Bundle BCU Quality, Safety and Experience Committee 3 September 2026

1 PRELIMINARY MATTERS

1.1 13:00 - QS26.120 Welcome & Apologies
Caroline Turner, Chair

1.2 13:01 - QS26.121 Declarations of Interest
Caroline Turner, Chair

1.3 13:02 - QS26.122 Minutes of the Previous Meeting - 2 July 2026
Caroline Turner, Chair
1.3 QSE 02.07.26 Unconfirmed Public Minutes

1.4 13:05 - QS26.122 Action Log & Matters Arising
Caroline Turner, Chair
1.4 QSE Action Log PUBLIC 2026

1.5 13:10 - QS26.123 Patient Story Item - Emergency Departments
1.5 Storytelling Emergency Department Experience

2 INTEGRATED PERFORMANCE

2.1 13:30 - QS26.124 Integrated Quality Report
Dr Clara Day, Executive Medical Director
2.1 QSE Integrated Quality Report Sept

2.2 13:55 - QS26.125 Integrated Performance Report
Olivia Shorrocks, Director of Performance
2.2.1 IQPR QSE 03092026
2.2.2 IQPR - QSE 03092026

3 STRATEGIC ITEMS

3.1 14:15 - QS26.126 Planned Care
Danielle Edwards, Programme Director Planned Care / Dr Clara Day, Executive Medical Director
3.1 QSE Planned Care

3.2 14:25 - QS26.127 Urgent & Emergency Care
Bridget Elliott, Recovery Director
3.2 QSE UEC Paper

3.3 14:35 - QS26.128 Fragile Services & Clinical Services Plan / Quality Management System
Dr Clara Day, Executive Medical Director / Paolo Tardivel, Exec Director of Transformation & Strategic Planning
3.3.1 Fragile Services Framework QSE Sept 26
3.3.2 Appendix A
3.3.3 Appendix B

3.4 14:55 - QS26.129 Nurse Staffing Act
Alison Griffiths, Director of Nursing Workforce, Staffing & Professional Standards
3.4.1 Nurse Staffing Levels - September 2026
3.4.2 Appendix 1 Nurse Staffing

3.5 15:05 - QS26.130 Research & Development - Commercial Recovery Plan
Dr Clara Day, Executive Medical Director
- 3.5.1 QSE - R&D Commercial Recovery Plan
- 3.5.2 Appendix 1

4 GOVERNANCE, RISK & ASSURANCE

4.1 15:15 - QS26.131 Board Assurance Framework
Pam Wenger, Director of Corporate Governance
- 4.1.1 BAF
- 4.1.2 Appendix 1 - QSE - Portal - Board Assurance Framework
- 4.1.3 Appendix 2 - Extant Open BAF Actions

4.2 15:25 - QS26.132 Corporate Governance Report
Pam Wenger, Director of Corporate Governance
- 4.2.1 Corporate Governance Report
- 4.2.2 QSE Committee Annual Report 2025-26
- 4.2.3 QSE Committee Self Assessment Presentation 2025-26 V1.0
- 4.2.4 Draft Cycle of Business for the QSE Committee 2026-27
- 4.2.5 Quality Safety and Experience Committee ToR

5 FOR INFORMATION

5.1 15:35 - QS26.133 Mental Health Oversight and Development Group
Teresa Owen, Executive Director of Allied Health Professionals & Health Sciences
- 5.1 AAA Report MHODG 160726

6 15:45 - CLOSING BUSINESS

6.1 QS26.134 Agree Items for Referral to Board / Other Committees
Caroline Turner, Chair

6.2 QS26.135 Review of Meeting Effectiveness
Caroline Turner, Chair

6.3 QS26.136 Date of the Next Meeting - 5 November 2026
Caroline Turner, Chair

6.4 QS26.137 Resolution to Exclude the Press and Public
'Those representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960'

Betsi Cadwaladr University Health Board (BCUHB)
Unconfirmed Minutes of the Quality, Safety & Experience Committee
held in Public on 2 July 2026
held in the Boardroom, Carlton Court, St Asaph and via Microsoft Teams

In Attendance	
Name	**Title**
Caroline Turner	Independent Member, Chair
Tehmeena Ajmal	Chief Operating Officer
Dr Clara Day	Executive Medical Director
Glesni Driver	Head of Statutory Compliance & Inquiries (via teams)
Matt Joyes	Deputy Director of Legal Services
Stuart Keen	Director of Environment & Estates (via teams)
Joanne Kendrick	Head of Quality
Mike Larvin	Independent Member (via teams)
Chris Lothian-Field	Independent Member
Chris Lynes	Deputy Executive Director of Nursing & Midwifery
Phylis Makarunje	Aspiring Board Member
Jane Moore	Executive Director of Public Health
Teresa Owen	Executive Director of Allied Health Professionals & Health Sciences
Geoff Ryall-Harvey	Llais
Paolo Tardivel	Executive Director of Transformation & Strategic Planning
Pam Wenger	Director of Corporate Governance
Committee Support	
Philippa Peake-Jones	Head of Corporate Governance
Harriet Abbott	Secretariat

PRELIMINARY MATTERS

QS26.88 Welcome and Apologies

Apologies were received from Dyfed Edwards, Urtha Felda, Lois Lloyd, Ed Williams and Angela Wood.

QS26.89 Declarations of Interest

Mike Larvin declared a potential interest regarding the sentinel stroke audit referenced within the Integrated Quality report item.

QS26.90 Unconfirmed Minutes of the Meeting held on 7 May 2026

Members reviewed the minutes from the previous meeting. No amendments were noted.

It was resolved that the Committee:

- **APPROVED** the minutes of the previous meeting on 7 May 2026.

QS26.91 Matters Arising & Action Log

Members reviewed the action log, noting progress against the actions.

It was resolved, that the Committee:

- **AGREED** to close the items proposed for closure.

[Chris Lothian-Field, Phylis Makarunje and Tehmeena Ajmal joined the meeting].

QS26.92 Patient Story

The Committee received the patient story item focused on Emergency Departments.

In discussing the item, the Committee:

- Noted the crucial role the chaplaincy service provides to patients and their families.
- Noted the importance of this service being available in Welsh, emphasising the importance of this in regards to patient experience.
- Noted that the lead Chaplin for BCU is based at Ysbyty Gwynedd, but can cover the region due to a number of vacancies in the service.

It was resolved that the Committee:

- **NOTED** the update.

GOVERNANCE, RISK & ASSURANCE

QS26.93 Integrated Quality Report

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

- There are over 5,000 open patient safety incidents, with concerns that 60% of these are overdue (over 30 days old). Targeted work is in place with each IHC to review and develop targeted metrics. It is noted that some of these incidents are historical and relate to the old Datix system and require closure.
- Performance against National Reportable Incident (NRI) targets is positive, with no NRIs open over 12 months for BCUHB. Some work is needed to identify trends.
- An increase in Never Events is noted, with two events noted within the reporting month.
- A new ruling by the Supreme Court has been passed regarding application of Deprivation of Liberty Safeguards (DoLS). Guidance has not yet been received, however safeguards are to be put in place locally to ensure compliance as an organisation. A summary was received at Executive Committee earlier in the week outlining the Health Board's interim approach, which will be shared with members for awareness.
- The newly implemented Listening to People Framework (LTP Framework) has been embraced well, with performance against the compliance metrics for early resolution well above target. A small number of historic cases, under the previous Putting Things Right framework, remain open, totalling approx. 20 cases. These relate to more complex cases, with aim for closure by the end of the second quarter.

- Wrexham Maelor Hospital has been identified as a borderline outlier as part of a sentinel stroke audit regarding mixed adjusted mortality cases. A piece of work is underway associated with this, along with the national audit team to review data. It was advised that the stroke service has now been combined regionally.
- A visit from Healthcare Inspectorate Wales (HIW) was conducted in Ysbyty Glan Clwyd (YGC) Emergency Department in May 2026. The formal report is expected Mid-August – September, but an immediate response was received regarding concerns, and the service escalated to requiring Significant Improvement. Whilst the formal report is outstanding, further discussion on this item will be covered within the private part of the Committee's meeting.

In discussing the item, the Committee:

- Reviewed information regarding patient safety incidents, noting required improvements relating to historical challenges, limited operational capacity and governance. A reduction in the backlog is expected from this work.
- Noted no visible pattern between incident service or location regarding Never Events. A theme in incidents involving retention of foreign objects has been seen. The Executive Medical Director has written to all departments reminding of protocol, and the auditing process is under review. Whilst a slight spike in incidents has been seen, it was clarified that these numbers are small in relation to the number of procedures undertaken per day in BCUHB. It was agreed to add data regarding the number of procedures undertaken for the period relating to the incident period to provide context.
- Highlighted the importance of a safety culture, ensuring that people feel confident to challenge and report incidents.
- Noted successful implementation of the Listening To People (LTP) Framework within the Health Board, however acknowledged that communication with Llais has not been as effective. Members of the Committee plan to visit the People's Enquiry and Resolution Service (PEARS) during the autumn.
- Emphasised the need for a clear governance process, ensuring an operational governance framework is in place across the organisation to minimise duplication. This links with the Foundations for the Future programme. A paper is due to go to Audit Committee regarding this in August 2026.
- Were advised that no further Prevention of Future Death reports (PFD) or Coroner Assurance reports have been received since the report for this meeting was published.

The following action was agreed:

- **Action QS26.93.1**: summary received at Executive Committee regarding application of DoLS to be shared with members for awareness.
- **Action QS26.93.2**: Data to be added to the report going forward regarding the number of procedures undertaken in total during the reporting period for context.

It was resolved, that the Committee:

- **NOTED** the report.

QS26.94 Integrated Performance Report

Members reviewed the information within the report, noting points were discussed within item QS26.93.

It was noted that there was a lack of consistent timeframes at parts within the report, and the Committee request this be reviewed to ensure consistency in future reports.

The following action was agreed:

- **Action QS26.94.1**: consistent timeframes to be included within future reports.

It was resolved, that the Committee:

- **NOTED** the report.

QS26.95 Clinical Service Plan

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

- Following the Clinical Leadership Event held in May 2026, a number of key themes were identified, including importance of psychological safety and culture, transparent decision-making, collaboration and tackling inequalities.
- The session was well attended by clinical leaders.
- A service fragility assessment is being developed, and the process will align with the quality management system principles.

In discussing the item, the Committee:

- Noted the positive engagement during the event and emphasised the involvement of clinicians from a range of services to enable implementation and sustainability.
- Were advised that the work would require external support regarding capacity to enable effective development and implementation.

It was resolved, that the Committee:

- **NOTED** the report.

[Paolo Tardivel left the meeting].

STRATEGIC ITEMS

QS26.96 Planned Care – Cancer Services

The item was presented by the Chief Operating Officer, which focused primarily on Cancer Services. The following points were highlighted:

- Cancer is the leading cause of premature death in North Wales, with rates linked to aging and deprivation.
- Improvement in survival rates is linked to availability of treatments and medication.
- It is important to consider how monies are invested in medicines management given the increasing drugs cost associated with increasing survival rates.
- Cancer services waiting times are currently 54%, which is under both the standard target (70%) and de-escalation target (55% sustained for 4 months).

- Issues remain largely in endoscopy and biopsy, where demand exceeds capacity. A capacity and demand exercise is taking place to unpick. Instances of insourcing and outsourcing are in place, which have a large funding implication.
- Each IHC is still operating under a different model, and there is currently no specific psychological support available in the West Area.

In discussing the item, the Committee:

- Emphasised the need to combine with the Community by Design programme to ensure ongoing services and support for those living with cancer.
- Reference the need of ensuring health inequalities are considered.
- Noted the cancer diagnosis rate, and advised that NICE guidance would estimate a referral to positive diagnosis rate of around 5%.
- Requested inclusion in future papers of further detail on rates regarding different tumour sites, patterns relating to age and geography.
- Noted the assurance provided through the paper, whilst recognising areas needing improvement such as timeliness.

The following action was agreed:

- **Action QS26.96.1**: future reports to include further detail on rates regarding different tumour sites and patterns relating to age and geography.

It was resolved, that the Committee:

- **NOTED** the report.

QS26.97 Urgent & Emergency Care (UEC)

The item was presented by the Chief Operating Officer. The following points were highlighted:

- There are ongoing concerns on how quality and safety is maintained within UEC.
- There are increasing pressures around reducing ambulance handover delays due to a programme handover scheduled for delivery from September. This will enable ambulance crews to leave a patient in ED if needing to respond and support another patient via ambulance. A Quality Impact Assessment (QIA) is required to review associated risk. Whilst expected to improve ambulance handover delays, this will increase pressure and likelihood of instances of corridor care.
- Some positive areas of work are noted around manging pressure and demand, but these are not yet sustained for prolonged periods. Specific site plans are required to be in place.
- A business case regarding Urgent & Emergency Care was approved through the Board at the end of June 2026. Further work is needed in acute medicine and wider site support.

In discussing the item, the Committee:

- Were advised that following a quality review undertaken in November 2025, fortnightly meetings are now in place focused on quality of care. A set of quality metrics for care in ED's are being finalised, following work from the group. This will ensure regular oversight on site, which is reviewed monthly.

- Noted recent visits from Independent Members to a number of ED's across the Health Board, which noted increasing volumes of patients. The importance of these visits was highlighted, and how they are valued by committee members and operational teams for visibility and transparency.
- Noted positive feedback regarding patients discharges on pathway three (sect 6.4 on paper) but referenced the need of ensure the most appropriate pathway is chosen for discharge to prevent unnecessary delay. It was advised through discussion that following review, there have been trends noting assessments to understand the appropriate pathway being completed too early, forming an inaccurate picture of the support required on discharge.

[Glesni Driver left the meeting].

- Noted good progress, and requested further detail be included in future for the Committee to give assurance to Board.

It was resolved, that the Committee:

- **NOTED** the report.

IMPROVING QUALITY, OUTCOMES & EXPERIENCE

QS26.98 Maternity & Neonatal Report

The item was presented by the Chief Operating Officer. The following points were highlighted:

- The item referenced update on Ministerial expectations from 2025.
- Implementation of the perinatal surveillance dashboard will enable real time monitoring.
- Ongoing workforce shortages are impacting on service delivery.
- It was reflected within the Integrated Medium Term Plan (IMTP), that there is a lack of Key Performance Indicators (KPIs) and timely targets to benchmark services, with operational pressures limiting transformational ability.
- There are some risks regarding financial investment and recruitment. Some benefit has been seen through delivery as a pan BCU service, rather than per IHC.
- A reduction in birth rates has been seen, whilst rate of caesarean section has increased. The recent Ockenden report was referenced (and had been discussed in the private section of the last meeting), and how this is being considered and learning taken and embedded within services.
- It was agreed that future maternity reports will include 12-month rolling data where appropriate.

The following action was agreed:

- **Action QS26.98.1**: Future maternity reports to include 12-month rolling data where appropriate.

It was resolved, that the Committee:

- **NOTED** the report.

[Tehmeena Ajmal left the meeting].

QS26.99 Nursing Staffing Paper

This item was deferred to the next meeting. Further amendments and governance are required on the item, as the item was written prior to approval of the urgent & emergency care paper approved by the Board on 25 June 2026.

EFFECTIVE ENVIRONMENT FOR LEARNING & SKILLS DEVELOPMENT

QS26.100 Research, Development & Innovation

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

- A national review has been undertaken by Welsh Government (included as an appendix). Mike Larvin, Independent Member, is assisting with this as lead regarding research through Chairing the group overseeing recommendations. A Terms of Reference for the group is being developed.

In discussing the item, the Committee:

- Confirmed that a single tender waiver is being developed regarding this.
- Advised that a review is being undertaken by Internal Audit. Following this, an external review will be completed including recommendation to ensure cohesion. This is due to be received at Audit Committee in August 2026 once undertaken.
- Agreed for the topic to be included on the Cycle of Business (COB) going forward to ensure appropriate governance and visibility.
- Were advised that members of the University Research Group had received media approaches regarding the internal audit review of the Centre for Mental Health. It was reiterated that all media enquiries and associated correspondence should be managed through University Communications in accordance with agreed protocols.

The following actions were agreed:

- **Action QS26.100.1**: Ensure research, development & innovation is included on the Committee COB.

It was resolved, that the Committee:

- **NOTED** the report.

GOVERNANCE, RISK & ASSURANCE

QS26.101 Corporate Risk Register

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

- CRR25.01 has been referenced through several papers during today's meeting.
- CRR25.08: groups are being established reporting directly to the executive to address. Changes and improvement are expected during the next reporting period.

In discussing the item, the Committee:

- Suggested further clarity regarding the distinction between risks and operational issues, ensuring appropriateness for the risk register.

- Suggested consideration of separating planned care and urgent care components.

It was resolved, that the Committee:

- **NOTED** the report.

QS26.102 Corporate Governance Report

The Head of Corporate Governance updated regarding the item. The following points were highlighted:

- Items considered within the private section of the Committee now include rationale and resolution for clarity.
- The draft Cycle of Business circulated included comments and amendments when reviewed by the membership earlier in the year. This is to be sighted prior to submission to Board in July.
- The annual self-assessment will be shared with Committee members in the coming weeks for completion.

It was resolved that the Committee:

- **NOTED** the report.

FOR INFORMATION

QS26.103 Mental Health Oversight Delivery Group (previously noted as Operational Delivery Group)

Correction to the title of the agenda item was advised, clarifying the correct name of "Mental Health Oversight and Delivery Group".

In discussing the item, the Committee:

- noted disappointed in the quoracy, emphasising the importance of attendance at the meeting.
- requested an update regarding the new Mental Health Quality Statement be brought to Committee in Autumn 2026.

The following action was agreed:

- **Action QS26.103.1**: an update regarding implementation of the new Mental Health Quality Statement be brought to Committee in Autumn 2026.

It was resolved that the Committee:

- **NOTED** the report.

QS26.104 MHLD Advocacy Annual Report

In discussing the item, the Committee:

- Advised that the report would also be considered by the Mental Health Legislation Committee in August 2026 for awareness.

It was resolved that the Committee:

- **NOTED** the report.

QS26.105 Quality Governance Report – Audit Wales

In discussing the item, the Committee:

- Were advised the report provided follow up to a previous review in 2022, looking at the recommendations and quality governance report. Interviews were conducted with individuals during 2025 as part of the follow up review.
- Several recommendations from 2022 are now shown as complete. One specific recommendation required immediate resolution, which has now been resolved. This concerned reporting on NRI.
- Reference the importance of use of consistent reporting periods for data sets.
- It was clarified that this is an All-Wales piece of work, not specific to BCUHB. It was agreed for an update to be received at Committee bi-annually, to highlight progress and update on outputs. It was also agreed for an update regarding quality of commissioned work to be received at the next Committee meeting.

The following actions were agreed:

- **Action QS26.105.1**: An update regarding the Quality Governance Report (Audit Wales) to be received bi-annually at committee.
- **Action QS26.105.2**: an update regarding quality of commissioned work to be received at the next Committee meeting.

It was resolved that the Committee:

- **NOTED** the report.

CLOSING BUSINESS

QS26.106 Agree Items for Referral to Board / Other Committees

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

1. Regarding the new NHS Concerns, Complaints and Redress Arrangements. Listening to People has now been implemented, the Health Board worked closely with NHS P&I on the transition, some documents and training were delayed but the HB was prepared for the implementation and transition from putting things right . Llais noted that communication with their organisation was not as effective. Members of the Committee will visit the People's Enquiry and Resolution Service (PEARS) during the Autumn.
2. There is an understandable and significant pressure to improve ambulance handover delays to a level of zero 45 min breaches by the autumn. This will reduce community risk for patients awaiting an ambulance. This must however be balanced by ensuring that this doesn't result in increased risk in overcrowded departments. A local Quality Impact Assessment will be performed alongside continued work to reduce occupancy within the Emergency Departments.
3. The Committee noted the importance of ensuring appropriate implementation of the recent Supreme Court judgement on Deprivation of Liberty Safeguards (DoLS), including staff training, communication with patients and families, and ongoing monitoring of any implications for safeguarding arrangements.
4. HHIW has designated YGC ED as a Service Requiring Significant Improvement, with BCUHB required to act on several immediate actions. A plan is in place to

deliver against these actions, with Health Board wide learning being developed. The full report is not due until late summer.

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

1. The Committee received assurance that patient experience feedback remains overwhelmingly positive once patients access services, demonstrating the continued commitment of staff to delivering compassionate, person-centred care, even during periods of significant operational pressure. This patient experience is lower in Emergency Departments than for other services but with the majority of patients describing their experience of care as positive.
2. The Committee noted positive examples of holistic care and support, including the contribution of chaplaincy services, Welsh language provision and personalised care approaches which can have a significant impact on patient and family experience.
3. The Committee received assurance that work is underway to simplify governance arrangements across the organisation, focusing on effective and streamlined assurance processes that support operational delivery.
4. Cancer treatment performance in national audits is strong, particularly in relation to outcomes survival and adherence to clinical guidance. Focussed improvements programmes to specific diagnostic and treatment pathways are noted.
5. There was good assurance from the Improving Quality, Outputs and Experience Maternity and Neonatal report, noting maternal and neonatal outcomes. This report will be reviewed in QSE every 4 months. Learning is being collated from Welsh and English reports, including English National Maternity and Neonatal Investigation and review and the Ockenden review in maternity services at Nottingham University Hospitals NHS Trust.
6. The Committee received the Mental Health and Learning Disabilities Advocacy Annual Report and was assured that advocacy services continue to support the rights, voice and involvement of service users in decisions relating to their care and treatment.

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

1. That future safety reporting should continue to provide appropriate context alongside incident and never event data, including evidence of learning, trends and improvement actions, whilst maintaining a balanced view that reflects strengths as well as areas requiring improvement.
2. Emphasised the importance of maintaining a positive safety culture that supports open reporting, learning and continuous improvement across services.
3. The Urgent and Emergency Care Programme update was received, noting that for further iterations enhanced detail will be required for the Committee to be assured as the emerging picture evolves.
4. Received an update on Research, Development and Innovation, noting that there would be an external review relating to provision of national standards. This will include some aspects relating to the Centre for Mental Health and Society as raised by Internal Audit.
5. Received the Quality Governance Report from Audit Wales and agreed that an update will be received in six months' time.

It was noted that the further details may be required prior to receipt at Board regarding the Cancer Services update including further details on quality elements.

QS26.107 Review of Meeting Effectiveness

The Committee:

- Noted the meeting covered a range of topics with relevant, meaningful discussion and detailed papers with insightful questions for assurance.

QS26.108 Date of next meeting

3 September 2026

QS26.109 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'

Quality, Safety and Experience Committee PUBLIC Action Log

Updated 24.08.26

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** 24.06.26 – still awaiting receipt
2	QS26.10.1	15.01.26	**Challenged Services** Utilisation of risk registers and risk flagging to be an item for QSE development session	Executive Medical Director	Nov 26	**Remain Open** To be included at future development session.
3	QS26.38.1	05.03.26	**Learning Repository** A demonstration of the system to be given in a future development session	Exec Director of Nursing & Midwifery	Nov 26	**Remain Open** To be included at future development session.
4	QS26.64.2	07.05.26	**Integrated Quality Report** A Welsh language briefing to be included at a future development session.	Exec. Director of Allied Health Professionals & Health Sciences	Nov 26	**Remain Open** To be included at future development session.
5	QS26.64.3	07.05.26	**Integrated Quality Report** A demonstration on the Quality Score Card to be given at a	Exec Director of Nursing & Midwifery	Nov 26	**Remain Open** To be included at future development

			future development session			session.
6	QS26.69.1	07.05.26	**Clinical Services Plan** The Clinical Services Plan be included as a topic on at a future development session for further information	Executive Medical Director	Nov 26	**Remain Open** To be included at future development session.
7	QS26.72.1	07.05.26	**Mortality** The next mortality report to committee to include reference to MHLD data.	Executive Medical Director / Exec. Director of Allied Health Professionals & Health Sciences	May 2027	**Remain Open** Item next due May 2027
8	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	Next scheduled on COB for Jan 27
9	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	Not yet due
10	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	21.07.26 – agreed to schedule for November due to number of items on Sept agenda
				Suggest Close		
1	QS26.105.1	02.07.26	**Quality Governance Report** An update regarding the Quality Governance Report	Executive Medical Director	July 2026	Proposed for closure 15.07.26 – added to COB

			(Audit Wales) to be received bi-annually at committee.			
2	QS26.101.1	02.07.26	**Corporate Governance Report** Ensure research, development & innovation is included on the Committee COB.	Head of Corporate Governance	July 2026	Proposed for closure Item is included on COB
3	QS26.71.2	07.05.26	**Adult Mental Health & Learning Disabilities** 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	Proposed for closure 18.05.26 – next MHLD update due Jan 27 as per COB 16.07.26 – update on action to be given at Sept meeting through action log.
4	QS26.67.1	07.05.26	**Nurse Staffing Act** 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~~ Sept 2026	Proposed for closure 18.05.26 – on July agenda. 02.07.26 – item deferred to next meeting due to relevant updates since paper drafted. 16.7.25 – included on Sept agenda
5	QS26.93.2	02.07.26	**Integrated Quality Report** 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	Proposed for closure 16.7.26 – to be cover in September's report
6	QS26.94.1	02.07.26	**Integrated Performance Report**	Director of Performance	Sept 2026	Proposed for closure 16.7.26 – referenced on sept agenda

			Consistent timeframes to be included within future reports			
7	QS26.96.1	02.07.26	**Planned Care (Cancer Services)** 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	Proposed for closure 16.7.26 – referenced on sept agenda
8	QS26.93.1	02.07.26	**Deprivation of Liberties** Summary received at Executive Committee regarding application of DoLS to be shared with members for awareness.	Secretariat	July 2026	Proposed for closure Shared with members following meeting.
Closed Actions (Closed at 02.07.26 meeting)						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
1	QS26.64.1	07.05.26	**Integrated Quality Report** Regulatory paper to be merged with the Integrated Quality Report going forward.	Exec Director of Nursing & Midwifery / Head of Quality	July 2026	Proposed for closure To be included within report when next update on regulatory paper is due.
2	QS26.71.1	07.05.26	**Adult Mental Health & Learning Disabilities** a chairs report from Operational Delivery Group (ODG) to be included on the QSE agenda for information going forward.	Exec. Director of Allied Health Professionals & Health Sciences	July 2026	Closed 18.05.26 – added to draft cycle of business

4	QS26.71.3	07.05.26	**Adult Mental Health & Learning Disabilities** The advocacy annual report to be included for information at the next QSE meeting.	Exec. Director of Allied Health Professionals & Health Sciences	July 2026	Closed 18.05.26 – included on July agenda for information
5	QS25/11.1	20.02.25	**QS25/11 Colonoscopy Performance Update** Clarify when the Colonoscopy data/paper can be reported back into QSE.	~~Exec. Dir. of Nursing & Midwifery~~ **~~(Angela Wood)~~** ~~to link in with Interim Chief Operation Officer)~~ **~~(Imran Devji)~~** **Tehmeena Ajmal – Chief Operating Officer**	~~May 2025~~ May 2026	Closed 24.02.25 From AW - Email sent to Imran, awaiting clarification 03.07.25 AW confirmed that she had met with Tehmeena Ajmal, COO. A further update will be provided at the November meeting. 07.01.26 – awaiting update 05.03.26 – AW advised with Chief Operating Officer. Awaiting update, and action lead updated. 13.04.26 – update requested 29.04.26 – to be merged with action QS24/121.1, with update to be provided in the meeting for context under matters arising. 13.05.26 – TA advised for EW to link with Rachael Hayward/David Fletcher for sign off of info ahead of update to Committee. 24.06.26 – briefing shared with members

Quality Safety & Experience Committee

STORYTELLING: EMERGENCY DEPARTMENT EXPERIENCE

Dyddiad y Cyfarfod Date of Meeting	03 September 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Rachel Wright, People's Experience Lead Manager
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	

Pwrpas yr Adroddiad Report Purpose	For Assurance

**Crynodeb Gweithredol
Executive Summary**

This report presents a patient experience story from an individual who shares their experience of accessing Ysbyty Glan Clwyd, Emergency Department on Friday 13th December 2024.

The storyteller wishes to share their experience of how she required Interventional Radiology out of hours, but was advised this service was not available.

The storyteller describes the treatment and care she received at Ysbyty Glan Clwyd and Queen Elizabeth Hospital, Birmingham.

The storyteller hopes this experience can be used to improve care, communication and create robust procedures.

**Ymgysylltu (mewnol/allanol) yr ymgymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp)
Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)**

Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	**Dyddiad Date**	**Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data**

Acronymau / Rhestr Termau **Acronyms / Glossary of Terms**	
AMU	Acute Medical Unit
MRCP	Magnetic Resonance Cholangiopancreatograph
INR	International Normalised Ratio

STORYTELLING: MOMENTS THAT MATTER

1. Y SEFYLLFA SITUATION

1.1 The Committee is invited to receive a patient experience story describing a patient's experience of her treatment and care when attending the Emergency Department in Ysbyty Glan Clwyd. The report identifies opportunities to further improve patient experience.

2 Y CEFNDIR BACKGROUND

2.1 Introduction

Due to my complex health issues, I have learned to advocate for myself. I'm a patient at several different hospitals. But I have never had to advocate so hard for myself as I did in December 2024. I realised that the only person who was going to fight for me was me, whilst being gravely ill and bleeding internally. I was confidently able to advocate for myself due to my experience as a lifelong patient, but no one was listening to me.

I am a public Governor at a Regional Paediatric Hospital in North West England.

2.2 Admission

On Friday 13th December 2024 at 16:44, I walked into Ysbyty Glan Clwyd with jaundice and upper quadrant pain. Referred by my GP who had already called ahead. The pain seemed to indicate possible kidney involvement. The GP was of the belief that the antibiotics were the cause of the jaundice. The Dr immediately realised how serious the situation was and requested an urgent ultrasound (within 24 hours), and a Magnetic Resonance Cholangiopancreatograph (MRCP), which the doctor was informed that would have to wait until Monday. My Bilirubin on entry was 100 (normal range 3 - 21). Bilirubin measures waste product circulating in the bloodstream, broken down by the liver. There should be almost none in the bloodstream. I was visibly jaundice; this would get much worse over the next 48 hours.

On Saturday 14 December 2024 (13:04) I was still waiting for an urgent ultrasound scan. I was transferred from the Emergency Department to the Acute Medical Unit (AMU). I felt that the standard of care I received had deteriorated once I arrived on AMU. There was no bedside monitoring available at AMU. As I have a diagnosis of congenital heart disease, I would have expected to have had cardiac monitoring. Observations were completed every few hours.

On Sunday 15 December 2024, I was informed by a nurse that the ultrasound “was never going to happen over the weekend”, and that I should not have been

told it would. I was still fully mobile but by now very jaundice. The same nurse bleeped an on-call doctor. When the doctor arrived (13:45), he seemed to realise immediately how serious it was. At this point, I hadn't seen a Dr for 24 hours. He said it was too late for an ultrasound and put me in a CT scanner within 10 minutes of request.

They identified a potential bleed on the liver. Which resulted in a haematoma. The doctor explained that I would need to be transferred to a specialist liver unit. The doctor spent two hours contacting various specialist units in England. I also informed him that he needed to ring the on-call Adult Congenital Heart Disease Consultant (ACHD) at Liverpool Heart and Chest Hospital who would be able to advise him on the cardiac implications and what to do about my excessively high International Normalised Ratio (INR). The INR was probably the cause of the bleed. At this point there were very few answers. The high INR was caused by the antibiotics. Fortunately, he did as I advised. However, I still had to insist on a transfer to the Intensive Care Unit (ICU). I explained to the outreach team that, if the consultant believed I needed to be in a specialist unit, then I certainly needed to be on ICU, where I could be constantly monitored. I was moved to ICU within 30 minutes.

Treatment included being given platelets (clotting factor) and the insertion of an arterial line. Arterial lines are used for critically ill patients to monitor blood pressure, easy access for blood sampling etc. None of this would have been available had I remained on AMU. I firmly believe that, prior to Birmingham, this escalation saved my life.

The transfer request was agreed by Queen Elizabeth Hospital, Birmingham.

2.3 Queen Elizabeth Hospital, Birmingham

On Monday 16th December 2024 at 17:00 I was transferred to the Queen Elizabeth Hospital, Birmingham with the aim of putting me on the transplant list. A very real possibility in the first week.

My Bilirubin on arriving in Birmingham was 495. I spent 8 days critical in the Critical Care Unit (100 beds), and a further 5 weeks being cared for the Liver Medicine Unit. Treatment included inserting coils to stop the liver bleed. A procedure which required general anaesthetic and a surgical team. I did not get any sleep for 2 whole weeks, which could possibly be attributed to PTSD.

My care in Birmingham was exemplary. Critical Care, Liver Medicine, Congenital Cardiology, Haematology, Physiotherapy, Radiology and Microbiology were all involved in my care. There was always a doctor available regardless of the time of day and they listened to the patient.

The haematoma was originally 12cm in diameter. My most recent CT (2025) it was 9cm. Nobody can tell me whether it will ever disappear. It may simply become encapsulated by the body and remain there. We have no idea what future health implications may be. I firmly believe that the delays in my care significantly contributed to the size of the haematoma. I have no way of knowing

whether the urgent ultrasound would have avoided it altogether. But I strongly suspect it would.

I was later informed that I was bleeding internally before I attended the Emergency Department (YGC). I strongly believe that a lack of urgency over the weekend admission on the request for the ultrasound scan led to significant serious deterioration. Due to the delay in imaging, I have no way of knowing if I could have avoided the need for a specialist unit. I needed Interventional Radiology, but Birmingham was advised on the telephone that the Health Board does not offer it. The impact of this not being available means only stable patients can be transferred out of North Wales to another NHS Trust. I feel there is inequity in care, as this limits North Wales patients' opportunities of survival.

2.4 Complaint

In July 2025, I raised a formal complaint about my experience. I received a 7-page report in response to my complaint. It concluded by saying that whilst they recognised that there had been a breach in duty of care because there was a delay in imaging, there had been no harm. Throughout the complaint investigation process I did not receive any communication from staff investigating my complaint. I was not given the opportunity to share my experience, of what I describe as a truly horrific, and almost fatal experience.

I am grateful for the opportunity to have shared my experience with the Chairman of the Health Board and IHC Central Director of Operations.

3 MATERION PENODOL I'W HYSTYRIED
SPECIFIC MATTERS FOR CONSIDERATION

3.1 The storytellers suggested opportunities for improvement:

- Access to out of hours Interventional Radiology.
- Staff to listen to patients with complex health issues – they know when they are not well.
- Improved communication and formal processes to transfer scan requests at shift change when a patient moves wards (move from Emergency Department to AMU).
- Health Board wide understanding of emergency imaging protocols.
- Robust escalation processes in place to prevent deterioration in conditions.
- Consider the suitability of placing patients with complex health conditions in AMU where there is insufficient monitoring e.g. cardiac monitoring.

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

The Committee is asked to note the patient experience.

5 ARGYMHELLION
RECOMMENDATIONS

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

- Note the patient experience.
- Consider the learning identified within the patient story.

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

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

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

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

Quality Safety & Experience Committee

INTEGRATED QUALITY REPORT

Dyddiad y Cyfarfod **Date of Meeting**	03 September 2026
Statws Cyhoeddi **Publication Status**	Open/ Public Not Applicable
Enw a theitl Awdur(on) yr Adroddiad **Report Author name and title**	• Patient Safety: Chris Lynes, Deputy Director of Nursing (Patient Safety) and Tracey Radcliffe, Head of Patient Safety • Safeguarding and Public Protection: Michelle Denwood, Director of Safeguarding and Public Protection • IPC: Deputy Director of Nursing Infection Prevention and Decontamination • 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 • Quality Assurance: Jo Kendrick, Head of Quality, Erika Dennis, Quality Lead Manager, Sarah Musgrave Quality Learning Business Manager • 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 **Lead Executive Team Member name and title**	• Dr Clara Day, Executive Medical Director • Teresa Owen, Executive Director of AHPs and Healthcare Science • Dr Jane Moore, Executive Director of Public Health

Pwrpas yr Adroddiad **Report Purpose**	For Noting

Crynodeb Gweithredol
Executive Summary

The Health Board continues to face significant quality and safety pressures across a number of high-risk areas. Persistent overcrowding within Emergency Departments, increasing Never Events, healthcare-associated infection performance below trajectory, and growing complaint volumes continue to present risks to patient safety, organisational learning, staff wellbeing and regulatory assurance.

Emergency Departments remain a major area of concern and external scrutiny, particularly following the escalation of the Ysbyty Glan Clwyd Emergency Department to a Service Requiring Significant Improvement by HIW. Whilst self-assessment and peer review activity at Wrexham Maelor and Ysbyty Gwynedd demonstrate encouraging levels of compliance and organisational learning, patient experience across emergency care remains significantly below that achieved elsewhere in the Health Board.

Patient safety performance remains challenged, with 5,528 open incidents, over 62% of which are overdue (mainly within the moderate harm category), alongside 13 Never Events reported over the previous 12 months. Recurring themes relating to compliance with invasive procedure safety standards, medicines management and clinical governance continue to require executive attention. Additional concerns have been identified regarding the reliability of resuscitation equipment checking processes and Venous Thromboembolism risk assessment compliance.

The report also highlights growing concerns regarding endoscopy waiting list backlogs, surveillance delays and service fragility, alongside continuing challenges in achieving healthcare-associated infection reduction trajectories, particularly for *C. difficile*, MSSA and MRSA.

Despite these challenges, there are areas of positive assurance. The Health Board continues to perform strongly against national complaint handling measures, maintains the shortest median NRI investigation completion time in Wales, has improved NICE compliance arrangements, is progressing the implementation of Nursing and Midwifery Quality Standards, and continues to deliver regulatory improvement plans across a number of services. A Tier 2 audit programme related to highest risk is also proposed to improve assurance in these areas.

Overall, assurance can be provided that improvement programmes, governance mechanisms and regulatory oversight arrangements are in place across all key risk areas. However, sustained executive focus and organisational action remain essential to address emergency care pressures, patient safety performance,

infection prevention and control, service fragility and deteriorating patient experience.

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

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

2.1 BCUHB remains committed to delivering high-quality services across all areas of care. To provide assurance and drive continuous improvement, the BCUHB routinely monitors a range of quality metrics. These measures enable informed decision-making, support organisational learning, and underpin growth and development.

2.2 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

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

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

3.2 Persistent backlog of incident investigations, including high levels of overdue incidents, creating risks to timely learning, assurance, Duty of Candour compliance and organisational governance

3.3 Ongoing increase in Never Events and BCUHB's position as the highest rate per 100,000 population in Wales, presenting patient safety and reputational risks.

3.4 Failure to achieve IPC improvement trajectories for several healthcare-associated infections, particularly C. difficile and MSSA, with associated risks to patient safety, operational capacity and regulatory assurance.

3.5 Sustained increase in complaint volumes and declining patient experience scores, particularly within urgent and emergency care settings, reflecting ongoing system pressures and potential reputational impact.

3.6 Delays in delivery of a number of HIW improvement plans and outstanding regulatory actions which continue to require executive oversight and monitoring.

4 ARGYMHELLION / RECOMMENDATIONS

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

Note the contents of the Integrated Quality Report and the assurance provided regarding quality, safety and experience across BCUHB.

Support the improvement actions and governance arrangements outlined within the report to address identified risks and sustain organisational learning and quality improvement.

Approve the Tier 2 Audit Programme for 2026/2027

ASESIAD / ASSESSMENT	
Cysylltiad â'r Bwriadau Strategol **Link to Strategic Intentions**	3. Improve Access, Outcomes and Experience If more than one applies, please list below: Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below: 4. Improving quality, outcomes and experience
Yr Egwyddorion Dylunio Design Principles	Simplify, Standardise, and Adopt Best Practices Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd **Corporate Risks and Board Assurance Framework**	**BAF 26_04**: Failure to Deliver and Create a Modern, People-Centred Healthcare System that is Future Focused **CRR25-02** – Future Demand & Sustainable Workforce, **CRR25-04** – Modernising Digital Infrastructure to Enable Safe, Integrated Care, **CRR25-05** – Strategic Change Impacting Care and Staff Delivery, **CRR25-06** – Delivery of the 2026/27 Financial Plan and Financial Sustainability, **CRR25-07** – Leadership and Operating Model, **CRR25-08** – Non-Compliance with Regulatory and Legislative Requirements, **CRR25-09** – Safe Environment, **CRR25-10** – Health and Safety, **CRR25-11** – ICT Failure and Cyber Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Equality Act 2010 Public Sector Equality Duty:	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A

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	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	This report is purely administrative in nature and submitted for information only.
Equality Act 2010 - Socio-economic Duty *Has BCUHB provided evidence of 'Due Regard' to compliance of the Socio-economic Duty when making strategic decisions?*	Do/Yes: ☒	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: 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? *WP8a Template*	Canlyniad/Outcome: Do/Yes:	Naddo/No:X
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale: Canlynaid/Outcome:	This report is purely administrative in nature and submitted for information only.
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Human Rights Act *Have Human Right based concerns been addressed within WP8a*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
Compliance to the Welsh Language requirements? *Have you undertaken an Impact Assessment*	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Naddo/No: ☒
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	This report is purely administrative in nature and submitted for information only
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	

Compliance to giving 'Due Regard' to the principles of the Armed Forces Covenant *Have the principles of the Armed Forces Covenant been addressed within WP8a*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	This report is purely administrative in nature and submitted for information only
Ansawdd *A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Galluogwyr Ansawdd Enablers of Quality All Apply Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales	
Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Asesiad o Effaith ar Ddiogelu Data *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?* **Data Protection Impact Assessment** *Have you undertaken a Data Protection Impact Assessment Screening?*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	This report is purely administrative in nature and submitted for information only
	Do/Yes: ☐	Naddo/No: ☒

Asesiad o Effaith ar Atal Twyll *A ydych chi wedi ystyried yr effeithiau ar atal twyll?* **Counter Fraud Impact** *Have you considered the counter fraud impacts*	Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	This report is purely administrative in nature and submitted for information only
Cyfreithiol **Legal**	Choose an item.	
Enw Da **Reputational**	Yes (Include further detail below)	
	Please see report for further details	
Effaith ar Adnoddau *(Pobl / Ariannol)* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

1. QUALITY CONCERNS RISK OVERVIEW

1.1
- 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.

1.2 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 are included within the paper relating to Urgent and Emergency Care to this committee. In addition, an update on the actions following the HIW inspection of the Emergency Department of Ysbyty Glan Clwyd is included within the private session of QSE as the report is not as yet published.

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

- The 'Challenged Services' as previously identified by Welsh Government, have had a defined improvement programme within BCUHB for the last two years. An update on these services is provided separately to QSE.

- In addition, there is now a programme of work in place to develop further the Quality Management System to aid proactive identification of fragile services; this is detailed in a separate paper.
- Gastroenterology, and particularly endoscopy, was identified as an additional fragile service following a Rapid Quality Review in February 2026. Updates to this service are included within the Integrated Quality Reports for this meeting.
- Delayed access to planned care can also occur with service fragility. Updates on improvement programmes to ensure sustainable change in these services is included within the Planned Care paper.

1.4 A broader organisational risk is the variability in understanding, measuring and delivering good quality care to known standards may lead to inconsistent practice and a failure to consistently provide safe and effective care. Elements of concern relating to this risk are outlined within the Integrated Quality Reports. This includes as examples Never Events, medicine management, venous thromboembolism management

1.5 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

1.6 The Tier 2 audit programme has been developed around these organisational risks and is included within this paper for approval

2. Endoscopy

2.1 BCUHB Endoscopy continues to face significant quality and patient safety risks due to extensive diagnostic, cancer and surveillance waiting list backlogs, alongside workforce and infrastructure constraints. Incident review regularly highlights that patients are waiting for prolonged periods of time for intervention and that booking oversight processes need review. Patients on surveillance lists are at particular risk of breaching surveillance intervals as urgent suspected cancer pathways are prioritised.

2.2 The Endoscopy Network oversight group has been tasked with enhanced oversight across all areas; a Clinical Director for Endoscopy is currently out for expressions of interest to support a more robust approach with interim cover provided by a senior medical leader during this time of enhanced concern. Urgent Executive review is in process to ensure progress as required.

3. Ablett Unit MHLD

3.1 Healthcare Inspectorate Wales (HIW) undertook an unannounced inspection of the Ablett Unit, Glan Clwyd Hospital, between 27–29 April 2026.

The inspection found that patients generally reported positive experiences of care, describing staff as caring, respectful and supportive, with positive feedback regarding advocacy services and therapeutic activities.

Key findings included:

- Positive patient feedback regarding the care, compassion and professionalism of ward staff.
- Long-standing environmental concerns, including shared bedrooms, limited ward space, inadequate facilities and an environment deemed not fit for purpose for modern mental health inpatient care.
- Governance weaknesses, including a number of out-of-date policies and evidence that recommendations from previous HIW inspections had not been consistently embedded or sustained.
- Concerns regarding use of the Section 136 suite for patients awaiting alternative placements, indicating ongoing bed capacity and flow pressures.
- Inconsistencies in care planning documentation, discharge planning processes and access to therapeutic services, including occupational therapy and psychology support.
- Positive findings relating to safeguarding arrangements, risk management processes, mandatory training compliance and visible ward-level leadership.

3.2 **Progress against the Improvement Plan**

There was a delay between submission of the improvement plan and formal acceptance by HIW.

A comprehensive improvement plan is now being monitored through the Health Board's governance arrangements. Progress is being made against the required actions, with particular focus on strengthening governance oversight, policy review processes, care planning standards, environmental risk management and patient flow arrangements. Regular review meetings are in place to monitor delivery, provide assurance regarding evidence submissions and ensure actions are completed within agreed timescales. Further assurance will continue to be sought regarding the sustainability of improvements, particularly in relation to long-standing environmental and governance issues highlighted by HIW.

4 Never Events

4.1 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.

4.2 BCUHB reported four Never Events occurring in the reporting period.
As shown in the table below

- Retained foreign object post procedure (n=2)
    - ♣ Swab retained following a procedure outside of theatre.
    - ♣ Tampon retained following episiotomy and delivery

- Misplaced Naso-gastric tube (n=1)
  Patient administered feed when tube not correctly placed
- Administration of medication by the wrong route (n=1)
  Controlled drug administered at incorrect dose and via incorrect route.

The above mentioned Never Events are currently going through the full investigation process. Further detail and initial learning can be found in the confidential quality report

4.3 Never Events occurring within BCUHB remains at a level higher than is acceptable, with 13 Never Events reported in a rolling period, August 2025 to July 2026, with limited time between events, 28 median days.

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	5	Oct 2025 (1), Nov 2025 (1), April 2026 (1), Jun 2026 (2)
Wrong implant/prosthesis	2	Oct 2025 (1), Feb 2026 (1)
Wrong site surgery	4	Oct 2025 (1), Dec 2025 (1), Mar 2026 (2)
Total Never Events	**13**	Jun 2025 to Jul 2026

4.4 For period April 2025 to March2026 (Data supplied by BCUHB Clinical Coding) the number of procedures recorded are as below. This emphasises the rare nature of Never Events but by definition they should not occur.

Procedure	Count of procedures
Naso/Oro-gastric tubes inserted	1249
Chest drains	220
Implants/prothesis inserted	26289

4.5 Benchmarking across Wales per 100,000 population, emphasises the need to improve performance.

Never Events	Aneurin Bevan	BCUHB	Cardiff &Vale	Cwm Taf	Hywel Da	Swansea Bay
01/07/2025-30/06/2026 (n)	4	12	8	2	1	0
Per 100k population	0.67	1.73	1.54	0.45	0.26	0

A Health Board wide programme is underway to consolidate all LocSSIPs and ensure that continuous audit programmes are in place. Audits do occur routinely in the theatre environment with oversight within IHC / divisional governance groups. The work programme is intended to extend assurance arrangements across all invasive procedures (it has often been procedures performed outside of formal theatre environment where issues have arisen) and strengthen reporting through governance processes. All clinical leads have been asked to do a stocktake of local LocSSIPs and audit practice and to discuss within departmental meetings.
Whilst robust action is being taken in response to each incident, the recurring themes observed across recent Never Events indicate an ongoing need to strengthen compliance, assurance and safety culture across the organisation.

5. Secondary care position against AMR WHC (period ending March 2026)

5.1 Total antimicrobial consumption across secondary care sites in BCUHB has been reported as a 2.1% decrease compared to the baseline year 2019/20. The target for 2025/26 was to reach 3% reduction. A reduction was seen in both Ysbyty Gwynedd and Wrexham Maelor hospitals but there was an increase in Ysbyty Glan Clwyd.

The target to prescribe 70% of antibiotics from the Access category (narrow spectrum antibiotics) across all sites has seen an increase to approx. 64%.

Work is underway to utilise the electronic prescribing system (EPMA) to further support antimicrobial stewardship. In July there was the introduction of duration being mandated when prescribing an antimicrobial in response to data showing in May that less than 50% of prescriptions for antimicrobials had an end date prescribed resulting in patients receiving longer courses.

6 Medicines Management

6.1 A thematic review of Controlled Drug incidents has identified recurring risks associated with medicines administration, storage, security arrangements and documentation standards. While most incidents have resulted in minimal patient harm, the findings are consistent with themes emerging from recent Never Events, Ombudsman concerns and the Controlled Drug Accountable Officer report. A programme of work has therefore commenced to support both safer prescribing and administration led by Deputy Director of Nursing and Chief Pharmacist and will focus on education, training and adherence to medicines management policies

7 Venous Thromboembolism (VTE) risk assessments

7.1 Low compliance with Venous Thromboembolism (VTE) risk assessments remains a patient safety concern. A multidisciplinary review concluded that the challenges relate primarily to compliance with clinical practice standards rather than limitations within digital systems. A targeted improvement programme has therefore been agreed, combining system optimisation, education, audit and strengthened clinical accountability.

7.2 The Strategic Clinical Effectiveness Group has also approved a revised Tier 2 Audit Programme for 2026/27 which includes VTE prevention

8 My Kit Check (MKC) Concerns Overview

8.1 Resuscitation Services have highlighted significant concerns regarding the reliability and compliance of resuscitation equipment checks across BCUHB, based on the last three months of My Kit Check (MKC) and face-to-face audit data from the East area. The findings are expected to be representative across the organisation.

Key Findings

- 25% of resuscitation equipment carriers (trolleys/bags) were **not rescue-ready** at the time of audit due to missing and/or expired items.
- 38% of carriers had missed routine checks within the previous three months.
- 86% of carriers showed alerts for missed checks on the day of audit. Whilst some may reflect timing of checks undertaken outside normal hours, the figure remains concerning.
- 33% of carriers required re-auditing, driven by issues such as missed checks, expired/incorrect stock, or overstocking identified during face-to-face audits.

There is evidence that MKC records may be providing false assurance, with discrepancies identified between what is recorded electronically and the actual status of equipment found during physical inspection. Following recent incidents in the West ED and subsequent spot checks, Resuscitation Services are strengthening audit processes to specifically compare face-to-face findings against MKC records. This is a potential patient safety risk.

Actions underway include

- Introduction of a revised audit tool across all areas to identify discrepancies between MKC records and physical equipment checks.
- Escalation and education for persistently non-compliant areas.
- A Patient Safety Notice to reinforce the importance of diligent checking of resuscitation equipment.
- Recognition of the need for a more robust process to update MKC governance contacts when matrons or service leads move posts. To support this a task and Finish group is being established to determine immediate actions and learning. The group with include representation from all IHC's and Divisions.

9 Tier 2 Audit Plan for 2026-2027

9.1 In response to the need to strengthen the strategic focus and impact of clinical audit activity across the Health Board, a series of discussions were held during April to June 2026 involving Strategic Clinical Effectiveness Group (CEG), IHC/Division Medical Directors and Clinical Director, Nursing and Pharmacy representatives.

9.2 The purpose of these initial meetings and discussions was to review the current Tier 2 Clinical Audit Programme and develop a more focused, risk-based approach for 2026/2027. It was recognised that clinical audit activity should provide assurance in relation to key organisational

risks, support delivery of Health Board priorities, respond to areas of external scrutiny and demonstrate measurable improvement in the quality and safety of care. This also reflects concerns raised with Audit Wales Quality Governance review

9.3 The review sought to define a small number of strategically important audits capable of delivering meaningful improvement and organisational learning. Discussions also considered how audit activity could better align with ongoing quality improvement programmes, regulatory requirements and areas of known clinical variation.

9.4 To support this work, proposed audit themes were developed using a framework that considered:

- Organisational and clinical risks.
- Areas subject to external scrutiny and regulatory review.
- Patient safety priorities.
- Existing improvement programmes.
- Opportunities for cross-divisional learning and assurance.

The capacity required to deliver audits effectively across the Health Board.

9.5 Agreed Priority Themes

Priority Theme	Rationale
Deteriorating Patient	Supports the Health Board deteriorating patient workstream and focuses on key patient safety processes including Treatment Escalation Plan (TEP), DNACPR, sepsis and resuscitation care.
Urgent and Emergency Care	Focus on patient flow through the emergency care pathway, including both front-door and discharge processes, reflecting ongoing UEC improvement programmes and external scrutiny findings.
Hospital Acquired Thrombosis (HAT) / VTE Prevention	Review compliance with risk assessment, prophylaxis, documentation standards and EPMA-supported processes.
Cancer Pathways	Assess delays and variation within priority cancer pathways and support improvement in timeliness of diagnosis and treatment.
Antimicrobial Prescribing	Evaluate antimicrobial stewardship arrangements following EPMA implementation, including prescribing review and stop-date compliance.
Non-Obstetric Ultrasound Referrals	Review appropriateness of referrals against emerging national guidance and agreed clinical pathways.

WHO Surgical Safety Checklist and LocSSIPs	Assess compliance with key theatre safety processes and invasive procedure standards.

9.6 Next Steps

Following agreement of the priority themes, detailed audit registrations and proposals will be developed, including audit scope, methodology, performance measures and reporting arrangements. Progress and delivery will be monitored through the Strategic Clinical Effectiveness Group, with a continued focus on demonstrating measurable improvement, reducing organisational risk and strengthening assurance to the Board via QSE Committee. **The Committee is asked to approve the Tier 2 Audit plan for 2025-2026**

Clinical Effectiveness

10. Clinical Audit

10.1 During June and July, there were six Tier 1 National Clinical Audit reports published scheduled for responses during August and September 2026. Two Outcome Reviews reported both scheduled for responses during August 2026.

10.2 **Six National Audit reports have been published in June and July, all included BCU identifiable data.** The table below outlines the benchmarking information:

Tier 1 Project reference	Title	*Performance against*	
		National Benchmark	*Last BCU report*
*NCAORP/ 2026-27-10	National Respiratory Audit Programme (NRAP): COPD: Room to breathe: A longitudinal review of respiratory data (1 Apr 2024 - 31 Mar 2025)	A	A
*NCAORP/ 2026-27-11	National Respiratory Audit Programme (NRAP): Adult Asthma: Room to breathe: A longitudinal review of respiratory data (1 Apr 2024 - 31 Mar 2025)	A	A
*NCAORP/ 2026-27-12	National Respiratory Audit Programme (NRAP): Children & Young Peoples Asthma: Room to breathe: A longitudinal review of respiratory data (1 Apr 2024 - 31 Mar 2025)	G	A
*NCAORP/ 2026-27-13	National Respiratory Audit Programme (NRAP): Pulmonary Rehabilitation: Room to breathe: A longitudinal review of respiratory data (1 Apr 2024 - 31 Mar 2025)	A	G
NCAORP/ 2026-27-52	NCEPOD Acute illness in People with Learning Disabilities	N/A	N/A
NCAORP/ 2026-27-38	Mothers and Babies: Reducing risk through Audits and Confidential Enquiries across the UK	N/A	N/A

	(MBRRACE): Perinatal Mortality Surveillance 2026 Report (2024)		
NCAORP/ 2026-27-41	National Ovarian Cancer Audit (NOCA): State of the Nation Report 2026	G	G
NCAORP/ 2026-27-36	National Clinical Audit of Seizures and Epilepsies for Children and Young People (Epilepsy 12): 2026 combined organisational and clinical audits: Clinical Cohort 7	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

*Update	Service / Site	Reason for Outlier Status	Current Position / Update	Key Challenges	Actions / Mitigation
National Respiratory Audit Programme (NRAP)	**IHC West**	Data submission ceased following the departure of the clinical lead in March 2024. The programme also included previous non-participation in the National Asthma Audit for Children and Young People at Ysbyty Gwynedd.	A new clinical lead was appointed in February 2026. Data submission recommenced in April 2026 and nine cases have been submitted to date. Data collection for the current National Asthma Audit is underway and the service remains committed to future participation.	Previous audit findings identified challenges in discharge planning and timely follow-up. The absence of dedicated paediatric asthma nursing support remains a significant barrier to achieving national standards.	Clinical leadership restored and audit submissions recommenced. Ongoing review of asthma care pathways and collaboration with the regional asthma network to improve service delivery and audit participation.
COPD Secondary Care Audit	**IHC East**	Non-participation in the audit programme.	Clinical project leads are in place; however, audit data collection and submission remain incomplete.	Lack of funded administrative support for data collection and submission. Business case for an audit clerk was not approved. Insufficient SPA time within the clinical workforce.	Directorate continues to review administrative capacity and identify opportunities to support participation. Significant improvement is unlikely without additional resource.
Adult Asthma Secondary Care Audit (NRAP)	**IHC East**	Formal outlier status due to non-participation in the Adult Asthma Audit.	Outlier correspondence has been received and responded to via the Chief Executive Officer.	Absence of funded audit clerk support and insufficient clinical SPA capacity for audit activities.	Issues are being considered as part of wider respiratory service development and regional working arrangements.

Area	Health Board Response
Acknowledgement	The Health Board acknowledges the challenges affecting participation in national respiratory audit programmes.
Regional Approach	As part of the ongoing regionalisation of respiratory services across the three acute hospitals, opportunities are being explored to align and strengthen respiratory services.
Resource Optimisation	Consideration is being given to pooling available resources and improving data collection processes across sites.
Quality Improvement	Work is underway to support greater standardisation of clinical practice, shared learning and quality improvement across the region.
Future Focus	The Health Board remains committed to improving participation in national audits and addressing barriers to compliance with national standards where resources allow.

Overall Assurance: Whilst workforce, administrative and funding constraints continue to affect participation in some respiratory audits, there is evidence of renewed engagement and ongoing commitment to audit participation, service improvement, and regional collaboration to address identified gaps.

11 Formation of the Executive Delivery Group for Clinical Quality

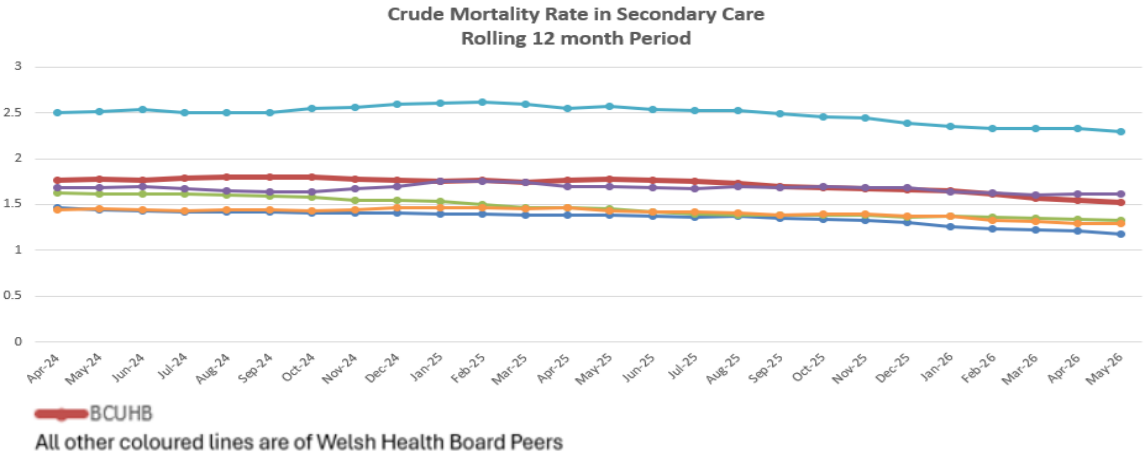
11.1 The Clinical Executives have proposed to merge the Strategic Clinical Effectiveness Group (SCEG) and the Executive Quality Delivery Group (EQDG) to establish a single, integrated forum for oversight of quality, safety, clinical effectiveness and improvement. The merger will strengthen multidisciplinary leadership by bringing together all clinical professions, quality, and operational perspectives within one governance structure, reducing duplication and enabling a more coordinated approach to assurance and decision-making. The new arrangements will support improved alignment between clinical effectiveness, patient safety, quality improvement and regulatory requirements, ensuring that risks, performance issues and improvement actions are considered holistically. In addition, the merger will streamline reporting processes, improve organisational oversight of quality priorities, and enhance the Health Board's ability to provide timely assurance to the Executive Committee and Board regarding the delivery of safe, effective and high-quality care.

