meetings are undertaken because of the confidential nature of the business. Such confidential issues may include commercially sensitive issues, personal issues or discussing plans in their formative stages.

HEIW's governance arrangements were strengthened during 2024/25 and these enhanced practices continued throughout 2025/26. The processes for meetings were streamlined through the introduction of consent agendas for committee meetings starting from March 2025, facilitating the efficient handling of routine matters and allocating dedicated time to address strategic and higher-priority issues.

The template used for Committee highlight reports to the Board was reviewed and the Alert, Advise, Assure (AAA) Highlight Report was introduced in April 2025, providing a concise summary of key issues, enabling the Board to grasp critical information and make informed decisions.

### 2.2.1 Audit and Assurance Committee

An important committee of the Board in relation to this Governance Statement is the Audit and Assurance Committee. The Committee keeps under review the design and adequacy of HEIW's governance and assurance arrangements and its system of internal control. During 2025/26, key issues considered by the Audit and Assurance Committee relating to the overall governance of the organisation included:

- Reviewing the draft Annual Accounts for 2024/25.
- Reviewing procurement compliance, and the procurement compliance annual report.
- Revisiting its terms of reference, which will be kept under regular review.
- Approving the Internal Audit Plan for 2025/26 and monitoring the resulting Internal Audit Reports. Noting key areas of risk and tracking the management responses made to improve systems and organisational policies.
- Providing assurance of appropriate oversight of the policy lifecycle.
- Considering the 2024/25 Complaints and Concerns Annual Report.
- Approving the Counter Fraud Annual Plan 2025/26, noting the 2024/25 Counter Fraud Annual Report and keeping under review the resultant counter fraud work.
- Ensuring effective financial systems and controls procedures are in place.
- Further developing the Board's risk management systems and processes and monitoring the same including review of revisions to the Risk Management Policy.
- Reviewing HEIW's Standing Orders, Board Assurance Framework and HEIW's Declaration of Interest Register and Gifts, Hospitality and Sponsorship Register.
- Considering, the 2025 Structured Assessment, the findings from the Audit Wales Review of Securing Value from Commissioned Education Places, the Audit Wales National Fraud Initiative 2024-25 Report, the 2025 Audit Wales Audit Summary Report, and Audit Wales 2025 Audit Plans.
- Providing assurance to the Board in respect of Information Management and Information Governance, reviewing the Senior Information Risk Owner Annual Report 2024/25, Information Governance Toolkit and receiving regular updates on cyber security.
- Self-assessment and review of Committee effectiveness.

The committee provides an Annual Report of its work to the Board and undertook a self-assessment for 2025/26 at its meetings in February and April 2026. A questionnaire based on the National Audit Office Audit and Risk Committee Checklist was developed and circulated to committee members and attendees. The self-assessment identified two areas of focus including governance and assurance, and engagement and communications across HEIW. A self-assessment action plan has been developed in response to the findings of the self-assessment process.

### 2.2.2 Remuneration and Terms of Service Committee

The Remuneration and Terms of Service Committee considers and recommends to the Board salaries, and terms and conditions of employment for the Executive Team and other senior staff. During 2025/26 key issues considered by the Remuneration and Terms of Service Committee included:

- Review of its own terms of reference.
- Hosting of secondment on behalf of Welsh Government.
- Performance of Chief Executive Officer and executive directors against individual objectives.
- Recruitment, appointment and remuneration of senior staff.
- Consideration of casework updates and actions in line with employment policies.
- Real living wage update.
- Executive Senior Pay Annual Pay Award for 2025/26.

### 2.2.3 Education, Commissioning and Quality Committee

The Education, Commissioning and Quality Committee enables the Board to undertake greater scrutiny in respect of commissioning, monitoring and quality assessing of education and training. The committee considered the following key matters in 2025/26:

- Reviewed its own terms of reference.
- Reviewed the draft Education and Training Plan Recommendations for 2026/27.
- Received assurance reports on education and procurement activity.
- Considered the contract extension process for education contracts.
- Considered and made recommendations of approval to the Board in respect of Education Contracts.
- Received quality assurance updates in respect of medicine, dental, pharmacy, optometry and nursing and health professionals.

- Received an update in relation to independent prescribing and implementation of skills.
- Received updates on the 2025 General Medical Council National Training Survey findings and the 2025 National Student Survey findings.
- Received updates on escalations and areas of concern highlighted through contract tender and award processes, performance monitoring arrangements and through the concerns and complaints management process including graduate employment opportunities and nurse education provision.
- Received an update on the Implementation of recommendations 3 and 7d of the Infected Blood Inquiry in Wales.
- Reviewed the Audit Wales, Securing Values from Commissioned Education Places Report.
- Received updates in respect of the work undertaken by the Stakeholder Reference Group.
- Received an update in respect of the Workforce Supply and Oversight Group.
- Self-assessment and review of Committee effectiveness.

The committee provides an Annual Report of its work to the Board and undertook a self-assessment for 2025/26 at its meetings in November 2025 and March 2026. The self-assessment identified three areas of focus including strengthening reporting on data triangulation (including quality of education and articulation of impact), inclusion of horizon scanning agenda items and strengthening the information reported to the Committee in relation to learner and trainee insights.

## 2.3 Advisory Groups

### 2.3.1 Stakeholder Reference Group

Our Stakeholder Reference Group (SRG) plays an important advisory role in shaping HEIW's strategic direction. By bringing together representatives from NHS Wales, Welsh Government, professional bodies, education providers, trade unions, social care and the voluntary sector, the group provides a valuable forum for engagement, dialogue and collaboration across the health and care system. Throughout the year, members offered insight and constructive challenge on key strategic developments, including the Education and Training Plan, the Integrated Medium-Term Plan (IMTP) and the development of HEIW's first Education Strategy. Discussions also explored workforce trends and modelling, current workforce supply challenges, and opportunities to strengthen education and training through innovation, including digital and AI-enabled learning.

Through this collaborative approach, the SRG helps ensure HEIW's plans remain ambitious, evidence-informed and aligned with system priorities, supporting the development of a skilled and sustainable workforce for Wales.

**SRG helps advise HEIW's strategic direction, by working with:**

- Welsh Government
- NHS Wales
- Professional Bodies
- Education Providers
- Trade Unions
- Social Care and Voluntary Sectors

**SRG members provide HEIW's strategic direction on:**

- Education and Training Plan
- the Integrated Medium-Term Plan (IMTP)
- The development of HEIW's first Education Strategy

## 2.3.2 Local Partnership Forum

The HEIW Local Partnership Forum (LPF) provides the formal mechanism for social partnership within HEIW. It is the formal method for engagement, consultation, negotiation and communication between the trade unions and HEIW management and ensures continued partnership working. The LPF is scheduled to meet bi-monthly to deal with a range of operational and strategic issues.

The LPF has received presentations on and considered a range of topics through 2025/26 which included:

- HEIW Internal Workforce Plan 2025 – 2030
- Speaking Up Safely
- HEIW New Ways of Working Model Review
- The Integrated Medium-Term Plan

- Staff Survey
- The Welsh Race Equality Standard
- Social Partnership and Public Procurement (Wales) Act 2015
- The Education and Training Plan 2026/27
- A Leadership Update
- Welsh Health Circular Non-Pay Implementation 2022-25 collective agreement – Protected CPD
- All Wales Mediation Network
- Workforce Policies (5 received during 2025/26)
- Social Partnership Annual Report
- My Health Passport

The LPF terms of reference is reviewed annually.

Through 2025/26 the LPF remained part of the formal policy approval process for HEIW, supporting the work of the Policy Review group and reviewed policies.

## 2.4 Membership of the Board and its Committees

In Appendix 1, the membership of the Board and its committees is outlined for the year end 31 March 2026, along with attendance at Board and committee meetings for this year. Members are involved in a range of other activities on behalf of the Board, such as regular development and briefing meetings, and a range of other internal and external meetings.

Any proposed changes to the structure and membership of Board Committees requires Board approval. The Audit and Assurance Committee, the Education Commissioning and Quality Committee, and the Remuneration and Terms of Service Committee have considered their own terms of reference. The Board will ensure that terms of reference for each committee are reviewed annually to ensure the work of committees clearly reflects any governance requirements, changes to delegation arrangements or areas of responsibility. The Audit and Assurance Committee and the Education Commissioning and Quality Committee are also required to develop annual reports of their business and activities.

## 3. The Purpose of the System of Internal Control

HEIW's Board system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risks. It can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of HEIW policies, aims and objectives, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively, and economically.

The system of internal control has been in place for the year ended 31 March 2026 and up to the date of approval of the Annual Report and Accounts. We use the Board Assurance Framework system and process to monitor, seek assurance and ensure that shortfalls are addressed through the scrutiny of the Board and its Committees. Oversight of our Corporate Risk Register system is provided through scrutiny and monitoring by the Board and its Committees. The effectiveness of the system of internal control is assessed by our internal and external auditors. A diagram of the Board Control Framework is set out below.

**Levels of Assurance**

**First Line: Operational**

- Organisational structures – evidence of delegation of responsibility through line Management arrangements.
- Compliance with appraisal process.
- Compliance with policies and procedures.
- Incident reporting and thematic reviews.
- Compliance with Risk Management processes and systems.
- Performance Reports, Complaints and Trainee Experience Reports, Finance Reports.

**Second Line: Risk and Compliance**

- Reports to Assurance and Oversight Committees.
- Audit and Assurance Committee.
- Education Commissioning and Quality Committee.
- Remuneration and Terms of Service Committee.
- Health and Safety Groups etc.
- Findings and/or reports from inspections, Annual Reporting, Performance report through to Committees.

**Second Line: Risk and Compliance**

**Third Line: Independent**

- Internal Audit Plan.
- Audit Wales.
- External Audits (e.g. Annual Accounts and Annual Report).
- Healthcare Inspectorate Wales Inspections.
- Regulators.
- Reviews and Reports by Royal Colleges.
- External visits and accreditations.
- Independent Reviews.

## 4. Capacity to Handle Risk

We have continued to develop and embed our approaches to risk management and emergency preparedness throughout 2025/26. Our Risk Management Policy is reviewed on an annual basis and was reviewed and approved by the Board in March 2026.

HEIW's risk appetite statement was last reviewed by Board in March 2025. The statement set out below describes the risks it is prepared to accept or tolerate in the pursuit of its strategic priorities:

> 'HEIW recognises that, as an improvement based organisation, it is impossible for it to deliver its services and achieve positive outcomes for its stakeholders without a high appetite for risk. Indeed, only by taking risks can HEIW realise its aims.
>
> HEIW nevertheless recognises that its appetite for risk will differ depending on the activity undertaken. Its acceptance of risk will be based on ensuring that potential benefits and risks are fully understood before decisions on funding are made, and that appropriate actions are taken.
>
> HEIW's risk appetite considers its capacity for risk, which is the amount of risk it is able to bear (or loss we can endure) having regard to its financial and other resources, before a breach in statutory obligations and duties occurs'.

Consideration of Strategic Risks and Corporate Risk both form part of the Board Assurance Framework. While they are complimentary, they do not cover the same areas. Strategic Risks are fundamental risks to an organisation's Strategic Priorities. These risks are embedded and do not change much in the course of a year. Corporate risks identify more precise day-to-day activities and are more likely to change over the course of the year.

HEIW's risk tolerance in respect of each of its statutory functions is incorporated within the Corporate Risk Register. This will ensure a consistent, integrated approach whereby all risks are clearly linked to organisational objectives with a line of sight to the Board Assurance Framework.

HEIW's strategic risks are reviewed by the Board on an annual basis to ensure they continue to align with our Integrated Medium-Term Plan. The key strategic risks for HEIW are outlined below.

## HEIW Strategic Risks 2025/26

| | | |
|---|---|---|
| 1 | **Strategic Risk** | Effective stakeholder engagement in the development and implementation of our strategic objectives. |

If our engagement with our partners and stakeholders is not extensive and effective, then there is a real risk that we will not achieve buy-in from our partners and our work won't be informed by service need.

| | | |
|---|---|---|
| 2 | **Strategic Risk** | Achievement of statutory financial duty: operating effectively within available revenue resources. |

If the challenging financial environment results in HEIW not securing the funding required to deliver its strategic priorities, then this may impact the organisation's ability to deliver its plans.

| | | |
|---|---|---|
| 3 | **Strategic Risk** | Interface with Welsh Government. |

If the interface with Welsh Government and its other agencies is not effective, this could impact on access to resources and HEIW's ability to deliver its functions and purpose.

| | | |
|---|---|---|
| 4 | **Strategic Risk** | Change in the shape of the working population. |

If there is a continued reduction in the size of the working population and a more plural intergenerational attitude to work this will impact the sustainability of the NHS workforce pipeline and place pressure on the existing workforce impacting services.

| | | |
|---|---|---|
| 5 | **Strategic Risk** | Quality and experience of training |

If we do not ensure that our learners receive the appropriate quality and experience of education and training, then we will not provide a workforce that meets the current and future workforce needs of the NHS impacting patient care.

| 6 | Strategic Risk | Digital transformation |
|---|---|---|
| If we fail to digitally transform this will hinder innovative digital and data solutions for staff and users across Wales, impacting our commitment to HEIW's digital strategy. This will lead to operational inefficiencies, data security issues, and challenges in staff attraction and retention. | | |

The organisation has a Strategic Risks Control Framework, which identifies and maps the controls and key sources of assurance against HEIW's Strategic Risks.

## 4.1 Risk Management

The Board sees active and integrated risk management as key elements of all aspects of our functions and responsibilities, especially to support the successful delivery of our business.

The Chief Executive as the Accountable Officer has overall responsibility for the management of risk for HEIW. The Board and its committees identify and monitor risks within the organisation. Specifically, Executive Team meetings present an opportunity for the executive function to consider and address risk and actively engage with and report to the Board and its committees on the organisation's risk profile. The Corporate Risk Register is reviewed monthly by the Executive Team, and quarterly by the Audit and Assurance Committee. The Board reviews the Corporate Risk Register at every meeting. Risks are escalated to the Board as appropriate.

At an operational level, executive directors are responsible for regularly reviewing their Directorate Risk Registers and for ensuring that effective controls and action plans are in place for monitoring progress.



## 4.2 HEIW's Risks

A number of key risks and challenges arose during the year, due to the complex environment. The Corporate Risk Register is continuously updated to capture HEIW's risks as they are identified. 2025-26 saw the highest number of red risks added to the Corporate Risk Register to date. Further information regarding the risks and the effect on the delivery of our Integrated Medium Term Plan Priorities can be found in the performance report.

| Risk Title | Risk Description | Risk Mitigations and Progress |
|---|---|---|
| Cyber Security | If reasonable steps are not taken in respect of cyber security and resilience, HEIW may not be able to adequately protect itself, detect, respond, and recover from a cyber-attack resulting in critical system(s) disruption; disruption of operational functions and output; breach of critical and personal data; financial penalties and reputational damage. | HEIW continued to implement the Cyber Security Plan, recruit to vacant positions within the Cyber Security team and deliver a joint Information Governance and Cyber Security Framework. The team prioritised efforts to ensure key security requirements were met including targeted enhancements across security operations and work to augment the security event monitoring tool. |
| Higher Education Institutions Achieving Commissioning Levels | If Higher Education Institutions (HEIs) do not achieve fill rates, then HEIW shall not meet its commitments within the Annual Education and Training Plan for workforce supply to the NHS or utilise the full investment agreed through the plan. | HEIWs performance management framework, the Education and Training Plan, the Performance Oversight Group, our Careersville platform supported the mitigation of this risk.<br><br>HEIW put in place targeted training, while expanding diverse applicant pipelines to increase progression opportunities and enhanced recruitment through engagement with Higher Education Institutions and ongoing national marketing.<br><br>HEIW continued to monitor and report nursing programme recruitment, application and fill rates, to ensure recruitment was maximised. |

| Risk Title | Risk Description | Risk Mitigations and Progress |
|---|---|---|
| Physician Associates | If professional bodies and NHS organisations do not support the Physician Associate (PA) role, there is a risk to future recruitment and retention of PAs and the viability of PA courses in Wales. | The NHS Wales led multistakeholder group was established to review concerns and agree a Wales specific approach to support safe and effective deployment of Medical Associate Practitioners (MAPs).<br><br>The Leng Review was published in July 2025. The recommendations were supported in principle by Welsh Government and considered by the Welsh Government led implementation Board, where HEIW is a member, which commenced in December 2025.<br><br>HEIW is providing opportunities for PA graduates who have not found roles to maintain clinical knowledge and skills. HEIW continued to monitor the availability of PA roles in Wales. |
| Cardiff University Nursing Provision | If the outcome of the consultation launched by Cardiff University on the future of its Nursing provision leads to changes in its nurse education provision, then this may destabilise Nurse recruitment impacting the September 2025 cohort and the experience of existing students. | Weekly meetings between HEIW and Cardiff University were established to understand potential consultation outcomes and ensure the needs of current, and 2025 student intakes were met, informed by stakeholder feedback. HEIW undertook scenario planning, maintained engagement with other providers, and briefed the Board in May 2025, which agreed the approach to securing appropriate nursing student capacity, with Welsh Government kept informed throughout. |

| Risk Title | Risk Description | Risk Mitigations and Progress |
|---|---|---|
| Codi Implementation | If the data issues following Codi* Go Live are not resolved within time, then there is a risk that data sent to Health boards and NHS Wales Shared Services Partnership is incorrect. The impact could lead to incorrect placement data being sent to Health Organisations affecting pay and staff rotas for postgraduate trainees. | *Codi implementation was added as a red risk to the Corporate Risk Register in April 2025. To mitigate the risk, it was agreed to delay the launch of Codi and revert to the intrepid platform until the final relaunch of Codi. The detailed plan was communicated with stakeholders and the recovery plan, including lessons learned was put in place.<br><br>(* - Codi is a single integrated digital platform designed to bring together multiple HEIW applications that manage training, appraisal, and workforce data for NHS Wales professionals). |
| Codi Launch | If lessons are not learned from the Codi launch on 31 March, then there is a risk the rescheduled launch of the platform is not successful. Further impacting core services provided to Health Boards and Medical professionals throughout NHS Wales and having an adverse effect on HEIWs reputation. | HEIW enacted the Codi relaunch recovery plan which included the resource requirements and timescales. HEIW allocated additional resources to the team and enacted a new data migration approach which led to the successful phased relaunch of Codi at the end of 2025. |
| Role Vacancies for Graduates | If there are insufficient vacancies available to graduates, this will impact on employment, value from investment in education and reputation of NHS Wales as a place to train, and impact on HEIW's reputation. | To support graduates into roles, HEIW made available to employers a full timeline and information regarding graduates, vacancies and offers, supported by dashboards. This aimed to inform early escalation both locally and within NHS Wales organisations and Welsh Government. HEIW also supported the exploration of appropriate alternative opportunities within NHS Wales for graduates. |

| Risk Title | Risk Description | Risk Mitigations and Progress |
|---|---|---|
| | | In January 2026, the Workforce Oversight Supply Group was established. The group aims to support increased data-informed system collaboration around the graduate pipeline and vacancies across multiple disciplines. |
| Education and Training Plan 2026-27 | If Welsh Government funding of the Education and Training Plan (ETP) 2026-27 is less than the recommended level this will require education and training to be prioritised and will impact on future workforce supply. | HEIW provided additional information for Welsh Government to consider the impact of various funding scenarios including flat funding.<br><br>On 9 March, Welsh Government published a written statement confirming that funding will be maintained at existing level. Given that this was less than the recommended level by HEIW, this the risk was reassessed as an issue. |
| Data and Analytics Team Capacity and Capability | If resource capacity and capability is not increased within the data and analytics team, then there is a risk that dashboards and insights will not be delivered, and that the organisation will make ill informed decisions. | HEIW completed a review into the upskilling and training of staff, and a review into the standing operating procedures in place. Additional resources were considered and this included the creation of new job descriptions for additional posts and the procurement of professional services. |

| Risk Title | Risk Description | Risk Mitigations and Progress |
|---|---|---|
| Postgraduate Medical Recruitment | If proposals to prioritise UK medical graduates are not carefully considered, there could be a negative impact on fill rates and services in Wales and a potential risk to the sustainability of the four nation national recruitment process. | Twice weekly meetings between four nations statutory education bodies and government representatives were convened to ensure devolved nation requirements and risks were recognised and to influence proposals to address issues of foundation oversubscription and high competition ratios at the foundation to speciality transition point.<br><br>HEIW continued to have ongoing discussions with the Department of Health and Social care and developed nations regarding options to address the issues. |

Further information can be found in the Board papers on our website: https://heiw.nhs.wales/about-us/board-and-committee-meetings/.

The Board is also committed to ensuring staff throughout the organisation are trained and equipped to appropriately assess, manage, escalate and report risk. HEIW managers have continued to receive internal training on risk during 2025/26.

## 4.3 Crisis Management and Business Continuity

HEIW has a Crisis Management and Business Continuity (CM&BC) Policy and plan in accordance with the Civil Contingencies Act and the Emergency Planning Guidance as issued by Welsh Government.

The HEIW CM&BC Policy and plan has been in operation throughout 2025/26. During this period, local Business Continuity Plans (BCPs) were reviewed and developed to ensure alignment with the organisational CM&BC plan and were then subject to internal scenario testing throughout June and July 2025. This testing ensured that they remained fit for purpose but also granted HEIW colleagues an opportunity to see how these arrangements would be employed in practice.

In line with the CM&BC Policy and plan, HEIW's Crisis Management Team (CMT) has the role of monitoring the impact and co-ordinating the management of the risks arising. The CMT has also ensured the Executive Team and Board are regularly briefed and have assessed if any CM&BC risks should be escalated and included within the corporate risk register.

No major incidents occurred during 2025/26 and the CMT was not stood up during this period for its intended purpose. The CM&BC Project Board has met regularly throughout 2025/26 to monitor the policy and plan and to ensure that they remain sensitive to all possible CM&BC scenarios, mindful particularly of the continuing risks to our IT systems posed by a developing technological landscape. HEIW continues to work closely with a wide range of partners, including the Welsh Government, in order to prepare for, mitigate and manage system-wide risks.

In February 2025, NHS Wales Shared Services Partnership conducted an internal Business Continuity Planning audit in which HEIW received Reasonable Assurance against our CM&BC framework arrangements.

HEIW continues to operate a 2:3 working model based on full time office-based staff working from Ty Dysgu two days a week and from home three days a week. This has been in place since 2022 as response to the impact of the cost-of-living crisis.

**HEIW Working Model**

| | | | | | |
|---|---|---|---|---|---|
| **3** | Number of Days working in Ty Dysgu | **2** | Number of Days working at home | **2:3** | Ratio |

## 5. The Control Framework

NHS Wales organisations are not required to comply with all elements of the corporate governance code for central government departments. However, an assessment was undertaken against the main principles as they relate to NHS public sector organisations in Wales and of the Governance, Leadership and Accountability Standard. In response to last year's self-assessment the Board has focussed on the following areas:

- Improving and enhancing communication and stakeholder engagement.
- Reviewing strategic planning and implementation.
- Continuing to develop performance and lessons learned reporting.
- Develop approaches in relation to Upholding Professional Standards in Wales Cases.
- Improved focus on Board Development and Board member development at Board Development Sessions.
- Continuing to implement measures in relation to encouraging applicants to Board positions from under-represented groups and listening to the student and learner voice.

The information provided in this governance statement also provides an assessment of how we comply with the main principles of the Code as they relate to HEIW as an NHS public sector organisation. The Board recognises that not all reporting elements of the Code are outlined in this governance statement but are reported more fully in the organisation's wider Annual Report. The Board is satisfied that it is complying with the main principles of the Code and is conducting its business in an open and transparent manner in line with, the Code. There have been no reported departures from the Corporate Governance Code.

The corporate governance code for central government departments can be found at: https://www.gov.uk/government/publications/corporate-governance-code-for-central-government-departments-2017

HEIW's risk management framework complies materially with the Orange Book, the public sector guide outlining the major principles on the Management of Risk, taking into account the organisation's size, structure and needs. There have been no reported departures from the Orange Book.

The Orange Book can be accessed at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/815635/Orange_Book_Management_of_Risk.pdf



The Health and Care Standards set out the requirement for the delivery of health care in Wales. As an education and training body with no direct contact to patients our focus in respect of the Health and Care Standards relate to staff and resources. Improvements to these areas are captured in our Performance Report.

## 6. Planning Arrangements

The Board-approved Integrated Medium-Term Plan (IMTP) for 2025-28 was submitted to the Welsh Government prior to 31 March 2025, in accordance with the NHS Planning Framework and our statutory duty to produce a financially balanced three-year integrated plan. The Board is responsible for setting the organisation's strategy and was integral to the plan's development, the implementation of which has continued throughout 2025-26.

HEIW's strategic priorities, objectives and deliverables can be found in the Delivery and Performance Analysis section of the Performance Report. Measuring their implementation is central to the planning and performance practices in place to give the Board assurance on our ability to deliver as an organisation. As the strategic workforce body for NHS Wales, our IMTP is shaped heavily by the Workforce Strategy for Health and Care (which can be found at the following link: https://heiw.nhs.wales/files/workforce-strategy/), alongside a focus on supporting and addressing the significant workforce challenges linked with service drivers and Cabinet Secretary Priorities. The plan was developed through engagement with our Board, NHS Wales and Welsh Government colleagues, our wider stakeholders and our staff.

The development of our 2025-28 IMTP was facilitated by conversations with all NHS organisations via our established Stakeholder Reference Group, but also by means of meetings with individual health boards and national organisations to ascertain areas of shared focus. Our plan sought to reflect the requirements set out in our Welsh Government Remit Letter, which was received in February 2025, and the plan's structure – which highlighted the need to deliver both Strategic Objectives and our 'Core Business' activities – was designed to accommodate the breadth of our activities.

Our Board has regularly assured and scrutinised the delivery of the 2025-28 IMTP. This has been facilitated by the application of our new Performance Framework (endorsed by Board in May 2025) and Board's reviewing of regular Integrated Performance Reports. We have sought to focus on the delivery of data driven insights, with a particular focus on demonstrating the impact and added value of the work undertaken by HEIW, as well as highlighting our achievements, challenges, and the mitigating actions that we have developed and employed.

During 2025-26, we have further embedded our internal service review process. This mandates bi-annual service review meetings between our Executive Team, senior leaders and their teams to review the progress of key projects or programmes of work. Following each round of service reviews, the Planning and Performance team has sought to ensure that lessons and best practice are disseminated across the organisation, whilst presenting Board with a thematic analysis to provide further assurance on the performance of the organisation.

In March 2026, the Board approved the IMTP 2026-29, which was submitted to Welsh Government prior to 31 March 2026. The 2026-29 plan incorporates 3-year Strategic Priorities, aligned to the Remit Letter, Cabinet Secretary Priorities and HEIW statutory functions, whose delivery will be taken forward during 2026-27.

## 7. Other Control Framework Elements (Disclosure Statements)

### 7.1 Equality, Diversity and Human Rights Legislation

At HEIW, we remain firmly committed to eliminating discrimination and promoting diversity and inclusion through equality of opportunity and everything that we do. We have continued to embed equality, diversity, and inclusion through strong, compassionate leadership, co-production, collaboration, and direct engagement with those affected by the decisions we make. We value our workforce's individual uniqueness and diversity and believe that this helps us deliver quality services that support the needs of our wider NHS Wales workforce and reflect everyone across our communities.

The Public Sector Equality Duty (PSED) seeks to ensure that equality is properly considered within Public Sector organisations and influences decision-making at all levels. As a listed body in Wales under the Public Sector Equality Duty (Equality Act, 2010), HEIW has control measures in place to ensure compliance with all of the organisation's obligations under equality, diversity and human rights legislation. Oversight is led by our Equality, Diversity and Inclusion (EDI) Steering Group, chaired by our Chief Executive and Director of Workforce and Organisational Development, and supported by staff networks, equality champions, and independent members of our Board.

Welsh Government has published distinct national action plans and standards to support public sector bodies in closing the implementation gap and meeting their duties under the PSED.

As of February 2026, these include (but are not limited to):

- **The Anti-Racist Wales Action Plan (ArWAP)**
- **The LGBTQ+ Action Plan (2023)**
- **Disabled People's Rights Plan (December 2025)**

Our Strategic Equality Plan (SEP), set sets out our commitment and direction of travel over the next four years, which align with the objectives outlined in national action plans and standards. Our three equality objectives focus on the way we attract, recruit, retain and develop our HEIW workforce, inclusive practices in the attraction, education and training of the future health workforce and leaders in NHS Wales and our engagement with our workforce, stakeholders, communities and service users. Progress and key highlights in the delivery of our SEP during this period can be found in our Equality and Gender Pay Gap Report 2024/25.

## 7.2 Equality, Diversity and Human Rights Legislation

For HEIW, as the strategic workforce body for NHS Wales, WBFGA is a key framework for delivering sustainable health education and workforce planning. We came under the remit of the Act during this financial year. It integrates seamlessly with HEIW's mission to improve the health and well-being of the people of Wales through education, training, and workforce development. By adopting the Act's principles, HEIW ensures its well-being objectives align with broader public health goals while contributing to a sustainable future for Wales.

Through the WBFGA, HEIW also ensures alignment with the Social Partnership Duty, which fosters collaboration between employers, employees, and trade unions to deliver fair work and improve well-being. This approach strengthens HEIW's ability to create inclusive workplaces, promote equality, and ensure decision-making reflects the needs and voices of its workforce and stakeholders.

We have established three well-being objectives, in accordance with the sustainable development principle, which is linked to the goals and ways of working of the Act.

The well-being objectives are:

| | |
|---|---|
| 1 | A Flexible and Adaptable Workforce |
| 2 | Embedding Compassionate Leadership |
| 3 | A Culture That Supports Well-being |

Well-being objectives are mapped to our existing IMTP objectives and thus progress against embedding these objectives is consolidated in our Wellbeing of Future Generations Act Annual Report which was presented to July Board. Further information can be found in our Performance Report.

## 7.3 Pension Scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations. On an annual basis, HEIW submits a 'Contributions Assurance Statement' to the NHS Business Services Authority to confirm it has complied with the relevant regulations.

New starters are automatically enrolled in the pension scheme and staff who are members of the NHS Pension Scheme are able to access a Total Reward Statement (TRS) through the Electronic Staff Record self-service function. The TRS includes the following section: NHS Pension (Annual Benefit Statement). This has now been updated to include the McCloud remedy options.

## 7.4 Welsh Risk Pool



The Welsh Risk Pool Services (WRPS) is a risk sharing mechanism, akin to an insurance arrangement which provides indemnity to NHS Wales's organisations against negligence claims and losses. Individual NHS organisations must meet the first £25,000 of a claim or loss which is similar to an insurance policy excess charge. From 1 April 2026, this figure increases to £50,000.

## 7.5 Quality and Quality Improvement

In accordance with the Duty of Quality, HEIW's quality and quality improvements are considered separately in our Annual Quality Report. Further information regarding quality can be found in the Quality Plan section of the Performance Report.

## 7.6 Welsh Language

HEIW is currently in the process of coming under Welsh Language Standards (under the auspices of the Welsh Language Measure 2011) and expects to become subject to Standards in 2026/27. In the meantime, we will continue to work in line with our Welsh Language Scheme, which is based on the Welsh Language Standards. This has been approved by the Welsh Language Commissioner's Office under the original (1993) Welsh Language Act and has been in operation since 2022 at HEIW.

Welsh Government's Strategic Framework More Than Just Words (MTJW) to strengthen the provision of Welsh language services for health and social care, included several actions requiring HEIW to take the lead nationally. We submit a report annually on MTJW to the Welsh Government. Our work supporting the implementation of MTJW over the past year included:

### Strategic Workforce Planning for the Welsh language

While introduced in 2024 it is now embedded into strategic health sector policy and has influenced Welsh Government strategies including the Mental Health and Wellbeing Strategy (April 2025). This supports NHS organisations to plan services around Welsh-language need rather than reacting to it.

### Raising Awareness and Learning Opportunities

HEIW collaborated with Welsh Government to create and disseminate language awareness videos which are now available on YouTube and incorporated in our Revalidation Support Unit programme. Language awareness sessions have also been incorporated in the Advanced Clinical Leadership training programme and also for the national induction programme for new board members.

### Engagement with Students and Future Workforce

The Welsh Health Students Forum has been revitalised to strengthen awareness among students about the importance of Welsh in healthcare. More than Just Words and the Welsh language have been positioned as a key message for all post registration students.

### Promotion of Welsh Medium Career Pathways

HEIW commissioned Syrjeri Sgiliau, an innovative teaching resource designed to inspire primary school children about NHS careers, including the value of Welsh language skills. This was promoted in both Urdd and National Eisteddfod.



HEIW also continues to fund Tomorrow's Doctors and Tomorrow's Healthcare Workers with the Coleg Cymraeg Cenedlaethol.

## 7.7 Stakeholders and Partners

Effective communication, engagement and partnership working are central to our role in developing a skilled, sustainable health and care workforce in Wales. Collaborating with NHS organisations, education providers, professional bodies, social care partners and learners, ensures our plans are evidence-informed, responsive to system needs, and aligned with strategic priorities. This approach builds trust, enables co-production, and maximises the impact of workforce and education initiatives, ensuring stakeholders can actively contribute, access information easily, and shape services that meet real-world needs.

### Key communication and engagement key activities

- Developed and launched a comprehensive Stakeholder Engagement Action Plan (2025–2027) to strengthen collaboration.
- Engaged stakeholders through the Stakeholder Reference Group and professional advisory forums, enabling stakeholders and partners to provide input on key items including the Education Strategy, IMTP and workforce priorities.
- Conducted consultations including the Palliative and End-of-Life Care and digital and AI learning initiatives, receiving over 1600+ responses to inform planning and testing.
- Hosted events including the Wales Health Science Conference 2025 (300+ participants/day), NHS Executive Clinical Showcase, the HEIW Annual General Meeting and 2024–25 Showcase (45 external stakeholders), and a visit from the Chief Medical Officer, strengthening partnerships and co-production.
- Published 208 news articles raising awareness of HEIW achievements focusing on benefits and impact for staff and patients.
- Delivered regional roadshows and interactive engagement sessions, connecting HEIW with learners, professionals, and communities to co-produce education and workforce solutions.
- Redesigned the HEIW website to improve user experience, clarity and navigation, enabling stakeholders and partners to easily access key resources and information.
- Embedded the Tractivity Customer Relationship Management system, sending 164 targeted mailshots with open rates up to 69.1% and click-through rates up to 53.75% - above industry averages. We are managing over 23,888 contacts, ensuring stakeholders received timely, tailored updates.

- Delivered IMTP communications across all eight strategic priorities, including workforce planning, pharmacy, Allied Health Professionals, digital transformation, and compassionate care.
- Published an 8-topic Strategic Priority Blog Series, sharing insight on nursing, AI in healthcare, digital capability, evolving roles, and primary care, improving transparency and knowledge sharing.
- Promoted key workforce resources and campaigns: Workforce Vacancy Dashboard, Cognitive Disabilities Model e-learning, perinatal mental health modules, Mental Health Workforce Plan campaign (16K Facebook reach; 5.2% LinkedIn engagement rate), Eating Disorders e-learning campaign (2% Facebook, 6.7% LinkedIn engagement rate), and IMTP video (12.8K LinkedIn impressions, 5.6K views, 4.35% engagement rate), all exceeding industry benchmarks.
- Supported service development and workforce training initiatives, including National Imaging Academy Wales, launching the first accredited Adult Peripheral Venous Cannulation course to address service needs and improve patient care.
- Produced newsletters, webinars, plus social media campaigns with a cumulative reach of over 1.25m stakeholders including LinkedIn engagement averaging 6.13% (double industry average), ensuring awareness of key initiatives.
- Promoted HEIW's strategic role through media coverage and mentions across BBC, ITV, Nursing Times, Nation Cymru, and others.
- Facilitated co-production and collaborative learning, ensuring stakeholders could influence workforce priorities, training content and strategic planning while strengthening relationships across the health and care system.

## 7.8 Sustainability

HEIW continues to operate under the Board approved Biodiversity and Decarbonisation Strategy 2021-24, whilst working to develop a new strategy. The strategy is intended to help reduce the impact of climate change and improve biodiversity. The strategy sets out HEIW's high-level aspirations and intentions to meet its sustainability requirements; calls its staff, stakeholders, partners and suppliers to action; and identifies the positive changes necessary to achieve longer-term goals for Wales. It focuses on five key areas for action. These are:

| | |
|---|---|
| 1 | **Engaging and supporting our staff.** |
| 2 | **Sustainable procurement.** |
| 3 | **Developing our office, Ty Dysgu, and supporting our local communities.** |

## 4 Environmental sustainability

## 5 Sustainable healthcare in education and training

HEIW is implementing its Sustainability Action Plan to deliver the strategy and reports progress to Welsh Government in line with National Climate Emergency Programme requirements.

In 2025/26, we have:



Developed and published an Integrated Equality Impact Assessment for the Environmental Sustainability Programme of work 2025-27.




Contributed to the development of the refreshed NHS Wales Decarbonisation Strategic Delivery Plan 2025-30, ensuring that climate education and awareness raising of sustainable healthcare are effectively addressed in the refreshed plan.



Played an integral role in the all-Wales Climate Smart Education Task and Finish Group, established under the Health and Social Care Climate Emergency National Programme governance structure. This included the development of a new Climate Education hub on Y Ty Dysgu to provide climate education to the whole of the NHS Wales workforce.



Established the internal governance structure for developing HEIW's Climate Adaptation Plan, to help HEIW build resilience to the current and future impacts of climate change, contributed to a new informal all-Wales collaboration, created to improve the efficiency and effectiveness of the work being done to increase resilience across the system as a whole.



Continued to maintain the green spaces in the grounds of Ty Dysgu and to take an active role in improving surrounding areas.



Demonstrated our ongoing commitment to support staff to make more sustainable and active travel choices by achieving level 1 of the Healthy Travel Charter alongside other NHS Wales and public sector organisations and continuing to engage staff and raise awareness of the benefits of sustainable travel.



Increased staff knowledge and understanding of sustainability issues through supporting a number of events to promote biodiversity. These included 'Let's Go Green for Halloween' and support for Working Wardrobe (donating good quality workwear), and monthly bulletins of key environmental dates and news on the staff intranet.



Continued to provide opportunities for staff to recycle hard-to-recycle items via our staff Ecozone.

HEIW is a key contributor to actions in the refreshed NHS Wales Decarbonisation Strategic Delivery Plan 2025-2030 (published November 2025) that pertains to the education of the workforce. As well as reducing HEIW's impact on the environment, we have an important role to play in promoting sustainable healthcare through education, training and leadership.

In 2025/26, we also continued to implement the Climate Smart Education and Training action plan to help embed the principles of sustainable healthcare into education and training pathways. During this period, we trained a further 30 Climate Smart Champions from across NHS Wales (bringing the total to c.230 over the last three years) to continue promoting sustainable healthcare practice. This is considered further within the sustainability section in the Performance Report part of the Annual Report.

## 7.9 Ministerial Directions

Whilst Ministerial Directions are received by NHS Wales organisations, these are not always applicable to HEIW. Ministerial Directions issued throughout the year are listed on the Welsh Government website Health and social care | Topic | GOV.WALES. Details of the ministerial directions received and their applicability to HEIW as at year end 31 March 2026 are included in Appendix 3 to the Governance Statement.

## 7.10 Data Breaches

Incidents resulting in a personal data breach are reported in accordance with HEIW's statutory requirements and documented Breach Reporting Procedure. A personal data breach means a breach of security leading to the accidental or unlawful destruction, loss, alteration, unauthorised disclosure of, or access to, personal data. This includes data breaches that are the result of both accidental and deliberate causes.

When a personal data breach has occurred, the UK General Data Protection Regulation (UK GDPR) requires that organisations establish the likelihood and severity of the risk to individual's rights and freedoms. If it's likely the data breach will result in a risk to individuals and/or a high risk to individuals rights and freedoms, the breach must be reported to the Information Commissioners Office (ICO). If the risk to individuals is high, those individuals must be notified without undue delay.

HEIW uses an internal scoring system, documented in the Breach Reporting Procedure, to assess the potential severity of the risk. This facilitates an appropriate impact assessment and reporting requirements, such as reporting the data breach to the ICO.

The system considers the number of affected individuals to establish a baseline score of a data breach. This can range from a baseline score of zero to three. The system also considers several key sensitivity factors which can increase or decrease the baseline score. Sensitivity factors which increase the score include clinical information at risk; special categories of data; sensitive health information; previous incidents; complaints made to the ICO; and the harm, detriment, or distress on affected individuals. Security controls (e.g., use of encryption) in place which can reduce the potential impact are factored into the scoring system and will therefore reduce the baseline score.