11.2 Draft Terms of reference are included in Appendix 1. The first meeting is scheduled for September.

12. MORTALITY

12.1 **Review of Mortality Data taken from CHKS iCompare System:**

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



12.2 Crude mortality rate in BCUHB has been above the national average since April 2024, although the gap has reduced in recent months. Crude mortality rates for other Welsh Health Boards are included in the graph above for comparison.

12.3 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.

13. Nursing and Midwifery Quality Standards (NMQS)

13.1 The new Nursing and Midwifery Quality Standards (NMQS Standards 1-11) have been developed and approved by senior nursing leaders and will replace the current Ward Accreditation monthly metrics. The standards comprise a series of evidence-based questions with robust criteria aligned to Health Board and national policies. These have been refined through ongoing ward support visits to ensure practicality and relevance in clinical settings.

13.2 Working in collaboration with DDaT, a new dashboard has been developed to present NMQS data. The design has prioritised user experience and familiarity by aligning the look and functionality with the existing Quality and Assurance dashboard. User testing of the standards, e-form and dashboard across ward teams has been completed, with positive feedback received from both self-assessment and peer review users.

13.3 Mental Health and Learning Disabilities (MHLD) inpatient areas went live with the NMQS e-form and dashboard on 1 July, with implementation across all remaining inpatient areas scheduled for 1 September. In addition, work is underway with specialist services, including Neonatal and MHLD teams, to develop a bespoke Standard 12 to address area-specific requirements. This approach can be replicated for other specialist services as required.

13.4 To support implementation, a new electronic data collection form has been developed, enabling the capture of qualitative narrative in addition to previous Yes/No/Not Applicable responses. The system also facilitates peer review assessments using the same standards, enabling direct comparison between self-assessment and peer review outcomes.

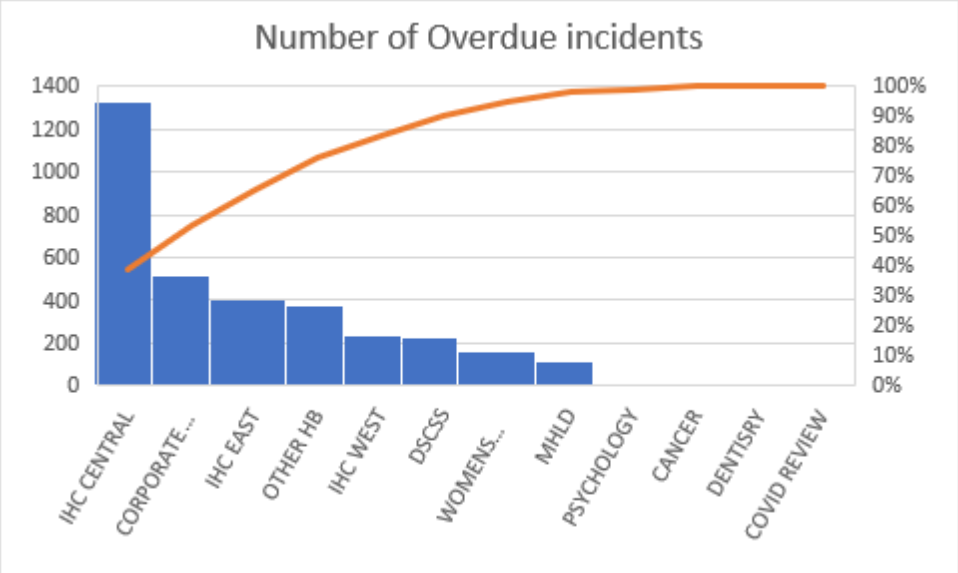
13.5 Senior nursing leaders have agreed the assessment frequency model, comprising monthly Ward Manager self-assessments and three-monthly peer reviews**.** Further discussions are planned regarding a proportionate approach to data collection, including the potential to reduce assessment frequency where both self-assessment and peer review standards consistently demonstrate sustained compliance.

14 Patient Safety Incidents

14.1 **Incidents**

There are currently 5528 open incidents of these, 62.68% are overdue, which is a worsening position to the previous reporting period. The volume of open incidents remains high. Largest caseloads as below

- IHC Central -1,882 open, 1331over due (70.72%)
- IHC East – 867open, 402 overdue (46.37%)
- Corporate Services – 569 open, 517 overdue (90.86%)
- IHC West -548 open, 234 overdue (42.70%)



14.2 In recent months, the Patient Safety Team (PST) has undertaken a targeted approach of support focused on the timely completion of Rapid Reviews (RRs) and Interim Harm Reviews, recognising these as key areas contributing to delays within the incident management process. This has included focused engagement with services, bespoke advice and guidance, and ongoing monitoring to support improvements in timeliness and quality.

14.3 To support wider improvement, the Patient Safety Team continues to work collaboratively with Integrated Health Communities (IHCs) and Divisions to review and refresh local trajectories. This work is focused on ensuring that each area has a realistic and achievable improvement plan which reflects operational pressures while supporting sustained improvement in incident management performance.

14.4 Supporting staff to manage and investigate incidents effectively remains a key priority for the Patient Safety Team. Monthly Incident Management training, bi-monthly Investigating Officer (IO) training, weekly Incident Management drop-in sessions, and weekly Nationally Reportable Incident (NRI) drop-in sessions continue to be delivered to build knowledge, confidence and capability across the organisation.

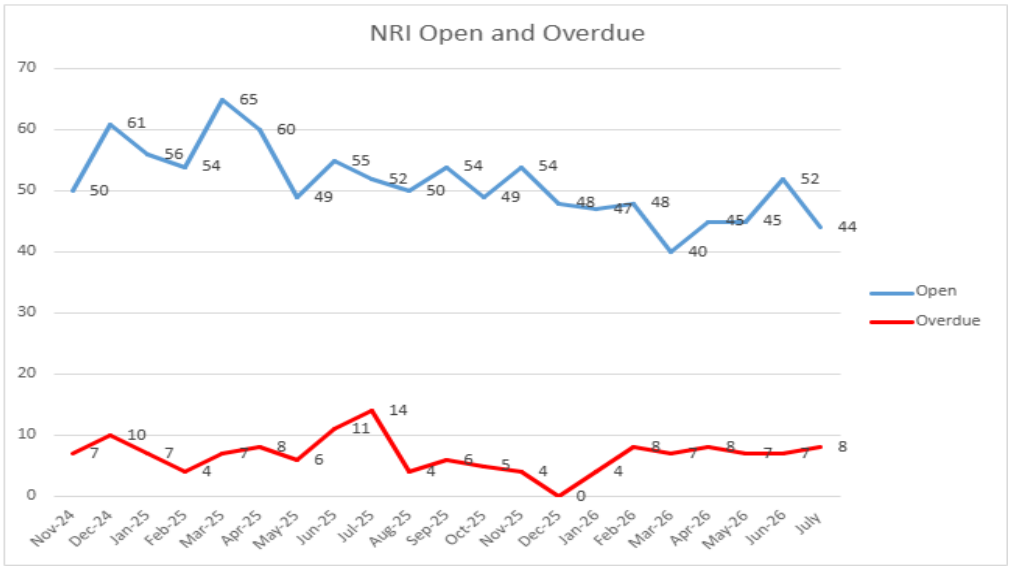
14.5 **Nationally Reportable Incidents**

From 01st June 2026 to 31st July 2026, there were 17 Nationally Reportable Incidents (NRIs) submitted (by incident date) compared with 11 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.) These can be categorised as follows: -

BCU UHB top 10 NRI categories occurring by volume (incident dates...

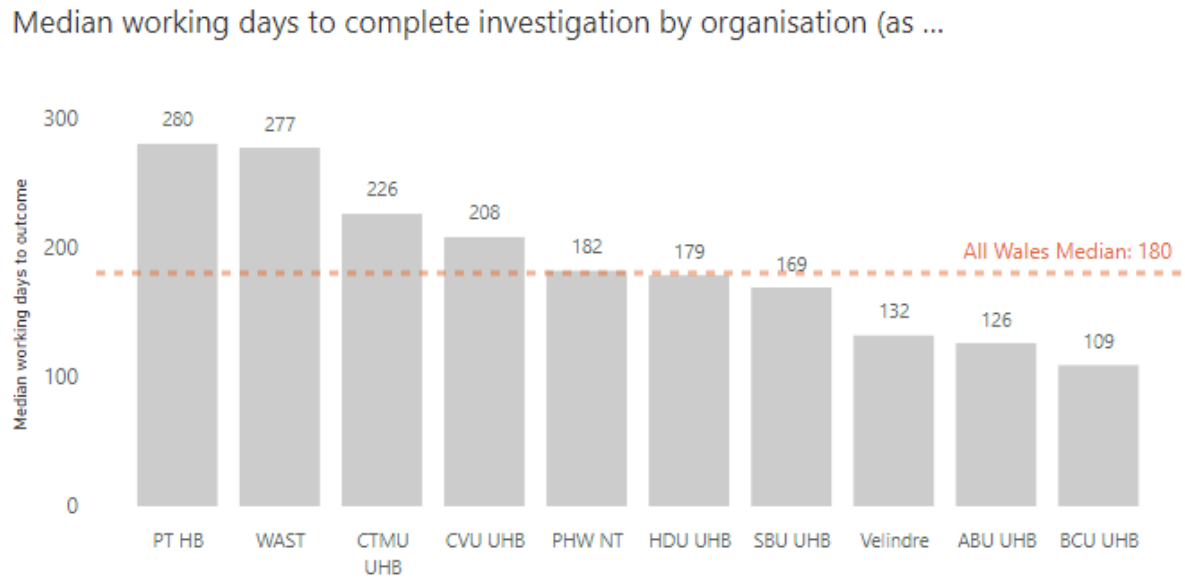
NRI category	Total
Unexpected death	4
Treatment or procedure issues	3
Healthcare Acquired Infection (community, primary care or hospital)	2
Administration errors	1
Blood / plasma products transfusion	1
Clinical assessment, clinical diagnosis	1
Medical devices	1
Medication prescribing error	1
Neonate	1
Safeguarding - Adult	1
Screening and surveillance	1

The total number of NRI investigations that were open as at the end of July 2026 was 44 with 8 overdue closures.



14.6 The proportion of NRIs that remain open for more than 365 calendar days is a new measure in the Beacon dashboard. BCUHB does not have any within this threshold.

The median working days to completion is the lowest in Wales at 109 compared to the All-Wales median of 180 days.



14.7 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.

15 Patient Safety Alerts

15.1 During June and July 2026, the Patient Safety Team received and disseminated 43 safety alerts (19 in June and 24 in July), including 12 Field Safety Notices/Corrective Actions, 8 Pharmacy/MHRA Medicines Alerts, 3 Internal Alerts and 1 Clinical/Equipment Safety Alert. There are currently 32 open alerts progressing through established governance arrangements, with five national alerts remaining under active review

15.2 **PSA019 Delayed administration of Rasbricase:** All required actions have been completed and the alert is now compliant. Compliance evidence was submitted to the WG on 30 July 2026

15.3 **PSA020 – Incorrect Recording of Penicillin vs Penicillamine Allergy:** Deadline for compliance is 30/11/2026. Implementation of ePMA has now completed. System warnings and reporting options being explored. Meeting 15th May 2026, initial progress done by ePMA team and report established for identification of patients in BCUHB that have penicillamine allergy. Need to link in with GP practices and review other data systems where this information is held.

15.4 **PSA021 – Risk Associated with Adult Breathing Circuits Lacking a Patent Exhalation Route:** Deadline for compliance is 28/08/2026.
A formal Task and Finish Group has now been established with an agreed draft Terms of Reference and defined scope across all IHCs and relevant services. Clinical Lead and Chair confirmed. Baseline assessments of equipment, training, current practice and associated risks are underway to inform the implementation plan and support organisational compliance

15.5 **Profemur Hip Replacements (DSI/2025/005):** Profemur Cobalt Chrome Modular Neck Hip Replacements: Higher than anticipated risk of revision surgery, metal-wear effects and component fracture. Field Safety Notice Recall.

Local review of data demonstrated lower than expected revision rates and only one patient currently identified within the highest MHRA risk group. Use of Profemur implants has ceased across the Health Board. Patient cohort validation, patient communications, funding arrangements, and implementation of the look-back programme remain in progress**.**

The identification of the patient cohort should be completed in next few months; there will then need to be ongoing clinical review of patients in the higher risk and symptomatic groups.

The principal risk remains the possibility of previously unidentified patients developing late implant-related complications, including wear, corrosion or fracture, requiring ongoing surveillance, timely review and effective patient communication

15.6 **Work is underway to assess organisational compliance and identify any affected Exactech Knee and Ankle UHMWPE Inserts (FSN Ref: CRC2021-08-13-01):**
Work is underway to validate the affected patient cohort and assess organisational impact following identification of a potential risk of implant failure requiring revision surgery. Initial NJR data identified 114 patients, although local clinical intelligence suggests the number may be closer to 400 patients. A proposed clinical management pathway has been developed, with

further work ongoing to confirm patient numbers, resource requirements and governance arrangements. Progress continues through Orthopaedic and Planned Care governance structures

15.7 **Assurance on Alarm "Latching" Functionality in Acute Monitored Environments (WHC/2026/024):** This alert relates to a Regulation 28 Prevention of Future Deaths Report concerning the potential risk of non-latching alarms in acute monitored environments, which may result in missed patient deterioration. An audit of all networked patient monitors across the three acute sites has now been completed. Findings confirmed that all monitors are configured as non-latching, except for the Coronary Care Unit (CCU) at Ysbyty Gwynedd, where latching alarms remain enabled following review and agreement by the clinical team as the most appropriate configuration for that environment. Healthcare Technology Management (HTM) colleagues at YGC are aware of and support this arrangement. The associated Datix record has been updated in response to the WHC notification request, and feedback on the audit findings and local assurance arrangements will be provided to the All-Wales Medical Equipment Managers Group (MEMG). Oversight continues through the Medical Devices Governance & Assurance Group (MDGAG).

15.8 **MDA/2023/03 – Medical Beds, Rails and Associated Equipment:** This high-risk national alert remains under active management. Significant progress has been made, including implementation of a risk assessment tool, approval of relevant documentation and ongoing staff training. Four actions remain outstanding relating to workforce training compliance, community equipment inventory management, review of bed provision for patients with atypical anatomy, and assurance of up-to-date bed rail risk assessments. Continued oversight is being provided through the Medical Devices Governance & Assurance Group pending formal closure.

16. Examples of ongoing learning and improvement ("Closing the loop")

16.1 A thematic review has identified occasions where trauma calls have not been activated when they would ordinarily have been expected. These decisions have generally followed clinical review of pre-alert information, with clinicians determining that trauma activation was not required. However, some of these cases have subsequently resulted in incidents. As a result, work is underway within the Emergency Department to reinforce adherence to trauma protocols. The emerging view is that where the criteria are met, a trauma call should be activated, with teams preferring to stand down an unnecessary response rather than risk failing to provide the most appropriate level of care for a patient who requires it. Audits of care will be reviewed within local governance meetings.

16.2 In relation to systemic anti-cancer treatments (SACT), improvements have been made across the entire pathway, beginning from prescribing and pharmacy ordering processes. Pre-assessment clinics have now been established across all three sites, helping to identify and manage potential safety risks before treatment. The introduction of these clinics has strengthened patient safety, improved communication between patients and clinical teams, reduced cancelled treatments, enabled more effective use of treatment chairs, and ultimately enhanced the overall patient experience and safety of the cancer care pathway.

16.3 Following the external review of an incident where a patient was granted Section 17 leave and whilst on leave was found to have died by ligature. learning has been identified in relation to the application of the Section 17 Leave Policy and Procedure. While the legal requirements of the Mental Health Act were met during that incident, the review highlighted

that clearer guidance for Lead Clinicians, inclusive of Consultant Psychiatrists and Consultants on Call, would be beneficial. This is to ensure clinicians adhere with the Section 17 leave Policy and have due awareness regarding the scrutiny required in regards to permitting Section 17 leave for patients who have been admitted or detained on Section within the preceding 72 hours.

To ensure this learning is embedded, additional text will be added to the Section 17 Leave Policy/Procedure which is currently under review. This will provide clear direction for clinicians that Section 17 leave does not go ahead without necessary safeguards in place and the people who are expected to support the leave are informed, and have agreed.

The Policy/Procedure will now state it would be considered best practice to ensure clinicians are in possession of all the relevant history and risk information relevant to the patient prior to authorising or granting Section 17 leave. A Learning Brief will be distributed to that effect, and wider learning from the incident will be included in a future Learning Event for the Division.

Safeguarding and Public Protection

17. Police investigation and Court Proceedings conclusion

17.1 These were linked investigations being conducted by North Wales Police and detectives.

Both investigations involved five (5) young female girls, who reported a series of serious sexual offences that occurred in Rhyl and the surrounding areas between April 2022 and March 2024

17.2 Offences disclosed include modern slavery, human trafficking, rape and other sexual offences, child abduction, drug supply, and illegal firearm possession.

17.3 All victims were teenagers at the time of the alleged incidents.

17.4 Partnership working was key and North Wales Police had been working closely with the Crown Prosecution Service, local authorities, Betsi Cadwaladr University Health Board, The Probation Service, and other key stakeholders as part of this investigation.

17.5 As of 3rd August, the criminal process reached its 16th week in Caernarfon Crown Court. The media reported five people have been convicted of offences relating to child trafficking and sexual exploitation conspiracy in Rhyl and the surrounding area, all were found guilty of a significant number of offences.
BCUHB Safeguarding and Public Protection Team were fully engaged.

17.6 North Wales Safeguarding Board have commissioned a Single Unified Safeguarding Review (SUSR) of which the Safeguarding and Public Protection Team are fully engaged and providing additional supervision and support for all BCUHB staff members. This is a challenging and resource demanding review.

17.7 <u>Organisational Oversight</u>
Sexual Offences Incidents Review Group is a new group which is to be implemented at the request of the Executive Director of Nursing and aligned to the Quality, Risk and Safeguarding agenda.

17.8 The purpose of this review group is to provide Betsi Cadwaladr University Health Board (BCUHB) with a systematic, organisation-wide understanding of reported sexual offences incidents, to identify themes, trends, and location-based hotspots, and to strengthen prevention, safeguarding, reporting, and response arrangements. The group will report to the Safeguarding Governance and Performance Group and Patient Safety Group in line with BCUHB governance arrangements

Infection Prevention Control

18. Strategic Improvement Goals (2025-2027)

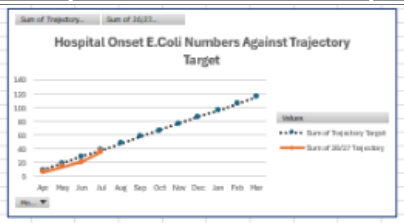
18.1 Performance against the HCAI improvement goals is mixed, with 2 organisms currently below trajectory, 3 exceeding their target trajectories and 2 on trajectory.

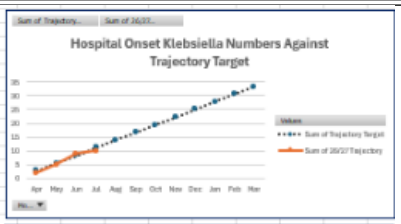
Goal Area	Target	Current Status vs. Trajectory
E. coli (Hospital-onset)	10% Reduction	Below trajectory (-2 cases)
MRSA	< Previous Year	Above trajectory (+3 cases)
C. difficile	25% Reduction	Above trajectory (at +27 cases)
Klebsiella (Hospital-onset)	10% Reduction	Below trajectory (-2 case)
Pseudomonas (Hospital-onset)	10% Reduction	Above trajectory (+1 case)
MSSA	20% Reduction	Above trajectory (+39 cases)

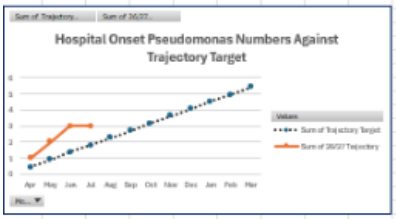
18.2 Additional expectations:

Goal Area	Target	Current Status vs. Trajectory
Klebsiella (community onset)	< Previous Year	Above trajectory (+1 case)
Pseudomonas (community onset)	< Previous Year	On trajectory (6 cases)
Staphylococcus aureus	< Previous Year	Above trajectory (+42 cases)

18.3







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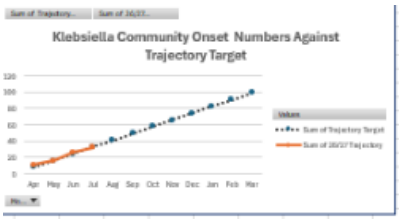
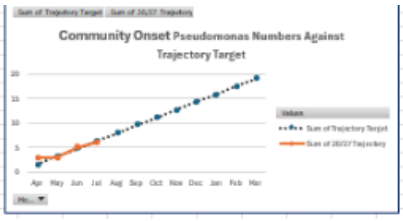
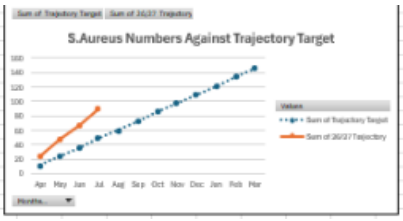






18.5 Additionally, a clinician-led audit on hospital-acquired pneumonia is currently in the implementation stages.

18.6 Outbreak activity reduced during June and July. There were 14 reported outbreaks due to C. diff (6), Norovirus (4), and CPE (2), Covid (1) An overall increase from 10 in the previous recording period

Impact:

- 4 full ward closures and 8 bay closures
- 234 total bed days were lost, with Norovirus accounting for 55% (129 days)

18.7 **Actions to improve position of "Below Target" Goal Areas**

18.8

C.Difficile

- National C. difficile Collaborative, delivering targeted behavioural and quality improvement projects
- Faecal Microbiota Transplant (FMT) Service supporting management of recurrent infection;
- C. difficile cohort capacity and estates development improving isolation capacity and reducing transmission risk
- Enhanced high level disinfection technology ensuring the most effective method for C. Difficile
- Enhanced surveillance to identify trends earlier
- Workforce development and audit & assurance supporting compliance with IPC measures
- Antimicrobial stewardship work addressing a key modifiable risk factor.

18.9 **MSSA/MRSA (Staphylococcus aureus)**

- Workforce development, leadership and culture to improve compliance with hand hygiene, screening, aseptic technique and invasive device care;
- Audit, compliance and triangulated assurance focusing on hand hygiene and infection prevention practices
- Enhanced surveillance to identify recurrent themes through PIR processes
- Environmental cleanliness and ATP Monitoring providing assurance on cleaning standards.

18.10 **Pseudomonas Surveillance and Epidemiological Review**

- Strengthening the PIR process and understanding attributable healthcare-associated cases

- Enhanced surveillance to identify trends and risk factors
- Audit programme supporting compliance with water safety and environmental controls
- Environmental monitoring providing additional assurance of environmental standards.

18.11 **Klebsiella species**
Enhanced surveillance and data-driven decision

- Making to improve understanding of acquisition patterns and risk factors
- Antimicrobial Stewardship Programme supporting reduction in antimicrobial resistance pressures
- Workforce development and audit and assurance reinforcing best practice in infection prevention and management.

18.12 Collectively, these initiatives support a whole-system approach to reducing healthcare-associated infections, improving compliance with IPC standards and delivering sustainable improvements in patient safety

18.13 In addition, the following work is being undertaken

Outbreak Preparedness and Organisational Resilience
The Health Board continues to strengthen its outbreak preparedness arrangements through updated policies, clear escalation processes, and ongoing organisational learning. This includes planning for seasonal pressures such as influenza and norovirus.

In September the Infection Prevention Team will host a webinar which will cover a range of current and emerging infection prevention topics, including winter preparedness and seasonal infections

18.14 **Patient and Public Engagement**
Work is underway to strengthen patient and public involvement in IPC, including the development of educational materials and initiatives to promote good infection prevention behaviours among patients and visitors.

Patient and Carer Experience

19. Complaints

19.1 The Welsh Government implemented a series of changes to National Health Service (NHS Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. These changes aim to modernise how concerns and complaints about NHS care are raised, investigated, and resolved, ensuring the system is fit for current and future needs. The change in legislation entitled Listening to People: The NHS Complaints, Incident and Redress Process came into force on the 1st April, 2026.

19.2 The new Listening to People: The NHS Wales Complaints, incidents and redress framework was successfully launched on the 1st April, 2026, and all key milestones of the

Implementation plan were achieved on time. The first 4 months of the new service have been challenging with gaps in staffing, but following a successful recruitment campaign, this should ease pressures over the forthcoming months.

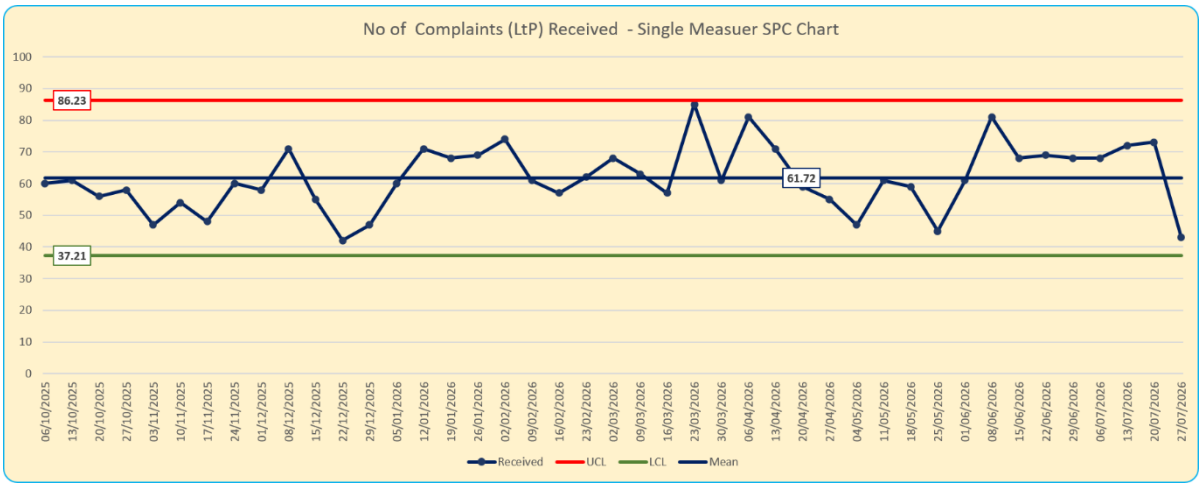
19.3 The following table displays key complaints metrics as of 3th August 2026

Metric	Status	Trend
Total Open Complaints	324	Increase from 286
Number Overdue	61	Decrease from 83
Overall Compliance (Target 75%)	81.17%	Increase from 70.89%

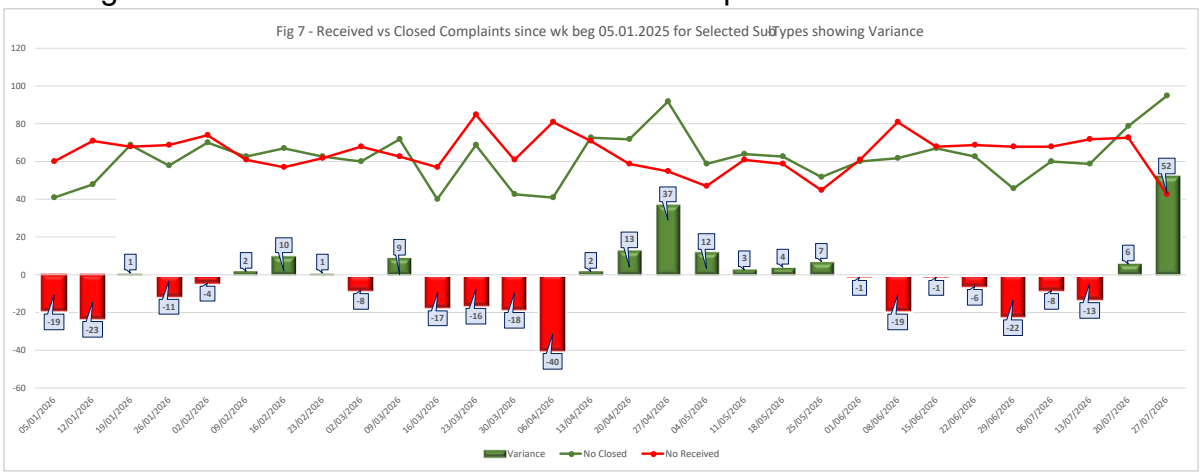
19.4 As anticipated the overall compliance rate has decreased, driven by remaining legacy complaints under Putting Things Right (PTR). There are 12 complaints remaining open, Pre-1st April (Managed Under PTR), down from 54 in the previous reporting period.

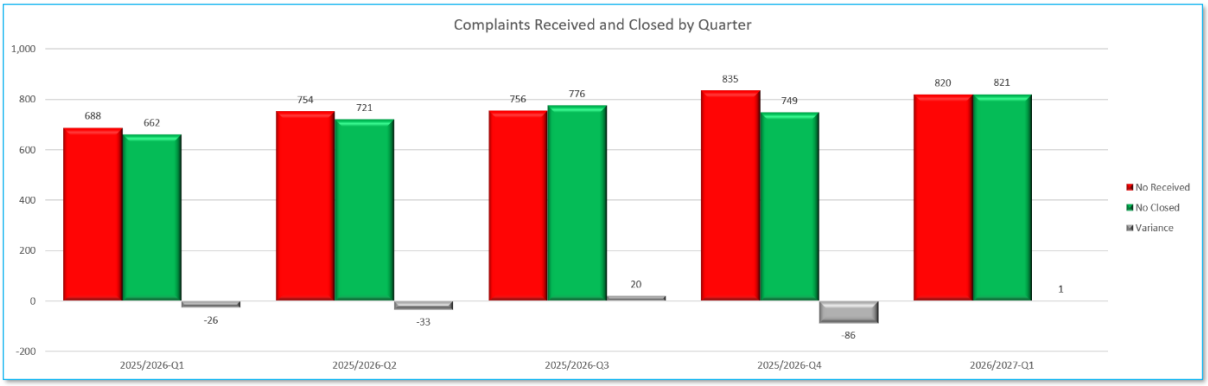
Complaint Subtype	Total	Overdue	Compliance
Manged by PTR	12	12	0.00% (Target 75%)
LTP Early Resolution	22	3	86.36% (Target 40%)
LTP 30 WD	209	38	81.82% (Target 75%)
LTP 60 WD	80	8	90% (Target 75%)
LTP 90 WD	0	0	100% (Target 75%)
LTP 120 WD	1	0	100% (Target 75%)

19.5 Between 1st June and 3rd August 2026, the health board received 603 complaints (a 34% increase from 450) in the previous reporting period and closed 591 complaints a negative variance of 12. We are receiving our highest number of complaints each month (Quarter), since April 2023. This increase is consistent nationally, regarding NHS treatment and care, Complaints Received SPC chart



The chart below, shows weeks net amounts of complaints (received Vs closed), with red bars showing weeks where we have received more complaints than we have closed





During periods of escalation of a deteriorating position, prioritisation of senior staff time towards complaint management and response approval results in a corresponding reduction in capacity for quality improvement activity. Consequently, there is a risk that resource is diverted away from initiatives focused on improving patient care and experience, hence

reducing the organisations' ability to address the underlying causes of concerns, and reducing future complaints and incidents.

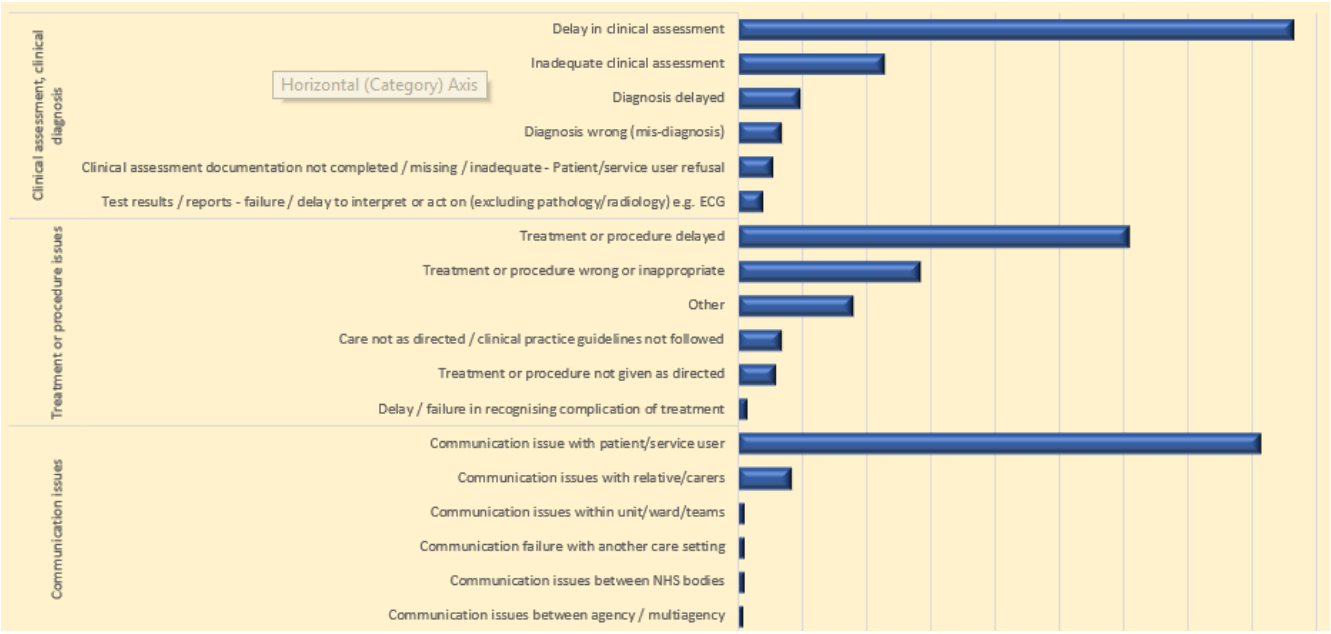
Achieving the nexus of increasing the level of complaint responses vs reducing the number of complaints coming into the organisation remains incredibly challenging.

The table below shows that YGC has more than twice as many open complaints compared to East and west. The three IHCs account for 238/334 Total complaints.

IHC	Within 30-day target	Overdue	Total open
Central	93	27	**120**
East	58	6	**64**
West	46	8	**54**
Total	197	41	**238**

The top five themes of complaints, are as follows

- Delay in clinical assessment
- Communication issue with patient Service User **(Rising)**
- Treatment or Procedure delayed
- Treatment procedure wrong or inappropriate
- Inadequate clinical assessment



19.6 168 Complaint Early Resolutions (10 working days) have been attempted between 1st April 2026 and 3rd August 2026, with 99 being completed within the time (71.81%). Performance has improved in Quarter 2 with (85.71%) of Early resolutions completed within the timeframe. For assurance, in cases where there is harm alleged these are all subject to a full investigation.

19.7 Benchmarking nationally BCUHB continues to perform well:

Average Closure Time: BCUHB is the best performing health board in Wales, resolving complaints in an average of 21 working days.

Real-Time Performance: BCUHB has consistently performed better than the Welsh national average for closing complaints within 30 days of receipt since September 2024 and continues to do so, only falling below target in two of those months

Overdue Complaints: BCUHB's performance on overdue complaints is the fourth best in Wales (behind Velindre, Powys, PHW), and significantly better than other health boards of a comparable size.

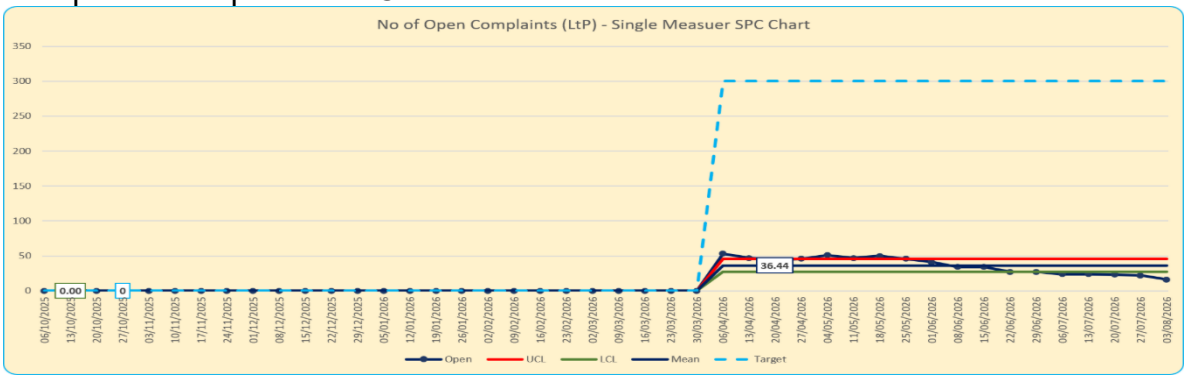
19.8 **Re-opened Complaints**: There is no data available nationally to benchmark re-opened complaints.

19.9 The Health Board currently has 16 re-opened complaints open (down from 41) of which 13 are overdue (over 30 working days) down from 24. However, compliance remains low at 18.75%. Targeted interventions are being undertaken with IHC/ Divisions.

Note: However, an important distinction needs to be made that re-opened complaints are not to be regarded as directly related to dissatisfaction, and in most cases are an attempt an undertaking a supportive and person-centred resolution process.

19.10 The purpose of a re-opened complaint is to not only improve patient experience, it is not unusual to be asked additional questions once a response has been provided, or simply the complainant requires some further clarity. This person-centred approach, reduces PSOW referrals and intervention, reducing workloads further down the line, and improving public trust and confidence in our complaint management processes.

19.11 Re-opened complaints SPC chart



20 Patient Feedback

20.1 The People's Enquiry and Resolution Service (PEARS) supported the resolution of 765 enquiries between 1st June 2026 and 31st July 2026.

20.2 The top 3 enquiry themes included appointments, access to services, and test and investigation results.

20.3 Findings from the All-Wales People's Experience Survey remain highly positive. Based on 9,119 responses, 85.67% (down from 86.97%) of patients rated their overall experience as 'Good" or 'Very Good.

Satisfaction levels were high with people reporting they were 'Always' treated with dignity and respect (85.55%) and being able to communicate in a preferred language (91.06%) which exceeded the national benchmark of 85% satisfaction.

Across the health board the "Civica" score deemed a positive response where the response chosen by respondents is "always" or "usually", exceeded above 85% positive scores in all Civica Questions

20.4 The following table displays key feedback metrics for the reporting period, which have fallen slightly compared to the previous reporting period ("Always Selected")

Survey Question	% of "always" response	Trend (vs. previous reporting period)
Felt well cared for	75.09%	Decrease from 75.49%
Felt listened to	79.19%	Decrease from 79.38%
Involved in decisions about their care	76.76%	Decrease from 77.76%
Explained in a way they could understand	80.79 %	Decrease from 82.04%

Nationally we ranked 5th in terms of best overall patient experience, with a score of 8.3 / 10 (SBU = 8.9, PHW = 9.1, Velindre 9.43)

We receive consistently lower scores in each month between 1st August 2025 and 1st July 2026, but not significantly lower than the All-Wales Average. However, Since the 1st April our average experience rating has fallen each consecutive month, from 8.46 (1st April 26) to 8.19 (1ST July 26) and is the lowest over the last 12 months, and coincides with an increasing number of complaints. Our ED scores will be pulling down our average score.

20.5 We received 212 Easy Read versions of the NHS Wales People's Experience Survey also yielded positive results, with 86.60% of respondents sharing a positive experience (17.53% good and 69.07% very good).

20.6 Whilst compassion remains a significant strength, patient feedback highlights opportunities for improvement relating to comfort and aspects of the care environment. The findings provide valuable insight into areas of excellence whilst identifying priorities for continuous service improvement.

20.7 The People's Experience Service (PES) was established on 1 April 2026 and aims to address the issues raised by patients. During the reporting period, the team conducted 48 Care2Share patient interviews across a range of healthcare settings to capture real-time patient experiences and identify opportunities for service improvement.

20.8 In addition to routine Care2Share activity, the team undertook targeted engagement and improvement work at several sites, including the Shooting Star Unit, Hergest Unit and Abergele Hospital, working directly with patients, carers and staff to better understand experiences and support local service development. 4 Patient Stories were also produced

20.9 The team also supported work in response to Healthcare Inspectorate Wales (HIW) actions identified within the Emergency Department at Ysbyty Glan Clwyd. This included undertaking patient surveys, facilitating staff breakout sessions focused on accessible healthcare, and conducting a comprehensive review of patient information materials to ensure they met the needs of patients and visitors.

20.10 **Advocacy and Support**

The Chaplain and Spiritual Care Service responded to 154 requests for support from staff, patients, relatives, and community faith leaders in the reporting period.

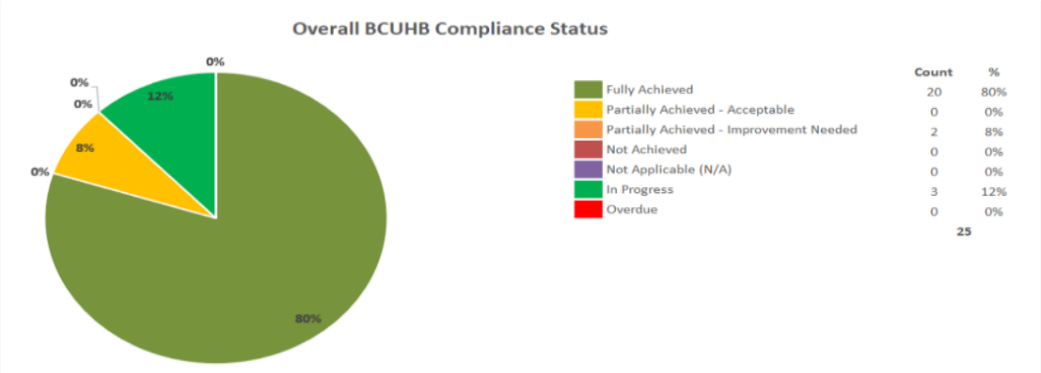
This focus on the patient's experience of care is matched by an equal focus on the effectiveness of the clinical care provided.

21. NICE Guidelines

21.1 BCUHB NICE compliance performance continues to demonstrate steady improvement, reflecting the positive impact of ongoing engagement from both clinicians and operational management teams. This collaborative approach has strengthened the organisation's ability to implement NICE guidance effectively, contributing to improved compliance outcomes and providing assurance that progress is being sustained 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 SCEG.

21.2 Below is the current position up to the end of July 2026 of NICE across BCUHB:



21.3 Instances of '**Not Achieved'** compliance (where the service **has not met the standards** that the National Institute for Health and Care Excellence (NICE) recommendations) are now being escalated monthly to Strategic Clinical Effectiveness Group (SCEG) to provide targeted support and drive improvements in compliance, which is starting to take effect. Where there is consistent non-compliance identified in significant guidance, a BCUHB wide-approach will be undertaken to explore constraints and agree mitigations.

22 Quality Assurance

22.1 Health Inspectorate Wales

22.2 HIW inspection action plans remain in progress, with some overdue actions requiring continued monitoring. Recent assurance requests relate to staffing, safety, person-centred care and environmental issues.

22.3 The Quality Assurance Team continue to work with clinical areas to progress HIW action plans, the below are all open HIW improvement plans, with targeted plans to progress

completion. Continuous monitoring via Local HIW Review Meeting, Regulatory Assurance Group (RAG), and Executive Quality Delivery Group (EQDG).

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

- **Status:** Overdue
- **Recommendations:** 16
- **Actions:** 51 total, 33 completed (65%)
- **Outstanding: 18** actions remain (one partially complete, overdue)
- **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.

Summary of Overdue Actions

Four actions remain overdue. One action relates to Mental Health training compliance and has been delayed due to a lack of available training provision since June 2026. All remaining staff requiring training have now been booked onto sessions scheduled for 9 September 2026, which is expected to achieve 100% compliance.

The remaining overdue actions relate to stakeholder engagement and co-production activities. Progress has been affected by challenges securing the availability of participants and facilitators to support planned engagement events. A revised programme of engagement activity and associated service improvements has now been agreed, with publication scheduled for 1 September 2026.

Progress to establish engagement arrangements with the North Wales Flyers group was also delayed due to existing commitments and limited availability within the group. An engagement plan has now been agreed, commencing in September 2026, and has been strengthened through a commitment for Conwy practitioners to attend North Wales Flyers meetings on a fortnightly basis to support ongoing engagement and co-production activity.

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

- **Status:** Overdue
- **Recommendations:** 16

- **Actions:** 52 total, 24 completed (46%)
- **Progress Status:** 28 actions remain (9 overdue, 13 partially complete overdue, 6 in progress)
- **Closure Date:** TBC

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

- **Status:** Overdue
- **Recommendations:** 24
- **Actions:** 26 total, 17 completed (60%)
- **Progress Status: 9** actions remain (2 overdue, 7 in progress) Two overdue actions remaining pertain to Speak out Safely Communication and the Radiology newsletter. The Professional Service Manager has confirmed that these actions will be closed prior to the next reporting period.
- **Closure Date:** TBC

Summary of Overdue Actions

Five actions remain overdue. The Professional Service Manager has confirmed that evidence demonstrating completion of these actions has been collated by the service and is currently undergoing final review and assurance. Once validated, the actions will be updated and the improvement plan is expected to have no remaining overdue actions.

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

- **Status**: Overdue
- **Recommendations**:6
- **Actions**:20 total, 3 completed (15%)
- **Progress Status**:17 actions remain (1 partially complete overdue) The partially complete overdue action is pertaining to documented visits, which have not yet taken place. Email evidence has been uploaded to AMaT to confirm these visits will take place. The action will be closed once further evidence has been provided.
- **Closure Date**: TBC

Summary of Overdue Actions

The **one overdue action** is pertaining to a quarterly report regarding Board to Floor engagement, which is currently being progressed by the service

22.8 **Requests for Assurance**: BCUHB responded to requests for assurance from HIW concerning Ysbyty Maelor Emergency Department and Pantomime Ward, Ysbyty Gwynedd Moelwyn Ward and Ysbyty Gwynedd Emergency Department and Aran Ward. In each case the improvement actions were detailed and HIW were assured by the BCUHB responses.

22.9 **Concerns / Requests for Assurance (3)**

Ysbyty Maelor Emergency Department and Pantomime Ward

HIW sought assurance from the Health Board regarding the following: -

- Nutrition and diabetic care in the Emergency Department.
- Lack of appropriate food in both the Emergency Department and Pantomime Ward
- Discharge, self-discharge, capacity and safeguarding processes
- Ward cleanliness and infection prevention

22.10 **Ysbyty Gwynedd, Moelwyn Ward**

HIW sought assurance from the Health Board relating to a patient reportedly smoking regularly outside the hospital entrance, with cigarettes and a lighter allegedly stored by ward staff in a locked medicine locker. It is further alleged that the locker is located near an oxygen outlet used by another patient, raising a potential fire safety concern.

22.11 **Ysbyty Gwynedd Emergency Department and Aran Ward**

HIW sought assurance regarding concerns relating to a patient's care within the Emergency Department and Aran Ward. The concerns encompassed the timeliness and quality of assessment, admission and fundamental care; nutritional support; person-centred care delivery; implementation of agreed clinical plans; multidisciplinary communication and information sharing; patient and family engagement; workforce pressures; infection prevention and control; patient safety; and organisational culture and governance arrangements

23 Care Inspectorate Wales (CIW)

23.1 **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 Health Board is awaiting receipt of the formal inspection report and improvement plan; however, high-level feedback was provided following the inspection.

An improvement plan is being progressed with service managers and will be further refined on receipt of the formal CIW report and recommendations.

The plan will be subject to thorough scrutiny by the Regulatory Assurance Group (RAG), which reports directly to the Executive Delivery Group (EDG).

24 Public Services Ombudsman for Wales

24.1 BCUHB has maintained sustained compliance with Ombudsman requirements, with overall compliance against recommendations at 91%. Engagement with the Ombudsman's office has strengthened, supporting timely resolution and improved assurance.

24.2 BCUHB currently has 38 open Ombudsman cases, down from 50 in previous reporting period.

Notification of New Full Investigations	0
Awaiting Draft Report	20
Draft Report Received	0
Awaiting Final Report	1
Final Report Received and working on action plans	8
Early Resolution Proposals	5
Further Info requested during investigation	0
Enquiries	0
Further evidence requested for Sign Off	2
Total Cases Open	**38**

24.3 **Public Interest Reports**

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

24.4 **Final Public Interest Report 202404388**

The Ombudsman's investigation has considered the following:
The care and treatment the patient received, following his prostate cancer diagnosis, between September 2023 and July 2024. In particular, the significance of the delays in him receiving a PET scan and oestrogen, and whether this impacted the spread of his cancer.
A draft Public Interest Report was received in January 2026, shared with the IHC (West) and accepted by the responsible Medical Director on behalf of the Health Board.
The final report was issued on 4 March 2026, shared with the IHC (West), Executive Team and Press Desk. The report was published in the press on 18 March 2026.
Six recommendations were issued by the Ombudsman. Four actions are complete and the remaining two actions are progressing in line with agreed timescales.

24.5 **Final Public Interest Report 202501841**

The Ombudsman's investigation has considered the following:

a) Whether it was clinically appropriate to prescribe Sevredol (morphine sulphate)
b) Whether the patient and the family were provided with sufficient information and support to minimise the safety risks associated with the prescription of Sevredol.

The draft Public Interest report was received on 10 March 2026, shared with the IHC (West) and accepted by the responsible Medical Director on behalf of the Health Board.

The final report was received on the 5 June 2026 and shared with the West IHC, Executive Team and Press desk. The report was published in the press on 19 June 2026.

Eight recommendations were issued by the Ombudsman. Five actions are complete and two actions are progressing in line with agreed timescales.

25 Organisational Learning

25.1 The Digital Learning Repository continues to become established as a key component of the organisation's learning infrastructure. Having acted as an early adopter, the Mental Health Division is now transitioning to a position of routine learning submissions, demonstrating a sustained commitment to sharing validated learning and embedding organisational learning into everyday practice. This progression reflects growing confidence across services in utilising the repository to capture, disseminate and apply learning from patient safety events in a consistent, accessible and meaningful way.

25.2 The inaugural Discovery and Learning Meeting will take place on 15 September 2026, strengthening the Health Board's approach to organisational learning. The forum has been established to provide a structured mechanism for the proactive identification, review and oversight of learning arising from public inquiries, independent reviews and other significant sources of organisational intelligence. Bringing together colleagues from across the organisation, the meeting will support the identification of lessons, recommendations, emerging themes and opportunities for improvement, while promoting a coordinated approach to implementation and monitoring. Through collective review and shared oversight, the forum will provide greater assurance that learning is systematically identified, disseminated, embedded and translated into sustainable improvements in practice and patient outcomes.

25.3 In parallel, initial work to strengthen quality assurance and organisational learning arrangements with commissioned services has commenced. Engagement with a number of commissioned services has focused on exploring approaches to identifying and sharing learning and insights generated across the wider health and care system. This work remains at an early stage but will support the development of a more coordinated approach to organisational learning, helping to ensure that relevant learning is recognised, shared and considered alongside existing Health Board learning processes.

26 HealthCare Law

26.1 Coroner and Inquests

26.2 During the reporting period, no new Prevention of Future Death (PFD) Reports were issued to the Health Board by the Coroner's Court. In addition, no conclusions of neglect were returned against the Health Board during the reporting period.

26.3 <u>Response to Prevention of Future Deaths</u>

The Health Board submitted a response to a Prevention of Future Deaths (PFD) Report issued following an inquest into a death in South Wales. Although the death did not involve services provided by the Health Board, the concerns raised regarding resuscitation equipment and medicines management were reviewed, and assurance was provided regarding existing arrangements and ongoing participation in national improvement work. No additional requests for assurance or formal concerns requiring a response were received from coroners during the reporting period.

27 Liability Claims

27.1 The Health Board continues to maintain focused oversight of Learning from Events Reports (LFERs) required by the Welsh Risk Pool. As at the end of July 2026, there were 16 overdue LFERs across claims and redress matters.

27.2 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. One penalty has been incurred during the current financial year.

27.3 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

28 Other Healthcare Legal Update

28.1 During July 2026, the Health Board supported a “Meet the Coroner” learning event for staff, providing practical insight into the coronial process, including witness statements, inquests and expectations following a patient death. The event formed part of the Health Board’s wider approach to organisational learning and supporting staff engagement with legal processes.

28.2 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.

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Quality Safety & Experience Committee

INTEGRATED QUALITY AND PERFORMANCE REPORT (IQPR)

Dyddiad y Cyfarfod Date of Meeting	03 September 2026
Statws Cyhoeddi Publication Status	Open/ Public
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Olivia Shorrocks Cyfarwyddwr Perfformiad Director of Performance
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Russell Caldicott Cyfarwyddwr Gweithredol Cyllid Executive Director of Finance
Pwrpas yr Adroddiad Report Purpose	For noting

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

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

INTEGRATED PERFORMANCE AND QUALITY REPORT

1.0 Y SEFYLLFA / SITUATION

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

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

2.0 Y CEFNDIR / BACKGROUND

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

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

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

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

3.1 Performance and access

The health board made sustained progress in reducing **planned care** waiting times through to March 2026, outperforming forecast trajectories. The number of patients waiting over 104 weeks has reduced by 79% since its peak in July 2024. Whilst there was an increase of patients waiting over two years in the first two months of quarter 1, the health board recovered the position and reported 2,191 breaches at the end of quarter one. A small number of patients were waiting more than three years at the end of the quarter. This demonstrates the fragility of progress achieved to date and the need for sustained delivery of recovery actions.

Cancer performance remains the worst in Wales at 53.59% (May 2026) and a provisional outturn of 53.5% for June 2026. This is significantly below the required standard. The challenges are notable in skin, breast, urology, colorectal, and head and neck services, reflecting ongoing capacity, pathway and demand pressures. The health board has resubmitted data from quarter 4 (in line with agreed protocols) and this will show an improved performance earlier in the year when published in August.

Diagnostic performance has continued to improve, however, sustaining this improvement remains dependent on addressing ongoing capacity constraints within key services, particularly radiology, non-obstetric ultrasound and endoscopy, where demand and workforce pressures continue to impact performance.

An interim Planned Care Recovery Director was appointed in May 2026 to lead delivery of planned care recovery plans from Quarter 2 with focus on improving operational delivery, productivity, data validation and targeted commissioning.

After a period of sustained improvement during 2025, performance against the percentage of people accessing **adult psychological therapy** within 26 weeks of referral remains below the national 80% standard with 51.2% of patients starting treatment within 26 weeks in June.

Access for children requiring **neurodevelopment** assessments remains poor at 14.9% within 26 weeks for BCUHB against a 80% target. No health board is achieving the standard at latest monitoring with latest all- Wales performance of 23.3%. There is a focus on reducing the extreme waits with a 66% reduction seen in number of patients waiting more than 3 years between December 2025 and June 2026.

Urgent and emergency care services across the health board continue to operate under ongoing pressure, and present risks to patient safety and experience, quality of care, staff wellbeing and organisational reputation. In June, ambulance conveyances were static (3,340), with 39% of handovers achieved within the 45-minute target, well below the requirement of 100%. There is an improving trajectory against the special measures target for one hour ambulance handovers. Emergency department 12-hour performance has deteriorated by 1% over the past three months, 24% of patients continue to wait over 12 hours in ED's and MIU's. Time to triage is above target (median 21 minutes against the 15-minute target), while median time to clinician stands at 127 minutes (67 minutes over the national target). The number of patients with delayed pathways of care and number of delayed days has increased with West IHC accounting for 50.4% (6,592) of all delayed bed days across BCU. Improvement work has been supported by a dedicated intervention team. Following an inspection of the

Emergency Department at Ysbyty Glan Clwyd in June 2026, Healthcare Inspectorate Wales (HIW) identified a number of areas requiring immediate assurance and designated the service as an area of significant concern. A detailed recovery plan has been developed to respond to the concerns raised

3.2 Quality, safety and patient experience

1 new never event has been reported in July 2026, this is in addition to the four never events reported in Quarter 1 (1 in April and 3 in June). Data indicates that BCUHB is an outlier compared to other health boards accounting for 50% of the never events reported during first quarter of 2026/27 (this doesn't include July case). 13 never events have been recorded for the period July 2025 – July 2026. The most frequent theme was wrong site procedure

While each event has been subject to immediate escalation and investigation, the recurring nature of the themes identified continues to be a significant concern and highlights the need for strengthened assurance and compliance arrangements.

A health board wide programme is underway to consolidate all LocSSIPS and ensure that continuous audit programmes are in place. The work programme is intended to extend assurance arrangements across all invasive procedures and strengthen reporting through governance processes.

The number of open complaints is increasing. At the end of November 2025 there were 243 complaints open. This has increased to 324 at the start of August – an increase of a third. The Central IHC has the highest number of open complaints.

3.3 Finance and sustainability

The health board's financial plan identified an £89 million gap to achieve a break-even position. After delivering a targeted £46 million savings, a planned deficit of £43 million remains, meaning the organisation is not currently forecast to meet its statutory financial duty.

At the end of July 2026, the year-to-date deficit is £22.9 million, which is £8.6 million adverse to the planned year to date deficit of £14.3m due to pressures predominantly relating to pay, prescribing and CHC. Whilst significant progress to accelerate the conversion of identified opportunities into green-rated schemes has been achieved in Month 4 (July), further focus is required on closing the savings gap, containing cost overruns and recovering the year-to-date deficit above plan.

The health board is targeting £46 million of savings, with an additional stretch target of £17 million, bringing the total savings requirement to £63 million (2.4% of turnover). Subject to assurance on delivery would result in £26 million of Welsh Risk Pool costs being mitigated by Welsh Government and the Health Board being able

to submit a balanced plan for 2026/27 and attain the key statutory duty of break-even.

As at July 2026, savings schemes with a forecast deliverable value of £43.9 million have been progressed, but only £28.2 million of these saving are budget reducing, highlighting the need for significant further work to identify and deliver recurrent budget releasing savings and restore a sustainable financial trajectory.

Failure to achieve the statutory financial duty places at risk access to approximately £82 million of Welsh Government 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

Sickness absence remains high at 6.09%, with long-term sickness continuing to account for the majority of absence. Short-term sickness remained at 0.79% in June 2026, while long-term sickness was stable at 3.95%.

The overall vacancy rate is 8.4%. Agency usage within nursing and midwifery has continued to fall over the past year, reflecting progress in workforce stabilisation. Nursing workforce turnover has also reduced, supporting greater continuity of care and improved workforce sustainability. Despite this progress, workforce availability continues to present challenges across a number of services and remains a key enabler of operational recovery.

4.0 ASSESSMENT

Whilst improvement has been achieved in some areas over the past year, the health board continues to face significant challenges in delivering sustained recovery and there is a risk of slippage as waiting lists start to grow. Performance against national standards remains below expectation in many services, most notably urgent and emergency care, cancer and planned care. 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. Taken together, these factors mean the organisation remains some distance from achieving the level of performance and sustainability required for de-escalation from Special Measures. 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 considerable scrutiny, despite this there is considerable risk that the health board's trajectories will not be met this quarter. Committee members are therefore asked to provide robust oversight and challenge, ensuring that recovery plans are delivering measurable improvement and that management actions are commensurate with the scale of the operational, quality and financial challenges facing the health board.

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

	Mental Health and Learning Disabilities
MMR	Measles, Mumps and Rubella
NHS	National Health Service
NR	non-recurrent
PADR	Performance Appraisal and Development Review
PFIG	Performance, Finance, and Information Governance Committee
QSE	Quality, Safety, and Experience Committee
SB	Swansea Bay University Health Board
SM	Special Measures
WAST	Welsh Ambulance Services NHS Trust
WG	Welsh Government
YTD	year to date

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

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

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

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

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

Thursday, 3 September 2026

Trugaredd
Compassion

Agored
Openness

Parch
Respect

Quality, Safety and Experience Committee

Integrated Quality and Performance Report (IQPR)

Table of Contents

Introduction

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

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

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

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

- **Escalate** (Serious concerns, action required): There is no confidence that the actions taken in place will address performance issues. Executive level intervention is necessary to resolve the situation.

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

What is our data telling us?