A personal data breach scoring two or more should be considered for reporting to the ICO. Personal data breaches scoring less than two are considered non-reportable and are appropriately managed internally. The ICO self-assessment tool for data breaches is also used alongside the internal scoring system to support a comprehensive assessment. All reported data breaches are logged internally.

All personal data breaches are appropriately investigated and are reported to the Information Governance and Information Management Group (IGIMG). Where appropriate or mandated, breaches are reported to the Audit and Assurance Committee (AAC) and Welsh Government (WG).

During the 2025/26 period there have been no personal data breaches meeting the threshold for reporting to the ICO or the WG. All reported personal data breaches have been managed internally; recorded appropriately and reported to the IGIMG for appropriate oversight and to facilitate lessons learned and improvement.

## 8. Review of Effectiveness

As Accountable Officer, the CEO has responsibility for reviewing the effectiveness of the system of internal control. The review of the system of internal control is informed by the work of the internal auditors, and the executive officers within the organisation who have responsibility for the development and maintenance of the internal control framework, and comments made by external auditors in their audit letter and other reports.

The Board and its committees rely on several sources of internal and external assurances which demonstrate the effectiveness of HEIW's' system of internal control and advise where there are areas of improvement. These elements are detailed above in the Levels of Assurance diagram in the Governance Statement.

The processes in place to maintain and review the effectiveness of the system of internal control include:

- Board and committee oversight of internal and external sources of assurance and holding to account executive directors and senior managers.
- Executive directors and senior managers who have responsibility for development, implementation and maintenance of the internal control framework and the continuing improvement in effectiveness within the organisation.
- The review and oversight of the principal risks on the Corporate Risk Register and the Board Assurance Framework by the Board and committees.
- The oversight of operational risk through the Board and its committees.
- Oversight of fraud risk through the Counter Fraud team.
- The monitoring of the implementation of recommendations through the audit tracker overseen by the Audit and Assurance Committee.
- Audit and Assurance Committee oversight of audit, risk management and assurance arrangements.

## 8.1 Audit and Assurance Committee Chair's Reflection

HEIW's Board received the Audit and Assurance Committee's 2025/26 Annual Report at its meeting in April. The Committee Chair's reflections within the Committee's Annual Report were as follows:

### Committee Chair's Reflections:

The Committee continues to meet in person whenever possible, whilst recognising location and time constraints for busy attendees as this helps build cohesion and understanding. Regular meetings have taken place, with as much business as possible taken in open session, with a high standard of papers, scrutiny and discussions.

There has been good engagement and attendance at Committee meetings of all parties, and thanks must go to everyone for playing their part to ensure that the Committee makes a positive contribution to HEIW's ongoing development. The support for the meetings has been excellent and ensures that the business runs smoothly. Many thanks to Dafydd and the team for this.

The Committee benefits both from the quality of the reports received and the challenge and scrutiny of their content. Reports cover internal issues relating to HEIW and external issues of interest to HEIW and contain sufficient detail to allow for reflection, learning and continuous scrutiny of the risks relating to the organisation has led to some being signed off and closed down, while others have emerged and will be monitored closely going forward.

The Committee has received regular reports from Audit Wales, Internal Audit and Counter Fraud, indicating areas which could merit more detailed examination, and we continue to focus on those recommendations where attention is needed. I am grateful for the professional and helpful manner in which all this work has been undertaken which has enabled the Committee to operate efficiently and effectively and encourage organisational improvement.

I would also like to thank my fellow Independent Members for their excellent support and engagement during the year. John Gammon continued as Vice Chair of the Committee and provides valuable insight and experience. Alun Lloyd was appointed a member of the Committee in 2025 and has brought fresh insights and considerable financial experience. Thanks to both my colleagues for their valuable input and support.

It is a credit to all involved in supporting the work of the Audit and Assurance Committee that, although there has been some change in the membership of the Committee, the Committee has remained focussed and had continued to provide the Board with assurance. It has been pleasing to see members of the executive team at the Audit and Assurance Committee, both as presenters and observers, and we hope that this will continue next year.

This year marks my final year as Chair of the Committee. The role of Chair has passed to Alun Lloyd, with Dawn Jones, Independent Member, welcomed onto the Committee in February 2026.

## 8.2 Internal Audit

Internal Audit provides the CEO, as Accountable Officer and the Board through the Audit and Assurance Committee, with a flow of assurance on the system of internal control. The CEO commissioned a programme of audit work which has been delivered in accordance with public sector internal audit standards by the NHS Wales Shared Services Partnership. The scope of this work is agreed with the Audit and Assurance Committee and is focussed on significant risk areas and local improvement priorities.

The overall opinion by the Head of Internal Audit (HoIA) on governance, risk management and control is a function of this risk based audit programme and contributes to the picture of assurance available to the Board in reviewing effectiveness and supporting our drive for continuous improvement.

The Head of Internal Audit is satisfied that there has been sufficient internal audit coverage during the reporting period in order to provide the Head of Internal Audit Annual Opinion. In forming the opinion, the Head of Internal Audit has considered the impact of the audits that have not been fully completed.

### 8.2.1 The Head of Internal Audit Conclusion:

The scope of the opinion of the HoIA is confined to those areas examined in the risk-based audit plan, which has been agreed with senior management and approved, by the Audit and Assurance Committee. The HoIA assessment should be interpreted in this context when reviewing the effectiveness of the system of internal control and should be seen as an internal driver for continuous improvement.

The HoIA opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control is set out below.

## Assurance rating

| | | |
|---|---|---|
| Substantial assurance |  | The board can take substantial assurance that arrangements to secure governance, risk management and intenral control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with low impact on residual risk exposure. |

The audit work undertaken during 2025/26, has been reported to the Audit and Assurance Committee.

The evidence base upon which the overall opinion is formed is as follows:

- An assessment of the range of individual opinions arising from the work undertaken in respect of the individual risk-based audit reports contained within the Internal Audit plan which have been reported to the Audit and Assurance Committee throughout 2025/26. This assessment has taken account of the relative materiality of these areas.

- Other assurance reviews, which impact on the Head of Internal Audit Opinion including audit work performed at other organisations. While undertaken formally as part of a particular health organisation's audit programme, the work covers activities relating to other health bodies. For example, NHS Wales Shared Services Partnership. Other knowledge and information that the Head of Internal Audit has obtained during the year including cumulative information and knowledge over time; observation of Board and other key committee meetings; meetings with Executive Directors, senior managers and Independent Members; the results of ad hoc work and support provided; liaison with other assurance providers and regulators; and research. Cumulative audit knowledge of the organisation that the Head of Internal Audit considers relevant to the Opinion for this year.

## 8.2.2 Internal audit report assurance ratings

A summary of the reviews and associated assurance ratings in each of the domains is set out below. It is confirmed that during the reporting period, HEIW did not receive any 'no assurance' reports.

| Domain | Internal Audit Plan Year | Internal Audit | Assurance Rating | Received by Audit and Assurance Committee |
|---|---|---|---|---|
| Corporate Governance, Risk Management and Regulatory Compliance | 2024/25 | Business Continuity Planning | Reasonable | April 2025 |
| | 2025/26 | Corporate Governance Arrangements | Substantial | February 2026 |
| | 2025/26 | Speaking Up Safely | Substantial | April 2026 |
| Strategic Planning, performance management and reporting | 2024/25 | Duty of Quality | Substantial | July 2025 |
| | 2024/25 | Payment of Placement Expenses | Reasonable | April 2025 |
| | 2025/26 | Finance – Capital Expenditure | Reasonable | October 2025 |
| Information Governance and Security | 2025/26 | IT Arrangements Internal | Substantial | October 2025 |
| Operational Service and Functional Management | 2024/25 | Single Lead Employer | Reasonable | April 2025 |
| | 2024/25 | Annual Review of Competence Progression (ARCP) | Substantial | May 2025 |
| | 2024/25 | Bursary | Limited | July 2025 |
| | 2025/26 | Bursary Follow Up | N/A | February 2026 |
| | 2025/26 | Revalidation Support Unit (RSU) | Substantial | October 2025 |

| Domain | Internal Audit Plan Year | Internal Audit | Assurance Rating | Received by Audit and Assurance Committee |
|---|---|---|---|---|
| | 2025/26 | Monitoring of Services Commissioned by Health Boards | Substantial | February 2026 |
| | 2025/26 | Pharmacy Workforce Plan | Substantial | April 2026 |
| | 2025/26 | Practice Education Facilitators | Substantial | April 2026 |
| Workforce Management | 2025/26 | Train, Work, Live | Reasonable | February 2026 |
| | 2025/26 | Mental Health Workforce Plan | Reasonable | February 2026 |

## 8.3 Audit Wales Structured Assessment

The Auditor General for Wales is the statutory external auditor for the NHS in Wales. Audit Wales (AW) undertakes the external auditor role for HEIW on behalf of the Auditor General.

AW's structured assessment for 2025 looked at how well HEIW was governed and whether the organisation made the best use of its resources.

The assessment found that:

> ‘HEIW understands the challenging environment it operates in and its current and future challenges. This includes increasing financial pressure which may have a wider impact on the NHS workforce in Wales. It has a good focus on both the medium and the long-term workforce needs which inform its priorities expressed in its plans. HEIW has robust governance, planning, and financial arrangements. Members and officers are engaged, and scrutiny and oversight remain strong. HEIW should now focus on reporting the benefits and impact from its activities and design Board Development Sessions to continuously improve’.

Audit Wales made the following recommendations based on the 2025 Structured Assessment work.

- HEIW should have in place strong and consistent guidance to capture and triangulate the information from learner experience presentations.

- HEIW should clarify the purpose and impact of Board Development Sessions and design a programme accordingly.
- HEIW should formally communicate to stakeholders how its financial pressures may risk the sustainability of the wider NHS workforce.

Two of the Structured Assessment recommendations have been implemented. Internal governance arrangements are in place to ensure that learner feedback and any other intelligence is triangulated across professions and providers and appropriately escalated. The executive led oversight group has been established to ensure appropriate focus on this area. In relation to Board Development Sessions, meeting purpose and impact have been considered and actions implemented following Board member feedback. Work is progressing to ensure formal communication is in place with stakeholders in relation to financial pressures which risk the sustainability of the wider NHS workforce. The Board currently receives information through bi-monthly performance reporting, through the Integrated Medium-Term Plan and the Education and Training Plan.

During the year, Audit Wales completed a Securing Value from Commissioned Education Places audit which assessed how HEIW assesses and secures value for money when it invests in education and training.

The assessment found that:

> ‘HEIW’s planning and contracting approach has a good focus on actions that will add value for students and, ultimately, for NHS Wales. However, HEIW needs to improve how it assesses and communicates the impact and value of its education investments to help guide future priorities. Our follow-up of the 2022 Review of Annual Commissioning Arrangements identified that HEIW has made good progress although we have identified that the recommendation that relates to contract business meeting minutes requires further work’.

Audit Wales made the following recommendations as a result of the audit which focus on enabling HEIW to understand and demonstrate the value of its education commissioning.

**Determining measures and analysing value for money of commissioned education.**

**Reporting at least annually on the value and impact of education commissioning to the Education Commissioning and Quality Committee.**

Both recommendations are in the process of being implemented. HEIW will review and strengthen the current value for money framework for commissioned education and training by identifying a focused set of appropriate measures that are feasible, proportionate and analytically robust. In relation to annual reporting, a report will be produced at the end of each academic cycle to reflect outcomes in the previous academic session.

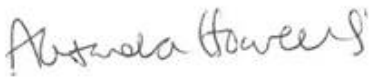
## 8.4 Data Quality

The quality and effectiveness of the information and data provided to the Board is continually reviewed at each meeting of the Board. The Performance Report and Dashboard has been subject to development and revision throughout the year to provide further clarity for the Board. Throughout 2025/26, the Board was assured by the quality of information provided.

# Conclusion – Corporate Governance Report

During the period 1 April 2025 – 31 March 2026, there have been no significant internal control or governance issues identified. This is due to the establishment of sound systems of internal control in place to ensure HEIW met its objectives. It is recognised that further work will be necessary in 2026/27 to further develop these arrangements. It will be important to communicate widely with staff to further embed these arrangements.

Signed by:



**Alex Howells**
Chief Executive Officer
24 June 2026

# Statement of the Chief Executive's Responsibilities as Accountable Officer

The Welsh ministers have directed that the Chief Executive should be the Accountable Officer to the Special Health Authority.

The relevant responsibilities of Accountable Officers, including their responsibility for the propriety and regularity of the public finances for which they are answerable, and for the keeping of proper records, are set out in the Accountable Officer's Memorandum issued by Welsh Government.

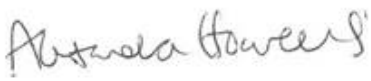
The Accountable Officer is required to confirm that, as far as she is aware, there is no relevant audit information of which the entity's auditors are unaware, and the Accountable Officer has taken all the steps that they ought to have taken to make themselves aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

The Accountable Officer is required to confirm that that the Annual Report and accounts as a whole is fair, balanced and understandable and that they take personal responsibility for the annual report and accounts and the judgements required for determining that it is fair, balanced and understandable.

The Accountable Officer is responsible for authorising the issue of the financial statements on the date they were certified by the Auditor General for Wales.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Signed by:



**Alex Howells**
Chief Executive Officer
24 June 2026

# Directors' Report

The information required for this report can be found in the tables and sections of the Annual Report detailed below.

## Composition of Board

Appendix 1 of the Governance Statement, Board and Committee Membership provides detailed information in relation to the composition of the Board including executive directors and independent members, who have authority or responsibility for directing or controlling the major activities of HEIW during the financial year 2025/26. This includes the names of the Chair and Chief Executive. Appendix 1 also includes the names of the directors forming the Audit and Assurance Committee.

## Board and Board level committee meeting dates for the period ending 31 March 2026

Appendix 2 of the Governance Statement, provides information on the dates of the Board and Committee meetings held during the period 1 April 2025 to 31 March 2026.

## Declaration of interests

Details of company directorships and other significant interests held by members of the Board which may conflict with the responsibilities as Board members are maintained and updated on a regular basis. A register of interests is available in the key documents section of our website at heiw.nhs.wales/files/doi-register/. A hard copy can be obtained from the Board Secretary on request.

## Cost allocation and charging requirements

HEIW confirms it has complied with cost allocation and the charging requirements set out in HM Treasury guidance during the year.

## Information governance

During 2025/26, no data breach met the assessment criteria for reporting to the Information Commissioners Office. (details can be found in the Data Breach section of the Governance Statement).

## Environmental, social and community issues

HEIW is cognisant of the impact it has on the environment and takes steps to minimise this, in line with the NHS Wales Decarbonisation Strategic Delivery Plan. Details of the Board approved HEIW Decarbonisation Strategy and approach to sustainability are outlined in the sustainability sections of the Corporate Governance Report and the Performance Report.

From a social and community impact perspective, HEIW has continued to offer opportunities for students (future workforce) to experience NHS Wales, focussing on key projects adding value to the role of HEIW.

# Statement of directors' responsibilities in respect of the accounts

The directors are required under the National Health Service Act (Wales) 2006 to prepare accounts for each financial year. The Welsh ministers, with the approval of the Treasury, direct that these accounts give a true and fair view of the state of affairs of the special health authority and of the income and expenditure of the special health authority for that period.

In preparing those accounts, the directors are required to:

- apply on a consistent basis accounting principles laid down by the Welsh ministers with the approval of the Treasury.
- make judgements and estimates which are responsible and prudent.
- state whether accounting standards have been followed, subject to any material departures disclosed and explained in the account.

The directors confirm that they have complied with the above requirements in preparing the accounts.

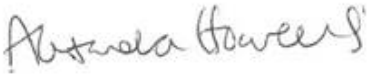
The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the authority and to enable them to ensure that the accounts comply with the requirements outlined in the above-mentioned direction by Welsh ministers.

By order of the Board, signed:

**Chair**
24 June 2026



**Chief Executive Officer**
24 June 2026



**Director of Finance, Planning & Performance**
24 June 2026



## Appendix 1 - Board and committee membership and attendance since 1 April 2025 to 31 March 2026:

| Name | Position | Area of Expertise/ Representation Role | Board/ Committee Membership | Meeting Attendance 2025/26 | Independent Member Champion Roles |
|---|---|---|---|---|---|
| Chris Jones | Chair | Primary Care Widening Access Prevention | Board (Chair) | 8/8 | Welsh Language |
| | | | Remuneration and Terms of Service (RATS) Committee (Chair) | 9/9 | |
| John Gammon | Independent Member | Education/ Training | Board | 7/8 | Digital Research |
| | | | Audit and Assurance Committee | 5/6 | |
| | | | RATS Committee | 8/9 | |
| Donna Macarthur | Independent Member | | Board | 8/8 | North Wales |
| | | | Education, Commissioning and Quality Committee | 4/4 | |
| | | | RATS Committee | 8/9 | |
| Jayne Sadgrove* | Independent Member | Speaking Up Safely Champion | Board | 6/7 | Speaking Up Safely |
| | | | Audit and Assurance Committee | 5/5 | |
| | | | RATS Committee | 5/7 | |
| Dawn Jones** | Independent Member | Engagement and Communication. Data and Digital | Board | 7/8 | |
| | | | Audit and Assurance Committee | 1/1 | |
| | | | Education, Commissioning and Quality Committee | 2/4 | |
| | | | RATS Committee | 8/9 | |

| Name | Position | Area of Expertise/ Representation Role | Board/ Committee Membership | Meeting Attendance 2025/26 | Independent Member Champion Roles |
|---|---|---|---|---|---|
| Judith Hardisty | Independent Member | Speaking Up Safely Champion | Board | 6/8 | Speaking Up Safely |
| | | | Education, Commissioning and Quality Committee | 4/4 | |
| | | | RATS Committee | 9/9 | |
| Alun Lloyd | Independent Member | | Board | 8/8 | |
| | | | Audit and Assurance Committee | 6/6 | |
| | | | RATS Committee | 9/9 | |

| Name | Position | Area of Expertise/ Representation Role | Board/ Committee Membership | Meeting Attendance 2025/26 | Independent Member Champion Roles |
|---|---|---|---|---|---|
| Alex Howells | Chief Executive | | Board | 8/8 | n/a |
| Lisa Llewelyn *** | Executive Director of Nursing, Health Professions and Quality | | Board | 7/7 | n/a |
| Glyn Jones | Director of Finance, Planning and Performance and Deputy CEO | | Board | 8/8 | n/a |
| Tom Lawson | Medical Director | | Board | 8/8 | n/a |
| Helen Watkins | Director of Workforce and Organisational Development | | Board | 7/8 | n/a |
| Sam Donohue **** | Executive Director of Nursing, Health Professions and Quality | | Board | 1/1 | n/a |

Please note: The Director of Finance, Planning and Performance is the lead officer for the Audit and Assurance Committee. The Director of Workforce and Organisational Development is the lead officer for the Remuneration and Terms of Service Committee. The Medical Director, the Executive Director of Nursing, Health Professionals and Quality and the Director of Education, Strategy and Transformation are the lead officers for the Education Commissioning and Quality Committee.

(*) **Jayne Sadgrove** resigned as Independent Member and left HEIW on 31 January 2026. Attendance therefore reflects the number of meetings to end of the term.

(**) **Dawn Jones** was appointed as a member of the Audit and Assurance Committee on 29 January 2026. Attendance therefore reflects the number of meetings since appointment.

(***) **Lisa Llewellyn**, resigned as Executive Director of Nursing, Health Professionals and Quality on 3 March 2026. Attendance therefore reflects the number of meetings to end of role.

(****) **Sam Donohue** was appointed as Executive Director of Nursing, Health Professions and Quality on 3 March 2026. Attendance therefore reflects the number of meetings since appointment.

## Appendix 2 - Dates of Board and Committee meetings held during the period 1 April 2025 to 31 March 2026

The Board and its Committees are fully established and operated in line with the Board's standing orders. Appendix 2 outlines the dates of Board, Board Development and Committee meetings held during the period 1 April 2025 to 31 March 2026, with all meetings being deemed quorate when held.

| Board / Committee | Apr 2025 | May 2025 | Jun 2025 | Jul 2025 | Aug 2025 | Sep 2025 | Oct 2025 | Nov 2025 | Dec 2025 | Jan 2026 | Feb 2026 | Mar 2026 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Board | | 29/05/25 | 26/06/25 | 31/07/25 | 28/08/25 | 25/09/25 | | 27/11/25 | | 29/01/26 | | 26/03/26 |
| Board Development | 24/04/25 | | 26/06/25 | | 28/08/25 | | 02/10/25 | | 11/12/25 | | 26/02/26 | |
| Audit and Assurance Committee | 10/04/25 | 06/05/25 | 19/06/25 | 03/07/25 | | | 09/10/25 | | | | 09/02/26 | |

| Board / Committee | Apr 2025 | May 2025 | Jun 2025 | Jul 2025 | Aug 2025 | Sep 2025 | Oct 2025 | Nov 2025 | Dec 2025 | Jan 2026 | Feb 2026 | Mar 2026 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Education Commissioning and Quality Committee | | | | 17/07/25 | | 11/09/25 | | 13/11/25 | | | | 12/03/26 |
| Remuneration and Terms of Service Committee | 24/04/25 | 12/05/25 | | 31/07/25 | 14/08/25 | | 30/10/25 | 10/11/25 | | 29/01/26 | 26/02/26 | 26/03/26 |

## Appendix 3 - Table of Welsh Health Circulars (WHC) 1 April 2025 – 31 March 2026

| Name | Date | Action to Demonstrate Implementation/ Response |
|---|---|---|
| WHC/2024/015 - Peoples Experience / PES / Peoples Experience Framework. | April 2025 | The Welsh Health Circular is not directly applicable to HEIW, however has been noted. The Framework has been shared internally to reflect on the experience of students in accordance with the Framework. |
| WHC/2025/011 - Introduction of the NHS Wales digital health identity standard for primary care (NHS login) (WHC/2025/11). | April 2025 | The Welsh Health Circular is not directly applicable to HEIW, however has been noted. |
| WHC 2025 010 - Letter to Primary Care re Antiviral Prescribing COVID-19. | April 2025 | The Welsh Health Circular is not directly applicable to HEIW, however has been noted. |
| WHC 2025 004 - Welsh Health Circular - National Clinical Audit Plan 2025 26. | April 2025 | The Welsh Health Circular is not directly applicable to HEIW, however has been noted. |
| WHC/2025/013 - 2025/26 NHS Wales Financial Monitoring Return Guidance. | April 2025 | The Welsh Health Circular has been implemented. The monitoring return guidance is incorporated into the monthly financial reporting and reporting timetable for 2025-26. |
| WHC 2025 016 - Welsh Health Circular - Update on NHS Wales vaccination programmes against respiratory syncytial virus (RSV). | May 2025 | The Welsh Health Circular is not directly applicable to HEIW, however has been noted. |

| Name | Date | Action to Demonstrate Implementation/ Response |
|---|---|---|
| WHC 2025 006 - 2025 WHC. Mental Health Outcomes Measures. | May 2025 | The Welsh Health Circular is not directly applicable to HEIW, however has been noted. |
| WHC/2025/017 - Tranexamic acid use Infected Blood Inquiry. | May 2025 | The Welsh Health Circular is not directly applicable to HEIW, however has been noted. |
| WHC/2025/018 - Tirzepatide (Mounjaro®). | May 2025 | The Welsh Health Circular is not directly applicable to HEIW, however has been noted. |
| WHC/2025/019 - Changes to the routine childhood vaccination schedule and to the selective hepatitis B vaccination programme from 01 July 2025. | May 2025 | The Welsh Health Circular is not directly applicable to HEIW, however has been noted. |
| WHC 2025/012 - updates to NHS Wales SFIs for public procurement reforms. | May 2025 | Approved changes to the Standing Financial Instructions and Financial Delegation Limits at the HEIW Board meeting on 31 July 2025. Financial limits updated in Oracle and financial limit app. |
| WHC/2025/021 - Introduction of routine vaccination programmes for the prevention of mpox and gonorrhoea. | June 2025 | The Welsh Health Circular is not directly applicable to HEIW, however has been noted. |
| WHC/2025/020 - The National Influenza Immunisation Programme 2025-26. | June 2025 | The Welsh Health Circular is not directly applicable to HEIW, however has been noted. Occupational Health requirements are included in the University service specifications. This ensures that students have the opportunity to access Occupations Health services including immunisations. |
| WHC/2025/023 - PPE stockpile volumes in Wales. | June 2025 | The Welsh Health Circular is not directly applicable to HEIW, however has been noted. HEIW PPE stock reviewed and considered. |
| WHC/2025/008 - Introduction of a National Mandatory Licensing Scheme for Special Procedures in Wales. | June 2025 | The Welsh Health Circular is not directly applicable to HEIW, however has been noted. |
| WHC/2025/022 - National COVID-19 Vaccination Programme. | June 2025 | Communications sent to HEIW staff. |

| Name | Date | Action to Demonstrate Implementation/ Response |
|---|---|---|
| WHC/2025/028 - Expansion of the shingles immunisation programme for severely immunosuppressed individuals aged 18-49. | July 2025 | The Welsh Health Circular is not directly applicable to HEIW, however has been noted. |
| WHC/2025/025 - Overseas Visitors' Eligibility to Receive Free Primary Care. | July 2025 | The Welsh Health Circular is not directly applicable to HEIW, however has been noted. |
| WHC/2025/029 - Introduction of Nirsevimab passive immunisation against Respiratory Syncytial Virus (RSV) in at risk infants for upcoming 2025/26 RSV Season. | July 2025 | The Welsh Health Circular is not directly applicable to HEIW, however has been noted. |
| WHC/2025/027 - For the Gluten Free Subsidy scheme. | July 2025 | The Welsh Health Circular is not directly applicable to HEIW, however has been noted. |
| WHC/2025/026 - The safe and responsible adoption of ambient voice technologies ('AI Scribes') in clinical and practice settings. | August 2025 | The Welsh Health Circular is not directly applicable to HEIW, however has been noted. The policy position of use of AVTs will be noted in the development of HEIWs AI development work and guidance to clinical and non clinical staff. |
| WHC/2025/038 - All-Wales NHS Accessible Communication and Information Standards. | September 2025 | The Welsh Health Circular is not directly applicable to HEIW, however has been noted. As part of NHS Wales, HEIW are committed to ensuring that all our communications and engagement materials are accessible, inclusive, and compliant with relevant legislation. This includes the HEIW website, publications and events which meet accessibility standards and can be adapted or provided in alternative formats on request. |
| WHC/2025/034 - Phase 1 Planned Care Referrals DSCN. | September 2025 | The Welsh Health Circular is not directly applicable to HEIW, however has been noted. |
| WHC/2025/037 - IBI Recommendation 7e: Implementing SHOT Reports. | September 2025 | The Welsh Health Circular is not directly applicable to HEIW, however has been noted. |
| WHC/2025/031 - 3Ps Waiting Well SPOC DSCN. | September 2025 | The Welsh Health Circular is not directly applicable to HEIW, however has been noted. |
| WHC/2025/043 - New clinical pathway for treating and managing obesity. | October 2025 | The Welsh Health Circular is not directly applicable to HEIW, however has been noted. |

| Name | Date | Action to Demonstrate Implementation/ Response |
|---|---|---|
| WHC/2025/039 - AMR & HCAI improvement goals for 2025-2027. | October 2025 | The Welsh Health Circular is not directly applicable to HEIW, however has been noted. |
| WHC/2025/046 - The introduction of a routine NHS varicella (chickenpox) vaccination programme for young children in Wales from 1 January 2026. | October 2025 | The Welsh Health Circular is not directly applicable to HEIW, however has been noted. |
| WHC/2025/051 - Safety netting discharge leaflets for adults and children. | December 2025 | The Welsh Health Circular is not directly applicable to HEIW, however has been noted. |
| WHC/2025/049 - development and implementation of a Patient Travel Policy. | December 2025 | The Welsh Health Circular is not directly applicable to HEIW, however has been noted. |
| WHC/2025/054 - Pneumococcal vaccination product change. | December 2025 | The Welsh Health Circular is not directly applicable to HEIW, however has been noted. |
| WHC/2025/055 - 2026-27 Health Board allocation and 2026-27 Health Board allocation - Final Tables. | December 2025 | The Welsh Health Circular is not directly applicable to HEIW, however has been noted. |
| WHC/2026/001 - Timelines and responsibilities for implementing the patient and family initiated escalation approach, Call4Concern. | January 2026 | The Welsh Health Circular is not directly applicable to HEIW, however has been noted. |
| WHC/2025/052 - COVID-19 spring vaccination programme 2026. | January 2026 | The Welsh Health Circular is not directly applicable to HEIW, however has been noted. |
| WHC/2025/053 - Expansion of RSV vaccine eligibility to adults aged 80+ and residents in a care. | February 2026 | The Welsh Health Circular is not directly applicable to HEIW, however has been noted. |
| WHC/2025/041 - Directions to apply Code of Practice Quality Assurance & Performance Management, Escalating Concerns, Closure of Regulated Care & Support Services - Feb 26. | February 2026 | The Welsh Health Circular is not directly applicable to HEIW, however has been noted. The Code of Practice applies to local authorities, Local Health Boards and NHS trusts in Wales in relation to the commissioning of regulated care and support services registered with Care Inspectorate Wales (acting on behalf of the Welsh Ministers) under the Regulation and Inspection of Social Care (Wales) Act 2016. |
| WHC/2026/007 - Welsh Health Circular - Bone Cement. | February 2026 | The Welsh Health Circular is not directly applicable to HEIW, however has been noted. |

| Name | Date | Action to Demonstrate Implementation/ Response |
|---|---|---|
| WHC/2026/002 – Planned Care Activity DSCN. | March 2026 | HEIW will increasingly use this data for secondary uses only for supply and demand modelling and system intelligence. We do not produce this data. |
| WHC/2026/008 – NHS Research and Development Finance Policy. | March 2026 | HEIW currently does not spend money on research and development. However, as part of developing a future research strategy, the financial / accounting arrangements (set out in the WHC) will need to be reflected in the strategy. |
| WHC/2026/004 – Refreshed Intellectual Property guidance and template policy for NHS Wales organisations. | March 2026 | HEIW will ensure that actions are referenced in the Research and Innovation Strategy currently being developed. |
| WHC/2026/006 – The new NHS Wales Complaints Policy, called Listening to People. | March 2026 | HEIW is updating the HEIW Complaints Handling Policy to reflect Listening to People |
| WHC/2026/017 – Enabling community pharmacies to supply medicines ordered by optometrists as part of providing NHS care in Wales. | March 2026 | The WHC will be shared amongst pharmacy and optometry staff in HEIW to ensure awareness that may be required for future continuous professional development/educational activity. The communication to contractors will be led by the contractor negotiating bodies. |

# Remuneration and Staff Report

The information contained in this report relates to the remuneration of the senior managers employed by Health Education & Improvement Wales (HEIW) and also provides details of the wider profile and policies relevant to all staff in the organisation.

The Pay Policy Statement set out in Annex 3 relates to HEIW's strategic stance on senior manager remuneration and to provide a clear statement of the principles underpinning decisions on the use of public funds.

The definition of "Senior Manager" is: 'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS body. This means those who influence the decisions of the entity as a whole rather than the decisions of individual directorates or departments.' For HEIW, the senior managers are considered to be the regular attendees of Board meetings, i.e. Members of the Executive Team and the independent members.

## Remuneration & Terms of Service Committee

The terms of reference and operating arrangements for the Remuneration and Terms of Service Committee are set out in HEIW's standing orders. The purpose of the Committee is to provide advice to the Board on the remuneration and terms of service and performance for the Chief Executive, Executive Directors and other senior staff. It also provides assurance to the Board in relation to HEIW's arrangements for the remuneration and terms of service, including contractual arrangements, for all staff. Further details of the membership and role of the Remuneration and Terms of Service Committee is provided in the Annual Governance Statement.

## Salary and Pension Disclosures

Details of salaries and pension benefits for senior managers captured within this report are given in Annexes 1 and 2. The single figure of remuneration (Annex 1) is intended to be a comprehensive figure that includes all types of reward received by senior managers in the period being reported on, including fixed and variable elements as well as pension provision.

The single figure of remuneration includes the following:



Pensionable and non-pensionable elements of salaries and fees.



Benefits in kind (taxable, total to the nearest £100).



Pension related benefits - those benefits accruing to senior managers from membership of a participating defined benefit pension scheme.

HEIW has not paid any annual or long term performance related bonuses.

Annual salary figures are shown after any reduction resulting from participation in a salary sacrifice scheme. Where an individual has elected to participate in such a scheme, the amount sacrificed is disclosed in a footnote to the table.

## Pay Terms & Conditions/Pay Awards

During 2025/26 NHS Wales staff received pay awards dependent upon their relevant terms and conditions. The main awards included:

- Medical & Dental (Pay Letter M&D(W) 01/2025 v3), which set out the following items:
  - To increase the pay scales by 4% uplift to basic pay, backdated to 1 April 2025, for salaried GMPs and GDPs.
  - To uplift MN25 Min and 01 pay points.
  - To increase the pay scales by 4% uplift to basic pay, back dated to 1 April 2025, for consultants.
  - To increase the pay scales by 4% uplift to basic pay, and an additional £750 consolidated payment added to basic pay, back dated to 1 April 2025, for Resident doctors and dentists.
  - To increase the pay scales by 4% uplift to basic pay, back dated to 1 April 2025, for Specialty and Associate Specialists on the 2008 contract.
  - To increase the pay scales by 4% uplift to basic pay, back dated to 1 April 2025, for Specialty and Specialist doctors on the 2021 contract.
  - To increase the pay scales by 4% uplift to basic pay, backdated to 1 April 2025, for salaried GDPs. 1 Allowances and awards.
  - There is also an increase of 4% to the GMP Trainers' Grant and GMP Appraisers' rate.
  - There will also be an increase of 4% to the Dental Foundation Trainers' Grant and services costs.
  - An increase in national clinical impact awards in Wales from 1 April 2025 to £10,500 for N0, £21,000 for N1, £31,500 for N2 and £42,000 for N3.
  - All other allowances, with the exception of 'Transport fees and Allowances' set out in Annex A section 8 of the pay circular, will increase by 4%.
- Agenda for Change (Pay Letter AfC(W) 02/2025):
  - To increase the pay scales for bands by 3.6% on top of the pay scales set out in AfC(W) 02/2024 from 1 April 2025.
  - This percentage increase does not apply to the pay scales set out in AfC(W) 01/2025 as the payment to the Living Wage Foundation rate was an advanced payment.
  - To increase the sleeping and on call allowance by 3.6%.
- Executive & Senior Staff (Pay Letter ESP(W) 01/2026 Version 2):
  - An increase of 3.25% on top of the pay scales set out in ESP(W) 02/2024 from 1 April 2025.
  - This does include those on Welsh Government approved spot salaries above the role's ESP point.
- The fees paid to the Chair and Independent Members were increased by Welsh Government from 1 January 2026 as follows:
  - Chair from £43,326 to £46,110.
  - Independent Members from £9,360 to £9,840.

## Pensions Benefits

The value of pension related benefits accrued during the year is calculated as the real increase in pension multiplied by 20 less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.

The pension benefit figure is calculated on the basis of an increase in the value over the financial year. Where an individual has become or ceased to be a 'Senior Manager' during the year any increase or decrease in benefits are pro-rated over the period they were in that post.

Annex 2 gives the total pension benefits for all senior managers. The inflationary rate applied to the values of pensions, lump sums and Cash Equivalent Transfer Values (CETV) at 31 March 2025 is 1.7% as set out in the 'Disclosure of Senior Managers' Remuneration (Greenbury) 2026' guidance document.

## Remuneration Relationship

NHS Bodies in Wales bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and 25 percentile, median and 75th percentile remuneration of the organisation's workforce. This information is provided within note 9.6 (Fair Pay Disclosures) in the annual accounts.

# 2025/26 Staff Report

## Number of senior staff

As of 31 March 2026, there were 8 senior staff that made up the Executive Team; they were also members of the Board or regular attendees. All senior staff are directly employed by HEIW. These are:

| | |
|---|---|
| 1 | Chief Executive |
| 2 | Director of Finance, Planning and Performance/Deputy Chief Executive |
| 3 | Director of Workforce & OD |
| 4 | Medical Director |
| 5 | Director of Nursing and Health Profession Education |
| 6 | Director of Digital, Data & Engagement |
| 7 | Director of Education Strategy & Transformation |
| 8 | Board Secretary |

Their pay bands are broken down as follows:

| Numbers of Senior Staff @ 31 March 2026 | |
|---|---|
| Executive and Senior Pay scale | 6 |
| Agenda for Change Pay scale | 1 |
| Medical & Dental Pay Scale | 1 |

## Staff Numbers

The following table shows the average number of staff employed (FTE) by Health Education & Improvement Wales, by group from 1 April 2025 to 31 March 2026:

| Staff Group | Permanently Employed (Inc. Fixed Term) (Ave FTE) | Agency Staff (Ave FTE) | Staff on Inward Secondment (Ave FTE) | 2025/26 Total (Ave FTE) |
|---|---|---|---|---|
| Administrative and Clerical and Board Members | 383.38 | 8.04 | 23.16 | 414.58 |
| Medical & Dental | 49.31 | 0 | 2.73 | 52.04 |
| Professional Scientific and Technical Staff | 40.71 | 0 | 1.80 | 42.51 |
| Additional Clinical Services | 0.93 | 0 | 0.80 | 1.73 |
| Nursing & Midwifery | 11.69 | 0 | 10.01 | 21.70 |
| Allied Health Professionals | 6.25 | 0 | 0 | 6.25 |
| Healthcare Scientists | 3.03 | 0 | 0 | 3.03 |
| **Totals** | **495.31** | **8.04** | **38.50** | **541.85** |

The table above does not include the Chair or Independent Members.

## Staff Composition

The gender breakdown of the Executive Team and other employees as of 31 March 2026 was as follows:

| Staff Composition @ 31 Mar 2026 (headcount) | Male | Female |
|---|---|---|
| Senior Staff (Executive Team) | 4 | 4 |
| Other Employees | 186 | 477 |
| All Staff | 190 | 481 |
| % All Staff | 28.3% | 71.7% |

The data in the table above is taken from ESR Business Intelligence and includes staff with permanent and fixed term assignments.

Due to the nature of its work, HEIW employs a number of individuals on a sessional basis. This results in the headcount of staff for the organisation being significantly higher than the full time equivalent.

## Sickness Absence data

The following table provides information on the number of days lost due to sickness:

| | From 1 April 2024 to 31 March 2025 | From 1 April 2025 to 31 March 2026 |
|---|---|---|
| | Number | Number |
| Days lost (long term) | 3,916.98 | 4,196.03 |
| Days lost (short term) | 1,428.68 | 1,196.93 |
| Total FTE days lost | 5,345.66 | 5,392.96 |
| Average working days lost | 11.05 | 10.74 |
| Total staff employed in period (headcount)* | 722 | 716 |
| Total staff employed in period with no absence (headcount) | 517 | 516 |
| Percentage staff with no sick leave | 71.61% | 72.07% |

The staff numbers in the tables above are calculated on different bases depending on the requirements of the individual disclosures (e.g. full-time equivalents, headcount, average for the year, total at a specific point).

*This is assignment headcount taken from the ESR NHS Absence Analysis Dashboard.

HEIW's rolling sickness absence rate was 2.94% (FTE) as at 31 March 2026, this represents a slight decrease over the last 12 months the rate remains stable. This remains below the NHS Wales target of 4.1%.

The ratio between long term and short-term sickness has remained similar to last year with long term sickness accounting for the majority of all sickness absence. A significant amount of sickness absence is caused by a small number of long-term sickness absence cases.

**Sickness absence rates**

| 2.94% | 4.1% | 73.3% | 26.7% |
|---|---|---|---|
| HEIW's rolling sickness absence rate (as of Mar 31 2026) | NHS Wales target | Long Term Sickness Recorded | Short Term Sickness Recorded |

The biggest single reason for sickness absence is due to anxiety/stress/depression/ other psychiatric illness, which is responsible for 45.8% of absence days and 52.6% of FTE days lost. This can be work related, home related or a combination of both. The People Business Partners provide pro-active support for case and staff have access to a range of well-being resources including an Employee Assistance Programme.

## Staff Policies Applied During the Financial Year

HEIW is now in its seventh year following its establishment in October 2018. The establishment of HEIW as a new organisation involved the Transfer of Undertaking Protection of Employment (TUPE) transfer of staff including staff from Cardiff University into the new organisation and the NHS. In addition, there have been a number of much smaller TUPE transfers in the intervening years both from within the NHS and from Cardiff University. Those that transferred from Cardiff University retained their university contract terms and conditions and at the time of transfer in 2018 these amounted to the majority of the total staff.