Performance and access

The health board has been on an improving trajectory, with reductions in waiting times reported until the end of March 2026, with performance exceeding the forecasted position. Whilst the position deteriorated during April and May, there has been improvements noted in June with the end of Q1 position at 2,191. A small number of three-year breaches were reported in June. A single integrated recovery plan has been submitted to Welsh Government. Cancer performance remains the worst in Wales. There is a continued focus on operational delivery, productivity, validation, and targeted commissioning. Urgent and Emergency Care (UEC) performance remains under significant pressure with ambulance handover delays over 45 minutes significantly above the Welsh Government expectation of zero, however the health board did achieve the Quarter 1 trajectory. Median time to assessment remains substantially above the 60-minute national and Special Measures target, despite remaining ahead of the health board trajectory. Deterioration in four, and twelve-hour emergency department performance and increasing delayed pathways of care are driving sustained bed occupancy pressures. Overall, while some measures remain on trajectory, performance continues to reflect ongoing system wide flow constraints. The health board has agreed three immediate focus areas in the UEC Improvement plan; Discharge to Recover and Assess (D2RA), Frailty, and Clinical Engagement to drive improvement in quarter 2.

Quality, safety and patient experience

1 new never event has been reported in July 2026, following on from four never events reported in Quarter 1 (1 in April and 3 in June). The health board has reported the highest number of never events when compared to other health boards over the last 12 months. The number of open complaints has increased. . At the end of November 2025 there were 243 complaints open. At the start of august 2026 there are now 324 – an increase of a third. Competing priorities have impacted on availability of appropriate staff to undertake and author complaint responses and senior staff required to undertake the quality assurance, review and approval process.

Finance and sustainability

As at the end of Month 4 (July 2026) the health board is reporting an in-month deficit of £5.8m, a £2.2m adverse variance compared to the profiled financial plan deficit of £3.6m. Year-to-date position is a deficit of £22.9m, an adverse variance of £8.6m compared to the planned year to date deficit of £14.3m primarily driven by pressures relating to pay, prescribing and Continuing Healthcare (CHC).The 2026/27 £43.0m financial plan deficit 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. The health board has identified £43.9m Green schemes, an increase of £19.8m from previous month. Of the identified schemes, only £28.2m of these savings 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.

People and places

Overall sickness absence rates remain high for the time of year at 6.09%. Short-term sickness remains at 0.79% for June 2026, with long-term sickness stable at 3.95%. Overall vacancy rate is 8.4%. Nursing and midwifery agency usage continues to decrease since May 2025 (3.7%) to June 2026 where it stands at 2.4% equating to 163 less full-time equivalent (FTE) agency use compared to the same period in 2025. The rolling 12-month nursing staff turnover percentage has reduced to **7%** as of June 2026.

Executive Summary: Performance and access

Planned care - since July 2024 there has been a 79% reduction in waits over 2 years from 10,400 to under 2,200 – the lowest position since March 2021. Whilst position deteriorated during April and May, there has been improvements noted in June with the end of Q1 position at 2,191. The overall waiting list decreased for seven consecutive month during the latter part of 2025/26 supported by national programme to increase outpatient activity. Since April 2026, the total waiting list has increased month on month. Referral pathway refinement is a key focus area within the planned care programme and includes continued roll out of the community health pathways.

Waiting times for **diagnostic** procedures within 8 weeks continues to improve falling from c22,000 waiting over 8 weeks in January 2026 to below 9,000 at the end of May. This is a 61% reduction in patients waiting in excess of target during the period.

Cancer performance remains disappointing, with an overall deterioration from over 60% at the end of March 2025 to 53.5% at the end of June 2026 against a standard target of 75%. Recovery focus is on skin, colorectal, urology and breast.

Urgent and emergency care services across the health board continue to operate under ongoing pressure, and present risks to patient safety and experience, quality of care, staff wellbeing and organisational reputation. In June, ambulance conveyances are static (3,340), with 39% of handovers achieved within the 45-minute target. Emergency department 12-hour performance has deteriorated by 1% over the past three months, 24% of patients continue to wait over 12 hours in ED's and MIU's. Time to triage is above target (median 21 minutes against the 15-minute target), while median time to clinician stands at 127 minutes (67 minutes over the national target). The number of PoCD patients and number of delayed days has increased with West IHC accounting for 50.4% (6,592) of all delayed bed days across BCU, with 43.3% relating to patients with mental health and learning disabilities.

Adult Mental Health performance remains compliant at health board level against both Part 1a and Part 1b access standards. Performance continues to improve against Part 2 Valid Care and Treatment Plan compliance, although this remains below the national target. Whilst overall performance remains compliant, there continues to be variation across localities and pathways, with recovery activity focused on improving equitable access and reducing longer waits.

Psychological therapy performance remains below the national standard, although operational recovery activity continues. Current improvement work is focused on increasing operational capacity, resolving accommodation constraints and reducing waiting times whilst maintaining patient safety.

Children and Adolescent Mental Health performance remain compliant with the 80% standard at the end of June with Part 1a – Assessment performance at 86.8% and Part 1b – interventions at 81.8%. Part 2 performance also remains compliant with 90% standard at 94.5% in June**.**

Neurodevelopment Assessments remain significantly below expectation with those waiting less than 26 weeks to start an ADHD or ASD assessment at 14.9% as at the end of June 2026 although this does show a 2.2% increase from the position of 12.7% at end of May 2026. No health board is currently achieving target of 80% with April 2026 all-Wales performance at 23.3%

Executive Summary: Quality, safety and patient experience

Patient Experience 330 complaints were received during June 2026, mainly relating to delays/lack of treatment or assessment (79), incorrect/insufficient treatment or assessment (78) and communication with patient/service user (24). Listening to People has been implemented and the early resolution approach is being supported and encouraged. On average, the health board resolves complaints within 21 working days and with a closure within 30 days rate remaining one of the best performing in Wales. BCUHB's performance on overdue complaints remains as the third best in Wales. As of the 31 March 2026 (latest national data available) BCUHB contribute just 61 complaints of the 1,210 that are overdue nationally (5.04%)

Patient Safety Incidents – As at 13 July snapshot date, the BCUHB rate for National Reportable Incidents in June 2026, is 1.59 compared to all Wales 1.20 (per 100,000 population). Time to complete investigation is 107 days which is currently the lowest across Wales with a median of 180 days.

Patient Safety – Never Events – A total of 13 Never Events have been recorded for the period July 2025 – July 2026. Following a period of 59 days safe care between April and June 2026, three Never Events were reported between 13 and 17 June 2026. In July 2026, 1 Never Event was reported. The most frequent theme was wrong site procedures, along with incidents involving retained items and implant or prosthesis errors. The latest Never Event reported in July involved a misplaced nasogastric tube (NGT). All Never Event incidents have been managed in accordance with required processes, including Duty of Candour, and that comprehensive action plans are in place. Executive oversight has been strengthened through the Executive Incident Committee Oversight Panel and corresponding quality governance arrangements.

New Nursing and Midwifery Quality Standards (NMQS) – New and updated NMQS have been developed aligned to the QMS methodology .MHLD inpatients go live on 1st July and all other inpatient on the 1 September. A communications plan has been agreed, and further work is underway with Clinical executives to expand the Quality Standards to include the wider MDT.

Safe Use of Portable CD Oxygen Cylinders - A range of targeted improvements have been implemented across the health board to minimise risks to patients requiring oxygen via portable CD cylinders. A mandatory eLearning package has been developed and implemented across the health board. Current compliance stands at 88.15%. , the package is under review by the Welsh Risk Pool with the aim of adoption as an All-Wales training resource

Executive Summary: Finance and sustainability

Financial Plan

•The 2026/27 £43.0m financial plan deficit 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. Focus is required on accelerating the transition of identified savings schemes to green-rated and budget releasing delivery status.

Financial Position

•As at the end of Month 4 (July 2026) the health board is reporting an in-month deficit of £5.8m, which is £2.2m adverse compared to the Month 4 profiled financial plan deficit of £3.6m.

•Year-to-date position is reporting a deficit of £22.9m, £8.6m adverse to the planned year to date £14.3m deficit. The adverse variance to plan indicating a run rate exceeding plan by approximately £2.1m per month, the adverse position primarily driven by pressures relating to pay, prescribing and Continuing Healthcare (CHC).

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

	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)	(5.8)	(4.8)	(3.8)	(2.8)	(1.8)	(1.8)	(1.8)	2.60	(22.9)	(43.0)

Savings and Mitigations

•As at the end of July (Month 4), the health board has identified £43.9m Green saving schemes, an increase of £19.8m from previous month.

•In-month savings delivery is £9.8m and total year-to-date savings delivery is £17.9m, of which £10.1m is budget releasing, resulting in a £5.2m impact on the position.

•Further focus is required on accelerating the transition of identified savings schemes to green-rated and budget releasing delivery status, containing cost overruns and recovering the year to date deficit above plan.

•Welsh Government require the health board to deliver the key duty and submit a balanced plan, which would require enhanced savings delivery stretch target of £63m (an additional £17m on the £46m contained within the plan). This would enable £26m of Welsh Risk Pool costs being mitigated by Welsh Government and the Health Board being able to submit a balanced plan for 2026/27 and attain the key statutory duty of break-even.

Capital Programme

The approved Capital Resource Limit (CRL) for 2026-27 is £58.6m, which is forecast to be spent in full.

Executive Summary: People and places

Vacancy Rate

The vacancy rate for June 2026 stands at 8.4%, representing a 0.2% increase from May 2026 and a 0.2% deterioration compared to the same period last year. Positive progress is being seen across key clinical staff groups, including Registered Nursing, Allied Health Professionals (AHPs), and Additional Professional Scientific and Technical staff, all of which have reported reductions in vacancy WTE. Despite this improvement, recruitment challenges, delays associated with establishment controls, and a number of hard-to-fill roles continue to impact the organisation's ability to reduce vacancies at pace. However, progress is being supported through strengthened workforce planning, targeted recruitment activity, improved application filtering processes, and focused interventions in priority areas. In partnership with Finance colleagues. Work is underway to review the establishment control process with the aim of streamlining arrangements

Workforce Planning and Efficiency Programme

Strategic workforce planning has strengthened through targeted support to Fragile Services, with workforce action plans developed to stabilise services and mitigate workforce risks. Governance has been enhanced to embed workforce planning within service redesign, while the Interprofessional Education Group is aligning workforce planning, education commissioning and future workforce supply. Ongoing engagement with HEIW is also informing future workforce modelling and planning tools.

Progress against workforce productivity priorities has continued but has been constrained by delays in ratifying the revised Consultant Job Planning Policy. This has slowed progress towards the 90% consultant job plan compliance target, compounded by a large number of historic job plans expiring in March 2026. Compliance improvement work continues, with further progress expected once the policy is agreed and implemented.

Reducing temporary staffing reliance and optimising workforce deployment remain key priorities. Enhanced oversight of long-term medical agency use is now in place through strengthened governance and work through the Value and Sustainability Programme. Actions through the insourced medical bank service and the Variable Pay and Agency Control Framework are supporting reduced agency dependence, with delivery remaining achievable if planned controls and interventions continue to be embedded.

Overall, progress reflects a more strategic, integrated and evidence-based approach to workforce planning. While delays to consultant job planning policy approval have affected delivery in some areas, the Health Board is strengthening the governance, systems and workforce intelligence needed to support sustainable workforce transformation, reduce temporary staffing dependence, and align workforce capacity and capability with service, financial and population health priorities.

Turnover

Rolling turnover is currently 7.0%, a reduction of 0.1% compared to June 2025. Registered Nursing continues to report the lowest turnover rate at 4.8%, while Estates and Ancillary staff groups report the highest turnover rate at 11.6%. A range of retention initiatives remain in place, to support workforce stability and improve retention across the organisation.

Sickness Absence

The rolling sickness absence rate has increased marginally over the last 12 months, rising by 0.1% to 6.16% in June 2026. Long-term absence remains the primary contributor at 3.95%, compared to 0.79% for short-term absence. The in month sickness rate for June 2026 is 6.09%, which is unchanged compared to the previous month and remains higher than rates recorded during the same period over the previous two years, all of which were below 5.8%. The in month long term sickness rate has increased by 0.4% to 4.0% compared to the previous year, while the short-term sickness rate has risen by 0.1% to 0.79%. Organisation wide sickness reduction work is underway, with hotspot areas identified for targeted intervention to support staff attendance and deliver a measurable reduction in absence levels.

Agency Workforce Usage

Agency utilisation continues to improve, reducing from 3.3% in June 2025 to 2.4% in June 2026. This equates to approximately £600,000 lower in month expenditure compared to the previous year and 163 fewer equivalent FTEs utilised. Significant progress has been achieved within Registered Nursing, where agency usage is 2% lower than in June 2025. This reflects the utilisation of 112 fewer equivalent FTEs, alongside a reduction in agency expenditure of £486,876.

Performance Appraisal and Development Review (PADR)

PADR compliance stands at 80% in June 2026, remaining unchanged from the previous month but representing a 1.7% decline compared to the same period last year.

Mandatory Training Compliance

Level 1 Mandatory Training compliance remains above the organisational target of 85%, currently standing at 90.5%. Continued focus is being directed towards improving compliance among bank staff, medical staff, and departments currently below the required threshold, with targeted interventions in place to support achievement of the organisational target.

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. Whilst much of this work sits outside traditional operational performance management, it underpins delivery of the Annual Delivery Plan, NHS Wales Performance Framework, Ministerial priorities and the emerging 10-year strategy.

Overall performance is positive and improving. Encouraging progress continues across smoking cessation services, substance misuse treatment and improvement in several diabetes care process measures. There is good vaccination uptake on the majority of programmes, apart from HPV and RSV. Progress is proving more challenging diabetes care, which continues to perform below national ambition and remains a key area requiring continued executive oversight.

Areas of Positive Performance

- 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.
- The majority of vaccination and immunisations programmes continue to perform well, with particular progress on staff flu vaccination and Covid vaccination in the community. However, HPV and RSV 75+ uptake are areas of focus, together with reducing unwarranted variation and addressing inequalities remain key priorities.
- 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.
- Public Health continues to support delivery of strategic prevention programmes aligned to the Health Board's priorities, including health protection, population health management and reducing health inequalities.

Areas Requiring Focus

- Performance for diabetes care is an improving picture; however, we need to increase our improvement trajectory in order to progress our performance against other Welsh Health Boards. There is a focus on prevention, early intervention and primary care delivery.
- Continued focus is required to ensure prevention programmes are fully embedded within wider organisational planning and operational delivery, recognising that improving population health is a whole Health Board responsibility rather than solely the responsibility of the Public Health Directorate.

Next Steps

Work is underway to strengthen the Health Board's approach to Prevention and Population Health reporting through an Integrated Performance Framework aligned to the Annual Delivery Plan, NHS Wales Performance Framework, Ministerial priorities and Corporate Risk. Future reporting will place greater emphasis on concise, performance-led reporting, supported by reporting by exception and clear corrective actions for areas performing below trajectory.

Section 1
Performance and access

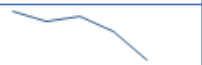
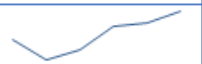
Scorecard : Performance and access – (1 of 3)

REF	Measure Description	Target Suite			Wales Benchmark	Actual Performance				Status
		NT	SM	AP		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%	-	17%	6th of 6 (at May 26)	10.6%	11.6%	10.0%		Escalate
3AP01	Number of ambulance patient handovers over 45 minutes	0	-	2318	7th of 7 (at May 26)	1960	2143	2059		Escalate
LMU02	Number of ambulance patient handovers over 1 hour	-	1710	0	6th of 6 (at Apr 26)	1697	1820	1755		Escalate
LMU03	Number of ambulance patient handovers over 4 hour	-	-	0	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	08:52		Advise
LMU05	Median emergency ambulance response time to red: emergency category calls	6-8 Mins	-	-	N/A	09:21	09:12	09:58		Advise
LMU06	Total number of attendances to Minor Injury Units (MIUs)	-	-	-	N/A	5443	5992	6232		Alert
LMU07	Total number of attendances to acute emergency departments	-	-	-	N/A	15070	15724	15771		Alert
LMU08	Median time from arrival at an emergency department to triage by a clinician	-	60	-	4th of 6 (at Mar 26)	19.00	19.00	21.00		Alert
3AP04	Median time from arrival at an emergency department to assessment by a clinical decision maker	-	-	160	5th of 6 (at Mar 26)	114.0	128.0	127.0		Alert
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	95%	-	0	6th of 7 (at May 26)	61.0%	60.3%	59.9%		Alert
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	2210	3189	7th of 7 (at May 26)	3405	3645	3793		Escalate
LMU09	Total number of patients who spent over 24 hours in the ED	-	-	0	N/A	1708	1783	1864		Escalate
LMU10	Total number of patients who spent over 48 hours in the ED	-	-	-	N/A	464	463	466		Escalate
LMU11	Number of patients who did not wait to be seen at the ED	-	-	-	N/A	1408	1725	1745		Escalate
LMU12	Consistently realise 33% of discharges by midday.	-	-	33%	N/A	17.1%	16.7%	17.2%		Alert
LMU13	Total number of unplanned returns to ED within 48 hours with the same complaint	-	-	-	N/A	1297	1356	1393		Escalate

Scorecard : Performance and access (2 of 3)

REF	Measure Description	Target Suite			Wales Benchmark	Actual Performance				Status
		NT	SM	AP		Apr-26	May-26	Jun-26	6 Month Activity	
3AP05	Number of Pathways of Care Delayed discharges (total patients)	-	0	260	8th of 8 (at Apr 26)	293	308	317		Alert
3AP06	Number of bed days lost to delayed pathways of care (total)	-	-	11628	N/A	13874	12784	13085		Escalate
LMS01	Stroke: percentage patients received CT scan within 20 minutes of clock start	-	-	-	N/A	30.9%	21.9%	23.5%		Escalate
LMS02	Stroke: percentage of eligible patients thombolysed	-	-	-	N/A	100.0%	100.0%	100.0%		Assure
LMS05	Stroke: Thrombolysis Patients with Door-To-Needle <=45 mins	-	-	-	N/A	6.3%	7.7%	0.0%		Escalate
LMS06	Stroke: percentage direct admission to ASU within 4 hours	-	-	-	N/A	29.1%	33.6%	32.3%		Escalate
3BP03	Number of patients waiting more than 26 weeks for a new outpatient appointment (Welsh Patients Only)	0	-	15.0%	7th of 8 (at May 26)	16583	16971	17378		Alert
3BP02	Number of patients waiting over 52 weeks for a new outpatient appointment	-	-	0	7th of 7 (at Mar 26)	5922	5385	4963		Advise
3BP01	Number of patients waiting more than 104 weeks for referral to treatment	0	2112	1597	8th of 8 (at May 26)	2436	2528	2191		Alert
3BP14	Percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)	75%	55%	56%	6th of 6 (at May 26)	52.6%	53.9%	53.5%		Escalate
3BP15	Number of patients on an active suspected cancer pathway after day 62	-	-	1286	N/A	192	211	221		Escalate
3BP16	Number of pathways waiting more than 8 weeks for a specified diagnostic (all ages)	0	6242	12000	7th of 7 (at May 26)	12386	10461	8465		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	95%	-	-	8th of 8 (at May 26)	40.3%	38.9%	38.4%		Alert
3BP04	Number of patients waiting for a follow up outpatient appointment who are delayed by over 100%	96,059	137002	138903	7th of 7 (at May 26)	131031	137003	139713		Alert
3EP01	Percentage of Local Primary Mental Health Support Service (LPMHSS) assessments undertaken within (up to and including) 28 days of the date of receipt	80%	-	80.0%	5th of 7 (at May 26)	92.9%	93.3%	86.8%		Assure
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%	6th of 7 (at May 26)	78.1%	82.8%	81.8%		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	80%	-	80.0%	4th of 7 (at May 26)	84.4%	89.9%	88.3%		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%	5th of 7 (at May 26)	85.5%	85.7%	90.7%		Assure

Scorecard : Performance and access (3 of 3)

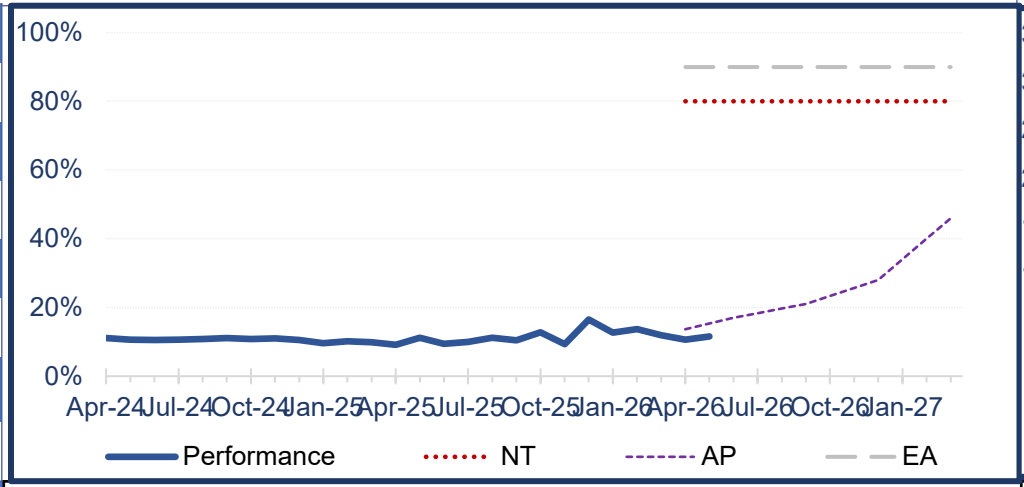
REF	Measure Description	Target Suite			Wales Benchmark	Actual Performance				Status
		NT	SM	AP		Apr-26	May-26	Jun-26	6 Month Activity	
LMM01	Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan (for those age 18 years and over)	-	-	-	5th of 7 (at Mar 26)	86.5%	86.6%	RIA		Alert
NPF19	Percentage of patients waiting less than 26 weeks to start a psychological therapy in specialist Adult Mental Health	80%	-	-	3rd of 7 (at Mar 26)	50.6%	50.0%	51.2%		Alert
3DP06	Material reduction in the number of adult mental health out of area placements	-	-	-	N/A	27	16	RIA		Alert
NPF18	Percentage of children and young people waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment	80%	-	-	7th of 7 (at Mar 26)	12.2%	12.7%	RIA		Alert
3BP05	Number of patients (all ages) waiting more than 14 weeks for a specified therapy (excluding audiology)	0		-	6th of 7 (at Mar 26)	1423	1632	1676		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	-	-	N/A	20	31	46		Advise
NPF31	Number of children waiting more than 6 weeks for all audiology pathways (to include new assessment and intervention pathways)	0	-	-	N/A	678	695	741		Alert
3BP11	Percentage of lists with a start time 15 minutes or more past the scheduled start time	-	-	-	N/A	41.4%	40.2%	41.1%		Alert
3BP12	Percentage of theatre procedures finished more than 60 minutes early	-	-	-	N/A	23.2%	22.4%	26.1%		Alert
LMP01	Number of cases per theatre session	-	-	-	N/A	2.1	2.1	2.1		Alert
LMP02	Percentage of scheduled operations cancelled either on the day or the day before the scheduled operation	-	-	-	N/A	12.9%	12.7%	15.1%		Alert
LMP03	Percentage Treat in Turn Rate (Stage 4)	-	-	-	N/A	20.0%	25.0%	23.0%		Alert

UEC: Ambulance Handover

Metric Overview	ID	Metric	SM De-escalation	Planning / Performance Framework	Q1	Q2	Q3	Q4
	3AP02	Percentage of ambulance patient handovers within 15 minutes	N/A	90%	17%	21%	28%	46%
	3AP01	Number of ambulance patient handovers over 45 minutes	970 (1 hr handover)	Zero	2,318	1,923	1,282	950

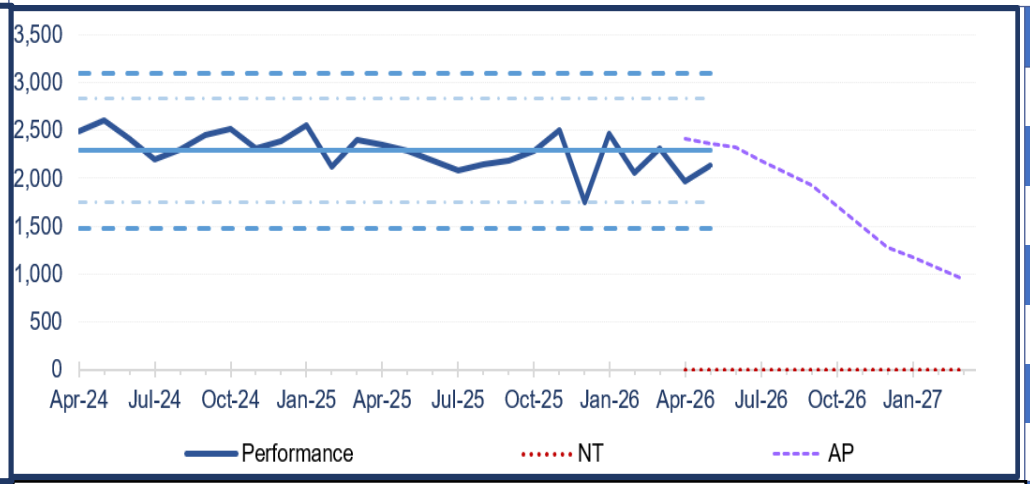
Percentage of ambulance patient handovers within 15 minutes

Latest Month	Profile	Actual	Status	Benchmark
June 2026	17%	10.6%	Escalate	BCU ranked as 6 of 6 as of May 2026



Number of ambulance patient handovers over 45 minutes

Latest Month	Profile	Actual	Status	Benchmark
June 2026	2,318	2,059	Escalate	BCU ranked 6 of 6 as of May 2026.



What does the data tell us? – Performance against these two metrics at the start of the emergency pathway are in line with previous months activity but fall short of national expectations and is significantly below the 90% target. Performance relating to ambulance handovers exceeding 45 minutes is below the Quarter 1 profile but remains significantly above the Welsh Government expectation of zero. Management information shows Wrexham Maelor had a positive week commencing 6th July with 17% handovers taking place over 45 minutes. Focused improvement is required over the next month to maintain alignment with the planned trajectory and support delivery within the performance framework.

Actions being taken to improve – An integrated UEC Improvement Plan, setting out targets and trajectories to achieve Handover 45 by September 2026, has been agreed. The UEC improvement plan focuses on: Optima hospital flow - Discharge to Recover then Assess (D2RA), Frailty at the front door and Clinical engagement. These priority areas are designed to enhance flow and are expected to contribute towards improvements in Handover 45 performance, alongside other interventions.

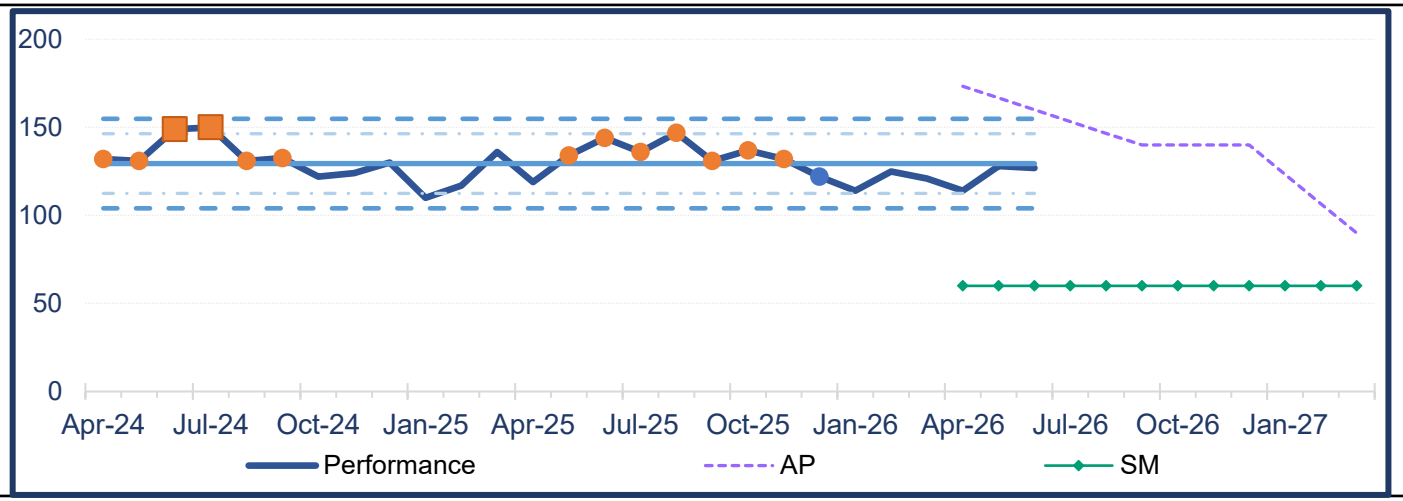
Expected impact upon forecasted performance –Performance against 15-minute handovers did not meet the expected quarter 1 target and presents a significant delivery risk for Quarter 4. While performance for handovers exceeding 45 minutes met the quarter 1 trajectory, substantial and sustained improvement will be required to achieve the national target of zero by September 2026

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
June 2026
Profile
160
Actual
127
Status
Advise



Benchmark	BCU ranked 5 of 6.

What does the data tell us? Performance improved between February and April 2026, with the median time to assessment reducing by 11 minutes. Performance then deteriorated in May, reaching 128 minutes, with a further one-minute improvement noted in June. Performance remains ahead of the health board trajectory of 160 minutes, it is still 57 minutes above the national and special measures target of 60 minutes.

Actions being taken to improve – The Emergency Department workforce business case was approved by the Health Board in June 2026, securing up to £6.65 million recurrent funding to support implementation of the Resident Doctors Contract, establish compliant staffing rotas, and increase substantive staffing levels. This investment is expected to reduce reliance on locum and agency staff while strengthening workforce sustainability across Emergency Departments.

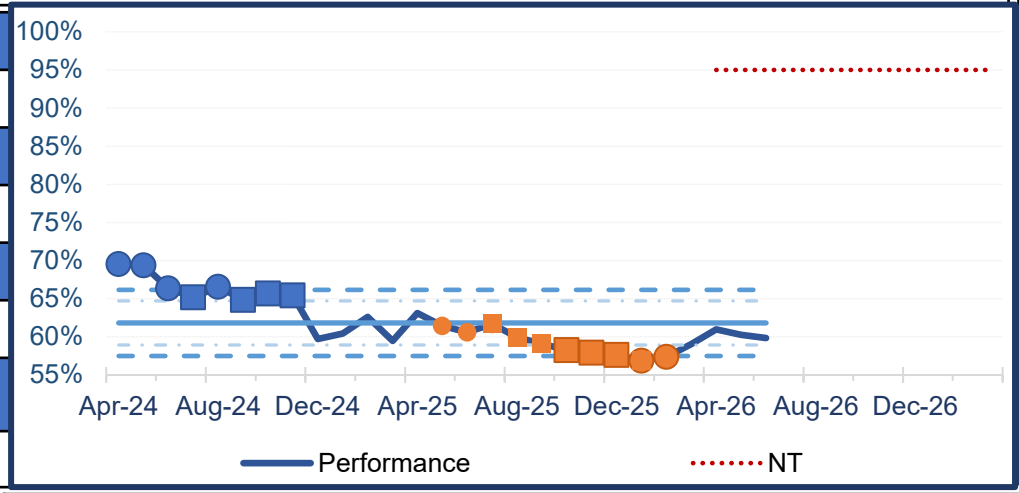
Expected impact upon forecasted performance – Based on the current trend, the median time to clinical decision maker is meeting the health board's internal trajectory and, if this rate of improvement is sustained, remains on course to deliver the required target by March 2027.

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

Metric Overview	ID	Metric	SM De-escalation	Planning / Performance Framework	Q1	Q2	Q3	Q4
	Local	Number of patients who spend 4 hours or more in ED 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 (35%)	2,743 (30%)	2,297 (25%)	1,850 (20%)

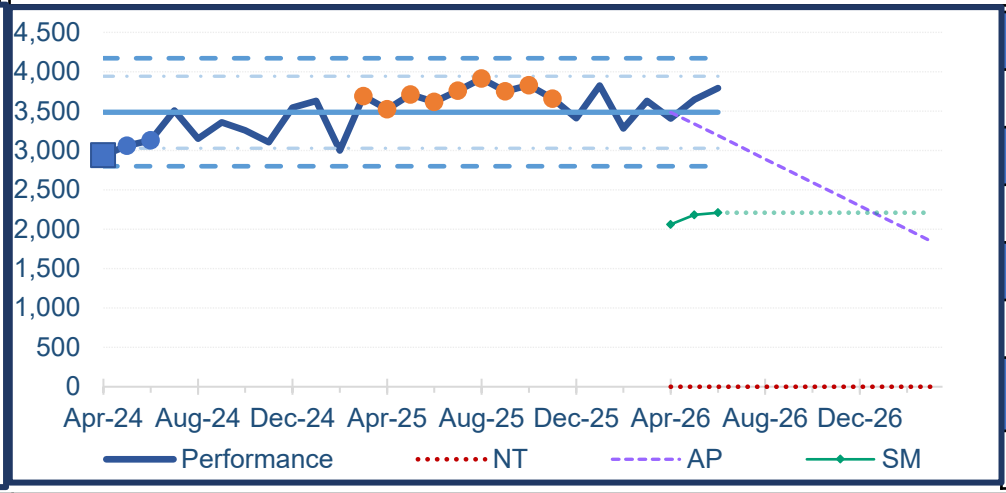
Number of patients who spend 4 hours or more in ED

Latest Month	Profile	Actual	Status
June 26	95%	59.9%	Escalation



Benchmark BCU ranked as 6 of 7 as of May 2026.

Number of patients who spend 12 hours or more in ED



Latest Month	Profile	Actual	Status
June 26	3,189	3,793 (17.2%)	Escalation

Benchmark BCU ranked as 7 of 7 as of May 2026.

What does the data tell us? Performance against both metrics is below the health board's trajectory and the special measures target of 10% for 12-hour delays in ED and MIU's by September 2026. In June 2026, performance deteriorated slightly in the number of patients waiting over four hours in the Emergency Department compared to the previous month. BCU twelve-hour performance for June is 17.2%, West 13%, Central 17.8 and East 20.9%. Integrated Health Communities (IHCs) have agreed UEC improvement plans with actions aligned to achieving the 10% target by September 2026, demonstrating a clear commitment to improving performance. However, given current operational pressures and the scale of improvement required, confidence in achieving the target remains low. Despite this, IHCs remain focused on delivering their plans and maximising all opportunities to improve performance over the coming months.

Actions being taken to improve – A pilot Urgent Treatment Centre (UTC) will be introduced within the Ysbyty Glan Clwyd ED footprint, led by Emergency nurse practitioners (ENPs) and supported by middle-grade doctors, to manage patients with minor injuries and illnesses and improve patient flow. Care in Undesignated Areas remains a key risk, with additional flexible staffing being deployed in line with GIRFT guidance to support the elimination of corridor care. Across Ysbyty Gwynedd and Wrexham Maelor, greater use of SDEC, DOSA, MDUs and specialty hot clinics is being pursued to increase same-day assessment and treatment and reduce avoidable admissions. A further review of Professional Standards is underway to strengthen specialty response times in ED, supported by improved performance visibility to identify delays and drive timely intervention.

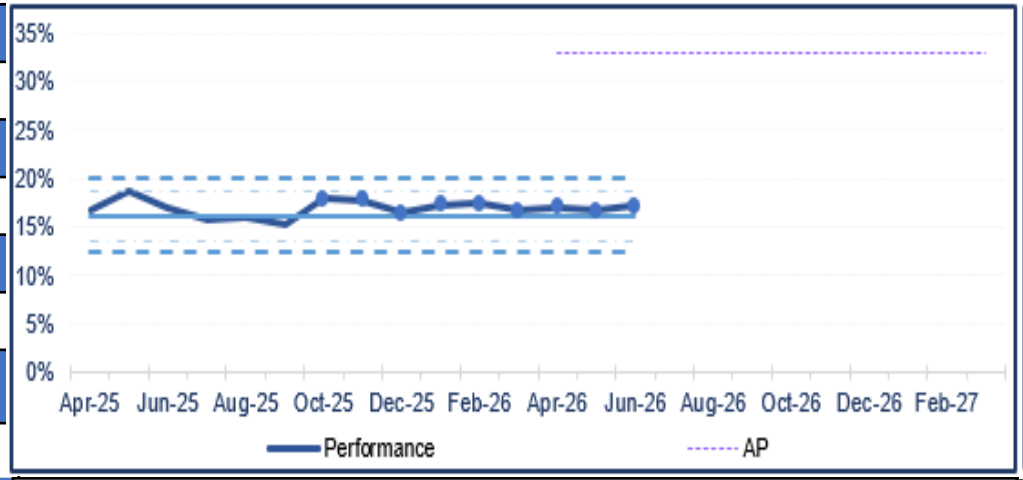
Expected impact upon forecasted performance – Both metrics did not meet the Q1 target. Further sustained improvements will be required as part of ongoing improvement plans to improve the position

UEC: Discharges before midday

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

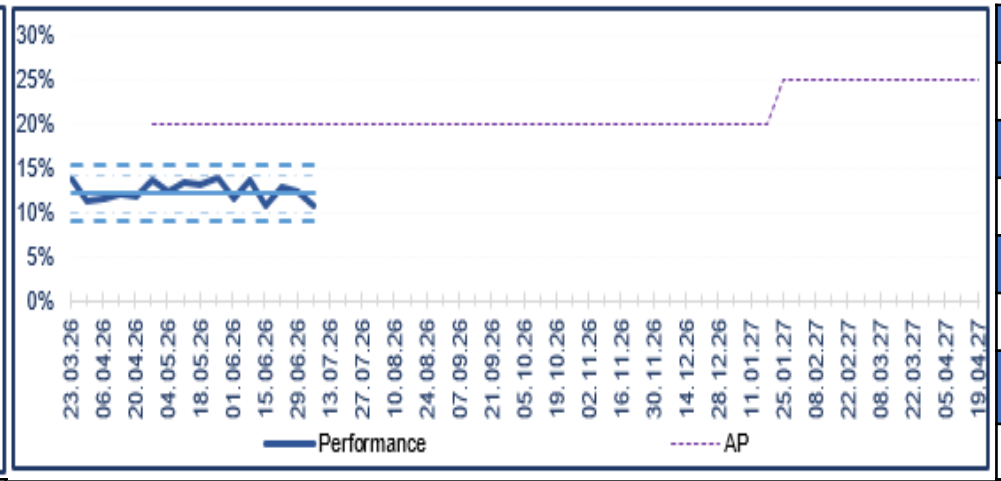
Discharges before midday - Weekday

Latest Month	Profile	Actual	Status	Benchmark
June 2026	33%	17.2%	Alert	N/A



Discharges before midday - Weekend

Latest Month	Profile	Actual	Status	Benchmark
w/c 6th June	17%	10.9%	Alert	N/A



What does the data tell us? – Both metrics remain below the agreed trajectory. However, weekday performance has shown slight improvement, improving by 0.5% in June. Weekend discharges have deteriorated by 1.3% in June reflecting ongoing operational pressure, a widening gap against plan, and a continued adverse impact on patient flow, including afternoon bottlenecks.

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

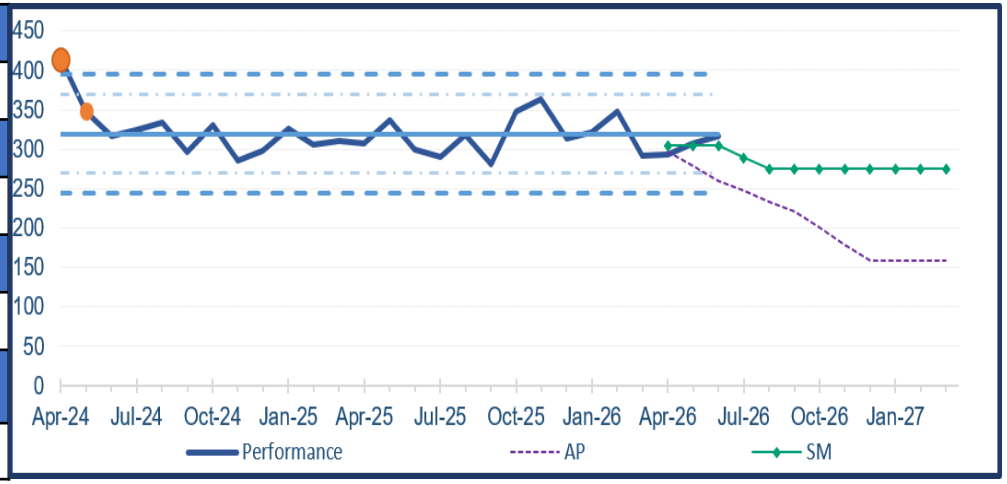
Expected impact upon forecasted performance – The Health Board did not achieve its quarter 1 target for discharges before midday. Based on current performance trends, discharge levels are not forecast to deliver the step change required during Quarter 2 to achieve planned trajectories.

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

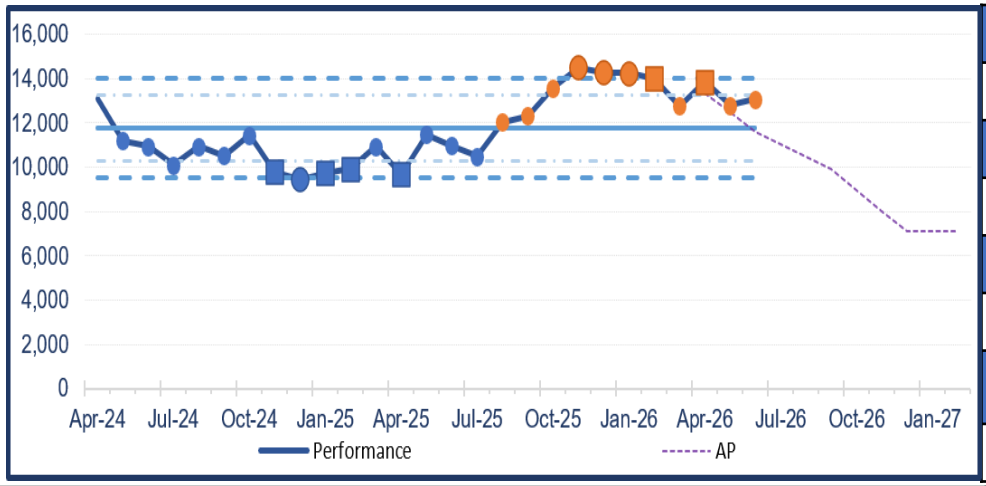
Latest Month
June 2026
Profile
260
Actual
317
Status
Alert



Benchmark

BCU ranked as 8 of 8 as of May 2026.

Number of bed days lost to delayed pathways of care



Latest Month
June 2026
Profile
9,926
Actual
11,628
Status
Escalate

Benchmark

N/A

What does the data tell us? Patients on a Delayed Pathway of Care (PoCD) increased by 9 in June and remain above both the Special Measures de-escalation trajectory and the Annual Plan trajectory. Bed days lost due to PoCD totalled 11,628 in June, 17.2% above the Quarter 1 profile. West IHC continues to be a significant outlier, accounting for 50.4% (6,592) of all bed days lost across BCU. Within West, 43.3% of delayed bed days relate to patients with mental health and learning disabilities, a substantially higher proportion than in other IHCs. Whilst the number of patients on delayed pathways remains broadly comparable across IHCs (Central 82, East 113, West 122), Central continues to achieve more timely discharges through stronger community discharge capacity. In contrast, longer delays in West and East are driving the higher level of bed days lost despite similar patient volumes.

Actions being taken to improve – North Wales partners are implementing a regional improvement programme focused on strengthening oversight of POCDs through the Right Patient Right Place (RPRP) dashboard, standardising escalation processes, and ensuring timely movement through Discharge to Recover and Assess (D2RA) pathways. Key initiatives include establishing Integrated Discharge Hubs, embedding a Home First approach, introducing Trusted Assessments to reduce duplication, and improving data quality and consistency to support faster discharge decision-making.

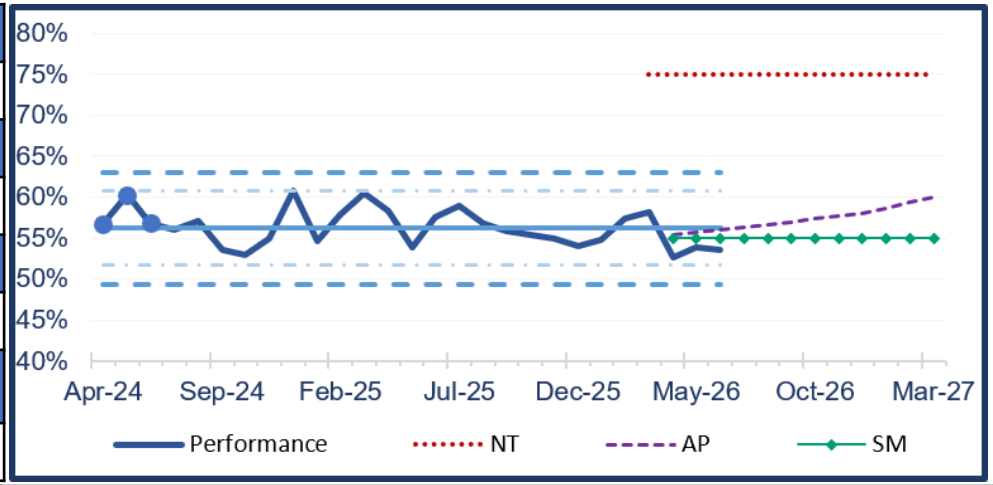
Expected impact upon forecasted performance –Significant improvement will need to be made over the next month to meet ongoing targets. Continual improvement in reducing the number of delays is predicted but reducing the days delays will require focused actions

Planned Care: Suspected Cancer Pathway

Metric 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

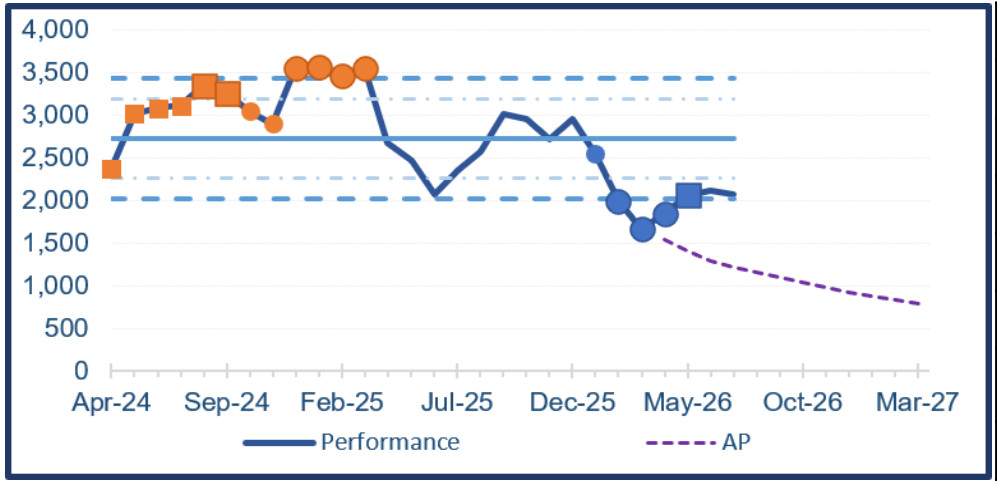
Suspected cancer pathway 62 days wait

Latest Month	Profile	Actual	Status
June 2026	56.0%	53.5%	Escalate



Benchmark: BCU ranked 6 of 6 at May 2026

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



Latest Month	Profile	Actual	Status
July 2026	1,222	2,067	Escalate

Benchmark: Number of patients after day 62 has increased across all health boards but percentage increase higher within BCUHB

What does the data tell us? - Cancer performance has shown no improvement since January 2025. The number of patients waiting over 62 days on a suspected cancer pathway continues to increase with both metrics adverse to the agreed trajectory. There is Welsh Government expectation that the health board attains performance of 55% by the end of Quarter 2. Between January and May 2026, 25,165 patients were told that they did not have cancer.

Actions being taken to improve – A plan has now been agreed to reduce the backlog of dermatology patients through an increase in teledermoscopy, additionality and locum recruitment. For Breast surgery additional theatre capacity has been agreed to reduce waits and recover position by end of September. Insourced prostate capacity recommenced in June and will continue for six months whilst service reviews biopsy capacity.

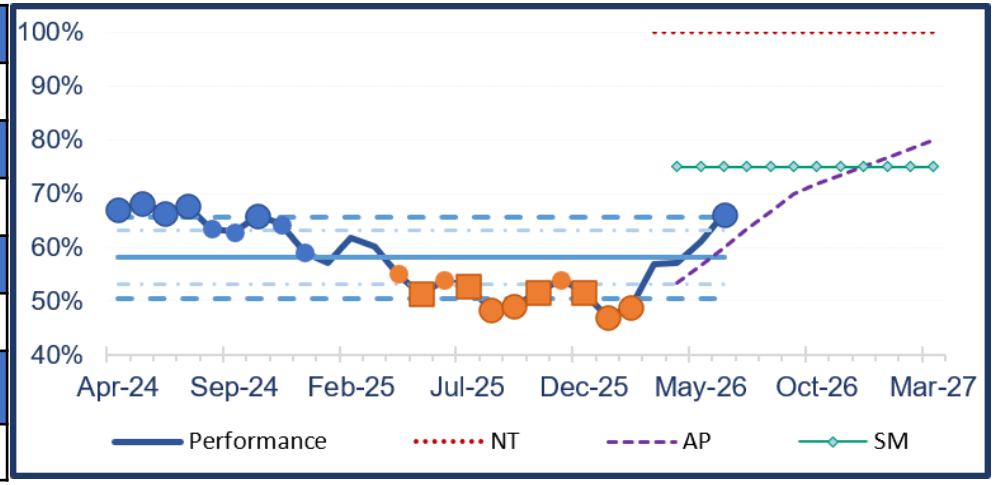
Expected impact upon forecasted performance – Timely mobilisation of actions is key to delivery recovery. The continued increase in number of patients on an active pathways after day 62 places significant risk on delivery of targets during quarter 2. Escalation has taken place to address the issues.

Planned Care: 8-weeks Diagnostic Waits

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

8 weeks diagnostic waits

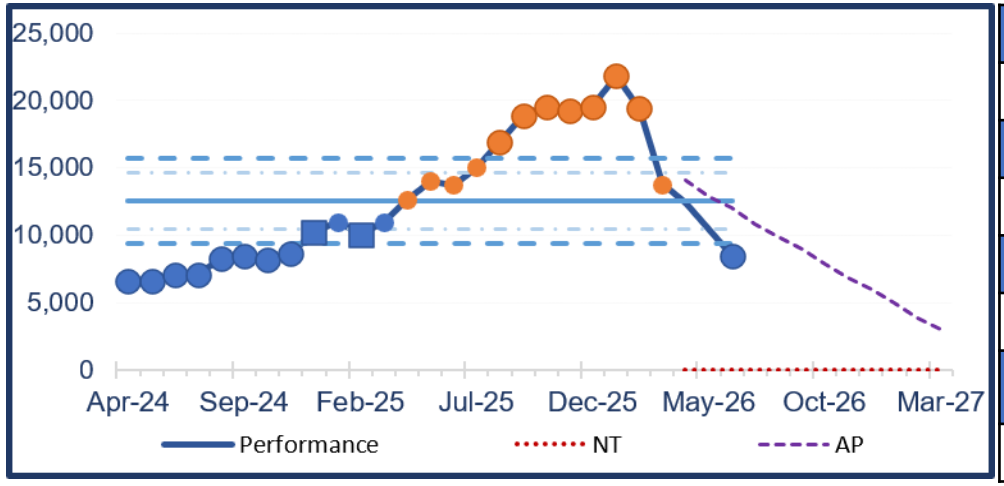
Latest Month
June 2026
Profile
60.0%
Actual
66.1%
Status
Alert



Benchmark

BCU ranked 7 of 7 at May 2026

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



Latest Month
June 2026
Profile
12,000
Actual
8,465
Status
Alert

Benchmark

BCU ranked 7 of 7 and accounts for 29% of all Wales backlog at May 2026

What does the data tell us? – Waiting times for **diagnostic** procedures within 8 weeks improved by 61% from January 2026 falling to below 9,000 at the end of June with performance ahead of trajectory at the end of quarter 1. Despite this improvement 8,465 patients are waiting over 8 weeks for a diagnostic procedure against a national target of zero with Welsh Government expectation to reach the 75% by end of September 2026 rather than the IMTP trajectory of end of quarter 3. Challenges remain around modalities of Endoscopy, Imaging and Pathology.

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

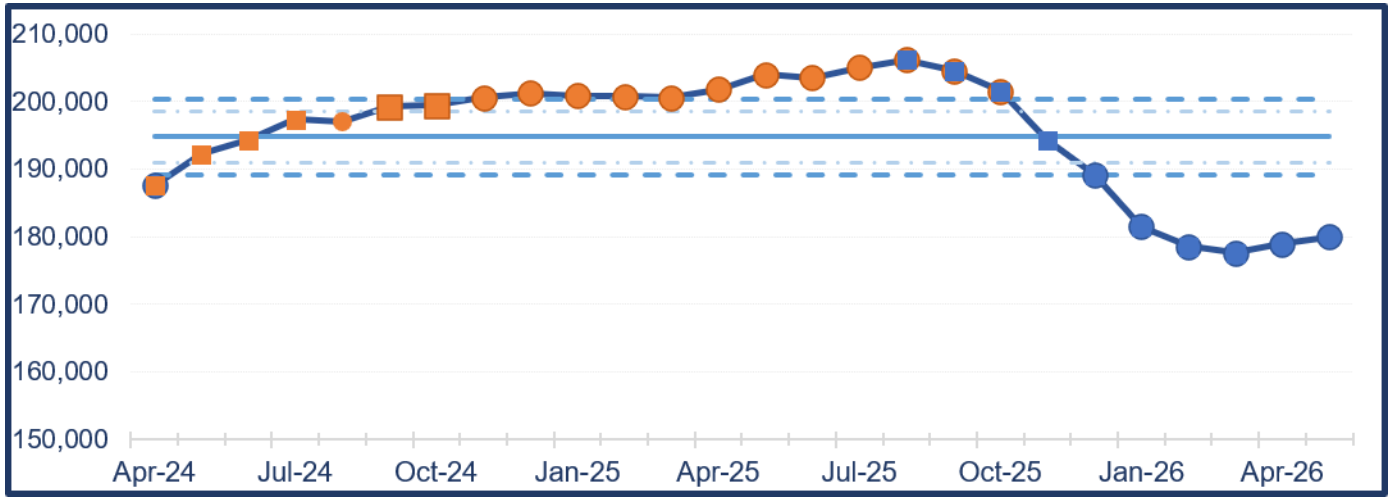
Expected impact upon forecasted performance – Finalisation of plans within key pressure areas of endoscopy, non obstetric ultrasound and echocardiogram in addition to securing required arrangements beyond first half beyond the end of the first quarter is key for continuation of improvement trajectory Q2 onwards. Sustainability remains a challenge.

Planned Care : Referral to Treatment Metrics

Metric Overview	ID	Metric	SM De-escalation	Planning / Performance Framework	Q1	Q2	Q3	Q4
	Local	Total RTT Pathways	N/A	N/A	Reduction	Reduction	Reduction	Reduction

Total RTT Pathways

Latest Month
June 2026
Profile
Reduction
Actual
180,619
Status
Alert



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

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

Actions being taken to improve – Active programme of delivery with two concurrent programme approach – i) in year delivery programme to tackle immediate improvement through additional investment and ii) major change programme for long-term sustainable systemic improvement embedding best practice. The Planned Care Major Change Programme provides the framework to integrate pathway redesign, national best practice, GIRFT recommendations and value-based healthcare principles. One on the focuses of this programme is to improve referral management with a focus on best practice, community health pathways and advice and guidance. The programmes and plans are supported by the Intensive Support Team (sponsored by the partnership of the health board, Welsh Government and NHS Performance and Improvement).Work is

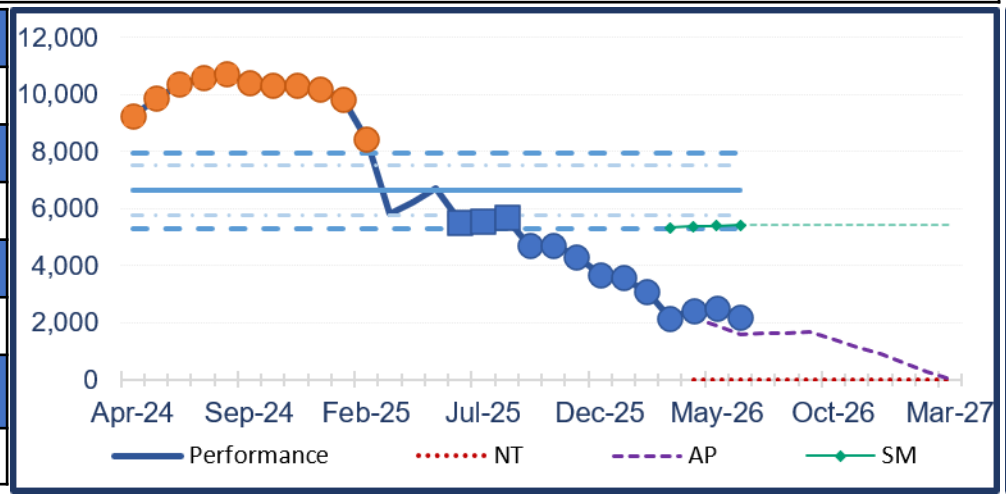
Expected impact upon forecasted performance – The overall waiting list should continue to fall as workstreams are mobilised as part of the operational improvement plans and the major change programme – however there has been an increase over the last 3 months

Planned Care : Referral to Treatment Metrics

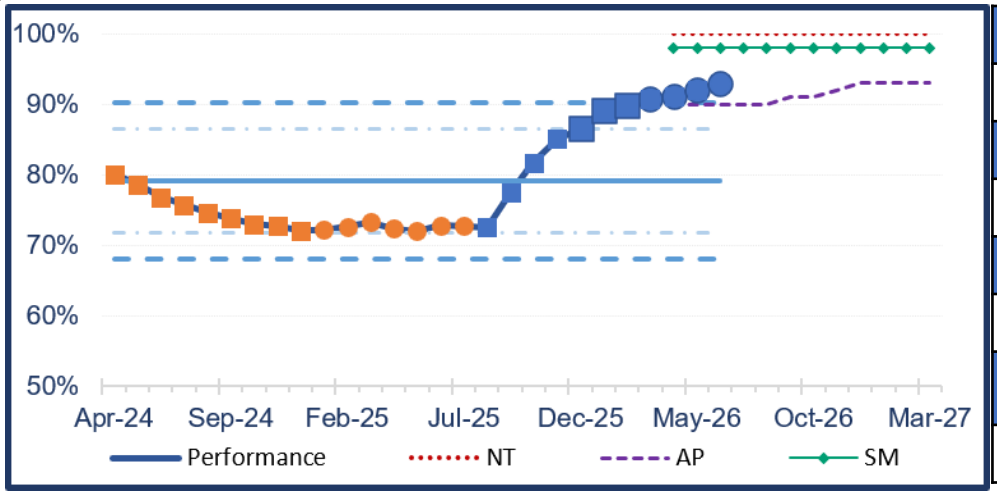
Metric Overview	ID	Metric	SM De-escalation	Planning / Performance Framework	Q1	Q2	Q3	Q4
	3BP01	104 weeks for referral to treatment	3% of open pathways	Zero	1,597	1,668	894	0
	3BP02	Open outpatient pathways waiting < 52 weeks	98%	100%	90%	91%	93%	93%

104 weeks for referral to treatment

Latest Month
June 2026
Profile
1,597
Actual
2,191
Status
Alert



Open outpatient pathways waiting < 52 weeks



Latest Month
June 2026
Profile
90%
Actual
93.0%
Status
Advise

Benchmark	BCU ranked 8 of 8 at May 2026	BCU ranked 7 of 8 at May 2026	Benchmark

What does the data tell us? – There has been a reduction in overall number of patients waiting for treatment over 2-years from 10,400 in July 2024 to under 2,200 at end of March 2026. Whilst performance was adrift to profile during April and May the end of June position was in line with end of March level but was adrift of the trajectory within the IMTP. The health board met the end of Q1 trajectory for % of open outpatient pathways within 52 weeks (93% at latest month against trajectory of 90%). The number of patients waiting over 52 weeks for a first new outpatient appointment has reduced from 31,000 in August 2025 to <5,000 at the end of June 2026 (83% improvement) but remains below 98% national target.

Actions being taken to improve – Work is taking place to finalise the single integrated recovery plan for planned care led by the recently appointed Recovery Director working to the Chief Operating Officer with continuation of focused support by the national intervention support team. This work which has specialty level focus is expected to strengthen delivery grip, coordination and pace of improvement and includes focus on both internal productivity opportunities as well as assessing additionality where relevant .