The number of staff on Cardiff University terms and conditions continues to fall particularly among Administrative and Clerical Staff (including managers) and is now less than 50. However there remains a significant proportion of medical and dental staff on Cardiff University terms and conditions, although they are paid on NHS pay scales the number is reducing at a slower rate. We would anticipate that total number of staff remaining on Cardiff University terms and conditions of service will continue to reduce as staff move to other jobs in HEIW, leave HEIW or retire.

The HEIW Local Partnership Forum (LPF) provides the formal mechanism for social partnership within HEIW. It is the formal method for engagement, consultation, negotiation and communication between the trade unions and HEIW management and ensures continued partnership working. During 2025/26 the LPF met regularly and dealt with a range of operational and strategic issues. The LPF forms a key part of the approval process for workforce polices including part of the governance process for All Wales policies approved through the Wales Partnership Forum and supports the work of the Policy Review Group.

During 2025/26 the following polices were considered by the LPF before going to the Executives for final sign off:

| Policy name | New /Review | Applicable to |
|---|---|---|
| NHS Wales Reserve Forces Training and Mobilisation Policy | Review | All Staff |
| NHS Wales Anti-Sexual Harassment Policy | New | All Staff |
| All Wales Disciplinary Policy | New | Agenda of Change Staff |
| All Wales Improving Performance at Work Policy | New | Agenda for Change Staff |
| Performance Appraisal and Development Review (PADR) Policy | New | All Staff unless other arrangements specified i.e. Medical & Dental |

All newly appointed staff are employed on NHS terms and conditions of service either, Agenda for Change or Medical & Dental. Former Cardiff University staff continue to have the option to transfer to NHS terms and conditions of service and the number of administrative and managerial staff remaining on Cardiff University terms and conditions of service is reducing. Where former Cardiff University staff covered by TUPE regulations accept a new post within HEIW either permanently or temporarily that results in a contractual change they will transfer to NHS terms and conditions of service. Once transferred they are unable to return to Cardiff University terms and conditions.

We have continued to recruit to new and vacant posts during 2025/26, ESR recorded 94 new starters and 94 leavers across 2025/26. These totals include:



### Graduate Management Trainees

(13 joined and 14 left) and Interns (11 joined and 12 left), who are employed by HEIW on temporary contracts for the duration of the training programmes.



### GP Appraisers

7 individuals joined HEIW and 6 left during the year. These roles are sessional, with a combined total FTE of less than 0.8.



### Fixed-Term Appointments

HEIW employs individuals on fixed-term contracts for specific pieces of work. During 2025/26 15 individuals joined on such contracts and 21 left.



### Retirement

15 individuals were noted on ESR as leaving due to retirement.

During 2025/26 we continued to work to hybrid operating model of 2 days in the office and 3 days working from home. This is a continuation of the initial agreement made to move from the previous hybrid working model of 3 days in the office and 2 days working at home and we have seen attendance in the office increase over the year. It is common for teams to use 'anchor days' when the whole team is in the office. A review of the operating model commenced in 2025 under the title 'Ways of Working' and is due to report in 2026.

## Other Employment Matters

Across Wales 6.2% of the population identify themselves as from a minority ethnic background. Within our local areas of Cardiff and Rhondda Cynon Taff this is 16% and 4% respectively. From those who have declared their ethnicity, those from a minority ethnic background make up 5.08% of our total workforce. Although this remains less than the overall NHS Wales profile of 10.6%, our work on the delivery of the workforce race equality standard (WRES) focuses on us identifying and understanding any barriers within our local recruitment practices and encouraging new and existing staff to update their ethnicity to enable us to have a better understanding of the diversity of our workforce.

HEIW is committed to eliminating discrimination and promoting diversity and inclusion through equality of opportunity and through everything that we do. As such, we are fully committed to meeting duties set out in the Public Sector Equality Duties Act (2011), the Anti-Racist Wales Action Plan 2022, the LGBTQ+ Action Plan 2023 and the Workforce Race Equality Standard (WRES).

**Percentage of minority groups in Wales and the Healthcare workforces**




Wales National Average - Minority Ethnic background.



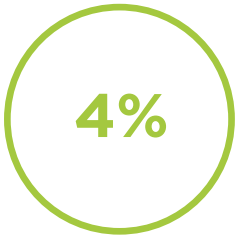

HEIW Workforce - Minority Ethnic background.




NHS Wales Workforce - Minority Ethnic background.




% that identify as an ethnic minority in the Cardiff area.




% that identify as an ethnic minority in Rhondda Cynon Taff.

## Expenditure on Consultancy & Temporary Staff

For the purpose of the statutory accounts, consultancy is defined as time limited/ ad-hoc assignments that are not related to the day-to-day activities of HEIW.

During 2025/26 HEIW's expenditure on consultancy was £366k.

Total costs on agency staff charged to revenue totalled £396k. A further £329k of agency costs were charged to capital schemes.

## Tax Assurance for Off-Payroll Engagements

HEIW is required to disclose any arrangements it has whereby individuals are paid through their own companies or off payroll.

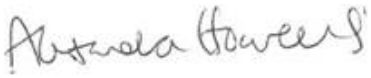
There were none during this period.

## Exit Packages

Details of exit packages are included within note 9.5 of the Annual Accounts.

## Statement of Assurance

I confirm that there is no relevant audit information in the Annual Report of which the Audit Wales is unaware. As Chief Executive, I have taken all the steps in order to make myself aware of any relevant information and ensure the Audit Wales is aware of that information.



**Alex Howells**
Chief Executive Officer and Accountable Officer
Health Education & Improvement Wales
24 June 2026

# Annex 1a: Single Figure of Remuneration 2025/26

| Single Figure of Remuneration | | | | | |
|---|---|---|---|---|---|
| **Name** | **Title** | **Salary (Bands of £5k) £'000** | **Taxable Benefits to nearest £100 £'000** | **Pension Benefit (Bands of £2.5k) £'000** | **Total (Bands of £5k) £'000** |
| Alex Howells | Chief Executive | 185 - 190 | 0 | 72.5 – 75.0 | 255 – 260 |
| Glyn Jones | Deputy Chief Executive /Director of Finance Planning and Performance | 140 – 145 | 1 | 52.5 – 55.0 | 190 - 195 |
| Dafydd Bebb | Board Secretary | 110 – 115 | 0 | 30.0 – 32.5 | 140 -145 |
| Sam Donohue[1] | Director of Nursing, Health Professionals and Quality (from 02/03/26) | 10 – 15 | 0 | 0* | 10 – 15 |
| Tom Lawson[2] | Medical Director | 205 – 210 | 0 | 250.0 – 252.5 | 460 - 465 |
| Lisa Llewelyn[3] | Director of Nursing, Health Professionals and Quality (to 03/03/26) | 115 - 120 | 0 | 60.0 – 62.5 | 175 – 180 |
| Ian Mathieson | Director of Education, Strategy and Transformation | 110 – 115 | 0 | 27.5 – 30.0 | 135 – 140 |
| Sian Richards | Director of Digital, Data and Engagement | 125 – 130 | 0 | 52.5 – 55.0 | 180 – 185 |
| Helen Watkins[4] | Director of Workforce and Organisational Development | 120 – 125 | 17 | 70.0 – 72.5 | 190 - 195 |

| | | | | | |
|---|---|---|---|---|---|
| Dr. Chris Jones | Chair | 40 – 45 | 0 | 0 | 40 - 45 |
| Donna MacArthur[5] | Independent Member and Vice-Chair | 10 – 15 | 22 | 0 | 10 - 15 |
| John Gammon[6] | Independent Member | 10 – 15 | 7 | 0 | 10 – 15 |
| Judith Hardisty | Independent Member | 5 – 10 | 14 | 0 | 10 – 15 |
| Dawn Jones | Independent Member | 5 – 10 | 0 | 0 | 5 - 10 |
| Alun Lloyd[7] | Independent Member | 5 – 10 | 0 | 0 | 5 - 10 |
| Jayne Sadgrove[8] | Independent Member | 5 – 10 | 8 | 0 | 5 - 10 |

The value of 'Pension Benefit' in the table above, which is included within the 'Total' column, is calculated as follows: (real increase in pension† X 20) + (real increase in any lump sum†) – (contributions made by the employee).

†Excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This is not an amount that has been paid to an individual during the year. These figures can be influenced by many factors e.g. changes in a persons salary, any additional contributions made by the employee and other valuation factors affecting the pension scheme as a whole.

*Where the calculation of pension benefits results in a negative figure the Greenbury Disclosure of Senior Managers states that a zero value should be disclosed.

[1] Sam Donohue joined HEIW as Director of Nursing, Health Professionals and Quality on 02/03/2026. The full year equivalent salary for the role is £125k - £130k. As the commencement date was after the deadline to request pensions information the pensions benefit value is reported as £0 for the 2025/26 financial year.

[2] Tom Lawson was Interim Medical Director until 31/08/2025 (full year equivalent salary including enhancements was £205k - £210k) and was appointed substantively into the role from 01/09/2025 (full year equivalent salary including enhancements is £205k - £210k).

[3] Lisa Llewelyn left HEIW on 03/03/2026. The full year equivalent salary for the role was £125k - £130k.

[4] The salary and total remuneration values for Helen Watkins do not include salary sacrifice lease car deductions totalling £8,677 for the year.

[5] Donna MacArthur was an Independent Member until 31/07/2025 (full year equivalent payment excluding taxable allowances was £5k - £10k) and was appointed Vice-Chair from 01/08/2025 (full year equivalent payment excluding taxable allowances is £10k - £15k).

[6] John Gammon was Vice-Chair until 31/07/2025 (full year equivalent payment excluding taxable allowances was £10k - £15k) and Independent Member from 01/08/2025 (full year equivalent excluding taxable allowances is £5k - £10k).

[7] Alun Lloyd joined HEIW as an independent Member on 01/04/2025.

[8] Jayne Sadgrove was an Independent Member until 31/01/2026. The full year equivalent payment excluding taxable allowances was £5k - £10k.

All taxable benefits reported in annex 1a, except for those listed in the footnotes above, relate to the payment of travel expenses.

## Annex 1b: Single Figure of Remuneration 2024/25

| Single Figure of Remuneration | | | | | |
|---|---|---|---|---|---|
| **Name** | **Title** | **Salary (Bands of £5k) (Restated) £'000** | **Taxable Benefits to nearest £100 (Restated) £00** | **Pension Benefit (Bands of £2.5k) £'000** | **Total (Bands of £5k) (Restated) £'000** |
| Alex Howells | Chief Executive | 175 – 180 | - | 77.5 – 80.0 | 255 – 260 |
| Julie Rogers[1] | Director of Workforce and OD / Deputy CEO (until 30/06/24) | 35 – 40 | - | 12.5 – 15.0 | 45 - 50 |
| Glyn Jones[2] | Director of Finance, Planning & Performance (until 30/06/24) | 30 – 35 | 4 | 42.5 – 45.0 | 175 – 180 |
| | Deputy Chief Executive, Director of Finance, Planning & Performance (from 01/07/24) | 100 – 105 | | | |
| Dafydd Bebb | Board Secretary | 105 – 110 | - | 30.0 – 32.5 | 135 – 140 |
| Prof. Push Mangat[3] | Medical Director (until 31/05/24) | 25 – 30 | - | - | 25 – 30 |

| | | | | | |
|---|---|---|---|---|---|
| Sian Richards[4] | Director of Digital Development (until 31/05/24) | 15 – 20 | - | 107.5 – 110.0 | 230 – 235 |
| | Director of Digital, Data and Engagement (from 01/06/24) | 105 – 110 | | | |
| Lisa Llewelyn | Director of Nursing, Allied Health Professionals & Quality | 120 – 125 | - | 57.5 – 60.0 | 180 – 185 |
| Prof. Tom Lawson[5] | Acting Medical Director (from 01/06/24) | 165 – 170 | - | 250.0 – 252.5 | 415 - 420 |
| Dr. Ian Mathieson[6] | Director of Education Strategy and Transformation (from 01/07/24) | 80 – 85 | - | 17.5 – 20.0 | 95 - 100 |
| Helen Watkins[7] | Director of Workforce and Organisational Development (from 01/08/24) | 75 – 80 | 8 | 72.5 – 75.0 | 150 - 155 |
| Angie Oliver[8] | Interim Director of Workforce and Organisational Development (from 01/07/24 to 31/07/24) | 10 – 15 | - | N/A[9] | 10-15[9] |

| | | | | | |
|---|---|---|---|---|---|
| Dr. Chris Jones | Chair | 40 – 45 | - | - | 40 – 45 |
| Gill Lewis[10] | Non-Executive Director (until 31/01/25) | 5 – 10 | - | - | 5 - 10 |
| Prof. John Gammon[11] | Non-Executive Director | 5 – 10 | 8 | - | 10 – 15 |
| Donna MacArthur[12] | Non-Executive Director | 5 – 10 | 15 | - | 10 – 15 |
| Jayne Sadgrove[13] | Non-Executive Director | 5 – 10 | 14 | - | 10 – 15 |
| Dawn Jones | Non-Executive Director | 5 – 10 | - | - | 5 - 10 |
| Judith Hardisty[14] | Non-Executive Director (from 01/07/24) | 5 – 10 | 11 | - | 5 - 10 |

The value of 'Pension Benefit' in the table above is calculated as follows:

(real increase in pension† X 20) + (real increase in any lump sum†) – (contributions made by the employee).

†Excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.

This is not an amount that has been paid to an individual during the year. These figures can be influenced by many factors e.g. changes in a persons salary, any additional contributions made by the employee, and other valuation factors affecting the pension scheme as a whole.

*Where the calculation of pension benefits results in a negative figure the Greenbury Disclosure of Senior Managers states that a zero value should be disclosed.

1 Julie Rogers left HEIW on 30 June 2024. The full year equivalent salary is £135k – £140k.

2 Glyn Jones was Director of Finance, Planning & Performance until 30 June 2024 (Full year equivalent salary is £125k – £130k) and Deputy Chief Executive, Director of Finance, Planning & Performance from 1 July 2024 (Full year equivalent salary is £135k – £140k). Taxable benefits relate to the payment of travel expenses.

3 Professor Push Mangat was Medical Director until 31 May (Full year equivalent salary is £150k – £155k) and was seconded to Welsh Government from 1 June 2024. He was not a member of the HEIW Board during the period of the secondment. Pushpinder Mangat chose not to be covered by the NHS pension scheme for the period employed by HEIW and therefore no pension benefits accrued.

4 Sian Richards was Director of Digital Development until 31 May 2024 (Full year equivalent salary is £105k – £110k) and Director of Digital, Data and Engagement from 1 June 2024 (Full year equivalent salary is £125k – £130k).

5 Professor Tom Lawson was appointed as Acting Medical Director from 1 June 24. The full year equivalent salary is £200k – £205k.

6 Dr Ian Mathieson joined HEIW as Director of Education Strategy and Transformation from 1 July 2024. The full year equivalent salary is £105k – £110k.

7 Helen Watkins joined HEIW as Director of Workforce and Organisational Development from 1 August 2024. The full year equivalent salary excluding salary sacrifice deductions £125k – £130k. Taxable benefits relate to the provision of a is salary sacrifice lease car. The salary and total remuneration values have been restated to exclude the cost of salary sacrifice deductions totalling £5,061 for the period employed by HEIW.

8 Angie Oliver was Interim Director of Workforce and Organisational Development for the period 1 to 31 July 2024. The full year equivalent salary is £125k - £130k.

9 Pension benefit information for Angie Oliver was not requested from the NHS Business Services Authority by the submission deadline. Therefore, the reported total single figure of remuneration of £10k to £15k does not include pension benefits earned during the year.

10 Gill Lewis' term as Independent Member ended on 31 January 2025. The full year equivalent salary (excluding taxable allowances) is in the range £10k - £15k.

[11] Professor John Gammon became Vice-Chair of the HEIW Board on 1 February 2025. The full year equivalent salary of the Vice-Chair role (excluding taxable allowances) is in the range £10k - £15k. Taxable benefits relate to the payment of travel expenses.

[12] Taxable benefits relate to the payment of travel expenses.

[13] Taxable benefits relate to the payment of travel expenses.

[14] Judith Hardisty joined HEIW as Independent Member on 1 July 2024. The full year equivalent salary (excluding taxable allowances) is in the range £5k - £10k. Taxable benefits relate to the payment of travel expenses.

All taxable benefits reported in annex 1b relate to the payment of travel expenses.

## Annex 2: Pension Benefits – 2025/26

| Name | Title | Real increase in pension at pension age (bands of £2,500) £'000 | Real increase in pension lump sum at pension age (bands of £2,500) £'000 | Total accrued pension at pension age at 31 March 2026 (bands of £5,000) £'000 | Lump sum at pension age related to accrued pension at 31 March 2026 (bands of £5,000) £'000 | Cash Equiv-alent Transfer Value at 31 March 2026 £'000 | Cash Equivalent Transfer Value at 31 March 2025 £'000 | Real increase in Cash Equivalent Transfer Value £'000 | Employer's contribution to stakehold-er pension £'000 |
|---|---|---|---|---|---|---|---|---|---|
| Alex Howells | Chief Executive | 2.5 – 5.0 | 2.5 – 5.0 | 85 – 90 | 215 - 220 | 2,073 | 1,923 | 94 | - |
| Glyn Jones | Deputy Chief Executive /Director of Finance Planning and Performance | 2.5 – 5.0 | 0 | 35 – 40 | 0 | 660 | 582 | 50 | - |
| Dafydd Bebb | Board Secretary | 0.0 – 2.5 | 0 | 15 – 20 | 0 | 266 | 225 | 23 | - |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Sam Donohue | Director of Nursing, Health Professionals and Quality (from 03/03/26) | NA[1] | NA[1] | NA[1] | NA[1] | NA[1] | NA1 | NA[1] | - |
| Tom Lawson | Medical Director | 12.5 – 15.0 | 25.0 – 27.5 | 90 – 95 | 250 – 255 | 2,337 | 1,983 | 294 | - |
| Lisa Llewelyn | Director of Nursing, Health Professionals and Quality (to 02/03/26) | 2.5 – 5.0 | 0* | 70 – 75 | 180 – 185 | ** | ** | ** | - |
| Ian Mathieson | Director of Education, Strategy and Transformation | 0.0 – 2.5 | 0 | 0 – 5 | 0 | 53 | 22 | 17 | - |
| Sian Richards | Director of Digital, Data and Engagement | 2.5 – 5.0 | 2.5 – 5.0 | 40 – 45 | 90 – 95 | 785 | 709 | 46 | - |
| Helen Watkins | Director of Workforce and Organisational Development | 2.5 – 5.0 | 5.0 – 7.5 | 45 – 50 | 115 – 120 | 1,098 | 987 | 79 | - |

*Where the calculation of pension benefits results in a negative figure the Greenbury Disclosure of Senior Managers states that a zero value should be disclosed.

** No CETV is reported for senior managers over Normal Pension Age (NPA).

[1] Pension information for Sam Donohue is not available for 2025/26.

# Annex 3: Pay Policy Statement

## Salary and pension entitlements of senior managers 2025/26

The pay and Terms and Conditions of Employment for the executive team and senior managers have been, and will be determined by the HEIW Board, based on the recommendations of the Remuneration and Terms of Service Committee, within the framework set by Welsh Government. The Remuneration and Terms of Service Committee also considers applications relating to the Voluntary Release Scheme. The Remuneration and Terms of Service Committee members are all Independent Members of the Board and the committee is chaired by HEIW's chairperson. The Terms of Reference for the Committee are regularly being reviewed.

## Auditors

The auditors have reviewed this report for consistency with other information in the financial statements and will provide an opinion on the following disclosures:

- Single total figure of remuneration for each director.
- CETV disclosures for each director.
- Payments to past directors, if relevant.
- Payments for loss of office, if relevant.
- Fair pay disclosures (included in annual accounts).
- Exit packages (included in annual accounts) if relevant.
- Analysis of staff numbers.

# The Welsh Parliament Accountability and Audit Report

## Senedd Cymru/ Welsh Parliamentary Accountability and Audit Report for the year ended 31 March 2026

### Regularity of Expenditure

Regularity is the requirement for all items of expenditure and receipts to be dealt with in accordance with the legislation authorising them, any applicable delegated authority and the rules of Government Accounting.

The Health Education and Improvement Wales (HEIW) Board ensures the funding provided by Welsh Ministers has been expended for the purposes intended by Welsh Ministers and that the resources authorised by Welsh Ministers to be used have been used for the purposes for which the use was authorised.

The Chief Executive is the Accountable Officer and ensures that the financial statements are prepared in accordance with legislative requirements and the Treasury's Financial Reporting Manual. In preparing the financial statements, the Chief Executive is required to:

- Observe the accounts directions issued by Welsh Ministers, including the relevant accounting and disclosure requirements and apply appropriate accounting policies on a consistent basis.
- Make judgements and estimates on a reasonable basis.
- State whether applicable accounting standards have been followed and disclosed and explain any material departures from them.
- Prepare them on a going concern basis on the presumption that the services of the Special Health Authority will continue in operation.

### Fees and Charges

Where HEIW undertakes an activity which is not funded directly by the Welsh Government, HEIW receives income to cover its costs. Further detail of income received is published in the annual accounts.

HEIW confirms it has complied with cost allocation and the charging requirements set out in HM Treasury guidance during the year.

## Remote Contingent Liabilities

Remote contingent liabilities are those liabilities that due to the unlikelihood of a resultant charge against HEIW are therefore not recognised as an expense nor as a contingent liability. Detailed below are the remote contingent liabilities as at 31 March 2025.

| | 2025 - 2026 |
|---|---|
| Guarantees | nil |
| Indemnities | nil |

# The Certificate and report of the Auditor General for Wales to the Senedd

## Opinion on financial statements

I certify that I have audited the financial statements of Health Education and Improvement Wales for the year ended 31 March 2026 under Section 61 of the Public Audit (Wales) Act 2004.

These comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Cash Flow Statement and Statement of Changes in Taxpayers' Equity and related notes, including a summary of material accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and UK adopted international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual.

In my opinion, in all material respects, the financial statements:

- Give a true and fair view of the state of affairs of Health Education and Improvement Wales as at 31 March 2026 and of its net operating costs for the year then ended.
- Have been properly prepared in accordance with UK adopted international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual.
- Have been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Ministers.

## Opinion on regularity

In my opinion, in all material respects, the expenditure and income in the financial statements have been applied to the purposes intended by the Senedd and the financial transactions recorded in the financial statements conform to the authorities which govern them.

## Basis for opinions

I conducted my audit in accordance with applicable law and International Standards on Auditing in the UK (ISAs (UK)) and Practice Note 10 'Audit of Financial Statements of Public Sector Entities in the United Kingdom'. My responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of my certificate.

My staff and I are independent of the Board in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK including the Financial Reporting Council's Ethical Standard, and I have fulfilled my other ethical responsibilities in accordance with these requirements. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinions.

## Conclusions relating to going concern

In auditing the financial statements, I have concluded that the use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work I have performed, I have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the body's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from when the financial statements are authorised for issue.

My responsibilities and the responsibilities of the directors with respect to going concern are described in the relevant sections of this certificate.

The going concern basis of accounting for Health Education and Improvement Wales is adopted in consideration of the requirements set out in HM Treasury's Government Financial Reporting Manual, which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it anticipated that the services which they provide will continue into the future.

## Other Information

The other information comprises the information included in the annual report other than the financial statements and my auditor's report thereon.

The Chief Executive is responsible for the other information contained within the annual report. My opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in my report, I do not express any form of assurance conclusion thereon.

My responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or knowledge obtained in the course of the audit, or otherwise appears to be materially misstated. If I identify such material inconsistencies or apparent material misstatements, I am required to determine whether this gives rise to a material misstatement in the financial statements themselves.

If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact.

I have nothing to report in this regard.

## Opinion on other matters

In my opinion, the part of the remuneration report to be audited has been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Ministers.

In my opinion, based on the work undertaken in the course of my audit:

- the parts of the Accountability Report subject to audit have been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Minsters' directions.
- the information given in the Performance and Accountability Reports for the financial year for which the financial statements are prepared is consistent with the financial statements and is in accordance with Welsh Ministers' guidance.

## Matters on which I report by exception

In the light of the knowledge and understanding of Health Education and Improvement Wales and its environment obtained in the course of the audit, I have not identified material misstatements in the Performance Report or the Governance Statement.

I have nothing to report in respect of the following matters, which I report to you, if, in my opinion:

- I have not received all the information and explanations I require for my audit.
- adequate accounting records have not been kept, or returns adequate for my audit have not been received from branches not visited by my team.
- the financial statements and the audited part of the Accountability Report are not in agreement with the accounting records and returns.
- information specified by HM Treasury or Welsh Ministers regarding remuneration and other transactions is not disclosed.
- certain disclosures of remuneration specified by HM Treasury's Government Financial Reporting Manual are not made or parts of the Remuneration Report to be audited are not in agreement with the accounting records and returns.
- the Governance Statement does not reflect compliance with HM Treasury's guidance.

## Responsibilities of Directors and the Chief Executive for the financial statements

As explained more fully in the Statements of Directors' and Chief Executive's Responsibilities, the Directors and the Chief Executive are responsible for:

- maintaining adequate accounting records.
- the preparation of financial statements and annual report in accordance with the applicable financial reporting framework and for being satisfied that they give a true and fair view.
- ensuring that the annual report and financial statements as a whole are fair, balanced and understandable.
- ensuring the regularity of financial transactions.
- internal controls as the Directors and Chief Executive determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.
- assessing Health Education and Improvement Wales' ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Directors and Chief Executive anticipate that the services provided by Health Education and Improvement Wales will not continue to be provided in the future.

## Auditor's responsibilities for the audit of the financial statements

My responsibility is to audit, certify and report on the financial statements in accordance with the National Health Service (Wales) Act 2006.

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue a certificate that includes my opinion.

Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. I design procedures in line with my responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud.

My procedures included the following:

- Enquiring of management, the audited entity's head of internal audit and those charged with governance, including obtaining and reviewing supporting documentation relating to Health Education and Improvement Wales policies and procedures concerned with:

- identifying, evaluating and complying with laws and regulations and whether they were aware of any instances of non-compliance.
- detecting and responding to the risks of fraud and whether they have knowledge of any actual, suspected or alleged fraud.
- the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations.

- Considering as an audit team how and where fraud might occur in the financial statements and any potential indicators of fraud. As part of this discussion, I identified potential for fraud in the posting of unusual journals.
- Obtaining an understanding of Health Education and Improvement Wales' framework of authority as well as other legal and regulatory frameworks that Health Education and Improvement Wales operates in, focusing on those laws and regulations that had a direct effect on the financial statements or that had a fundamental effect on the operations of Health Education and Improvement Wales.
- Obtaining an understanding of related party relationships.

In addition to the above, my procedures to respond to identified risks included the following:

- Reviewing the financial statement disclosures and testing to supporting documentation to assess compliance with relevant laws and regulations discussed above.
- Enquiring of management and the Audit and Assurance Committee about actual and potential litigation and claims.
- Reading minutes of meetings of those charged with governance and the Board.
- In addressing the risk of fraud through management override of controls, testing the appropriateness of journal entries and other adjustments; assessing whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluating the business rationale of any significant transactions that are unusual or outside the normal course of business.

I also communicated relevant identified laws and regulations and potential fraud risks to all audit team members and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

The extent to which my procedures are capable of detecting irregularities, including fraud, is affected by the inherent difficulty in detecting irregularities, the effectiveness of Health Education and Improvement Wales' controls, and the nature, timing and extent of the audit procedures performed.

A further description of the auditor's responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website www.frc.org.uk/auditorsresponsibilities. This description forms part of my auditor's report.

## Other auditor's responsibilities

I am also required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by the Senedd and the financial transactions recorded in the financial statements conform to the authorities which govern them.

I communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

## Report

I have no observations to make on these financial statements.

**Adrian Crompton**
Auditor General for Wales
26 June 2026

1 Capital Quarter
Tyndall Street
Cardiff,
CF10 4BZ




GIG
CYMRU
NHS
WALES
ADULT 1T
Allyn

# **Financial Statements** and Notes



# Annual Accounts 2025 - 2026

## Foreword

These accounts have been prepared by Heath Education and Improvement Wales, a Welsh Special Health Authority under schedule 9 section 178 Para 3(1) of the National Health Service (Wales) Act 2006 (c.42) in the form in which the Welsh Ministers have, with the approval of the Treasury, directed.

These accounts cover the period 1 April 2025 to 3 March 2026.

## Statutory background

HEIW was established as a Special Health Authority by establishment order 2017 No. 913 (W. 224), which was made 11 September 2017 and came into force on the 5 October 2017.

HEIW operated in a shadow form until 1 October 2018 with all establishment and set up costs being borne by the Welsh Government, and with the predecessor bodies of NHS Wales Shared Services Partnership (NWSSP) hosted by Velindre University NHS Trust and Cardiff University delivering operational activity to 30 September 2018. On 1 October 2018 staff were transferred into HEIW and the organisation became fully operational.

HEIW has a leading role in the education, training, development and shaping of the healthcare workforce, supporting high-quality care for the people of Wales.

## Performance Management and Financial Results

HEIW must comply fully with the Treasury's Financial Reporting Manual to the extent that it is applicable to them. As a result, the Primary Statement of in-year income and expenditure is the Statement of Comprehensive Net Expenditure, which shows the net operating cost incurred by HEIW which is funded by the Welsh Government. This funding is allocated on receipt directly to the General Fund in the Statement of Financial Position.

HEIW has an annual requirement to achieve a balanced year end position against the Resource and Capital limits set for the year.

Performance against these limits is reported in Note 2 to the financial statements.

# Statement of Comprehensive Net Expenditure for the period ended 31 March 2026

| | Note | 2025 - 2026 £000 | 2024 - 2025 £000 |
|---|---|---|---|
| Non Medical Education And Training | 3.1 | 151,177 | 138,215 |
| Postgraduate Medical, Dental & Pharmacy Education | 3.2 | 178,901 | 162,163 |
| Other Operating Expenditure | 3.3 | 55,958 | 52,232 |
| Less: Miscellaneous Income | 4 | 386,036<br>(2,113) | 352,610<br>(1,439) |
| **Net operating costs before interest and other gains and losses** | | **383,923** | **351,171** |
| Investment Revenue | 5 | 0 | 0 |
| Other (Gains) / Losses | 6 | 0 | 0 |
| Finance costs | 7 | 50 | 11 |
| **Net operating costs for the financial period** | | **383,973** | **351,182** |

See note 2 on page 22 for details of performance against Revenue and Capital allocations. The notes on pages 8 to 64 form part of these accounts.

# Other Comprehensive Net Expenditure

| | 2025 - 2026 £000 | 2024 - 2025 £000 |
|---|---|---|
| Net (gain) / loss on revaluation of property, plant and equipment | 0 | 0 |
| Net (gain)/loss on revaluation of right of use assets | 0 | 0 |
| Net (gain) / loss on revaluation of intangibles | 0 | 0 |
| Net (gain)/loss on revaluation of financial assets | 0 | 0 |
| Net (gain) loss on revaluation of PPE & Intangible assets held for sale | 0 | 0 |
| Net (gain)/loss on revaluation of financial assets held for sale | 0 | 0 |

| | | |
|---|---|---|
| Impairment and reversals | 0 | 0 |
| Net (gain) / loss on other reserves | 0 | 0 |
| Other comprehensive net expenditure for the period | 0 | 0 |
| **Total comprehensive net expenditure for the period** | **383,973** | **351,182** |

The notes on pages 8 to 64 form part of these accounts.

## Statement of Financial Position as at 31 March 2026

| | | 31 March 2026 | 31 March 2025 |
|---|---|---|---|
| | Note | £000 | £000 |
| **Non-current assets** | | | |
| Property, plant and equipment | 11 | 1,633 | 1,810 |
| Right of Use Assets | 11.3 | 640 | 909 |
| Intangible assets | 12 | 3,416 | 2,305 |
| Trade and other receivables | 15 | 418 | 446 |
| Other financial assets | 16 | 0 | 0 |
| **Total non-current assets** | | **6,107** | **5,470** |
| **Current assets** | | | |
| Inventories | 14 | 0 | 0 |
| Trade and other receivables | 15 | 11,186 | 10,775 |
| Other financial assets | 16 | 0 | 0 |
| Cash and cash equivalents | 17 | 1,682 | 3,611 |
| Non-current assets classified as "Held for Sale" | 11 | 12,868<br>0 | 14,386<br>0 |
| **Total current assets** | | **12,868** | **14,386** |
| **Total assets** | | **18,975** | **19,856** |
| **Current liabilities** | | | |
| Trade and other payables | 18 | **(13,441)** | **(14,542)** |
| Other financial liabilities | 19 | 0 | 0 |

| | | | |
|---|---|---|---|
| Provisions | 20 | (324) | (536) |
| **Total current liabilities** | | **(13,765)** | **(15,078)** |
| **Net current assets/ (liabilities)** | | **(897)** | **(692)** |

| | | | |
|---|---|---|---|
| **Non-current liabilities** | | | |
| Trade and other payables | 18 | (374) | (679) |
| Other financial liabilities | 19 | 0 | 0 |
| Provisions | 20 | 0 | 0 |
| **Total current liabilities** | | **(374)** | **(679)** |
| **Total assets employed** | | **4,836** | **4,099** |

| | | | |
|---|---|---|---|
| **Financed by:** | | | |
| **Taxpayers' equity** | | | |
| General Fund | | 4,836 | 4,099 |
| Revaluation reserve | | 0 | 0 |
| **Total taxpayers' equity** | | **4,836** | **4,099** |

The notes on pages 8 to 64 form part of these accounts. The financial statements on pages 2 to 7 were approved by the Board on 24.06.2026.



**Alex Howells**
Chief Executive and Accountable Officer
24 June 2026

# Statement of Changes in Taxpayers' Equity
# For the period ended 31 March 2026

| Changes in taxpayers' equity | General Fund £000 | Revaluation Reserve £000 | Total Reserves £000 |
|---|---|---|---|
| **Balance b/f as at 31 March 2025** | **4,099** | **0** | **4,099** |
| NHS Wales Transfer | **0** | **0** | 0 |
| RoU Asset Transitioning Adjustment | **0** | **0** | 0 |
| Impact of IFRS 16 on PPP/ PFI Liability | **0** | **0** | 0 |
| **Balance at 1 April 2025** | **4,099** | **0** | **4,099** |
| Net operating cost for the period | **(383,973)** | | **(383,973)** |
| Net gain/(loss) on revaluation of property, plant and equipment | **0** | **0** | 0 |
| Net gain/(loss) on revaluation of right of use assets | **0** | **0** | 0 |
| Net gain/(loss) on revaluation of intangible assets | **0** | **0** | 0 |
| Net gain/(loss) on revaluation of financial assets | **0** | **0** | 0 |
| Net gain/(loss) on revaluation of PPE and Intangible assets held for sa | **0** | **0** | 0 |
| Net gain/(loss) on revaluation of financial assets held for sale | **0** | **0** | 0 |
| Impairments and reversals | **0** | **0** | 0 |
| Other reserve movement | **0** | **0** | 0 |
| Transfers between reserves | **0** | **0** | 0 |
| Release of reserves to SoCNE | **0** | **0** | 0 |
| Transfers to/from (please specify) | **0** | **0** | 0 |
| Net gain/(loss) on Other Reserve | **0** | **0** | 0 |

| | | | |
|---|---|---|---|
| **Total recognised income and expense for period** | **(383,973)** | **0** | **(383,973)** |
| Net Welsh Government funding | 379,687 | | 379,687 |
| Welsh Government notional funding | **5,023** | | 5,023 |
| **Balance at 31 March 2026** | **4,836** | **0** | **4,836** |

Notional Welsh Government funding line includes 9.4% staff employer pension costs paid centrally by Welsh Government.

The Department of Health and Social Care (DHSC) 2023-24 consultation on the NHS Pension Scheme confirmed that the transitional approach that has operated since 2019-20 for employer contributions will continue in 2025-26. From 1 April 2024 an employer rate of 23.7% (23.78% inclusive of the administration charge) should be applied. However, the NHS Business Services Authority will continue to only collect 14.38% from NHS Wales employers under their normal monthly payment process to the NHS Pension Scheme.

Notional Welsh Government funding split:

Notional 9.4% staff employer pension:

**SHA Staff:**
£2.313m (Note 3.3).

**Single Lead Employer (SLE) Staff:**
£2.710m, comprising £2.687m (Note 3.2) and £0.023m (Note 3.3).

The notes on pages 8 to 64 form part of these accounts.



# Statement of Changes in Taxpayers' Equity
# For the period ended 31 March 2025

| | General Fund £000 | Revaluation Reserve £000 | Total Reserves £000 |
|---|---|---|---|
| **Changes in taxpayers' equity** | | | |
| **Balance b/f as at 31 March 2024** | **2,610** | **0** | **2,610** |
| NHS Wales Transfer | 0 | 0 | 0 |
| RoU Asset Transitioning Adjustment | 0 | 0 | 0 |
| Impact of IFRS 16 on PPP/ PFI Liability | 0 | 0 | 0 |
| **Balance at 1 April 2024** | **2,610** | **0** | **2,610** |
| Net operating cost for the period | **(351,182)** | | **(351,182)** |
| Net gain/(loss) on revaluation of property, plant and equipment | 0 | 0 | 0 |
| Net gain/(loss) on revaluation of right of use assets | 0 | 0 | 0 |
| Net gain/(loss) on revaluation of intangible assets | 0 | 0 | 0 |
| Net gain/(loss) on revaluation of financial assets | 0 | 0 | 0 |
| Net gain/(loss) on revaluation of PPE and Intangible assets held for sa | 0 | 0 | 0 |
| Net gain/(loss) on revaluation of financial assets held for sale | 0 | 0 | 0 |
| Impairments and reversals | 0 | 0 | 0 |
| Movements other reserves | 0 | 0 | 0 |
| Transfers between reserves | 0 | 0 | 0 |
| Release of reserves to SoCNE | 0 | 0 | 0 |
| Transfers to/from NHS Wales bodies | 0 | 0 | 0 |
| Net gain/(loss) on Other Reserve | 0 | 0 | 0 |

| | | | |
|---|---|---|---|
| **Total recognised income and expense for period** | **(351,182)** | **0** | **(351,182)** |
| Net Welsh Government funding | 347,900 | | 347,900 |
| Welsh Government notional funding | 4,771 | | 4,771 |
| **Balance at 31 March 2025** | **4,099** | **0** | **4,099** |

Notional Welsh Government funding line includes 9.4% staff employer pension costs paid centrally by Welsh Government.

The Department of Health and Social Care (DHSC) 2023–24 consultation on the NHS Pension Scheme confirmed that the transitional approach that has operated since 2019–20 for employer contributions will continue in 2024–25. From 1 April 2024 an employer rate of 23.7% (23.78% inclusive of the administration charge) will apply. However, the NHS Business Services Authority will continue to only collect 14.38% from NHS Wales employers under their normal monthly payment process to the NHS Pension Scheme. This has resulted in an increase in the central payments made by Welsh Government from 6.3% to 9.4%.

Notional Welsh Government funding split:

Notional 9.4% staff employer pension:

**SHA Staff:**
£2.148m (Note 3.3).

**Single Lead Employer (SLE) Staff:**
£2.623m, (Note 3.2).

The notes on pages 8 to 64 form part of these accounts.

# Statement of Cash Flows for period ended 31 March 2026

| | | 2025 - 2026 £000 | 2024 - 2025 £000 |
|---|---|---|---|
| **Cash Flows from operating activities** | **notes** | | |
| Net operating cost for the financial period | | **(383,973)** | **(351,182)** |
| Movements in Working Capital | 27 | **(1,041)** | **(3,902)** |
| Other cash flow adjustments | 28 | 5,873 | 6,038 |
| Provisions utilised | 20 | **(87)** | 0 |
| Net cash outflow from operating activities | | **(379,228)** | **(349,046)** |

| | 2025 - 2026 £000 | 2024 - 2025 £000 |
|---|---|---|
| **Cash Flows from investing activities** | | |
| Purchase of property, plant and equipment | **(246)** | **(314)** |
| Proceeds from disposal of property, plant and equipment | **0** | 0 |
| Purchase of intangible assets | **(1,827)** | **(1,405)** |
| Proceeds from disposal of intangible assets | **0** | 0 |
| Payment for other financial assets | **0** | 0 |
| Proceeds from disposal of other financial assets | **0** | 0 |
| Payment for other assets | **0** | 0 |
| Proceeds from disposal of other assets | **0** | 0 |
| **Net cash inflow/(outflow) from investing activities** | **(2,073)** | **(1,719)** |
| **Net cash inflow/(outflow) before financing** | **(381,301)** | **(350,765)** |

| | 2025 - 2026 £000 | 2024 - 2025 £000 |
|---|---|---|
| **Cash Flows from financing activities** | | |
| Welsh Government funding (including capital) | **379,687** | 347,900 |
| Capital receipts surrendered | **0** | 0 |
| Capital grants received | **0** | 0 |
| Capital element of payments in respect of finance leases and on-SoFP | **0** | 0 |
| Capital element of payments in respect of on-SoFP PFI | **0** | 0 |
| Capital element of payments in respect of Right of Use Assets | **(315)** | **(311)** |
| Cash transferred (to)/ from other NHS bodies | **0** | 0 |
| **Net financing** | 379,372 | 347,589 |
| **Net increase/(decrease) in cash and cash equivalents** | **(1,929)** | **(3,176)** |
| **Cash and cash equivalents (and bank overdrafts) at 1 April 2025** | 3,611 | 6,787 |
| **Cash and cash equivalents (and bank overdrafts) at 31 March 2026** | 1,682 | 3,611 |

The notes on pages 8 to 64 form part of these accounts.

# Notes to the Accounts

## 1. Accounting policies

The Minister for Health and Social Services has directed that the financial statements of Special Health Authorities (SHAs) in Wales shall meet the accounting requirements of the NHS Wales Manual for Accounts. Consequently, the following financial statements have been prepared in accordance with the 2025-26 Manual for Accounts. The accounting policies contained in that manual follow the 2025-26 Financial Reporting Manual (FReM), in accordance with international accounting standards in conformity with the requirements of the Companies Act 2006, to the extent that they are meaningful and appropriate to the NHS in Wales.

Where the Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the SHA for the purpose of giving a true and fair view has been selected. The particular policies adopted by the SHA are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

### 1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets and inventories.

### 1.2 Activities are considered

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

### 1.3 Income and funding

The main source of funding for the SHA are allocations (Welsh Government funding) from the Welsh Government within an approved cash limit, which is credited to the General Fund of the SHA. Welsh Government funding is recognised in the financial period in which the cash is received.

Non-discretionary funding outside the Revenue Resource Limit is allocated to match actual expenditure incurred. Non-discretionary expenditure is disclosed in the accounts and deducted from operating costs charged against the Revenue Resource Limit.
Funding for the acquisition of fixed assets received from the Welsh Government is credited to the General Fund.

Miscellaneous income is income which relates directly to the operating activities of the SHA and is not funded directly by the Welsh Government. This includes payment for services uniquely provided

by the SHA for the Welsh Government. Income received from other NHS Organisations transacting with the SHA is always treated as miscellaneous income.

From 2018-19, IFRS 15 Revenue from Contracts with Customers has been applied, as interpreted and adapted for the public sector, in the FREM. It replaces the previous standards IAS 11 Construction Contracts and IAS 18 Revenue and related IFRIC and SIC interpretations. The potential amendments identified as a result of the adoption of IFRS 15 are significantly below materiality levels.

Income is accounted for applying the accruals convention. Income is recognised in the period in which services are provided. Where income had been received from third parties for a specific activity to be delivered in the following financial year, that income will be deferred.

Only non-NHS income may be deferred.

## 1.4 Employee benefits

### 1.4.1 Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

### 1.4.2 Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

The Department of Health and Social Care (DHSC) 2023-24 consultation on the NHS Pension Scheme confirmed that the transitional approach that has operated since 2019-20 for employer contributions will continue in 2025-26. From 1 April 2024 an employer rate of 23.7% (23.78% inclusive of the administration charge) will apply. However, the NHS Business Services Authority will continue to only collect 14.38% f rom NHS Wales employers under their normal monthly payment process to the NHS Pension Scheme. This has a resulted in an increase in the central payments made by Welsh Government directly to the Pension Scheme administrator, the NHS Business Services Authority (BSA the NHS Pensions Agency) from 6.3% to 9.4%.

However, NHS Wales' organisations are required to account for their staff employer contributions of 23.78% in full and on a gross basis, in their annual accounts. Payments made on their behalf by Welsh Government are accounted for on a notional basis. For detailed information see Other Note within these accounts.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the NHS Wales organisation commits itself to the retirement, regardless of the method of payment.

### 1.4.3. NEST Pension Scheme

An alternative pensions scheme for employees not eligible to join the NHS Pensions scheme has to be offered. The NEST (National Employment Savings Trust) Pension scheme is a defined contribution scheme and therefore the cost to the NHS body of participating in the scheme is equal to the contributions payable to the scheme for the accounting period.

## 1.5 Other expenses

Other operating expenses for goods or services are recognised when, and to the extent that, they have been received. They are measured at the fair value of the consideration payable.

## 1.6 Property, plant and equipment

Other operating expenses for goods or services are recognised when, and to the extent that, they have been received. They are measured at the fair value of the consideration payable.

### 1.6.1 Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes.
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the NHS Wales organisation.
- it is expected to be used for more than one financial year.
- the cost of the item can be measured reliably.
- the item has cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.
- Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

## 1.6.2 Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

At the Statement of Financial Position date the building asset held by the SHA relates solely to expenditure on leasehold improvements, which is carried at depreciated cost.
Future asset purchases that are not leasehold improvements will be carried on the following basis:

Land and buildings used for services or for administrative purposes are stated in the Statement of Financial Position (SoFP) at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. NHS Wales' organisations have applied these new valuation requirements from 1 April 2009.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure.Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure.

References in IAS 36 to the recognition of an impairment loss of a revalued asset being treated as a revaluation decrease to the extent that the impairment does not exceed the amount in the revaluation surplus for the same asset, are adapted such that only those impairment losses that do not result from a clear consumption of economic benefit or reduction of service potential (including as a result of loss or damage resulting from normal business operations) should be taken to the revaluation reserve. Impairment losses that arise from a clear consumption of economic benefit should be taken to the Statement of Comprehensive Net Expenditure (SoCNE).

From 2015-16, IFRS 13 Fair Value Measurement must be complied with in full. However IAS 16 and IAS 38 have been adapted for the public sector context which limits the circumstances under which a valuation is prepared under IFRS 13. Assets which are held for their service potential and are in use should be measured at their current value in existing use. For specialised assets current value in existing use should be interpreted as the present value of the assets remaining service potential, which can be assumed to be at least equal to the cost of replacing that service potential. Where there is no single class of asset that falls within IFRS 13, disclosures should be for material items only.

In accordance with the adaptation of IAS 16 in table 6.2 of the FReM, for non-specialised assets in operational use, current value in existing use is interpreted as market value for existing use which is defined in the RICS Red Book as Existing Use Value (EUV).

Assets which were most recently held for their service potential but are surplus should be valued at current value in existing use, if there are restrictions on the NHS organisation or the asset which would prevent access to the market at the reporting date. If the NHS organisation could access the market then the surplus asset should be used at fair value using IFRS 13. In determining whether such an asset which is not in use is surplus, an assessment should be made on whether there is a clear plan to bring the asset back into use as an operational asset. Where there is a clear plan, the asset is not surplus and the current value in existing use should be maintained. Otherwise the asset should be assessed as being surplus and valued under IFRS13.

Assets which are not held for their service potential should be valued in accordance with IFRS 5 or IAS 40 depending on whether the asset is actively held for sale. Where an asset is not being used to deliver services and there is no plan to bring it back into use, with no restrictions on sale, and it does not meet the IAS 40 and IFRS 5 criteria, these assets are surplus and are valued at fair value using IFRS 13.

### 1.6.3 Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any carrying value of the item replaced is written-out and charged to the SoCNE. As highlighted in previous years the NHS in Wales does not have systems in place to ensure that all items being "replaced" can be identified and hence the cost involved to be quantified.

The NHS in Wales has thus established a national protocol to ensure it complies with the standard as far as it is able to which is outlined in the capital accounting chapter of the Manual For Accounts. This dictates that to ensure that asset carrying values are not materially overstated. For All Wales Capital Schemes that are completed in a financial year, NHS Wales organisations are required to obtain a revaluation during that year (prior to them being brought into use) and also similar revaluations are needed for all Discretionary Building Schemes completed which have a spend greater than £0.5m. The write downs identified are then charged to operating expenses.

## 1.7 Intangible assets

### 1.7.1 Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the NHS Wales organisation; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use.
- the intention to complete the intangible asset and use it.
- the ability to use the intangible asset.
- how the intangible asset will generate probable future economic benefits.
- the availability of adequate technical, financial and other resources to complete the intangible asset and use it.
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

### 1.7.2 Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

## 1.8 Depreciation, amortisation and impairments

Freehold land, assets under construction and assets held for sale are not depreciated. Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets.

The estimated useful life of an asset is the period over which the NHS Wales Organisation expects to obtain economic benefits or service potential from the asset. This is specific to the NHS Wales organisation and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and estimated useful lives.

At each reporting period end, the NHS Wales organisation checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

Impairment losses that do not result from a loss of economic value or service potential are taken to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to the SoCNE. Impairment losses that arise from a clear consumption of economic benefit are taken to the SoCNE. The balance on any revaluation reserve (up to the level of the impairment) to which the impairment would have been charged under IAS 36 are transferred to retained earnings. Right of use (ROU) asset impairments are reflected in ROU liability.

## 1.9 Research and Development

Research and development expenditure is charged to operating costs in the year in which it is incurred, except insofar as it relates to a clearly defined project, which can be separated from patient care activity and benefits there from can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SoCNE on a systematic basis over the period expected to benefit from the project.

## 1.10 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the SoCNE. On disposal, the balance for the asset on the revaluation reserve, is transferred to the General Fund. Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead it is retained as an operational asset and its economic life adjusted. The asset is derecognised when it is scrapped or demolished.

## 1.11 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration.

IFRS 16 leases is effective across public sector from 1 April 2022. The transition to IFRS 16 has been completed in accordance with paragraph C5 (b) of the Standard, applying IFRS 16 requirements retrospectively recognising the cumulative effects at the date of initial application.

In the transition to IFRS 16 a number of elections and practical expedients offered in the standard have been employed. These are as follows:
The entity has applied the practical expedient offered in the standard per paragraph C3 to apply IFRS 16 to contracts or arrangements previously identified as containing a lease under the previous leasing standards IAS 17 leases and IFRIC 4 determining whether an arrangement contains a lease and not to those that were identified as not containing a lease under previous leasing standards.

On initial application HEIW has measured the right of use assets for leases previously classified as operating leases per IFRS 16 C8 (b)(ii), at an amount equal to the lease liability adjusted for accrued or prepaid lease payments.

No adjustments have been made for operating leases in which the underlying asset is of low value per paragraph C9 (a) of the standard.

The transitional provisions have not been applied to operating leases whose terms end within 12 months of the date of initial application has been employed per paragraph C10 (c) of IFRS 16.

Hindsight is used to determine the lease term when contracts or arrangements contain options to extend or terminate the lease in accordance with C10 (e) of IFRS 16.

Due to transitional provisions employed the requirements for identifying a lease within paragraphs 9 to 11 of IFRS 16 are not employed for leases in existence at the initial date of application. Leases entered into on or after the 1 April 2022 will be assessed under the requirements of IFRS 16. There are further expedients or election that have been employed by HEIW in applying IFRS 16.

These include:

- the measurement requirements under IFRS 16 are not applied to leases with a term of 12 months or less under paragraph 5 (a) of IFRS 16.
- the measurement requirements under IFRS 16 are not applied to leases where the underlying asset is of a low value which are identified as those assets of a value of less than £5,000, excluding any irrecoverable VAT, under paragraph 5 (b) of IFRS 16.

The entity will not apply IFRS 16 to any new leases of intangible assets applying the treatment described in section 1.7 instead.

HEIW is required to apply IFRS 16 to lease like arrangements entered into with other public sector entities that are in substance akin to an enforceable contract, that in their formal legal form may not be enforceable. There are currently no such arangements in place.

HEIW is required to apply IFRS 16 to lease like arrangements entered into in which consideration exchanged is nil or nominal, therefore significantly below market value. These arrangements are

are described as peppercorn leases. Such arrangements are again required to meet the definition of a lease in every other respect prior to inclusion in the scope of IFRS 16. The accounting for peppercorn arrangements aligns to that identified for donated assets. Peppercorn leases are different in substance to arrangements in which consideration is below market value but not significantly below market value. There are currently no such arrangements in place.

The nature of the accounting policy change for the lessee is more significant than for the lessor under IFRS 16. IFRS 16 introduces a singular lessee approach to measurement and classification in which lessees recognise a right of use asset.

For the lessor leases remain classified as finance leases when substantially all the risks and rewards incidental to ownership of an underlying asset are transferred to the lessee. When this transfer does not occur, leases are classified as operating leases.

### 1.11.1 HEIW as lessee

At the commencement date for the leasing arrangement a lessee shall recognise a right of use asset and corresponding lease liability. The entity employs a revaluation model for the subsequent measurement of its right of use assets unless cost is considered to be an appropriate proxy for current value in existing use or fair value in line with the accounting policy for owned assets. Where consideration exchanged is identified as below market value, cost is not considered to be an appropriate proxy to value the right of use asset.

Irrecoverable VAT is expensed in the period to which it relates and therefore not included in the measurement of the lease liability and consequently the value of the right of use asset.

The incremental borrowing rate of 0.95% has been applied to the lease liabilities recognised at the date of initial application of IFRS 16.

Where changes in future lease payments result from a change in an index or rate or rent review, the lease liabilities are remeasured using an unchanged discount rate. Where there is a change in a lease term or an option to purchase the underlying asset HEIW applies a revised rate to the remaining lease liability.

Where existing leases are modified HEIW must determine whether the arrangement constitutes a separate lease and apply the standard accordingly.

Lease payments are recognised as an expense on a straight-line or another systematic basis over the lease term, where the lease term is in substance 12 months or less, or is elected as a lease containing low value underlying asset by HEIW.

### 1.11.2 HEIW as lessor

The enity does not lease any of its assets and is therefore not a lessor.

## 1.12 Inventories

Whilst it is accounting convention for inventories to be valued at the lower of cost and net realisable value using the weighted average or "first-in first-out" cost formula, it should be recognised that the NHS is a special case in that inventories are not generally held for the intention of resale and indeed there is no market readily available where such items could be sold. Inventories are valued at cost and this is considered to be a reasonable approximation to fair value due to the high turnover of stocks. Work in progress comprises goods in intermediate stages of production. Partially completed contracts for patient services are not accounted for as work-in-progress.

HEIW does not currently hold any inventory.

## 1.13 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in three months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value. In the Statement of Cash flows (SoCF), cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the cash management.

## 1.14 Provisions

Provisions are recognised when the NHS Wales organisation has a present legal or constructive obligation as a result of a past event, it is probable that the NHS Wales organisation will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using the discount rate supplied by HM Treasury.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the NHS Wales organisation has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the NHS Wales organisation has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

### 1.14.1 Clinical negligence and personal injury costs

The Welsh Risk Pool Services (WRPS) operates a risk pooling scheme which is co-funded by the Welsh Government with the option to access a risk sharing agreement funded by the participative NHS Wales bodies. The risk sharing option was implemented in both 2024-25 and 2025-26, although no costs were apportioned to the SHA during the year. The WRP is hosted by Velindre University NHS Trust.

## 1.15 Discount Rates

Where discount is applied, a disclosure detailing the impact of the discounting on liabilities to be included for the relevant notes. The disclosure should include where possible undiscounted values to demonstrate the impact. An explanation of the source of the discount rate or how the discount rate has been determined to be included.

## 1.16 Financial Instruments

From 2018-19 IFRS 9 Financial Instruments has applied, as interpreted and adapted for the public sector, in the FReM. The principal impact of IFRS 9 adoption by NHS Wales' organisations, was to change the calculation basis for bad debt provisions, changing from an incurred loss basis to a lifetime expected credit loss (ECL) basis.

All entities applying the FReM recognised the difference between previous carrying amount and the carrying amount at the beginning of the annual reporting period that included the date of initial application in the opening general fund within Taxpayer's equity.

## 1.17 Financial assets

Financial assets are recognised on the SoFP when the NHS Wales organisation becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

The accounting policy choice allowed under IFRS 9 for long term trade receivables, contract assets which do contain a significant financing component (in accordance with IFRS 15), and lease receivables within the scope of IAS 17 has been withdrawn and entities should always recognise a loss allowance at an amount equal to lifetime Expected Credit Losses. All entities applying the FReM should utilise IFRS 9's simplified approach to impairment for relevant assets.

IFRS 9 requirements required a revised approach for the calculation of the bad debt provision, applying the principles of expected credit loss, using the practical expedients within IFRS 9 to construct a provision matrix.

### 1.17.1 Financial assets are initially recognised at fair value

Financial assets are classified into the following categories: financial assets 'at fair value through SoCNE'; 'held to maturity investments'; 'available for sale' financial assets, and 'loans and receivables'. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

### 1.17.2 Financial assets at fair value through SoCNE

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through SoCNE. They are held at fair value, with any resultant gain or loss recognised in the SoCNE. The net gain or loss incorporates any interest earned on the financial asset.

### 1.17.3 Held to maturity investments

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

### 1.17.4 Available for sale financial assets

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to the SoCNE on de-recognition.

### 1.17.5 Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the net carrying amount of the financial asset.

At the SOFP date, the NHS Wales organisation assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the SoCNE and the carrying amount of the asset is reduced directly, or through a provision of impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment

was recognised, the previously recognised impairment loss is reversed through the SoCNE to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

### 1.18 Financial liabilities

Financial liabilities are recognised on the SOFP when the NHS Wales organisation becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

#### 1.18.1 Financial liabilities are initially recognised at fair value

Financial liabilities are classified as either financial liabilities at fair value through the SoCNE or other financial liabilities.

#### 1.18.2 Financial liabilities at fair value through the SoCNE

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the SoCNE. The net gain or loss incorporates any interest earned on the financial asset.

#### 1.18.3 Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

### 1.19 Value Added Tax (VAT)

Most of the activities of the NHS Wales organisation are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

## 1.20 Foreign currencies

Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange gains and losses are taken to the SoCNE. At the SoFP date, monetary items denominated in foreign currencies are retranslated at the rates prevailing at the reporting date.

## 1.21 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the SHA has no beneficial interest in them. HEIW does not hold any third party assets.

## 1.22 Losses and Special Payments

Losses and special payments are items that the Welsh Government would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings in the SoCNE on an accruals basis, including losses which would have been made good through insurance cover had the NHS Wales organisation not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses register which is prepared on a cash basis.

HEIW accounts for all losses and special payments gross (including assistance from the WRP).

HEIW accrues or provides for the best estimate of future pay-outs for certain liabilities and discloses all other potential payments as contingent liabilities, unless he probability of the liabilities becoming payable is remote.

All claims for losses and special payments are provided for, where the probability of settlement of an individual claim is over 50%. Where reliable estimates can be made, incidents of clinical negligence against which a claim has not, as yet, been received are provided in the same way. Expected reimbursements from the WRP are included in debtors. For those claims where the probability of settlement is between 5- 50%, the liability is disclosed as a contingent liability.

## 1.23 Pooled budget

HEIW has not entered into pooled budgets with Local Authorities. Under the arrangements funds are pooled in accordance with section 33 of the NHS (Wales) Act 2006 for specific activities defined in the Pooled budget Note.

## 1.24 Critical Accounting Judgements and key sources of estimation uncertainty

In the application of the accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources.

The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or the period of the revision and future periods if the revision affects both current and future periods.

## 1.25 Key sources of estimation uncertainty

The are no estimation uncertainties at the SoFP date that have a significant risk of causing material adjustment to the carrying amounts of assets and liabilities within the next financial year.

## 1.26 Private Finance Initiative (PFI) transactions

The SHA has no PFI arrangements.

## 1.27 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS Wales organisation, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS Wales organisation. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

Remote contingent liabilities are those that are disclosed under Parliamentary reporting requirements and not under IAS 37 and, where practical, an estimate of their financial effect is required.

## 1.28 Absorption accounting

Transfers of function are accounted for as either by merger or by absorption accounting dependent upon the treatment prescribed in the FReM. Absorption accounting requires that entities account for their transactions in the period in which they took place with no restatement of performance required.

Where there is a transfer of function the gain or loss resulting from the assets and liabilities transferring is recognised in the SoCNE and is disclosed separately from the operating costs.

### 1.29 Accounting standards that have been issued but not yet been adopted

The following accounting standards have been issued and or amended by the IASB and IFRIC but have not been adopted because they are not yet required to be adopted by the FReM:

IFRS14 Regulatory Deferral Accounts - Not UK endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable.

IFRS 18 Presentation and Disclosure in Financial Statements - Application required for accounting periods beginning on or after 1 January 2027. Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted.

IFRS 19 Subsidiaries without Public Accountability: Disclosures - Application required for accounting periods beginning on or after 1 January 2027. Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted.

### 1.30 Accounting standards issued that have been adopted early

During 2025-26 there have been no accounting standards that have been adopted early. All early adoption of accounting standards will be led by HM Treasury.

### 1.31 Charities

HEIW has no NHS Charitable Funds.

## 2. Financial Duties Performance

The statutory financial duties of Special Health Authorities are set out in section 172 of the National Health Service (Wales) Act 2006.

Section 172(1) sets out what is referred to as the 'First Financial Duty' - a duty to secure that SHA expenditure does not exceed the aggregate of the funding allotted to it for a financial year. Under the powers of direction in the National Health Service (Wales) Act section 172(6) WHC/2019/004 clarified that the annual statutory financial duty is set separately for revenue and capital resource allocations.

## 2.1 Revenue Resource Performance

| | Financial performance 2025-26 £000 |
|---|---|
| **Net operating costs for the period** | **383,973** |
| Less general ophthalmic services expenditure and other non-cash limited expenditure | **0** |
| Less revenue consequences of bringing PFI schemes onto SoFP | **0** |
| Less any non funded revenue consequences of IFRS | **0** |
| Total operating expenses | 383,973 |
| Revenue Resource Allocation | **384,503** |
| **Under /(over) spend against Allocation** | **530** |

HEIW has met its financial duty to break-even against its Revenue Resource Limit over the period.

## 2.2 Capital Resource Performance

| | 2025-26 £000 |
|---|---|
| **Gross capital expenditure** | **1,640** |
| Add: Losses on disposal of donated assets | **0** |
| Less NBV on disposal of property, plant and equipment, right of use and intangible assets | **0** |
| Adjustment for transfers (to)/from NHS Trusts | **0** |
| Less: capital grants received | **0** |
| Less: donations received | **0** |
| Less IFRS16 Peppercorn income | **0** |
| Less initial recognition of RoU Asset Dilapidations | **0** |
| Add: recognition of RoU Assets Dilapidations on crystallisation | **0** |
| Charge against Capital Resource Allocation | 1,640 |
| Capital Resource Allocation | **1,698** |
| **(Over) / Underspend against Capital Resource Allocation** | **58** |

HEIW has met its financial duty to break-even against its Capital Resource Limit over the period.

## 2.3 Integrated Medium Term Plan

The SHA has submitted an Integrated Medium Term Plan for the period 2025-28 in accordance with NHS Wales Planning Framework 2025-28. However, as this was not a statutory requirement for SHAs under the NHS Finance (Wales) Act 2014 the plan did not require Ministerial approval.

## 2.4 Creditor payment

The SHA is required to pay 95% of the number of non-NHS bills within 30 days of receipt of goods or a valid invoice (whichever is the later). The SHA has achieved the following results:

| | 2025 - 2026 | 2024 - 2025 |
|---|---|---|
| Total number of non-NHS bills paid | 8,623 | 8,504 |
| Total number of non-NHS bills paid within target | 8,437 | 8,242 |
| **Percentage of non-NHS bills paid within target** | **97.8%** | **96.9%** |

The SHA has met the target.

# 3. Analysis of gross operating costs

## 3.1 Non Medical Education and Training

| | 2025 - 2026 £000 | 2024 - 2025 £000 |
|---|---|---|
| Student Training Fees (Universities) | **78,536** | 71,231 |
| Funding for Healthcare Education Fees (Health Boards & Trusts) | **5,802** | 5,967 |
| Student Bursaries Reimbursement (Universities) | **19,020** | 18,424 |
| Student Salaries Reimbursement (Health Boards & Trusts) | **33,045** | 28,675 |
| Advanced Practice Training fees | **2,176** | 2,023 |
| Healthcare Support Working Training | **2,306** | 2,438 |
| Non-Medical Prescribing | **419** | 364 |
| Training related Travel and Subsistence | **6,787** | 5,995 |
| Disability Support Allowance | **1,625** | 1,156 |
| Mental Health Workforce Plan | **1,461** | 1,942 |
| **Total** | **151,177** | **138,215** |

## 3.2 Postgraduate Medical, Dental & Pharmacy Education

| | 2025 - 2026 £000 | 2024 - 2025 £000 |
|---|---|---|
| Training Grade Salaries | **87,918** | 72,340 |
| Postgraduate Centre and Study Leave | **4,985** | 4,965 |
| GP Registrars | **51,327** | 51,643 |
| Dental Foundation Trainees | **11,724** | 10,993 |
| Pharmacy Training | **14,290** | 13,043 |
| Induction & Refresher | **139** | 244 |
| Welsh Clinical Academic Training | **1,812** | 2,065 |
| GP CPD and Appraisal Costs | **1,192** | 1,143 |
| Trainee Relocation Expenses | **2,429** | 2,629 |
| Primary Care | **1,618** | 1,467 |
| Optometry | **401** | 423 |
| Other | **1,066** | 1,208 |
| **Total** | **178,901** | **162,163** |

## 3.3 Other Operating Expenditure

| | 2025 - 2026 £000 | 2024 - 2025 £000 |
|---|---|---|
| Local Health Boards | **549** | 477 |
| Welsh NHS Trusts | **177** | 211 |
| Welsh Special Health Authorities | **0** | 0 |
| Goods and services from other NHS bodies | **55** | 0 |
| Goods and services from NHSW JCC | **0** | 0 |
| Local Authorities | **0** | 0 |
| Purchase of healthcare from non-NHS bodies | **0** | 0 |
| Welsh Government | **0** | 0 |
| Other NHS Trusts | **0** | 0 |
| Directors' costs | **1,679** | 1,562 |
| Operational Staff costs | **36,839** | 34,036 |
| Supplies and services - clinical | **101** | 101 |
| Supplies and services - general | **5,078** | 4,292 |
| Consultancy Services | **366** | 208 |
| Establishment | **4,552** | 4,887 |
| Transport | **0** | 0 |
| Premises | **3,150** | 3,188 |
| External Contractors | **547** | 653 |

| | | |
|---|---|---|
| Depreciation | **512** | 478 |
| Depreciation RoU Asset) | **288** | 287 |
| Amortisation | **175** | 0 |
| Fixed asset impairments and reversals (Property, plant & equipment) | **0** | 0 |
| Fixed asset impairments and reversals (RoU Assets) | **0** | 0 |
| Fixed asset impairments and reversals (Intangible assets) | **0** | 0 |
| Impairments & reversals of financial assets | **0** | 0 |
| Impairments & reversals of non-current assets held for sale | **0** | 0 |
| Audit fees | **208** | 177 |
| Other auditors' remuneration | **0** | 0 |
| Losses, special payments and irrecoverable debts | **(81)** | 200 |
| Research and Development | **0** | 0 |
| Expense related to short-term leases | **0** | 0 |
| Expense related to low-value asset leases (excluding short-term leases) | **0** | 0 |
| **Other operating costs** | **1,763** | 1,475 |
| **Total** | **55,958** | **52,232** |

## 3.4 Losses, special payments and irrecoverable debts:

| **Charges to operating expenses** | | |
|---|---|---|
| **Increase/(decrease) in provision for future payments:** | **2025 - 2026 £000** | **2024 - 2025 £000** |
| **Clinical negligence;** | | |
| Secondary care | 0 | 0 |
| Primary care | 0 | 0 |
| Redress Secondary care | 0 | 0 |
| Redress Primary care | 0 | 0 |
| Personal injury | 0 | 0 |
| All other losses and special payments | **(24)** | 45 |
| Defence legal fees and other administrative costs | **(51)** | 51 |
| Gross increase/(decrease) in provision for future payments | **(75)** | 96 |
| Contribution to Welsh Risk Pool | **0** | 0 |
| Premium for other insurance arrangements | **0** | 0 |
| Irrecoverable debts | **(6)** | 104 |

| | | |
|---|---|---|
| **Less:** income received/due from Welsh Risk Pool | **0** | 0 |
| **Total** | **(81)** | **200** |

| | 2025 - 2026 £000 | 2024 - 2025 £000 |
|---|---|---|
| Permanent injury included within personal injury | **0** | 0 |

## 4. Miscellaneous Income

| | 2025 - 2026 £000 | 2024 - 2025 £000 |
|---|---|---|
| Local Health Boards | **396** | 48 |
| NHSW Joint Commissioning Committee | **0** | 0 |
| NHS trusts | **566** | 244 |
| Welsh Special Health Authorities | **180** | 107 |
| Foundation Trusts | **0** | 0 |
| Other NHS England bodies | **0** | 0 |
| Other NHS Bodies | **0** | 0 |
| Local authorities | **0** | 0 |
| Welsh Government | **218** | 214 |
| Welsh Government Hosted Bodies | **0** | 0 |

| **Non NHS:** | | |
|---|---|---|
| Private patient income | **0** | 0 |
| Overseas patients (non-reciprocal) | **0** | 0 |
| Injury Costs Recovery (ICR) Scheme | **0** | 0 |
| Other income from activities | **0** | 0 |

| | | |
|---|---|---|
| Patient transport services | **0** | 0 |
| Education, training and research | **730** | 792 |
| Charitable and other contributions to expenditure | **0** | 0 |
| Receipt of NWSSP Covid centrally purchased assets | **0** | 0 |
| Receipt of Covid centrally purchased assets from other organisations | **0** | 0 |
| Receipt of Government granted assets | **0** | 0 |
| Right of Use Grant (Peppercorn Lease) | **0** | 0 |
| Non-patient care income generation schemes | **0** | 0 |
| NWSSP | **0** | 0 |

| | | |
|---|---|---|
| Deferred income released to revenue | **0** | 0 |
| Right of Use Asset Sub-leasing rental income | **0** | 0 |
| Contingent rental income from finance leases | **0** | 0 |
| Rental income from operating leases | **0** | 0 |

| **Other income** | | |
|---|---|---|
| Provision of laundry, pathology, payroll services | **0** | 0 |
| Accommodation and catering charges | **0** | 0 |
| Mortuary fees | **0** | 0 |
| Staff payments for use of cars | **0** | 0 |
| Business units | **0** | 0 |
| Scheme Pays Reimbursement Notional | **0** | 0 |
| Other | **23** | 34 |
| **Total** | **2,113** | **1,439** |

Injury Cost Recovery (ICR) Scheme income is subject to a provision for impairment re personal injury claims

| | **2025 - 2026 %** | **2024 - 2025 %** |
|---|---|---|
| To reflect expected rates of collection ICR income is subject to a provision for impairment of: | **24.62** | 24.45 |

## 5. Investment Revenue

| | **2025 - 2026 £000** | **2024 - 2025 £000** |
|---|---|---|
| **Rental revenue:** | | |
| PFI Finance lease income | | |
| planned | **0** | 0 |
| contingent | **0** | 0 |
| Other finance lease revenue | **0** | 0 |

| **Interest revenue:** | | |
|---|---|---|
| Bank accounts | **0** | 0 |
| Other loans and receivables | **0** | 0 |
| Impaired financial assets | **0** | 0 |
| Other financial assets | **0** | 0 |
| **Total** | **0** | **0** |

## 6. Other gains and losses

| | 2025 - 2026 £000 | 2024 - 2025 £000 |
|---|---|---|
| Gain/(loss) on disposal of property, plant and equipment | 0 | 0 |
| Gain/(loss) on disposal other than by sale of right of use assets assets | 0 | 0 |
| Gain/(loss) on disposal of intangible assets | 0 | 0 |
| Gain/(loss) on disposal of assets held for sale | 0 | 0 |
| Gain/(loss) on disposal of financial assets | 0 | 0 |
| Change on foreign exchange | 0 | 0 |
| Change in fair value of financial assets at fair value through SoCNE | 0 | 0 |
| Change in fair value of financial liabilities at fair value through SoCNE | 0 | 0 |
| Recycling of gain/(loss) from equity on disposal of financial assets held for sale | 0 | 0 |
| **Total** | **0** | **0** |

## 7. Finance costs

| | 2025 - 2026 £000 | 2024 - 2025 £000 |
|---|---|---|
| Interest on loans and overdrafts | 0 | 0 |
| Interest on obligations under finance leases | 0 | 0 |
| Interest on obligations under Right of Use Leases | 8 | 11 |
| Interest on obligations under PFI contracts | | |
| main finance cost | 0 | 0 |
| contingent finance cost | 0 | 0 |
| Impact of IFRS 16 on PPP/PFI contracts | 0 | 0 |
| Interest on late payment of commercial debt | 0 | 0 |
| Other interest expense | 42 | 0 |
| **Total interest expense** | **50** | **11** |
| Provisions unwinding of discount | 0 | 0 |
| Other finance costs | 0 | 0 |
| **Total** | **50** | **11** |

## 8. Future charges to Statement of Comprehensive Net Expenditure (SoCNE)

### SHA as lessee

As at 31 March 2026 the SHA has 2 lease agreements that are not accounted for under IFRS16 as they are considered low value/short term assets. The leases both relate to equipment.

| Payments recognised as an expense | Low Value & Short Term 2025-26 £000 | Other 2025-26 £000 | Total 2025-26 £000 | 2024-25 £000 |
|---|---|---|---|---|
| Minimum lease payments | 5 | 0 | 5 | 5 |
| Contingent rents | 0 | 0 | 0 | 0 |
| Sub-lease payments | 0 | 0 | 0 | 0 |
| Total | 5 | 0 | 5 | 5 |

| Total future minimum lease payments | | | | |
|---|---|---|---|---|
| Payable | £000 | £000 | £000 | £000 |
| Not later than one year | 5 | 0 | 5 | 5 |
| Between one and five years | 0 | 0 | 11 | 16 |
| After 5 years | 0 | 0 | 0 | 0 |
| Total | 16 | 0 | 16 | 21 |

As a result of the implementation of IFRS 16 the current year operating lease figures relate to low value and short term leases only.

### SHA as lessor

| Rental revenue | 2025 - 2026 £000 | 2024 - 2025 £000 |
|---|---|---|
| Rent | 0 | 0 |
| Contingent rents | 0 | 0 |
| Total revenue rental | 0 | 0 |

| Total future minimum lease payments | | |
|---|---|---|
| Receivable | £000 | £000 |
| Not later than one year | 0 | 0 |
| Between one and five years | 0 | 0 |
| After 5 years | 0 | 0 |
| Total revenue rental | 0 | 0 |

# 9. Other gains and losses

## 9.1 Employee costs

| | Permanent Staff £000 | Staff on Inward Secondment £000 | Agency Staff £000 | Specialist Trainee (SLE) £000 | Other Staff £000 | Total £000 | Total £000 |
|---|---|---|---|---|---|---|---|
| Salaries and wages | 27,294 | 1,692 | 725 | 0 | 28 | 29,739 | 27,746 |
| Social security costs | 3,584 | 0 | 0 | 0 | 0 | 3,584 | 2,718 |
| Employer contributions to NHS Pension Scheme | 5,851 | 0 | 0 | 0 | 0 | 5,851 | 5,433 |
| Other pension costs | 3 | 0 | 0 | 0 | 0 | 3 | 5 |
| Other employment benefits | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Termination benefits | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total Employee costs** | 36,732 | 1,692 | 725 | 0 | 28 | 39,177 | 35,902 |

24/25 Comparative figures for employee costs have been restated to include amounts previously capitalised. This has increased prior year employee costs by £0.409m.

This is a presentational change to this note only and does not affect the amounts charged to the Statement of Comprehensive Net Expenditure for operational staff costs as detailed in note 3.3.

| | | |
|---|---|---|
| Charged to capital | 772 | 409 |
| Charged to revenue | 38,405 | 35,493 |
| | 39,177 | 35,902 |

| | | |
|---|---|---|
| Net movement in accrued employee benefits (untaken staff leave) | 37 | 53 |

## 9.2 Employee costs

| | Permanent Staff Number | Staff on Inward Secondment Number | Agency Staff Number | Specialist Trainee (SLE) Number | Other Staff Num-ber | Total 2025 - 2026 | Total 2024 - 2025 |
|---|---|---|---|---|---|---|---|
| Administrative, clerical and board members | 383 | 23 | 8 | 0 | 0 | 414 | 400 |
| Medical and dental | 49 | 3 | 0 | 0 | 0 | 52 | 52 |
| Nursing, midwifery registered | 12 | 10 | 0 | 0 | 0 | 22 | 16 |
| Professional, Scientific, and technical staff | 41 | 2 | 0 | 0 | 0 | 43 | 40 |
| Additional Clinical Services | 1 | 1 | 0 | 0 | 0 | 2 | 1 |

| | Permanent Staff Number | Staff on Inward Secondment Number | Agency Staff Number | Specialist Trainee (SLE) Number | Other Staff Num-ber | Total 2025 - 2026 | Total 2024 - 2025 |
|---|---|---|---|---|---|---|---|
| Allied Health Professions | 6 | 0 | 0 | 0 | 0 | 6 | 6 |
| Healthcare Scientists | 3 | 0 | 0 | 0 | 0 | 3 | 3 |
| Estates and Ancilliary | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Students | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | 495 | 39 | 8 | 0 | 0 | 542 | 518 |

### 9.3 Retirements due to ill-health

| | 2025 - 2026 | 2024 - 2025 |
|---|---|---|
| Number | 0 | 1 |
| Estimated additional pension costs £ | 0 | 509 |

The estimated additional pension costs of these ill-health retirements have been calculated on an average basis and are borne by the NHS Pension Scheme.

## 9.4 Employee benefits

HEIW SHA has four employee benefit schemes. There are two salary sacrifice schemes for bikes and lease cars and a further scheme for childcare vouchers that is closed to new entrants. There is also an employee loans and savings scheme offered through an external financial wellbeing provider.

### 9.5 Reporting of other compensation schemes - exit packages

#### 9.5.1 Exit Packages Costs and Numbers

| Exit packages cost band (including any special payment element)<br><br>Whole numbers only on all fields | 2025-26 Number of compulsory redundancies | 2025-26 Number of other departures | 2025-26 Total number of exit packages | 2025-26 Number of departures where special payments have been made | 2024-25 Total number of exit packages |
|---|---|---|---|---|---|
| less than £10,000 | 0 | 0 | 0 | 0 | 0 |
| £10,000 to £25,000 | 0 | 0 | 0 | 0 | 0 |
| £25,000 to £50,000 | 0 | 0 | 0 | 0 | 0 |
| £50,000 to £100,000 | 0 | 0 | 0 | 0 | 0 |
| £100,000 to £150,000 | 0 | 0 | 0 | 0 | 0 |

| | | | | | |
|---|---|---|---|---|---|
| £150,000 to £200,000 | 0 | 0 | 0 | 0 | 0 |
| more than £200,000 | 0 | 0 | 0 | 0 | 0 |
| **Total** | **0** | **0** | **0** | **0** | **0** |

| Exit packages cost band (including any special payment element) | 2025-26 Cost of compulsory redundancies £ | 2025-26 Cost of other departures £ | 2025-26 Total number of exit packages | 2025-26 Cost of special element included in exit packages £ | 2024-25 Total number of exit packages £ |
|---|---|---|---|---|---|
| less than £10,000 | 0 | 0 | 0 | 0 | 0 |
| £10,000 to £25,000 | 0 | 0 | 0 | 0 | 0 |
| £25,000 to £50,000 | 0 | 0 | 0 | 0 | 0 |
| £50,000 to £100,000 | 0 | 0 | 0 | 0 | 0 |
| £100,000 to £150,000 | 0 | 0 | 0 | 0 | 0 |
| £150,000 to £200,000 | 0 | 0 | 0 | 0 | 0 |
| more than £200,000 | 0 | 0 | 0 | 0 | 0 |
| **Total** | **0** | **0** | **0** | **0** | **0** |

| Total Exit Costs Paid in Year | Total paid in year 2025 - 2026 £ | Total paid in year 2024 - 2025 £ |
|---|---|---|
| Exit costs paid in year | 0 | 0 |
| **Total** | **0** | **0** |

This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period.