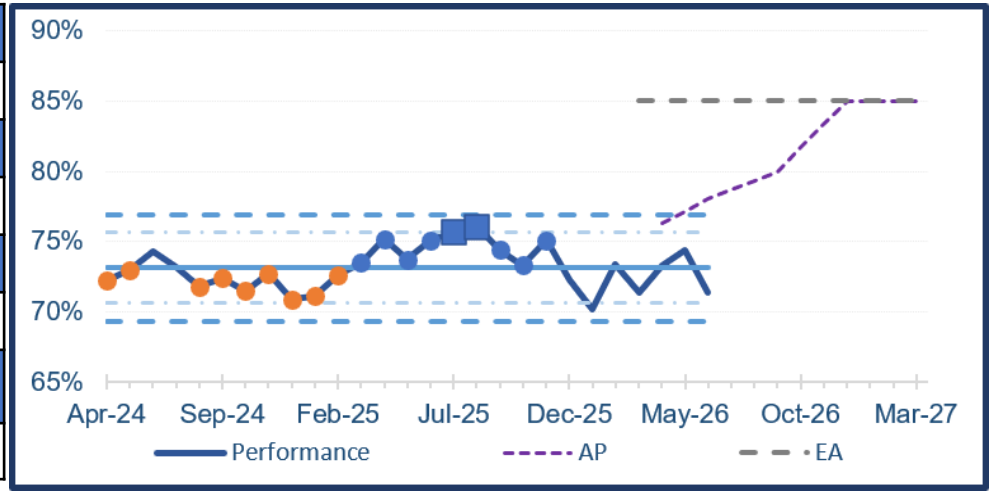
Expected impact upon forecasted performance – Current forecast data indicates that the 104 weeks metric will not meet the IMTP Q2 profile with current data indicating waits of c2,500 at quarter end. Re-profiling of delivery trajectories is currently underway as part of the single recovery plan review.

Planned Care : Productivity / Utilisation

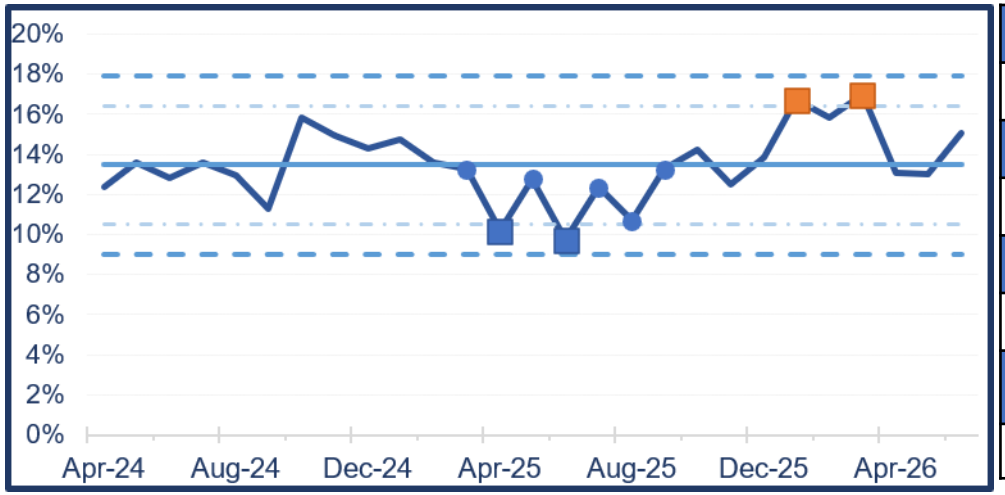
Metric Overview	ID	Metric	SM De-escalation	Planning / Performance Framework	Q1	Q2	Q3	Q4
	3BP13	Theatre session overall utilisation is reported as a key KPI to underpin the GIRFT standard	N/A	85%	78%	80%	85%	85%
	LMP02	Theatre Short Notice Cancellations	N/A	N/A	N/A	N/A	N/A	N/A

Theatre Session Overall Utilisation

Latest Month
June 2026
Profile
78%
Actual
71.4%
Status
Alert



Theatre Utilisation – Short Notice Cancellations



Latest Month
June 2026
Profile
N/A
Actual
15.1%
Status
Alert

What does the data tell us? – Performance against the overall utilisation metric has fluctuated between 70% and 76% over the last thirteen months. Whilst this remains within normal variation the position was over 6% adrift of the end of quarter 1 target and with the trajectory requiring improvement to 85% by end of March 2027, current performance does not suggest stepped change to reach required level. Cases per session (CPS) needs to monitored alongside overall utilisation. Latest twelve months data indicates that performance varies from 2.0 top 2.3 cases per session. At local level, the performance has been below 70% in West IHC (Oct-25, Mar-26) and East IHC (Jan-26) during the last twelve calendar months. Short notice cancellation data is at 15% as at end of June, the rate is c5% higher than same period last year.

Actions being taken to improve – Self assessment submitted nationally and meetings taking place to identify opportunities / gaps and risks to help inform planned care improvement plans with review meetings with national performance and improvement team ongoing with final specialty review to be completed by end of July. Findings from the self-assessment specialty reviews will inform priority actions, although the approach to incorporating these into service and transformation plans may need to align with any revised recovery plan priorities

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

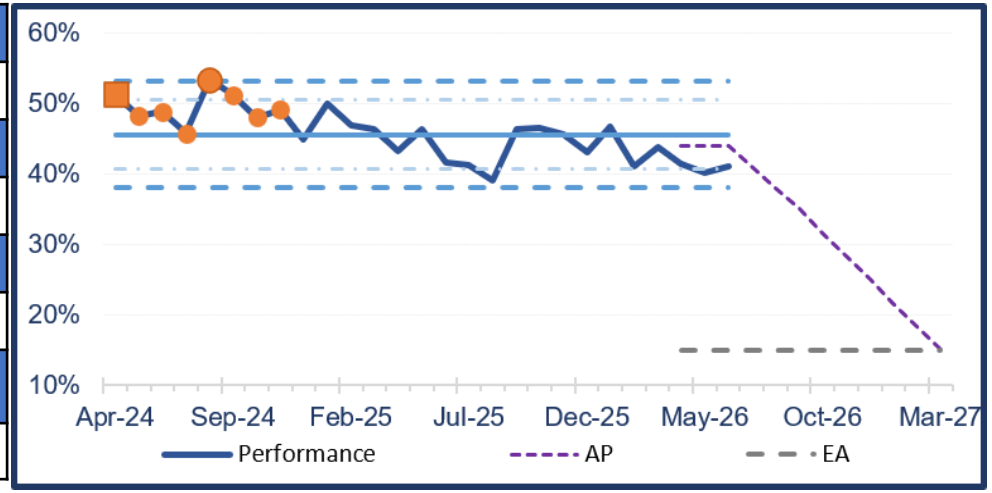
Area	CPS
West	2.0
Central	2.0
East	2.3
BCU	2.1

Planned Care : Productivity / Utilisation

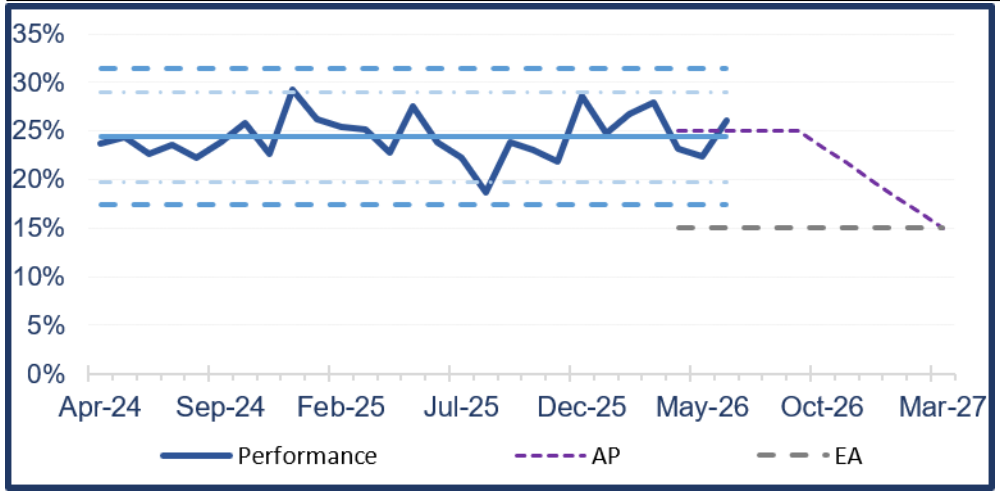
Metric Overview	ID	Metric	SM De-escalation	Planning / Performance Framework	Q1	Q2	Q3	Q4
	3BP11	Theatre session utilisation is improved to achieve GIRFT standard late starts (>15 mins)	N/A	<15%	44%	35%	25%	15%
	3BP11	Theatre session utilisation is improved to achieve GIRFT standard of early finishes (>60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

Theatre Utilisation – Late Start

Latest Month
June 2026
Profile
44.0%
Actual
41.1%
Status
Alert



Theatre Utilisation – Early Finish



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

What does the data tell us? – Data on late start in excess of fifteen minutes indicate that site pressures were the main contributor over the last three months with ward escalation and ward delay accounting for highest recorded late start reasons. During the period April – June 2026, the performance has been below the 44% target ranging between 40% and 41%.

For early finishes, overall performance over the last three months indicate that 24% of lists have early finish with completion of planned cases and cancellation of patients being the main reasons noted for theatre session early finish. Trauma and Orthopaedics and Urology are the specialties with main volume of early finish during the period.

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

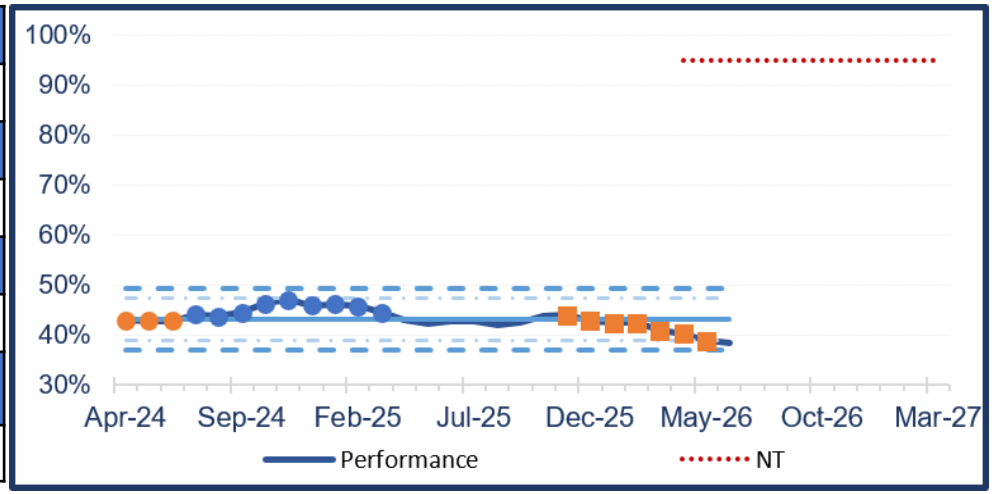
Expected impact upon forecasted performance – Levels of opportunity to increase theatre utilisation differ at specialty level dependent on procedure time.

Planned Care : Outpatient Activity

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

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

Latest Month
June 2026
Profile
Improvement
Actual
38.4%
Status
Alert



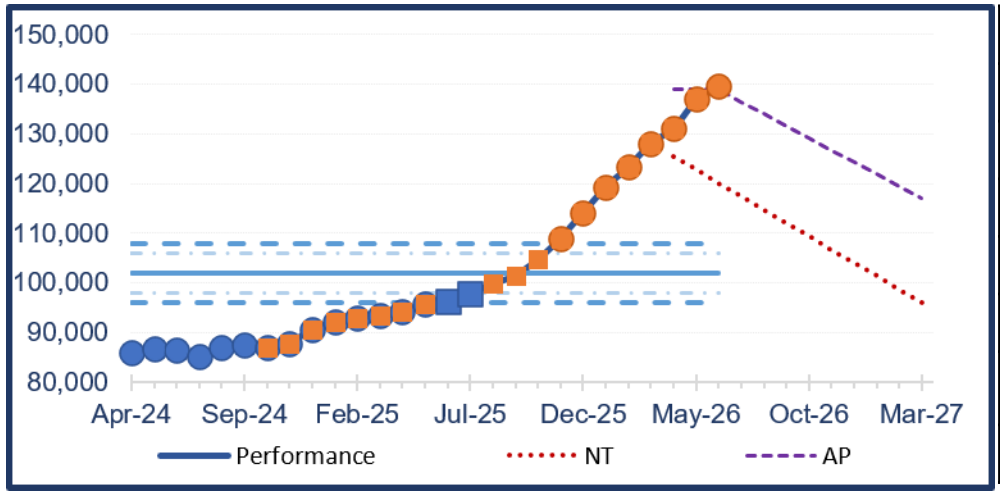
Benchmark BCU ranked 8 of 8 at May 2026

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

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

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

Follow Up Delayed by over 100%



Latest Month
June 2026
Profile
138,903
Actual
139,713
Status
Alert

Benchmark BCU ranked 7 of 7 at May 2026

What does the data tell us? – Number of patients overdue by 100% has been increasing month on month and adrift of end of Q1 trajectory by over 1k. The position is 45% higher than same reporting point in 2025 The health board accounts for 44% of the all Wales total

Actions being taken to improve – National Self-Management Protocols have been adopted and shared across services to support discharge and follow-up pathways. They have underpinned the expansion of See on Symptom (SOS) and Patient Initiated Follow-up (PIFU), with Q1 implementation in Dermatology and Breast pathways. A pilot to validate patients waiting 100% beyond target date has commenced in Gynaecology, with 25% of initial cohort of 805 patients appropriately closed.

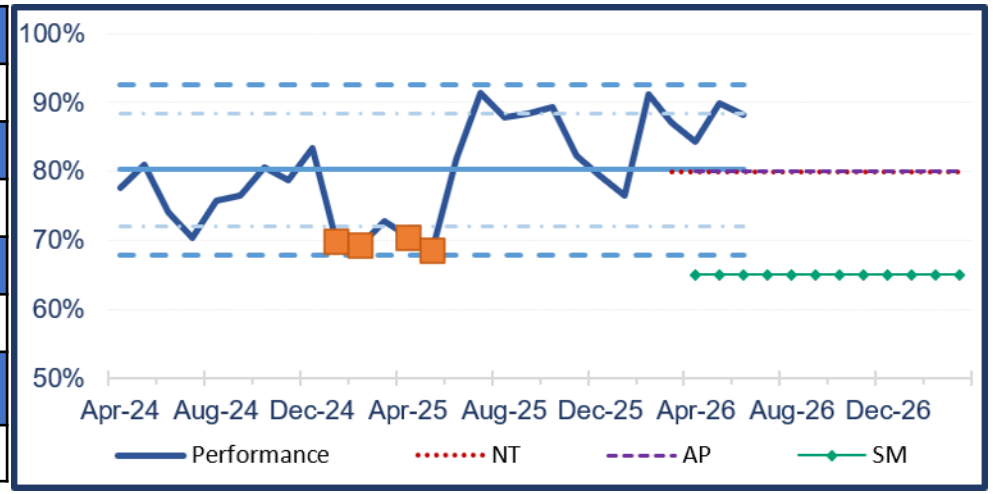
Expected impact upon forecasted performance – Actions are expected to significantly address follow up backlog volumes which will enable a re-balance of new to follow up ratio / clinical validation activity.

Adult Mental Health Measures

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

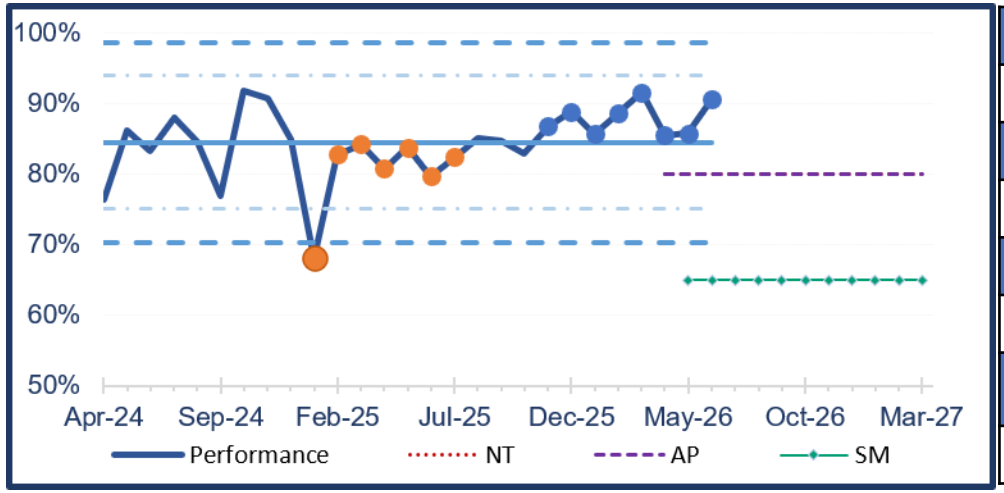
Mental Health Measure Part 1a - Assessments

Latest Month
June 2026
Profile
80%
Actual
88.3%
Status
Assure



Benchmark BCU ranked 4th of 7 at May 2026

Mental Health Measure Part 1b - 1st Intervention



Latest Month
June 2026
Profile
80%
Actual
90.7%
Status
Assure

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

What does the data tell us? Health Board performance remains compliant against both Adult Mental Health Measure targets. In **June 2026**, **88.3%** of adult assessments and **90.7%** of first therapeutic interventions were delivered within 28 days, both exceeding the national 80% standard. Overall performance has remained stable; however, variation across localities and pathways continues. The focus is increasingly shifting from maintaining overall compliance to improving equitable access and reducing unwarranted variation across the Health Board.

Actions being taken to improve? Recovery plans remain in place within areas of greatest operational pressure. The recent Corporate Performance Accountability Review confirmed that recovery activity continues through additional operational leadership, targeted capacity, management of long-wait cohorts and ongoing monitoring through established governance arrangements. Improvement activity remains focused on reducing variation whilst maintaining patient safety and supporting sustainable recovery.

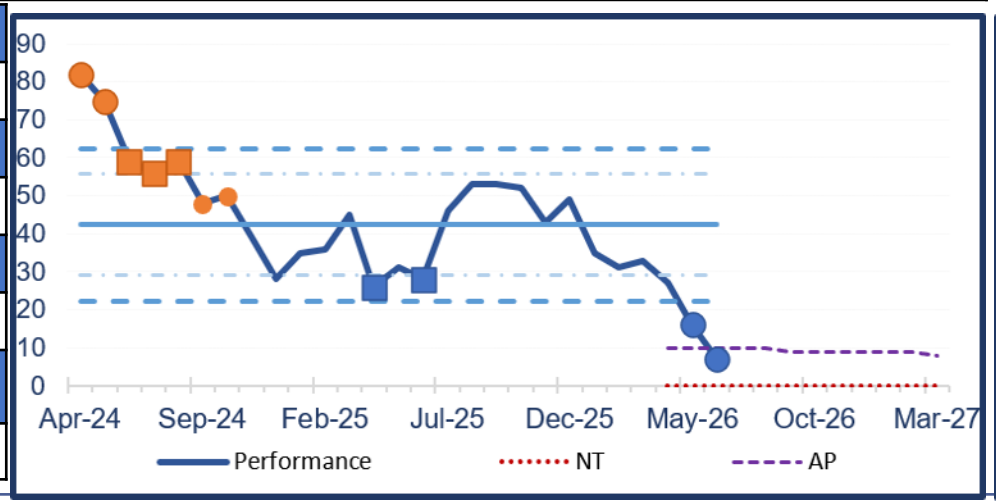
Expected impact upon forecasted performance Overall Health Board compliance is expected to remain above the national standard. Continued improvement is anticipated through delivery of local recovery plans, with a particular focus on reducing locality variation and the number of patients experiencing extended waits. A trajectory towards achieving the Part 2 standard by Quarter 4 has also been described operationally and will provide additional assurance as recovery progresses.

Adult Mental Health Measures

Metric Overview	ID	Metric	SM De-escalation	Planning / Performance Framework	Q1	Q2	Q3	Q4
	3DP06	Material reduction in the number of adult mental health out of area placements	N/A		10	9	9	8
	3BP05	Percentage of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health	N/A	80%	72%	72%	72%	72%

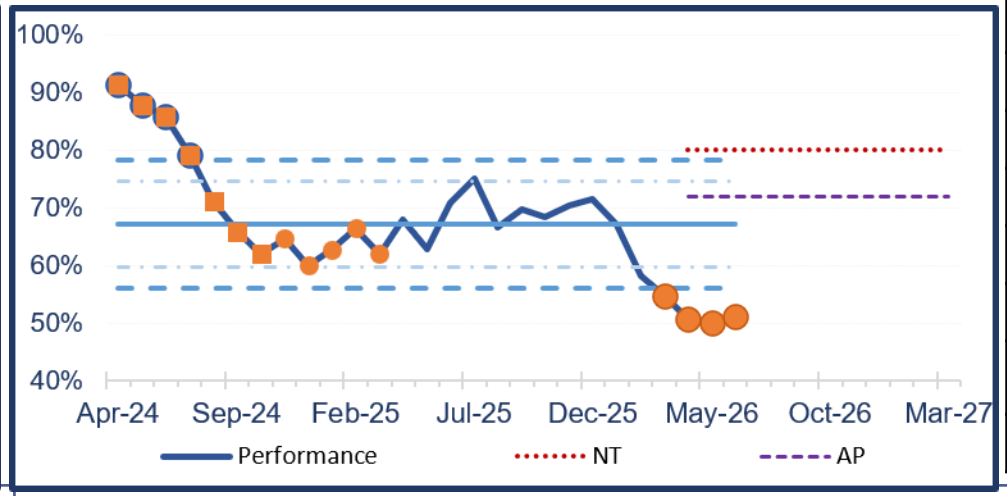
Out of Area Placements

Latest Month
June 2026
Profile
10
Actual
7
Status
Alert



Benchmark N/A

Psychological Therapies



Latest Month
June 2026
Profile
80%
Actual
51.2%
Status
Alert

Benchmark BCU ranked 6th of 7 at May 2026

What does the data tell us? Psychological Therapies performance remains below the national 80% standard, with 51.2% of patients starting treatment within 26 weeks in June. Health Board performance continues to be affected by variation across localities, with operational intelligence indicating that suitable accommodation and clinic capacity constraints remain significant factors affecting service delivery. Out-of-Area Placements continue to demonstrate sustained improvement, reducing further to 7 placements at end of June reporting position, representing the lowest sustained position since November 2022 and reflecting continued progress in reducing reliance on out-of-area care.

Actions being taken to improve For Psychological Therapies, recovery activity continues through operational oversight, recruitment and retention initiatives, and work to improve appropriate accommodation and clinic capacity. Recovery trajectories are being developed following the recent Corporate Performance Accountability Review. For Out-of-Area Placements, seven-day operational oversight, strengthened discharge planning, daily review processes and close partnership working continue to support reductions in placement numbers and duration.

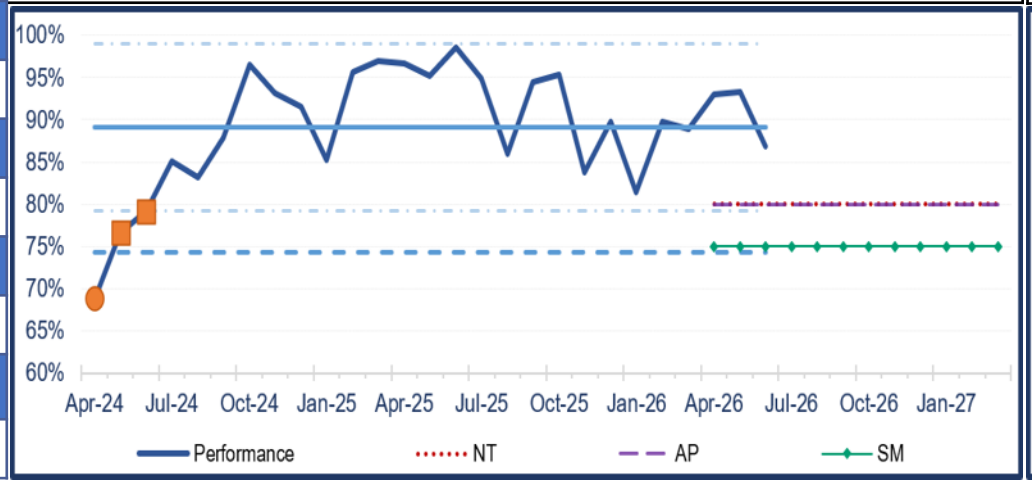
Expected impact upon forecasted performance Psychological Therapies performance is expected to improve as operational capacity constraints are addressed, although recovery is likely to be gradual. Continued improvement in Out-of-Area Placements is anticipated, with the Division expressing confidence that current operational arrangements are becoming embedded. Sustaining this position will remain dependent upon maintaining patient flow and reducing delayed pathways across the wider system.

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%

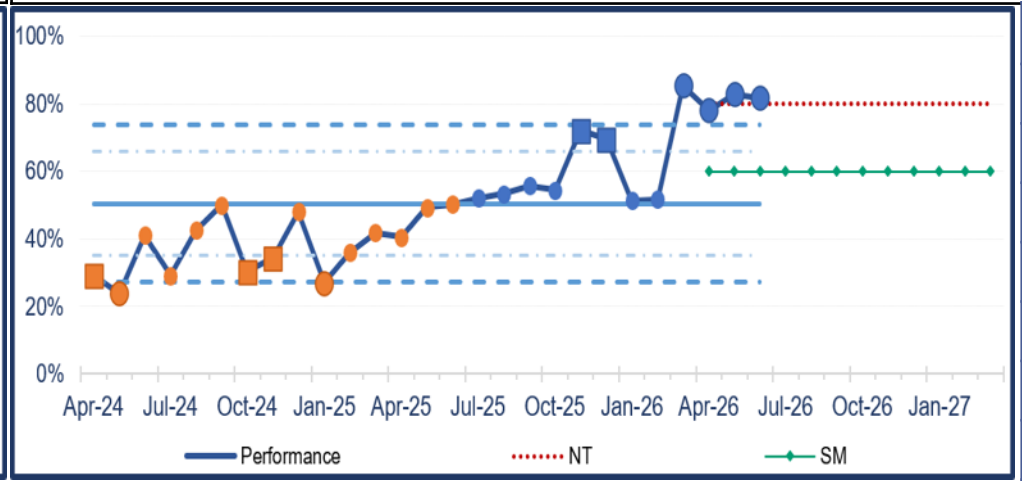
Measure – Part 1A (Assessments) – people aged under 18 years

Latest Month
June 2026
Profile
80%
Actual
86.8%
Status
Assure



Benchmark BCU ranked 5 of 7 at May 2026

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



Latest Month
June 2026
Profile
80%
Actual
81.8%
Status
Advise

Benchmark BCU ranked 6 of 7 at May 2026

What does the data tell us? – Performance has been above the target of 80% for the **assessment** metric since July 2024. The latest submitted data does show a slight dip from above 90% in prior month to 86.8% in June submitted data indicating performance remaining in excess of 90% with management data showing that the standard will be maintained during July. For the **interventions** metric, significant improvement was demonstrated during 2025/26 with performance improving from 40% at the start of the year to and end of March performance of 85.4%. Whilst performance dipped below the target of 80% in April, May and June performance has been above 80% target with management data indicating that standard will be maintained in July. In April the special measures threshold of 75% was maintained with performance of 78%.

Actions being taken to improve – Very high demand levels were experienced across all teams in June, these are being reviewed and demand closely monitored. Position for August looks more challenging, particularly in East as agency capacity reduces. A recovery delivery plan is being finalised by the East team to include refreshed demand and capacity modelling. The service offer regarding group therapy is being developed further over coming months.

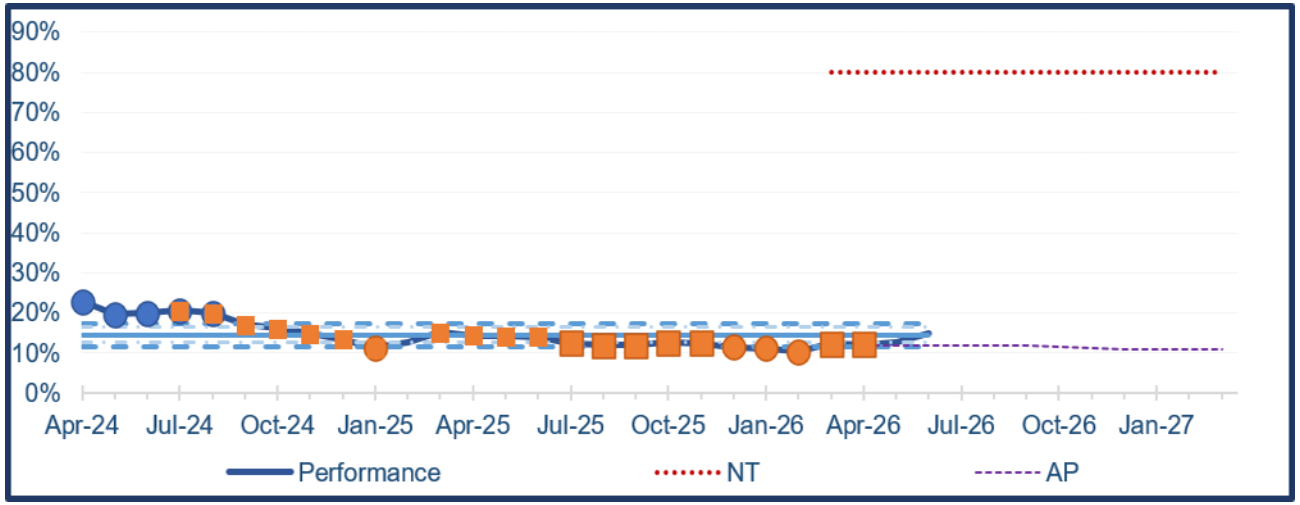
Expected impact upon forecasted performance – Performance against the metrics is expected to be maintained regionally during July but challenging forecast for August. Completion of demand and capacity work will be key in sustaining delivery.

Neurodevelopment (ND)

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

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

Latest Month
June 2026
Profile
12%
Actual
14.9%
Status
Alert



Waiting List Profile

Month	<26 weeks	26+ weeks	ND Total	Of which 3yr+	Of which 4+ yr
Dec-25	900	6,929	7,829	1,249	0
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

Benchmark	At May 2026, BCU ranked 6 of 7. No health board achieving target with All Wales Performance 23.3%

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 14.9% There has been improvement in reducing patients waiting in excess of three years from 1,249 in Dec-25 to 423 at end of June 2026 a 66% reduction.

Actions being taken to improve – Additional commissioning is taking place during 2026/27 with initial focus on extreme waits above four years. Whilst the aim was to clear all four year waits by mid-August this is unlikely to delays due to non-engagement by families or school information not being received. Discussions are taking place with procurement to increase this year's contract to provide an additional 700 assessments but this will be insufficient to manage all over three year demand in year with a current shortfall of c340 assessments. Patient validation exercise is taking place alongside a review of core activity capacity. Scoping activity is also taking place regarding increased prescribing requirement as additional assessment is resulting in additional demand on ADHD medication initiation.

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 in excess of 26 weeks, the focus on extreme waits is not expected to have a significant impact on the 26 week percentage during this financial year.

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		May-26	Jun-26	Jul-26	6 Month Activity	
NPF40	Nationally reportable incidents open over 12 months	0	-	-	1st of 11 (at Jun 26)	0	0	0		Assure
4HP02	12 month rolling average crude mortality rate	-	-	-	N/A	1.5	1.5	RIA		Assure
NPF41	Cumulative number of hospital onset Klebsiella spp BSI cases	7	-	-	3rd of 6 (at Jun 26)	5	9	10		Assure
NPF42	Cumulative number of hospital onset Pseudomonas aeruginosa BSI cases	0	-	-	4th of 6 (at Jun 26)	2	3	3		Alert
NPF43	Cumulative number of hospital onset E.coli BSI cases	26	0	-	5th of 6 (at Jun 26)	14	21	36		Alert
NPF44	Cumulative number of MSSA BSI cases	32	-	-	6th of 6 (at Jun 26)	46	63	84		Assure
NPF45	The cumulative rate of laboratory confirmed C.difficile cases per 100,000 of the population	-	-	-	5th of 6 (at Mar 26)	37.8	42.0	49.8		Assure
LMQ01	Number of new reported falls	-	-	-	N/A	386	354	372		Advise
LMQ02	Number of reported falls with actual harm (moderate and above, post review)	-	-	-	N/A	23	19	26		Advise
NPF50	Overall HB patient experience score (out of 10)	9	-	-	N/A	8.6	8.6	RIA		Advise
LMQ03	Number of avoidable hospital acquired pressure ulcers (HAPU) (post review)	-	-	-	N/A	57	65	51		Advise
LMQ04	Number of National reportable incidents (NRIs)	-	-	-	N/A	7	14	3		Assure
LMQ05	The number of complaints open	-	-	-	N/A	331	333	324		Alert

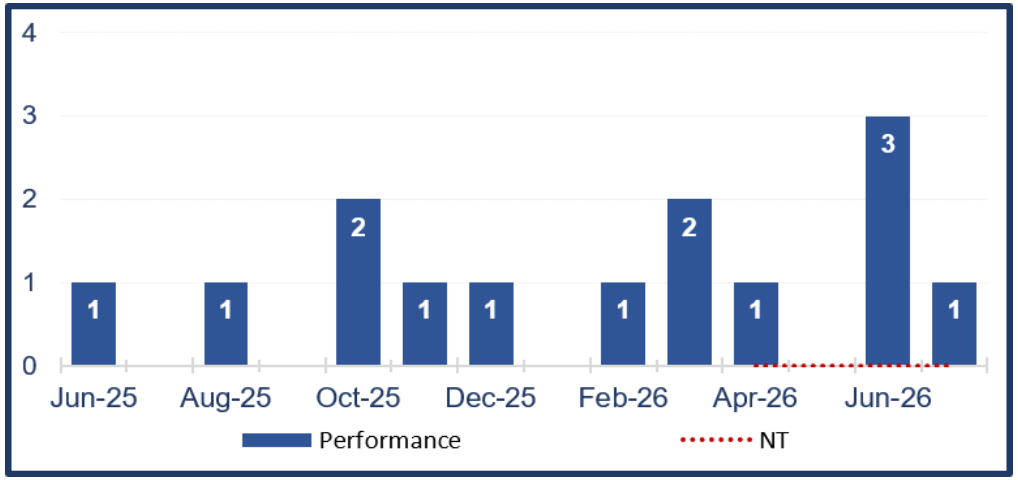
REF	Measure Description	Target Suite			Wales Benchmark	Actual Performance				Status
		NT	SM	AP		Q2 25/26	Q3 25/26	Q4 25/26	Notes	
3HP02	Gabapentin and pregabalin (DDDs per 1,000 patients)	10%↓ YoY	-	1613.4	4th of 7 (at Mar 26)	1676.5	1592.4	RIA		TBC

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)						

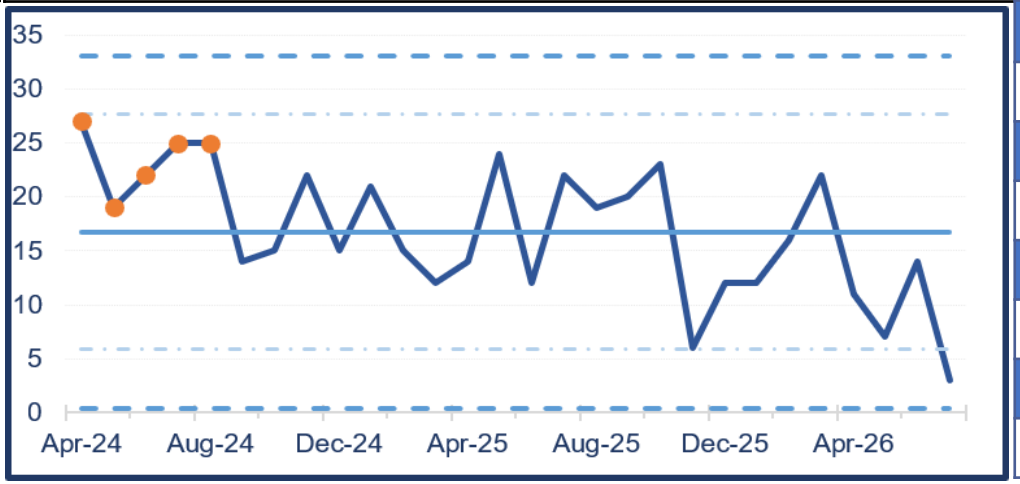
Number of new never events

Latest Month	Profile	Actual	Status
July 2026	0	1	Alert



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

Latest Month	Profile	Actual	Status
July 2026	N/A	3	Advise



Benchmark	BCU ranked joint 1st of 11 at May 2026	N/A	Benchmark

What does the data tell us? – BCUHB accounted for 43% of the reportable never events across Wales in the twelve-month period to June 2026. A total of 13 Never Events have been recorded for the period July 2025 – July 2026 with the one incident in July 2026 bringing the total to four since April 2026. The most frequent theme has been wrong site procedures, along with incidents involving retained items and implant or prosthesis errors. The latest Never Event reported in July involved a misplaced nasogastric tube (NGT).

Actions being taken to improve – All Never Event incidents have been managed in accordance with required processes, including Duty of Candour, and comprehensive action plans are in place following each incident. Executive oversight has been strengthened through the Executive Incident Committee Oversight Panel and corresponding quality governance arrangements. A Health Board wide programme is underway to consolidate all LocSSIPS and ensure that continuous audit programmes are in place. The work programme is intended to extend assurance arrangements across all invasive procedures, and strengthen reporting through governance processes. All clinical leads have been asked to do a stocktake of local LocSSIPs and audit practice and to discuss within departmental meetings. The LocSSIPs Oversight Group will initially meet in mid-August to take this work forward.

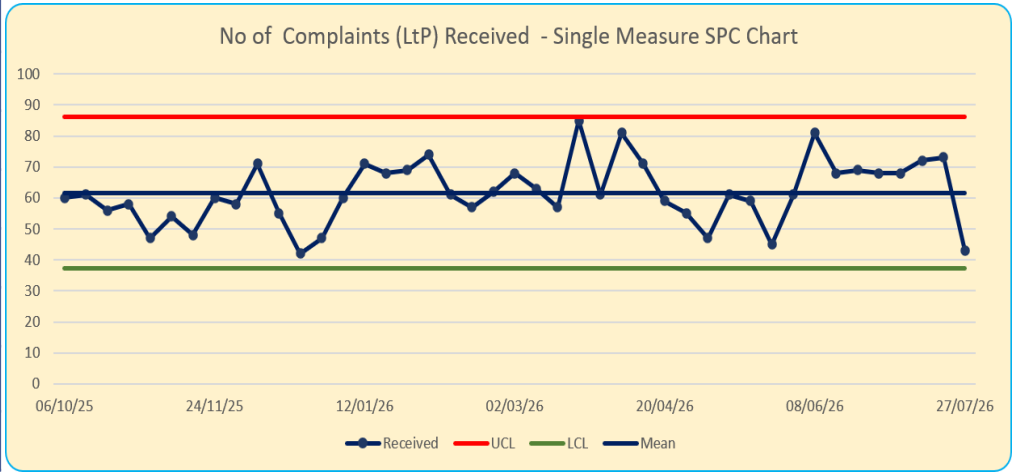
Expected impact upon forecasted performance – Ongoing learning and improvement of compliance is paramount, in order to provide assurance and reduce the risk of recurrence.

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

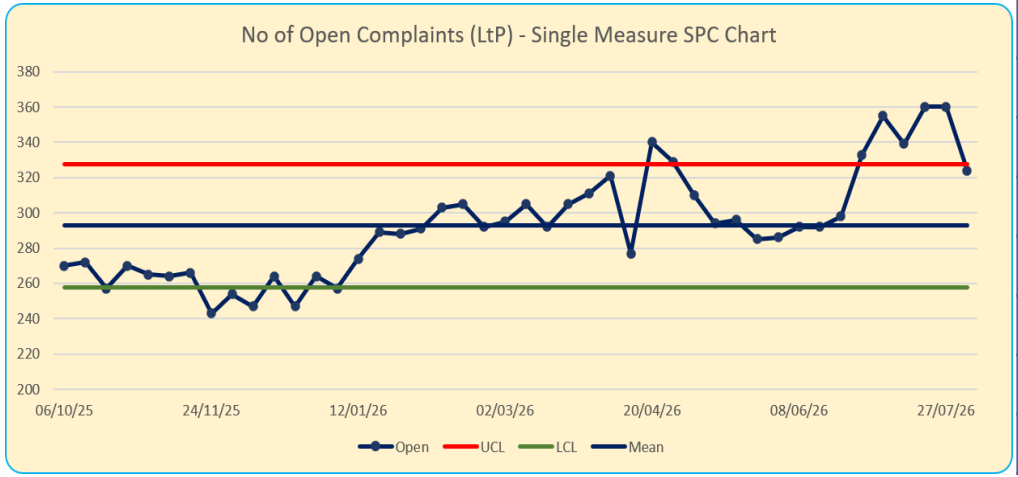
Number of complaints received (weekly)

Latest Position	Profile	Actual	Status	Benchmark
w/c 3rd August	N/A	34	Alert	N/A



Number of open complaints (weekly)

Latest Position	Profile	Actual	Status	Benchmark
w/c 3rd August	N/A	324	Advise	N/A



What does the data tell us? –620 (68.88 per week) complaints were received between 1 June and 3 August 2026, which was above the median average of 65 complaints per week received between 6 October 2025 and 1 June, 2026. The number of complaints being received by the health board is showing a rising trend above the median during the first part of 2026/27. One specific driver cannot be attributed to this rise. The increase in the use of Artificial intelligence to submit complaints, combined with persistent negative press coverage of the health board, are evident within the complaints received. The number of open complaints has increased from 243 at the end of November 2025 rising to 324 week commencing 3rd August, but down from 355 week commencing 6 July, 2026. This is attributed to capacity issues within services to respond to concerns, over the last 29 weeks we have received more complaints than we have closed on 16 occasions (weeks)

Actions being taken to improve – LTP Process refinement, recruitment into corporate services complaints ongoing, work programme for the Patient Experience Service with targeted Intervention, Use of Artificial Intelligence in raising complaints discussed nationally. Dedicated Teams channel between engagement team and PEARS to proactively engage with patients, who raise concerns via social media to prevent formal concerns, increasing use of Early Res (Formal complaint prevention)

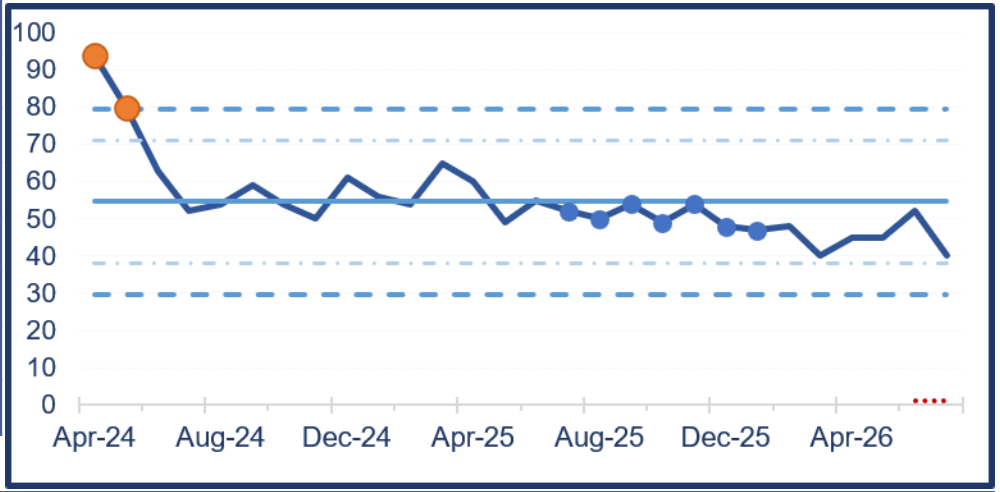
Expected impact upon forecasted performance – Reduction in the overall total number of complaints and those overdue to maintain compliance.

Quality: Patient Experience and Regulation 28 notices

All open NRIs

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

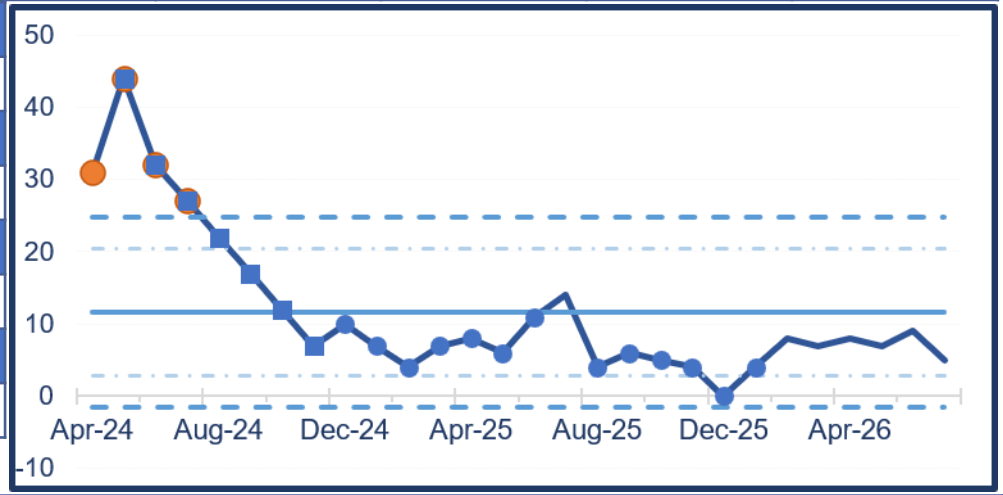
Latest Month
July 2026
Profile
N/A
Actual
40
Status
Advise



All overdue NRIs

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

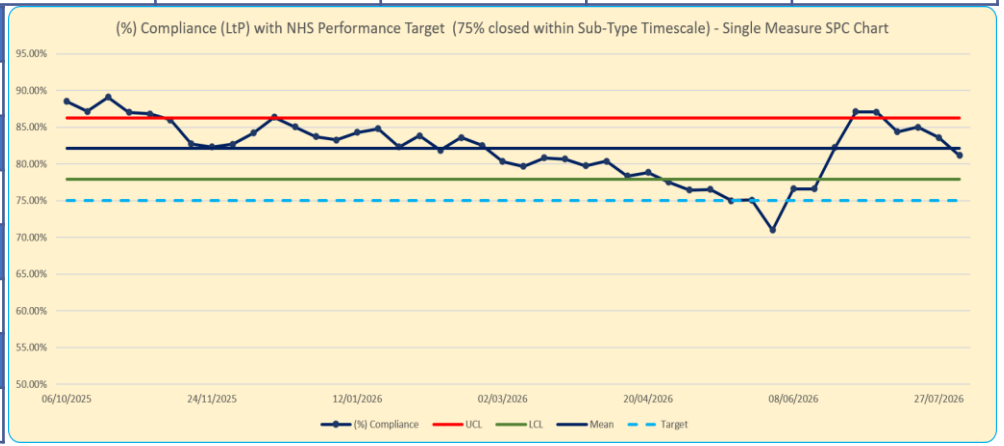
Latest Month
July 2026
Profile
N/A
Actual
5
Status
Advise



Percentage of complaints closed within agreed timescales

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

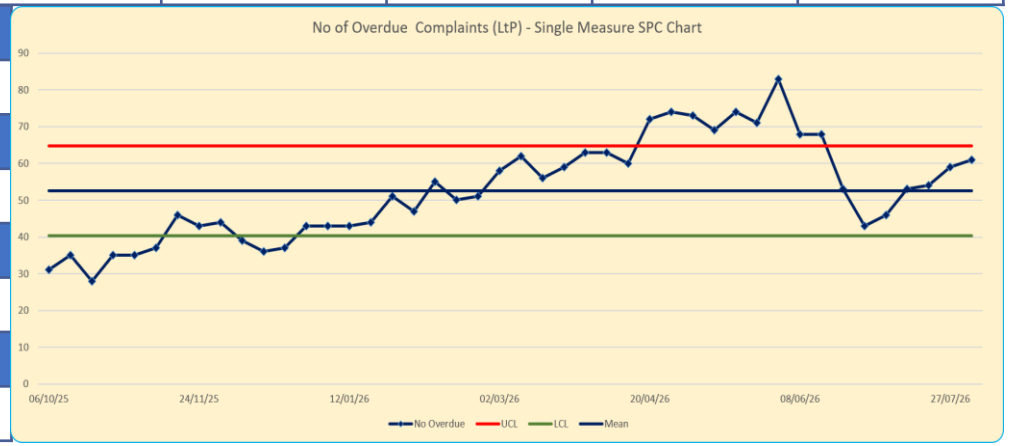
Latest Position
w/c 3rd August
Profile
N/A
Actual
81.2%
Status
Assure



Number of overdue complaints

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

Latest Position
w/c 3rd August
Profile
N/A
Actual
61
Status
Assure

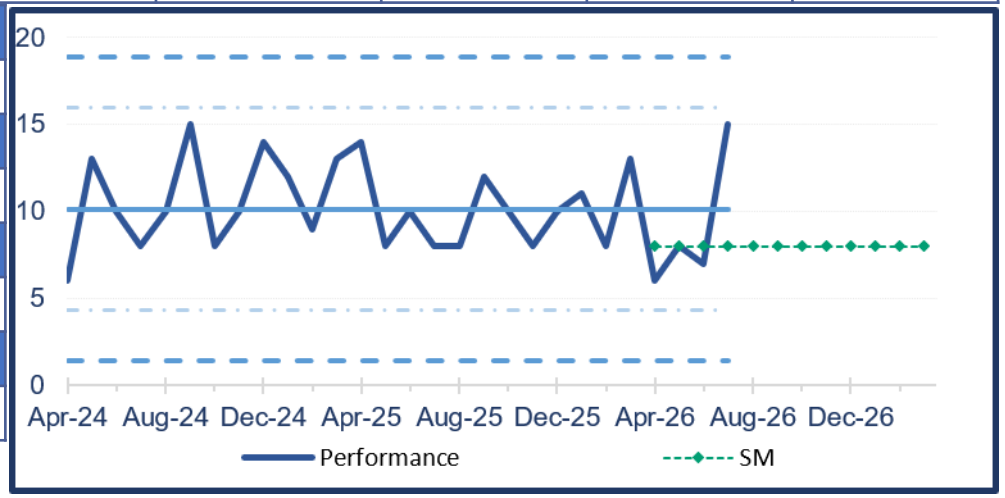


Quality: Infections

Number of hospital onset E-coli BSI cases

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

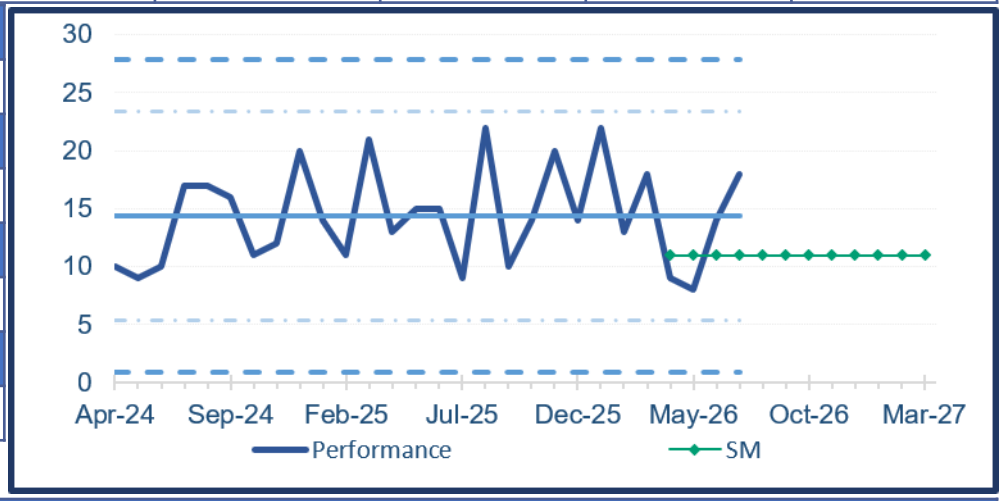
Latest Month
July 2026
Profile
N/A
Actual
15
Status
Advise



Number of hospital onset C-Diff cases

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

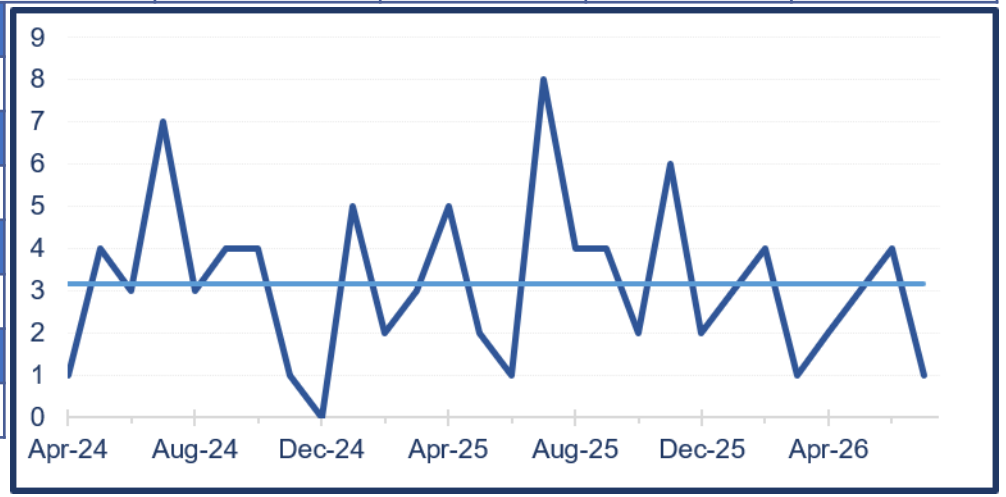
Latest Month
July 2026
Profile
N/A
Actual
18
Status
Advise



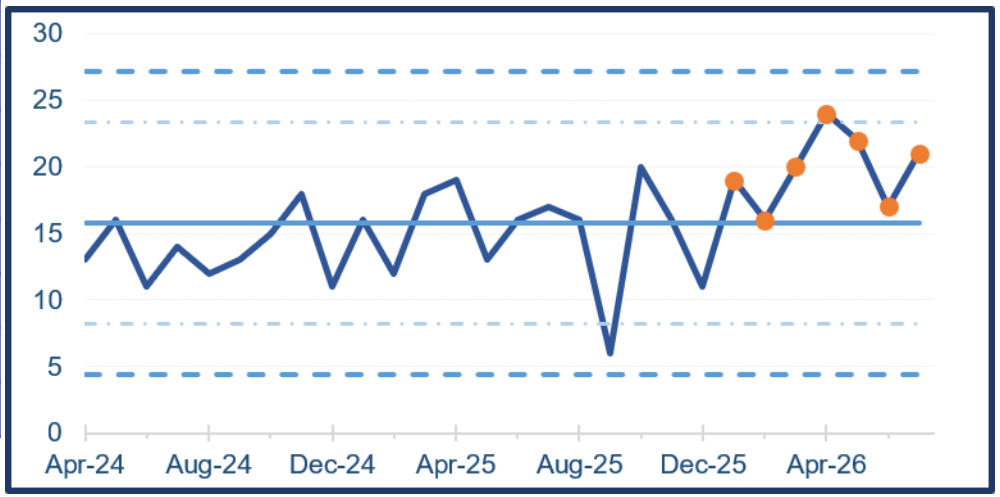
Number of hospital onset Klebsiella spp BSI cases

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

Latest Month
July 2026
Profile
N/A
Actual
1
Status
Advise



Latest Month
July 2026
Profile
N/A
Actual
21
Status
Advise

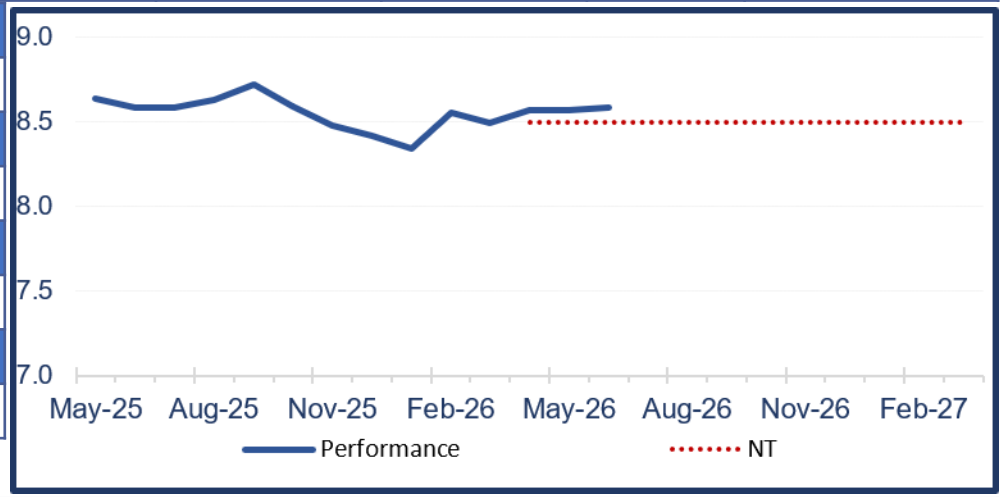


Quality: Patient Experience and Regulation 28 notices

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

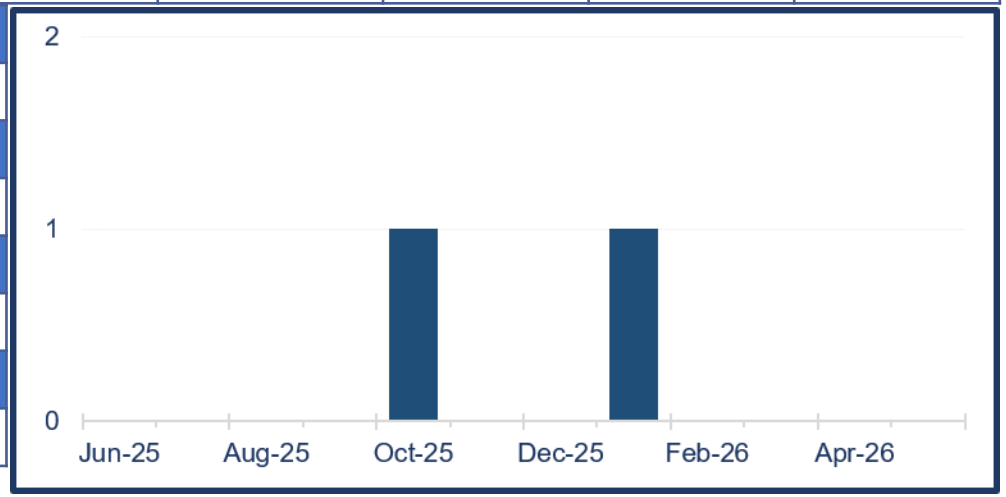
Latest Month
June 2026
Profile
Actual
8.6
Status
Advise



Regulation 28 notices (Prevention of Future Deaths reports)

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

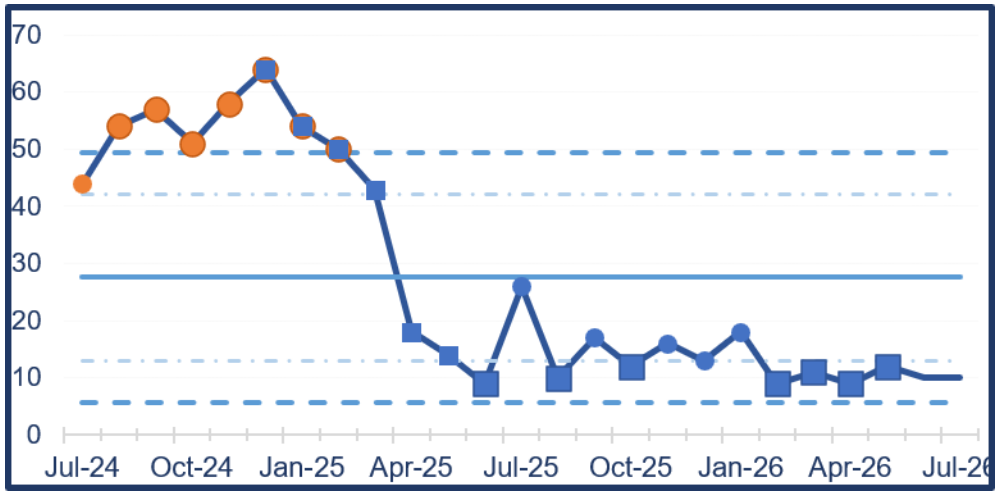
Latest Month
May 2026
Profile
Actual
0
Status
Advise