### 9.5.2 Analysis of other departures

| Type of other departures | 2025-26 Agreements Number | 2025-26 Total value of agreements £ |
|---|---|---|
| Voluntary redundancies including early retirement contractual costs | 0 | 0 |
| Contractual payments in lieu of notice* | 0 | 0 |
| Exit payments following Employment Tribunals or court orders | 0 | 0 |
| Non-contractual payments requiring Welsh Government Approval** | 0 | 0 |
| Other please specify | 0 | 0 |
| **Total** | 0 | 0 |

This disclosure provides detail for the number and value of exit packages agreed in the year.

As a single exit package can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in Note 9.5.1 which will be the number of individuals.

## 9.6 Fair Pay disclosures

### 9.6.1 Remuneration Relationship

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director /employee in their organisation and the 25th percentile, median and 75th percentile remuneration of the organisation's workforce.

| Total Pay and benefits | £'000 | £'000 |
|---|---|---|
| Chief Executive Total pay and benefits range. | 185 - 190 | 175 - 180 |
| Highest paid Director Total pay and benefits range. | 205 - 210 | 200 - 205 |

| Total pay and benefits mid-point | 2025-26 Chief Executive £ | 2025-26 Employee £ | 2025-26 Ratio | 2024-25 Chief Execu-tive £ | 2024 -25 Employee £ | 2024 -25 Ratio |
|---|---|---|---|---|---|---|
| 25th percentile pay ratio | 187,500 | 38,364 | 4.89:1 | 177,500 | 37,030 | 4.79:1 |
| Median pay | 187,500 | 56,514 | 3.32:1 | 177,500 | 54,550 | 3.25:1 |
| 75th percentile pay ratio | 187,500 | 118,152 | 1.59:1 | 177,500 | 113,607 | 1.56:1 |

| Salary component of total pay and benefits | | | | | | |
|---|---|---|---|---|---|---|
| 25th percentile pay ratio | **187,500** | **38,364** | | 177,500 | 37,030 | |
| Median pay | **187,500** | **56,514** | | 177,500 | 54,550 | |
| 75th percentile pay ratio | **187,500** | **118,152** | | 177,500 | 113,607 | |

| Total pay and benefits mid-point | 2025-26 Highest Paid Director £ | 2025-26 Employee £ | 2025-26 Ratio | 2024-25 Highest Paid Director £ | 2024 -25 Employee £ | 2024 -25 Ratio |
|---|---|---|---|---|---|---|
| 25th percentile pay ratio | **207,500** | **38,364** | **5.41:1** | 202, 500 | 37,030 | 5.47:1 |
| Median pay | **207,500** | **56,514** | **3.67:1** | 202, 500 | 54,550 | 3.71:1 |
| 75th percentile pay ratio | **207,500** | **118,152** | **1.76:1** | 202, 500 | 113,607 | 1.78:1 |

| Salary component of total pay and benefits | | | | | | |
|---|---|---|---|---|---|---|
| 25th percentile pay ratio | **207,500** | **38,364** | | 202, 500 | 37,030 | |
| Median pay | **207,500** | **56,514** | | 202, 500 | 54,550 | |
| 75th percentile pay ratio | **207,500** | **118,152** | | 202, 500 | 113,607 | |

In 2025-26, 1 (2024-25, 1) employee, who is a director of the organisation, received remuneration in excess of the Chief Executive. Remuneration for all staff ranged from £24,833 to £208,899 (2024-25: £23,465 to £202,284).

This range includes directors, except for the highest-paid Chief Executive Officer and Director as appropriate and excludes pension benefits for all employees. The calculation of the 2025/26 figures excludes fees paid to non-executive directors; however, these fees were included within the 2024/25 comparator figures.

## Financial year summary

Between 2024/25 and 2025/26, the ratio of the median workforce remuneration to that of the Chief Executive increased from 3.25:1 to 3.32:1. This increase is primarily attributable to the methodology used in the calculation, which applies the midpoint of the Chief Executive's salary £5,000 pay band rather than the actual salary. As the Chief Executive moved into a higher pay band during the period, this has resulted in an artificial inflation of the reported ratio.

When the actual salary is used, the 75th percentile, median, and 25th percentile pay ratios all show a slight decrease over the two years, reflecting the different pay awards applied across staff groups: Executive and Senior pay (3.25%), Medical and Dental staff (4.0%), and Agenda for Change staff (3.6%).

The median for total pay and benefits for the year was £56,514 (£54,550 2024/25), which equates to the entry step point of the 8a Agenda for Change payscale in both financial years.

Pay rates for all employees of HEIW are set nationally, predominately through the Executive and Senior Pay Terms and conditions of service, the Agenda for Change agreement and the Medical & Dental Terms and Conditions of Service. Where employees remain on the Cardiff University terms following TUPE into HEIW these are amended in line with any Agenda for Change pay awards during the year.

## 9.6.2 Percentage Changes

| | 2024-25 to 2025-26 % | 2023-24 to 2024-25 % |
|---|---|---|
| **% Change from previous financial year in respect of Chief Executive** | | |
| Salary and allowances | **3** | 5 |
| Performance pay and bonuses | **0** | 0 |

| | | |
|---|---|---|
| **% Change from previous financial year in respect of highest paid director** | | |
| Salary and allowances | **4** | N/A |
| Performance pay and bonuses | **0** | 0 |

For 2023/24, the Chief Executive was also the highest paid director; however, this was not the case for 2024/25 and 2025/26. Accordingly, a percentage change for the highest paid director in 2023/24 is shown as not applicable (N/A).

## 9.7 Pension Costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years".

An outline of these follows:

### a Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts.

These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

## b Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

## c National Employment Savings Trust (NEST)

NEST is a workplace pension scheme, which was set up by legislation and is treated as a trust-based scheme. The Trustee responsible for running the scheme is NEST Corporation. It's a non-departmental public body (NDPB) that operates at arm's length from government and is accountable to Parliament through the Department for Work and Pensions (DWP).

NEST Corporation has agreed a loan with the Department for Work and Pensions (DWP). This has paid for the scheme to be set up and will cover expected shortfalls in scheme costs during the earlier years while membership is growing.

NEST Corporation aims for the scheme to become self-financing while providing consistently low charges to members.

Using qualifying earnings to calculate contributions, currently the legal minimum level of contributions is 8% of a jobholder's qualifying earnings, for employers whose legal duties have started. The employer must pay at least 3% of this.

The earnings band used to calculate minimum contributions under existing legislation is called qualifying earnings. Qualifying earnings are currently those between £6,240 and £50,270 for the 2025-26 tax year (2024-25 £6,240 and £50,270).

Restrictions on the annual contribution limits were removed on 1 April 2017.

# 10. Public Sector Payment Policy - Measure of Compliance

## 10.1 Prompt payment code - measure of compliance

The Welsh Government requires that the SHA pay all their trade creditors in accordance with the CBI prompt payment code and Government Accounting rules. The Welsh Government has set as part of the SHA financial targets a requirement to pay 95% of the number of non-NHS creditors within 30 days of delivery.

| | 2025-26 Number | 2025-26 £000 | 2024-25 Number | 2024-25 £000 |
|---|---|---|---|---|
| **NHS** | | | | |
| Total bills paid | **4,297** | **159,958** | 3,868 | 147,168 |
| Total bills paid within target | **4,168** | **158,251** | 3,516 | 138,787 |
| **Percentage of bills paid within target** | **97.0%** | **98.9%** | **90.9%** | **94.3%** |
| **Non-NHS** | | | | |
| Total bills paid | **8,623** | **139,062** | 8,504 | 127,154 |
| Total bills paid within target | **8,437** | **137,747** | 8,242 | 123,140 |
| **Percentage of bills paid within target** | **97.8%** | **99.1%** | **96.9%** | **96.8%** |
| **Total** | | | | |
| Total bills paid | 12,920 | 299,020 | 12,372 | 274,322 |
| Total bills paid within target | 12,605 | 295,998 | 11,758 | 261,927 |
| **Percentage of bills paid within target** | **97.6%** | **99.0%** | **95.0%** | **95.5%** |

## 10.2 The Late Payment of Commercial Debts (Interest) Act 1998

| | 2025-26 £ | 2024-25 £ |
|---|---|---|
| Amounts included within finance costs (note 7) from claims made under this legislation | **23** | 0 |
| Compensation paid to cover debt recovery costs under this legislation | **40** | 0 |
| **Total** | **63** | **0** |

One claim was made in respect of late payment of commercial debts during 2025/26.

## 11. Property, plant and equipment

| 2025 - 26 | Land £000 | Buildings, excluding dwellings £000 | Dwellings £000 | Assets under construction & payments on account £000 | Plant and machinery £000 | Transport equip-ment £000 | Informa-tion technolo-gy £000 | Furni-ture & fit-tings £000 | Total £000 |
|---|---|---|---|---|---|---|---|---|---|
| **Cost or valuation at 1 April 2025** | 0 | 1,470 | 0 | 0 | 1,409 | 0 | 1,393 | 470 | 4,742 |
| Revaluation/ Indexation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Additions | | | | | | | | | |
| - purchased | 0 | 39 | 0 | 0 | 78 | 0 | 197 | 21 | 335 |
| - donated | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| - government granted | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Transfer from/into other organisations | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reclassifications | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Revaluations | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reversal of impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reclassified as held for sale | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Disposals | 0 | 0 | 0 | 0 | (118) | 0 | (91) | 0 | (209) |
| **At 31 March 2026** | 0 | 1,509 | 0 | 0 | 1,369 | 0 | 1,499 | 491 | 4,868 |

| 2025 - 26 | Land £000 | Buildings, excluding dwellings £000 | Dwellings £000 | Assets under construction & payments on account £000 | Plant and machinery £000 | Transport equip-ment £000 | Informa-tion technolo-gy £000 | Furni-ture & fit-tings £000 | Total £000 |
|---|---|---|---|---|---|---|---|---|---|
| **Depreciation at 1 April 2025** | **0** | **925** | **0** | **0** | **900** | **0** | **637** | **470** | **2,932** |
| Revaluation/ Indexation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Transfer from/into other organisations | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |
| Reclassifications | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |
| Revaluations | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |
| Reversal of impairments | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |
| Impairments | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |
| Reclassified as held for sale | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |
| Disposals | **0** | **0** | **0** | **0** | **(118)** | **0** | **(91)** | **0** | **(209)** |
| Provided during the period | **0** | **159** | **0** | **0** | **146** | **0** | **207** | **0** | 512 |
| **At 31 March 2026** | **0** | **1,084** | **0** | **0** | **928** | **0** | **753** | **470** | **3,235** |
| Net book value at 1 April 2025 | 0 | 545 | 0 | 0 | 509 | 0 | 756 | 0 | 1,810 |
| Net book value at 31 March 2026 | 0 | 425 | 0 | 0 | 441 | 0 | 756 | 21 | 1,633 |

| Net book value at 31 March 2026 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Purchased | 0 | 425 | 0 | 0 | 441 | 0 | 746 | 21 | 1,633 |
| Donated | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Government Granted | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **At 31 March 2026** | 0 | 425 | 0 | 0 | 441 | 0 | 746 | 21 | 1,633 |
| **Asset financing:** | | | | | | | | | |
| Owned | 0 | 425 | 0 | 0 | 441 | 0 | 746 | 21 | 1,633 |
| On-SoFP PPP/PFI contracts | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| PFI residual interests | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **At 31 March 2026** | 0 | 425 | 0 | 0 | 441 | 0 | 746 | 21 | 1,633 |

The net book value of land, buildings and dwellings at 31 March 2026 comprises:

| | £000 |
|---|---|
| Freehold | 0 |
| Long Leasehold | 425 |
| Short Leasehold | 0 |
| | 425 |

Building Assets' held by HEIW relate to leasehold improvements and are depreciated over the shorter of the remainder of the lease or the assessed life of the asset.

## 11.1 Property, plant and equipment

| 2024 - 25 | Land £000 | Buildings, excluding dwellings £000 | Dwellings £000 | Assets under construction & payments on account £000 | Plant and machinery £000 | Transport equip-ment £000 | Informa-tion technolo-gy £000 | Furni-ture & fit-tings £000 | Total £000 |
|---|---|---|---|---|---|---|---|---|---|
| **Cost or valuation at 1 April 2024** | **0** | **1,463** | **0** | **0** | **1,421** | **0** | **1,743** | **470** | **5,097** |
| Indexation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Additions | | | | | | | | | |
| - purchased | 0 | 7 | 0 | 0 | 78 | 0 | 316 | 0 | 323 |
| - donated | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| - government granted | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Transfer from/into other NHS bodies | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reclassifications | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Revaluations | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reversal of impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reclassified as held for sale | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Disposals | 0 | 0 | 0 | 0 | **(12)** | 0 | **(666)** | 0 | **(678)** |
| **At 31 March 2025** | **0** | **1,470** | **0** | **0** | **1,409** | **0** | **1,393** | **470** | **4,742** |

| 2024 - 25 | Land £000 | Buildings, excluding dwellings £000 | Dwellings £000 | Assets under construction & payments on account £000 | Plant and machinery £000 | Transport equip-ment £000 | Informa-tion technolo-gy £000 | Furni-ture & fit-tings £000 | Total £000 |
|---|---|---|---|---|---|---|---|---|---|
| **Depreciation at 1 April 2024** | **0** | **771** | **0** | **0** | **761** | **0** | **1,136** | **464** | **3,132** |
| Indexation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Transfer from/into other NHS bodies | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reclassifications | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Revaluations | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reversal of impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reclassified as held for sale | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Disposals | 0 | 0 | 0 | 0 | **(12)** | 0 | **(666)** | 0 | **(678)** |
| Provided during the year | 0 | 154 | 0 | 0 | 151 | 0 | 167 | 6 | 478 |
| **At 31 March 2025** | **0** | **925** | **0** | **0** | **900** | **0** | **637** | **470** | **2,932** |
| Net book value at 1 April 2024 | 0 | 692 | 0 | 0 | 660 | 0 | 607 | 6 | 1,965 |
| Net book value at 31 March 2025 | 0 | 545 | 0 | 0 | 509 | 0 | 756 | 0 | 1,810 |

| Net book value at 31 March 2025 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Purchased | 0 | 545 | 0 | 0 | 494 | 0 | 756 | 0 | 1,795 |
| Donated | 0 | 0 | 0 | 0 | 15 | 0 | 0 | 0 | 15 |
| Government Granted | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **At 31 March 2025** | **0** | **545** | **0** | **0** | **509** | **0** | **756** | **0** | **1,810** |
| **Asset financing:** | | | | | | | | | |
| Owned | 0 | 545 | 0 | 0 | 509 | 0 | 756 | 0 | 1,810 |
| On-SoFP PPP/PFI contracts | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| PFI residual interests | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **At 31 March 2025** | **0** | **545** | **0** | **0** | **509** | **0** | **756** | **0** | **1,810** |

The net book value of land, buildings and dwellings at 31 March 2025 comprises:

| | £000 |
|---|---|
| Freehold | 0 |
| Long Leasehold | 545 |
| Short Leasehold | 0 |
| | **545** |

## Additional disclosures re Property, Plant and Equipment

**Disclosures:**

### i) Donated Assets

HEIW has not received any donated assets during the year.

### ii) Valuations

The SHA is required to apply the revaluation model set out in IAS 16 and value its capital assets to fair value. Fair value is defined by IAS 16 as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction. This has been undertaken on the assumption that the property is sold as part of the continuing enterprise in operation.

### iii) Asset Lives

Depreciated as follows:

- Land is not depreciated.
- Buildings as determined by the Valuation Office Agency. Leasehold improvements are depreciated over the shorter of the remainder of the lease or the assessed life of the asset.
- Equipment 5-15 years.

### iv) Compensation

No compensation has been received from third parties for assets impaired, lost or given up, that is included in the income statement.

### v) Write Downs

There have not been any write downs during the year.

### vi) Open Market Value

SHA does not hold any property where the value is materially different from its open market value.

### vii) Assets Held for Sale or sold in the period

There are no assets held for sale or sold in the period

### viii) IFRS 13 Fair value measurement

There are no assets requiring Fair Value measurement under IFRS 13.

## 11.2 Non-current assets held for sale

| | Land £000 | Buildings, including dwelling £000 | Other property, plant and equipment £000 | Intangible assets £000 | Other assets £000 | Total £000 |
|---|---|---|---|---|---|---|
| **Balance at 1 April 2025** | **0** | **0** | **0** | **0** | **0** | **0** |
| Plus assets classified as held for sale in the period | **0** | **0** | **0** | **0** | **0** | 0 |
| Revaluation | **0** | **0** | **0** | **0** | **0** | 0 |
| Less assets sold in the period | **0** | **0** | **0** | **0** | **0** | 0 |
| Add reversal of impairment of assets held for sale | **0** | **0** | **0** | **0** | **0** | 0 |
| Less impairment of assets held for sale | **0** | **0** | **0** | **0** | **0** | 0 |
| Less assets no longer classified as held for sale, for reasons other than disposal by sale | **0** | **0** | **0** | **0** | **0** | 0 |
| **Balance carried forward 31 March 2026** | **0** | **0** | **0** | **0** | **0** | **0** |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Balance at 1 April 2024** | **0** | **0** | **0** | **0** | **0** | **0** |
| Plus assets classified as held for sale in the period | 0 | 0 | 0 | 0 | 0 | 0 |
| Revaluation | 0 | 0 | 0 | 0 | 0 | 0 |
| Less assets sold in the period | 0 | 0 | 0 | 0 | 0 | 0 |
| Add reversal of impairment of assets held for sale | 0 | 0 | 0 | 0 | 0 | 0 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Less impairment of assets held for sale | 0 | 0 | 0 | 0 | 0 | 0 |
| Less assets no longer classified as held for sale, for reasons other than disposal by sale | 0 | 0 | 0 | 0 | 0 | 0 |
| **Balance carried forward 31 March 2025** | **0** | **0** | **0** | **0** | **0** | **0** |

### Assets sold in the period

There were no assets sold in the period.

### Assets classified as held for sale during the period

No assets were classified as held for sale during 2025-26.

## 11.3 Right of Use Assets

The SHA right of use asset leases are disclosed across the relevant headings within the note. One is significant in their own right: with a net book value at 31 March 2026 of £500k or more:

Land and Building - One lease for SHA Headquarters with a NBV of £622k.

Table on next page

| 2025 - 26 | Land £000 | Land & buildings £000 | Buildings £000 | Dwellings £000 | Plant and machinery £000 | Transport equip-ment £000 | Informa-tion technolo-gy £000 | Furni-ture & fit-tings £000 | Total £000 |
|---|---|---|---|---|---|---|---|---|---|
| **Cost or valuation at 1 April** | 0 | 1,770 | 0 | 0 | 0 | 0 | 0 | 0 | 1,770 |
| Additions | 0 | 19 | 0 | 0 | 0 | 0 | 0 | 0 | 19 |
| Transfer from/into other NHS bodies | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Disposals other than by sale | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reclassifications | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Revaluations | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reversal of impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| De-recognition | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **At 31 March** | 0 | 1,789 | 0 | 0 | 0 | 0 | 0 | 0 | 1,789 |

| 2025 -26 | Land £000 | Land & buildings £000 | Buildings £000 | Dwellings £000 | Plant and machinery £000 | Transport equip-ment | Informa-tion technolo-gy £000 | Furni-ture & fit-tings £000 | Total £000 |
|---|---|---|---|---|---|---|---|---|---|
| **Depreciation at 1 April** | 0 | 861 | 0 | 0 | 0 | 0 | 0 | 0 | 861 |
| Recognition | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Transfers from/into other NHS bodies | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Disposals other than by sale | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reclassifications | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Revaluations | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reversal of impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| De-recognition | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Provided during the year | 0 | 288 | 0 | 0 | 0 | 0 | 0 | 0 | 28 |
| **At 31 March** | 0 | 1,149 | 0 | 0 | 0 | 0 | 0 | 0 | 1,149 |
| Net book value at 1 April | 0 | 909 | 0 | 0 | 509 | 0 | 756 | 0 | 909 |
| Net book value at 31 March | 0 | 640 | 0 | 0 | 441 | 0 | 756 | 21 | 640 |

| RoU Asset Total Value Split by Lessor | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 2025 - 26 | Land £000 | Land & buildings £000 | Buildings £000 | Dwellings £000 | Plant and machinery £000 | Transport equip-ment £000 | Informa-tion technolo-gy £000 | Furni-ture & fit-tings £000 | Total £000 |
| NHS Wales Peppercorn Leases | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| NHS Wales Market Value Leases | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other Public Sector Peppercorn Leases | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other Public Sector Market Value Leases | 0 | 640 | 0 | 0 | 0 | 0 | 0 | 0 | 640 |
| Private Sector Peppercorn Leases | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Private Sector Market Value Leases | 0 | 0 | 0 | 0 | 0 | | 0 | 0 | 0 |
| Total | 0 | 640 | 0 | 0 | 0 | 0 | 0 | 0 | 640 |

| 2024 - 25 | Land £000 | Land & buildings £000 | Buildings £000 | Dwellings £000 | Plant and machinery £000 | Transport equip-ment £000 | Informa-tion technolo-gy £000 | Furni-ture & fit-tings £000 | Total £000 |
|---|---|---|---|---|---|---|---|---|---|
| **Cost or valuation at 1 April** | **0** | **1,770** | **0** | **0** | **0** | **0** | **0** | **0** | **1,770** |
| Additions | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Transfer from/into other NHS bodies | | 0 | | | | | | | 0 |
| Disposals other than by sale | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reclassifications | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Revaluations | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reversal of impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| De-recognition | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **At 31 March** | **0** | **1,770** | **0** | **0** | **0** | **0** | **0** | **0** | **1,770** |

| 2024 - 25 | Land £000 | Land & buildings £000 | Buildings £000 | Dwellings £000 | Plant and machinery £000 | Transport equip-ment £000 | Informa-tion technolo-gy £000 | Furni-ture & fit-tings £000 | Total £000 |
|---|---|---|---|---|---|---|---|---|---|
| **Depreciation at 1 April** | **0** | **574** | **0** | **0** | **0** | **0** | **0** | **0** | **574** |
| Recognition | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Transfers from/into other NHS bodies | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Disposals other than by sale | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reclassifications | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Revaluations | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reversal of impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| De-recognition | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Provided during the year | 0 | 287 | 0 | 0 | 0 | 0 | 0 | 0 | 287 |
| **At 31 March** | **0** | **861** | **0** | **0** | **0** | **0** | **0** | **0** | **861** |
| Net book value at 1 April | 0 | 1,196 | 0 | 0 | 0 | 0 | 0 | 0 | 1,196 |
| Net book value at 31 March | 0 | 909 | 0 | 0 | 0 | 0 | 0 | 0 | 909 |

| RoU Asset Total Value Split by Lessor | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 2024 - 25 | Land £000 | Land & buildings £000 | Buildings £000 | Dwellings £000 | Plant and machinery £000 | Transport equip-ment £000 | Informa-tion technolo-gy £000 | Furni-ture & fit-tings £000 | Total £000 |
| NHS Wales Peppercorn Leases | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| NHS Wales Market Value Leases | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other Public Sector Peppercorn Leases | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other Public Sector Market Value Leases | 0 | 909 | 0 | 0 | 0 | 0 | 0 | 0 | 909 |
| Private Sector Peppercorn Leases | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Private Sector Market Value Leases | 0 | 0 | 0 | 0 | 0 | | 0 | 0 | 0 |
| **Total** | **0** | **909** | **0** | **0** | **0** | **0** | **0** | **0** | **909** |

| Quantitative disclosures | | | | | |
|---|---|---|---|---|---|
| **Mature Analysis & Contractual undiscounted cash flows relating to lease liabilities** | **2025-26 Land** | **2025-26 Buildings** | **2025-26 Other** | **2025-26 Total** | **2024-25 Total** |
| Less than 1 year | 0 | 329 | 0 | 329 | 322 |
| 2 -5 years | 0 | 376 | 0 | 376 | 685 |
| > 5 years | 0 | 0 | 0 | 0 | 0 |
| Less finance charges allocated to future periods | 0 | **(8)** | 0 | **(8)** | **(14)** |
| **Total** | **0** | **697** | **0** | **697** | **993** |

| **Lease Liabilities (net of irrecoverable VAT)** | **2025-26** | **2024-25** |
|---|---|---|
| Current | 323 | 314 |
| Non-Current | 374 | 679 |
| **Total** | **697** | **993** |

| | 2025-26 | 2024-25 |
|---|---|---|
| **Amounts Recognised in Statement of Comprehensive Net Expenditure** | | |
| Depreciation | 288 | 287 |
| Impairment | 0 | 0 |
| Variable lease payments not included in lease liabilities - Interest expense | 8 | 11 |
| Sub-leasing income | 0 | 0 |
| Expense related to short-term leases | 0 | 0 |
| Expense related to low-value asset leases (excluding short-term leases) | 0 | 0 |

| **Amounts Recognised in Statement of Cashflows (net of irrecoverable VAT)** | | |
|---|---|---|
| Interest expense | **(8)** | **(11)** |
| Repayments of principal on leases | **(315)** | **(311)** |
| **Total** | **(323)** | **(322)** |

## 12. Intangible non-current assets 2025-26

| 2025 - 26 | Software (purchased) £000 | Software (internally generated) £000 | Licences and trademarks £000 | Patents £000 | Development expenditure internally generated £000 | Assets under Construction £000 | Total £000 |
|---|---|---|---|---|---|---|---|
| **Cost or valuation at 1 April 2025** | 109 | 0 | 0 | 0 | 0 | 2,196 | 2,305 |
| Revaluation | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reclassifications | 2,113 | 1,107 | 0 | 0 | 0 | (3,220) | 0 |
| Reversal of impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Additions- purchased | 27 | 0 | 0 | 0 | 0 | 1,259 | 1,286 |
| Additions- internally generated | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Additions- donated | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Additions- government granted | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reclassified as held for sale | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Transfer from/into other NHS bodies | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Disposals | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Gross cost at 31 March 2026** | 2,249 | 1,107 | 0 | 0 | 0 | 235 | 3,591 |

| 2025 - 26 | Software (purchased) £000 | Software (internally generated) £000 | Licences and trademarks £000 | Patents £000 | Development expenditure internally generated £000 | Assets under Construction £000 | Total £000 |
|---|---|---|---|---|---|---|---|
| **Amortisation at 1 April 2025** | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Revaluation | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reclassifications | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reversal of impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Impairment | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Provided during the period | 125 | 50 | 0 | 0 | 0 | 0 | 175 |
| Reclassified as held for sale | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Transfer from/into other NHS bodies | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Disposals | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Amortisation at 31 March 2026** | 125 | 50 | 0 | 0 | 0 | 0 | 175 |
| **Net book value at 1 April 2025** | 109 | 0 | 0 | 0 | 0 | 2,196 | 2,305 |
| **Net book value at 31 March 2026** | 2,124 | 1,057 | 0 | 0 | 0 | 235 | 3,416 |

| 2025 - 26 | Software (purchased) £000 | Software (internally generated) £000 | Licences and trademarks £000 | Patents £000 | Development expenditure internally generated £000 | Assets under Construction £000 | Total £000 |
|---|---|---|---|---|---|---|---|
| **At 31 March 2026** | | | | | | | |
| Purchased | 2,124 | 0 | 0 | 0 | 0 | 235 | 2,359 |
| Donated | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Government Granted | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Internally generated | 0 | 1,057 | 0 | 0 | 0 | 0 | 1,057 |
| **Total at 31 March 2026** | 2,124 | 1,057 | 0 | 0 | 0 | 235 | 3,416 |

During 2025/26, two phases of Codi, a digital platform designed to manage education, training and workforce data for NHS professionals across Wales, was launched. Development expenditure on the platform commenced in 2023/24 and was capitalised and held on the balance sheet as an asset under construction prior to the system becoming available for use. During the year these costs were reclassified as an operational intangible asset.

Expenditure incurred on Phase 2, which was not operational at 31 March 2026, remains classified as an asset under construction at the year end.

## 12.1 Intangible non-current assets 2024-25

| 2024 - 25 | Software (purchased) £000 | Software (internally generated) £000 | Licences and trademarks £000 | Patents £000 | Development expenditure internally generated £000 | Assets under Construction £000 | Total £000 |
|---|---|---|---|---|---|---|---|
| Cost or valuation at 1 April 2024 | 109 | 0 | 0 | 0 | 0 | 465 | 465 |
| Revaluation | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reclassifications | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reversal of impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Additions- purchased | 109 | 0 | 0 | 0 | 0 | 1,322 | 1,431 |
| Additions- internally generated | 0 | 0 | 0 | 0 | 0 | 409 | 409 |
| Additions- donated | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Additions- government granted | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reclassified as held for sale | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Transfer from/into other NHS bodies | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Disposals | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Gross cost at 31 March 2025** | **109** | **0** | **0** | **0** | **0** | **2,196** | **2,305** |

| 2024 - 25 | Software (purchased) £000 | Software (internally generated) £000 | Licences and trademarks £000 | Patents £000 | Development expenditure internally generated £000 | Assets under Construction £000 | Total £000 |
|---|---|---|---|---|---|---|---|
| **Amortisation at 1 April 2024** | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Revaluation | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reclassifications | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reversal of impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Provided during the year | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reclassified as held for sale | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Transfer from/into other NHS bodies | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Disposals | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Amortisation at 31 March 2025** | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Net book value at 1 April 2024** | 109 | 0 | 0 | 0 | 0 | 465 | 465 |
| **Net book value at 31 March 2025** | 109 | 0 | 0 | 0 | 0 | 2,196 | 2,305 |
| **At 31 March 2025** | | | | | | | |
| Purchased | 109 | 0 | 0 | 0 | 0 | 1,531 | 1,640 |
| Donated | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Government Granted | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Internally generated | 0 | 0 | 0 | 0 | 0 | 665 | 665 |
| **Total at 31 March 2025** | 109 | 0 | 0 | 0 | 0 | 2,196 | 2,305 |

## Additional disclosures re Intangible Assets

**Disclosures:**

### i) Donated Assets

HEIW has not received any donated assets during the year.

### ii) Recognition

Intangible assets acquired separately are initially recognised at fair value. The amount recognised for internally-generated intangible assets is the sum of the expenditure incurred to date when the criteria for recognising internally generated assets has been met (see accounting policy 1.7 for criteria).

### iii) Asset Lives

The useful economic life of Intangible non-current assets are assigned on an individual basis based on the professional judgement of Trust professionals and Finance Staff. The appropriateness of these lives is reviewed on an annual basis. All fully depreciated assets still in use are being carried at nil net book value.

## 13. Impairments

| | 2025-26 Property, plant & equipment £000 | 2025-26 Right of Use Assets £000 | 2025-26 Intangible assets £000 | 2025-26 Held for sale assets £000 | 2025-26 Financial Assets £000 | 2025-26 Total Asset Impairment £000 |
|---|---|---|---|---|---|---|
| **Impairments arising from:** | | | | | | |
| Loss or damage from normal operations | 0 | 0 | 0 | 0 | 0 | 0 |
| Abandonment in the course of construction | 0 | 0 | 0 | 0 | 0 | 0 |
| Over specification of assets (Gold Plating) | 0 | 0 | 0 | 0 | 0 | 0 |
| Loss as a result of a catastrophe | 0 | 0 | 0 | 0 | 0 | 0 |
| Unforeseen obsolescence | 0 | 0 | 0 | 0 | 0 | 0 |
| Changes in market price | 0 | 0 | 0 | 0 | 0 | 0 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Others (specify) | 0 | 0 | 0 | 0 | 0 | 0 |
| Reversal of impairments | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total of all impairments** | 0 | 0 | 0 | 0 | 0 | 0 |

| **Analysis of impairments charged to reserves in period:** | | | | | | |
|---|---|---|---|---|---|---|
| Impairments charged to the Statement of Comprehensive Net Expenditure | 0 | 0 | 0 | 0 | 0 | 0 |
| Impairments as a result of revaluation/ indexation charged to Revaluation Reserve | 0 | 0 | 0 | 0 | 0 | 0 |
| Impairments as a result of a loss of economic value or service potential Charged to Revaluation Reserve | 0 | 0 | 0 | 0 | 0 | 0 |
| Right of Use (RoU) asset impairments reflected in RoU Liability | 0 | 0 | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 | 0 | 0 |

| | 2024-25 Property, plant & equipment £000 | 2024-25 Right of Use Assets £000 | 2024-25 Intangible assets £000 | 2024-25 Held for sale assets £000 | 2024-25 Financial Assets £000 | 2024-25 Total Asset Impairment £000 |
|---|---|---|---|---|---|---|
| **Impairments arising from:** | | | | | | |
| Loss or damage from normal operations | 0 | 0 | 0 | 0 | 0 | 0 |
| Abandonment in the course of construction | 0 | 0 | 0 | 0 | 0 | 0 |
| Over specification of assets (Gold Plating) | 0 | 0 | 0 | 0 | 0 | 0 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Loss as a result of a catastrophe | 0 | 0 | 0 | 0 | 0 | 0 |
| Unforeseen obsolescence | 0 | 0 | 0 | 0 | 0 | 0 |
| Changes in market price | 0 | 0 | 0 | 0 | 0 | 0 |
| Others (specify) | 0 | 0 | 0 | 0 | 0 | 0 |
| Reversal of impairments | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total of all impairments** | **0** | **0** | **0** | **0** | **0** | **0** |

| **Analysis of impairments charged to reserves in period:** | | | | | | |
|---|---|---|---|---|---|---|
| Impairments charged to the Statement of Comprehensive Net Expenditure | 0 | 0 | 0 | 0 | 0 | 0 |
| Impairments as a result of revaluation/ indexation charged to Revaluation Reserve | 0 | 0 | 0 | 0 | 0 | 0 |
| Impairments as a result of a loss of economic value or service potential Charged to Revaluation Reserve | 0 | 0 | 0 | 0 | 0 | 0 |
| Right of Use (RoU) asset impairments reflected in RoU Liability | 0 | 0 | 0 | 0 | 0 | 0 |
| | **0** | **0** | **0** | **0** | **0** | **0** |

# 14. Inventories

## 14.1 Inventories

| | 31 March 2026 £000 | 31 March 2025 £000 |
|---|---|---|
| Drugs | 0 | 0 |
| Consumables | 0 | 0 |
| Energy | 0 | 0 |
| Work in progress | 0 | 0 |
| Other | 0 | 0 |
| **Total** | **0** | **0** |
| Of which held at realisable value | 0 | 0 |

## 14.2 Inventories recognised in expenses

| | 31 March 2026 £000 | 31 March 2025 £000 |
|---|---|---|
| Inventories recognised as an expense in the period | 0 | 0 |
| Write-down of inventories (including losses) | 0 | 0 |
| Reversal of write-downs that reduced the expense | 0 | 0 |
| **Total** | **0** | **0** |

# 15. Trade and other Receivables

| | 31 March 2026 £000 | 31 March 2025 £000 |
|---|---|---|
| **Current** | | |
| Welsh Government | 0 | 10 |
| NHSW Joint Commissioning Committee | 0 | 0 |
| Welsh Health Boards | 176 | 396 |
| Welsh NHS Trusts | 217 | 283 |
| Welsh Special Health Authorities | 4 | 93 |
| Non - Welsh Trusts | 11 | 15 |

| | 31 March 2026 £000 | 31 March 2025 £000 |
|---|---|---|
| Other NHS | 13 | 0 |
| 2019-20 Scheme Pays - Welsh Government Reimbursement | 0 | 0 |
| Welsh Risk Pool Claim Reimbursement; | | |
| NHS Wales Secondary Health Sector | 0 | 0 |
| NHS Wales Primary Sector FLS Reimbursement | 0 | 0 |
| NHS Wales Redress | 0 | 0 |
| Other | 0 | 0 |
| Local Authorities | 0 | 0 |
| Other receivables | 2,811 | 2,743 |
| Provision for irrecoverable debts | (593) | (599) |
| Pension Prepayments NHS Pensions | 0 | 0 |
| Other prepayments | 8,547 | 7,834 |
| Other accrued income | 0 | 0 |
| Right of Use capital receivables | 0 | 0 |
| **Capital Receivables** | | |
| Tangibles capital receivables | 0 | 0 |
| Intangibles capital receivables | 0 | 0 |
| Other capital prepayments | 0 | 0 |
| **Sub total** | 11,186 | 10,775 |

| | | |
|---|---|---|
| **Non-current** | | |
| Welsh Government | 0 | 0 |
| NHSW Joint Commissioning Committee | 0 | 0 |
| Welsh Health Boards | 0 | 0 |
| Welsh NHS Trusts | 0 | 0 |
| Welsh Special Health Authorities | 0 | 0 |
| Non - Welsh Trusts | 0 | 0 |
| Other NHS | 0 | 0 |
| 2019-20 Scheme Pays - Welsh Government Reimbursement | 0 | 0 |
| Welsh Risk Pool Claim Reimbursement; | | |
| NHS Wales Secondary Health Sector | 0 | 0 |
| NHS Wales Primary Sector FLS Reimbursement | 0 | 0 |

| | 31 March 2026 £000 | 31 March 2025 £000 |
|---|---|---|
| NHS Wales Redress | **0** | 0 |
| Other | **0** | 0 |
| Local Authorities | **0** | 0 |
| Other receivables | **418** | 446 |
| Provision for irrecoverable debts | **0** | 0 |
| Pension Prepayments NHS Pensions | **0** | 0 |
| Pension Prepayments NEST | **0** | 0 |
| Other prepayments | **0** | 0 |
| Other accrued income | **0** | 0 |
| Right of Use capital receivables | **0** | 0 |
| **Capital Receivables** | | |
| Tangibles capital receivables | **0** | 0 |
| Intangibles capital receivables | **0** | 0 |
| Other capital prepayments | **0** | 0 |
| **Sub total** | **418** | **446** |
| **Total** | **11,604** | **11.221** |

| | 31 March 2026 £000 | 31 March 2025 £000 |
|---|---|---|
| **Receivables past their due date but not impaired** | | |
| By up to three months | **39** | 33 |
| By three to six months | **0** | 2 |
| By more than six months | **42** | 31 |
| | **81** | **66** |

| Expected Credit Losses (ECL) previously Allowance for bad and doubtful debts | | |
|---|---|---|
| Balance at 1 April | (599) | (494) |
| Transfer to other NHS Wales body | 0 | 0 |
| Amount written off during the period | 0 | 43 |
| Amount recovered during the period | 57 | 44 |
| (Increase) / decrease in receivables impaired | (51) | (192) |
| ECL/Bad debts recovered during period | 0 | 0 |
| **Balance at 31 March** | **(593)** | **(599)** |

In determining whether a debt is impaired consideration is given to the age of the debt and the results of actions taken to recover the debt, including reference to credit agencies.

| Receivables VAT | | |
|---|---|---|
| Trade receivables | 147 | 172 |
| Other | 0 | 0 |
| **Total** | **147** | **172** |

## 16. Other Financial Assets

| | Current 31 March 2026 £000 | Current 31 March 2025 £000 | Non current 31 March 2026 £000 | Non current 31 March 2025 £000 |
|---|---|---|---|---|
| **Financial assets** | | | | |
| Shares and equity type investments | | | | |
| Held to maturity investments at amortised costs | 0 | 0 | 0 | 0 |
| At fair value through SOCNE | 0 | 0 | 0 | 0 |
| Available for sale at FV | 0 | 0 | 0 | 0 |
| Deposits | 0 | 0 | 0 | 0 |
| Loans at amortised cost | 0 | 0 | 0 | 0 |
| Derivatives | 0 | 0 | 0 | 0 |
| Other (Specify) | 0 | 0 | 0 | 0 |
| Held to maturity investments at amortised costs | 0 | 0 | 0 | 0 |

| | Current 31 March 2026 £000 | Current 31 March 2025 £000 | Non current 31 March 2026 £000 | Non current 31 March 2025 £000 |
|---|---|---|---|---|
| At fair value through SOCNE | 0 | 0 | 0 | 0 |
| Available for sale at FV | 0 | 0 | 0 | 0 |
| **Capital Financial Assets** | | | | |
| Loans at amortised cost | 0 | 0 | 0 | 0 |
| Right of Use Asset Finance Sublease | 0 | 0 | 0 | 0 |
| **Total** | 0 | 0 | 0 | 0 |

RoU Sub-leasing income Recognised in Statement of Comprehensive Net Expenditure

| | 2025 - 26 | 2024 - 25 |
|---|---|---|
| RoU Sub-leasing income | 0 | 0 |

## 17. Cash and cash equivalents

| | 31 March 2026 £000 | 31 March 2025 £000 |
|---|---|---|
| Opening Balance | 3,611 | 6,787 |
| Net change in cash and cash equivalent balances | (1,929) | (3,176) |
| **Balance at 31 March** | 1,682 | 3,611 |

| **Made up of:** | | |
|---|---|---|
| Cash held at Government Banking Service (GBS) | 1,682 | 3,611 |
| Commercial banks | 0 | 0 |
| Cash in hand | 0 | 0 |
| **Cash and cash equivalents as in Statement of Financial Position** | 1,682 | 3,611 |
| Bank overdraft - GBS | 0 | 0 |
| Bank overdraft - Commercial banks | 0 | 0 |
| **Cash and cash equivalents as in Statement of Cash Flows** | 1,682 | 3,611 |

In response to the IAS 7 requirement for additional disclosure, the changes in liabilities arising for financing activities are;

**Lease Liabilities (ROUA)** £0.296m
**Lease Liabilities (short-term and low value leases)** £0m

The movement relates to cash, no comparative information is required by IAS 7 in 2025-26.