Number of overdue Learning from Event Reports (LFERs)

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

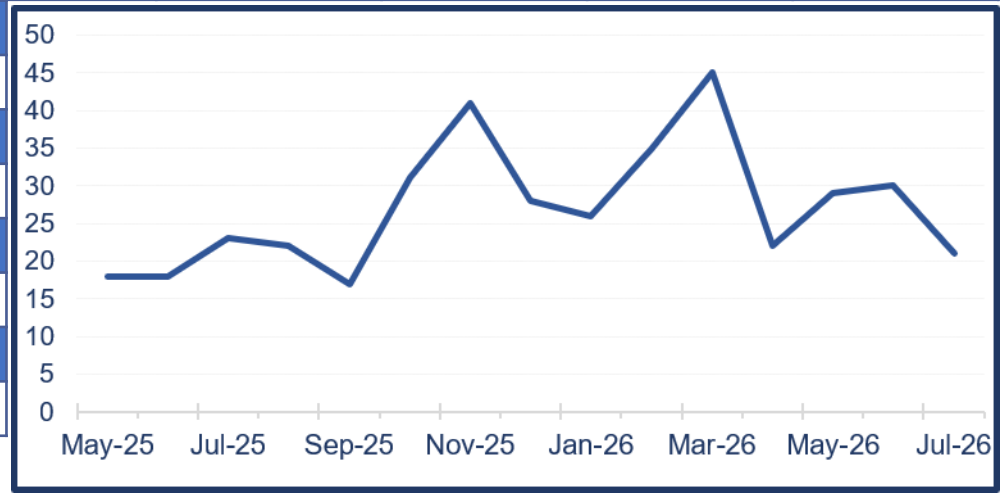
Latest Month
July 2026
Profile
N/A
Actual
10
Status
Assure



Number of new Ombudsman contacts

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

Latest Month
July 2026
Profile
N/A
Actual
21
Status
Assure



Section 3
People and places

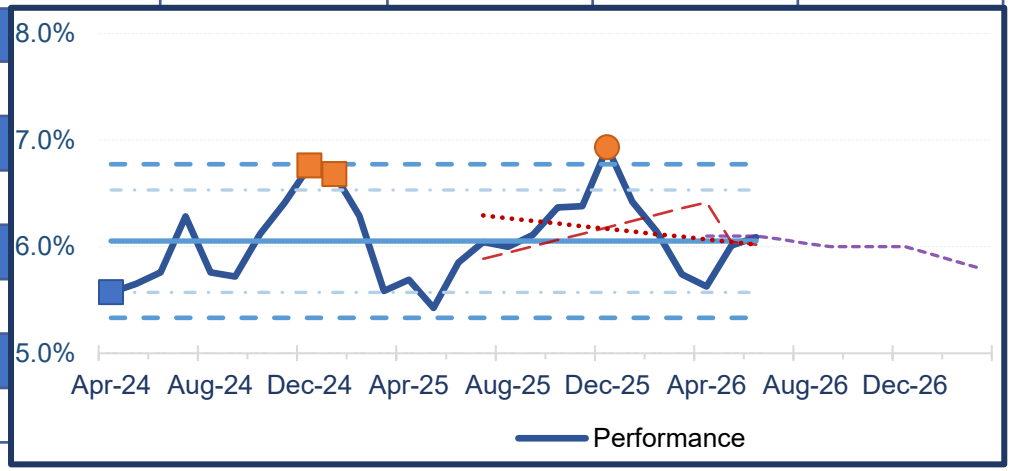
Scorecard: People and places

REF	Measure Description	Target Suite			Wales Benchmark	Actual Performance				Status
		NT	SM	AP		Apr-26	May-26	Jun-26	6 Month Activity	
NPF36	Percentage of sickness absence rate of staff (month by month)	YoY↓	-	-	7th of 13 (at Feb 26)	5.63%	6.01%	6.09%		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)	80.8%	80.0%	80.0%		Assure
LMW06	Percentage compliance for all completed level 1 competencies of the Core Skills and Training Framework by organisation	-	-	-	N/A	90.8%	90.6%	90.5%		Assure
LMW07 (NPF37*)	Turnover rate for nurse and midwifery registered staff leaving BCUHB (monthly, not 12 month rolling figure)	-	-	-	N/A	0.47%	0.39%	0.53%		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 out of 13 at April 2026

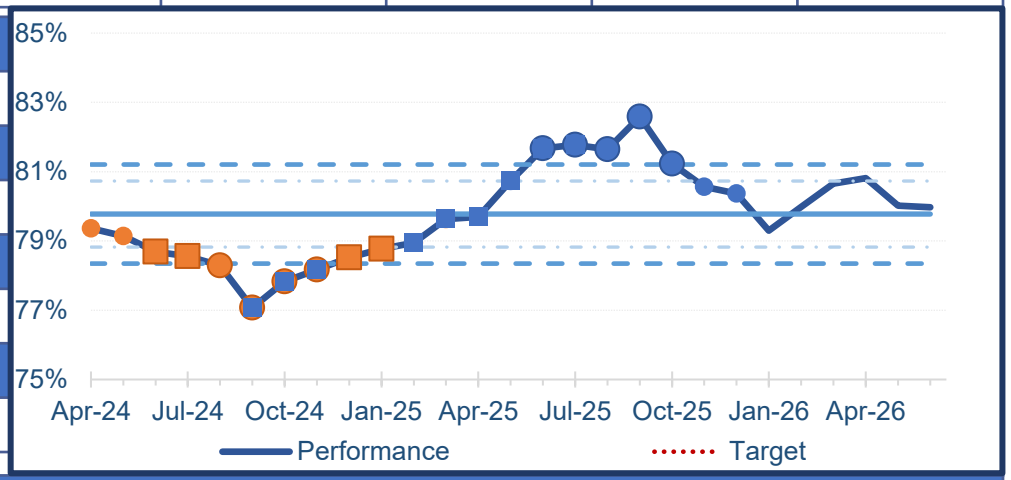
Latest Month	Profile	Actual	Status
June 2026	6.1%	6.1%	Alert



Percentage of Performance Appraisal Development Reviews (PADRs) undertaken

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

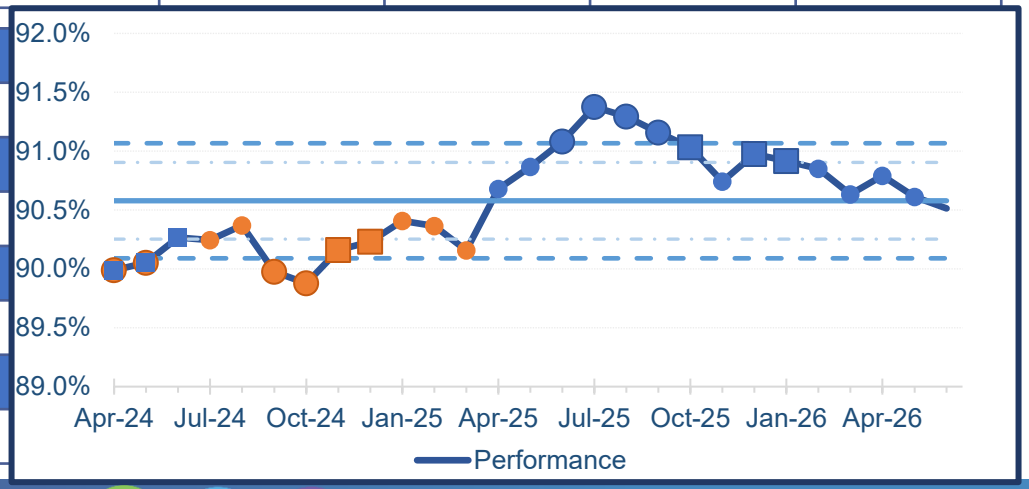
Latest Month	Profile	Actual	Status
June-26	N/A	80%	Advise



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

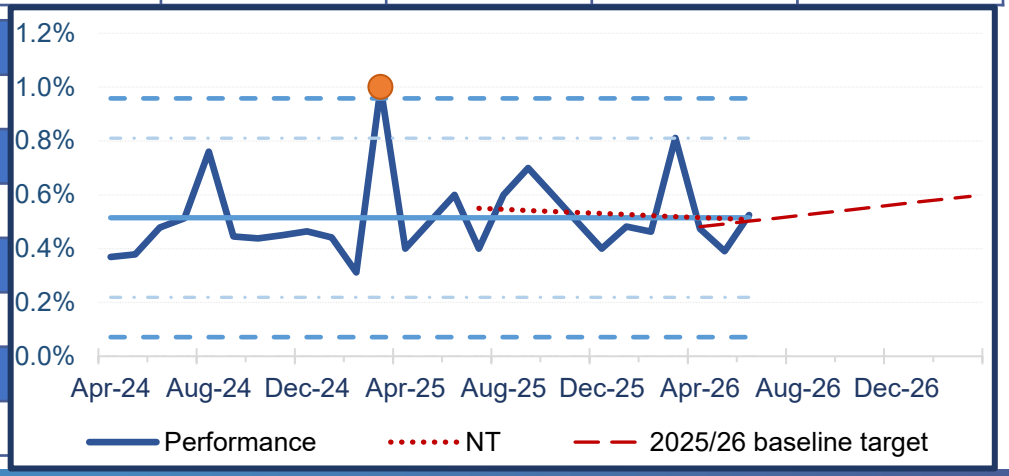
Latest Month	Profile	Actual	Status
June-26	N/A	90.5%	Advise



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	Profile	Actual	Status
June-26	N/A	0.53%	Advise

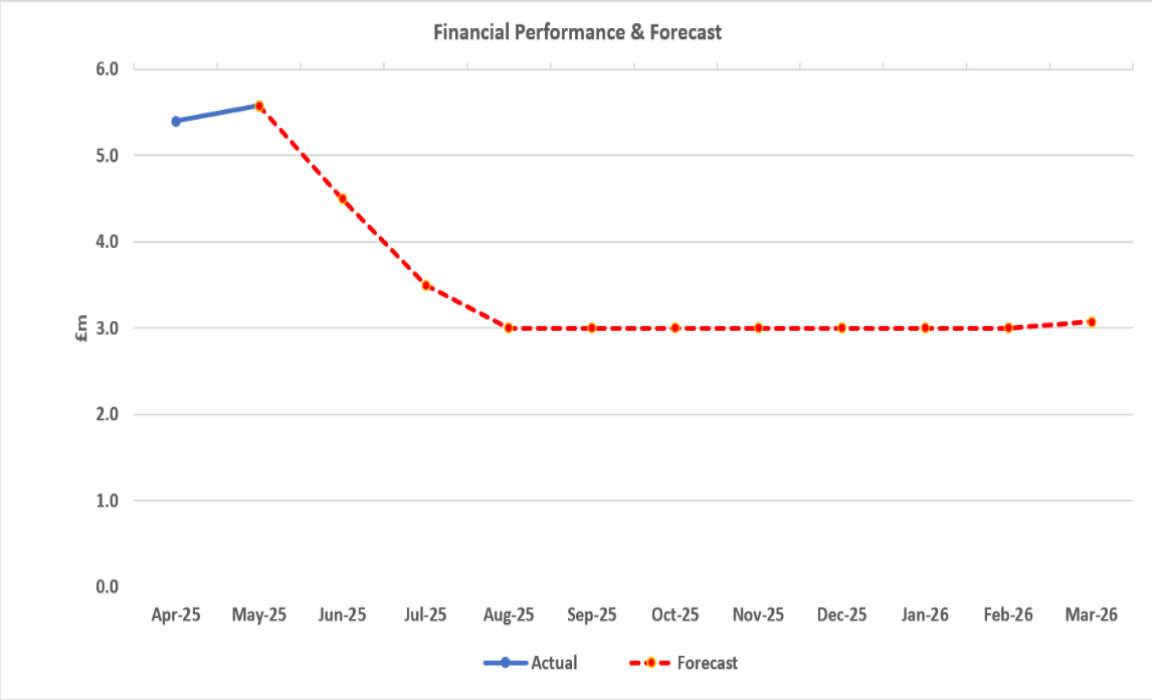


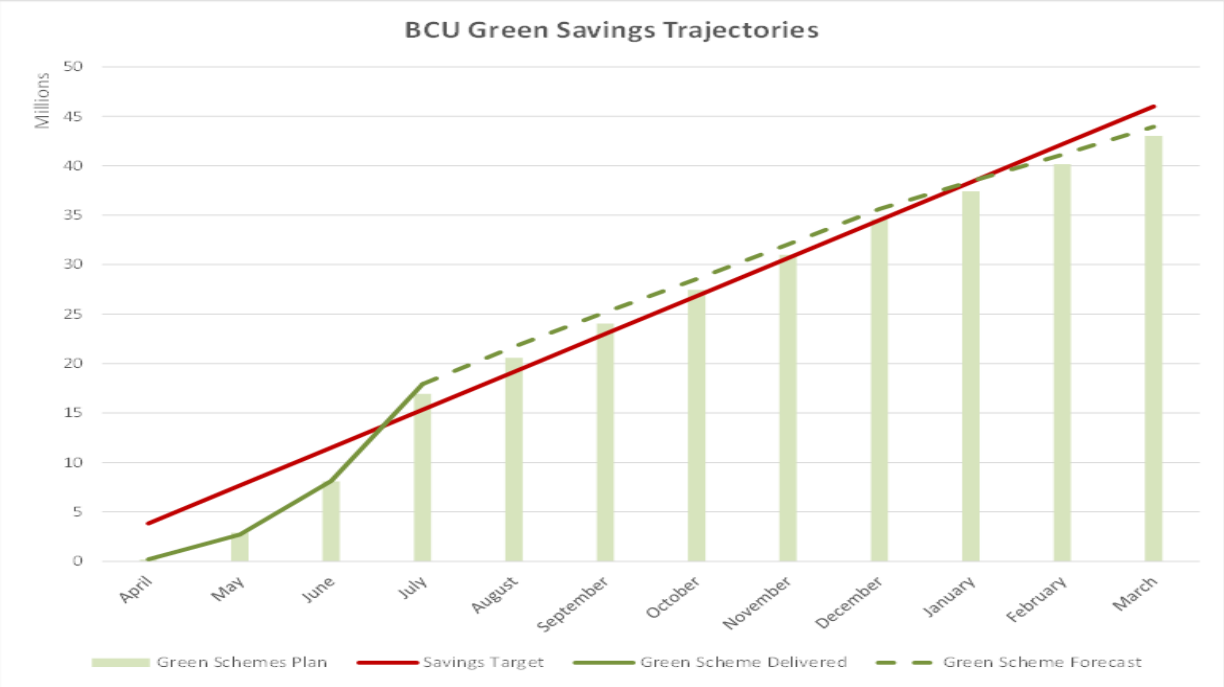
Section 4
Finance and sustainability

Scorecard: Finance and sustainability

REF	Measure Description	Target Suite			Wales Benchmark	Actual Performance				Status
		NT	SM	AP		May-26	Jun-26	Jul-26	6 Month Activity	
NPF38	Agency spend (30% reduction in 2026-27 from 2025-26 outturn)	30%↓	-	-	13th of 13 (at May 26)	22.0%	20.0%	21.0%		TBC
LMF01	Revenue position - expenditure over profile deficit position per month (£m)	43	-	-	N/A	2.0	2.6	2.2		TBC
LMF02	Value and sustainability forecast (up to pipeline) (£m)	46	-	-	N/A	45.2	43.6	55.6		TBC
4GP01	Green deliverable schemes (cash releasing savings forecast) (£m)	46	-	-	N/A	13.3	24.1	43.9		TBC
LMF03	Budget releasing savings (£m)	46	-	-	N/A	4.6	10.1	28.2		TBC
LMF04	Capital spend (£m)	58.6	-	-	N/A	1.7	2.8	4.0		TBC
LMF05	PSPP: Non-NHS invoices paid within 30 days by number	95%	-	-	N/A	-	92.6%	-	Quarterly	Alert
LMF06	PSPP: Non-NHS invoices paid within 30 days by value	95%	-	-	N/A	-	96.9%	-	Quarterly	Assure
LMF07	PSPP: NHS invoices paid within 30 days by number	95%	-	-	N/A	-	89.0%	-	Quarterly	Alert
LMF08	PSPP: NHS invoices paid within 30 days by value	95%	-	-	N/A	-	98.0%	-	Quarterly	Assure

Scorecard: Finance and sustainability





Scorecard: Finance and sustainability

	Actual				Forecast								2026/27 Cumulative against Plan			
	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	Budget	Actual	Variance	Variance
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	%
Revenue Resource Limit	(197.0)	(197.3)	(200.1)	(202.7)	(196.4)	(197.3)	(197.3)	(197.0)	(199.5)	(198.5)	(196.7)	(206.8)	(797.2)	(797.2)	**0.0**	0.0%
Miscellaneous Income	(14.7)	(15.4)	(15.3)	(16.1)	(15.2)	(15.0)	(15.0)	(15.0)	(15.0)	(15.0)	(15.0)	(17.1)	(59.4)	(61.5)	**(2.1)**	3.5%
Health Board Pay Expenditure	101.6	102.4	104.9	102.9	100.7	100.9	100.8	100.6	100.8	101.1	100.9	100.8	409.1	411.8	**2.7**	0.7%
Non-Pay Expenditure	115.5	115.9	116.7	121.7	116.7	116.2	115.3	114.2	115.6	114.2	112.5	120.5	447.5	469.8	**22.3**	5.0%
Total Deficit / (Surplus)	**5.4**	**5.6**	**6.2**	**5.8**	**5.8**	**4.8**	**3.8**	**2.8**	**1.8**	**1.8**	**1.8**	**(2.6)**	**0.0**	**22.9**	**22.9**	
Planned Deficit	**3.6**	**3.6**	**3.6**	**3.6**	**3.6**	**3.6**	**3.6**	**3.6**	**3.6**	**3.6**	**3.6**	**3.6**	**14.3**	**0.0**	**14.3**	**100.00%**
Total Deficit / (Surplus) above Plan	**1.8**	**2.0**	**2.6**	**2.2**	**2.2**	**1.2**	**0.2**	**(0.7)**	**(1.8)**	**(1.8)**	**(1.8)**	**(6.2)**	**14.3**	**22.9**	**8.6**	

Section 5
Population health and prevention

Scorecard: Population health and prevention

REF	Measure Description	Target Suite			Wales Benchmark	Actual Performance				Status
		NT	SM	AP		Q2 25/26	Q3 25/26	Q1 26/27	Notes	
1AP01	Percentage of adult smokers who make a quit attempt via smoking cessation services	Q1: 1.5%	-	-	2nd of 7 (at Dec 25)	6.0%	8.1%	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%	-	-	4th of 7 (at Dec 25)	78.5%	93.6%	RIA		Advise
1DP01	Percentage of children who are up to date with the scheduled vaccinations by age 5 ('4 in 1' preschool booster, the Hib/MenC booster and the second MMR dose)	95%	-	-	3rd of 7 (at Dec 25)	89.7%	87.6%	RIA		Advise
1DP02	Percentage of children receiving the Human Papillomavirus (HPV) vaccination by the age of 15	90%	-	-	7th of 7 (at Dec 25)	70.3%	70.8%	RIA	School year based programme	Advise
LMPH01	Percentage of teenagers receiving the MenACWY vaccination by the end of year 11	-	-	-	N/A	73.1%	74.5%	RIA		TBC
LMPH02	Number of patients who started a L2 WM intervention	-	-	-	N/A	422	519	434		TBC

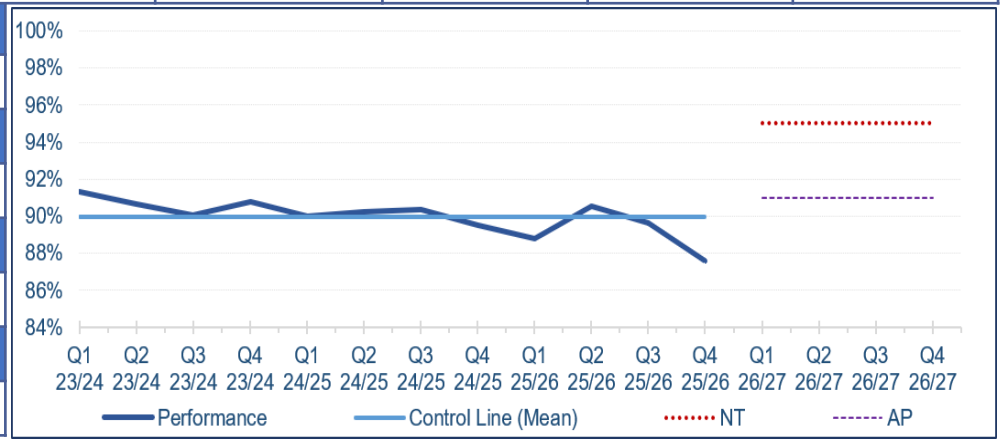
REF	Measure Description	Target Suite			Wales Benchmark	Actual Performance				Status
		NT	SM	AP		Apr-26	May-26	Jun-26	6 Month Activity	
1BP02	Percentage of patients offered an index colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioner assessment appointment	90%	-	-	4th of 7 (at Feb 26)	8.6%	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 Dec 25)	97.6%	97.1%	RIA		Assure
LMPH03	Percentage of patients (*adults) with diabetes who received all eight NICE recommended care processes	-	-	-	7th of 7 (at Mar 26)	43.7%	43.2%	43.0%		Advise
1AP07	Percentage of patients (*adults) with diabetes who have had foot surveillance recorded within last 15 months	80%	-	-	N/A	67.1%	66.1%	65.3%		Advise
1AP08	Percentage of patients (*adults) with diabetes who have had their urine albumin recorded within last 15 months	80%	-	-	N/A	65.0%	64.6%	64.4%		Advise
LMPH04	Babies exclusively breast fed at birth	-	-	-	N/A	#REF!	RIA	RIA		TBC
LMPH05	Percentage of babies who are exclusively breastfed at 10 days old	-	-	-	N/A	39.8%	33.0%	RIA		TBC
2AP01	Increase in % of adult populations accessing NHS Dental care over a 24 month period	-	-	-	N/A	181706	179750	179432		TBC
2AP02	Increase in % of child populations accessing NHS Dental care over a 12 month period	-	-	-	N/A	56025	55525	55351		TBC
3HP01	Percentage of community pharmacies providing Pharmacist Independent Prescribing service (PIPS)	63%	-	-	N/A	43.4%	42.7%	47.6%		TBC

Population health and prevention

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 3rd out of 7 at Q3 25/26

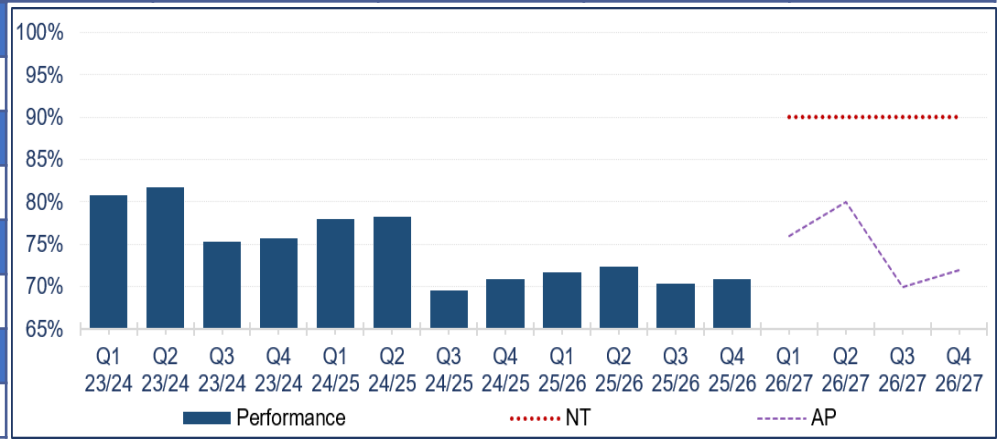
Latest Month
Q4 2025/26
Profile
N/A
Actual
87.9%
Status
Advise



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

SM De-Escalation	N/A	Framework	90%	Latest Benchmark	BCU ranked 7th out of 7 at Q3 25/26

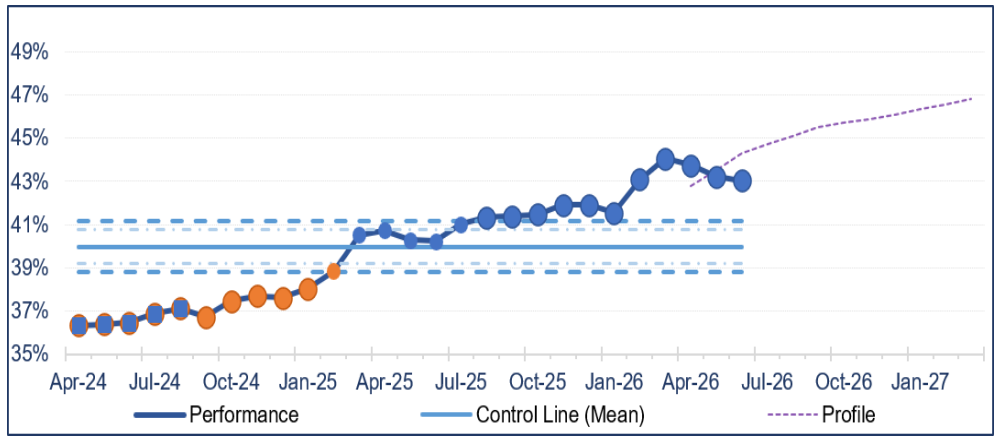
Latest Month
Q4 2025/26
Profile
N/A
Actual
70.8%
Status
Advise



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

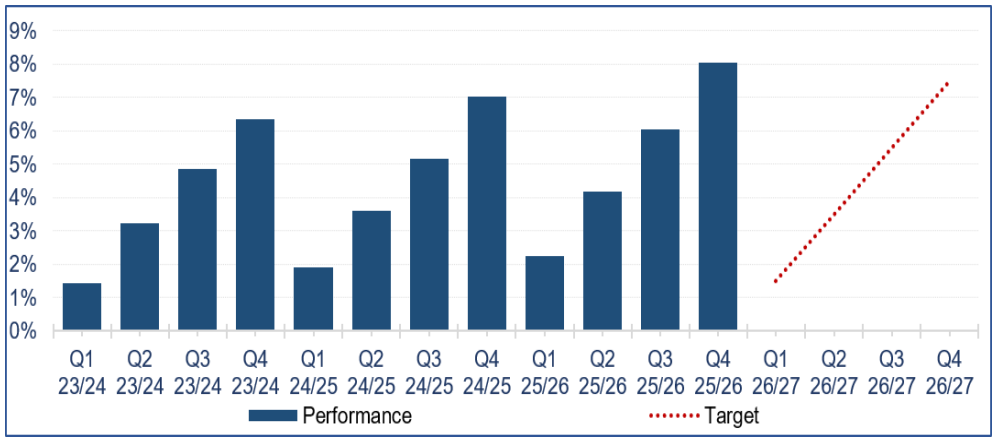
Latest Month
June-26
Profile
44.3%
Actual
43.0%
Status
Alert



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 2nd out of 7 at Q3 25/26

Latest Month
Q4 2025/26
Profile
N/A
Actual
8.1%
Status
Assure



Appendices

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

Interpreting Statistical Process Control (SPC) Charts

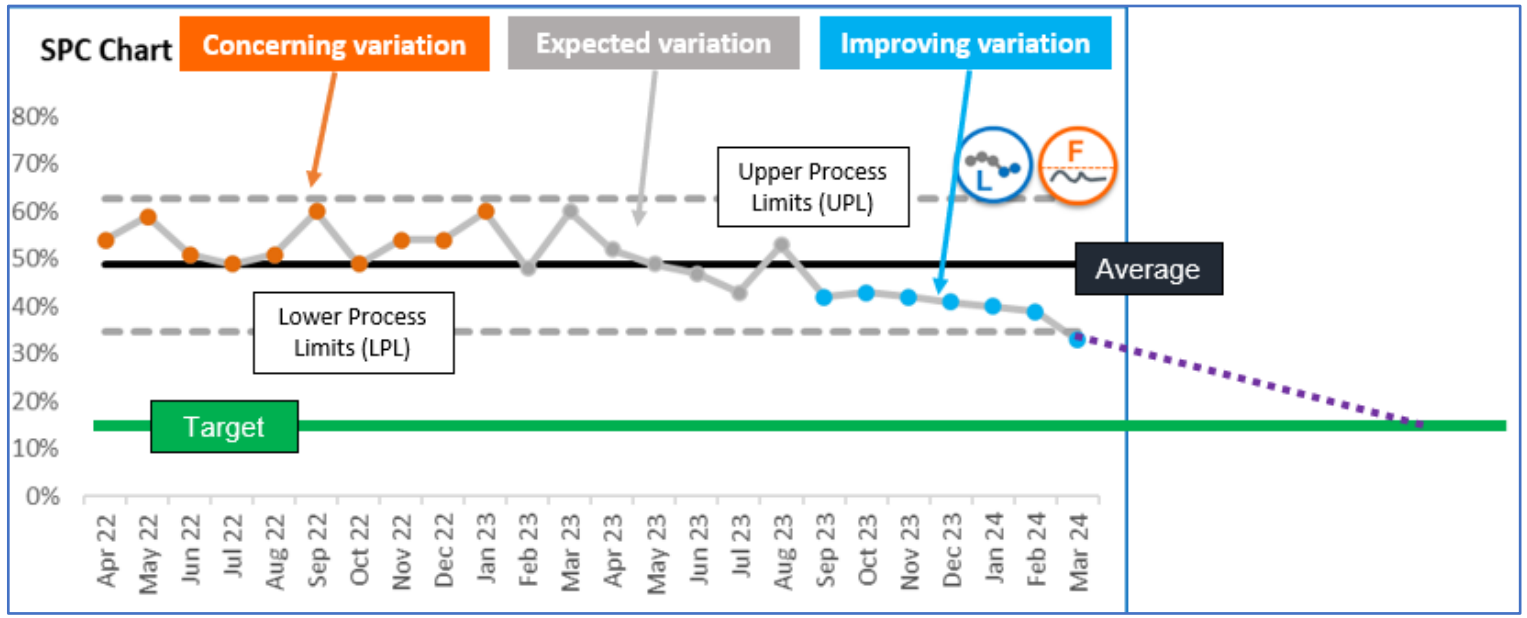
A statistical process control (SPC) chart is a useful tool to help distinguish between signals (which should be reacted to) and noise (which should not as it is occurring randomly).

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 UPDATE

Dyddiad y Cyfarfod **Date of Meeting**	03 September 2026
Statws Cyhoeddi **Publication Status**	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad **Report Author name and title**	Danielle Edwards, Programme Director for Planned Care
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol **Lead Executive Team Member name and title**	Carol Shillabeer, Chief Executive Officer

Pwrpas yr Adroddiad **Report Purpose**	For Noting

Crynodeb Gweithredol
Executive Summary

Betsi Cadwaladr University Health Board (BCUHB) has delivered significant improvements in planned care performance during 2025/26 and continuing into June 2026, with 156-week waits reduced from 592 patients to 7, 104-week waits reduced from 5,747 to 2,167, and patients waiting over 52 weeks for a first outpatient appointment reduced by 83%. Diagnostic performance has also improved, with 8-week breaches reducing to 8,465 by June 2026 following targeted additional activity.

Despite this progress, substantial challenges remain across key specialties including Dermatology, ENT, Gastroenterology, Ophthalmology, Orthopaedics and Urology, alongside ongoing diagnostic capacity constraints in Endoscopy, Imaging and Pathology. To accelerate recovery, the Health Board has appointed a Recovery Director and completed specialty-level reviews across all services. A single integrated recovery and transformation approach is being developed, focused on improving productivity, increasing validation, strengthening pathway management, maximising regional capacity through a "One BCU" model, and targeted use of insourcing and outsourcing.

The Planned Care Programme continues to provide the strategic framework for sustainable transformation, with 16 approved projects supporting demand

management, pathway redesign, referral optimisation and waiting list recovery. Quarter 1 and early Quarter 2 have seen strong progress in several transformational initiatives. Deployment of the tranche Patient Validation Chatbot has shown positive early results in Gynaecology, removing 25% of trial cohort, while Community Health Pathways exceeded delivery targets, supporting more consistent referral management. Teledermoscopy activity continues to deliver between a 58- 66% discharge rate, reducing unnecessary outpatient appointments, and the Breast Pain Pathway remains on track for implementation, supporting improved cancer pathway performance by ensuring low-risk patients are managed outside urgent cancer pathways. A pilot of partial booking has also been approved in ENT to reduce non-attendance rates, improve waiting list accuracy and enhance patient safety through earlier patient engagement and validation.

Reducing the significant follow-up backlog remains a major priority. As of August 2026, 142,620 patients were overdue a follow-up appointment by 100% (unbooked and reportable), including 57,598 waiting more than 12 months beyond their planned review date. A clinically-led four-tier validation and pathway review approach has been established, with early implementation in Gynaecology demonstrating positive results, with 18% of patients appropriately removed from the waiting list following the 1st Tier of the validation exercise. Alongside this, nationally endorsed See on Symptom (SOS) and Patient Initiated Follow-Up (PIFU) pathways are being expanded to support appropriate follow-up, reduce unnecessary appointments and improve patient self-management.

Cancer services continue to face significant pressure. Cancer incidence is projected to rise substantially over the coming decade, driven largely by North Wales' ageing population and persistent health inequalities. Current cancer performance remains significantly below target at 53.5%, with particular challenges in skin, breast, urology, colorectal and head and neck pathways. Diagnostic bottlenecks, workforce fragility and increasing demand continue to constrain improvement. The Health Board is therefore focusing on expanding diagnostic capacity, redesigning pathways, strengthening workforce models and developing sustainable approaches to cancer follow-up and survivorship care.

Key risks requiring ongoing executive oversight include diagnostic capacity constraints, a significant histopathology reporting backlog of approximately 4,000 cases, continued reliance on insourcing in some specialties, workforce challenges across cancer and diagnostic services, and the need to accelerate validation activity to support waiting list recovery. Nevertheless, the reduction in long waits, improving diagnostic performance, decreasing Prevention of Future Death notices and the breadth of transformation activity, provide evidence of sustained progress towards the Health Board's ambition of eliminating waits over 104 weeks by April 2027 while delivering safer, more sustainable and equitable planned care services across North Wales.

Ymgysylltu (mewnol/allanol) yr ymgymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp) **Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)**		
Pwyllgor / Grŵp / Unigolion **Committee / Group / Individuals**	**Dyddiad** **Date**	**Canlyniad, Tystiolaeth a Data** **Outcome, Evidence and Data**
Speciality level reviews	June-Aug 2026	
Performance, Finance & Information Governance Committee	17/07/2026 28/07/2026	Part A recovery submission Part B recovery submission

Acronymau / Rhestr Termau **Acronyms / Glossary of Terms**	
CIN self-assessments	National specialty self-assessments against best practice (including GIRFT) to reduce unwarranted variation, maximise capacity, improve outcomes and safety, and ensure equitable access to standardised, evidence-based pathways through robust governance
Clerical Validation	Skilled technical and administrative validation of the pathway to ensure accuracy and appropriate listing
Clinical Validation	Validation of the patient's clinical suitability
Community Health Pathways (CHPs)	Digital tool designed to support healthcare professionals (HCPs) in primary care settings by facilitating adherence to standardised, evidence based, and locally adapted clinical pathways
GIRFT	Get it Right First Time - a national NHS England programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change
IMTP	Integrated Medium Term Plan
One Waiting List	All patients are waiting to be seen within a speciality 'in turn' across the whole Health Board (rather than a list per main hospital site)

Partial Booking	The patient is sent a letter asking them to contact to arrange an appointment, with reminder letters.
Patient Validation Chat-bot (EBO)	A system whereby the patient is contacted via a text message and invited to join a virtual conversation to ask if they still want, or need their appointment, capturing the reason for the response and signposting to waiting well and mental health resources
See on Symptom (SOS) and Patient Initiated Follow-up (PIFU)	See on Symptom (SOS) and Patient-Initiated Follow-Up (PIFU) enable patients to access specialist follow-up when symptoms arise or when they feel review is needed, reducing unnecessary routine appointments while maintaining timely clinical support
Surgical Hub Accreditation	Nationally-led pan-Wales review of surgical hubs against a common criteria to support effective theatre optimisation
Surgicube	A compact, HEPA-filtered surgical unit that creates an ultra-clean, localised environment for minimally invasive procedures
Teledermoscopy	Remote dermatology technique that uses dermoscopic imaging to assess skin lesions and support early detection of skin cancers
Welsh General Ophthalmic Services (WGOS)	Following legislative changes in 2023, Wales General Ophthalmic Services (WGOS) replaced General Ophthalmic Services (Wales) (GOS[W]), Eye Health Examination Wales (EHEW), Low Vision Services Wales (LVSW), and many various local enhanced service pathways.
WPRS WAP Full e-Referrals	National system that manages the referrals from primary care into secondary care for electronic triage, with the ability to provide e-advice and guidance back to the referrer

PLANNED CARE UPDATE

1. Y SEFYLLFA / SITUATION

1.1 Throughout 2025-26 Betsi Cadwaladr University Health Board (BCUHB) made significant improvements in multiple areas. This includes:

- Reducing the number of 156-week breaches from 592 patients at the end of March 2025 to 7 patients at the end of June 2026.
- Reducing the number of 104-week breaches from 5,747 patients at the end of March 2025 to 2,167 patients at the end of June 2026.
- Reducing the number of patients waiting over 52-weeks for their first outpatient by 83% from March 2025 to June 2026.

1.2 The number of 8-week diagnostic breaches decreased from 10,950 patients at the end of March 2025 to 8,465 patients at the end of June 2026. The position deteriorated during 2025/26 as a result of additional national insourcing appointments to reduce Stage 1 waiting lists; once seen these patients move onto a Stage 2 in large volumes, resulting in additional diagnostic demand. This was mitigated through additionality, resulting in an improvement into June 2026.

1.3 A review of all specialities, services and modalities has been undertaken across the region to understand what is required to ensure no patients are waiting >104-weeks for planned care or >8-weeks for diagnostics. Services that are pivotal include Dermatology, ENT, Gastroenterology, General Surgery, Gynaecology, Ophthalmology, Oral Surgery, Pain, Trauma & Orthopaedics, Urology and Cardiac Physiology.

1.4 Cancer remains one of the leading causes of morbidity and mortality across North Wales. The pattern of disease seen within BCUHB mirrors the wider Welsh picture, with skin, prostate, breast, lung and colorectal cancers accounting for the largest proportion of diagnoses.

1.5 Population ageing is the main driver of rising cancer incidence. With over half of cancers diagnosed in people aged 70+; North Wales' older population profile is increasing demand for diagnostic, treatment and survivorship services.

1.6 Significant inequalities exist across Wales, with cancer incidence rates approximately 20% higher in the most deprived communities compared with the least deprived. Deprivation is also associated with poorer survival outcomes and higher cancer mortality.

1.7 Public Health Wales projects that annual cancer diagnoses across Wales will increase from around 20,000 cases in 2019 to approximately 24,000 by 2035, driven largely by demographic change. This trend will have significant implications for cancer services across North Wales.

2 Y CEFNDIR / BACKGROUND

2.1 Recovery Programme

2.2 The Health Board has appointed a Recovery Directory to support the delivery of planned care recovery. The immediate ambition is to consolidate all planned care improvement and recovery activity into a single delivery plan. This approach is currently being finalised, with governance arrangements under development. In the interim, the Programme will continue to operate through its existing structure while the recovery plan is established, with the intention of transitioning to a single integrated plan.

2.3 Speciality level reviews have been completed with clinicians and operational leads from across the Health Board to identify issues, opportunities and priorities. The plan will operate increasingly at a speciality level, that is utilising capacity across the Health Board rather than site by site. This will enable the Health Board to equalise waits across the region and make best use of available capacity, ensuring the Health Board operates as a single regional organisation. Key to successful delivery will be ensuring active involvement from Clinical, Nurse and Quality & Safety leads.

2.4 Actions to address these challenges and recover the 104-week wait position in planned care and 8-week position in diagnostics have been identified. These include improved productivity and efficiency (particularly in Stage 1), targeted insourcing & outsourcing (particularly at stage 4 and includes maintaining diagnostic insourcing where required), increased validation, improved booking processes, use of Surgicube and existing theatres at weekends with insourced teams, strengthened pathway management & tracking and additional capacity to ensure that all patients have undertaken pre-op in a timely manner.

Table 1: Baseline end of Quarter 1 2026

REF	Measure Description	Actual Performance			
		Apr-26	May-26	Jun-26	6 Month Activity
3BP03	Number of patients waiting more than 26 weeks for a new outpatient appointment (Welsh Patients Only)	16,583	16,971	17,378	
3BP02	Number of patients waiting over 52 weeks for a new outpatient appointment	5,922	5,385	4,963	
3BP01	Number of patients waiting more than 104 weeks for referral to treatment	2,436	2,528	2,191	
N/A	Percentage Treat in Turn Rate (Stage 1)	42%	41%	40%	
LMP03	Percentage Treat in Turn Rate (Stage 4)	20%	25%	23%	
3BP14	Percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)	52.6%	53.9%	RIA	
3BP15	Number of patients on an active suspected cancer pathway after day 62	192	211	RIA	
3BP16	Number of pathways waiting more than 8 weeks for a specified diagnostic (all ages)	12,386	10,461	8,465	
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	40.3%	38.9%	38.4%	
3BP04	Number of patients waiting for a follow up outpatient appointment who are delayed by over 100%	131,031	137,003	139,713	
3BP11	Percentage of lists with a start time 15 minutes or more past the scheduled start time	41.4%	40.2%	41.1%	
3BP12	Percentage of theatre procedures finished more than 60 minutes early	23.2%	22.4%	26.1%	
LMP01	Number of cases per theatre session	2.1	2.1	2.1	
LMP02	Percentage of scheduled operations cancelled either on the day or the day before the scheduled operation	13.1%	13.0%	15.1%	
N/A	Percentage of cataract lists with 7 cases per session	6.67%	9.26%	3.08%	
N/A	Percentage of arthroplasty lists with 4 cases per session	8.25%	7.78%	8.86%	
N/A	Percentage of hernia lists with 6 cases per session	0.00%	2.94%	2.33%	
N/A	BADS day case rate	85%	82%	83%	

2.5 Planned Care Programme – Supporting Sustainable Change

2.6 The Planned Care Major Change Programme continues to provide the strategic framework for planned care transformation across BCUHB, delivering against IMTP commitments while supporting immediate recovery and longer-term sustainability objectives. Following closure of the 2025/26 programme, lessons learned were incorporated into the 2026/27 prioritisation process, resulting in 15 approved projects and initiatives, with 1 additional project pilot approved to start in the July meeting, and a further 8 opportunities identified for future development.

2.7 Overall, the programme has delivered strong Q1 progress, with the majority of planned milestones achieved. Key successes include the expansion of referral management and pathway redesign initiatives, progress toward a single pan-BCUHB waiting list approach, completion of national specialty optimisation self-assessments, continued rollout of patient-led follow-up models and commencement of the follow-up reduction backlog, and preparation for Surgical Hub Accreditation. Several workstreams remain at risk for Q2 due to workforce, financial and digital capacity constraints, which are managed via the programme risk register.

2.8 Key achievements during Q1 into Q2 include:

2.8.1 Deployment of the tranche Patient Validation Chatbot has shown positive early results in Gynaecology Stage 1 (>68 weeks), with 25% (18/73) patients appropriately removed following validation. A phased rollout is planned across c.3,800 Stage 1 patients waiting >52 weeks, with further clinical engagement before extending to Stage 4 cohorts. This will ensure a consistent and high-quality conversation is regularly had with our patients to ask if they still want or need their appointments, and if not why.

2.8.2 National WPRS WAP Full e-Referrals have expanded, with 10 specialties now live across BCUHB, and T&O and General Surgery on track for early Q3 implementation. Used by all Health Boards across Wales, this ensures all triaging of referrals is undertaken digitally in a consistent way to enable a more effective, efficient and timely management of referrals, that ensures equitability of access to care for patients that need to be waiting for secondary care treatment and/or providing advice and guidance back to the primary care referrer (6.8% returned with advice and guidance in July 2026).

2.8.3 228 Community Health Pathways (CHPs) were delivered, exceeding the Q1 target and supporting more consistent referral management. Work is underway to embed CHP thresholds into clinical triage by exploring whether they can be added to the e-referral (WAP Full) system as pre-set text. This would enable referrals that do not meet thresholds to receive standardised feedback and signposting to CHPs through Advice and Guidance, supporting primary care clinicians to follow referral pathways and determine when secondary care referral is appropriate.

2.8.4 Increased Teledermoscopy capacity has maintained a 66% discharge rate and reduced unnecessary outpatient appointments when implemented. Additional Waiting List Initiative (WLI) activity has increased weekly utilisation from 92 to 120 sessions, enabling faster patient outcomes and earlier face-to-face appointments where needed.

2.8.5 The ‘One BCUHB Waiting List’ review confirmed that current digital systems can support a single referral, triage and booking process. The Programme Board endorsed further development and requested a detailed implementation plan, including pilots in three specialties. This will ensure that our systems and administrative processes can support services moving to a pan-BCU waiting list, treating in turn across North Wales.

2.8.6 The Surgical Hub Accreditation application has been submitted, with Llandudno selected for national cohort two review circa January 2027. Work has commenced to prepare with learning from cohort one Health Boards.

2.8.7 The locally adapted and clinically ratified Breast Pain Pathway remains on track for Q3 launch, improving compliance with national pathways and increasing straight-to-test rates to ensure timely, appropriate care for women. A Breast Pain Pathway can significantly improve Urgent Suspected Cancer (USC) performance by ensuring that patients with breast pain alone, who are at very low risk of breast cancer, are managed appropriately outside the USC pathway. This helps services focus limited diagnostic capacity on patients with a higher likelihood of cancer.

2.8.8 Review meetings on Clinical Implementation Network (CIN) Optimisation Self-Assessments with National Performance and Improvement team and National Clinical Leads are almost complete, with actions being aligned to recovery and transformation priorities. These self-assessments align with best practice e.g. Get it Right First Time (GIRFT) and are set to support services across Wales to identify areas for improvement.

2.8.9 Approval has been granted for a 'partial booking' pilot in Central ENT, targeting high Did Not Attend (DNA) (8.6%) and Could Not Attend (CNA) (18.7%) rates, with Dermatology (Acne) also being explored. Currently services mainly 'direct book', meaning that the patient is sent a date and asked to contact us if they cannot attend. 'Partial booking' is where they are sent a letter asking them to contact us to arrange an agreed date. In addition to reducing DNA and CNA rates, the partial booking model offers significant patient safety benefits. By engaging patients directly to agree appointment dates, the service gains an opportunity to validate ongoing clinical need, identify changes in symptoms, confirm patient availability, and address potential barriers to attendance. This supports earlier identification of patients requiring escalation, reduces delays caused by missed appointments, improves waiting list accuracy, and enables available capacity to be utilised for patients with the greatest clinical need.

2.8.10 Nationally released CIN follow-up protocols (See on Symptom and PIFU) have been adopted locally and are now live for Gynaecology and Dermatology Cancer pathways. They support appropriate follow-up, reduce unnecessary appointments, and promote self-management, with rollout planned across Breast, Dermatology and T&O. Evaluation is underway to assess uptake and impact.

2.8.11 A plan is in place and progress is being made in reducing the follow-up backlog.

2.9 As at 24th August 2026, there are 142,620 patients 100% overdue their follow-up appointment (unbooked, reportable); of which 57,598 are over 12-months. The top ten specialities with the largest volume backlog volume are:

Main Specialty	Total Waiters
130 - Ophthalmology	22,554
301 - Gastroenterology	15,305
110 - Trauma & Orthopaedics	12,238
101 - Urology	11,713
120 - ENT	9,060
100 - General Surgery	9,048
330 - Dermatology	7,882
320 - Cardiology	7,025
502 - Gynaecology	5,539
145 - Oral & Maxillo Facial Surgery	4,620

2.10 A four-tier approach has been established to address patients waiting over 12-months and more than 100% beyond their planned review date:

2.10.1 Tier 1 – validates where patients have been seen in the same speciality since they have been waiting for a follow-up appointment.
2.10.2 Tier 2 – validates where patients have a Stage 1 to 4 open pathway in the same speciality, while waiting for a follow-up appointment.
2.10.3 Tier 3 – contacts the remaining patients to ask if they still need their follow up appointment.
2.10.4 Tier 4 – where there is a national follow-up pathway that has been locally agreed, place the remaining patients on the appropriate SOS/PIFU to support the patient to re-engage for an appointment at the time when symptoms present/condition worsens.

2.11 A full EQIA has been undertaken with clinical leadership, informing the process through the four tiers, in particular ensuring the communication approach in Tier 3 is inclusive i.e. the option appraisal found the safest and operationally viable method to be two letters asking the patient to contact us via telephone for a conversation; if there is no response, the patient will receive a non-contact letter advising they will be discharged with information on how to contact the service back to be reinstated within 4-weeks of the letter.

2.12 Piloting in Gynaecology has shown early success, with 18% of patients appropriately removed from the waiting list following Tier 1 validation. Tier 2 is now underway with the remaining Gynaecology patients, with Gastroenterology and Trauma & Orthopaedics being prepared to implement Tier 1.

2.13 Sustainable Aspirations

2.14 Our approach to developing more sustainable services is reflected in the Welsh Government Recovery Plan submission across both the recovery actions and broadening the initiatives on the Planned Care Programme to deliver sustainable change, based upon the following:

2.14.1 Delivering cancer services in line with national standards.

2.14.2 Reducing the overall size of the waiting list by 20% within 18-months.

2.14.3 Reducing referrals into the Health Board through demand management, Community Health Pathways, integrated advice and guidance, GP and professional triage, appropriate and effective utilisation of the workforce.

2.14.4 Ensuring that no one waits longer than 52-weeks for a first outpatient appointment, underpinned by a review of outpatient utilisation and capacity.

2.14.5 Developing a stable diagnostics service that incorporates straight to test, the implementation of alternative approaches and is underpinned by robust demand and capacity planning ensuring that diagnostics are delivered within 8-weeks.

2.14.6 Ensure that internal delivery is maximised through protected elective capacity, ringfenced Day of Surgery Admission wards, dedicated planned care anaesthetics capacity, improved paediatric surgery ward staffing at weekends and use of Operios for delivery of minor operations.

2.14.7 Ensure that theatre activity is in line with Getting It Right First Time (GIRFT) and industry standards.

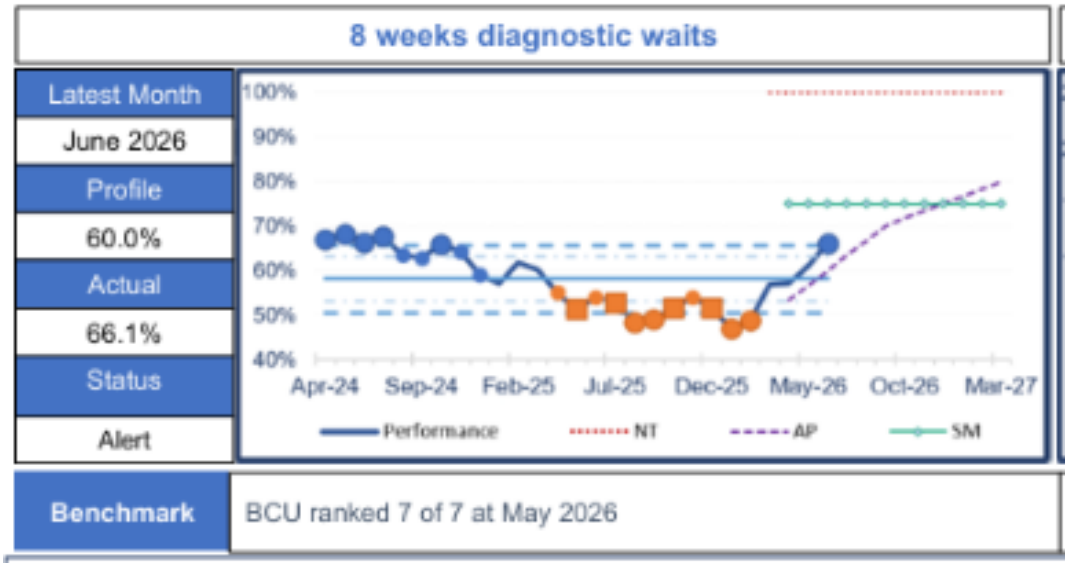
2.14.8 No patients to be waiting over 104-weeks by April 2027 and move towards a maximum of 78-weeks waiting times by March 2028.

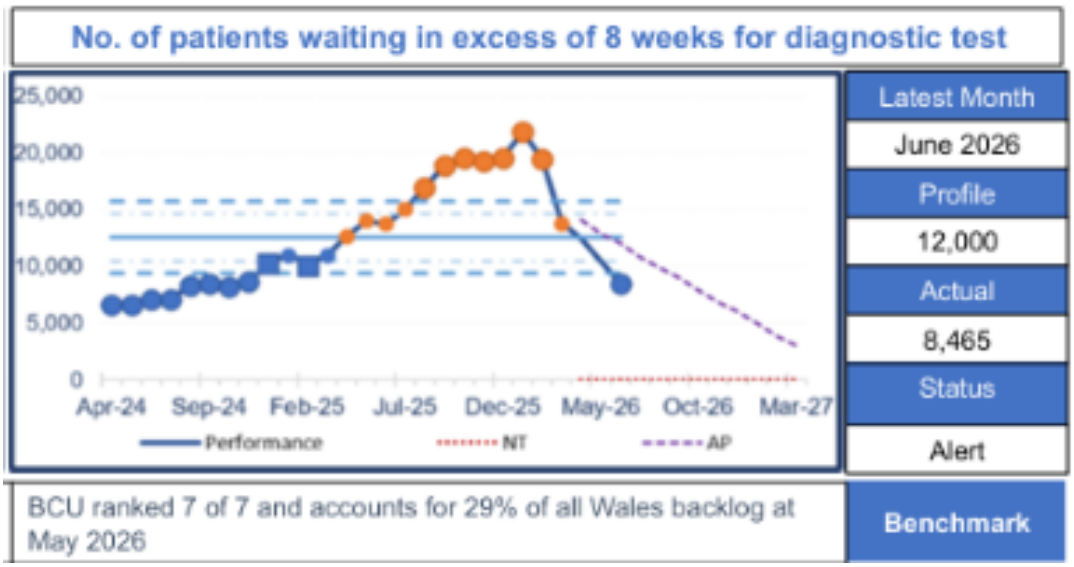
2.14.9 Direct list cataracts and manage a programme to reduce cataract waiting times to 52-weeks, through outsourcing, improved productivity and a realignment of the cataract delivery model through the development of a central site or a strategic partnership.

2.14.10 Transform the new and follow up outpatient model to one that where the default option is discharge first, followed by a See on Symptom (SOS) pathway, and activity based on industry standards for new to follow up activity.

2.15 Diagnostics

2.16 Waiting times for diagnostic procedures within 8-weeks improved by 61% between January and June 2026, reducing to fewer than 9,000 patients by the end of June and performing ahead of trajectory at the end of Quarter 1. Despite this progress, 8,465 patients were still waiting longer than 8-weeks for a diagnostic procedure against a national target of zero. However, the focus is on improving performance towards the special measures de-escalation target of 75% of patients waiting less than 8-weeks by the end of September 2026, ahead of the IMTP trajectory of Quarter 3. Challenges remain across Endoscopy, Imaging and Pathology services.





2.17 With support from NHSP&I, sustainable approaches to diagnostics are set out in BCUHB's Recovery Plan. These are supplemented by specific actions for each modality:

2.17.1 Validate and standardise vetting processes.
2.17.2 Improve referral quality, clinical prioritisation, and risk stratification.
2.17.3 Standardise referral and imaging pathways across sites.
2.17.4 Review community and high-volume pathways to reduce avoidable demand.
2.17.5 Use AI-supported image prioritisation where clinically governed.
2.17.6 Standardise booking and scheduling across BCUHB sites.
2.17.7 Apply standardised reporting templates to support consistent decisions.
2.17.8 Reduce DNAs and CNAs through digital booking systems.
2.17.9 Improve reporting turnaround times and reduce reporting backlog volumes.
2.17.10 Improve visibility of demand, clinical priority, and breach risk through better data.
2.17.11 Use consultant-led triage to support appropriate clinical prioritisation.
2.17.12 Develop virtual triage clinics where this reduces avoidable diagnostic demand.
2.17.13 Strengthen direct access pathways with clear referral criteria and governance.
2.17.14 Improve integration with primary care for clinically appropriate community pathways.

3 Cancer in North Wales: Tumour Site Profile, Demographic Trends and Geographical Variation

3.1 The increasing burden of cancer across North Wales reinforces the need for sustained investment in prevention, early diagnosis, treatment capacity and workforce development.

3.2 The Welsh Government and NHS Wales have identified cancer as a key priority through the NHS Planning Framework and the Quality Statement for Cancer, with an emphasis on improving outcomes, reducing inequalities and delivering timely access to diagnosis and treatment. A new cancer strategy for Wales is planned for February 2027. Within BCUHB, the projected growth in cancer incidence is expected to have implications across a number of strategic programmes, including:

3.2.1 Cancer pathway performance.
3.2.2 Diagnostic recovery and expansion.
3.2.3 Workforce sustainability.

3.2.4 Regionalisation of specialist services.
3.2.5 Personalised care and survivorship programmes.
3.2.6 Health inequalities and targeted prevention initiatives.

3.3 The five most commonly diagnosed cancers in north Wales are:

3.3.1 *Skin cancer* – the most common cancer; increasing incidence driven by sun exposure.

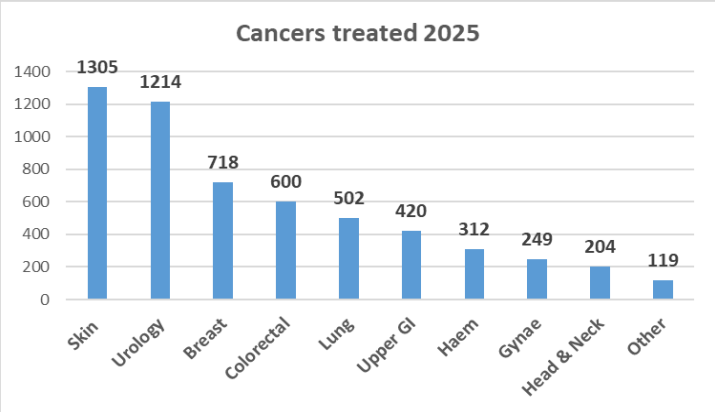
3.3.2 *Prostate cancer* – strongly associated with increasing age and expected to increase further as the population ages.

3.3.3 *Breast cancer* – a significant contributor to diagnostic, surgical and systemic treatment activity; increased detection through screening and symptomatic routes continues to drive demand.

3.3.4 *Colorectal (bowel) cancer* – incidence rises substantially with age; future growth expected due to demographic changes.

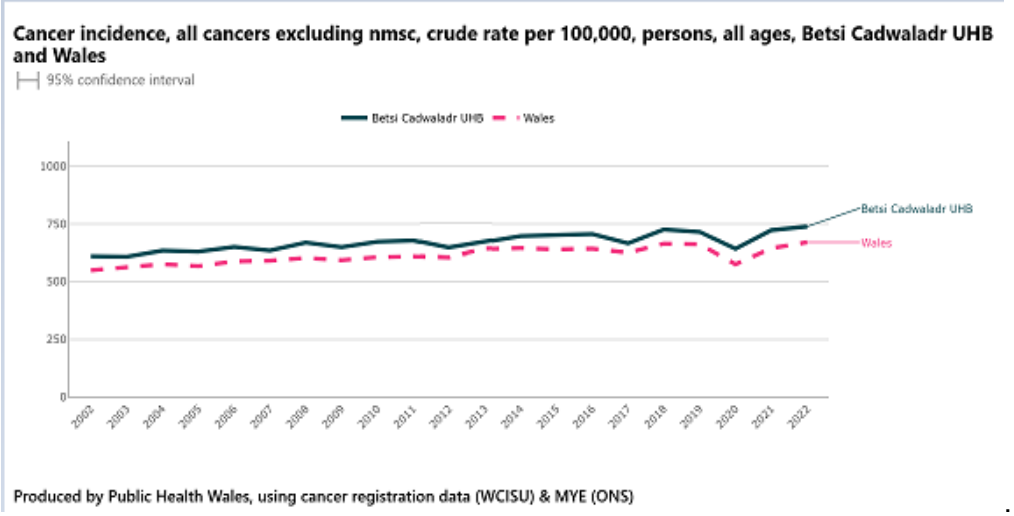
3.3.5 *Lung cancer* – remains the leading cause of cancer death; closely associated with smoking history and deprivation. A lung screening programme is due to launch nationally in 2028.

Table 2: Types of cancers treated across 2025 calendar year



3.4 Age related patters show that over 50% of all cancers diagnosed in Wales occur in individuals aged 70 years and over. This pattern has remained consistent for more than two decades. The older demographic profile of North Wales means cancer incidence is higher than the all-Wales average:

Table 3: Cancer incidents per 100,000 persons over 20 years



3.5 Cancer incidence remains strongly associated with deprivation. In Wales, age-standardised cancer incidence rates are approximately 20% higher in the most deprived communities compared with the least deprived communities. This gap has remained largely unchanged over recent years. People living in the most deprived areas are more likely to develop cancer, more likely to die from cancer and less likely to survive five years after diagnosis.

3.6 <u>The North Wales population contains communities with differing risk profiles:</u>

3.6.1 Areas with higher levels of deprivation may experience greater cancer incidence and poorer outcomes.
3.6.2 Rural and coastal communities often have older populations, contributing to higher numbers of cancer diagnoses.
3.6.3 Variations in smoking prevalence, obesity and other risk factors contribute to differing disease burdens across localities.

3.7 These factors necessitate a targeted approach to prevention, screening uptake and early diagnosis initiatives.

3.8 Public Health Wales projects approximately 24,000 new cancer diagnoses per year in Wales by 2035, compared with around 20,000 in 2019. The projected increase is largely attributable to population ageing.

3.9 For BCUHB, this is expected to result in:
3.9.1 Increased referrals into cancer pathways.
3.9.2 Higher demand for diagnostic capacity.
3.9.3 Greater pressure on treatment services.

3.9.4 Increased demand for cancer nurse specialists and allied health professionals.

3.9.5 Growth in survivorship and long-term follow-up requirements.

4 MATERION PENODOL I'W HYSTYRIED
SPECIFIC MATTERS FOR CONSIDERATION

4.1 Public Interest Report 202404388 – Timely Access to Positron Emission Tomography (PET) Scan and Oestrogen

4.2 The Ombudsman's Final Public Interest Report (issued 4 March 2026) examined the patient's prostate cancer care between September 2023 and July 2024, focusing on delays in receiving a PET scan and oestrogen treatment, and whether these delays affected the progression of their cancer. All actions due by April 2026 have been completed, including issuing an apology and sharing the report's findings with clinical teams and complaints staff to support learning and improve investigation processes.

4.3 The remaining actions due by September 2026 are on track, including a review of the local prostate cancer pathway and an audit to assess the impact of improvements made. The case is also being reviewed under the Duty of Candour to understand how the cancer pathway exceeded 180 days. In addition, an audit of patients requiring PET scans over the last two years has been completed, with findings to be shared with the Ombudsman. Current PET scan waiting times are meeting the Joint Commissioning Committee (JCC) target of 10 days.

4.4 Regulation 28 Report to Prevent Future Deaths (13 January 2026) – Gastroenterology and Endoscopy Services

4.5 The Health Board noted the conclusion of the inquest that the patient's death was due to natural causes, and that the matters identified during the course of the evidence did not impact upon the outcome. Notwithstanding this, the Health Board recognised the significance of the wider systemic issues highlighted during the inquest and welcomes the opportunity to set out the actions taken and planned to reduce the risk of future harm to patients.

4.6 The Health Board continues to address workforce, capacity and infrastructure challenges within Gastroenterology and Endoscopy services through Health Board-wide recruitment, new workforce models, and the rollout of capsule sponge endoscopy.

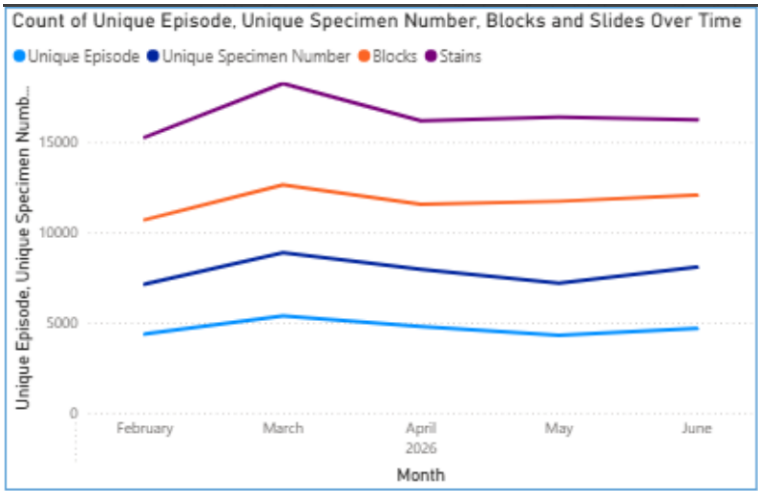
4.7 To reduce waiting times, additional diagnostic capacity was introduced through a temporary endoscopy unit at Ysbyty Gwynedd (which has now been removed), enhanced referral and triage processes, and ongoing validation of waiting lists, with around 40% of more than 1,000 reviewed referrals removed where endoscopy was no longer required.

4.8 Governance and executive oversight have been strengthened following a Rapid Quality Review in February 2026. Longer-term improvement is being driven through the development of an Integrated Digestive Disease Service, providing shared leadership, standardised pathways, coordinated workforce planning and stronger governance.

4.9 Pathology Backlog

4.10 Histopathology services at Ysbyty Gwynedd (YG) are experiencing a significant reporting backlog, with around 4,000 cases awaiting reporting, including urgent and screening specimens. The longest waits for a histopathology report are currently approximately 14 weeks, creating potential risks to patient safety and quality of care through delayed diagnosis, treatment planning, and recovery pathway delivery. All available internal mitigation measures, including additional reporting sessions, have been fully utilised and no further capacity exists within the service to address demand or reduce the backlog.

4.11 The backlog is being managed through established performance and risk management processes, with cases prioritised according to clinical urgency, particularly cancer, screening, and other high-risk pathways. To support recovery, the service proposes procuring external telepathology support through an NHS framework direct award for 2026-27. This will provide reporting capacity for Dermatology and Endoscopy cases linked to 104-week recovery plans, other specialty recovery programmes, and targeted backlog clearance. The aim is to reduce reporting delays, improve turnaround times, support recovery trajectories, and minimise the risk of patient harm associated with prolonged diagnostic waits.



4.12 Ophthalmology - Wales General Ophthalmic Services (WGOS)

4.13 WGOS were introduced on 20 October 2023, with unification of the service architecture, governance and evaluation across Wales to provide care closer to home and ensure that people only attend hospital eye services when required. WGOS is a Primary Care Optometry service delivered from both

fixed location premises in the community and closer to/in homes via mobile/domiciliary providers. WGOS is made up of five tiers of eye care services that can be summarised as:

- Tier 1 – Eye Examination
- Tier 2 – Including Examinations for Urgent Eye Problems
- Tier 3 – Low Vision Assessment
- Tier 4 – Referral Refinement/Monitoring
- Tier 5 – Independent Prescribing

4.14 The primary care team has recently completed an exercise to identify service gaps, to help us determine where to focus efforts to increase availability and support the 'care closer to home' ethos. The aim remains a minimum of two practices per cluster delivering each modality under WGOS 3, 4 and 5.

4.15 The heat map below shows the percentage of practices providing WGOS 1-5 by cluster and highlights the gaps in the current service provision:

	Heat map showing the % of practices providing WGOS 1-5 across BCUHB Clusters						
Cluster	**WGOS 1**	**WGOS 2**	**WGOS 3**	**WGOS 4 HCQ**	**WGOS 4 Med Ret**	**WGOS 4 Glaucoma**	**WGOS 5**
Anglesey	100%	100%	57%	29%	43%	43%	0%
Arfon	100%	100%	57%	0%	43%	43%	43%
Dwyfor & North Meirionydd	100%	100%	100%	0%	40%	40%	20%
South Meirionydd	100%	100%	100%	0%	100%	100%	100%
Conwy East	100%	100%	50%	0%	50%	50%	25%
Conwy West	100%	100%	57%	29%	57%	14%	14%
Central & South Denbighshire	100%	100%	33%	0%	33%	33%	33%
North Denbighshire	100%	100%	33%	0%	66%	17%	50%
Central Wrexham	100%	100%	30%	10%	50%	57%	40%
North West Wrexham	100%	100%	0%	0%	0%	0%	0%
South Wrexham	100%	100%	50%	0%	50%	0%	50%
North East Flintshire	100%	100%	17%	17%	17%	17%	33%
North West Flintshire	100%	100%	33%	66%	100%	33%	33%
South Flintshire	100%	100%	14%	0%	33%	14%	43%

Key:	100% provision	>50% provision	<50% provision

4.16 The Health Board will continue to work towards ensuring sufficient WGOS coverage, particularly in areas where the health needs of the local population indicate a requirement for WGOS 3–5 services. Currently, some patients may need to travel outside their local cluster area to access WGOS 4 and 5 provision.

4.17 To address this, the Health Board is maintaining close collaboration with key stakeholders and engaging with the optometry community to encourage increased participation and sign-up. We are also working closely with the primary care academy, cluster leads, HEIW and Teach and Treat centre to promote qualifications where needed.

4.18 Additionally, information from the BCUHB Eye Health Needs Assessment, and the workforce toolkit submitted by practices as part the Quality for Optometry practice will inform future planning, with consideration being given to those cluster areas with the greatest needs. Eye Health Needs Assessment - Betsi Cadwaladr University Health Board (nhs.wales)

Gynaecology Oncology

4.19 Women's Services has identified a small number of cases involving delays in cancer diagnosis and treatment through incident reporting and rapid reviews. While case numbers remain low, early findings highlight the need for a detailed review to understand contributory factors, identify learning, and assess any required system-wide improvements.

4.20 A multidisciplinary review panel has been established to undertake an in-depth review of six cases across North Wales (four East, two Central). The panel, comprising clinical, nursing, management and governance representatives, will review patient pathways to identify common themes, improvement opportunities, and actions to strengthen the timeliness of cancer diagnosis and treatment.

4.21 The review is scheduled for 22 September 2026, with a dedicated Terms of Reference being developed to provide governance, define scope and methodology, and oversee reporting and outcomes.

4.22 Cancer Tumour Sites

4.23 BCUHB Cancer performance is consistently the worst in Wales at 53.5% (June 2026). This is significantly below the required standard. The challenges are notable in skin, breast, urology, colorectal, and head and neck services, reflecting ongoing capacity, pathway and demand pressures.

4.24 The following strategic considerations emerge from the available evidence:

4.24.1 *Prevention* - Approximately four in ten cancers are associated with modifiable risk factors including smoking, obesity, alcohol consumption and physical inactivity. Investment in prevention remains one of the most effective mechanisms to reduce future cancer burden.

4.24.2 *Early Diagnosis* - Reducing variation in screening uptake and encouraging earlier presentation remain critical opportunities to improve outcomes and reduce inequalities.

4.24.3 *Service Capacity* - The anticipated increase in cancer incidence will require continued focus on:

- Diagnostic capacity.
- Workforce sustainability.
- Treatment capacity.
- Recovery and redesign of pathways.
- Sustainable models of follow-up and survivorship care.

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

5.1 Corporate Risk CRR 25-01 - Timely Patient Access to Safe and Effective Care

Intended Outcome

5.2 By March 2027, patients consistently receive timely, effective, and safe care, evidenced by:

5.2.1 Reduction in long-wait patients (>104 weeks) and breaches of national access standards.

5.2.2 Fewer harm events linked to delayed care.

5.2.3 Improved quality metrics including length of stay, readmission rates, and patient-reported outcome measures (PROMs).

5.2.4 Reduction in regulatory and legal cases associated with delayed access.

5.2.5 A demonstrable shift in focus from access process metrics to sustained improvement in patient safety, experience, and outcomes.

5.3 Diagnostics

5.3.1 Diagnostic performance has started to improve (with weekly fluctuation), however, sustaining this improvement remains dependent on addressing ongoing capacity constraints within key services, particularly radiology, non-obstetric ultrasound and endoscopy, where demand and workforce pressures continue to impact performance.

5.4 Cancer Services

5.4.1 Increasing Demand - Rising cancer incidence and increasing complexity are increasing pressures within the service.

5.4.2 Diagnostic Capacity Constraints - Diagnostic services, particularly endoscopy and image-guided biopsy, remain the primary system bottleneck. Demand continues to exceed capacity, contributing directly to delays and below target pathway performance, with further pressure expected from future screening programmes.

5.4.3 Workforce Fragility and Unsustainable Models - Services are heavily reliant on insourcing and locum provision, particularly in Dermatology and Gastroenterology.

5.4.4 Cancer Waiting Times Performance - Performance remains significantly below target (54% vs 70%), with the greatest pressures in urology, breast and skin pathways. Improvement is constrained by underlying diagnostic and workforce limitations

5.4.5 Clinical Leadership - Vacancies in key leadership roles are limiting strategic oversight, consistency, and the pace of service improvement.

5.4.6 Patient Experience and Support Gaps - There is variation in access to key services, including prehabilitation, psychological support, and specialist supportive care.

5.5 Planned Care Programme

5.5.1 Planned Care Programme leadership: The Chief Operating Officer (COO) was also the SRO for the Programme. Interim leadership recruitment for the COO is progressing, but longer-term SRO arrangements for the Planned Care Programme remain to be confirmed.

5.5.2 Validation Performance: Validation remains off track due to limited capacity. Core team appointments have now been made, but benefits are unlikely before Q3.

6 ARGYMHELLION / RECOMMENDATIONS

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

- Note the report

ASESIAD / ASSESSMENT	
Cysylltiad â'r Bwriadau Strategol **Link to Strategic Intentions**	3. Improve Access, Outcomes and Experience If more than one applies, please list below:
Yr Egwyddorion Dylunio Design Principles	Equity and Accessibility
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd **Corporate Risks and Board Assurance Framework**	CRR 25-01

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

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

Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Asesiad o Effaith ar Ddiogelu Data *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?* **Data Protection Impact Assessment** *Have you undertaken a Data Protection Impact Assessment Screening?*	Do/Yes: ☒	Naddo/No: ☐
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	All projects undertake a DPIA where applicable
Asesiad o Effaith ar Atal Twyll *A ydych chi wedi ystyried yr effeithiau ar atal twyll?* **Counter Fraud Impact** *Have you considered the counter fraud impacts*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Cyfreithiol **Legal**	There are no specific legal implications related to the activity outlined in this report.	
Enw Da **Reputational**	Yes (Include further detail below)	
	There is a risk to the reputation of the Health Board as a result of harm caused by long waiting times for patients	
Effaith ar Adnoddau *(Pobl / Ariannol)* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	Yes – part of the Welsh Government Recovery Submission bid	

Quality Safety & Experience Committee

URGENT & EMERGENCY CARE PROGRAMME UPDATE

Dyddiad y Cyfarfod **Date of Meeting**	03 September 2026
Statws Cyhoeddi **Publication Status**	Open/ Public Not Applicable
Enw a theitl Awdur(on) yr Adroddiad **Report Author name and title**	Bridget Elliott, Recovery Director (UEC) Karen Mottart, Medical Director
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol **Lead Executive Team Member name and title**	Clara Day, Executive Medical Director

Pwrpas yr Adroddiad **Report Purpose**	For Assurance

Crynodeb Gweithredol
Executive Summary

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

Executive Summary

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

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

Plans are focused on stabilisation, delivery and sustainability of improvement across the highest-risk areas of concern within the UEC system:

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

The Health Board's UEC strategic direction is aligned to ensuring that we stabilise services, improve flow, reduce harm and deliver sustainable system transformation. From a QSE perspective, the current position reflects a gap against Health and Care Quality Standards, particularly in timely, safe and person-centred care.

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

Performance relating to ambulance handovers exceeding 45 minutes is below the Quarter 2 profile, representing a positive position against trajectory, but remains significantly above the WG expectation of zero.

Emergency department 12-hour performance has improved from 24% in June to 16%. However, whilst we have seen improvements, there is a rise in the absolute number of long waits and this metric remains one of our biggest priorities to recover to the National target of 10%.

29% of patients were assessed by a clinician within 60 minutes compared to the national target standard of 100%.

BCUHB have successfully recruited and employed Senior Leadership to support UEC, a Recovery Director who commenced in August. Their role is primarily to hold the ring on all UEC recovery activities, as well as aligning the UEC Improvement Plan with our Major Change programmes. This is an interim post for 6 months and will be monitored against improvement and key milestones achieved.

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

Acronymau / Rhestr Termau **Acronyms / Glossary of Terms**	
UEC	Urgent & Emergency Care
IMTP	Integrated Medium Term Plan
ED	Emergency Department
POCD	Pathways of Care Delays
WG	Welsh Government
EICOP	Executive Integrated Concerns Oversight Panel
YGC	Ysbyty Glan Clwyd
SOP	Standing Operating Procedure
GIRFT	Getting Things Right First Time
HALO	Hospital Ambulance Liaison Officer
IHC	Integrated Health Community
WAST	Welsh Ambulance Service (NHS) Trust
D2RA	Discharge to Recover then Assess
SDEC	Same Day Emergency Care
SPOA	Single Point of Access
NHSP&I	NHS Performance & Improvement (team)

URGENT & EMERGENCY CARE (UEC) UPDATE

1. Y SEFYLLFA / SITUATION

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

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

1.3. NHS Performance & Improvement (NHSP&I) have instigated additional interventional support and continue to monitor progress closely. Urgent Emergency Care (UEC) remains the highest safety and operational risk and priority for the Health Board, with support and focus from a dedicated intervention team supporting improvement. The Health Inspectorate Wales (HIW) Inspection of Ysbyty Glan Clwyd (YGC) Emergency Department triggered a number of immediate assurances and prompted HIW to designate the service as one of significant concern.

2. Y CEFNDIR / BACKGROUND

2.1. UEC services across the health board continue to operate under sustained pressure, driven by high demand, constrained patient flow, delayed discharge pathways and workforce challenges.

2.2. These factors continue to present risks to patient safety and experience, quality of care, staff wellbeing and organisational reputation.

2.3. Since the last Board report NHSP&I have been formally commissioned by WG to lead a mandated intervention into BCUHB. The purpose of this mandated intervention is to understand the reasons behind challenged operational performance / organisational failure, as well as support the development and delivery of rapid solutions to reset organisation onto a sustained path of recovery. Mandated intervention is deemed to be required where there are concerns regarding the organisation's capacity and or capability to undertake such activities themselves and/or where the risks or challenges are of such significance that they require a more centrally determined and directed approach.

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

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

3.1. Quality and Safety

3.1.1. EDs remain a significant area of focus due to continuing operational pressures, overcrowding, patient flow challenges and regulatory scrutiny.

3.1.2. Concerns and incidents are highlighted and triangulated through several sources including the Executive Integrated Concerns Oversight Panel (EICOP) incidents HIW concerns, performance concerns, patient experience concerns, corporate risk register and HM Coroner concerns.

3.1.3. The oversight of quality-of-care provision within the EDs has been within a fortnightly EICOP structured review, commencing following a Rapid Quality Review in November 2025. A set of metrics to provide assurance of quality of ED care has now been developed and agreed by Executive Committee and EQDG to commence reporting within August. This will ensure a standardised approach to strengthen the way in which quality is measured and monitored across the three Emergency departments.

Quality Domain	Ref	Quality Metric
Safe Care	S1	National Reportable Incidents (NRIs)
	S2	Total Incidents
	S3	Falls
	S4	Hospital Acquired Pressure Ulcers
	S5	Intentional Rounding Compliance
	S6	Patients in Undesignated Areas
	S6.1	Patients Nursed in Waiting Room
	S7	Medication Safety Incidents Causing Moderate Harm or Above
	S8	Daily Equipment and Controlled Drug Checks
	S9	Never Events
	S10a	Adult Did Not Stay
	S10b	Paediatric Did Not Stay
	S11	Recording Who Accompanied Patient Compliance
Timely & Equitable Care	T1	Time to Assessment by Senior Clinical Decision Maker
	T2	Time to Triage Within 15 Minutes
	T3a	Ambulance Handover Waits >45 Minutes
	T3b	>12 Hours in Ambulance
	T4	Forward Waiting Transfers
	T5	12 Hour Waits in ED
	T6	Non-admitted Patients >12 Hours in ED
Effective Care	E1.1	NEWS2 Compliance and Early Recognition of Deterioration
	E1.2	Safeguarding Policy and Procedure Compliance
	E1.3	Referral to Specialty Review

	E1.4	Time to CT for Stroke Diagnosis
Efficient Care	E2.1a	Nursing Rosters Filled
	E2.1b	Paediatric Nursing Rosters Filled
	E2.2	Daily Board Rounds Completed
	E2.3	Two-hourly Safety Huddles Completed
Patient Experience	P1	Patient Experience (Good/Very Good)
	P2	Number of Complaints

3.2. Emergency Department Self Assessments following HIW inspection

3.2.1. The HIW inspection of YGC ED in May 2026 resulted in escalation to a Service Requiring Significant Improvement. Concerns raised requiring Immediate Action included:

- Strengthened leadership and governance within the site and IHC with clear routes of escalation to enable whole site response to support ED.
- An urgent investigation and support to address identified concerns for culture and staff wellbeing within the department. This includes clear routes and responses for staff to be able to escalate concerns, anonymously if desired.
- An increase in the number of paediatric trained nurses on duty with some changes to layout within the paediatric ED area.
- Enhancing care for patients within the waiting rooms.
- Ensuring all medication and equipment is in date and regularly checked.

3.2.1 A comprehensive action plan associated with these issues has been developed and is being delivered.

3.2.2 In addition, the full report has now been received in draft format by the Health Board with a plan submitted in response to further required actions. HIW are due to publish all reports and plans in early September

3.2.3 To ensure learning across BCUHB, the EDs at Wrexham Maelor and Ysbyty Gwynedd have been asked to self-assess against immediate learning and peer review visits undertaken.

3.3 Wrexham Maelor Emergency Department self-assessment

3.3.1 The service demonstrates a largely positive level of compliance across the key themes reviewed, with evidence of established governance, patient safety processes, staffing arrangements and assurance mechanisms. There is good paediatric nurse staffing and clear operational oversight.

3.4 Ysbyty Gwynedd Emergency Department

3.4.1 The self-assessment demonstrates a generally positive level of compliance across the HIW improvement actions. This includes good staff engagement with established forums and mechanisms of feedback. Paediatric nurse staffing is increasing and there is good training for all in paediatric care with

consultants with additional qualifications in post. Further work is required to improve speciality response times and system flow.

3.5 Peer Reviews

3.5.1 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. This enables review activity to remain proportionate, targeted and responsive to changing risk profiles across the organisation.

Emergency Department, Wrexham Maelor

3.5.2 Peer review undertaken on 16th July 2026. The review identified a generally positive culture within the department, with staff reporting strong managerial support, visible leadership, and evidence of organisational learning being shared across teams. The review team found no immediate significant patient safety risks requiring urgent escalation; however, a number of environmental, safety and governance issues requiring local action were highlighted.

3.5.3 Areas requiring further review included:

- the continued use of temporary pod structures within the resuscitation area, which were reported to impact visibility and patient observation
- opportunities to improve patient signage and wayfinding
- concerns regarding confidentiality associated with the current streaming model location at the department entrance.

3.5.4 During the visit, a small number of patients were being cared for in corridor spaces; however, reviewers observed staff providing appropriate care, offering explanations and apologies to patients affected by delays.

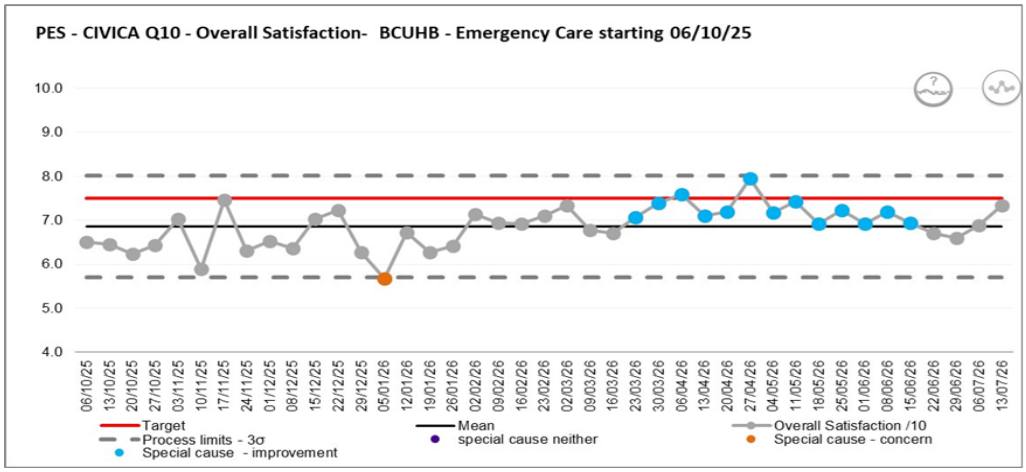
3.5.5 A peer review will be undertaken at Emergency Department Ysbyty Gwynedd in the coming weeks.

3.6 ED Patient Experience

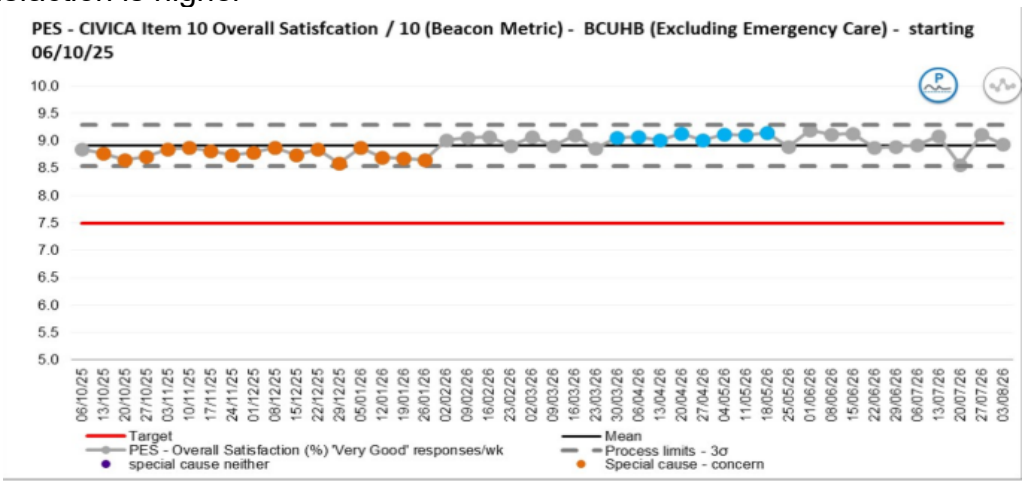
3.6.1 Patient experience data demonstrates that Emergency Departments continue to report significantly lower satisfaction levels than other services across BCUHB and are not currently achieving the all-Wales benchmark for patient experience. The findings provide further evidence of the impact of sustained pressures within urgent

and emergency care services. This data is reviewed regularly within the departments along with qualitative feedback and used to inform improvement plans.

Site	Mean /10	LCL*	UCL*
BCUHB – Including Emergency Care	8.49	8.13	8.84
BCUHB – Excluding Emergency Care	8.92	8.60	9.25
BCUHB – ALL Emergency Care Settings	6.86	5.71	8.01
IHC – Centre – Emergency Care	6.57	4.66	8.48
IHC – East – Emergency Care	6.73	4.87	8.60
IHC – West – Emergency Care	7.57	3.97	10.00

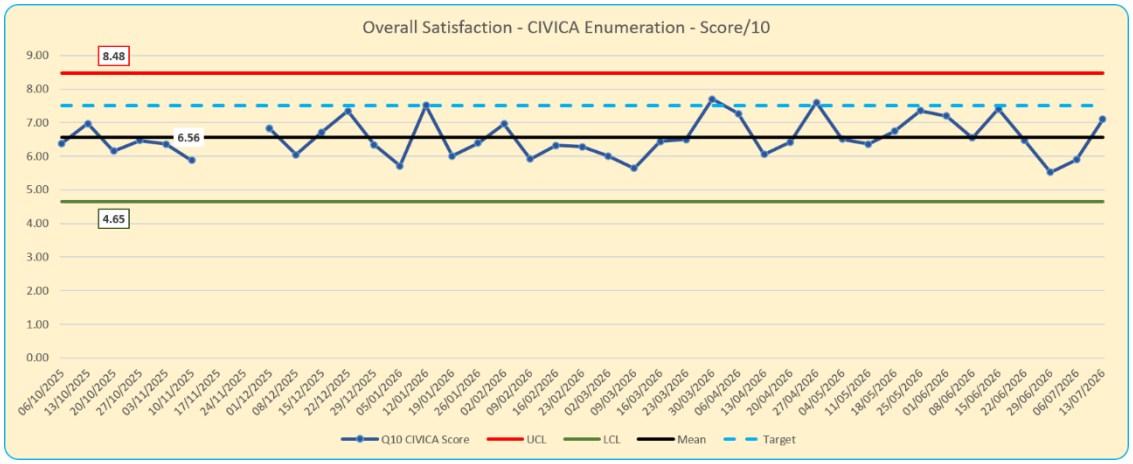


3.6.2 When compared to the rest of BCUHB and excluding Emergency departments overall satisfaction is higher

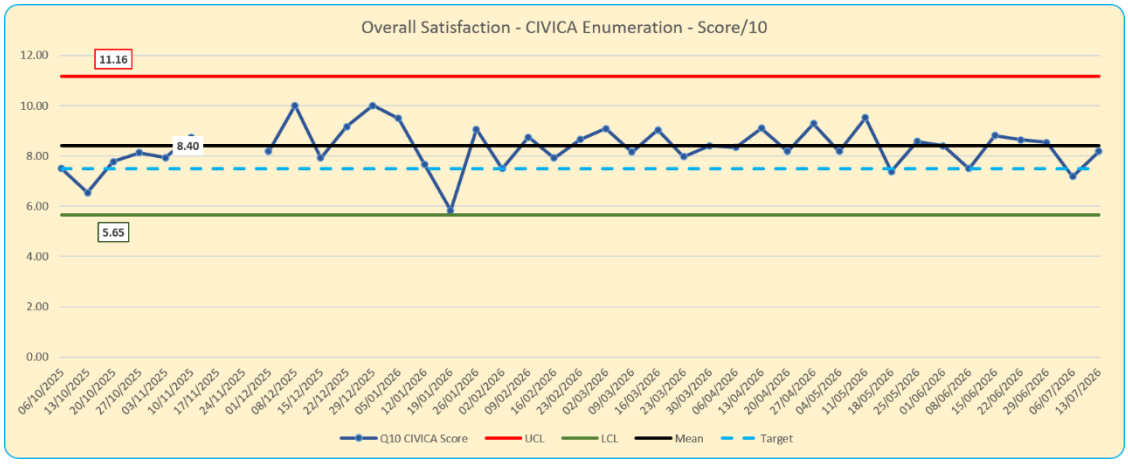


3.6.3 When looking at overall satisfaction across the three Emergency Departments, the below charts show that Central is performing below target, East generally above target and West on or just above target over recent months. Qualitative feedback consistently highlight concerns with wait and the environment but compassionate and good clinical care from staff.

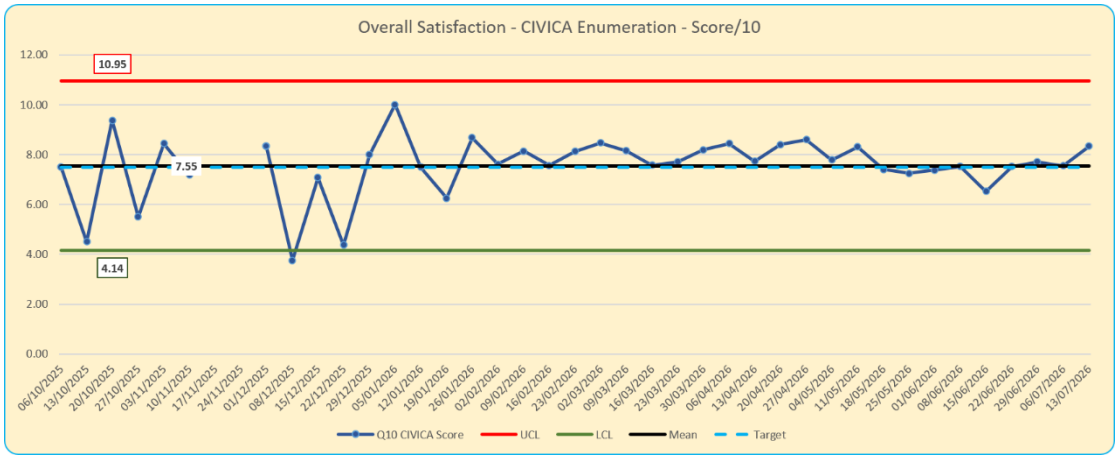
3.6.4 IHC Central Emergency Department – Overall satisfaction experience (out of 10)



3.6.5 IHC East Emergency Department – Overall satisfaction experience (out of 10)



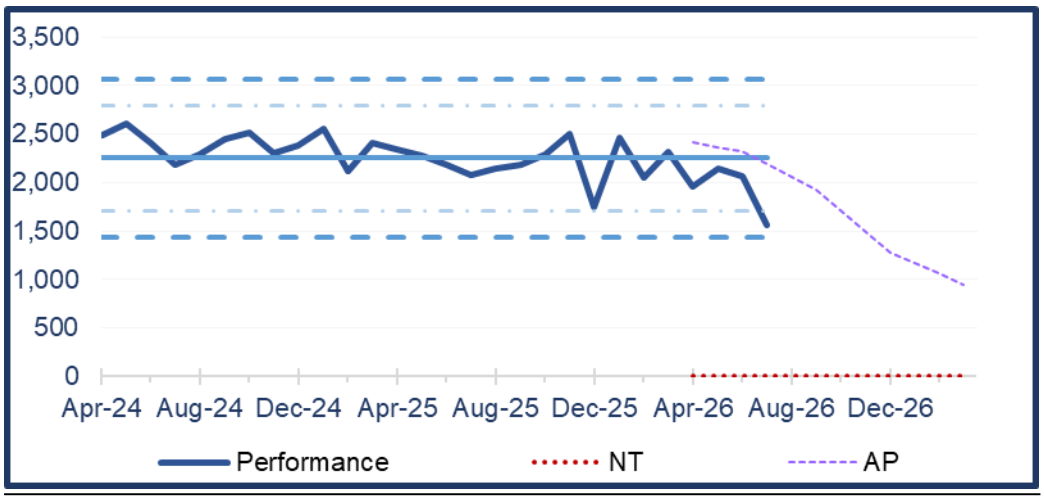
3.6.6 IHC West Emergency Department – Overall satisfaction experience (out of 10)



4. Performance

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

4.2. Number of ambulance patient handovers over 45 minutes

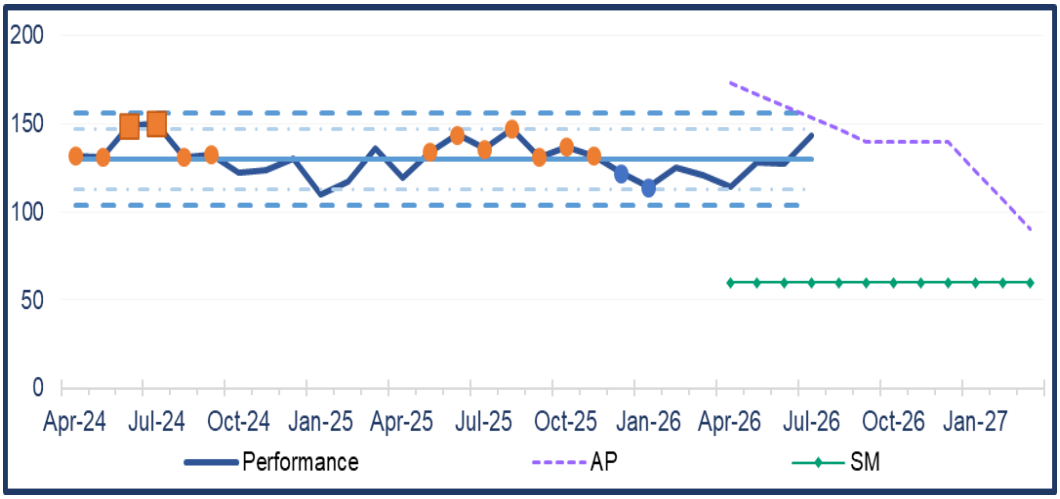


4.2.1. Performance against this metric relating to ambulance handovers exceeding 45 minutes has improved and is ahead of the health board's trajectory, which is positive but remains above the Welsh Government expectation of zero. Prolonged ambulance handovers present a direct patient safety risk, as patients remain in vehicles or handover areas without full access to ED clinical teams, which can delay definitive assessment and treatment. All EDs have processes in place to promptly review patients with an ambulance, start treatment if needed and to liaise closely with ambulance staff in case of deterioration. There is an addition a risk to delayed care within the community to patients awaiting a response.

4.2.2. The July position for BCU is 263 patients short of achieving the September target of 970. We are currently recording the lowest number of patients being handed over 1 hour since 1st August 2024. Wrexham Maelor has made significant improvement in handover performance in July with 70% of handovers being completed within 45 minutes.

4.2.3. Focused improvement with all Operational Teams has been increased, trajectories have been shared and daily input at Tactical level has been instigated. Weekly review and discussions with IHC Leaders are now in place led by Performance Director.

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



4.3.1. Delays to senior clinical assessment increase the risk of missed or delayed diagnoses and extend overall length of stay within the emergency pathway.

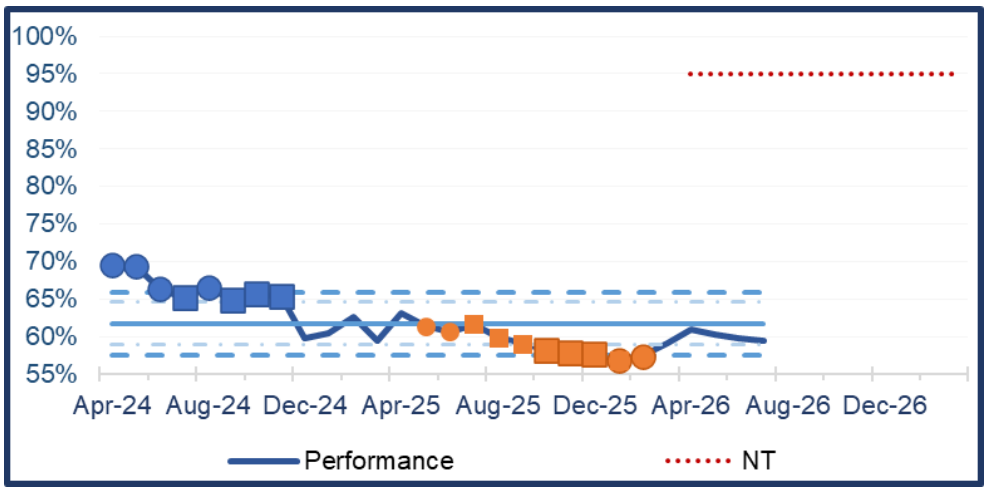
4.3.2. Performance from April to July 2026 has deteriorated month on month with the median time to assessment increasing by 29 minutes. Performance is not meeting the quarter 2 health board trajectory of 140 minutes, and 1 hour 23 minutes above the national and special measures target of 60 minutes. In July 2026, 29% of patients were assessed by a clinician within 60 minutes compared to the National target standard of 100%. Performance remains substantially below the expected level, and without sustained improvement the service is unlikely to achieve its forecast trajectory.

4.3.3. Focussed work plans are in place in all departments to support productivity within a very busy environment and to ensure that patients awaiting clinical review have tests at triage reviewed in a timely manner and are appropriately observed whilst awaiting review.

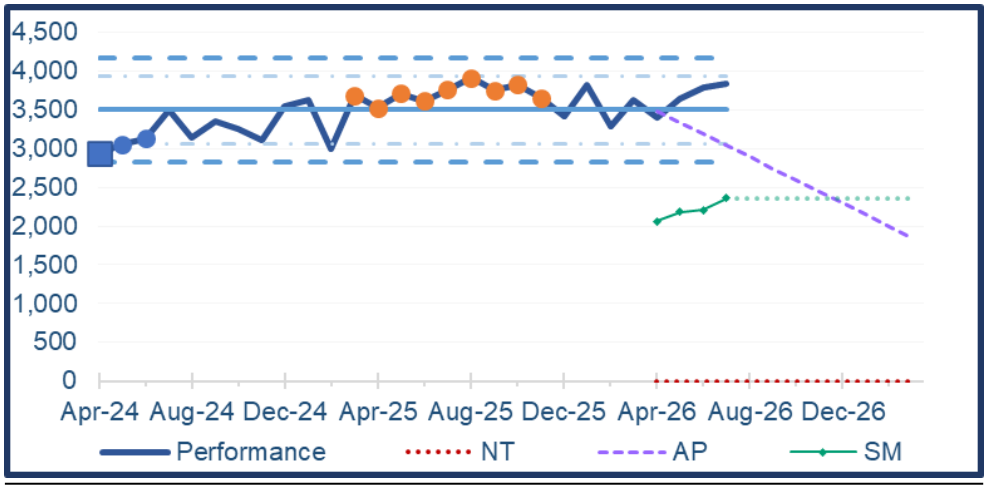
4.3.4. A business case to enhance permanent staffing within the EDs for both nursing and resident doctors was approved by Board in June. Recruitment is now in progress. This will support consistency of staffing and working to standards of care.

4.3.5. Furthermore, there is work being focussed on Operational Dashboards with 8 Steps Patient ED Pathway soon to be available to all BCU Staff. Once refreshed and released all sites will have access to the same metrics and be able to focus on what is causing the delays, when they are happening and align their resources to support the improvement of this.

4.4. 4 hour performance



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

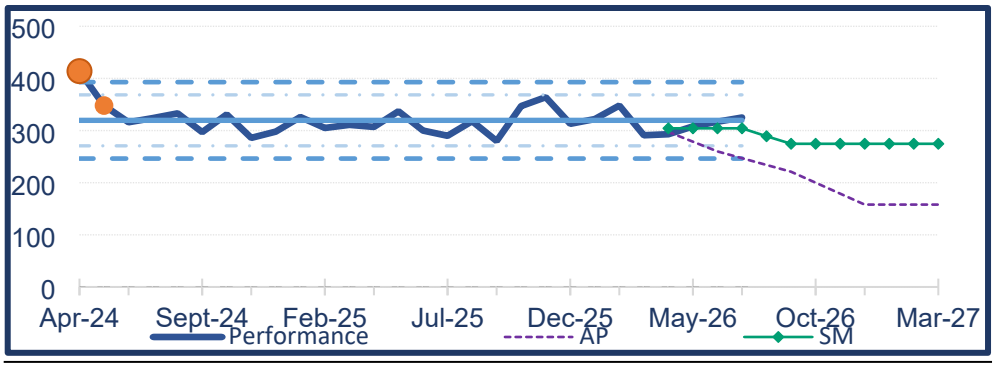


4.5.1. These metrics assess the flow through the emergency pathway, performance against both metrics is below the health board's trajectory and the national target of 10% for 12 hour delays in ED and MIUs by September 2026.

4.5.2. In July 2026, performance deteriorated in the number of patients waiting over 4 hours in the Emergency Department compared to the previous month. BCU 12 hour performance for July is 16%, West 12% Central 17 and East 20%. Performance deteriorated in the number of patients waiting over 12 hours within ED & MIU'S compared to the previous month. However, the percentage of patients breaching 12 hours across ED & MIU's improved, indicating that overall attendance growth outpaced the increase in breaches. Whilst percentage performance has improved, the rise in the absolute number of long waits continues to impact patient flow and remains an area of concern.

4.5.3. It is recognised that extended ED stays are associated with increased mortality, higher risk of deterioration and poorer patient outcomes, particularly for frail and elderly patients

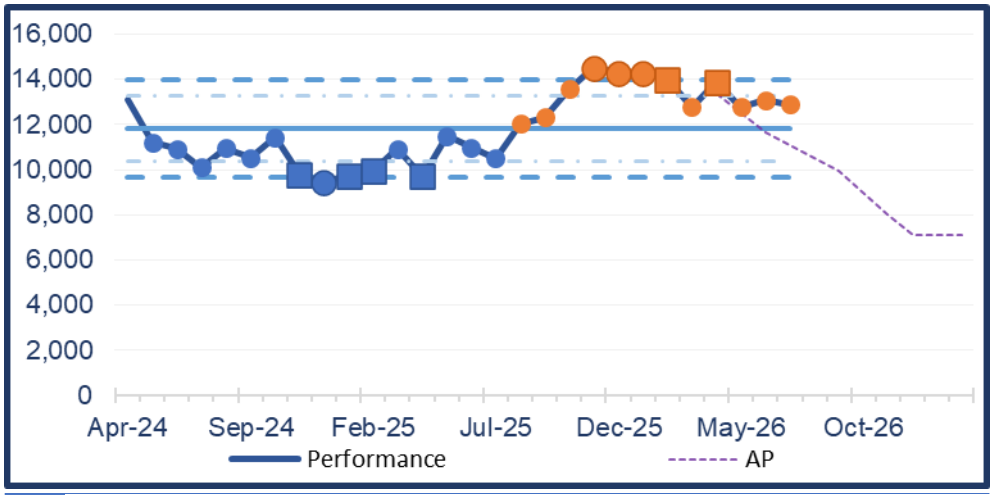
4.6. Pathway of Care Delays (PoCD)



4.6.1. Patients on a Delayed Pathway of Care (PoCD) increased by 8 in July and remain above both the Special Measures de-escalation trajectory and the Annual Plan trajectory. Bed days lost due to PoCD totalled 12,889 in July, 29.9% above the Quarter 2 profile. West IHC continues to be a significant outlier, accounting for 51.8% (6,679) of all bed days lost across BCU. Within West, 44.8% of delayed bed days relate to patients with mental health and learning disabilities, this is largely down to Bryn Y Neuadd based over in the West.

4.6.2. Whilst the number of patients on delayed pathways remains broadly comparable across IHCs (Central 101, East 116, West 108), Central continues to achieve more timely discharges through stronger community discharge capacity. In contrast, longer delays in West and East are driving the higher level of bed days lost despite similar patient volumes.

4.7. Number of bed days lost to delayed pathways of care



4.7.1. BCUHB are working very closely with the NW Regional Partnership Board and meet weekly to discuss and work together to strengthen focus on Pathway of Care Delays.

4.7.2. In conjunction with NWRPB, BCUHB have created reliable dashboards to be able to identify delays and bottlenecks in the system. The live data available via the Right Patient Right Place dashboard, alongside the validated POCD data identifies where delays are occurring and, more importantly, what is driving those delays locally.

4.7.3. NWRPB has funded a Senior nursing post, hosted to BCUHB whose focus will be to support the safe and timely transfer of care for individuals back to their communities from hospital. This is a 12-month seconded post with a member of staff from Nottingham Integrated Care Board (ICB) assigned to this post to work across North Wales from September 2026.

4.7.4. In addition to managing performance and recovery activities against the UEC Performance Standards, work is underway to begin issuing Operational Data Packs to IHCs. These packs will provide guidelines in the demand and capacity and provide a true line of sight for operational teams to be able to realign and maximise their resources to support the sites. The packs will then be reviewed quarterly by UEC Leadership team to assess where the demand and capacity may shift depending on the actions undertaken by the teams. The Digital, Data & Technology (DDAT) team are also working on forecasting demand and capacity, as well as providing intelligence for Winter planning.

4.8. **Staff Experience**

4.8.1. Clinical Engagement is one of the Health Boards strategic priorities within its Urgent & Emergency Care Improvement plan. Strengthening clinical leadership, ownership and accountability to drive sustainable improvement across the system. We are working on collating responses to questionnaire called ‘New Policy Framework for Emergency and Acute Care in Wales’.

4.8.2. WG are developing a new policy framework aimed at improving outcomes and experiences for people who need emergency and acute care services in Wales. BCUHB Communications teams are supporting this feedback template by engaging with all our stakeholders with an aim to submit responses by 1st October 2026. We will also be able to review the feedback and identify areas which can continue to feed in and shape UEC Improvement as well as support defining UEC Operating Framework for BCUHB.

5. System Risk Position (Quality & Safety)

5.1. The aggregation of demand, flow and workforce constraints means the Health Board is currently operating at a heightened and sustained level of clinical risk across UEC pathways.

5.2. The risks are not confined to ED and is systemic, spanning ambulance handover, assessment, inpatient flow and discharge. While mitigations are in place, the level of risk remains above tolerable thresholds at peak periods.

5.3. Executive oversight arrangements (including EICOP and weekly UEC oversight) provide grip, however, risk reduction is dependent on sustained improvement in flow, workforce stability and system wide discharge performance.

6. 90-Day Improvement Plans

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

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

6.3. To strengthen local operational governance arrangements, it has been identified that an UEC Operational Delivery Plan is needed, with the key UEC performance indicators forming the core framework for ongoing performance monitoring and reporting. This will support internal governance processes, providing oversight of delivery, quality and patient safety, and enabling timely identification and management of performance issues. Oversight will be provided through established governance structures, led by the Recovery Director and Chief Operating Officer, with Committee and Board support sought to ensure appropriate scrutiny, assurance and organisational accountability.

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

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

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

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

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

7.5. There remains a risk of avoidable patient harm associated with delays in assessment, treatment and admission, particularly for high acuity and frail patients. While no single theme dominates, the cumulative impact of delays across the pathway increase the likelihood of deterioration.

7.6. Workforce fragility presents a quality & safety risk, with high reliance on temporary staffing, gaps in rotas and staff fatigue affecting continuity of care, situational awareness and the ability to maintain optimal clinical standards.

7.7. There is a reputational and regulatory risk arising from the HIW escalation of Ysbyty Glan Clwyd ED, with potential for further external scrutiny if sustained improvements in safety and experience are not demonstrated.

7.8. Mitigations focus on strengthening senior clinical presence, standardising escalation processes, improving flow through discharge, and enhancing real time oversight of quality indicators. However, these actions reduce rather than eliminate risk at current demand levels.

8. ARGYMHELLION / RECOMMENDATIONS

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

8.1.1. **Note** progress and current quality, safety and risk position within the UEC 90-Day Improvement Planning
8.1.2. **Take assurance** that robust governance and mitigations are in place
8.1.3. **Support** continued delivery of the UEC Programme aligned to the IMTP 2026–2029
8.1.4. **Endorse** ongoing monitoring and review through Board and Committee structure

ASESIAD / ASSESSMENT		
Cysylltiad â'r Bwriadau Strategol Link to Strategic Intentions	3. Improve Access, Outcomes and Experience	
	If more than one applies, please list below:	
Yr Egwyddorion Dylunio Design Principles	Equity and Accessibility	
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	CRR25-01 Timely Access to Care BAF24-07	
ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Equality Act 2010 **Public Sector Equality Duty:** **Has BCUHB provided evidence of 'Due Regard' to compliance with the three parts of the Public Sector Equality Duty (General Duty):** https://www.gov.wales/public-sector-equality-duty-htmlPublic Sector Equality Duty [HTML] | GOV.WALES	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Equality Act 2010 - Socio-economic Duty *Has BCUHB provided evidence of 'Due Regard' to compliance of ther Socio-economic Duty when making strategic decisions?*	Do/Yes: ☒	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Have you completed an Integrated Equality Impact Assessment WP8a? *WP8a Template*	Canlyniad/Outcome: Do/Yes:	Naddo/No: ☒
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale: Canlynaid/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Human Rights Act *Have Human Right based concerns been addressed within WP8a*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
Compliance to the Welsh Language requirements? *Have you undertaken an Impact Assessment*	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Naddo/No: ☒
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Compliance to giving 'Due Regard' to the principles of the Armed Forces Covenant *Have the principles of the Armed Forces Covenant been addressed within WP8a*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Ansawdd	Do/Yes: ☐	Naddo/No: ☒

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?*	Canlyniad/Outcome:	
	Galluogwyr Ansawdd **Enablers of Quality** Choose an item. Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals	Not Applicable	
Effaith Amgylcheddol / Cynaliadwyedd (5Rs) **Environmental /Sustainability Impact (5Rs)**	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Asesiad o Effaith ar Ddiogelu Data *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?* **Data Protection Impact Assessment** *Have you undertaken a Data Protection Impact Assessment Screening?*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Asesiad o Effaith ar Atal Twyll *A ydych chi wedi ystyried yr effeithiau ar atal twyll?* **Counter Fraud Impact** *Have you considered the counter fraud impacts*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Cyfreithiol **Legal**	There are no specific legal implications related to the activity outlined in this report.	
Enw Da **Reputational**	Yes (Include further detail below)	
	There is a reputational risk to the Health Board of lengthy delays and potential harm	
Effaith ar Adnoddau *(Pobl / Ariannol)* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Quality Safety & Experience Committee

FRAGILE SERVICES: CURRENT POSITION AND DEVELOPMENT OF AN INTEGRATED QUALITY AND SUSTAINABILITY FRAMEWORK

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	Not Applicable
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Lead Executive Team Member name and title	Clara Day, Executive Medical Director Paolo Tardivel, Interim Executive Director of Transformation & Strategic Planning

Report Purpose	For Noting

Executive Summary

Purpose of the paper

This paper provides an overview of the Health Board's current fragile services position and an update on the development of the Fragile Services Framework. It explains how the framework will support earlier identification and management of services at risk of deterioration and describes its alignment with the Health Board's Quality Management System (QMS) and Clinical Service Planning (CSP) programmes.

Summary

The current fragile services portfolio continues to demonstrate a mixed picture. Progress has been achieved across a number of historically challenged services through recovery initiatives, pathway redesign, insourcing arrangements and strengthened governance, resulting in reductions in waiting list backlogs, improved access and enhanced oversight. However, several services continue to face significant workforce, leadership, capacity and infrastructure challenges.

Learning from both CSP Phase 1 (Challenged Services) and current fragile services demonstrates that service fragility is rarely attributable to a single issue. Instead, fragility typically occurs where workforce, capacity, quality and infrastructure pressures combine, creating a risk to the sustainable delivery of safe and timely care. Workforce sustainability remains the most significant recurring risk.

In response, the Health Board has developed a Fragile Services Framework to support earlier identification of services at risk and provide a consistent, proactive organisational response.

The framework is closely aligned with the Health Board's Quality Management System (QMS) and Clinical Service Planning (CSP) programmes. Through QMS, it supports a systematic approach to quality planning, assurance, improvement and governance. Through CSP, it provides a mechanism for identifying underlying structural issues requiring workforce planning, service redesign and investment to support delivery of the Future Clinical Model.

The framework will become the Health Board's principal mechanism for identifying, prioritising and supporting fragile services through existing governance arrangements, strengthening organisational assurance and supporting a more coordinated approach to service resilience and sustainability.

Committee recommendation / ask
The Committee is asked to note progress, endorse the direction of travel, and support the next phase of development and implementation.

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

Acronyms / Glossary of Terms	
IMTP	Integrated Medium Term Plan
ADP	Annual Delivery Plan
CSP	Clinical Services Plan
GI	Gastro-intestinal
YGC	Ysbyty Glan Clwyd
Cone Beam CT	Cone Beam Computed Tomography: a special type of 3-dimensional x-ray
IPEDG	Integrated Performance Executive Delivery Group
QMS	Quality Management System
QSE	Quality, Safety and Experience
PDSA	Plan-Do-Study-Act

1. Current Fragile Services Position

The Health Board's approach to fragile services has evolved from the former Welsh Government-defined 'Challenged Services' approach. Historically eight services were identified under the Special Measures framework: Vascular, Urology, Ophthalmology, Orthodontics, Orthopaedics, Dermatology, Plastics and Oncology. Since the development of the 2026-29 IMTP, Plastics and Oncology have been removed from the cohort and Gastroenterology has been added, reflecting the transition from externally defined challenged services to an internally driven model of identifying and managing service fragility.

Whilst the underlying causes vary between specialties, assessment of the former challenged services identifies a consistent pattern of fragility across three principal areas:

- Workforce sustainability, recruitment challenges and clinical leadership gaps
- Persistent imbalance between demand and available capacity
- Structural service model and infrastructure constraints including estates, equipment, diagnostics, and digital systems.

Progress has been made across several services through improvement plans, planned care recovery initiatives, and strengthened governance arrangements. Examples include reductions in waiting list backlogs, expansion of community-based models of care, productivity improvements and strengthened organisational oversight. However, workforce fragility remains the most significant unresolved risk across most services and continues to limit the pace and sustainability of improvement.

A consistent finding is that services demonstrating fragility are rarely affected by a single issue. Rather, fragility tends to emerge where workforce, performance, quality, and infrastructure pressures interact over time, increasing the risk that services are unable to sustainably deliver safe, effective, and timely care.

The Quarter 1 Annual Delivery Plan (ADP) reporting (Table 1) demonstrates that whilst improvement plans are delivering benefits within individual services, many of the underlying structural issues require longer-term action through Clinical Service Planning (CSP), workforce planning, and service transformation.

The term 'Fragile Service' refers to a service where cumulative risks exceed its ability to consistently deliver, safe, effective, and timely care.

*Table 1: Fragile Services: ADP Q1 Key updates summary *Plastics and Oncology have been included in this summary as Challenged Services*

Service	Current Position (Q1)	Key Issues & mitigation	RAG status (fragility)
Dermatology	• Increased waiting times for suspected skin cancer patients. • Teledermoscopy maintained a 66% discharge rate, reducing unnecessary outpatient appointments and improving access to specialist dermatology assessment.	**Issues**: Ongoing inability to recruit substantive consultants resulting in continued reliance on interim staffing and non-sustainable workforce arrangements **Mitigation:** insourcing West IHC (contracted until September 2026), locum staffing and increases in capacity (Connah's Quay). Restructuring to allow focus on Urgent Suspected Cancer patients by Consultant capacity.	
Gastroenterology	• Interim regional model for Gastro-intestinal (GI) bleed provision in place with weekend emergency endoscopy (excluding overnight). • Standardised referral and treatment pathways across primary and secondary care progressing. • No agreed clinical or operational leadership in place to drive forward improvements.	**Issues**: Overnight endoscopy cover is unavailable **Mitigation**: ongoing medical management provided until the service is available the following day	
Ophthalmology	• Long waiting times remain despite improvements in cataract pathways (One Stop Pre-Operative Assessment Clinics and High Volume Low Complexity (HVLC) surgical lists), Teach & Treat and data quality. • Digital solutions (e-referral and Electronic Health Record) in progress	**Issues:** Workforce and leadership gaps are constraining delivery of service transformation and pathway redesign. **Mitigation**: collaborative working across IHCs, with recruitment of West IHC Ophthalmology lead to strengthen local leadership; operational workforce planning in progress	

Service	Current Position (Q1)	Key Issues & mitigation	RAG status (fragility)
Orthodontics	• Stage 1 waiting times have improved through insourcing (85% decrease) but conversion to follow-up and treatment places further pressure on service capacity. • Proposals to improve access to Cone Beam CT scanning have been completed, supporting enhanced diagnostic capability.	**Issues**: Significant and growing treatment backlog exceeds current capacity. Workforce and service model challenges remain unresolved. **Mitigation**: exploring options for further capacity with external agencies and strategic partnerships. Undertaking operational workforce planning. Developing patient communication to manage expectations in relation to long waits for treatment	
Orthopaedics	• Llandudno Orthopaedic Hub was not opened in Q1 as planned with a confirmed patient date still pending (due to capital contract completion).	**Issues**: Delay to opening of the Llandudno Orthopaedic Hub has prevented planned capacity increases. **Mitigation**: continue to use Abergele Hospital capacity	
Urology	• Agreement to send 20 RAS (robotic assisted) prostatectomy patients per annum to Arrowe Park, this commenced in June 2026. • Improvement in waits for first appointments and diagnostics: 104+ week waits (un-booked patients) reduced from: 1,272 (March 2025) to 113 (July 2026)., and 52+ week waits for first appointment (un-booked patients) reduced from: 1,855 (March 2025) to 41 (July 2026). • Progress has been made with a strategic move away from long-distance outsourcing (e.g. London-based providers): mobilisation of plan with the Wirral to support 20	**Issues:** Fragile on-call model remains unsustainable. A longer-term regional solution has yet to be agreed. Requirement for Robotic Platform to support repatriation of cancer activity to North Wales **Mitigation**: Centre IHC have recruited a number of locums to underpin the on-call rota. This has stabilised and mitigated the short-term risks. Commissioning with external providers to ensure RAS surgery in Urology is available to patients in North Wales. A Rapid Quality Review is scheduled for September 2026.	