## 18. Trade and other payables

| | 31 March 2026 £000 | 31 March 2025 £000 |
|---|---|---|
| **Current** | | |
| Welsh Government | **0** | 0 |
| NHSW Joint Commissioning Committee | **0** | 0 |
| Welsh Health Boards | **5,678** | 4,553 |
| Welsh NHS Trusts | **738** | 2,525 |
| Welsh Special Health Authorities | **1** | 5 |
| Other NHS | **170** | 101 |
| Taxation and social security payable / refunds | **53** | 37 |
| Refunds of taxation by HMRC | **0** | 0 |
| VAT payable to HMRC | **0** | 0 |
| Other taxes payable to HMRC | **0** | 0 |
| NI contributions payable to HMRC | **0** | 0 |
| Non-NHS trade payables - revenue | **2,031** | 3,760 |
| Local Authorities | **0** | 4 |
| Overdraft | **0** | 0 |
| Rentals due under operating leases | **0** | 0 |
| Pensions: staff | **514** | 482 |
| Non NHS Accruals | **3,665** | 2,045 |
| Deferred Income: | | |
| Deferred Income brought forward | **5** | 0 |
| Deferred Income Additions | **9** | 5 |

| | 31 March 2026 £000 | 31 March 2025 £000 |
|---|---|---|
| Transfer to / from current/non current deferred income | 0 | 0 |
| Released to SoCNE | (5) | 0 |
| Other creditors | 0 | 0 |
| Payments on account | 0 | 0 |
| Impact of IFRS 16 on SoFP PFI contracts | 0 | 0 |
| Right of Use asset payables | 323 | 314 |
| **Capital asset payables** | | |
| Tangibles - Payables | 98 | 9 |
| Intangibles - Payables | 161 | 702 |
| Obligations under finance leases, HP contracts | 0 | 0 |
| Imputed finance lease element of on SoFP PFI contracts | 0 | 0 |
| PFI assets – deferred credits | 0 | 0 |
| Capital Payments on account | 0 | 0 |
| **Sub total** | 13,441 | 14,542 |

| | 31 March 2026 £000 | 31 March 2025 £000 |
|---|---|---|
| **Non-current** | | |
| Welsh Government | 0 | 0 |
| NHSW Joint Commissioning Committee | 0 | 0 |
| Welsh Health Boards | 0 | 0 |
| Welsh NHS Trusts | 0 | 0 |
| Welsh Special Health Authorities | 0 | 0 |
| Other NHS | 0 | 0 |
| Taxation and social security payable / refunds | 0 | 0 |
| Refunds of taxation by HMRC | 0 | 0 |
| VAT payable to HMRC | 0 | 0 |
| Other taxes payable to HMRC | 0 | 0 |
| NI contributions payable to HMRC | 0 | 0 |
| Non-NHS trade payables - revenue | 0 | 0 |

| | 31 March 2026 £000 | 31 March 2025 £000 |
|---|---|---|
| Local Authorities | **0** | 0 |
| Overdraft | **0** | 0 |
| Rentals due under operating leases | **0** | 0 |
| Pensions: staff | **0** | 0 |
| Non NHS Accruals | **0** | 0 |
| Deferred Income: | **0** | 0 |
| Deferred Income brought forward | **0** | 0 |
| Deferred Income Additions | **0** | 0 |
| Transfer to / from current/non current deferred income | **0** | 0 |
| Released to SoCNE | **0** | 0 |
| Other creditors | **0** | 0 |
| Payments on account | **0** | 0 |
| Impact of IFRS 16 on SoFP PFI contracts | **0** | 0 |
| Right of Use asset payables | **374** | 679 |
| **Capital asset payables** | | |
| Capital Creditors - Tangibles | **0** | 0 |
| Capital Creditors - Intangibles | **0** | 0 |
| Obligations under finance leases, HP contracts | **0** | 0 |
| Imputed finance lease element of on SoFP PFI contracts | **0** | 0 |
| PFI assets – deferred credits | **0** | 0 |
| Capital Payments on account | **0** | 0 |
| **Sub total** | **374** | **679** |
| **Total** | **13,815** | **15,221** |

It is intended to pay all invoices within the 30 day period directed by the Welsh Government.

Amounts falling due more than one year are expected to be settled as follows:

| | 2025 - 26 £000 | 2024 - 25 £000 |
|---|---|---|
| Between one and two years | 327 | 317 |
| Between two and five years | 47 | 362 |
| In five years or more | 0 | 0 |
| Sub total | 374 | 679 |

## 19. Other financial liabilities

| Financial liabilities | Current 31 March 2026 £000 | Current 31 March 2025 £000 | Non current 31 March 2026 £000 | Non current 31 March 2025 £000 |
|---|---|---|---|---|
| **Financial Guarantees:** | | | | |
| At amortised cost | 0 | 0 | 0 | 0 |
| At fair value through SoCNE | 0 | 0 | 0 | 0 |
| Derivatives at fair value through SoCNE | 0 | 0 | 0 | 0 |
| **Other:** | | | | |
| At amortised cost | 0 | 0 | 0 | 0 |
| At fair value through SoCNE | 0 | 0 | 0 | 0 |
| **Total** | 0 | 0 | 0 | 0 |

# 20. Provisions

| 2025 - 26 | At 1 April 2025 £000 | Structured settlement cases transferred to Risk Pool £000 | Transfer of provisions to creditors £000 | Transfer between current and non-current £000 | Arising during the period £000 | Utilised during the period £000 | Reversed unused £000 | Unwind-ing of discount £000 | At 31 March 2026 £000 |
|---|---|---|---|---|---|---|---|---|---|
| **Current** | **£000** | **£000** | **£000** | **£000** | **£000** | **£000** | **£000** | **£000** | **£000** |
| Clinical negligence: | | | | | | | | | |
| Secondary care | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Primary care | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Redress Secondary care | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Redress Primary care | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 |
| Personal injury | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| All other losses and special payments | 45 | 0 | 0 | 0 | 15 | 0 | (39) | 0 | 21 |
| Defence legal fees and other administration | 51 | 0 | 0 | 0 | 0 | 0 | (51) | 0 | 0 |
| Pensions relating to former directors | 0 | | | 0 | 0 | 0 | 0 | 0 | 0 |
| Pensions relating to other staff | 0 | | | 0 | 0 | 0 | 0 | 0 | 0 |
| 2019-20 Scheme Pays - Reimbursement | 0 | | | 0 | 0 | 0 | 0 | 0 | 0 |

| 2025 - 26 | At 1 April 2025 £000 | Structured settlement cases transferred to Risk Pool £000 | Transfer of provisions to creditors £000 | Transfer between current and non-current £000 | Arising during the period £000 | Utilised during the period £000 | Reversed unused £000 | Unwind-ing of discount £000 | At 31 March 2026 £000 |
|---|---|---|---|---|---|---|---|---|---|
| Restructuring | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other | 440 | 0 | 0 | 0 | 98 | (87) | (148) | 0 | 0 |
| **Capital provisions** | | | | | | | | | |
| RoU Asset Dilapidations CAME | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 303 |
| Other Capital Provisions | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | **536** | **0** | **0** | **0** | **113** | **(87)** | **(238)** | **0** | **324** |

| **Non-current** | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Clinical negligence: | | | | | | | | | |
| Secondary care | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Primary care | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Redress Secondary care | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Redress Primary care | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Personal injury | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| All other losses and special payments | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

| 2025 - 26 | At 1 April 2025 £000 | Structured settlement cases transferred to Risk Pool £000 | Transfer of provisions to creditors £000 | Transfer between current and non-current £000 | Arising during the period £000 | Utilised during the period £000 | Reversed unused £000 | Unwind-ing of discount £000 | At 31 March 2026 £000 |
|---|---|---|---|---|---|---|---|---|---|
| Defence legal fees and other administration | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 |
| Pensions relating to former directors | 0 | | | 0 | 0 | 0 | 0 | 0 | 0 |
| Pensions relating to other staff | 0 | | | 0 | 0 | 0 | 0 | 0 | 0 |
| 2019-20 Scheme Pays - Reimbursement | 0 | | | 0 | 0 | 0 | 0 | 0 | 0 |
| Restructuring | 0 | | | 0 | 0 | 0 | 0 | 0 | 0 |
| Other | 0 | | | 0 | 0 | 0 | 0 | 0 | 0 |
| **Capital provisions** | | | | | | | | | |
| RoU Asset Dilapidations CAME | 0 | | | 0 | 0 | 0 | 0 | 0 | 0 |
| Other Capital Provisions | 0 | | | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |

| 2025 - 26 | At 1 April 2025 £000 | Structured settlement cases transferred to Risk Pool £000 | Transfer of provisions to creditors £000 | Transfer between current and non-current £000 | Arising during the period £000 | Utilised during the period £000 | Reversed unused £000 | Unwind-ing of discount £000 | At 31 March 2026 £000 |
|---|---|---|---|---|---|---|---|---|---|
| **Total** | | | | | | | | | |
| Clinical negligence: | | | | | | | | | |
| Secondary care | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Primary care | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Redress Secondary care | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Redress Primary care | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Personal injury | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| All other losses and special payments | 45 | 0 | 0 | 0 | 15 | 0 | **(39)** | 0 | 21 |
| Defence legal fees and other administration | 51 | 0 | 0 | 0 | 0 | 0 | **(51)** | | 0 |
| Pensions relating to former directors | 0 | | | 0 | 0 | 0 | 0 | 0 | 0 |
| Pensions relating to other staff | 0 | | | 0 | 0 | 0 | 0 | 0 | 0 |
| 2019-20 Scheme Pays - Reimbursement | 0 | | | 0 | 0 | 0 | 0 | 0 | 0 |

| 2025 - 26 | At 1 April 2025 £000 | Structured settlement cases transferred to Risk Pool £000 | Transfer of provisions to creditors £000 | Transfer between current and non-current £000 | Arising during the period £000 | Utilised during the period £000 | Reversed unused £000 | Unwind-ing of discount £000 | At 31 March 2026 £000 |
|---|---|---|---|---|---|---|---|---|---|
| Restructuring | 0 | | | 0 | 0 | 0 | 0 | 0 | 0 |
| Other | 440 | | | 0 | 98 | (87) | (148) | 0 | 303 |
| **Capital provisions** | | | | | | | | | |
| RoU Asset Dilapidations CAME | 0 | | | 0 | 0 | 0 | 0 | 0 | 0 |
| Other Capital Provisions | 0 | | | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | **536** | **0** | **0** | **0** | **113** | **(87)** | **(238)** | **0** | **324** |

| | to 31 March 2027 £000 | Between 1 April 2027 31 March 2031 £000 | Thereafter £000 | Total £000 |
|---|---|---|---|---|
| Clinical negligence:- | | | | |
| Secondary care | 0 | **0** | **0** | 0 |
| Primary care | 0 | **0** | **0** | 0 |
| Redress Secondary care | 0 | **0** | **0** | 0 |
| Redress Primary care | 0 | **0** | **0** | 0 |
| Personal injury | 0 | **0** | **0** | 0 |
| All other losses and special payments | 21 | **0** | **0** | 21 |

| | to 31 March 2027 £000 | Between 1 April 2027 31 March 2031 £000 | Thereafter £000 | Total £000 |
|---|---|---|---|---|
| Defence legal fees and other administration | 0 | 0 | 0 | 0 |
| Pensions relating to former directors | 0 | 0 | 0 | 0 |
| Pensions relating to other staff | 0 | 0 | 0 | 0 |
| 2019-20 Scheme Pays - Reimbursement | 0 | 0 | 0 | 0 |
| Restructuring | 303 | 0 | 0 | 303 |
| Other | 0 | 0 | 0 | 0 |
| **Capital provisions** | | | | |
| Restructuring | 0 | 0 | 0 | 0 |
| Other | 0 | 0 | 0 | 0 |
| **Total** | **324** | **0** | **0** | **324** |

A provision of £412k was held on the balance sheet as at 31 March 2025, relating to the potential repayment of VAT previously recovered on a number of specific items of expenditure currently subject to review by HMRC. During the year, the provision increased by £97k, including potential interest payable. Amounts of £87k were utilised following the conclusion of reviews, and £148k were reversed as unused where invoices had fallen out of time or cases concluded with a positive outcome. This resulted in a closing balance of £274k as at 31 March 2026.

A provision of £96k relating to potential defence and settlement costs for two Single Lead Employer tribunal cases was held on the balance sheet as at 31 March 2025. During the year, £90k was reversed following the withdrawal or resolution of cases, with no compensation payable. A closing provision of £6k remains at year end, relating to potential service-based costs arising from one of the brought-forward cases. HEIW is not a named party to the claim but may be liable to share costs in accordance with a Service Level Agreement with NHS Wales Shared Services Partnership.

In addition, settlement costs of £15k arose during the year in respect of one employment-related case for which HEIW is a named party. Total employment-related provisions at 31 March 2026 therefore amount to £21k, comprising both named and non-named cases.

A provision of £29k was also held at 31 March 2026 in respect of the potential reimbursement of course fees relating to prior-year agreements, with no movement during the year.

| 2024 - 25 | At 1 April 2024 £000 | Structured settlement cases transferred to Risk Pool £000 | Transfer of provisions to creditors £000 | Transfer between current and non-current £000 | Arising during the period £000 | Utilised during the period £000 | Reversed unused £000 | Unwind-ing of discount £000 | At 31 March 2025 £000 |
|---|---|---|---|---|---|---|---|---|---|
| **Current** | **£000** | **£000** | **£000** | **£000** | **£000** | **£000** | **£000** | **£000** | **£000** |
| Clinical negligence: | | | | | | | | | |
| Secondary care | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Primary care | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Redress Secondary care | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Redress Primary care | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Personal injury | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| All other losses and special payments | 0 | 0 | 0 | 0 | 45 | 0 | 0 | 0 | 45 |
| Defence legal fees and other administration | 0 | 0 | 0 | 0 | 51 | 0 | 0 | | 51 |
| Pensions relating to former directors | 0 | | | 0 | 0 | 0 | 0 | 0 | 0 |
| Pensions relating to other staff | 0 | | | 0 | 0 | 0 | 0 | 0 | 0 |
| 2019-20 Scheme Pays - Reimbursement | 0 | | | 0 | 0 | 0 | 0 | 0 | 0 |
| Restructuring | 0 | | | 0 | 0 | 0 | 0 | 0 | 0 |

| 2024 - 25 | At 1 April 2024 £000 | Structured settlement cases transferred to Risk Pool £000 | Transfer of provisions to creditors £000 | Transfer between current and non-current £000 | Arising during the period £000 | Utilised during the period £000 | Reversed unused £000 | Unwind-ing of discount £000 | At 31 March 2025 £000 |
|---|---|---|---|---|---|---|---|---|---|
| Other | 34 | 0 | 0 | 0 | 406 | 0 | 0 | 0 | 440 |
| **Capital provisions** | | | | | | | | | |
| RoU Asset Dilapidations CAME | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other Capital Provisions | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | **34** | **0** | **0** | **0** | **502** | **0** | **0** | **0** | **536** |

| **Non-current** | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Clinical negligence: | | | | | | | | | |
| Secondary care | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Primary care | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Redress Secondary care | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Redress Primary care | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 |
| Personal injury | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| All other losses and special payments | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 |

| 2024 - 25 | At 1 April 2024 £000 | Structured settlement cases transferred to Risk Pool £000 | Transfer of provisions to creditors £000 | Transfer between current and non-current £000 | Arising during the period £000 | Utilised during the period £000 | Reversed unused £000 | Unwind-ing of discount £000 | At 31 March 2025 £000 |
|---|---|---|---|---|---|---|---|---|---|
| Defence legal fees and other administration | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Pensions relating to former directors | 0 | | | 0 | 0 | 0 | 0 | 0 | 0 |
| Pensions relating to other staff | 0 | | | 0 | 0 | 0 | 0 | 0 | 0 |
| 2019-20 Scheme Pays - Reimbursement | 0 | | | 0 | 0 | 0 | 0 | 0 | 0 |
| Restructuring | 0 | | | 0 | 0 | 0 | 0 | 0 | 0 |
| Other | 0 | | | 0 | 0 | 0 | 0 | 0 | 0 |
| **Capital provisions** | | | | | | | | | |
| RoU Asset Dilapidations CAME | 0 | | | 0 | 0 | 0 | 0 | 0 | 0 |
| Other Capital Provisions | 0 | | | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |

| 2024 - 25 | At 1 April 2024 £000 | Structured settlement cases transferred to Risk Pool £000 | Transfer of provisions to creditors £000 | Transfer between current and non-current £000 | Arising during the period £000 | Utilised during the period £000 | Reversed unused £000 | Unwind-ing of discount £000 | At 31 March 2025 £000 |
|---|---|---|---|---|---|---|---|---|---|
| **Total** | | | | | | | | | |
| Clinical negligence: | | | | | | | | | |
| Secondary care | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Primary care | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Redress Secondary care | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Redress Primary care | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Personal injury | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| All other losses and special payments | 0 | 0 | 0 | 0 | 45 | 0 | 0 | 0 | 45 |
| Defence legal fees and other administration | 0 | 0 | 0 | 0 | 51 | 0 | 0 | | 51 |
| Pensions relating to former directors | 0 | | | 0 | 0 | 0 | 0 | 0 | 0 |
| Pensions relating to other staff | 0 | | | 0 | 0 | 0 | 0 | 0 | 0 |
| 2019-20 Scheme Pays - Reimbursement | 0 | | | 0 | 0 | 0 | 0 | 0 | 0 |
| Restructuring | 0 | | | 0 | 0 | 0 | 0 | 0 | 0 |
| Other | 34 | 0 | 0 | 0 | 406 | 0 | 0 | 0 | 440 |

| 2024 - 25 | At 1 April 2024 £000 | Structured settlement cases transferred to Risk Pool £000 | Transfer of provisions to creditors £000 | Transfer between current and non-current £000 | Arising during the period £000 | Utilised during the period £000 | Reversed unused £000 | Unwind-ing of discount £000 | At 31 March 2025 £000 |
|---|---|---|---|---|---|---|---|---|---|
| **Capital provisions** | | | | | | | | | |
| RoU Asset Dilapidations CAME | 0 | | | 0 | 0 | 0 | 0 | 0 | 0 |
| Other Capital Provisions | 0 | | | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | **34** | **0** | **0** | **0** | **502** | **0** | **0** | **0** | **536** |

Provisions relate to:

- Potential repayment of VAT recovered on a number of specific items of expenditure curently subject to review by HMRC.
- Potential defense and settlement costs for 2 Single Lead employer tribunal cases. HEIW is not a named party in the claims but may be liable to share costs as part of the Service Level Agreement with NHS Wales Shares Services Partnership.
- Potential reimbursement of course fees relating to prior year agreements.

# 21. Contingencies

## 21.1 Contingent liabilities

Provisions have not been made in these accounts for the following amounts:

| | 31 March 2026 £000 | 31 March 2025 £000 |
|---|---|---|
| **Legal claims for alleged medical or employer negligence** | | |
| Secondary Care | 0 | 0 |
| Primary Care | 0 | 0 |
| Secondary Care Redress | 0 | 0 |
| Primary Care Redress | 0 | 0 |
| Doubtful debts | 0 | 0 |
| Equal Pay costs | 0 | 0 |
| Defence costs | 0 | 0 |
| Continuing Health Care costs | 0 | 0 |
| Other | 0 | 0 |
| **Total value of disputed claims** | 0 | 0 |
| Less amounts recoverable in the event of claims being successful | 0 | 0 |
| **Net contingent liability** | 0 | 0 |

## 21.2 Remote Contingent liabilities

Please disclose the values of the following categories of remote contingent liabilities:

| | 31 March 2026 £000 | 31 March 2025 £000 |
|---|---|---|
| Guarantees | 0 | 0 |
| Indemnities | 0 | 0 |
| Letters of Comfort | 0 | 0 |
| **Total** | 0 | 0 |

### 21.3 Contingent assets

| | 31 March 2026 £000 | 31 March 2025 £000 |
|---|---|---|
| | 0 | 0 |
| | 0 | 0 |
| | 0 | 0 |
| Total | 0 | 0 |

## 22. Capital Contingencies

The disclosure of future capital commitments not already disclosed as liabilities in the accounts.

| | 31 March 2026 £000 | 31 March 2025 £000 |
|---|---|---|
| Property, plant and equipment | 0 | 0 |
| Right of Use Assets | 0 | 0 |
| Intangible assets | 0 | 0 |
| Total | 0 | 0 |

Capital Commitments include VAT where charged. In some cases VAT can subsequently be recovered under the Contracted Out Services rules.

## 23. Losses and special payments

Losses and special payments are charged to the Statement of Comprehensive Net Expenditure in accordance with IFRS but are recorded in the losses and special payments register when payment is made. Therefore, the payments in this note for settlement and claimant costs are prepared on a cash basis.

### Gross loss to the Exchequer

### 23.1 Number of cases and associated amounts paid out during the financial year

| | Amounts paid out during period to 31 March 2026 | |
|---|---|---|
| | Number of cases | £ |
| Clinical negligence:- | | |
| Secondary Care | 0 | 0 |
| Primary Care | 0 | 0 |

| | Amounts paid out during period to 31 March 2026 | |
|---|---|---|
| | Number of cases | £ |
| Redress Secondary Care | 0 | 0 |
| Redress Primary Care | 0 | 0 |
| Personal injury | 0 | 0 |
| All other losses and special payments | 0 | 0 |
| Total | 0 | 0 |

## 23.2 Analysis of number of cases and associated amounts paid out during the financial year

| | in year claims in excess of £300,00 | | Cumulative amount |
|---|---|---|---|
| Case Type | Number of cases | £ | £ |
| Cases in excess of £300,000: | | | |
| Sub-total | 0 | 0 | 0 |
| All other cases paid in year | 0 | 0 | 0 |
| Total cases paid in year | 0 | 0 | 0 |

## 23.3 Analysis of number of cases and associated amounts where no payments were made in financial year

| | Number of cases | £ |
|---|---|---|
| Cumulative amount up to £300k | 0 | 0 |
| Cumulative amount greater than £300k | 0 | 0 |
| Total | 0 | 0 |

# 24. Right of Use leases obligations

## 24.1 Obligations (as lessee)

Amounts payable under right of use asset leases:

| 2025 - 26 | Land 31 March 2026 £000 | Buildings 31 March 2026 £000 | Other 31 March 2026 £000 | Total 31 March 2026 £000 |
|---|---|---|---|---|
| **Minimum lease payments** | | | | |
| Within one year | 0 | 0 | 0 | 0 |
| Between one and five years | 0 | 0 | 0 | 0 |
| After five years | 0 | 0 | 0 | 0 |
| Less finance charges allocated to future periods | 0 | (8) | 0 | (8) |
| **Total** | 0 | (8) | 0 | (8) |
| Included in: | | | | |
| Current borrowings | 0 | 323 | 0 | 323 |
| Non-current borrowings | 0 | 374 | 0 | 374 |
| | 0 | 697 | 0 | 697 |
| **Present value of minimum lease payments** | | | | |
| Within one year | 0 | 323 | 0 | 323 |
| Between one and five years | 0 | 374 | 0 | 374 |
| After five years | 0 | 0 | 0 | 0 |
| **Present value of minimum lease payments** | 0 | 697 | 0 | 697 |
| Included in: | | | | |
| Current borrowings | 0 | 323 | 0 | 323 |
| Non-current borrowings | 0 | 374 | 0 | 374 |
| | 0 | 697 | 0 | 697 |

| 2024 - 25 | Land 31 March 2025 £000 | Buildings 31 March 2025 £000 | Other 31 March 2025 £000 | Total 31 March 2025 £000 |
|---|---|---|---|---|
| **Minimum lease payments** | | | | |
| Within one year | 0 | 322 | 0 | 322 |
| Between one and five years | 0 | 685 | 0 | 685 |
| After five years | 0 | 0 | 0 | 0 |
| Less finance charges allocated to future periods | 0 | **(14)** | 0 | **(14)** |
| **Minimum lease payments** | **0** | **993** | **0** | **993** |
| Included in: | | | | |
| Current borrowings | 0 | 314 | 0 | 314 |
| Non-current borrowings | 0 | 679 | 0 | 679 |
| | **0** | **993** | **0** | **993** |

| **Present value of minimum lease payments** | | | | |
|---|---|---|---|---|
| Within one year | 0 | 314 | 0 | 314 |
| Between one and five years | 0 | 679 | 0 | 679 |
| After five years | 0 | 0 | 0 | 0 |
| **Present value of minimum lease payments** | **0** | **993** | **0** | **993** |
| Included in: | | | | |
| Current borrowings | 0 | 314 | 0 | 314 |
| Non-current borrowings | 0 | 679 | 0 | 679 |
| | **0** | **993** | **0** | **993** |

## 24.2 Right of Use Assets lease receivables (as lessor)

The SHA did not hold any Right of Use Assets lease receivables, as a lessor, at the balance sheet date.

| | Amounts receivable under right of use assets: | |
|---|---|---|
| | 31 March 2026 £000 | 31 March 2025 £000 |
| **Gross Investment in leases** | | |
| Within one year | 0 | 0 |
| Between one and five years | 0 | 0 |
| After five years | 0 | 0 |
| Less finance charges allocated to future periods | 0 | 0 |
| **Minimum lease payments** | 0 | 0 |

| | | |
|---|---|---|
| Included in: | | |
| Current financial assets | 0 | 0 |
| Non-current financial assets | 0 | 0 |
| | 0 | 0 |

| | | |
|---|---|---|
| **Present value of minimum lease payments** | | |
| Within one year | 0 | |
| Between one and five years | 0 | 0 |
| After five years | 0 | 0 |
| Less finance charges allocated to future periods | 0 | 0 |
| **Present value of minimum lease payments** | 0 | 0 |

| | | |
|---|---|---|
| Included in: | | |
| Current financial assets | 0 | 0 |
| Non-current financial assets | 0 | 0 |
| | 0 | 0 |

# 25. Private Finance Initiative contracts

## 25.1 PFI schemes off-Statement of Financial Position

The SHA has no PFI schemes which are deemed to be on or off the statement of financial position.

# 26. Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. The SHA is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which these standards mainly apply. The SHA has limited powers to invest and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the SHA in undertaking its activities.

### Currency risk

The SHA is principally a domestic organisation with the majority of transactions, assets and liabilities being in the UK and Sterling based. The SHA has no overseas operations and therefore has low exposure to currency rate fluctuations.

### Interest rate risk

The SHA is not permitted to borrow. The SHA therefore has low exposure to interest rate fluctuations

### Credit risk

Because the majority of the SHA funding derives from funds voted by the Welsh Government the SHA has low exposure to credit risk.

### Liquidity risk

The SHA is required to operate within cash limits set by the Welsh Government for the financial year and draws down funds from the Welsh Government as the requirement arises. The SHA is not, therefore, exposed to significant liquidity risks.

## 27. Movements in working capital

| | 2025 - 26 £000 | 2024 - 25 £000 |
|---|---|---|
| (Increase)/decrease in inventories | 0 | 0 |
| (Increase)/decrease in trade and other receivables - non-current | 28 | (104) |
| (Increase)/decrease in trade and other receivables - current | (411) | (3,111) |
| Increase/(decrease) in trade and other payables - non-current | (305) | (314) |
| Increase/(decrease) in trade and other payables - current | (1,101) | (240) |
| | (1,789) | (3,769) |

| | | |
|---|---|---|
| Adjustment for accrual movements in fixed assets - creditors | 452 | (509) |
| Adjustment for accrual movements in fixed assets - debtors | 0 | 0 |
| Adjustment for accrual movements in right of use assets - creditors | 296 | 311 |
| Adjustment for accrual movements in right of use assets - debtors | 0 | 0 |
| Other adjustments | 0 | 65 |
| | (1,041) | (3,902) |

## 28. Other cash flow adjustments

| | 2025 - 26 £000 | 2024 - 25 £000 |
|---|---|---|
| Depreciation | 800 | 765 |
| Amortisation | 175 | 0 |
| (Gains)/Loss on Disposal | 0 | 0 |
| Impairments and reversals | 0 | 0 |
| Release of PFI deferred credits | 0 | 0 |
| Donated assets received credited to revenue but non-cash | 0 | 0 |
| Government Grant assets received credited to revenue but non-cash | 0 | 0 |
| Right of Use Grant (Peppercorn Lease) credited to revenue but non cash | 0 | 0 |

| | 2025 - 26 £000 | 2024 - 25 £000 |
|---|---|---|
| Non-cash movements in right of use assets | 0 | 0 |
| Non-cash movements in provisions | (125) | 502 |
| Other movements | 5,023 | 4,771 |
| **Total** | 5,873 | 6,038 |

Other movements are Notional funding received for the SHA notional 9.4% Staff Employer Pension Contributions funded directly to the NHSBA Pensions Division by Welsh Government.

## 29. Events after the Reporting Period

Subsequent to the reporting date, the SHA received confirmation from the Welsh Government of changes to remuneration rates for NHS Wales public appointees, approved prior to 31 March 2026 and effective from 1 January 2026. The financial impact has been recognised in these financial statements.

These financial statements were authorised for issue by the Chief Executive and Accountable Officer on 24.06.2026.

## 30. Related Party Transactions

The Welsh Government is regarded as a related party. During the accounting period SHA has had a significant number of material transactions with the Welsh Government and with other entities for which the Welsh Government is regarded as the parent body. These are set out on the table below along with details of the transactions with other organisations in which senior members of the organisation have an interest.erate within cash limits set by the Welsh Government for the financial year and draws down funds from the Welsh Government as the requirement arises. The SHA is not, therefore, exposed to significant liquidity risks.

| Related Party | Expenditure to related party £000 | Income from related party £000 | Amounts owed to related party £000 | Amounts due from related party £000 |
|---|---|---|---|---|
| Welsh Government | 7 | 380,175 | 0 | 0 |
| Welsh LHBS | 141,787 | 819 | 5,677 | 176 |
| Welsh NHS Trusts | 79,495 | 778 | 738 | 217 |
| Local Authorities | 437 | 0 | 4 | 0 |

| Related Party | Expenditure to related party £000 | Income from related party £000 | Amounts owed to related party £000 | Amounts due from related party £000 |
|---|---|---|---|---|
| Welsh Special Health Authorities | 800 | 184 | 1 | 4 |
| Swansea University | 26,084 | 551 | 554 | 557 |
| Cardiff University | 29,882 | 705 | 1,468 | 0 |
| Pembrokeshire College | 1 | 0 | 0 | 0 |
| | 278,501 | 383,212 | 8,442 | 954 |

In the table above:

Amounts due from related party' include prepaid expenditure that is reflected in the HEIW Statement of Financial Position as at 31 March 2025 and will be released to the Statement of Comprehensive Net Expenditure in future accounting periods.

Expenditure is shown net of any recovery where payments are made in advance on a contracted schedule and subsequently repaid to HEIW.

During the year, other than the individuals set out below, there were no other material related party transactions involving other board members or key senior management staff.

**Dr. Chris Jones** has an honorary fellowship at Cardiff University.

**Dr. Tom Lawson** is an honorary Chair at Cardiff University and is a consultant rheumatologist at Cardiff and Vale UHB.

**Professor John Gammon** is a Professor at Swansea University and is employed as Bank/ Consultant at Hywel Dda Health Board.

**Judith Hardisty** is a member of Board of Pembrokshire College.

**Jayne Sadgrove** is a Senior Professional Fellow at Cardiff University.

All other declarations where there were no transactions with HEIW during 2025/26 are published in the Register of Members Interest.

## 31. Third Party Assets

The SHA does not hold cash on behalf of third parties.

## 32. Pooled budgets

The SHA does not operate any pooled budgets.

## 33. Operating segments

IFRS 8 requires bodies to report information about each of its operating segments. The SHA is deemed to operate as one segment.

# 34. Other Information

## 34.1. 9.4% Staff Employer Pension Contributions - Notional Element

The value of notional transactions is based on estimated costs for the twelve month period 1 April 2025 to 31 March 2026. This has been calculated from actual Welsh Government expenditure for the 9.4% staff employer pension contributions between April 2025 and February 2026 alongside Health Board data for March 2026.

Transactions include notional expenditure in relation to the 9.4% paid to NHSBSA by Welsh Government and notional funding to cover that expenditure as follows:

### Statement of Comprehensive Net Expenditure for the period ended 31 March 2026

| | | 2025 - 26 £000 | 2024 - 25 £000 |
|---|---|---|---|
| 3.2 | Postgraduate Medical, Dental & Pharmacy Education | **2,687** | 2,622 |
| 3.3 | Other Operating Expenditure | **2,336** | 2,149 |

### Statement of Changes in Taxpayers' Equity For the period ended 31 March 2026

| | 2025 - 26 £000 | 2024 - 25 £000 |
|---|---|---|
| Net operating cost for the year | **(5,023)** | **(4,771)** |
| Notional Welsh Government Funding | **5,023** | 4,771 |

### Statement of Cash Flows for period ended 31 March 2026

| | 31 March 2026 | 31 March 2025 |
|---|---|---|
| Net operating cost for the financial year | **0** | 0 |
| Other cash flow adjustments | **5,023** | 4,771 |

## 2.1 Revenue Resource Performance

| | 31 March 2026 | 31 March 2025 |
|---|---|---|
| Revenue Resource Allocation | **5,023** | 4,771 |

## 3. Analysis of gross operating costs

| | 2025 - 26 £000 | 2024 - 25 £000 |
|---|---|---|
| **3.2 Postgraduate Medical, Dental & Pharmacy Training** | | |
| GP Registrars | **2,086** | 2,196 |
| Dental Foundation Trainees | **289** | 223 |
| Pharmacy Training | **303** | 193 |
| Induction & Refresher | **6** | 9 |
| Training Grade Salaries | **0** | 0 |
| Other | **3** | 1 |

| | | |
|---|---|---|
| **3.3 Other Operating Expenditure** | | |
| Directors' costs | **99** | 100 |
| Staff costs | **2,214** | 2,049 |
| Supplies and services - general | **23** | 0 |

### 9.1 Employee costs

| | 2025 - 26 £000 | 2024 - 25 £000 |
|---|---|---|
| **Permanent Staff** | | |
| Employer contributions to NHS Pension Scheme | **2,313** | 2,149 |
| Charged to capital | **26** | 25 |
| Charged to revenue | **2,287** | 2,124 |

## 18. Trade and other payables

| | 2025 - 26 £000 | 2024 - 25 £000 |
|---|---|---|
| **Current** | | |
| **Pensions:** staff | **0** | 0 |

## 28. Other cash flow adjustments

| | 2025 - 26 £000 | 2024 - 25 £000 |
|---|---|---|
| Other movements | **5,023** | 4,771 |

## Other

## 34.2 IFRS 17 - Insurance Contract Disclosure

The outcome of the annual contract review for a range of income contract types applicable to the organisation, did not identify any insurance contracts that fall within the scope of IFRS 17.

### Statement of Financial Position

| (Signage as per provision note disclosure) | £000 |
|---|---|
| Liability for incurred claims @ 1 April 2025 | 0 |
| Liability for remaining payments @ 31 March 2026 | 0 |
| | 0 |

| | |
|---|---|
| Arising during year | 0 |
| Utilised | 0 |
| Reversed unused | 0 |
| Movement in Discount Rates | 0 |
| | 0 |

### Statement of Comprehensive Net Expenditure / Statement of Comprehensive Income *Delete as appropriate

| (Signage as per provision note disclosure) | £000 |
|---|---|
| Insurance Income | 0 |
| Insurance expenditure | 0 |
| | 0 |

**The National Health Service in Wales accounts direction given by Welsh Ministers in accordance with Paragraph 3(1) of Schedule 9 to the National Health Service (Wales) Act 2006 (C.42) and with the approval of treasury.**

## Health and Education Improvement Wales

**1.**

Health Education and Improvement Wales (HEIW), a special health authority, shall prepare accounts for the financial period 5 October 2017 to 31 March 2019 and subsequent financial years in the form specified in paragraphs 2 to 4 below.

## Basis of Preparation

**2. The accounts of HEIW shall comply with:**

**(a)** the accounting principles and disclosure requirements of the Government Financial Reporting Manual ('the FReM') issued by HM Treasury which is in force for that financial year, as detailed in the NHS Wales Manual for Accounts; and

**(b)** any other specific guidance or disclosures required by the Welsh Government.

**3. The accounts shall be prepared so as to:**

**(a)** give a true and fair view of the state of affairs as at the year-end and of the net expenditure, financial position, cash flows and changes in taxpayers' equity for the financial year then ended; and any other specific guidance or disclosures required by the Welsh Government.

**(b)** provide disclosure of any material expenditure or income that has not been applied to the purposes intended by the Senedd Cymru - Welsh Parliament or material transactions that have not conformed to the authorities which govern them.

**4.**

Compliance with the requirements of the FReM as detailed in the NHS Wales Manual for Accounts will, in all but exceptional circumstances, be necessary for the accounts to give a true and fair view. If, in these exceptional circumstances, compliance with the requirements of the FReM as detailed in the NHS Wales Manual for Accounts is inconsistent with the requirement to give a true and fair view, the requirements of the FReM as detailed in the NHS Wales Manual for Accounts should be departed from only to the extent necessary to give a true and fair view. In such

cases, informed and unbiased judgment should be used to devise an appropriate alternative treatment which should be consistent both with the economic characteristics of the circumstances concerned and the spirit of the FReM. Any material departure from the FReM should be discussed in the first instance with the Welsh Government.

Signed by the authority of the Welsh Ministers

Signed:

Dated:
**Alan Brace**, Director of Finance HSSG




ICU / Resuscitation
Uned Gofal Dwys / Dadebr
Emergency Department
Adran Achosion Brys
Waiting Room
Ystafell Aros
Toilets
Toiledau
x-ray

GIG CYMRU NHS WALES

Addysg a Gwella Iechyd Cymru (AaGIC)
Health Education and Improvement Wales (HEIW)


Addysg a Gwella Iechyd Cymru (AaGIC) | Health Education and Improvement Wales (HEIW)

Tŷ Dysgu, Cefn Coed, Nantgarw, CF15 7QQ

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## Quality Safety & Experience Committee

# CORPORATE RISK REGISTER

| | |
|---|---|
| **Dyddiad y Cyfarfod**<br>**Date of Meeting** | 05 November 2026 |
| **Statws Cyhoeddi**<br>**Publication Status** | Open/ Public |
| | Not Applicable |
| **Enw a theitl Awdur(on) yr Adroddiad**<br>**Report Author name and title** | Anthony Hughes, Risk Assurance Manager<br>Jody Evans, Assistant Head of Risk Management |
| **Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol**<br>**Lead Executive Team Member name and title** | Pam Wenger, Director of Corporate Governance |

| | |
|---|---|
| **Pwrpas yr Adroddiad**<br>**Report Purpose** | Endorse for Board Approval |

**Crynodeb Gweithredol**
**Executive Summary**

The Committee is asked to **receive assurance** of the one updated Corporate Risk that falls under the remit and oversight of the Quality, Safety and Experience Committee:

- CRR25-01 'Timely Patient Access to Safe and Effective Care '

No changes to risk score is proposed. The risk currently exceeds the risk tolerance levels set within the Board's risk appetite.

Whilst governance and oversight arrangements continue to mature, there has been limited movement in residual risk scores. Future reporting will place greater emphasis on risk trajectory, delivery of mitigating actions and evidenced risk reduction, rather than solely focusing on the maturity of governance arrangements. Whilst assurance can be taken from the strengthening of risk management processes and governance oversight, overall assurance regarding the effectiveness of current controls remains moderate, reflecting the limited movement in risk scores and the number of risks that remain outside the Health Board's agreed risk appetite.

A programme of risk-specific meetings with Executive Leads is being established to further refine individual risks, to ensure actions are sufficiently targeted, and support delivery of measurable reductions in risk scores within the agreed risk appetite.