Service	Current Position (Q1)	Key Issues & mitigation	RAG status (fragility)
	robotic-assisted prostatectomies across the course of 2026/27 (first patient sent in June 2026)		
Vascular	• Sustained reduction in long waits, supported by alternative access routes such as nurse-led clinics and the development of Hot Clinics for higher-acuity patients. • Network Memorandum of Understanding (MOU) and transfer and repatriation protocols and agreements being developed and taken through IHC governance. • Educational Clinical Lead recruited to support potential return of FY1 Doctors	**Issues:** Clinical engagement with service governance to drive and embed improvements. **Mitigations**: working with Clinical Director/Lead and IHC Director to develop options for increased engagement.	
***Plastics**	• Waiting list position maintained with zero patients waiting > 104 weeks. • Connah's Quay model costed – based on weekly outpatient and minor operating capacity plus dressings clinic • All outstanding issues relating to SLA and contract now resolved, including travel funding for visiting surgeons	**Issues:** Delay to receiving contract proposal from Mersey and West Lancashire (MWL) in relation to Connah's Quay activity. **Mitigations:** Reviewed at Plastics Task & Finish Group with MWL and Joint Commissioning Committee (JCC). Proposal for Waiting List Initiatives (WLI's) in meantime to be submitted to JCC	
***Oncology**	• Medical Oncology consultant commencing September 2026 and two Clinical Oncology consultants recruited (waiting on third to confirm acceptance). • Performance against Systemic Anti-Cancer Therapy (SACT) and radiotherapy targets improved during July 2026 with all patients are booked in line with clinical priority to maximise safety and outcome. • Clinical strategy developed and progressing through BCU Governance (Clinical Effectiveness)	**Issues: D**espite appointment to substantive consultant vacancies, the locums currently employed will need to remain to maintain capacity/activity for specific tumour sites. **Mitigations:** Discussions have been undertaken with locums about becoming substantive or reducing their current rate, with all locum requests submitted for approval to RAMS and Establishment Control	

2. Emerging Learning from Fragile Services

The assessment of challenged and fragile services, together with learning from CSP Phase 1, has identified several important organisational lessons:

- **Fragility is predominantly systemic rather than service specific**

  Whilst individual services present different symptoms, the underlying causes of fragility are often common across specialties. Workforce gaps, increasing demand, infrastructure limitations and service model constraints repeatedly emerge as drivers of performance, access, and quality concerns.

- **Workforce fragility is the most significant recurring issue**

  Across the former challenged services cohort, workforce sustainability remains the principal constraint on performance improvement and service resilience. Whilst targeted interventions have improved stability in some areas, workforce planning remains critical to the development of sustainable services.

  Clinical leadership is fragmented and there is a reluctance to lead across BCUHB in these circumstances.

- **Improvement and service transformation must operate together**

  Many services have delivered meaningful operational improvements, including reductions in backlogs, improvements in access and strengthened governance arrangements. In several cases, this has been through insourcing rather than through local transformation, and is therefore not sustainable. However, experience suggests that improvement activity alone is unlikely to resolve underlying fragility where there are wider questions around service configuration, workforce models, or infrastructure. These issues require alignment with CSP and development of the Future Clinical Model.

- **Governance and Executive oversight accelerate improvement**

  A notable benefit of the challenged services approach has been the establishment of consistent executive oversight, structured reporting, and clearer accountability. Internal scrutiny arrangements have strengthened organisational assurance and improved visibility of service risks and recovery actions.

- **Clearer definitions and escalation criteria are required**

  One of the key lessons is the importance of having a clear definition of service fragility, agreed measures of progress and a transparent route for escalation and de-

escalation. This learning is directly informing development of the Fragile Services Framework.

3. Transition to Future Governance Arrangements

The development of the Fragile Services Framework represents a transition from the Welsh Government-defined Challenged Services model to a sustainable organisational approach for identifying, managing, and improving services at risk of fragility. This transition builds on the learning and governance arrangements established through CSP Phase 1 and seeks to ensure that service fragility is managed through routine organisational processes rather than standalone reporting arrangements.

The experience of CSP Phase 1 demonstrated the value of structured oversight, executive sponsorship, specialty-level planning, and clear accountability for delivery. It also highlighted that many of the challenges affecting fragile services are not solely operational and require alignment between improvement activity, quality management, workforce planning, and longer-term service redesign.

Going forward, improvement actions for services identified as fragile will be embedded within existing organisational arrangements:

- **Operational service teams** will retain responsibility for delivery of service improvement actions and ongoing management of identified risks.

- **Specialty plans and planned care recovery plans** will become the primary mechanism for tracking progress against agreed actions and monitoring service performance.

- **The Integrated Performance Executive Delivery Group (IPEDG)** will provide executive oversight of delivery, performance, and recovery actions, receiving assurance that services are progressing agreed improvement plans.

- **Clinical Service Planning (CSP)** will lead consideration of wider structural issues, including service models, configuration, workforce sustainability, and future service design where these are identified as contributory factors to fragility.

- **The Quality Management System (QMS)** will provide the vehicle for continuous improvement, assurance, and organisational learning, supporting services to move through a cycle of identification, planning, improvement, monitoring, and review.

- **Reporting and assurance** will continue through established governance arrangements, including the relevant Executive Delivery Groups, Quality structures, and Board Committees.

The Fragile Services Framework will provide an organisational mechanism for identifying and prioritising services requiring additional support, whilst ensuring that improvement activity is delivered through existing operational, planning and governance processes. This approach, aligned with the CSP Phase 1 transition arrangements approved through the Strategic Planning and Service Change Group, is intended to promote sustainability, reduce duplication and ensure a clear line of sight between immediate service risks and the longer-term ambitions of the Clinical Services Plan and Future Clinical Model. This will also ensure that fragile service recovery becomes embedded within routine operational management rather than continuing as a standalone programme.

4. Fragile Service Framework Development

The case for change is driven by the growing gap between demand for services and the system's capacity to meet that demand safely and consistently.

The Health Board continues to operate in an increasingly complex environment, characterised by workforce constraints, rising demand, performance pressures, and financial challenges.

Without a structured and consistent approach, there is a risk that fragility is:

- Identified too late when services are already in crisis
- Managed reactively, rather than proactively
- Addressed inconsistently across the organisation
- Not fully linked to planning, investment, and improvement decisions

This work represents a shift toward earlier recognition, clearer prioritisation, and more effective intervention, enabling the Health Board to move from reactive management to proactive stewardship of service quality and sustainability.

Risks to patient care are increasingly systemic and interconnected, rather than isolated within individual services. Workforce gaps, for example, can lead to delays in care, which in turn increase clinical risk and negatively impact patient experience.

Nationally, the **NHS Wales Oversight and Escalation Framework (2024)**[1] sets clear expectations that Health Boards should have effective processes for recognising and responding to services at risk of fragility.

The Special Measures (Level 5) Framework (2025) outlines specifically de-escalation criteria for the Health Board to meet:

- Evidence that the Health Board has the appropriate mechanism to understand the drivers behind a fragile service through the triangulation of key data points, including staffing levels, staff and patient feedback, concerns, incidents, stakeholder feedback

[1] NHS Oversight, Assurance, Escalation and Intervention Framework

(HIW, AW, Coroners, Royal Colleges, HTA, MHRA, Llais, etc), mortality reviews, duty of quality/candour, infection prevention and control, performance and clinical and medical leadership.

- for each clinical service evidence:
    - whether staff have all the information they need to deliver safe care and treatment to people?
    - how are people's care and treatment outcomes monitored and how do they compare with other similar services?
    - how does the service make sure that staff have the skills, knowledge and experience to deliver effective care, support and treatment?
    - how well do staff, teams and services work together within and across organisations to deliver effective care and treatment?
    - how consent to care and treatment is sought in line with legislation and guidance?
    - clear and effective processes for managing risks, issues and performance.
    - strong clinical leadership, with an effective integrated improvement plan, project management structure and effective transformation support.
    - effective response to recommendations from the Royal Colleges, HIW and other reviews are discharged and either verified or delivered or scheduled for delivery within the health board's longer-term improvement plan.
- evidence that the Board is sighted on clinical services and has a robust response to these issues that is being addressed by the health board.

While relevant intelligence already exists across performance, quality, workforce, and finance reporting, it can be fragmented and viewed in isolation. This framework brings these elements together into a single, structured view of service fragility, enabling earlier recognition of risk and a more coordinated organisational response.

- **Alignment with QMS and CSP**

The Fragile Services Framework is a key enabler of both the QMS and CSP, providing a practical link between operational risk, quality improvement, and long-term service sustainability.

QMS principles have been embedded throughout the development of the Fragile Services Framework, ensuring that quality and sustainability are integral to its design and implementation. The overarching aim is not only to address current service fragility but to establish the systems, processes, and culture required to support high-quality, sustainable services over the long term. Positioning QMS at the core of the Framework ensures a systematic approach to continuous improvement, risk management, assurance, and service resilience, enabling services to maintain quality and performance in the face of ongoing operational challenges.

The Fragile Services Framework reflects all four domains of the QMS. Through **Quality Planning**, it enables proactive identification of risks and the development of sustainable service solutions. Through **Quality Control**, it provides a consistent mechanism for assessing and monitoring service fragility. Through **Quality Improvement**, it drives actions aimed at strengthening resilience and reducing future vulnerability. Finally, through **Quality Assurance**, it ensures that appropriate oversight, accountability, and monitoring arrangements are in place to sustain improvements and maintain high standards of care. Together, these elements reinforce the Framework's focus on long-term service sustainability rather than short-term operational recovery.

QMS domains and examples of their key indictors

<table>
<tr>
<td>Quality Planning
Voice of the patient and carer:
• Patient & carer feedback
• Complaints & Incidents
• Focus groups
Planning tools:
• Performance data
• Benchmarking
• Population health
• Outcome data
External Guidance/Best Practice
• NICE/GIRFT
• Royal College
• National Frameworks
Strategy, objectives & goals
• Linked to organisational vision
• Organisational priorities</td>
<td>Quality Improvement
Improvement priorities
• Identification
• Value-driven
Improvement Capacity & Capability
• The Betsi Way
• Skills training
• Celebrating success
• Learning from failure
• Improvement Activities
What are we trying to achieve?
• How will we know we have made an improvement?
• What changes do we need to make to accomplish our aim?</td>
</tr>
<tr>
<td>Quality Control
Document management
• Standard Operating Procedures
• Up to date and accessible information
Leadership, Governance and Escalation
• Escalation of concerns
• Roles and responsibilities
• Gemba – walking the floor
Daily Process Management
• Standardisation (reliable, consistent, with minimal variation
Control activities
• Data over time eg run charts/ statistical process control
• Real-time feedback
• audit</td>
<td>Quality Assurance
• Assurance approach & activities
• Inspections – internal and external
• Peer reviews
• Audit – internal and external
• Review of risks
• Concern management
• Performance, including workforce and finance
• Benchmarking
• Patient & staff surveys</td>
</tr>
</table>

From a **CSP** perspective, the Fragile Services Framework provides an important link between current service performance, sustainability and risk, and the development of the Future Clinical Model for North Wales. It helps identify where underlying service fragility may need to be addressed through future service planning, prioritisation, and investment decisions.

Initial testing through the PDSA cycle suggests that service fragility is often associated with wider structural factors, including workforce models, service configuration, pathway design, and capacity constraints. These issues are unlikely to be addressed through operational interventions alone and may require longer-term planning and service redesign.

The framework will therefore support:

- Prioritisation of services for detailed review and planning
- Workforce planning and service redesign
- Identification of opportunities for pathway redesign and service reconfiguration
- Development of service-specific plans aligned to the Future Clinical Model
- More informed decisions about resource allocation and investment

The framework will also support the ADP by identifying services that require targeted workforce action, investment, service review or inclusion within priority change programmes. This will create a clearer link between operational risk, annual planning decisions and prioritisation of resources, ensuring that planning activity is informed by a consistent assessment of service sustainability and fragility.

In this way, the framework helps bridge day-to-day operational pressures with longer-term strategic planning and transformation.

- **Overview of the framework and identification of key indicators**

This Fragile Services Framework provides the Health Board with a coherent, risk-based approach to identifying, assessing, and responding to services that may be vulnerable to deterioration. The framework supports both immediate operational improvement and longer-term service transformation, enabling a consistent and transparent methodology for recognising emerging risks before they escalate into significant service concerns.

By applying a common assessment process and defined fragility indicators, the framework supports objective decision-making, promotes consistency in assessment outcomes, and provides a transparent basis for organisational oversight and assurance.

The Fragile Services Framework draws upon a range of existing indicators across 6 key domains:

Domain	Example Indicators
Workforce & Staff Engagement	Including Vacancy Rate, Sickness, Turnover, Locum and Agency Spend, Staff Survey Results
Performance	Including Key Performance Indicators Relevant to the Service e.g. Referral to Treatment Waiting Times, Urgent Suspect Cancer Performance.
Service Delivery	Including Demand and Capacity Assessment, Risk Management.
Quality - Safety, Experience and Effectiveness	Including National Reportable Incidents, Incidents, Complaints, Prevention of Future Deaths, Tier 1 audits
External Reviews and Standards	Including Recent Reviews and Organisational Response e.g. GIRFT, Royal College, HIW, HEIW, Nice Guidance etc.
Cost Pressures	Including Outstanding Business Cases to Support Core Service Delivery

The indicators have been defined with the support of corporate services to ensure that they align as closely as possible with existing reporting arrangements.

Each domain is assessed using defined and benchmarked criteria, supported by quantitative performance and quality metrics and will be reviewed alongside qualitative operational and clinical intelligence. Collectively, this will provide a comprehensive organisational view of service fragility, enabling the Health Board to prioritise interventions, target resources effectively, and support the stabilisation, redesign or transformation of services where required.

- **High level Process for Fragile Service Identification**

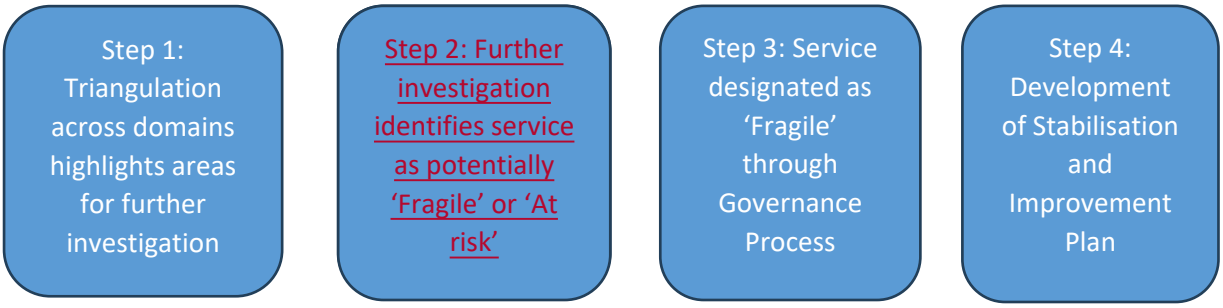

Table with full list of domains and fragility indicators are summarised in Appendix A.

Indicator thresholds are currently being defined with corporate services to allow for consistent and proportionate application across services.

An example of a Fragility Assessment Overview with scoring can be found in Appendix B.

- **Development Approach**

The framework is being developed using Plan–Do–Study–Act (PDSA) methodology, ensuring a structured and learning-based approach.

This enables the Health Board to:

Plan: Design the framework and define indicators

Do: Apply the framework in selected services

Study: Understand findings, impact, and limitations

Act: Refine the methodology and organisational response (adapt, adopt or abandon)

This iterative approach ensures that the framework is practical, proportionate and grounded in real service experience, rather than being implemented in a fixed form.

Future phases will include further PDSA cycles as the framework is scaled and embedded across the organisation.

- **Identification of Services for Assessment**

Services will be selected for assessment through a structured and intelligence-led process that combines routine organisational data with professional and operational insight. The purpose is to identify emerging risks at the earliest opportunity and prioritise services where there is evidence that quality, safety, access, performance, or sustainability may be adversely affected.

Potential services for assessment may be identified through a range of existing organisational processes, including

- performance reporting,
- quality and safety surveillance,
- workforce reviews,
- risk registers,
- specialty/service and directorate governance meetings,
- Clinical Service Planning,
- Annual Planning cycle,
- Executive Delivery Groups,
- internal or external reviews, and
- concerns escalated by clinical or operational leaders.

No single indicator will automatically result in a service being classified as fragile; rather, the framework relies on the triangulation of information across the six indicator domains to provide a comprehensive view of service resilience.

However, assessments may also be initiated outside this cycle where there is significant change in performance, workforce position, patient safety concerns, external scrutiny findings, or other intelligence suggesting an increased risk of service fragility.

5. Organisational Response

While the specific response model will be developed during the next phase of framework design, the overarching principle is that identification of a fragile service should trigger a proportionate organisational response rather than solely providing additional assurance reporting. The purpose of the framework is not simply to identify risk, but to create a consistent mechanism through which services can access the support, expertise and executive attention required to improve resilience and sustainability.

It is anticipated that, once a service is identified as fragile, an assessment will be undertaken to understand the underlying drivers of fragility across workforce, quality, demand and capacity, infrastructure, and strategic sustainability domains. This assessment will inform a tailored response that is proportionate to the level of risk and complexity identified. In some cases, this may require focused local improvement activity and enhanced monitoring; in others, it may necessitate corporate support, targeted investment, service redesign, regional collaboration, or inclusion within wider Clinical Services Plan transformation programmes.

The emerging model is expected to incorporate three interconnected levels of intervention:

- **Immediate stabilisation actions** to address risks to safety, quality, and service continuity;
- **Medium-term improvement activity** to strengthen operational resilience and performance;
- **Longer-term strategic planning** to secure sustainable clinical models and workforce arrangements.

This approach recognises, as previously stated, that fragility is rarely the result of a single issue and often reflects a combination of operational, workforce and system pressures that require coordinated action across organisational boundaries. However, it is vital that any plans are achievable within any capacity constraints within services and that improvement efforts are prioritised.

6. Next Steps

The next phase of this work will focus on:

Action	Output	By When
Transition from current Challenged Services Oversight arrangements to agreed Governance for Fragile Services	Revised Terms of Reference and focus of the Challenged Services Oversight Group	August 31st 2026 (Q2)
Refine and agree the Fragile Services Framework **assessment and identification** approach	Finalised SOP for fragility identification phase of the Fragile Services Framework.	30th Sept 2026 (Q2)
Refine and agree Fragile Services Framework **response** approach ensuring clear links with Clinical Service Plan (CSP)	Finalised and agreed Fragile Services Framework	30th November 2026 (Q3)
Operationalise the Fragile Services Framework	Service assessments undertaken and reported via agreed Governance routes	31st March 2027 (Q4)

7. Recommendations

The Committee is asked to:

- Note the current position of Challenged Services and the transition to Fragile Services
- Note the progress made in developing the Fragile Services Framework
- Endorse the direction of travel, including alignment with the Quality Management System and Clinical Service Planning
- Support the next phase of development and implementation

ASSESSMENT	
Link to Strategic Priorities	
	2. Developing strategy and long-lasting change
	If more than one applies, please list below:
Design Principles	Consistency with Organisational Values *All design principles apply*
Corporate Risks and Board Assurance Framework	*CR25-5 Strategic Change – impacting care and staff delivery*
Wellbeing of Future Generations Act – Wellbeing Goals	Not Applicable

IMPACT ASSESSMENTS		
Equality *Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)*	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	*Not applicable*
Socio-Economic Impact Assessment *Have you undertaken a Socio-Economic Impact Assessment*	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	*Not applicable*
Quality *Have you undertaken a Quality Impact Assessment Screening?*	**Enablers of Quality** Whole-systems Perspective	**Domains of Quality** All Apply
Wellbeing of Future Generations Act – Wellbeing Goals	Not Applicable	
Environmental /Sustainability Impact (5Rs)	No - Not Applicable	
Armed Forces Covenant Due Regard Duty Have you considered the Armed Forces Covenant Due Regard Duty?	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	*Not applicable*
Data Protection Impact Assessment *Have you undertaken a Data Protection Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	Not applicable
Counter Fraud Impact Assessment *Have you considered the counter fraud impacts*	Yes: ☐	No: ☒
	Outcome:	

	If no, please include rationale:	*Not applicable*
Legal	There are no specific legal implications related to the activity outlined in this report.	
Reputational	Yes (Include further detail below)	
	If the challenges outlined in this report are not adequately addressed then the organisation is likely to remain in Special Measures status, and thus contributing to the ongoing negative perception of healthcare delivery in North Wales	
Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

Domain	Ref.	Indicator	Purpose of Indicator
Workforce	W1.1	Percentage of **staff vacancies** over the last 12 months	To identify sustained workforce gaps, reduced resilience, rising workload pressure, and early warning of declining service stability.
	W1.2	Percentage of **staff sickness absence rate** over the last 12 months	To identify workforce strain, reduced capacity, and potential burnout, providing complementary insight into service resilience alongside vacancy and turnover measures.
	W1.3	12-month **rolling turnover rate** as a percentage	To reflect workforce stability, retention challenges, and loss of experience, indicating reduced continuity and increased risk to sustained service performance.
	W1.4	**Non-core spend** as a percentage of total pay bill over the last 12 months	To identify services with potential workforce fragility through dependence on non-core spend, highlighting sustainability and resilience concerns.
Staff Engagement	W1.5	**Staff Response Rate** to the NHS Wales Staff Survey 2025	To monitor staff engagement levels, with lower survey response rates potentially indicating workforce pressures, disengagement, or organisational fragility.
	W1.6	**Staff Engagement Index Score** from the NHS Wales Staff Survey 2025	To identify areas where low staff engagement may indicate increased risk to workforce sustainability and service delivery. This includes staff involvement, motivation and advocacy.
	W1.7	**Staff Morale Overall Positivity Score** from the NHS Staff Survey 2025	To assess workforce morale and resilience, identifying potential risks to wellbeing, retention, performance, and service sustainability. This includes stressors, thinking about leaving, work pressures and burnout.
Performance *Performance indictors to be agreed prior to assessment to ensure relevance to service.*	W2.1	Number of patients waiting **> 52 weeks** for a new outpatient appointment (stage 1)	To identify services experiencing capacity pressures through increasing long-wait patients, indicating potential fragility and sustainability concerns.
	W2.2	Number of patients waiting **< 52 weeks** for referral to treatment (all stages)	To identify services experiencing capacity pressures through increasing long-wait patients, indicating potential fragility and sustainability concerns.
	W2.3	Number of patients waiting **> 52 weeks** for referral to treatment (all stages)	To identify services experiencing capacity pressures through increasing long-wait patients, indicating potential fragility and sustainability concerns.

	W2.4	Number of patients waiting **> 104 weeks** for referral to treatment (all stages)	To identify services experiencing capacity pressures through increasing long-wait patients, indicating potential fragility and sustainability concerns.
	W2.5	Number of patients waiting **> 156 weeks** for referral to treatment (all stages)	To identify services experiencing capacity pressures through increasing long-wait patients, indicating potential fragility and sustainability concerns.
	W2.6	Number of patients waiting for a follow up outpatient appointment who are delayed by over 100%	To identify services experiencing capacity pressures through increasing long-wait patients, indicating potential fragility and sustainability concerns.
	W2.7	Urgent Suspect Cancer Performance	To identify services experiencing capacity pressures through increasing long-wait patients, indicating potential fragility and sustainability concerns.
Service Delivery	W3.1	Demand and Capacity Assessment	To identify services with a significant gap between actual demand and capacity (core activity), indicating potential fragility and sustainability concerns
	W3.2	Number of Tier 1 **Risks** on the Operational Risk Register	To monitor the scale of operational risks as an indicator of service resilience, stability, and capacity challenges.
	W3.3	Compliance with NICE guidance and service standards (GIRFT, CIN optimisation frameworks)	To monitor compliance against service standards and identify those services whose delivery falls below expected.
Quality – safety, experience and effectiveness	W4.1	Number of **National Reportable Incidents (NRIs)** in the last 12 months	To assess exposure to patient safety risks by tracking reportable incidents and their impact on service delivery.
	W4.2	Number of **Incidents** in the last 12 months	To assess service resilience and quality by monitoring incident trends, identifying potential risks to safety and performance.
	W4.3	Number of **Complaints** in the last 12 months	To assess emerging service challenges through complaint volumes, providing early warning of quality, access, or communication concerns.
	W4.4	Number of **Prevention of Future Deaths (PFDs)** in the last 12 months	To monitor serious safety risks requiring preventative action, providing insight into organisational resilience and service sustainability.
	W4.5	Overall **Patient Experience / Satisfaction Score** on CIVICA in the last 12 months	To assess how well services meet patient needs, providing insight into organisational resilience and performance.

Service Fragility Assessment	Service	Gastroenterology
	Date of Assessment	June 2026
	Overall Service Status	**FRAGILE**

Summary:
The service is delivering targeted performance improvements but remains structurally fragile. This is driven by medical workforce gaps, poor staff experience, and unresolved service risks, with ongoing impact on patient access, safety, and continuity of care.
Without further intervention, fragility is likely to persist due to structural workforce and demand pressures.

At – a – glance assessment

Domain	Status	Hi-level summary	Impact
Workforce		Severe medical workforce gaps and high agency reliance	Unsustainable delivery model with service dependent on temporary staffing leading to patients experiencing reduced continuity of care, potential delays in treatment, and variable clinical oversight.
		Persistent gaps in key roles (medical, clinical support groups)	Stability is improving overall, but critical roles remain unresolved
Staff Experience		Engagement, morale and burnout significantly worse than benchmarks	Retention risk and reduced service resilience leading to a risk of diminished quality of interactions and slower response times for patients.
Performance		Improvements made but underlying demand not reducing	Progress likely driven by short-term actions, not yet supported by sustainable capacity. Patients my see temporary improvements, but long waits and delays remain a risk
Service risk		Multiple high-risk issues including GI Bleed service gap	Direct patient safety and operational resilience concerns
Quality		Good patient satisfaction but safety signals present (incidents, complaints and Prevention of Future Deaths report)	Patient experience is positive, but safety indicators require scrutiny for learning and continuous improvement
Demand & Capacity		Demand exceeding sustainable capacity; mismatch not fully addressed	Ongoing pressure on the system resulting in patients experiencing long waits, delayed diagnostics/treatment and risk of deterioration.
Finance		High non-core spend driven by workforce gaps	Financial pressure not aligned with underlying service fragility which limits the ability to invest sustainable improvements that benefit patients

Priorities

Immediate stabilisation	1. Medical workforce recovery plan 2. Establish sustainable GI bleed service 3. Reduce agency reliance
Short-term stabilisation	1. Align demand vs capacity 2. Address long waits sustainably
Medium-term	1. Improve staff engagement and retention 2. Strengthen data and assurance gaps

RAG scoring Framework for Fragile Services Assessment

1. **Individual Metric within a Domain assessment**

Score	Definition
Green	Meets target/benchmark or improving and within tolerance
Amber	Moderate variance from target OR mixed picture/unstable trend
Red	Significant gap vs target OR deteriorating OR safety/sustainability risk

2. **Domain RAG**

Domain RAG is determined by:

- Predominance of rating/scores
- Override rules (critical risks)

Rule	Outcome
Majority Green	
Mixed, no critical risks	
Any critical risk trigger present	
Majority Red	

Critical Risk triggers - automatic RED triggers

A domain should be rated RED where any of the following apply:

- Unmitigated patient safety risk
- Significant workforce instability
- Sustained demand exceeding capacity (core activity)
- Multiple high or extreme operational risks
- Delivery dependent on temporary measures

Overall Service RAG

RAG	Score
Green	1
Amber	2
Red	3

Calculate the average across the domains

Condition	Score
Any 2 + Red domains including safety/workforce	Red
Any critical patient safety risk	Red
Average ≥ 2.3	Red
Average 1.6 – 2.2	Amber
Average ≤ 1.5	Green

Overall status	Definition
Green	Service delivering sustainably with manageable risks
Amber	Emerging fragility requiring active management
Red	Risks to sustainability, patient care or service delivery requiring intervention; material risks to patient safety, access or quality; improvement relies on short-term or temporary measures

Professional judgement

Domain ratings are based primarily on agreed criteria and available evidence. Professional judgement may adjust a rating by one level where data is incomplete or where sustainability, trajectory or patient risk are not fully reflected in the measures. Any adjustment must be explicitly stated.

QSE Committee

NURSE STAFFING LEVELS - SECTION 25A WARDS/DEPARTMENTS

Dyddiad y Cyfarfod Date of Meeting	03 September 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Alison Griffiths Director of Nursing Workforce, Staffing & Professional Standards Joanna Brown Nurse Staffing Programme Lead
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Angela Wood Executive Director of Nursing & Midwifery

Pwrpas yr Adroddiad Report Purpose	For Noting

**Crynodeb Gweithredol
Executive Summary**

This paper provides an update to the Quality, Safety and Experience Committee on Betsi Cadwaladr University Health Board's (BCUHB) progress towards compliance with Section 25A of the Nurse Staffing Levels (Wales) Act 2016. It has been prepared in response to the Committee's request for further assurance regarding governance arrangements, nurse staffing reviews, and progress towards statutory compliance within Section 25A areas.

Reviews of Section 25A nurse staffing establishments remain ongoing across the Health Board. To date, Emergency Departments, MHLD inpatient services and Community Hospital inpatient wards have been reviewed.

In June 2026, the Board approved recurrent investment of up to £3.85m for permanent nurse staffing across the three Emergency Departments. Equivalent recurrent investment has not yet been secured for MHLD and Community Hospital inpatient services, consequently, these services continue to manage establishment gaps through temporary staffing arrangements while also exploring opportunities to address requirements through workforce optimisation, service redesign and the reprioritisation of existing resources.

Subject to delivery of the anticipated efficiencies and recurrent savings identified within the MHLD Electronic Health Record (EHR) business case, these may provide a sustainable funding source to support the nurse staffing levels agreed through the Executive Nurse Staffing Review undertaken in Autumn 2024.

BCUHB operates a number of stand-alone community and mental health inpatient wards where staffing resilience is inherently reduced due to limited on-site workforce capacity and access to wider clinical support. These settings present increased risks to patient safety, staff wellbeing and operational continuity, particularly when responding to deteriorating patients or unplanned staffing shortfalls.

Whilst significant progress has been made in reviewing Section 25A services and securing investment for Emergency Departments, the Health Board is not yet able to provide full assurance of compliance across all reviewed services due to unfunded establishment gaps, workforce resilience concerns and reliance on temporary staffing and escalation capacity.

The accompanying Nurse Staffing QSE Presentation (Appendix 1) sets out the findings and outputs of the reviews undertaken by BCUHB in discharging its responsibilities under Section 25A of the Act.

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

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

1. NURSE STAFFING LEVELS - SECTION 25A WARDS Y SEFYLLFA
SITUATION

1.1 The Nurse Staffing Levels (Wales) Act 2016, became law in Wales in March 2016. The Act consists of 5 sections:

- 25A refers to the health boards'/trusts' overarching responsibility to have regard to providing sufficient nurses in all settings[1];
- 25B requires health boards/trusts to calculate and take all reasonable steps to maintain the nurse staffing level in all adult acute medical and surgical wards. Health boards/trusts are also required to inform patients of the nurse staffing level on those wards;
- 25C requires health boards/trusts to use a specific method to calculate the nurse staffing level in all adult acute medical and surgical wards;
- 25D relates to the statutory guidance released by Welsh Government
- 25E requires health boards/trusts to report their compliance in maintaining the nurse staffing level for each adult acute medical and surgical ward.

1.2 Responsibility for compliance with the Nurse Staffing Act extends across all levels of the organisation, from the ward to the Board. However, ultimate accountability for ensuring compliance rests with the Board and Chief Executive Officer.

1.3 This paper summarises the work undertaken to date in relation to Section 25A of the Nurse Staffing Levels (Wales) Act 2016 and, supported by the Nurse Staffing QSE Presentation (Appendix 1), provides an update on progress towards compliance. It also highlights the key risks identified through completed reviews, including establishment gaps, staffing resilience within stand-alone inpatient settings, and the impact of sustained escalation and surge capacity on the Health Board's ability to provide full assurance regarding statutory compliance.

[1] Section 25B of the Nurse Staffing Levels (Wales) Act 2016 applies to adult acute medical inpatient wards; adult acute surgical inpatient wards; and paediatric inpatient wards. Areas excluded from the definition of Section 25B wards and therefore classed as Section 25A areas include, but are not limited to areas such as, emergency departments, admission/assessment units, critical care/high dependency units, outpatient departments, day case areas, rehabilitation areas, theatres, procedural units, coronary care units, community settings.

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. In Welsh Health Boards, this duty is delegated to the Executive Director of Nursing.

2.2 In line with the Nurse Staffing Act, all areas within the organisation that are providing care to patients are required to undertake nurse staffing calculations. It is expected that these reviews will be undertaken routinely and in response to changes in patient acuity and / or dependency; when there is a change in the service model or delivery; or when concerns are raised through exception reporting or clinical governance.

2.3 The Nurse Staffing Levels (Wales) Act: Post-legislative Scrutiny (2024) identified the need for clear operational guidance to support the consistent application of section 25A across Welsh Health Boards. This work is ongoing at a national level under the auspices of the All-Wales Nurse Staffing Programme.

2.4 While national guidance is still being developed, the process for undertaking nurse staffing calculations within BCUHB is established through the NU28 - Nurse Staffing Levels Act - Governance and Compliance Policy and associated NU53 - Calculating and Maintaining Nurse Staffing Levels SOP.

2.5 Nursing workforce and nurse staffing arrangements across BCUHB are monitored in line with NU43 - Nursing & Midwifery Workforce Optimisation Standards SOP which supports the optimisation of substantive nursing establishments and internal bank resources through effective rostering and deployment practices. These arrangements are subject to continuous monitoring, evaluation, and organisational learning to support safe and sustainable workforce planning.

2.6 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 information from three key sources:

- Professional Judgement: the clinical expertise and experience of registered nurses and nurse leaders in assessing the staffing required to meet patient needs safely and effectively.
- Patient Acuity: assessment of the complexity, dependency and care needs of patients receiving care within the clinical area.
- Quality Indicators: measures of care quality, safety and patient outcomes that provide evidence of whether staffing levels are sufficient to support safe and effective care

3 MATERION PENODOL I'W HYSTYRIED
SPECIFIC MATTERS FOR CONSIDERATION

The HCSW Skill Set Assessment process, being undertaken in accordance with the NHS Wales Collective Agreement Framework, is currently in progress. On completion, the findings will be subject to detailed analysis to determine the implications for future workforce design, including the optimal balance of Band 2 and Band 3 roles within clinical teams. The outcomes will inform workforce planning, recruitment priorities and any changes required to support a safe, effective and sustainable staffing model.

3.1 Community hospital ward reviews will be revisited as the Community by Design Programme progresses and future service community service models are agreed. This will ensure that nurse staffing establishments remain aligned to the evolving model of care, service demand, patient acuity and the strategic ambition to deliver care closer to home wherever clinically appropriate.

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

4.1 The reviews completed to date have identified gaps between funded and calculated nurse staffing establishments, reflecting historic inconsistencies in the application and implementation of the nurse staffing process. While Emergency Departments have received recurrent investment to support compliance with calculated staffing requirements, equivalent funding has not yet been secured for MHLD and Community Hospital inpatient services. As a result, these services continue to manage establishment gaps through a combination of temporary staffing arrangements and service-led workforce optimisation initiatives.

4.2 The reviews have also highlighted workforce resilience risks within a number of stand-alone community and mental health inpatient settings, together with the continued reliance on escalation capacity to manage system pressures. Collectively, these factors present ongoing risks to statutory compliance, workforce sustainability, quality of care and financial control, limiting the level of assurance that can currently be provided to the Board. Continued oversight, alongside the development of sustainable workforce and service solutions, remains essential to mitigating these risks.

4.3 As a result, whilst assurance can be provided that statutory reviews are being undertaken in accordance with Health Board policy and governance arrangements, full assurance regarding compliance with Section 25A duties cannot yet be provided across all reviewed services.

5 ARGYMHELLION RECOMMENDATIONS

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

- Note the findings of the Section 25A reviews completed to date and the progress made towards compliance with the Nurse Staffing Levels (Wales) Act 2016, recognising that reviews of remaining Section 25A services are ongoing.
- Receive the Nurse Staffing QSE Presentation including the outcomes of reviews undertaken within Emergency Departments, MHLD inpatient services and Community Hospital inpatient wards.
- Acknowledge the identified gaps between funded and calculated nurse staffing establishments and the associated risks to statutory compliance, workforce sustainability, quality of care and financial control.
- Note that recurrent investment has been approved for Emergency Departments and that services within MHLD and Community Hospital settings continue to explore opportunities to address establishment gaps through workforce optimisation, service redesign and the reprioritisation of existing resources, supported where necessary by temporary staffing arrangements.
- Recognise the workforce resilience risks associated with a number of stand-alone community and mental health inpatient sites, including the current reliance on unfunded staffing arrangements to support safe service delivery.
- Support continued review of the Health Board's unfunded escalation and surge capacity, including consideration of sustainable workforce, operational and financial solutions where sustained demand exists.
- Seek assurance that nurse staffing risks, including funded establishment gaps, workforce resilience and escalation capacity, remain subject to ongoing corporate oversight through the Health Board's risk management arrangements until effective and sustainable mitigations are in place.
- Support the continuation of the rolling programme of Section 25A reviews, including future review of Community Hospital nurse staffing establishments as service models evolve through the Community by Design Programme.

ASESIAD / ASSESSMENT	
Cysylltiad â'r Bwriadau Strategol **Link to Strategic Intentions**	3. Improve Access, Outcomes and Experience
Yr Egwyddorion Dylunio **Design Principles**	Consistency with Organisational Values
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd **Corporate Risks and Board Assurance Framework**	The report highlights a number of risks to statutory compliance, workforce sustainability, quality of care and financial control. These include gaps between funded and calculated nurse staffing establishments, reduced staffing resilience within some inpatient services, and the ongoing reliance on temporary staffing arrangements and unfunded escalation capacity to support service delivery.

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Equality Act 2010 **Public Sector Equality Duty:** **Has BCUHB provided evidence of 'Due Regard' to compliance with the three parts of the Public Sector Equality Duty (General Duty):** https://www.gov.wales/public-sector-equality-duty-htmlPublic Sector Equality Duty [HTML] | GOV.WALES	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	Not Applicable
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	The report concerns internal workforce establishment decisions. 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 *Has BCUHB provided evidence of 'Due Regard' to compliance of ther Socio-economic Duty when making strategic decisions?*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	Not Applicable
	Os naddo, dylech gynnwys y rheswm: 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:	Not Applicable
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	The report concerns internal workforce establishment decisions. There is no impact in terms of equality.
Human Rights Act *Have Human Right based concerns been addressed within WP8a*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	Not Applicable
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	The proposal does not alter patient rights, service entitlements, privacy, liberty, or care pathways. It is an internal workforce establishment decision rather than one affecting individual rights.
Compliance to the Welsh Language requirements? *Have you undertaken an Impact Assessment*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	Not Applicable
	Os naddo, dylech gynnwys y rheswm: 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 *Have the principles of the Armed Forces Covenant been addressed within WP8a*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	Not Applicable
	Os naddo, dylech gynnwys y rheswm: 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. The proposal does not create or remove access to services that specifically affect

		veterans, serving personnel, or their families.
Ansawdd *A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	Not Applicable
	Galluogwyr Ansawdd **Enablers of Quality** Choose an item. Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	The report concerns internal workforce establishment decisions. There is no impact in terms of quality.
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant **Wellbeing of Future Generations Act – Wellbeing Goals**	Not Applicable	
Effaith Amgylcheddol / Cynaliadwyedd (5Rs) **Environmental /Sustainability Impact (5Rs)**	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Asesiad o Effaith ar Ddiogelu Data *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?* **Data Protection Impact Assessment** *Have you undertaken a Data Protection Impact Assessment Screening?*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	Not Applicable
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	The report concerns internal workforce establishment decisions. There is no impact in terms of data protection.
Asesiad o Effaith ar Atal Twyll *A ydych chi wedi ystyried yr effeithiau ar atal twyll?* **Counter Fraud Impact**	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	Not Applicable
	Os naddo, dylech gynnwys y rheswm:	The report concerns internal workforce

Have you considered the counter fraud impacts	If no, please include rationale:	establishment decisions. There is no impact in terms of counter fraud.
Cyfreithiol **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*"	
Enw Da **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, may attract scrutiny from regulators, the public, and Welsh Government.	
Effaith ar Adnoddau *(Pobl / Ariannol)* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	Temporary staffing costs will remain unless staffing gaps are addressed, including those associated with unfunded escalated beds.	

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Compassion

Agored
Openness

Parch
Respect

Presentation of the Nurse Staffing Levels: Section 25A Wards

Introduction

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- All patient care areas are expected to undertake nurse staffing calculations.
- Reviews of Section 25A nurse staffing establishments remain ongoing across the Health Board. To date, Emergency Departments, MHLD inpatient services and Community Hospital inpatient wards have been reviewed.
- While national guidance relating to the application of 25A across Welsh Health Boards is still being developed, the process for undertaking nurse staffing calculations within BCUHB is established through:
  - **NU28 - Nurse Staffing Levels Act - Governance and Compliance Policy**
  - **NU53 - Calculating and Maintaining Nurse Staffing Levels SOP**
- Nursing workforce and staffing are monitored in line with **NU43 - Nursing & Midwifery Workforce Optimisation Standards SOP** to ensure effective rostering, deployment and ongoing improvements.

Nurse Staffing Levels Calculations Process

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Review & Approval by Designated Person

Ward / Department Manager presentations to Associate Director of Nursing/Director of Nursing. All reviews are undertaken using an evidence-based triangulated approach (patient acuity/dependency, quality indicators and professional judgement).

Discussion takes place regarding current workforce issues/temporary staffing usage/future workforce needs/staff development & innovation.

A Health Board wide (multi-site) review is undertaken to ensure a consistent approach, share good practice/lessons learned/opportunity to improve patient care pathways.

Formal presentations are made to the Executive Director of Nursing and Midwifery.

Overall accountability for compliance with the Act rests with the Board and Chief Executive, the role of the designated person delegated to the Executive Director of Nursing and Midwifery.

Trugaredd
Compassion

Agored
Openness

Parch
Respect

Nurse Staffing Levels Summary

Nurse staffing reviews across Section 25A wards identified longstanding unaddressed practices and inconsistent processes, contributing to a system-wide gap between required and funded establishments. Earlier reviews lacked formal governance, resulting in misalignment of budgets and planned rosters needed to support safe and timely care.

Historical changes occurring prior to the EDoN reviews equated to 4.46 FTE RN and 91.03 FTE HCA. The EDoN reviews identified the requirements for a further 1.18 FTE RN and 31 FTE HCA. The total variance from budget is 16.68 FTE RN and 122.03 FTE HCA.

The table below summarises the outcomes of the EQ (excluding ED), community, and MHLD ward reviews, including historical FTE changes implemented at service level.

Ward / Department	Funded Bed numbers	Actual Bed numbers	Funded Trolleys	Actual Trolleys	Required Establishment RN	Required Establishment HCA	Funded RN	Funded HCA	Variance between current funded and required RN	Variance between current funded and required HCA	Exec DoN RN FTE Changes	Exec DoN HCA FTE Changes	Pre-Review RN FTE Changes	Pre-Review HCA FTE Changes
YMW EQ (Excluding ED)	52	52	42	42	57.25	45.49	53.86	30.33	3.39	15.16	0	0	3.39	15.16
YGC EQ (Excluding ED)	48	48	19	19	64.35	50.48	62.08	50.96	2.27	-0.48	2.84	0	-0.57	-0.48
YG EQ (Excluding ED)	48	53	30	25	63.36	46.65	62.93	42.15	0.43	4.5	0	2.84	0.43	1.66
EQ (Excluding ED) Total	148	153	91	86	184.96	142.62	178.87	123.44	6.09	19.18	2.84	2.84	3.25	16.34
Central Community Total	187	181	0	0	98.9	159.91	99.19	131.63	-0.29	28.28	0	2.84	-0.29	25.44
East Community Total	165	165	0	0	96.66	130.75	99.35	117.18	-2.69	13.57	-1.42	8.52	-1.27	5.05
West Community Total	146	146	0	0	93.8	119.4	84.45	114.74	9.35	4.66	0	0	9.35	4.66
Community Total	498	492	0	0	289.36	410.06	282.99	363.55	6.37	46.51	-1.42	11.36	7.79	35.15
MHLD Wards	250	250	-	-	286.25	378.9	304.6	321.83	-18.35	57.07	-0.24	16.8	-18.11	40.27
MHLD Duty Nurse	-	-	-	-	24.17	1.27	1.6	2	22.57	-0.73	0	0	22.57	-0.73
MHLD Total	250	250	-	-	310.42	380.17	306.2	323.83	4.22	56.34	-0.24	16.8	4.46	39.54
Grand Total (EQ, Community & MHLD)	896	895	91	86	784.74	932.85	768.06	810.82	16.68	122.03	1.18	31	15.5	91.03

Funded establishment sourced from Finance Ledger
The required establishment figures are inclusive of a 26.9% headroom.
Note: The required and funded establishment figures exclude any additional staffing requirements needed to support the unfunded bed base, and also exclude the supernumerary ward manager and ward support staff i.e. housekeepers, dementia support workers etc.

Sites

Trugaredd
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Openness

Parch
Respect

The Health Board have a number of stand alone sites across the community and mental health settings. Stand alone hospital wards present increased risks due to limited staffing resilience, reduced access to specialist support, and potential delays in responding to deteriorating patients. These factors can impact patient safety, staff wellbeing and operational effectiveness if robust mitigation arrangements are not in place.

Wards within stand alone sites:

- Community Ward, Chirk Hospital, East (30 beds)
- Community Ward, Denbigh Hospital, Central (19 beds)
- Community Ward, Ruthin Hospital, Central (27 beds)
- Community Ward, Alltwen Hospital, West (20 beds)
- Community Ward, Bryn Beryl Hospital, West (23 beds)
- Community Ward, Dolgellau Hospital, West (14 beds) – funded for 1 RN on nights, risk is mitigated through additional unfunded staffing which increases the night shift by 1 RN.
- Mental Health Ward, Cemlyn Ward, Cefni Hospital (13 beds)
- Mental Health Ward, Bryn Hesketh, Colwyn Bay (13 beds)
- Mental Health Ward, Tan Y Castell, Ruthin (8 beds) – funded for 1 RN on nights
- Mental Health Ward, Carreg Fawr, Bryn Y Neuadd (8 beds) – funded for 1 RN on nights
- Mental Health Ward, Coed Celyn, Wrexham (8 beds)

Whilst Penrhos Stanley Hospital, West, has two wards (33 beds total) both wards are currently budgeted for 1 RN on the late & night shifts. Risk is mitigated through additional unfunded staffing, increasing the late shift by 2 RN (1 per ward) and the night shift by 1 RN (supporting both wards).

Unfunded / Escalated Beds

Trugaredd
Compassion

Agored
Openness

Parch
Respect

Sustained pressures across the system continue to necessitate the routine use of escalation capacity, with an average of 157 unfunded beds or trolleys in operation at any given time. While a proportion of this activity can be absorbed within existing establishments, a significant proportion require additional staffing to maintain safe care delivery. This model is not sustainable without recurrent funding or de-escalation. The FTE uplift required to safely staff these areas is detailed in the table below.

IHC	Area	Ward	NSA Ward	Funded Bed Numbers	Unfunded Bed Numbers	Funded Trolley Numbers	Unfunded Trolley Numbers	Additional Establishment Required RN	Additional Establishment Required HCA	Early RN	Early HCA	Late RN	Late HCA	Twilight RN	Twilight HCA	Night RN	Night HCA
Central	YGC	EDOU	No	0	10	0	0	5.45	5.45	1	1	1	1	0	0	1	1
Central	YGC	Ward 14 - Discharge Hub	No	0	24	0	0	19.07	16.34	4	3	4	3	0	0	3	3
East	YMW	Fleming	Yes	8	21	0	0	8.53	14.21	2	3	2	3	0	0	1	2
East	YMW	Samaritan	No	0	13	0	0	11.37	11.37	2	2	2	2	0	0	2	2
East	YMW	SDEC	No	0	0	20	0	2.84	0	1	0	1	0	0	0	0	0
East	Community	Deeside Branwen	No	18	3	0	0	0	5.69	0	1	0	1	0	0	0	1
East	Community	Deeside Gladstone	No	20	8	0	0	2.84	2.84	1	0	1	0	0	0	0	1
East	Community	Evington Rehab	No	22	5	0	0	2.84	2.84	1	0	1	0	0	0	0	1
West	YG	Glaslyn Ward	Yes	26	4	0	0	5.69	0	1	0	1	0	0	0	1	0
West	YG	Ogwen Ward	Yes	24	6	0	0	2.84	2.84	1	0	1	0	0	0	0	1
West	YG	Prysor (Sat & Sun)	Yes	12	3	1	0	0	0.41	0	0	0	1	0	0	0	0
West	YG	Conwy SAU	No	24	6	5	0	2.84	5.69	1	1	1	1	0	0	0	1
West	YG	Gogarth AMAU (Mon - Fri)	No	28	4	5	3	3.86	3.86	0	1	0	1	0	0	2	1
		Gogarth AMAU (Sat & Sun)								0	0	0	0	0	0	1	1
West	YG	SDEC (Mon - Fri)	No	0	10	20	0	6.5	9.34	1	1	1	1	0	0	1	2
		SDEC (Sat & Sun)								2	2	2	2	0	0	1	2
West	YG	Tudno DOSA (Mon - Fri)	No	0	0	18	22	14.62	14.62	0	0	0	0	0	0	2	2
		Tudno DOSA (Sat & Sun)								2	2	2	2	0	0	2	2
West	Community	Dolgellau	No	14	4	0	0	0	2.84	0	1	0	1	0	0	0	0
West	Community	Morfa Alltwen	No	20	2	0	0	0	5.69	0	1	0	1	0	0	0	1
West	Community	Tryfan Step Down	No	24	4	0	0	2.84	2.84	1	0	1	0	0	0	0	1
Womens	YG	Ffrancon	Yes	12	5	0	0	2.84	5.69	1	1	1	1	0	0	0	1
TOTAL				**252**	**132**	**69**	**25**	**94.97**	**112.56**								

The additional establishment and staffing figures above demonstrate the requirements to permanently establish and recruit to the current unfunded bed base inclusive of a 26.9% headroom.

Recommendations

Trugaredd
Compassion

Agored
Openness

Parch
Respect

- Note the findings of the Section 25A reviews completed to date and the progress made towards compliance with the Nurse Staffing Levels (Wales) Act 2016, recognising that reviews of remaining Section 25A services are ongoing.
- Receive the Nurse Staffing QSE Presentation including the outcomes of reviews undertaken within Emergency Departments, MHLD inpatient services and Community Hospital inpatient wards.
- Acknowledge the identified gaps between funded and calculated nurse staffing establishments and the associated risks to statutory compliance, workforce sustainability, quality of care and financial control.
- Note that recurrent investment has been approved for Emergency Departments and that services within MHLD and Community Hospital settings continue to explore opportunities to address establishment gaps through workforce optimisation, service redesign and the reprioritisation of existing resources, supported where necessary by temporary staffing arrangements.

Recommendations

Trugaredd
Compassion

Agored
Openness

Parch
Respect

- Recognise the workforce resilience risks associated with a number of stand-alone community and mental health inpatient sites, including the current reliance on unfunded staffing arrangements to support safe service delivery.
- Support continued review of the Health Board's unfunded escalation and surge capacity, including consideration of sustainable workforce, operational and financial solutions where sustained demand exists.
- Seek assurance that nurse staffing risks, including funded establishment gaps, workforce resilience and escalation capacity, remain subject to ongoing corporate oversight through the Health Board's risk management arrangements until effective and sustainable mitigations are in place.
- Support the continuation of the rolling programme of Section 25A reviews, including future review of Community Hospital nurse staffing establishments as service models evolve through the Community by Design Programme.

Quality Safety & Experience Committee

Commercial Research Recovery Plan: Response to Action 3 of the Research and Development Annual Review 2026

Dyddiad y Cyfarfod **Date of Meeting**	03 September 2026
Statws Cyhoeddi **Publication Status**	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad **Report Author name and title**	Dr Jim McGuigan, Deputy Executive Medical Director
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol **Lead Executive Team Member name and title**	Clara Day – Executive Medical Director

Pwrpas yr Adroddiad **Report Purpose**	For Assurance and Endorsement

Crynodeb Gweithredol
Executive Summary

The Welsh Government Research and Development Annual Review reported on 17 June 2026. It concluded that the Health Board is not where Welsh Government would expect it to be in progressing research and development, and set four actions. Action 3 required a Commercial Research Recovery Plan by 31 July 2026. The plan was submitted on 29 July 2026 and is appended at Annex A.

Commercial activity has fallen below the level this organisation should sustain. The plan identifies four workforce constraints, in research pharmacy, imaging and radiotherapy, investigator time and delivery coordination; with research pharmacy workforce capacity being the binding constraint. Recovery will take 12 to 24 months and depends on rebuilding sponsor confidence as well as capacity, so stabilisation is placed ahead of growth. Controls that need no new funding are already running, including a mandatory pharmacy feasibility checkpoint before any sponsor commitment.

A modular VPAG application requests £461,561 across 2026 to 2029. Implementation continues more slowly if it is unsuccessful. As the taper applies, an

unfunded share of post costs rising to £295,675 in 2028/29 falls to the Health Board, to be met from commercial income the recovery has yet to generate.

Delivery is owned by the Associate Director for Research and Development and overseen monthly by the RDI Governance Group, with six-monthly reports to Welsh Government from the end of January 2027.

The committee is asked to note the outcome of the Research and Development Annual Review 2026, endorse both the Commercial Research Recovery Plan (Annex A) as submitted on 29 July 2026, and the sequencing of stabilisation of research activity ahead of growth, and agree quarterly assurance reporting to this Committee and onward to the Quality, Safety and Experience Committee.

Ymgysylltu (mewnol/allanol) yr ymgymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp) **Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)**		
Pwyllgor / Grŵp / Unigolion **Committee / Group / Individuals**	**Dyddiad Date**	**Canlyniad, Tystiolaeth a Data** **Outcome, Evidence and Data**
Welsh Government Science, Research and Evidence Division; Health and Care Research Wales	29 April 2026	Annual Review meeting. Outcome letter of 17 June 2026 set four actions for the Health Board.
Research, Development and Innovation Governance Group	July 2026	Plan developed and overseen. Monthly oversight of recovery delivery, single action log and risk register.
Pharmacy Leadership Team	July 2026	Research pharmacy demand and capacity assessment, workforce model and recruitment recovery.
Executive Medical Director	29 July 2026	Plan submitted to Welsh Government ahead of the 31 July 2026 deadline.
Welsh Government Science, Research and Evidence Division; Health and Care Research Wales	29 April 2026	Annual Review meeting. Outcome letter of 17 June 2026 set four actions for the Health Board.
Research, Development and Innovation Governance Group	July 2026	Plan developed and overseen. Monthly oversight of recovery delivery, single action log and risk register.

Executive Committee	26 August 2026	For Assurance

Acronymau / Rhestr Termau **Acronyms / Glossary of Terms**	
BI	Business Intelligence
CRO	Contract Research Organisation
CTIMP	Clinical Trial of an Investigational Medicinal Product
HCRW	Health and Care Research Wales
QSE	Quality, Safety and Experience Committee
RDI	Research, Development and Innovation
RTT	Recruitment to Time and Target
RTTQA	Radiotherapy Trials Quality Assurance
SDC	Support and Delivery Centre

COMMERCIAL RESEARCH RECOVERY PLAN: RESPONSE TO ACTION 3 OF THE RESEARCH AND DEVELOPMENT ANNUAL REVIEW 2026

1. Y SEFYLLFA
SITUATION

1.1 The Research and Development Annual Review 2026 concluded that the Health Board is not currently where Welsh Government would expect it to be in progressing the research and development agenda, and that these challenges are reflected in wider organisational performance and safety concerns. The review letter of 17 June 2026 set four actions. Action 3 required a Commercial Research Recovery Plan by 31 July 2026.

1.2 The plan was submitted on 29 July 2026 and is appended at Annex A. This paper seeks assurance and endorsement. The position on the remaining three actions is at paragraph 3.1.

2 Y CEFNDIR
BACKGROUND

2.1 The review assessed the Health Board against implementation of the NHS Research and Development Framework, two years on from the 2023 baseline assessment. Welsh Government recorded significant concerns about the delivery of commercial research and the associated reputational risk.

2.2 The position at year-end 2025/26 was 10 commercial studies open to recruitment, 7 of them CTIMPs, 183 commercial participants recruited, commercial income of £439,775 and recruitment to time and target of 20 per cent for closed studies. Three opportunities were declined or withdrawn because capacity could not be assured.

2.3 Set-up and first participant performance stood at 70 per cent against the 60-day standard and 33 per cent against the 30-day standard. Both are Q1 2026/27 figures, because measurement of these two indicators commenced only in that quarter.

2.4 A research pharmacy gap of 4 WTE has been identified; comprising Band 8a and Band 7 pharmacists and Band 6 and Band 5 technicians. This gap has resulted in studies not being opened despite willing clinical teams, and a commercial vaccine study was withdrawn by its sponsor following a recruitment pause. Recruitment to these posts is now in progress.

3 MATERION PENODOL I'W HYSTYRIED
SPECIFIC MATTERS FOR CONSIDERATION

3.1 The remaining three actions of the review are in train and do not depend upon on the decisions sought here:

3.2 Action 1**:** A formal engagement approach with Welsh Government and the Health and Care Research Wales Support and Delivery Centre, that includes oversight of external review plans review plans as they develop, including the agreed priorities, key deliverables, milestones, and timescales, to support oversight and alignment

3.3 Action 2, quarterly reviews of the new research governance structure, is being established with the first review planned for September 2026.

3.4 Action 4, an overview of national support accessed and required, has been submitted, with direct engagement with the Support and Delivery Centre arranged.

3.5 The plan restores reliable delivery of the existing portfolio before it pursues growth, and phases growth to demonstrated capacity. Controls requiring no new funding are already implemented. These are a mandatory pharmacy feasibility checkpoint before any sponsor commitment, with a recorded decision to accept, accept with conditions, defer, decline or escalate; a commercial study prioritisation framework; identification of studies needing no pharmacy or medicines support which can open while capacity recovers; earlier joint sight of the pipeline between R&D and Pharmacy; and monthly dashboard reporting of capacity, set-up, recruitment, delays, withdrawals and income.

3.6 Of the four constraints, pharmacy capacity and delivery coordination are treated as recovery investments. The Clinical Research Fellow and the radiographer element are growth investments, taken up only once stabilisation is demonstrated.

3.7 VPAG funding of £174,081 in 2026/27, £188,920 in 2027/28 and £98,560 in 2028/29 has been requested on the scheme's tapered profile. The Health Board contribution as the taper applies is nil, then £188,923, then £295,675. The assumption behind that contribution is commercial income growth from a portfolio that has not yet been restored. The substantive research pharmacy establishment is not included in these figures and will follow the demand and capacity assessment. It is the largest unpriced item.

3.8 The performance framework moves 60-day set-up from 70 per cent to 80 per cent and 30-day recruitment of a first participant from 33 per cent to 75 per cent within 2026/27. The second is a step change from a baseline measured over a single quarter. The first two quarterly reports should be treated as establishing whether that baseline is stable rather than as evidence of trajectory. An external review of the research and development programme is being commissioned and the plan will be adapted if it recommends a different approach.

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

4.1 Recovery is contingent on research pharmacy recruitment succeeding where previous rounds have not. Mitigations are fixed term, secondment and bank arrangements and a broader skill mix.

4.2 If the VPAG application is unsuccessful, delivery proceeds on existing resources and the timescale lengthens. The plan does not depend on the bid.

4.3 Sponsor confidence remains the binding constraint on portfolio recovery and further late withdrawals would compound the position. The mandatory pharmacy feasibility gateway is the principal control and its first ten decisions are to be audited.

5 ARGYMHELLION
RECOMMENDATIONS

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

- **NOTE** the outcome of the Research and Development Annual Review 2026, the four actions arising and the position on the three actions not covered by this paper.

- **ENDORSE** the Commercial Research Recovery Plan at Annex A, as submitted on 29 July 2026, and the sequencing of stabilisation ahead of growth.