The Committee is asked to:

- **REVIEW** and **SCRUTINISE** the corporate risk set out in the Appendix, including consideration of the current risk position, existing controls, and identified gaps.
- **ENDORSE** the risk for submission to the Board, noting that the risks remain above the Health Board's risk appetite and therefore represent a continued exposure.
- **NOTE** the programme of risk-specific meetings with Executive Leads is being established to further refine individual risks, ensure actions are sufficiently targeted, and support delivery of measurable reductions in risk scores within the agreed risk appetite.

| **Ymgysylltu (mewnol/allanol) yr ymgymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp)**<br>**Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)** | | |
|---|---|---|
| **Pwyllgor / Grŵp / Unigolion**<br>**Committee / Group / Individuals** | **Dyddiad**<br>**Date** | **Canlyniad, Tystiolaeth a Data**<br>**Outcome, Evidence and Data** |
| Risk Scrutiny Group (RSG) | 08/09/2026 | Risk Scrutiny Group stood down due to lack of quoracy for the meeting. The report was subsequently reviewed by the executive Team. |
| Executive Committee (EC) | 23/09/2026 | Full CRR presented to the Executive Committee. |
| Executive Committee (EC) | 21/10/2026 | Full CRR presented to the Executive Committee. |

| **Acronymau / Rhestr Termau**<br>**Acronyms / Glossary of Terms** | |
|---|---|
| CRR | Corporate Risk Register |
| RSG | Risk Scrutiny Group |
| BAF | Board Assurance Framework |

## CORPORATE RISK REGISTER

1. **Y SEFYLLFA**
**SITUATION**

The purpose of this report is to provide an update to the Committee on the most significant risks to which the committee has overall accountability and oversight of.

One consolidated Corporate Risk will fall under the remit and oversight of the Quality, Safety and Experience Committee:

- CRR25-01 'Timely Patient Access to Safe and Effective Care'

2. **Y CEFNDIR**
**BACKGROUND**

The Committee is asked to scrutinise and endorse the Corporate Risk within its remit prior to submission to the Board.

The risk has been mapped over to the newly approved Corporate Risk Register template. This provides improved clarity and consistency in the articulation of risk position, and strengthens the alignment between identified control gaps, mitigating actions and intended outcomes.

The Committee is invited to review the risk and provide feedback to support further refinement ahead of Board consideration.

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

**Overdue/Delayed Actions**

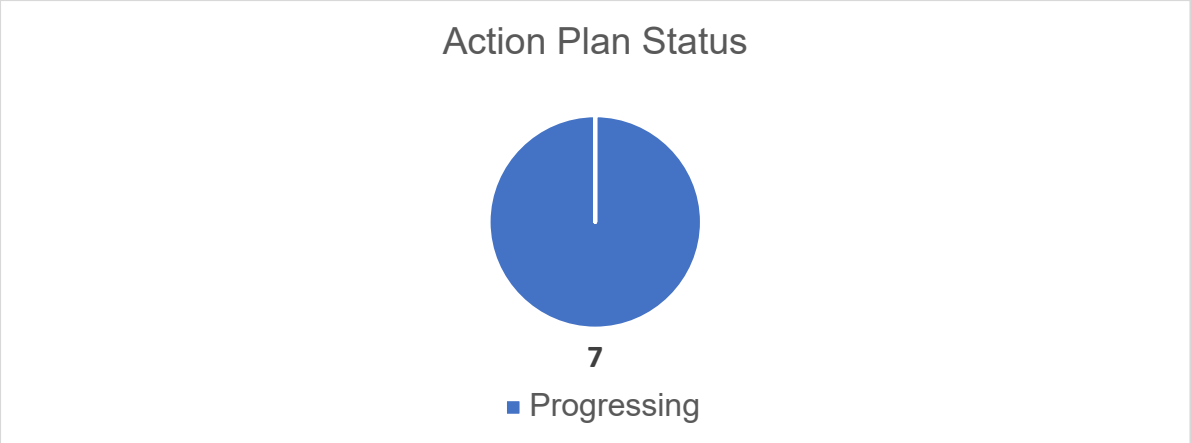
None

**Risks above Health Board appetite**

The risk reported to committee scores outside the tolerance range set within the Health Board's risk appetite.

| Risk Ref | Risks | Lead Exec Director | Current Risk Score | Risk Tolerance Range in Appetite Score |
|---|---|---|---|---|
| CRR25-01 | Timely Patient Access to Safe and Effective Care | Chief Operating Officer | **20** | Quality <15 |

**Action Plan status**




7 actions have been developed to mitigate the risk, with all 7 open actions progressing and on track.

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

The risk has been reviewed and updated by the relevant service, with no proposed changes in risk scoring. The risk score remains outside the tolerance levels established through the Board's agreed risk appetite.

Nine of the eleven Corporate Risks remain above the Board's agreed risk appetite. The focus must therefore be on demonstrable risk reduction, including whether mitigating actions are improving the risk trajectory and reducing residual risk exposure.

To strengthen accountability for delivery, it is proposed that detailed scrutiny of Corporate Risks and Board Assurance Framework risks is undertaken through the relevant Executive Delivery Groups, aligning responsibility for managing risk with the executive arrangements responsible for delivery and performance.

The Risk Scrutiny Group would provide corporate oversight of the effectiveness and consistency of risk management, including risk maturity, emerging and cross-cutting risks and appropriate challenge to significant risks.

The Committee would retain strategic oversight and assurance of the significant risks within its remit, with reporting focused on material changes in risk exposure, trajectory, delivery of key mitigations and matters requiring escalation or intervention.

Subject to approval through the appropriate governance route, the Risk Management Framework, reporting and escalation arrangements and relevant Terms of Reference will be updated to reflect these responsibilities.

## 5. ARGYMHELLION RECOMMENDATIONS

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

- **Review and scrutinise** the corporate risk set out in the Appendix, including consideration of the current risk position, existing controls, and identified gaps.
- **Endorse** the risk for submission to the Board, noting that the risks remain above the Health Board's risk appetite and therefore represent a continued exposure.
- **NOTE** the programme of risk-specific meetings with Executive Leads is being established to further refine individual risks, ensure actions are sufficiently targeted, and support delivery of measurable reductions in risk scores within the agreed risk appetite.

| ASESIAD / ASSESSMENT | |
|---|---|
| **Cysylltiad â'r Bwriadau Strategol**<br><br>**Link to Strategic Intentions** | 3. Improve Access, Outcomes and Experience<br><br>If more than one applies, please list below: |
| **Yr Egwyddorion Dylunio Design Principles** | People First |
| **Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd**<br>**Corporate Risks and Board Assurance Framework** | Corporate Risk Register and Board Assurance Framework - Betsi Cadwaladr University Health Board |

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

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

| | | |
|---|---|---|
| **Asesiad o Effaith ar Ddiogelu Data**<br>*A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?*<br>**Data Protection Impact Assessment**<br>*Have you undertaken a Data Protection Impact Assessment Screening?* | Canlyniad/Outcome: | |
| | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale: | No impacts identified – administrative report |
| **Asesiad o Effaith ar Atal Twyll**<br>*A ydych chi wedi ystyried yr effeithiau ar atal twyll?*<br>**Counter Fraud Impact**<br>*Have you considered the counter fraud impacts* | Do/Yes: ☐ | Naddo/No: ☒ |
| | Canlyniad/Outcome: | |
| | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale: | No impacts identified – administrative report |
| **Cyfreithiol**<br>**Legal** | There are no specific legal implications related to the activity outlined in this report. | |
| | | |
| **Enw Da**<br>**Reputational** | There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report. | |
| | | |
| **Effaith ar Adnoddau**<br>*(Pobl / Ariannol)*<br>**Resource Impact**<br>*(People / Financial)* | Yes (Include further detail below) | |
| | As per detail relating to resources within risk and actions. | |

# Corporate Risk Register

Quality, Safety and Experience Committee – 5th November 2026



GIG CYMRU NHS WALES

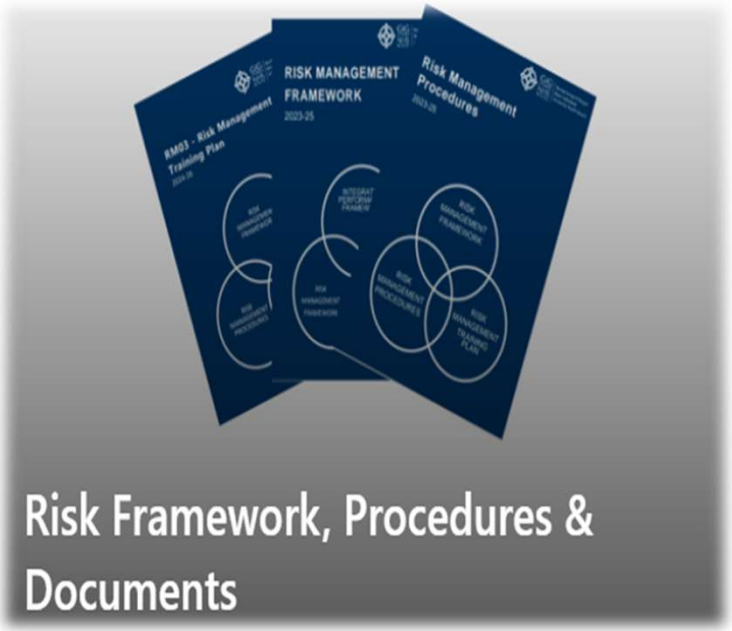
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

# Corporate Risk Register

This report provides the Quality, Safety and Experience (QSE) Committee with an update on the Corporate Risk Register (CRR) risk within its remit, specifically:

- CRR25-01 – 'Timely Patient Access to Safe and Effective Care'

Each risk sets out the current position, including progress against the delivery of associated mitigating actions.

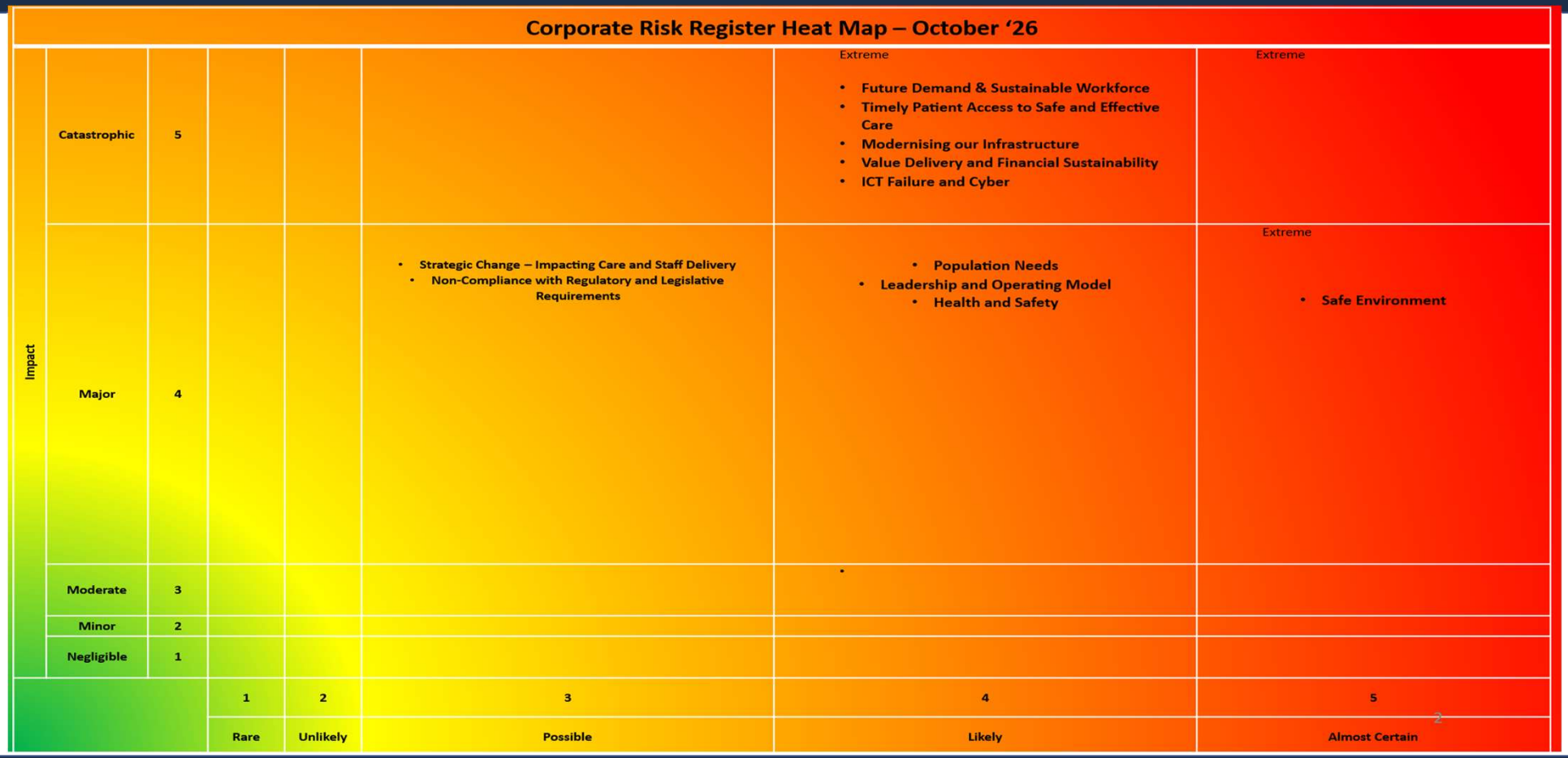


# Appendix 1 - Dashboard

| Lead | Ref | Risk Title | Current Score (Impact x Likelihood) | Risk Target Score | Appetite Main Risk Type Appetite Level | Lead Board Committee | Action Progression | | | Risk Management Commentary |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | Total | Completed | Delayed or Overdue | |
| COO | CRR25-01 | Timely Patient Access to Safe and Effective Care | 5x4<br>20 | 12 | Quality (<15)<br>Above Tolerance | Quality, Safety and Experience Committee | 7 | 0 | 0 | Action plan to be reviewed following feedback.<br>7 actions identified, all 7 progressing |

| Executive | |
|---|---|
| Chief Operating Officer | COO |
| | |

# Appendix 2 - Heatmap



Appendix 3 – Corporate Risk Register (QSE)

| CRR REF: 25-01 - Timely Patient Access to Safe and Effective Care | | |
|---|---|---|
| **Director Lead:** Chief Operating Officer | | **Date Opened:** 21/08/2025 |
| **Assuring Committee:** Quality, Safety and Experience Committee | | **Date Last Committee Review:** 02/07/2026 |
| **Date Last Reviewed:** 03/09/2026 | **Link to BAF**: BAF24-07 | **Target Risk Date:** 30/06/2027 |

***Risk Detail:***

**There is a risk that** patients may not receive timely access to the care they need; for planned care this may lead to a delay in definite treatment, deterioration in health or harm occurring whilst waiting, poor patient experience, and poorer outcome. In the unscheduled care pathway, patients may experience harm whilst waiting for ambulances in the community, may have prolonged waits for specialist medical care, this could lead to patient harm and poor patient experience.

**This may be caused by** capacity and demand mismatch, lack of oversight of waiting lists, lack of validation, the need to transform services and service models and delays due to waiting for diagnostic tests in the unscheduled arena it may be caused by poor flow through the health and social system, poor discharge practices, lack of appropriate residential and nursing placement.

**This may lead to** extended waiting lists, patient harm due to delays, and reputational or regulatory consequences.

**Mitigations/Controls in place**

1. System Resilience Hub in place with hospital escalation protocols, daily and weekend plans, and winter/festive plans. Daily Hub + rapid review + weekly executive oversight panels
2. 6 week rapid improvement plan with clinical and operational executive oversight
3. Quality, professional and operational standards
4. Major change programmes for Urgent and Emergency Care (UEC) and planned care aligned to the Six Goals for UEC framework and national objectives (such as timely access to care and building community capacity). Governance structure completed, all workstreams now all aligned.
5. Winter Resilience Plan complete evaluation and lessons learnt.
6. Revised Access policy to ensure standardised practice across the Health Board
7. Single Integrated Clinical Assessment Triage (SICAT) and GP Out of Hours (OOHs) joint model providing 24/7 triage and advice
8. Same Day Emergency Care (SDEC) services established at all acute sites
9. Routine clinical prioritisation of patients by risk in line with Referral to Treatment guidance
10. Outsourcing of radiology reporting and insourcing of CT, MRI, ultrasound
11. Diagnostic Quality Management System accreditation system embedded
12. Welsh Government short-term Neurodevelopment funding to support longest waiters, agency staff, overtime

| Gaps in Controls | Action | Action Owner | Due Date | Progression Analysis |
|---|---|---|---|---|
| **G1**<br>Fragility of UEC (Urgent Emergency Care) and specialist workforce posts, reliance on locums' temporary posts. | ED staffing business case approved by Health Board in June 2026 including recurrent investment of up to £6.65m for medical and nursing requirements. Recruitment underway to appoint to posts<br><br>**Outcome:**<br>A stable, sustainable UEC and frailty workforce with reduced reliance on locums, improved service continuity, and consistent delivery across all sites.<br><br>**Metric:**<br>Reduction in locum usage and vacancy rates in UEC and frailty posts,<br><br>**Impact on risk:**<br>Likelihood of risk will reduce as permanent posts are filled with further reduction expected as locum reliance decreases and workforce stability improves | Chief Operating Officer | Q1 2026/27 – 31/03/2027 | Progressing<br><br>Due date updated to reflect recruitment phase (from 30/06/2026) |
| **Gaps in Controls** | **Action** | **Action Owner** | **Due Date** | **Progression Analysis** |
| **G3**<br>Need for demand and capacity modelling and specialty-level trajectories | Complete demand and capacity analysis across Planned Care to inform forward activity planning<br><br>Demand & capacity (D&C) planning sessions were held in April and May with a specific focus on Cancer | Chief Operating Officer | 30/06/2026<br><br>31/03/2027 | Progressing (revised date from 31/03/2026) |

| | | | | |
|---|---|---|---|---|
| | and Diagnostics to enable more detailed discussions on demand and capacity for 26/27. Demand & capacity analysis progressing with productivity review per modality. Core priorities identified to support improved 8 week diagnostic position supported by NHS P&I<br><br>Planned Care Sprint undertaken first 2 weeks in March with clear actions to improve booking of long waiters into core capacity and transfers of care to appropriate services. Clear metrics monitored via a specific '104 sprint dashboard' to track improvement for 104 cohort bookings and at each stage.<br><br>Whilst significant progress made in 2025/26 for reductions in numbers of 156 / 104 and > 52 week waits a Planned Care recovery plan was approved by the Health Board in July and submitted to WG to recover the 104 week wait position and 8 week diagnostic position. Funding allocation of £5.4m for tranche 1 subsequently confirmed by WG.<br><br>Planned Care Recovery Director appointed to oversee delivery of the planned care recovery programme - specialty level recovery development sessions have been held to review capacity & demand in each IHC and at pan BCU level at each stage and as a whole to inform the recovery plan.<br><br>**Outcome**<br>Clear understanding of specialty level- demand and capacity, enabling improved activity planning, reduced long waits, and more efficient use of core capacity | | | Progressing revised date from 30/06/2026 |

| | | | | |
|---|---|---|---|---|
| | **Metric**<br>Reduction in number of long waiting patients (aligned to IMTP trajectory)<br><br>**Impact on Risk:**<br>Likelihood decreases as clearer planning reduces backlog risk and improves ability to meet demand. | | | |
| **Gaps in Controls** | **Action** | **Action Owner** | **Due Date** | **Progression Analysis** |
| **G4**<br>Inadequate Neurodevelopment (ND) capacity to manage waiting list | Eradicate all >3 year waits by end March 2027. Ministerial priority.<br><br>WG funding allocation of £2m confirmed to increase the ND assessment activity. Referrals have been sent to the remaining private provider with 650 assessments completed between April and August. A small number of over 4 year waiters remain and are being managed through the private provider and assessments commenced in next few weeks. Trajectories have been reviewed in relation to the over 3 years waiters and re-submitted to WG with a forecast of 344 >3 year waiters at the end of March 2027, the service will look to increase capacity however possible to reduce this figure.<br><br>All teams are finalising respective team job plans based on the prudent assessment approach adopted which may increase local capacity. A validation exercise based on the longest waiters has recently completed and review of the output of the exercise in terms of impact on the waiting list is ongoing. | Associate Directors Childrens | 31/03/2027 | Progressing<br><br>Revised date from 30/06/2026 to reflect current position from additional funding |

| | | | | |
|---|---|---|---|---|
| | The impact of increased assessments on internal waiting lists, escalated to Executive Committee and WG, with regards to ADHD medication reviews as more C&YP are diagnosed with ADHD. Approval secured from Executive Committee to utilise slippage from Children's Services core funding to increase capacity to undertake medication reviews. Teams are currently scoping options to increase prescribing capacity utilising BCUHB staff and reviewing the insourcing offer.<br><br>**Outcome** The capacity gap has reduced significantly, supported by a 63% increase in assessment activity in 2025/26. This has been achieved through a prudent delivery approach alongside commissioning of independent providers. Allocated funding will support backlog reduction for waits exceeding 3 years in Q1 26/27, whilst also contributing to longer term service sustainability.<br>**Metric** Ministerial milestone. Deliver and sustain no >3 year waits at the end of March.<br>**Impact on Risk** Failure to maintain increased assessment capacity and targeted backlog reduction may result in continued waits exceeding three years into 2026/27. This would lead to non-delivery of the ministerial milestone, prolonged delays for neurodevelopmental (ND) assessments, increased demand pressures on services, and potential deterioration in patient outcomes and experience | | | |

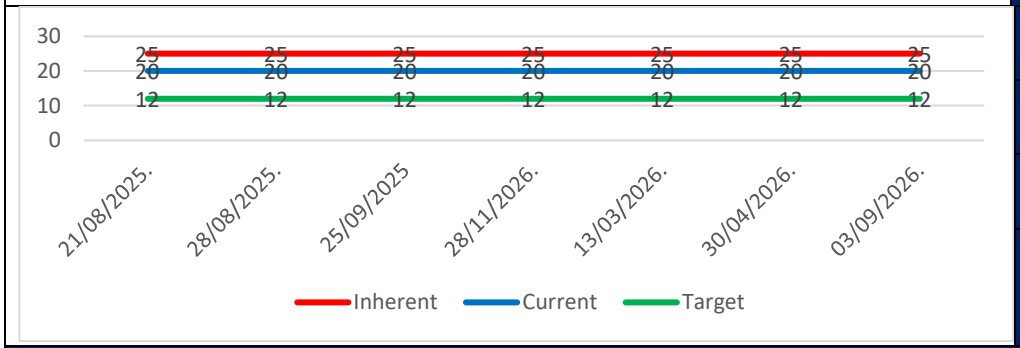
| | | | | |
|---|---|---|---|---|
| **G5**<br>Outdated diagnostic IT systems causing inefficiencies in reporting and turnaround times with diagnostics. | • Strengthen and enhance monitoring of reportable diagnostics through implementation of upgraded systems including:<br><br>- RISP (radiology) – completed RISP radiology system September 2025 completed.<br>- LIMs 2.0 (pathology) – ongoing roll out to be completed by end Q3<br><br>• Ensure existing services have mechanisms in place to report urgent and unsuspected findings, including Welsh Clinical Portal (WCP).<br><br>Enhanced / divisional monitoring of reportable diagnostics as a byproduct of planned care backlog recovery programmes. This will develop further with diagnostics division throughout 2026-27 to include UEC and urgent suspected cancer diagnostics<br><br>Update: Failure to act on Diagnostics Procedure to be presented at divisional meeting for discussion on the 10/10/2025 (NB: This action is delayed due to service focus on 8-week backlog reduction and supporting OPD programme. Proposed revise due date to Q1 2026-27). This procedure has been drafted and initial review at SCEG – further update to be provided with proposed revised due date to Q4 2026/27<br><br>**Outcome:** improved oversight and strengthened reporting of findings / responsive actions<br><br>**Metric:** reporting turnaround times maintained / improved, with outliers identified earlier for intervention | Associate Director, North Wales Managed Clinical Services | 30/06/2026<br><br>30/12/2026 | Progressing<br><br>Due date amended for LIMs to align with the correct reference to end of Q3 |

| | | | | |
|---|---|---|---|---|
| | **Impact on Risk:** overall reduction in likelihood of delayed diagnostic results to service users | | | |
| **Gaps in Controls** | • **Action** | **Action Owner** | **Due Date** | **Progression Analysis** |
| **G6**<br>Variation in acute medicine, SDEC (Same Day Emergency Care), frailty pathways across sites, No standardised model yet<br><br>Workforce recruitment impacted by non-recurrent (6 Goals) funding | • Complete pan BCUHB- baseline and gap analysis to inform a standardised frailty service model, develop unified Acute (front door) Frailty Services pathways aligned with SDEC and community services (Q2),<br><br>Baseline and gap analysis completed<br><br>Gap analysis completed and work identified requires investment, therefore as part of the IHC 90-day improvement cycles the UEC programme team will be identifying a phased work approach to create a more standardised model across BCU.<br><br>UEC Recovery Director appointed from August 2026 to oversee recovery programme. A revised UEC improvement plan and UEC structure drafted and awaiting Executive review and approval with the aim of establishing UEC Operational Delivery Group<br><br>• Finalise financial and workforce modelling required to deliver the national AFS model (Q1).<br><br>**Outcome** | UEC Programme Director | 30/09/2026<br><br>31/12/2026 updated due date to reflect the timescale of the 90 day plans | Progressing |

| | | | | |
|---|---|---|---|---|
| | A consistent, standardised frailty model across all acute sites, improving early assessment, flow, and access to same-day and community alternatives<br><br>**Metric**<br>Completion of baseline & gap analysis. Agreement of standardised AFS model for each site. Progress against recruitment to frailty workforce roles.<br><br>**Impact of Risk**<br>Risk reduces as variation decreases and standardised models strengthen service reliability and pathway consistency through pan BCU standardised approach. | | | |
| **G7**<br>Consistent application of "Our Next Patient Please" flow model. | • Develop draft Single Point of Access for alternative pathways & Primary Care redirection. Reduce unnecessary ED attendance; strengthen community pathways.<br><br>**Outcome**<br>Improved patient flow through earlier ward moves, reduced ED congestion, and strengthened use of alternative pathways and community services—leading to fewer unnecessary ED attendances and more efficient system-wide flow.<br><br>**Metric**<br>Reduction in ED congestion metrics (4 hour / 12 hour / time to triage / ambulance handover)<br>• Reduction in LoS / POCD<br><br>**Impact on Risk**<br>Risk decreases as improved flow reduces system pressure, ED overcrowding, and delays in urgent | Chief Operating Officer | 31/03/2027 | Progressing |

| | | | | |
|---|---|---|---|---|
| | and emergency care—lowering the likelihood and impact of service failure<br><br>Action update:<br>• Your Next Patient / Forward Waiting SOP developed<br>• Accelerated Boarding in Extremis SOP developed<br>The 'Your Next Patient' SOP has been approved and following Quality Assurance will be uploaded to the BCU Written Control Document system. As the SOP is embedded and becomes business as usual further work will include reviewing the criteria for triggering the SOP to ensure it is sensitive enough and reactive enough to the UEC pressures. | | | |
| **Gaps in Controls** | **Action** | **Action Owner** | **Due Date** | **Progression Analysis** |
| **G8**<br>Health Board improvement goal for Clostridioides Difficile Infection (CDI) reductions in 2025/2026 and 2026/27 to reduce the number of cases within the Health Board. | Implementation of Health Board improvement goal for CDI (Colostridioides Difficile Infection) reductions in line with the WHC Improvement Goals for 2025 - 2027<br><br>The Health Board has until March 2027 to reduce CDI by at least 25% against the 2024/2025 counts.<br><br>However due to an increase in the CDI rates, the team continue to escalate, share learning through deep dives and promote high level recommendations which due to other competing pressures present challenges in delivery<br><br>**Outcome**<br>Reduced incidence of Clostridioides difficile infection across the Health Board through strengthened | Deputy Director of Nursing Infection Prevention and Decontamination | 31/03/2027 | Progressing (revised date from 31/03/2026) |

| | | | | |
|---|---|---|---|---|
| | infection prevention-, antimicrobial stewardship, and system-wide adherence to improvement measures.<br><br>**Metric**<br>CDI incidence rate per 100,000 population<br><br>**Impact on Risk**<br>Risk decreases as CDI rates fall, demonstrating improved infection control and reduced harm as performance moves towards the 2025/26 reduction target. | | | |




| | Impact | Likelihood | Score |
|---|---|---|---|
| Inherent Risk Rating | 5 | 5 | 25 |
| Current Risk Rating | 5 | 4 | 20 |
| Target Risk Score | 4 | 3 | 12 |
| Risk Appetite | Quality <15 | | Not in Tolerance |

**Position & Intended Outcome for Risk**

The number of Prevention of Future Death (PFD) / Regulation 28 Notices issued to BCUHB were: 23 in 2023-24; 7 in 2024-25; 3 in 2025-26 to date. In 2023 the Health Board was an outlier and 9 cases directly related to the impact of delays in the health and social care system on the timeliness of responses by the HB and Welsh Ambulance Service and ongoing work is required to resolve the underlining delays to treatment. The goal being to be in line with WG targets.

Intended Outcome:

By 2027, patients consistently receive timely, effective, and safe care, evidenced by:

- Reduction in long-wait patients (>104 weeks) and breaches of national access standards.
- Fewer harm events linked to delayed care.
- Improved quality metrics including length of stay, readmission rates, and patient-reported outcome measures (PROMs).
- Reduction in regulatory and legal cases associated with delayed access.
- A demonstrable shift in focus from access process metrics to sustained improvement in patient safety, experience, and outcomes.

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

# Quality Safety & Experience Committee

## CORPORATE GOVERNANCE REPORT

| | |
|---|---|
| **Dyddiad y Cyfarfod<br>Date of Meeting** | 05 November 2026 |
| **Statws Cyhoeddi<br>Publication Status** | Open/ Public |
| | Not Applicable |
| **Enw a theitl Awdur(on) yr Adroddiad<br>Report Author name and title** | Philippa Peake-Jones, Head of Corporate Governance |
| **Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol<br>Lead Executive Team Member name and title** | Pam Wenger, Director of Corporate Governance |

| | |
|---|---|
| **Pwrpas yr Adroddiad<br>Report Purpose** | For Noting |

| **Crynodeb Gweithredol<br>Executive Summary** |
|---|
| The Committee is asked to:<br>• **NOTE** the summary of business considered in private session to be reported in public |

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

| **Acronymau / Rhestr Termau<br>Acronyms / Glossary of Terms** | |
|---|---|
| | |

## CORPORATE GOVERNANCE REPORT

1. **Y SEFYLLFA**
**SITUATION**

1 The Health Board is required to act according to its Standing Orders. This report contains information to allow the Health Board to conform to this.

2 It is essential that the Board has robust arrangements in place for Corporate Governance and failure to do so could have legal implications for the Health Board.

3 **Y CEFNDIR**
**BACKGROUND**

3.1 The purpose of this report is to provide the Committee with an update on key corporate governance matters.

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

4.1 **Summary of Business Considered in Private**

4.1.1 Standing Order 6.5.3 requires the Board to formally report any decisions taken in private session to the next meeting of the Board in public session. This principle is also applied to Committee meetings.

4.1.2 The below items were considered in private at the meeting held on 3 September 2026:

| Agenda Item | Subject (including narrative) | Committee Resolution | Rationale for item in Private |
|---|---|---|---|
| QS26.142 | Integrated Quality Performance Report | The Committee:<br>• **NOTED** the report. | Identifiable Information |
| QS26.143 | Annual Quality Report | The Committee:<br>• **ENDORSED** the report for Board Approval. | Draft Status |
| QS26.144 | Barrett's Oesophagus | The Committee:<br>• **NOTED** the report. | Business Sensitive |
| QS26.145 | HIW Plan – YGC Emergency Department | The Committee:<br>• **APPROVED** the report. | Draft Status |

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

5.1 There are no matters for escalation.

## 6 ARGYMHELLION
## RECOMMENDATIONS

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

- **NOTE** the matters considered in Private at the 3 September 2026 Committee.

| ASESIAD / ASSESSMENT | |
|---|---|
| **Cyswllt â'r Blaenoriaethau Strategol**<br>**Link to Strategic Priorities** | <br>1. Building an effective organisation |
| | |
| | Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:<br>If more than one applies, please list below: |
| **Yr Egwyddorion Dylunio**<br>**Design Principles** | Simplify, Standardise, and Adopt Best Practices<br>Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:<br>If more than one applies, please list below: |
| **Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd**<br>**Corporate Risks and Board Assurance Framework** | BAF24-01 Building an Effective and Accountable Organisation<br><br>CRR-16 – Leadership/Special Measures |

| ASESIADAU O EFFAITH / IMPACT ASSESSMENTS | | |
|---|---|---|
| **Cydraddoldeb**<br>*A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)*<br>**Equality**<br>*Have you undertaken an Equality Impact Assessment Screening (which includes the* | Do/Yes: ☐ | Naddo/No: ☒ |
| | Canlyniad/Outcome: | |
| | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale: | Not necessary for this report |

| | | |
|---|---|---|
| *requirements of the Welsh Language Standards)* | | |
| **Asesiad o'r Effaith Economaidd-gymdeithasol** *A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?* **Socio-Economic Impact Assessment** *Have you undertaken a Socio-Economic Impact Assessment* | Do/Yes: ☐ | Naddo/No: ☒ |
| | Canlyniad/Outcome: | |
| | Os naddo, dylech gynnwys y rheswm: If no, please include rationale: | Not necessary for this report |
| **Ansawdd** *A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?* **Quality** *Have you undertaken a Quality Impact Assessment Screening?* | **Galluogwyr Ansawdd Enablers of Quality** All Apply | **Meysydd Ansawdd Domains of Quality** All Apply |
| | Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below: | Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below: |
| | | |
| **Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals** | Not Applicable | |

| | | |
|---|---|---|
| **Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)** | Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below: | |
| | No - Not Applicable | |
| | Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list: | |
| **Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog** | Do/Yes: ☐ | Naddo/No: ☒ |
| | Canlyniad/Outcome: | |

| | | |
|---|---|---|
| A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog:<br>**Armed Forces Covenant Due Regard Duty**<br>Have you considered the Armed Forces Covenant Due Regard Duty? | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale: | Not necessary for this report |
| **Asesiad o Effaith ar Ddiogelu Data**<br>*A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?*<br>**Data Protection Impact Assessment**<br>*Have you undertaken a Data Protection Impact Assessment Screening?* | Do/Yes: ☐ | Naddo/No: ☒ |
| | Canlyniad/Outcome: | |
| | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale: | Not necessary for this report |
| **Asesiad o Effaith ar Atal Twyll**<br>*A ydych chi wedi ystyried yr effeithiau ar atal twyll?*<br>**Counter Fraud Impact Assessment**<br>*Have you considered the counter fraud impacts* | Do/Yes: ☐ | Naddo/No: ☒ |
| | Canlyniad/Outcome: | |
| | Os naddo, dylech gynnwys y rheswm:<br>If no, please include rationale: | Not necessary for this report |
| **Cyfreithiol**<br>**Legal** | There are no specific legal implications related to the activity outlined in this report. | |
| | | |
| **Enw Da**<br>**Reputational** | There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report. | |
| | | |
| **Effaith ar Adnoddau**<br>*(Pobl / Ariannol)*<br>**Resource Impact**<br>*(People / Financial)* | There is no direct impact on resources as a result of the activity outlined in this report. | |
| | | |

Archwilio Cymru
Audit Wales

# Are cancer services improving?

## Betsi Cadwaladr University Health Board

September 2026

We have prepared and published this report under section 61(3) (b) of the Public Audit Wales Act 2004.

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# Audit snapshot

## What we looked at

1 We looked at Betsi Cadwaladr University Health Board's (the Health Board's) approach to managing cancer services. This includes how it plans services, prevents cancer, supports early detection, and leads and oversees service performance.

2 We also reviewed trends in cancer service performance. Our 2025 national report on cancer services highlighted data quality concerns and recommended improvements at a national level. We have not reviewed data quality as part of this review

## Why this is important

3 Demand for cancer services is increasing, driven by factors such as:

- an ageing population;
- rising levels of obesity and alcohol use;
- better survival rates, meaning patients need ongoing follow-up and monitoring; and
- the ongoing introduction of new tests and treatments.

4 Cancer outcomes are worse when patients wait too long for treatment. Long waits can shorten life expectancy and reduce quality of life after treatment. This increases pressure on health boards to deliver timely care.

5 Cancer services account for a growing share of NHS spending. This is driven by increasing demand and the costs of new tests and treatments.

## What we have found

6 Access to cancer services remains well below the national standard. In March 2026, 54% of patients started treatment within 62 days of cancer first being suspected. The Health Board was once among the better performers in Wales but is now among the worst. As a result, many patients are waiting too long to start cancer treatment.

7 The Health Board has put recovery actions in place, but these have not led to sustained improvement. Progress relies heavily on temporary measures, such as insourcing and overtime. The Health Board mainly uses data to monitor current performance. It makes less use of data to predict demand, plan capacity and guide investment.

8 The Health Board provides prehabilitation support before, during and after cancer treatment. However, access to these services varies across sites. The Health Board does not always use learning from this work to improve services.

9 Senior leaders closely monitor cancer services, and staff work across teams to address delays. However, most effort focuses on current performance issues rather than long-term improvement. The Health Board does not have a single, costed plan for cancer services. As a result, it is not clear how it will address prevention, staff shortages, limited diagnostic capacity, ageing equipment and rising demand.

10 The Health Board knows that many cancers can be prevented. However, cancer leaders focus mainly on waiting times and performance. Prevention and early diagnosis are not given the same priority.

## What we recommend

11 We have made six recommendations to the Health Board in the following areas:

- developing a costed integrated cancer strategy and delivery plan;
- monitoring the delivery of the plan;

- improving demand and capacity forecasting;
- establishing a long-term workforce and infrastructure plan to create the capacity to meet current and future need;
- developing a sustainable cancer prevention programme; and
- strengthening the Cancer Board.

# Key facts and figures



The number of new suspected cancer referrals rose by 6% between 2022–23 and 2025-26.



The spend on cancer services increased from £135 million to £188 million between 2019–20 and 2023–24. This is £28 million more than if spend had increased with inflation over the same period.



In March 2026, most referrals were for suspected skin cancer (969), lower gastrointestinal (735) and upper gastrointestinal (595) cancers.



In March 2026, 54% of patients started treatment within 62 days, compared with the 75% target.



In March 2026, there was wide variation in treatment waiting times. Performance ranged from 69.4% for skin cancer to just 40% for lower gastrointestinal cancer, against the 75% target.



Between 2002 and 2024 one-year cancer mortality rates have fallen by 16.2%.

# Our findings

## Cancer service improvement planning

**Cancer plans are spread across different documents. There is no clear long-term plan to improve services, increase capacity or meet rising demand.**

### Cancer improvement plans

12 The Health Board has several plans for cancer services. The Cancer Roadmap (2024–2029) sets out its main aims. Other plans focus on reducing waits, improving cancer care and supporting services such as dermatology, breast, colorectal and urology. The Integrated Medium-Term Plan (IMTP) also includes actions to improve diagnostics, staffing and service capacity. However, there is no single consolidated plan that brings all of this work together and shows how services will improve over time. While cancer priorities are set out across several plans, it is not clear how these plans work together to manage long-term risks and improve services.

13 The Suspected Cancer Pathway (SCP) Delivery Plan sets out the Health Board's priorities for improving performance against the SCP target to start treatment within 62 days of first suspicion of cancer. The plan focuses on reducing pathway delays by increasing diagnostic and treatment capacity. However, many actions rely on short term measures, such as insourcing and overtime. The plan also does not set out the workforce, funding and infrastructure needed to sustain improvement. Actions to reduce inequalities are not a clear part of the plan.

14 The Health Board uses National Optimal Pathways[1] to check whether patients move through cancer services in a timely way. It reviews how well services follow these pathways. However, planning assumptions are often too optimistic. Some recovery plans include clear actions and named leads, but this is not consistent. Plans do not always show when actions will be completed or how they will improve services.

15 The Health Board works closely with hospitals in North-West England to provide cancer care. However, its plans do not clearly explain this dependency or how it affects service delivery. Plans also provide limited detail on how the Health Board oversees the quality and outcomes of care provided by other organisations. There is also limited evidence that the Health Board routinely uses learning from previous improvement work or best practice to shape future plans.

## Cancer intelligence and data

16 The Health Board needs to make better use of cancer data and intelligence. It uses data on pathway performance, long waits, differences between tumour sites, diagnostic delays and demand from screening services to manage current pressures. This helps staff understand where problems exist and manage services day to day.

17 However, the Health Board makes limited use of data to predict future demand, plan capacity or support long-term improvement. Also, the way services use data is not consistent across the Health Board. Some services, such as dermatology, breast and urology use data to support planning and improvement, while others use it mainly to manage day-to-day pressures. As a result, the Health Board is missing opportunities to improve planning, make best use of capacity, and respond to future demand.

[1] Standardised, evidence-based care pathways designed to improve cancer diagnosis and treatment.

## Supporting fragile services

18 The Health Board understands the main challenges facing cancer services and knows which services perform poorly. These challenges include staff shortages, delays in testing, ageing equipment and limited facilities. However, the level of risk varies between services and across North Wales.

19 The IMTP, Cancer Service Plan, SCP Delivery Plan and tumour-site plans all highlight cancer services risk. However, many actions focus on short-term fixes, such as extra clinic sessions, temporary staff and waiting list initiatives. These actions help services cope with current pressures, but they have not led to lasting improvement in cancer performance.

20 Some planned changes aim to help patients get diagnosed and treated more quickly. These include straight-to-test services, nurse-led triage and teledermoscopy. The Health Board is also helping more patients prepare for treatment through prehabilitation and receive radiotherapy closer to home. The changes have potential to deliver benefits in the longer-term. However, many are at an early stage, and it is too soon to know whether they will reduce current pressures and provide a sustainable solution. While some actions relate to longer-term solutions, these are often still being developed or depend on uncertain future funding and recruitment.

21 The Health Board works with partner organisations to help meet demand for cancer services. In the West, dermatology services rely on insourced staff because there are not enough permanent staff. The Health Board also works with specialist centres in North- West England so patients can receive specialist treatment.

# Financial and wider resource planning

## There is no clear, balanced, financial or wider resource plan for cancer services

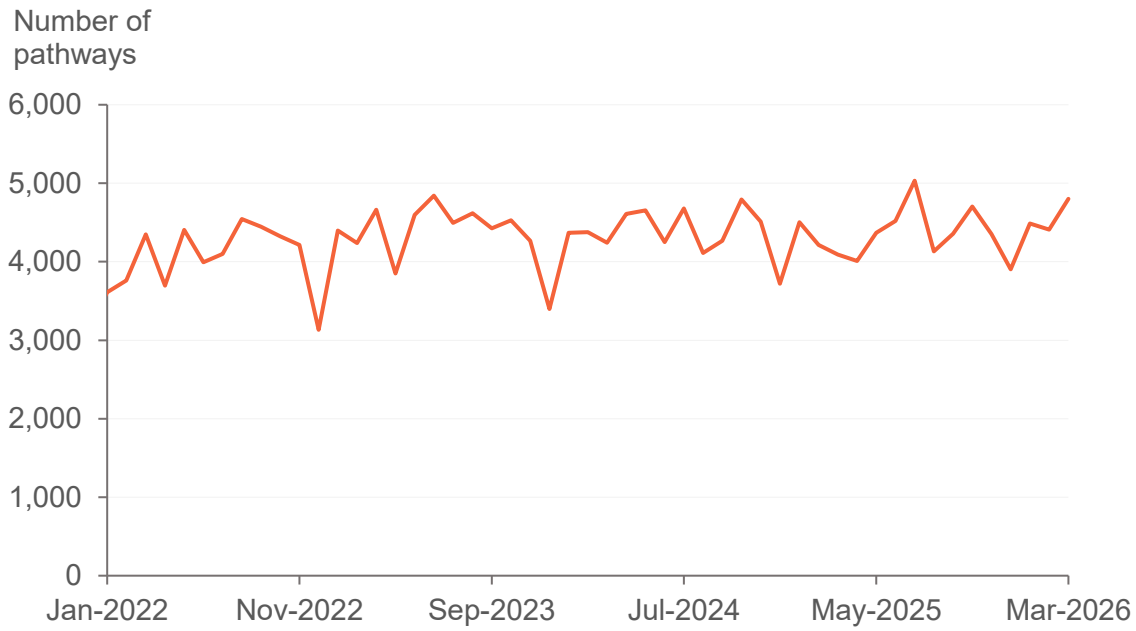
### Funding plans

22 The Health Board has not identified the total funding that it needs to deliver its cancer improvement plans. Instead, it relies on individual business cases and short-term funding to support service developments. This makes it difficult to understand the full cost of improving cancer services and meeting national standards and targets. It may also mean that the Health Board will not be able to sustainably fund all planned improvements.

23 The IMTP includes funding to improve cancer services. This includes diagnostics, radiotherapy and more staff capacity. Funding comes from several budgets, so it is hard to see the total spend on cancer services. Some proposals still need national funding and business case approval before work can start.

24 **Exhibit 1** shows the number of new suspected cancer pathways opened each month. This shows a slow but ongoing increase in demand. Changes in demand are not uniform across services though. The Health Board has seen a notable increase in referrals between 2022–23 and 2025–26 in urological (+21%), head and neck (+20%), and gynaecological (+19%) cancers.

## Exhibit 1: newly opened suspected cancer pathways, Betsi Cadwaladr University Health Board, January 2022 to March 2026 (numbers).



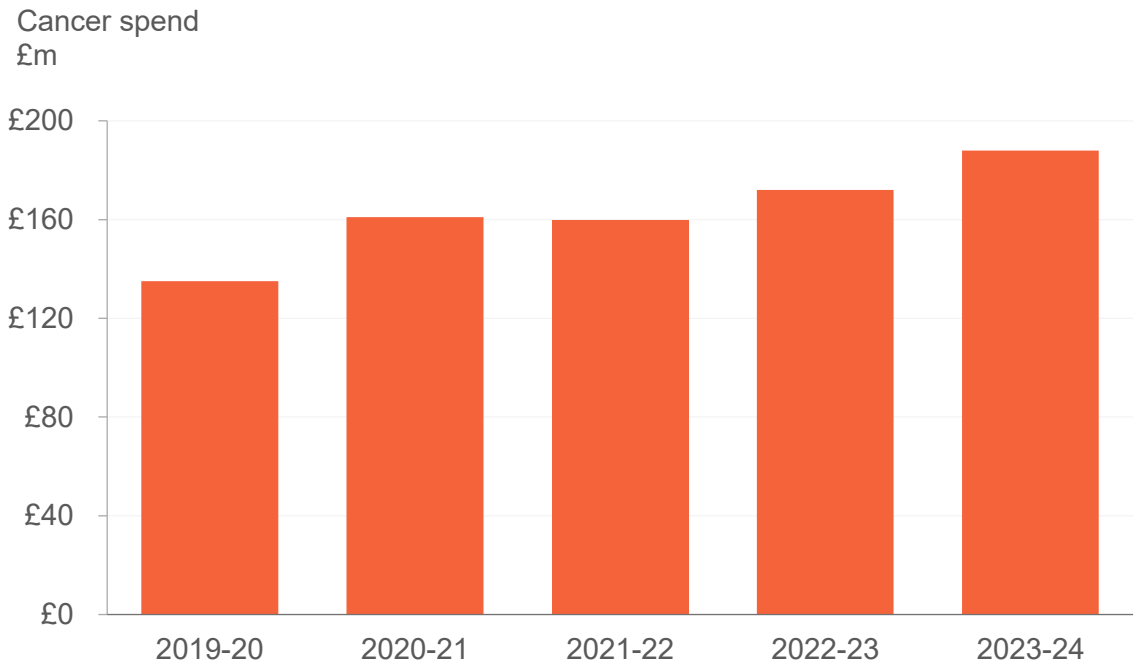

Source: Audit Wales analysis of Digital Health and Care Wales data

Note: Under the suspected cancer pathway (SCP), a pathway starts at the point of suspicion, for example when a GP makes a referral. Pathways are closed, and waiting times end, when patients start their first definitive treatment, are downgraded (told they do not have cancer), choose not to have treatment or if the patient dies. Note that patients can be on more than one pathway.

25 New demand is increasing and the costs have increased faster than inflation. **Exhibit 2** shows spending on cancer services between 2019–20 and 2023–24. Over this period, the Health Board's cancer spending rose by about 17% above inflation[2]. Spending on hospital cancer medicines has also increased. Between 2019–20 and 2024–25, the Health Board's spend rose from £135 million to around £188 million[3][4]. This is about £28 million more than if costs had increased in line with inflation (in 2023–24 prices).

26 The expenditure analysis is based on the cancer expenditure dataset reported to Welsh Government and should be interpreted as an indicator of overall spending trends.

**Exhibit 2: actual cancer services spend, Betsi Cadwaladr University Health Board, 2019–20 to 2023–24, (£million)**




[2] Inflation is calculated using 2023–24 as a baseline and HM Treasury inflation data.

[3] Some specialty medicine costs cover both cancer and other treatments but are included in the total. This is unlikely to have a substantial impact on the overall figures.

[4] Medicine figures cover hospital spending by the Health Board only and exclude costs for patients treated elsewhere.

Source: Audit Wales analysis of the Health Board's data, sourced from the Welsh Government

27 **Exhibits 1** and **2** show that spending has increased alongside rising demand. They also show that spending has grown faster than inflation, increasing the importance of effective financial planning. This limits assurance that cancer services will remain affordable and sustainable over the longer term.

28 There is evidence that services use financial information to support planning. This includes forecasts, staffing costs, other running costs, savings plans and known financial pressures. However, the Health Board has not brought this information into a single, costed plan for cancer.

## Wider resourcing requirements

29 The Health Board understands the main challenges facing cancer services. These include staff shortages, limited space, ageing equipment and gaps in services such as robotic surgery. These issues are recognised in the IMTP, Cancer Roadmap and tumour-site plans. However, these plans provide limited detail on future demand, resource needs and delivery timescales. While key requirements are identified, it is not clear how the Health Board will address them in a joined-up way or manage the long-term risks facing cancer services.

30 The Health Board uses tools such as teledermoscopy, Chemocare and electronic triage to support cancer services. However, many systems do not link well together. Staff still use spreadsheets and enter data by hand. The Health Board plans to introduce new systems, including electronic patient records and digital diagnostics. These projects aim to reduce pressure on services and improve performance.

31 Teams across cancer services, diagnostics and surgery work together to improve care. This has led to nurse-led triage, straight-to-test pathways and changes to multidisciplinary team working. The Health Board also works with specialist centres in North-West England so patients can access treatments that are not available in North Wales.

# Cancer prevention and population screening

## The Health Board is not maximising the benefits of cancer prevention or using data effectively to take targeted action or improve screening uptake

32 The All-Wales Cancer Improvement Plan sets out that 38% of cancers each year are preventable. For context, if the Health Board prevented 20% of cancers, this could have saved £2.6 million in bed day costs[5]. **Exhibit 3** gives an example of potential gains if the Health Board successfully implemented a cancer prevention strategy.

**Exhibit 3: potential capacity gains from cancer prevention, Betsi Cadwaladr University Health Board, based on 2024–25 activity**

| | 2024-25 actual | -10% reduction | -20% reduction | -38% reduction |
|---|---|---|---|---|
| Finished consultant episodes | **23,450** | **21,105** (2,345 reduction) | **18,760** (4,690 reduction) | **14,539** (8,911 reduction) |
| Admission episodes | **22,632** | **20,369** (2,263 reduction) | **18,106** (4,526 reduction) | **14,032** (8,600 reduction) |
| Bed days | **26,581** | **23,923** (2,658 reduction) | **21,265** (5,316 reduction) | **16,480** (10,101 reduction) |
| Bed day cost savings | | (**£1.3** million) | (**£2.6** million) | (**£5.0** million) |

[5] Based on 2024-25 activity data, and the most recent current financial data.

Source: Audit Wales analysis and modelling of Digital Health and Care Wales data from the Patient Episode Database for Wales, Headline Figures and Primary Diagnosis Datasets for Welsh providers

Notes:

1) The analysis outlines the broad impact of a 10%, 20% and 38% reduction in cancer cases, based on 2024–25 activity levels.

2) Savings calculation based on £500 per day cost of an NHS bed in Wales used in our 2025 National Cancer Services Report.

## Public health risk assessment

33 The Health Board understands the main factors linked to cancer, including smoking, excess weight, poverty and unequal access to care. It uses this information to target support, including help to stop smoking, manage weight, and increase vaccination and screening uptake. However, the Health Board is not making enough use of this data to plan for future demand. As a result, planning focuses more on current pressures than future needs.

34 The Health Board is working closely with its Public Health Directorate, alongside Public Health Wales NHS Trust, to understand local health needs. However, cancer forums focus mainly on current demand, long waits and cancer treatment targets. They don’t give enough attention to prevention and early diagnosis.

## Approaches to improving population lifestyles

35 The Health Board provides services to help reduce the risk of cancer. These include supporting people to stop smoking, manage weight, increase vaccination uptake and improve healthy lifestyles. However, limited funding and competing demands reduce the reach and impact of these services.

36 The Health Board is targeting some services at people most at risk of cancer, and some have achieved good results. For example, smoking cessation services, which have exceeded national targets. However, limited funding and staff shortages restrict what these services can achieve. Many programmes rely on short-term funding, making it hard to plan for the future. The Health Board does not always use learning from this work to develop long-term funded plans.

37 Data shows that screening does not always help patients get diagnosed and treated quickly. Delays are common in bowel and breast cancer services, where increasing demand, diagnostic capacity constraints, workforce shortages and wider service pressures mean patients do not always receive follow-up tests and treatment within expected timescales.

38 The Health Board works with its Public Health Directorate, alongside Public Health Wales NHS Trust, to review screening rates, delays and differences between groups. It uses this information to identify where uptake is low and target improvement actions.

39 The Health Board does not make full use of this information when planning for the future. The IMTP recognises that higher screening uptake will increase demand for tests and treatment. However, there is little evidence of plans to provide the extra capacity needed. As a result, existing delays may reduce the benefits of screening programmes.

40 Human papillomavirus vaccination (HPV) uptake is 72% against the Welsh Government 90% target. The Health Board has plans to improve uptake through targeted action. This includes work with schools, primary care and groups with lower participation.

# Cancer leadership and oversight

## Cancer leadership manages current performance and risks but is less focused on longer-term service improvement and redesign

### Managerial leadership

41 The Health Board has clear leadership for cancer services. Cancer service managers, clinicians, diagnostic teams and oncology staff oversee cancer care. They review performance, manage risks and address delays. Most of their work focuses on current services and waiting times. However, they give less attention to the changes needed to create a sustainable workforce, expand services and improve care over the longer term.

42 Leadership capacity varies between tumour sites. Some services do not have enough clinical leadership support. This can make it harder to improve services and manage change. As a result, joint working often focuses on current pressures and waiting times. There is less evidence of teams working together to improve services over the long term, improve patient pathways, or reduce differences in access, experience and outcomes.

43 Several teams manage cancer services, including cancer, diagnostic and oncology teams. As a result, services may not always work together in a consistent way to address problems that affect patient care.

44 The Health Board works with third sector organisations to support patient care and wellbeing. While these arrangements provide additional support for patients, there is limited evidence of the role that third sector partners play in wider cancer planning and service improvement.

## Oversight and scrutiny

45 The Health Board has governance arrangements in place to oversee cancer services. They monitor performance and risks, but there is limited evidence that they are driving improvement. Board and committees oversee cancer performance, pathway delays, service risks and performance against national targets. This helps the Health Board to identify and escalate risks and performance concerns. However, their impact on improving services and performance is less clear.

46 The Board and committees do not always track whether the Health Board has delivered the agreed actions, and if so, whether the actions have resolved underlying problems. As a result, governance is stronger at identifying issues than demonstrating sustained improvement.

47 Attendance at the Cancer Board is mixed, which may limit its ability to drive improvement. Interviews suggest that the Cancer Board is not always used effectively to support change. Discussions tend to focus on performance targets and day-to-day pressures. There is less routine focus on patient outcomes, inequalities or the impact of improvement work.

48 Several governance groups and committees share responsibility for cancer services. While this provides oversight from different parts of the organisation, it can make accountability for the whole cancer pathway less clear. It can also make it harder to coordinate improvement work across services and ensure that actions are joined up.

# Cancer performance

## Actions to improve services have not led to lasting improvements against national targets

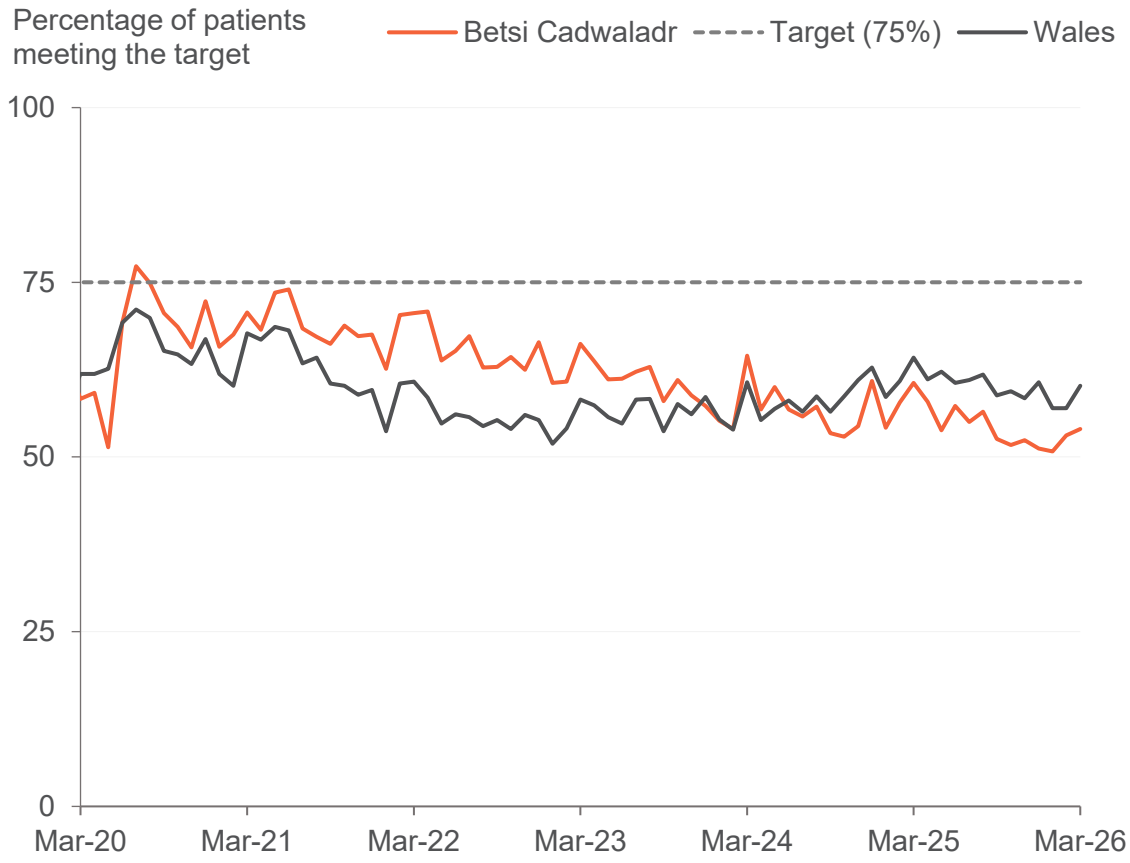
### 62-day cancer performance

50 The Welsh Government target is for 75% of patients to start their first treatment within 62 days of cancer first being suspected.

51 Early diagnosis and prompt treatment improve outcomes. They increase survival rates and enhance quality of life. Long waits can lead to more advanced cancer. This may reduce life expectancy, limit treatment options and affect physical health after treatment.

52 The Health Board's cancer performance is significantly below the national cancer target of 75% (**Exhibit 4**). While fluctuating, performance has shown a general deterioration over the last 4 years. This has seen the Health Board moving from one of the best performers in Wales to one of the worst.

**Exhibit 4: patients meeting the 62-day cancer treatment target, Betsi Cadwaladr University Health Board, March 2020 to March 2026 (percentage)**

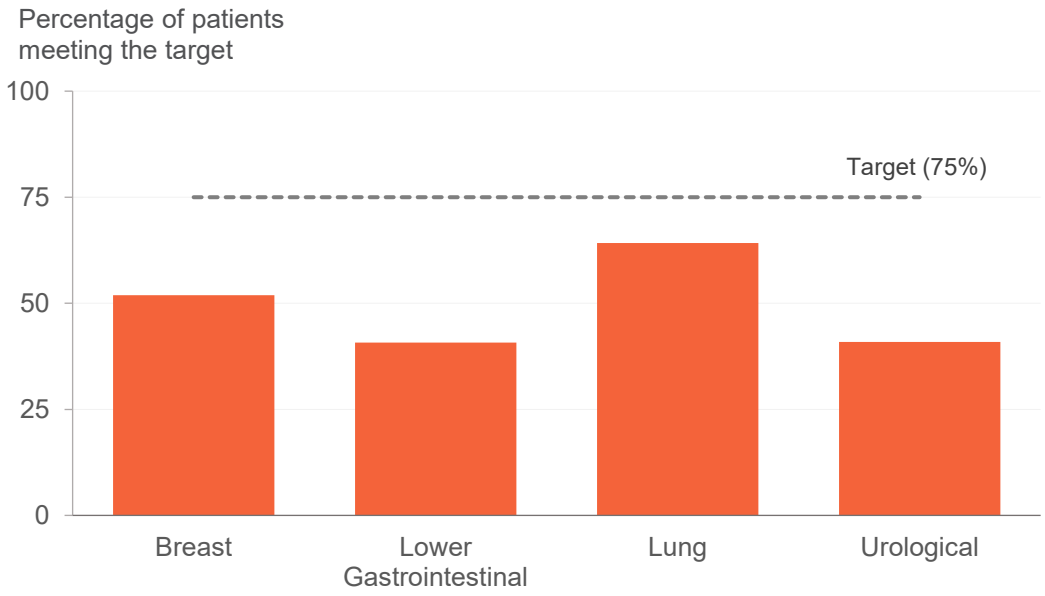



Source: Audit Wales analysis of Digital Health and Care Wales data

Note: The data includes patients who started treatment and confirmed that that they do not have cancer.

53 Overall performance also hides large differences between tumour types. Some services, such as skin cancer, perform better with a greater proportion of patients starting treatment within 62 days. However, performance is weaker in other areas. **Exhibit 5** shows performance across four common cancer tumour sites. It highlights very concerning lower gastrointestinal and urological and breast cancer wait performance, in particular.

**Exhibit 5: patients meeting the 62-day cancer treatment target, Betsi Cadwaladr Health Board, 12-month average during 2025–26**




Source: Audit Wales analysis of Digital Health and Care Wales data

Notes:

1. The data shows average 62- day performance over the most recent 12-month period (March 2025 to March 2026).

2. Note: The data includes patients who started treatment and confirmed that that they do not have cancer.

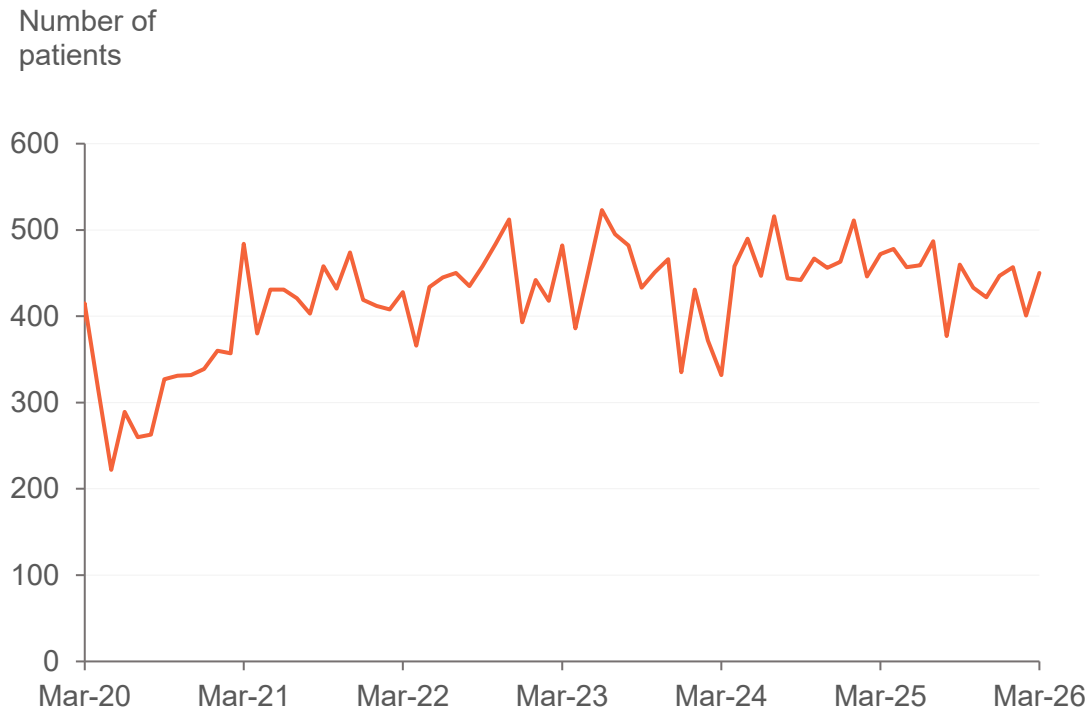
## Impact of action to improve cancer services

54 The Health Board has taken action to reduce some of the longest waits and manage immediate service pressures. However, performance is still below national targets which is likely to result in poorer outcomes for some patients. These actions include teledermoscopy, nurse-led triage, straight-to-test pathways, and more diagnostic support. It has also bought in extra clinical support to reduce waits. These actions have reduced backlogs and improved some services, especially skin cancer services. However, performance is still below target in many areas.

55 The Health Board knows why performance is still below target. Demand is rising, there are not enough staff, and patients face delays waiting for tests. The Health Board is recruiting staff, using temporary workers and adding extra capacity to reduce these pressures. However, many of these actions rely on short-term funding. They help in the short term but do not address the problems causing delays.

56 The Health Board's actions have improved access in some areas however, overall, the pace of improvement is slow. Service treatment levels overall are not increasing (**Exhibit 6**). This is resulting in 62-day waiting list performance remaining well below the national target.

**Exhibit 6: cancer patients starting treatment each month, Betsi Cadwaladr University Health Board, March 2020 to March 2026 (number)**




Source: Audit Wales analysis of Digital Health and Care Wales data

## Improving cancer outcomes

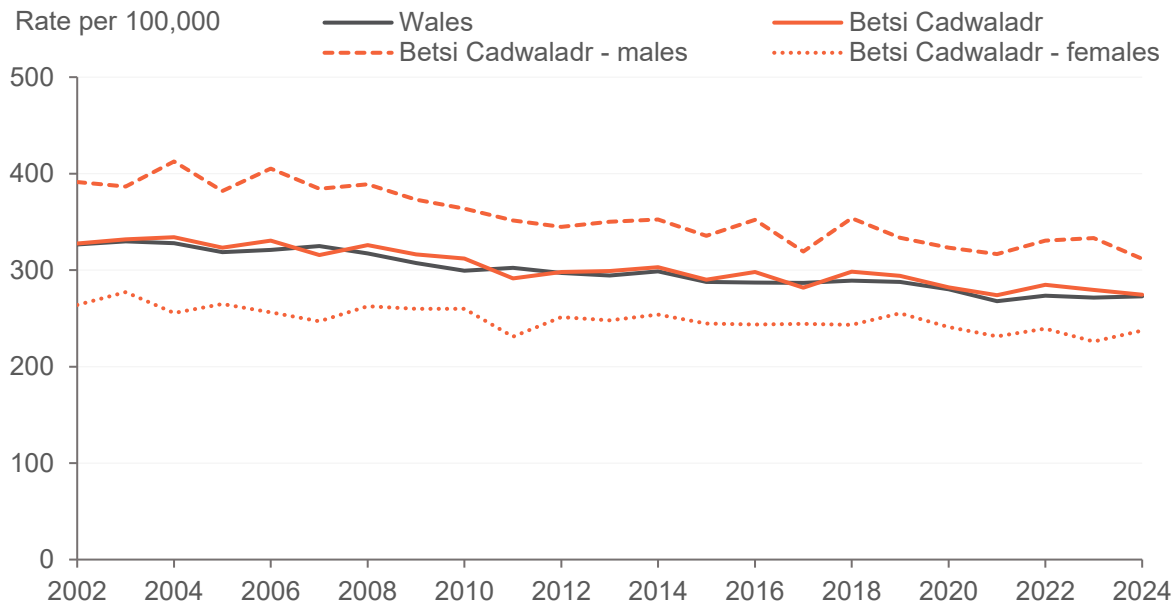
57 The Health Board does not make consistent use of cancer outcomes data. There is little evidence that it uses patient feedback, survival data or stage of diagnosis data to understand whether services meet patients' needs. There is also little evidence that it uses this information to improve services.

58 Some services make better use of data. The prehabilitation service tracks patient fitness, complications, readmissions and length of stay. Breast cancer services also use audit results, survival data and patient feedback. Staff use this information to improve care.

59 Evidence also shows that findings from national audits have led to changes in some lung and colorectal cancer pathways. However, these improvement approaches are not used consistently across cancer services. While a few services are learning from outcomes, there is little evidence that the Health Board is sharing this good practice more widely across all cancer services.

60 Analysis of one-year cancer mortality data from 2002 to 2024 (**Exhibit 7**) shows an ongoing reduction in mortality over the past 20 years. The Health Board's rate is similar to the Wales average. Men are still more likely to die from cancer than women, although the gap is narrowing.

## Exhibit 7: one-year cancer mortality, Betsi Cadwaladr University Health Board, 2002–2024 (per 100,000 population)




Source: Audit Wales analysis of Public Health Wales NHS Trust data

Note: Deaths where cancer is the primary cause, using the European Age Standardised Rate to enable fair comparisons over time and place.

61 While long-term trends are improving, our national report found that cancer outcomes are still poor compared to other countries. The Health Board needs to place greater focus on outcomes data to help identify priorities and target improvement work.

# Recommendations

## Cancer services planning

**R1** Develop an executive led single, costed plan for cancer services. The plan should align to the new National Cancer Strategy which will be published in February 2027. The plan should show how the Health Board will improve performance, reduce differences in access to care, and meet the suspected cancer pathway target. It should include clear actions, timescales, named leads and measures of success. (**paragraph 13**)

**R2** Put in place clear arrangements to monitor the cancer plan. Set out who is responsible for each action. Report progress regularly and track whether actions are improving services. (**paragraph 15**)

## Cancer intelligence and data

**R3** Improve forecasting across cancer services. Use this information to understand future demand, identify pressures earlier, and plan staff and services more effectively. This should help the Health Board target investment where it will have the greatest impact. (**paragraph 17)**

## Wider resourcing requirements

**R4** Develop enabling workforce and infrastructure plans that align the Health Board's capacity and demand analysis (see **recommendation 3**). The plans should address workforce shortages, estate and equipment constraints in the short-term. They should also target areas of expected growth in demand and create capacity to ensure that services are fit for the future. (**paragraph 28**)

## Cancer prevention and population screening

**R5** Develop a clear plan to help prevent cancer. The plan should increase screening uptake, support early diagnosis and reduce differences in access to care. It should include clear priorities, measures of success and long-term funding. (**paragraph 31)**

## Oversight and scrutiny

**R6** To strengthen the role of the Cancer Board, it should oversee the whole cancer pathway and be represented by all cancer services to improve care. It should make clear who is responsible for each action and regularly review progress against agreed plans and targets. (**paragraph 46**)

# Appendices

# 1 About our work

## Scope of the audit

We looked at the following areas:

- How well the Health Board plans its cancer services and whether they align with the National Cancer Plan, Quality Statement and Cancer Recovery Programme.
- How the Health Board seeks to reduce cancer prevalence by targeting preventative actions and supports screening programmes to detect cancer sooner.
- How cancer services are led and managed to drive improvements.
- How services are performing and the actions that the Health Board is taking to drive service improvement and achieve better patient outcomes.

We did not consider service quality, clinical governance or patient experience. We have not audited the data received by the Health Board or third parties.

## Audit questions and criteria

### Questions

We used the following questions to focus our fieldwork:

- Has the Health Board clearly set out how it will achieve timely and equitable access to cancer diagnosis and treatment?
- Has the Health Board set out a coherent approach to cancer prevention?
- Is the Health Board providing strong leadership and governance for timely and equitable access to cancer diagnosis and treatment?
- Is the Health Board making progress to deliver timely and equitable access to cancer diagnosis and treatment?

## Criteria

We assessed the Health Board's arrangements against the following criteria:

- The Health Board has clear funded plans based on sound business intelligence which sets out cancer services priorities and objectives, and the approach it is taking to achieve them.
- The Health Board has a clear approach to target population health improvements as means to reduce cancer prevalence in the longer-term.
- The Health Board's leadership for cancer services work collaboratively and are empowered to drive cancer service improvements in the short and longer-term.
- The Health Board is making continuous improvement on 62-day cancer performance, successfully addressing underperforming services and driving improvements to achieve better outcomes for patients.

# Methods

Our audit methods included document review, data analysis, and interviews. We interviewed the following:

- Health Board's cancer lead.
- Executive lead for cancer services.
- Clinical lead for cancer services.
- Director of Public Health.

We also held a focus group with the operational specialty management leads for lung, lower gastrointestinal, urological, and breast tumour sites.

# 2 Key terms in this report

| Term | Description |
|---|---|
| 62-day Suspected Cancer Pathway (SCP) | The all-Wales performance standard that 75% of patients should start their first definitive treatment within 62 days from the point of suspicion. |
| Admission episodes | The first period of care under a consultant with a health provider's episode of care. |
| Bed days | A day during which a patient occupies a hospital bed and stays overnight in the hospital. |
| Bed days cost savings | The financial benefits gained from reducing the number of hospital bed days. |
| Cancer Quality Statement | National statement outlining quality expectations for cancer care and outcomes across NHS Wales. |
| Cancer Recovery Programme | Programme of actions intended to restore/improve cancer services post-disruption (e.g., COVID-19), focusing on waits, pathways and outcomes. |
| European Age-Standardised Rate (EASR) | A rate adjusted to a standard European population age-structure to enable fair comparisons over time/places. |
| Finished consultant episodes | Refer to the periods of patient care under a consultant's supervision that have concluded due to discharge, transfer, or death. |
| Genomic cancer therapies / genetic testing | Testing and treatments guided by tumour or inherited genetic information to better target care and risk reduction. |

| Term | Description |
|---|---|
| Integrated Medium-Term Plan (IMTP) | A Health Board's three-year plan setting out service, workforce, finance and delivery objectives. |
| National Cancer Improvement Plan | National plan setting priorities and actions for improving cancer services across Wales, aligning health boards to common standards and trajectories. |
| Population health risks | Modifiable risk factors (e.g. smoking, obesity, alcohol) associated with cancer incidence in local populations. |
| Real terms spend | Expenditure adjusted for inflation to reflect true purchasing power over time. |
| Screening | A preventive medical test designed to detect cancer early, often before symptoms appear, improving the chances of successful treatment |
| Tumour site | The anatomical location/type of cancer (e.g. lower gastrointestinal, lung, breast, urological, skin). |

# 3 Management response form

This table will be completed after the report is received by Audit Committee

| Recommendation | Commentary on planned actions | Completion date | Responsible officer |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

# About us

The Auditor General for Wales is independent of the Welsh Government and the Senedd. The Auditor General's role is to examine and report on the accounts of the Welsh Government, the NHS in Wales and other related public bodies, together with those of councils and other local government bodies. The Auditor General also reports on these organisations' use of resources and suggests ways they can improve.

The Auditor General carries out their work with the help of staff and other resources from the Wales Audit Office, which is a body set up to support, advise and monitor the Auditor General's work.

Audit Wales is the umbrella term used for both the Auditor General for Wales and the Wales Audit Office. These are separate legal entities with the distinct roles outlined above. Audit Wales itself is not a legal entity.




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We welcome correspondence and telephone calls in Welsh and English.

Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

# Management response form

Archwilio Cymru
Audit Wales

| Audit Wales use only | |
|---|---|
| Audited body | Betsi Cadwaladr University Health Board |
| Audit name | Are cancer services improving? |
| Issue date | 29th July 2026 |

| Ref | Recommendation | Commentary on planned actions | Completion date for planned actions | Responsible officer (title) |
|---|---|---|---|---|
| R1 | Develop an executive led single, costed plan for cancer services. The plan should align to the new National Cancer Strategy which will be published in February 2027. The plan should show how the Health Board will improve performance, reduce differences in access to care, and meet the suspected cancer pathway target. It should include clear actions, | The Chief Operating Officer as Executive lead will oversee the development of a single costed plan for cancer, aligned to the forthcoming National Cancer Strategy, and in line with the development of the Health Board's broader Clinical Services Plan.<br>The plan will consolidate existing cancer improvement programmes into one overarching framework with clear priorities, milestones, accountable leads, resource requirements and success measures. | Q2 2027-28 | Chief Operating Officer |

| Ref | Recommendation | Commentary on planned actions | Completion date for planned actions | Responsible officer (title) |
|---|---|---|---|---|
| | timescales, named leads and measures of success. (paragraph 13) | The plan will specifically address Single Cancer Pathway performance recovery, reduction of unwarranted variation and inequalities in access, and delivery of sustainable improvements across the cancer pathway.<br>Annual review and refresh arrangements will be established to ensure alignment with national priorities. | | |
| **R2** | Put in place clear arrangements to monitor the cancer plan. Set out who is responsible for each action. Report progress regularly and track whether actions are improving services. (paragraph 15) | Each action in the above plan will be assigned to a named lead and monitored through a clear reporting schedule. Progress will be reviewed through the Cancer Partnership Board and escalated through existing corporate governance arrangements as required. | Q2 2027-28 | Chief Operating Officer |

| Ref | Recommendation | Commentary on planned actions | Completion date for planned actions | Responsible officer (title) |
|---|---|---|---|---|
| **R3** | Improve forecasting across cancer services. Use this information to understand future demand, identify pressures earlier, and plan staff and services more effectively. This should help the Health Board target investment where it will have the greatest impact. (paragraph 17) | The Health Board will ensure cancer demand, capacity and activity forecasting is built into its existing forecasting models.<br>Outputs will inform workforce planning, service redesign and investment decisions, supporting proactive management of demand and prioritisation of resources to areas of greatest need and impact. | Q4 2026-27 | Chief Operating Officer |
| **R4** | Develop an enabling workforce and infrastructure plan that aligns the Health Board's capacity and demand analysis (see recommendation 3). The plan should address workforce | The Health Board will ensure cancer needs are included within its Workforce and Infrastructure planning informed by the demand and capacity modelling above.<br>These plans will identify current and future workforce requirements, recruitment and retention priorities, succession planning | Q2 2027-28 | Chief Operating Officer supported by:<br>Director of Estates and Environment<br>and |

| Ref | Recommendation | Commentary on planned actions | Completion date for planned actions | Responsible officer (title) |
|---|---|---|---|---|
| | shortages, estate and equipment constraints in the short-term.<br>It should also target areas of expected growth in demand and create capacity to ensure that services are fit for the future.<br>(paragraph 28) | opportunities, and training needs. They will also assess estate, diagnostic and treatment capacity constraints, identifying short-term mitigations and longer-term investment requirements to ensure services remain sustainable and responsive to future demand. | | Director of Workforce and Organisational Development |
| **R5** | Develop a clear plan to help prevent cancer. The plan should increase screening uptake, support early diagnosis and reduce differences in access to care. It should include clear priorities, measures of success and long-term funding. (paragraph 31) | The Health Board will build on existing work to develop a Cancer Prevention, Screening and Early Diagnosis Improvement Plan, working collaboratively with public health, primary care and community partners.<br>The plan will focus on increasing screening uptake, improving awareness of cancer symptoms, supporting earlier diagnosis and reducing health inequalities. It will include | Q2 2027-28 | Chief Operating Officer |

| Ref | Recommendation | Commentary on planned actions | Completion date for planned actions | Responsible officer (title) |
|---|---|---|---|---|
| | | measurable objectives, targeted interventions for underserved populations and identification of sustainable funding opportunities to support delivery. | | |
| **R6** | To strengthen the role of the Cancer Board, the Board should oversee the whole cancer pathway and bring services together to improve care. It should make clear who is responsible for each action and regularly review progress against agreed plans and targets. (paragraph 46) | The Health Board will review the Cancer Partnership Board's terms of reference, membership and reporting arrangements to ensure the agreed structure provides oversight of the entire cancer pathway.<br>Clear accountability for delivery of actions and performance outcomes will be established. This will be taken forward as part of the Foundations for the Future organisational development programme | Q4 2026-27 | Chief Operating Officer |