- **AGREE** quarterly assurance reporting to this Committee and onward to the Quality, Safety and Experience Committee.

ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol **Link to Strategic Priorities**	 4. Improving quality, outcomes and experience
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Yr Egwyddorion Dylunio **Design Principles**	People First Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd **Corporate Risks and Board Assurance Framework**	CRR25-01 Timely patient access to safe and effective care BAF24-07 Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant **Wellbeing of Future Generations Act – Wellbeing Goals**	A Healthier Wales
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:

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

Socio-Economic Impact Assessment *Have you undertaken a Socio-Economic Impact Assessment*	If no, please include rationale:	
Ansawdd *A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	**Galluogwyr Ansawdd Enablers of Quality** All Apply	**Meysydd Ansawdd Domains of Quality** All Apply
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant **Wellbeing of Future Generations Act – Wellbeing Goals**	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:	If Armed Forces personnel are identified as part of the review and requires recall, then appropriate allowances will be made to accommodate their unique circumstances.
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	

Asesiad o Effaith ar Ddiogelu Data *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?* **Data Protection Impact Assessment** *Have you undertaken a Data Protection Impact Assessment Screening?*	Do/Yes: ☐	Naddo/No: ☐
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Asesiad o Effaith ar Atal Twyll *A ydych chi wedi ystyried yr effeithiau ar atal twyll?* **Counter Fraud Impact Assessment** *Have you considered the counter fraud impacts*	Do/Yes: ☐	Naddo/No: ☐
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Cyfreithiol **Legal**	There are no specific legal implications related to the activity outlined in this report.	
Enw Da **Reputational**	Yes (Include further detail below)	
	We have outlined in the main text the reputational risks for this look-back review. This includes, but is not limited to, loss of patient trust, regulatory scrutiny, and negative media coverage.	
Effaith ar Adnoddau *(Pobl / Ariannol)* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	
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Commercial Research Recovery Plan

Submission to Welsh Government in response to the Research and Development Annual Review 2026, Action 3

Version	6 Final
Owner	Associate Director for Research and Development
Lead Executive	Executive Medical Director
Oversight	Research, Development and Innovation (RDI) Governance Group — monthly
Reporting to Welsh Government	Six monthly progress reports against the performance framework, the first at the end of January 2027
Review	Reviewed by the RDI Governance Group monthly. The plan is formally refreshed at six and twelve months

1. Purpose

The Welsh Government Research and Development Annual Review 2026 asked BCUHB to develop a commercial research recovery plan setting out:

(a) the key issues affecting commercial research delivery,

(b) the actions being taken to address them,

(c) a clear summary of BCUHB's service offer to industry aligned to the Health and Care Research Wales (HCRW) offer, developed in collaboration with the HCRW Support and Delivery Centre and demonstrating how reliability and consistency will improve ahead of growth, by 31 July 2026.

This plan is a stabilisation and recovery plan. It restores reliable delivery before it pursues growth, and growth is phased to demonstrated capacity.

Accountability for delivery

Roles, responsibilities and accountability for the performance metrics in this plan are defined at the outset. Each metric has a named accountable role. Delivery teams report performance monthly to the R&D Senior Management Team (SMT), where team leaders account for their

studies against the set-up and recruitment measures. Underperformance is escalated from the R&D SMT to the RDI Governance Group, and from there to the Executive Medical Director where executive action is required. Dedicated resource will support KPI recovery, including the proposed delivery coordination role, whose purpose is attainment of the set-up and first participant recruitment measures.

2. Baseline Position as at end of 2025/26

Measure	Position
Commercial studies open to recruitment	10
Commercial portfolio involving CTIMPs	7
Commercial participant recruitment (2025/26)	183
60-day set-up performance	70%*
30-day recruitment of first participant	33%*
Recruitment to time and target (closed studies)	20%
Commercial income (2025/26)	£439,775
Opportunities declined or withdrawn due to capacity	3
Research pharmacy vacancy position	Confirmed gap: 1 WTE Band 8a Pharmacist, 1 WTE Band 7 Pharmacist, 1 WTE Band 6 Pharmacy Technician, 1 WTE Band 5 Pharmacy Technician. Recruitment in progress

*End of Q1 26/27 figures as newly commenced measurement

A recent illustration of the cost of constrained delivery: a commercial vaccine study was withdrawn by its sponsor following a recruitment pause, despite significant local effort. The sponsor relationship remains constructive, but the loss demonstrates how capacity and coordination gaps translate directly into lost studies and income.

3. What has constrained delivery?

BCUHB has not held a clearly defined, funded and resilient research pharmacy delivery model aligned to the expected CTIMP workload. Delivery has relied on small pockets of individual capacity rather than an establishment calculated from activity demand, weakened further by

vacancies, turnover and unsuccessful recruitment. Research pharmacy support is essential for the assessment, set-up, management, and oversight of (CTIMPs), and current workforce pressures have reduced the ability to provide this support consistently.

As a result, studies could not open despite willing clinical teams. Opportunities were declined where capacity to support research could not be assured. The Health Board has had to withdraw from three commercial studies recently after initial sponsor engagement, as pharmacy were unable to support set up and delivery

Analysis of the portfolio and pipeline identifies four workforce constraints; each is treated as a gap in this plan.

Constraint	Effect on delivery	Response
1. Research pharmacy capacity (primary constraint identified)	Insufficient pharmacist and technician capacity to assess, set up, manage and oversee CTIMPs, particularly oncology and haematology.	Fund and sustain a dedicated research pharmacy establishment. VPAG module M1.
2. Imaging and radiotherapy research capacity	Radiology operates largely as a reactive support service. There is no dedicated therapy radiographer time for the RTTQA that trials require. This can delay protocol review, feasibility work and imaging endpoint compliance and inhibit growth.	Dedicated diagnostic research radiographer time (growth) and therapy research radiographer time (growth). VPAG module M2.
3. Investigator time	Limited dedicated clinician time to open and run commercial trials in the highest-demand specialties.	Clinical Research Fellow, oncology and haematology. VPAG module M3 (growth phase).
4. Set-up and delivery coordination	No dedicated role monitors set-up and recruitment performance or works with the national delivery team. This contributes to under-achievement of the set-up, recruitment of first participant and RTT measures.	Delivery Co-Ordinator. VPAG module M4.

The responses are phased. Pharmacy capacity, and delivery set up coordination restore reliable delivery of the existing portfolio and are recovery investments. The Clinical Research Fellow and the diagnostic and therapy radiographer element build capacity for the portfolio the

recovered service can then take on, and are growth investments linked from stabilisation through to growth. This distinction is carried through the VPAG application.

4. Actions

4.1 Governance and process — implemented or in progress, no new funding

- RDI Governance Group established with monthly oversight of recovery, a single action log and risk register, reporting to the Executive Medical Director. Quarterly reporting to Executive Committee and on to Quality, Safety and Experience Committee.
- Mandatory pharmacy feasibility checkpoint before any sponsor commitment, with a recorded decision: accept, accept with conditions, defer, decline or escalate. This function is carried out at AAC (Assess, Arrange, Confirm) with escalations to Senior Team
- Commercial study prioritisation framework directing limited capacity to greatest patient benefit and organisational return, with less complex CTIMPs identified to open first.
- Identification of commercial trials requiring no pharmacy or medicines support, which can open while pharmacy capacity recovers.
- Monthly BI dashboard reporting capacity, set-up, recruitment, delays, withdrawals and income.
- Earlier joint sight of the pipeline between R&D and Pharmacy.

4.2 Workforce — closes constraints 1 to 4

- Complete a quantified pharmacy demand and capacity assessment and implement the resulting workforce model. Recruitment to the confirmed gap has transferred to Pharmacy management and is in progress.
- Secure additional dedicated diagnostic and therapy research radiographer capacity for protocol review, feasibility, imaging standardisation and RTTQA.
- Fund dedicated investigator time in oncology and haematology as a growth investment, taken up as stabilisation is demonstrated.
- Introduce a delivery coordination role whose purpose is attainment of the set-up and recruitment of first participant KPIs, monitoring RTT performance study by study and interfacing with the national delivery team.

These four actions are the subject of a modular VPAG bid totalling £461,561 over 2026–2029 on the scheme's tapered profile. Delivery proceeds on existing resources if the bid is unsuccessful but more slowly.

4.3 Sponsor confidence

- A single point of contact for sponsors and CROs, with defined service standards and feasibility response timelines.
- Standardised sponsor communication, including honest early notification where capacity is in question, replacing late withdrawal. This should be minimised with greater scrutiny at acceptance phase.
- Structured follow-up with sponsors of recently lost or paused studies to retain the relationship for future opportunities.
- Quarterly review of set-up performance and lessons learned, shared with delivery teams.

5. Collaboration with the HCRW Support and Delivery Centre

The Annual Review asked that this plan be developed in close collaboration with the HCRW Support and Delivery Centre. The R&D team has completed and submitted its assessment of support gaps and needs, and a face-to -ace meeting has been arranged for 10 August with colleagues from the Support and Delivery Centre to engage in a joint discussion.

The support asks BCUHB brings to that discussion are:

- Contract support for complex and medical-device commercial trials, where product-liability and sponsor-specific terms require specialist review currently dependent on a single individual.
- Access to pre-submission regulatory advice to avoid avoidable rejections.
- Clarification of roles and responsibilities between health board research teams and the national function, to remove duplicated queries and effort.
- All-Wales contracting of shared systems, avoiding duplication where each organisation currently contracts separately.
- Clearer and more succinct information on commercial expressions of interest, particularly for Primary Care.

6. BCUHB Commercial Research Service Offer

Aligned to the HCRW offer and UK commercial research expectations, BCUHB offers sponsors and CROs:

- Access to a population of approximately 700,000 across North Wales.
- Delivery of commercial interventional and observational studies, with experienced Principal Investigators in cancer, haematology, cardiology and respiratory medicine.
- Dedicated R&D support for feasibility, costing and contracting, with rapid feasibility assessment.
- A single point of contact, transparent communication and performance monitoring.
- Access to HCRW support infrastructure and UK-wide commercial delivery networks.

- Cross-border collaboration where a study cannot be delivered locally.

7. Delivery Plan

The plan is delivered in three phases. Each action below states what will be done and how.

Immediate (0 to 3 months) July- Sept 26

Action	Deliverable	Lead	Timeline	Governance oversight
Establish Commercial Research Recovery Group	Recovery programme established with agreed terms of reference, action log and risk register.	Associate Director for R&D	Month 1	RDI Governance Group (monthly), reporting from the R&D Senior Management Team
Confirm baseline position at year-end 2025/26	Validated baseline of commercial portfolio, pipeline, delayed studies, declined opportunities, pharmacy capacity, vacancies and income impact.	Associate Director for R&D	Month 1	RDI Governance Group
Complete pharmacy demand and capacity assessment	Quantified assessment of CTIMP activity demand, workforce requirement, current establishment, vacancies and capacity gap.	Pharmacy (research lead)	Months 1 to 2	Pharmacy Leadership Team and RDI Governance Group
Introduce mandatory pharmacy feasibility gateway	Standardised process requiring pharmacy approval prior to sponsor commitment. The first ten gateway	Associate Director for R&D	Month 2	RDI Governance Group

	decisions are audited to confirm the process is operating.			
Identify commercial trials requiring no pharmacy or medicines support	List of studies that can open while pharmacy capacity recovers, prioritised for set-up.	Associate Director for R&D	Months 1 to 3	RDI Governance Group
Develop minimum viable research pharmacy model	Defined workforce model including WTE requirement, skill mix, supervision arrangements and resilience requirements.	Pharmacy (research lead)	Month 2	Pharmacy Leadership Team
Produce workforce recovery plan	Recruitment and retention plan addressing vacancies, failed recruitment and interim mitigations.	Pharmacy (research lead) / Workforce	Month 2	Pharmacy Leadership Team and RDI Governance Group
Implement commercial study prioritisation framework	Agreed prioritisation criteria for commercial opportunities where capacity is limited.	Associate Director for R&D	Months 2 to 3	RDI Governance Group
Review BI performance dashboard	Monthly reporting of capacity, recruitment, study set-up, delays, withdrawals and commercial income.	Associate Director for R&D	Month 3	RDI Governance Group

Submit recovery progress update	Initial assurance report demonstrating actions completed, risks and recovery trajectory.	Associate Director for R&D	Month 3	RDI Governance Group / Welsh Government

Stabilisation (3 to 6 months) Oct-Dec 26

Action	Deliverable	Lead	Timeline	Governance oversight
Recruit to priority vacancies	Recruitment completed or alternative mitigations agreed.	Pharmacy (research lead) / Workforce	Months 4 to 6	RDI Governance Group
Reduce reliance on individual expertise	Cross training and succession plans in place for key functions.	Pharmacy (research lead)	Months 4 to 6	Pharmacy Leadership Team
Improve sponsor responsiveness	Defined service standards and feasibility timelines implemented.	Associate Director for R&D	Months 4 to 6	RDI Governance Group
Strengthen multidisciplinary support model	Agreed support arrangements with pharmacy, medical physics and other enabling services.	Associate Director for R&D	Months 4 to 6	RDI Governance Group
Review recovery progress against baseline	Formal review of portfolio growth, delays, withdrawals and capacity metrics.	Associate Director for R&D	Month 6	RDI Governance Group
Clinical Research Fellow in post to support growth linked from stabilisation*	Measurable increase in studies opened and delivered.	Associate Director for R&D	Month 3	RDI Governance Group

Research radiographer additional time to support commercial clinical trials*	Measurable increase in studies opened and delivered.	Associate Director for R&D	Month 3	RDI Governance Group
Embed post focusing on supporting set-up and recruitment*	Improved study set-up timelines and recruitment to time and target performance.	Associate Director for R&D	Month 2	RDI Governance Group

*Subject to successful VPAG funding.

Recovery and growth (6 to 12 months) Jan-June 2027

Action	Deliverable	Lead	Timeline	Governance oversight
Increase commercial study activity	Measurable increase in studies opened and delivered.	Associate Director for R&D	Months 6 to 12	RDI Governance Group
Reduce declined and withdrawn studies	Demonstrable reduction in opportunities lost through capacity constraints.	Associate Director for R&D	Months 6 to 12	RDI Governance Group
Improve delivery reliability	Improved study set-up and sponsor performance metrics.	Associate Director for R&D	Months 6 to 12	RDI Governance Group
Demonstrate sustainable pharmacy support model	Capacity shown to meet and sustain current demand for three consecutive months.	Pharmacy (research lead)	Months 9 to 12	Pharmacy Leadership Team

Review commercial service offer	Updated service offer aligned to available infrastructure and workforce.	Associate Director for R&D	Month 12	RDI Governance Group
Implement research pharmacy operating model	Agreed temporary or substantive workforce model in place.	Pharmacy (research lead)	Months 4 to 6	Pharmacy Leadership Team

8. Performance Framework (2026–2029)

Metric	Baseline (year-end 2025/26)	2026/27	2027/28	2028/29
60-day set-up	70% *Q1 26/27	80%	90%	>90%
30-day recruitment of first participant	33% *Q1 26/27	75%	90%	>90%
Recruitment to time and target (closed studies)	20%	70%	80%	80%
Commercial studies open to recruitment	10	10	12	15
Commercial participant recruitment	183	sustain	+10% (from baseline)	+30% (from baseline)
Commercial income	£439,775	sustain	+15% (from baseline)	+30% (from baseline)
Opportunities declined due to capacity	3	−25% (from baseline)	−50% (from baseline)	−75% (from baseline)
Commercial CTIMP portfolio (absolute number of studies)	7	7	8	10

These figures are shared with the VPAG application, so the plan and the bid report against one baseline of year-end 2025/26. The national set-up and recruitment-to-time-and-target

measures map onto the first three rows. CTIMP targets are expressed as absolute numbers of studies.

9. Financial Summary

	2026/27	2027/28	2028/29	Total
VPAG funding requested (four modules, tapered 100%/50%/25%)	£174,081	£188,920	£98,560	£461,461
BCUHB contribution as taper applies	0	£188,923	£295,675	£484,598

The income assumption is set out openly. As VPAG funding tapers, the unfunded share of post costs is met from commercial income generated by the restored portfolio. If income growth lags, the pace of growth is slowed rather than commitments extended beyond capacity. Substantive pharmacy establishment costs are being confirmed through the demand and capacity assessment.

10. Governance, Reporting and Review

Area	Accountable role	Frequency	Route
Recovery plan delivery	Associate Director for R&D	Monthly	RDI Governance Group
Commercial research recovery programme	Associate Director for R&D	Monthly	RDI Governance Group
Pharmacy workforce and capacity plan	Pharmacy (research lead)	Monthly	Pharmacy Leadership Team / RDI Governance Group
Commercial study pipeline and prioritisation	Associate Director for R&D	Monthly	Commercial Research Recovery Group

Performance dashboard and metrics	Associate Director for R&D	Monthly	RDI Governance Group
Workforce and recruitment recovery	Pharmacy (research lead) / Workforce	Monthly	Pharmacy Leadership Team
Welsh Government assurance reporting	Executive Medical Director	Six monthly	Welsh Government / HCRW
Board assurance reporting	Executive Medical Director	Quarterly	Executive Committee/QSE

The plan is a live document. The RDI Governance Group reviews progress monthly against the action log. The plan itself is formally refreshed at six and twelve months, and the refreshed version accompanies each six-monthly report to Welsh Government.

11. Risks and Mitigation

Risk	Impact	Mitigation
Pharmacy model not matched to demand	Cannot deliver current and future portfolio	Demand-and-capacity assessment; implement agreed model
Persistent recruitment difficulty	Capacity not restored	Fixed term, secondment and bank mitigations. Broader skill mix
Reliance on individual expertise	Reduced resilience	Cross-training and succession planning
Sponsor commitment before capacity confirmed	Delays, withdrawal, reputational damage	Mandatory feasibility gateway
Imaging / radiotherapy capacity unaddressed	Imaging-dependent trials cannot open	VPAG M2. Interim extended hours arrangements
VPAG bid unsuccessful	Slower recovery	Phased delivery on existing resources and income
Income growth lags taper	Post costs unfunded	Slow the phasing of growth. Review establishment
Growth outpaces capacity	Sponsor expectations missed	Growth phased to demonstrated capacity

Quality Safety & Experience Committee

BOARD ASSURANCE FRAMEWORK 2026-2027

Dyddiad y Cyfarfod **Date of Meeting**	03 September 2026
Statws Cyhoeddi **Publication Status**	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad **Report Author name and title**	Jody Evans Assistant Head of Risk Management
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol **Lead Executive Team Member name and title**	Pam Wenger Director of Corporate Governance

Pwrpas yr Adroddiad **Report Purpose**	For Assurance

Crynodeb Gweithredol
Executive Summary

The Board Assurance Framework (BAF) comprises five principal strategic risks aligned to the Health Board's Strategic Intentions and Integrated Medium-Term Plan (IMTP). This report provides an update on the assurance position for the following risks within the Committee's remit:

- **BAF 26_03: Failure to Improve Access, Outcomes and Experience.** This risk incorporates several key service areas requiring continued oversight and assurance, including; Fragile Services (3C), Mental Health & Learning Disabilities (MHLD) (3D), Child and Adolescent Mental Health Services (CAMHS) & Neurodevelopment (3E), Children & Young People Services (3F), Women's Health (3G), Pharmacy & Medicines Management (3H), and Dementia Services (3I).

- **BAF 26_04: Failure to Deliver and Create a Modern, People-Centred Healthcare System that is Future Focused.** Within the Committee's remit, this includes assurance relating to Research, Development & Innovation (4E) and Quality (4H).

The refreshed BAF has been developed to provide a clearer line of sight between the Health Board's strategic objectives, delivery plans, operational performance, and Board assurance arrangements. Progress has been made in identifying and

articulating key strategic risks, controls, sources of assurance, assurance gaps, and mitigating actions across the priorities within the Committee's remit.
BAF Risk 26_03 and 04 have been validated and published on the Risk Management Portal.

The overall assurance position remains predominantly Limited Assurance. However, the Committee should note that the Quality Priority (4H) has been assessed as providing Reasonable Assurance due to established quality governance arrangements, effective oversight, and ongoing quality improvement programmes.

The remaining priorities within the Committee's remit remain assessed as Limited Assurance. This should not be interpreted as a lack of governance, oversight, or management action. Rather, it reflects the relative maturity of the refreshed framework, the ongoing development of controls and assurance mechanisms, and the limited availability of outcome-based evidence demonstrating that mitigating actions are delivering measurable and sustainable improvements

Whilst governance arrangements, controls and improvement programmes are in place and subject to ongoing monitoring, further work is required to strengthen assurances.

The Committee is asked to review the current assurance position and determine whether it is satisfied that appropriate controls, assurances, and mitigating actions are in place to manage the principal strategic risks within its remit.

Ymgysylltu (mewnol/allanol) yr ymgymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp) **Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)**		
Pwyllgor / Grŵp / Unigolion **Committee / Group / Individuals**	**Dyddiad** **Date**	**Canlyniad, Tystiolaeth a Data** **Outcome, Evidence and Data**
Executive Directors	June – Aug 2026	Draft BAF risks circulated for review, challenge and validation.
Executive Committee	29 July 2026	Draft BAF risks circulated for review, challenge and validation.
Risk Scrutiny Group	20 July 2026	Draft BAF reviewed and endorsed subject to completion of outstanding Executive Director feedback and amendments.
Transformation and Improvement Team	Ongoing	Collaboration continuing to develop the BAF within the Portal and explore future reporting integration opportunities.

Acronymau / Rhestr Termau Acronyms / Glossary of Terms	
BAF	Board Assurance Framework
IMTP	Integrated Medium Term Plan
ADP	Annual Delivery Plan
EC	Executive Committee

BOARD ASSURANCE FRAMEWORK 2026-2027

1. Y SEFYLLFA
SITUATION

The Board Assurance Framework (BAF) has been refreshed to align with the Health Board's Strategic Intentions and Integrated Medium Term Plan (IMTP), providing a clear framework through which principal risks are identified, managed and monitored.

The Quality, Safety and Experience Committee has oversight responsibility for assurance relating to the following priorities within BAF Risks 26_03 and 26_04:

- **BAF 26_03: Failure to Improve Access, Outcomes and Experience**. This risk incorporates several key service areas requiring continued oversight and assurance, including Fragile Services (3C), MHLD (3D), CAMHS & Neurodevelopment (3E), Children & Young People Services (3F), Women's Health (3G), Pharmacy & Medicines Management (3H), and Dementia Services (3I).

- **BAF 26_04: Failure to Deliver and Create a Modern, People-Centred Healthcare System that is Future Focused.** Within the Committee's remit, this includes assurance relating to Research, Development & Innovation (4E) and Quality (4H).

The Committee's role is to seek assurance that these principal risks are being managed effectively and to provide assurance to the Board accordingly.

Whilst most assurance ratings remain limited, progress has been made in strengthening governance arrangements, defining controls, identifying assurance gaps and establishing improvement actions. Evidence of sustained impact and risk reduction will continue to emerge as the framework matures

However, assurance remains predominantly **Limited Assurance**, reflecting the need for further evidence to demonstrate the effectiveness, sustainability and impact of mitigating actions on reducing strategic risk exposure.

BAF Risk 26_03 and 04 have all been validated and uploaded to the Risk Management BAF Portal.

2 Y CEFNDIR
BACKGROUND

The refreshed Board Assurance Framework has been developed following approval of the Health Board's Strategic Intentions and Integrated Medium Term Plan.

A programme of work has been undertaken with Executive Directors and Risk Lead Owners to identify principal risks, review existing controls, establish sources of assurance and identify gaps requiring further management action. The refreshed framework is intended to strengthen the link between strategic objectives, operational delivery, performance monitoring and Board assurance.

The framework will continue to mature as further evidence becomes available through performance reporting, audit activity, external review and routine governance processes.

3 MATERION PENODOL I'W HYSTYRIED
SPECIFIC MATTERS FOR CONSIDERATION

The Committee is asked to note:

- The controls, sources of assurance and mitigating actions in place to manage the risks within the Committee's remit.
- That assurance ratings across the relevant risks remain predominantly Limited Assurance, with the exception of the Quality Priority (4H), for which Reasonable Assurance is proposed due to established quality governance arrangements, effective oversight, and ongoing quality improvement programmes.
- That further assurance is required to demonstrate the sustainability and effectiveness of mitigating actions and improvement programmes.
- That ongoing work is being undertaken to strengthen outcome-based measures, benefits realisation and independent assurance.

Cross-Cutting Assurance Themes

Review of the risks within the Committee's remit has identified several recurring themes:

- Workforce capacity, recruitment, retention and sustainability challenges are a consistent theme across many of the priorities within the Committee's remit and continue to impact service resilience and transformation delivery.

- Limited independent validation and outcome-based evidence are available to demonstrate the long-term effectiveness and sustainability of improvement programmes and redesigned service models.
- Variation in access, service delivery, pathway maturity and quality governance arrangements continues to require further standardisation, integration and strengthening of assurance mechanisms.

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

The Committee should note the following areas of significant concern:

BAF 26_03 - Failure to Improve Access, Outcomes and Experience

The Committee should note ongoing risks relating to workforce sustainability, increasing demand, service fragility, variation in access and pathway delivery, together with the need for further assurance regarding the effectiveness and sustainability of transformation programmes across Fragile Services, Mental Health & Learning Disabilities, CAMHS & Neurodevelopment, Children & Young People Services, Women's Health, Pharmacy & Medicines Management and Dementia Services.

BAF 26_04 - Failure to Deliver and Create a Modern, People-Centred Healthcare System that is Future Focused

The Committee should note risks associated with embedding the Quality Management System across the organisation, strengthening quality governance and organisational learning arrangements, and developing a sustainable research, development and innovation infrastructure capable of supporting service improvement, workforce development and future-focused healthcare delivery.

Overall Assurance Position

The Committee can take assurance that governance arrangements, controls and mitigating actions are in place to manage the principal risks within its remit. Whilst the majority of priorities remain assessed as Limited Assurance, the Quality Priority (4H) has been rated as a Reasonable Assurance rating, reflecting more mature governance arrangements, established controls and a broader range of assurance evidence. However, additional evidence is required across the remaining priorities to demonstrate the effectiveness and sustainability of controls and provide increased assurance that strategic risks are reducing over time. The overall assurance position therefore remains predominantly Limited Assurance.

5 ARGYMHELLION RECOMMENDATIONS

a. Gofynnir i'r Pwyllgor

The Committee is asked to:

- **NOTE** the current assurance position for BAF Risks 26_03, and 04.
- **REVIEW** the proposed assurance ratings and supporting rationale, noting that the Quality Priority (4H) has been assessed as providing Reasonable Assurance whilst the remaining priorities remain Limited Assurance.
- **NOTE** the key assurance gaps and areas requiring further management action.
- **SUPPORT** continued work to strengthen assurance evidence, benefits realisation and demonstration of risk reduction.
- **FOLLOWING DISCUSSION AND SCRUTINY** of the assurance presented, determine the level of assurance it is able to provide to the Board regarding the management of principal risks within its remit.

Appendices:

- Appendix 1 – BAF Risks Relevant to Committee
- Appendix 2 – Mapped Open Actions from Extant BAF 2024-2025 (Open actions from the previous Board Assurance Framework have been reviewed and mapped to the refreshed framework to ensure continuity of oversight and delivery where appropriate).

ASESIAD / ASSESSMENT	
Cysylltiad â'r Bwriadau Strategol **Link to Strategic Intentions**	Choose an item. If more than one applies, please list below: Improve Access, Outcomes and Experience Create a Modern, People Centred Healthcare System
Yr Egwyddorion Dylunio Design Principles	Simplify, Standardise, and Adopt Best Practices
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd **Corporate Risks and Board Assurance Framework**	This paper relates directly to the Board Assurance Framework and supports the Health Board's strategic risk management arrangements through the development and implementation of a refreshed BAF aligned to the IMTP.

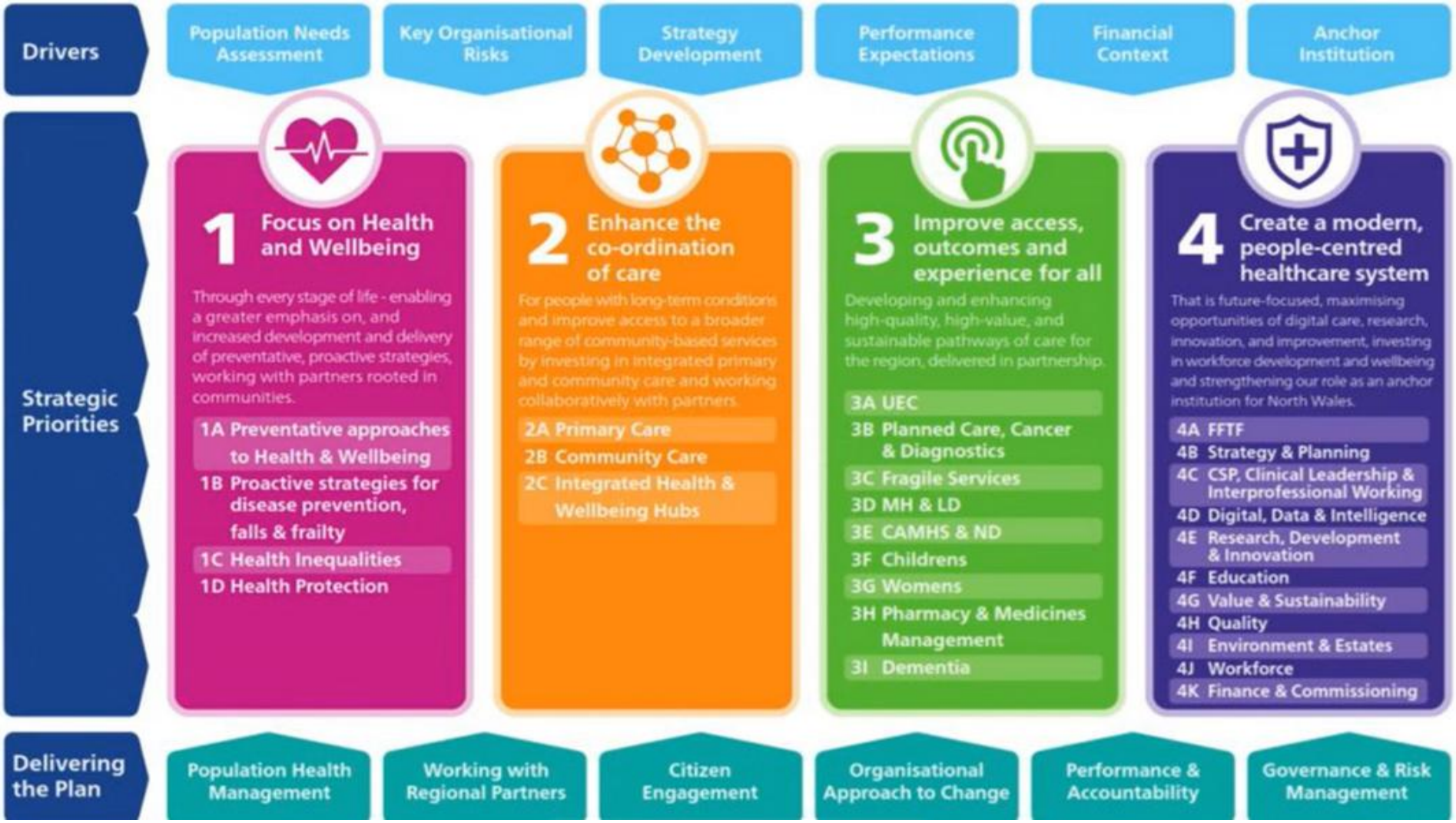
ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Equality Act 2010 Public Sector Equality Duty: **Has BCUHB provided evidence of 'Due Regard' to compliance with the three parts of the Public Sector Equality Duty (General Duty):** https://www.gov.wales/public-sector-equality-duty-htmlPublic Sector Equality Duty [HTML] | GOV.WALES	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Administrative Report.
Equality Act 2010 - Socio-economic Duty *Has BCUHB provided evidence of 'Due Regard' to compliance of ther Socio-*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm:	Administrative Report.

economic Duty when making strategic decisions?	If no, please include rationale:	
Have you completed an Integrated Equality Impact Assessment WP8a? *WP8a Template*	Canlyniad/Outcome: Do/Yes:	No
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale: Canlynaid/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Administrative Report
Human Rights Act *Have Human Right based concerns been addressed within WP8a*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
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: ☒ Administrative report
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	N/A
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:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Administrative report.
Ansawdd *A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?* **Quality**	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Galluogwyr Ansawdd Enablers of Quality	Administrative report.

Have you undertaken a Quality Impact Assessment Screening?	Choose an item. Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales	
Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Asesiad o Effaith ar Ddiogelu Data *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?* **Data Protection Impact Assessment** *Have you undertaken a Data Protection Impact Assessment Screening?*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Administrative report.
Asesiad o Effaith ar Atal Twyll *A ydych chi wedi ystyried yr effeithiau ar atal twyll?* **Counter Fraud Impact** *Have you considered the counter fraud impacts*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Administrative report.
Cyfreithiol **Legal**	There are no specific legal implications related to the activity outlined in this report.	
Enw Da **Reputational**	Yes (Include further detail below)	
	Positive impact through improved Board oversight, assurance and transparency regarding strategic risk management.	

Effaith ar Adnoddau *(Pobl / Ariannol)* **Resource Impact** *(People / Financial)*	Yes (Include further detail below) Existing resources have been utilised to undertake the BAF refresh. Efficiencies through integration with Portal reporting arrangements and alignment with ADP reporting processes.


GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board
Board Assurance Framework 2026-29


Drivers
Population Needs Assessment
Key Organisational Risks
Strategy Development
Performance Expectations
Financial Context
Anchor Institution
Strategic Priorities
1 Focus on Health and Wellbeing
Through every stage of life - enabling a greater emphasis on, and increased development and delivery of preventative, proactive strategies, working with partners rooted in communities.
1A Preventative approaches to Health & Wellbeing
1B Proactive strategies for disease prevention, falls & frailty
1C Health Inequalities
1D Health Protection
2 Enhance the co-ordination of care
For people with long-term conditions and improve access to a broader range of community-based services by investing in integrated primary and community care and working collaboratively with partners.
2A Primary Care
2B Community Care
2C Integrated Health & Wellbeing Hubs
3 Improve access, outcomes and experience for all
Developing and enhancing high-quality, high-value, and sustainable pathways of care for the region, delivered in partnership.
3A UEC
3B Planned Care, Cancer & Diagnostics
3C Fragile Services
3D MH & LD
3E CAMHS & ND
3F Childrens
3G Womens
3H Pharmacy & Medicines Management
3I Dementia
4 Create a modern, people-centred healthcare system
That is future-focused, maximising opportunities of digital care, research, innovation, and improvement, investing in workforce development and wellbeing and strengthening our role as an anchor institution for North Wales.
4A FFTF
4B Strategy & Planning
4C CSP, Clinical Leadership & Interprofessional Working
4D Digital, Data & Intelligence
4E Research, Development & Innovation
4F Education
4G Value & Sustainability
4H Quality
4I Environment & Estates
4J Workforce
4K Finance & Commissioning
Delivering the Plan
Population Health Management
Working with Regional Partners
Citizen Engagement
Organisational Approach to Change
Performance & Accountability
Governance & Risk Management

Board Assurance Framework

**The Board Assurance Framework (BAF) provides a single view of the organisation's principal risks, how they are being managed, and the level of assurance available to the Board.
It brings together strategic risks, controls, actions and assurance sources to support effective oversight and decision-making.**

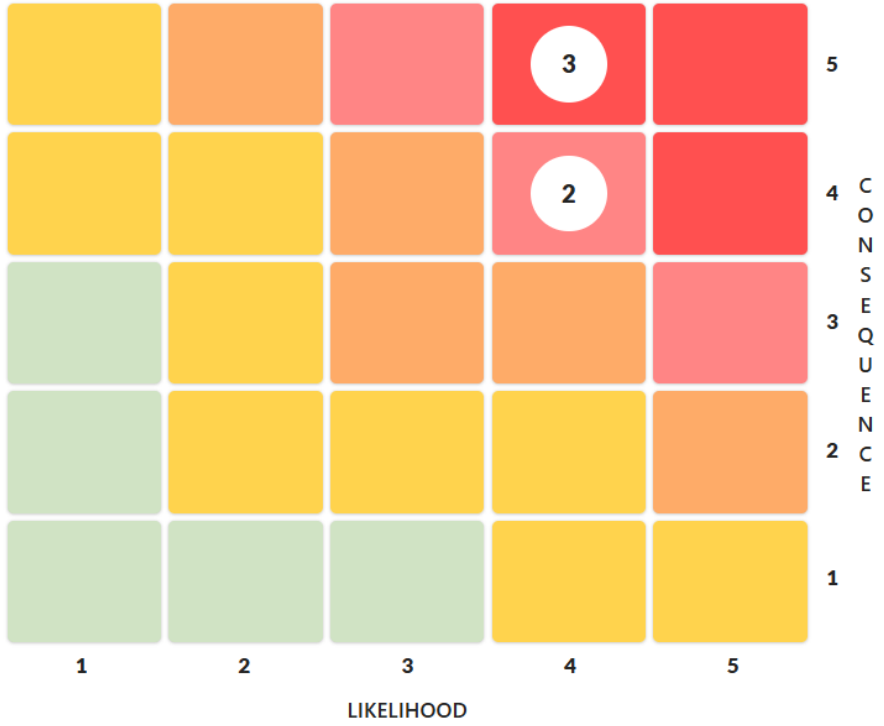
Pending Action

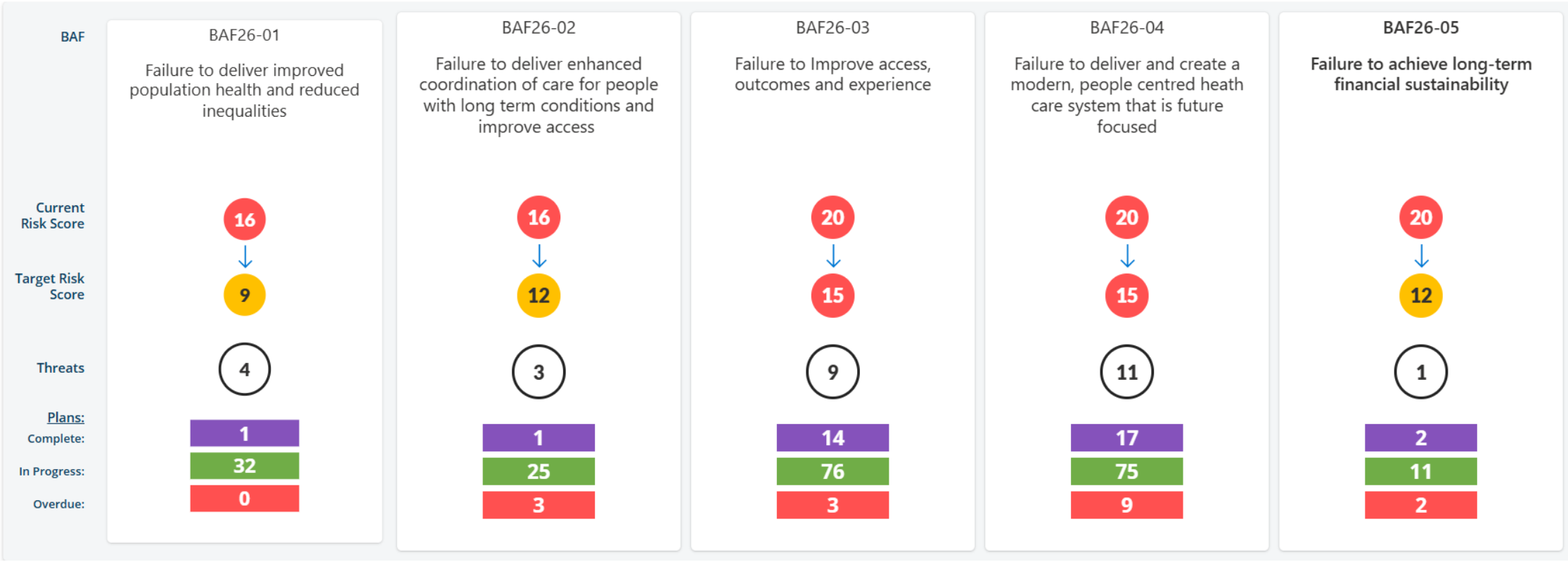
20	0	0
Plans Pending Update	Threats Pending Update	BAF Risks Pending Update

All Risks

Reset All Risks

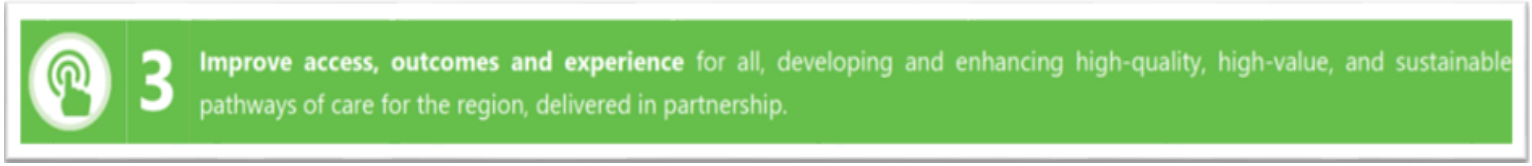
Risk Title	Current Score
BAF26-03 - Failure to Improve access, outcomes and experience	20
BAF26-05 - Failure to achieve long-term financial sustainability	20
BAF26-04 - Failure to deliver and create a modern, people centred heath care system that is future focused	20
BAF26-01 - Failure to deliver improved population health and reduced inequalities	16
BAF26-02 - Failure to deliver enhanced coordination of care for people with long term conditions and improve access	16




BAF
BAF26-01
Failure to deliver improved population health and reduced inequalities
BAF26-02
Failure to deliver enhanced coordination of care for people with long term conditions and improve access
BAF26-03
Failure to Improve access, outcomes and experience
BAF26-04
Failure to deliver and create a modern, people centred heath care system that is future focused
BAF26-05
Failure to achieve long-term financial sustainability
Current Risk Score
16
16
20
20
20
Target Risk Score
9
12
15
15
12
Threats
4
3
9
11
1
Plans:
Complete:
1
1
14
17
2
In Progress:
32
25
76
75
11
Overdue:
0
3
3
9
2

Key to lead committee assurance ratings:

 **Substantial Assurance**	The Committee is satisfied that there is reliable evidence supporting the effectiveness of the current risk treatment strategy in mitigating the threat, with minimal gaps in control. While the majority of actions have been addressed, some minor actions may still require completion before the risk score is reduced. However, the Committee has good assurance regarding action progress. Likelihood of risk materialising: Low.
 **Reasonable Assurance**	The Committee has seen sufficient evidence that the most significant actions to reduce the risk have been completed. There is assurance that the planned actions within the current risk treatment strategy are appropriate, with the majority of control and assurance gaps having been addressed. Likelihood of risk materialising: Low to moderate.
 **Limited Assurance**	The Committee does not have sufficient evidence for assurance that the current risk treatment strategy is effectively mitigating the threat. There remains to be some key gaps in controls that require management attention, and further external validation is needed. Until further controls are in place, there remains a number of actions to reduce the score. Likelihood of risk materialising: Moderate.
 **Unsatisfactory Assurance**	The Committee has no/little evidence for assurance that the current risk treatment strategy is effectively managing the threat. There remains to be several key gaps in controls that require management attention, and further external validation is needed. Until further controls are in place, there remains a number of actions to reduce the score. Likelihood of risk materialising: High



Principal risk (What could prevent us achieving this strategic objective)	**BAF 26 03 - Failure to Improve access, outcomes & experience** There is a risk that the organisation may be unable to deliver improved access, outcomes, and experience for all patients across the region if high-quality, high-value, and sustainable care pathways cannot be developed, enhanced, or delivered in effective partnership. This could result from constraints in workforce capacity, system pressures, service fragility, digital & infrastructure limitations, variation in pathway maturity, and insufficient collaboration with partners. Failure to mitigate this risk may lead to widening inequalities, reduced patient satisfaction, & an inability to meet regional population health needs		
Lead Committee	Performance Finance and Information Governance Committee, Quality, Safety Experience Committee, People & Culture Committee	**Risk Type**	**Quality**
Risk Lead	Chief Operating Officer	**Risk Appetite**	**<15**
Related Corporate Risks:	CRR25-01 – Timely Patient Access to Safe and Effective Care, CRR25-02 – Future Demand & Sustainable Workforce, CRR25-04 – Modernising Digital Infrastructure to Enable Safe, Integrated Care, CRR25-05 – Strategic Change Impacting Care and Staff Delivery, CRR25-06 – Delivery of the 2026/27 Financial Plan and Financial Sustainability, CRR08 – Partnership Working and System Integration		

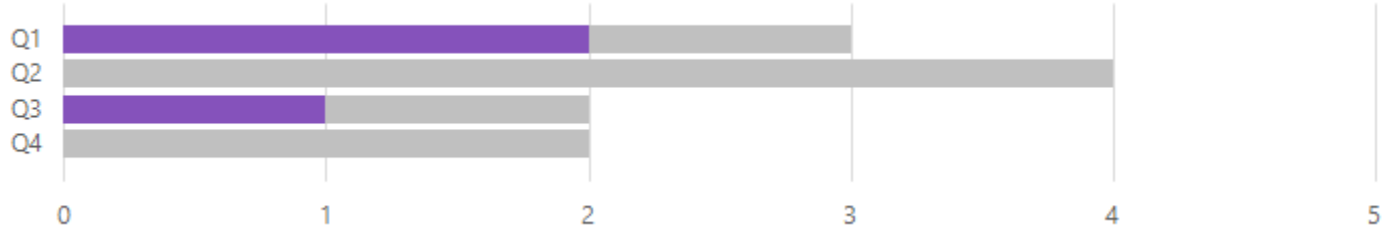
Risk Rating			**Review Dates**	
	Current Exposure	**Target**		
Consequence	5	5	**Initial assessment**	July 2026
Likelihood	4	3	**Last Committee review**	
Risk Rating	20	15	**Last Executive Review**	July 2026

Priority:	3C Fragile Services
Strategic Threat and Risks: There is a risk that the Health Board is unable to deliver safe, sustainable and equitable fragile services due to workforce constraints, financial limitations, challenges in agreeing service models, and operational pressures impacting delivery and resilience	
Accountable:	Chief Operating Officer

Primary risk controls:	Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating
Clinical Services Planning (CSP) Programme driving sustainable service models Fragile Services Programme governance and oversight Adoption of national guidance (GIRFT, Royal College standards, clinical networks) Workforce planning, succession planning and skill mix redesign Quality Management Systems (QMS) development across fragile services Networked service models across North Wales to share workforce and expertise Investment in external capacity where required Performance and quality oversight through IMTP delivery monitoring	G1: Ongoing workforce shortages and limited pipeline for key specialties G2: Lack of sustainable workforce models and over-reliance on traditional roles G3: Financial constraints limiting service redesign and sustainability G4: Fragmentation of services across sites limiting efficient use of capacity G5: Limited capacity to deliver transformation due to operational pressures G6: Variation in pathway design, quality systems and data maturity	**Management Assurance** CSP Programme and Fragile Services governance oversight Monitoring of IMTP deliverables (3C actions) Divisional reporting on workforce, performance and service delivery **Risk & Compliance Assurance** Compliance with GIRFT recommendations and Royal College standards Monitoring of RTT, diagnostics and specialty-specific performance measures Development and implementation of Quality Management Systems **Independent Assurance** External clinical networks and professional body reviews NHS Wales Performance & Improvement support and benchmarking	A1: Limited assurance that workforce models will deliver long-term sustainability A2: Insufficient independent validation of redesigned service models A3: Gaps in data quality and consistency across specialties A4: Limited evidence that service changes will improve resilience and outcomes A5: Insufficient assurance on reduction of reliance on locum/external capacity A6: Limited visibility of long-term financial sustainability across fragile services	

		Welsh Government oversight and reporting		

Plans to improve control :



Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
3C.2	Commence implementation of vascular service review as part of the first tranche of Clinical Services Plan reviews, to:-Help strengthen integrated working across hub and spoke sites, -Support development of a skilled, happy and sustainable workforce,-Improve patient outcomes across key pathways-Ensure greater alignment with national guidance and best practice.	G2 G4 G6	A1 A2 A6	Chief Operating Officer	**Q2 (Moderate Delivery Confidence)**
3C.7	Engagement and implementation of interim pan North Wales networked Dermatology service model, to better utilise resources (staff and funding) across North Wales. This is ahead of the full Clinical Services Plan work due to urgency around service sustainability especially in the West.	G4 G6	A2 A4	Chief Operating Officer	**Q1 (No Update provided during this reporting cycle)**
3C.8	Involvement in the full Clinical Services Plan work to design the long-term sustainable Dermatology model.	G4 G6	A2 A4	Chief Operating Officer	**Q4 (No Update provided during this reporting cycle)**

3C.9	Balancing Dermatology work between primary and community and secondary care – Further development of the Community Health Pathways and Teledermoscopy in order to reduce avoidable referrals into secondary care.	G2 G4 G6	A2 A4	Chief Operating Officer	**Q2 (No Update provided during this reporting cycle)**
3C.13	Full workforce review, succession planning, skills mix, expansion of roles such as Dentists with special interests, Orthodontic Therapists, to support more sustainable services.	G1 G2 G5	A1 A5	Chief Operating Officer	**Q4 (No Update provided during this reporting cycle)**
3C.14	Develop proposals to increase access to Cone Beam capable CT scanners, improving capacity and patient experience and travel.	G3 G6	A2 A4	Chief Operating Officer	**Q3 (Complete)**
3C.23	Full workforce review, succession planning, skills mix, expansion of roles such as Optometrists, Orthoptists, Advanced Clinical Practitioners, to support more sustainable services.	G1 G2 G5	A1 A5	Chief Operating Officer	**Q2 (Moderate Delivery Confidence)**
3C.36	Further development of QMS to provide structured view and understanding of the drivers behind fragile services, through the triangulation of broad range of key data points.	G6	A3 A4	Chief Operating Officer	**Q1 (Complete)**
3C.37	Use the new QMS capability to map the highest priority services of concern as part of the Clinical Services Plan work, capturing the main KPIs for each that will be tracked to measure improvement.	G6	A3 A4	Chief Operating Officer	**Q2 High Delivery Confidence**
3C.38	Ensure that services of concern monitoring, escalation and de-escalation processes, governance and reporting are adequately covered within the latest Performance and Accountability framework, covering both Executive and Board Member visibility. Including capturing how people's care and treatment outcomes are monitored and how they compare to similar services.	G6	A3 A4	Chief Operating Officer	**Q3 (No Update provided during this reporting cycle)**

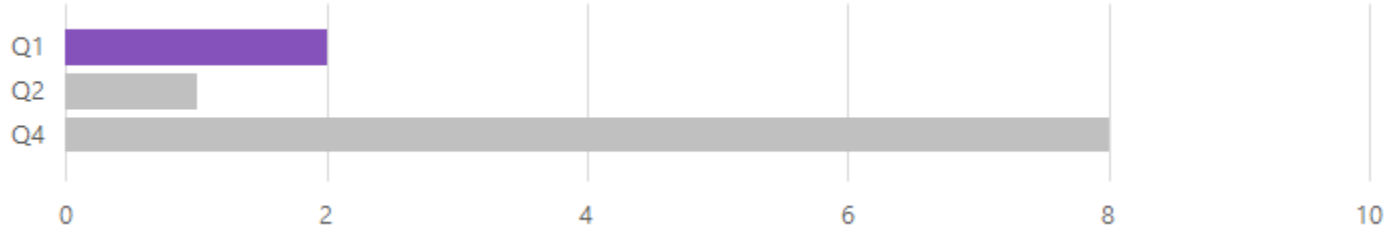
3C.39	Review and implement improvements to the governance surrounding services of concern, including establishment of both risks and separate issues logs.	G6		Chief Operating Officer	**Q1 (Complete)**

Priority:	**3D Mental Health & Learning Disabilities**
Strategic Threat and Risks: There is a risk that the Health Board is unable to deliver timely, safe and high-quality mental health and learning disability services due to workforce capacity constraints, increasing demand and complexity, limitations in digital infrastructure, and challenges in implementing system-wide transformation and sustainable service models	
Accountable:	Executive Director of Allied Health Professionals and Health Science

Primary risk controls:	**Gaps in control:**	**Sources of assurance:**	**Gaps in assurance:**	**Assurance Rating**
Mental Health Oversight and Development Group governance National Patient Safety Programme implementation (Safe discharge, 72-hour follow-up) Crisis Care Model implementation Development of Open Access Mental Health Service model Engagement with national workstreams (MH strategy, physical health, LD frameworks) Electronic Healthcare Record (EHR) Transformation Programme Performance monitoring through national Mental Health Measure standards Partnership working with Local Authorities and Regional Partnership Board	G1: Workforce capacity constraints impacting delivery and transformation G2: Lack of fully implemented and standardised service models (e.g. Open Access) G3: Continued reliance on out-of-area placements due to capacity issues G4: Incomplete digital infrastructure (EHR not fully embedded) G5: Variation across pathways and integration with partners G6: Estate and infrastructure limitations affecting service delivery	**Management Assurance** Mental Health Oversight & Development Group monitoring delivery IMTP deliverables tracking (3D.1–3D.11) Performance monitoring against Mental Health Measure targets Programme reporting for EHR, crisis model and safety initiatives **Risk & Compliance Assurance** Compliance with national safety standards (72-hour follow-up, safe discharge) National MH & LD programme alignment and reporting Internal audits and governance	A1: Limited assurance that transformation (e.g. Open Access model) will be delivered at pace A2: Insufficient independent validation of new service models A3: Gaps in digital and data visibility (pending EHR implementation) A4: Limited triangulation of quality, safety and performance outcomes A5: Limited assurance that out-of-area placements will be sustainably reduced A6: Insufficient evidence of	

		reviews Monitoring out-of-area placements and patient safety incidents **Independent Assurance** Welsh Government oversight and reporting NHS Wales Performance & Improvement support External inspections/reviews (e.g. HIW, Royal Colleges where applicable)	long-term sustainability (workforce and estates)	

Plans to improve control :



Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
3D.1	Engage with National Patient Safety Programme to improve quality and safety across services with the implementation Safe Discharge and 72-hour follow-up standards.	G2 G5	A3 A4	Executive Director of Allied Health Professionals and Health Science	**Q4 High Delivery Confidence**
3D.2	Train inpatient staff on the use of ReQol 10 Patient Reported Outcome Measures (PROMS) alongside the National Programme Safety team.	G2	A3	Executive Director of Allied Health Professionals and Health Science	**Q1 (Complete)**

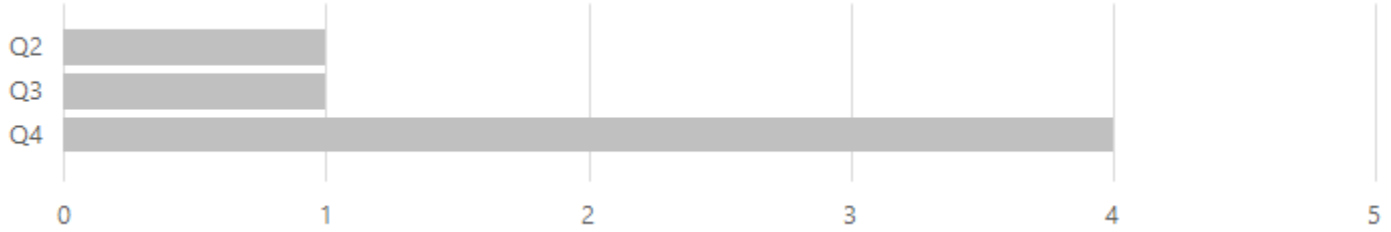
3D.3	Agree and develop with partners a phased Open Access Mental Health Service model with a view to implementing the demonstrator site by Q4 based on the international evidence base.	G1 G2 G5		Executive Director of Allied Health Professionals and Health Science	**Q1 (Complete)**
3D.4	Engage with the National workstream to Improve Physical Health of People with Severe and enduring Mental Illness including review and alignment of the BCU MHLD physical health policy in line with national developments.	G1 G2 G5	A1 A2 A5	Executive Director of Allied Health Professionals and Health Science	**Q4 High Delivery Confidence**
3D.5	Deliver a material reduction in the number of out of area placements through robust clinical and patient safety management (inclusive of community and acute staff) aligned to the implementation of the Crisis Care Model.	G2 G5	A2 A4	Executive Director of Allied Health Professionals and Health Science	**Q4 High Delivery Confidence**
3D.6	Reduce Health Inequalities for people with learning disabilities by increasing the uptake of the annual health checks and public health screening initiatives across services.	G1 G5	A4	Executive Director of Allied Health Professionals and Health Science	**Q4 High Delivery Confidence**
3D.7	Define and formally adopt a tiered crisis response framework for LD services with clear pathways for prevention, early intervention, urgent response, intermediate care provision in partnership with the Local authorities and post-crisis stabilisation.	G2 G5	A2 A4	Executive Director of Allied Health Professionals and Health Science	**Q4 High Delivery Confidence**
3D.8	Establish a digitally delivered specialist All-Wales gambling harm and treatment service.	G4	A2	Executive Director of Allied Health Professionals and Health Science	**Q2 High Delivery Confidence**
3D.9	Continue to progress the Electronic Healthcare Record (EHR) Transformation Programme which will reduce paper records and be a key enabler for service transformation, through commencing the implementation of the All Ages MHLD and continued engagement with WG regarding a wider EHR.	G4 G6	A3 A6	Executive Director of Allied Health Professionals and Health Science	**Q4 High Delivery Confidence**
3D.10	Strengthen the strategic case for the development of the purpose-built, future-proof Adult and Older People Mental Health Unit at the Ysbyty Glan Clwyd	G3 G6	A2 A6	Executive Director of Allied Health Professionals and Health Science	**Q4 High Delivery Confidence**

	site with the aim of presenting a full business case to Health Board for the approval by the end of Q4.				
3D.11	Progress the 13 key areas supported by the Board in the Scope of Mental Health Oversight and Development Group, including but not exhaustively; strategic plan and models of care, outcomes framework, performance, service user engagement, standards of clinical practice, workforce planning, estate and physical environment, culture and organisational development, leadership and management, legacy reviews, finance, dementia care and psychological therapies.	G1 G2 G6	A1 A6	Executive Director of Allied Health Professionals and Health Science	**Q4 High Delivery Confidence**

Priority:	**3E Child and Adolescent Mental Health (CAMHs) & Neurodevelopment (ND)**			
Strategic Threat and Risks: There is a risk that the Health Board is unable to deliver timely, equitable and effective CAMHS and neurodevelopment services due to increasing demand, workforce capacity constraints, long waiting times, and challenges in redesigning pathways towards a needs-led model and integrated system-wide approach				
Accountable:	Chief Operating Officer			
Primary risk controls:	**Gaps in control:**	**Sources of assurance:**	**Gaps in assurance:**	**Assurance Rating**
CAMHS transformation aligned to national Mental Health Strategy Neurodevelopment (ND) Improvement Programme Partnership working through Children's Regional Partnership Board Early Help / Open Access model development Crisis model redesign and implementation National guidance (NEST/NYTH framework, ND	G1: Workforce capacity constraints limiting service delivery G2: Long waiting lists and backlog in neurodevelopment assessments G3: Delays in access to CAMHS services and variation in pathways G4: Incomplete shift from diagnosis-led to needs-led model G5: Fragmentation across health, education and social care partners	**Management Assurance** CAMHS and ND programme governance Monitoring of IMTP deliverables (3E.1–3E.6) Performance reporting against Mental Health Measure and ND waiting times Regional partnership oversight (RPB)	A1: Limited assurance that waiting times will reduce at required pace A2: Insufficient independent validation of pathway redesign effectiveness A3: Limited consistent data across ND pathways A4: Weak evidence of improved outcomes following transformation	

Code of Practice) Pathway standardisation and redesign across CAMHS and ND Performance monitoring (waiting times, Mental Health Measure)	G6: Limited capacity for early intervention and prevention	**Risk & Compliance Assurance** Alignment with national frameworks (NEST/NYTH, ND Programme) Monitoring of waiting times and access standards Internal governance and pathway compliance reviews **Independent Assurance** Welsh Government oversight NHS Wales Performance & Improvement support Regional Partnership Board scrutiny External programme reporting (ND Improvement Programme)	A5: Limited assurance of whole-system integration across partners A6: Insufficient evidence of long-term sustainability of workforce models	

Plans to improve control :



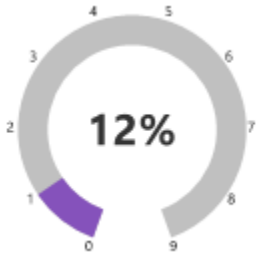
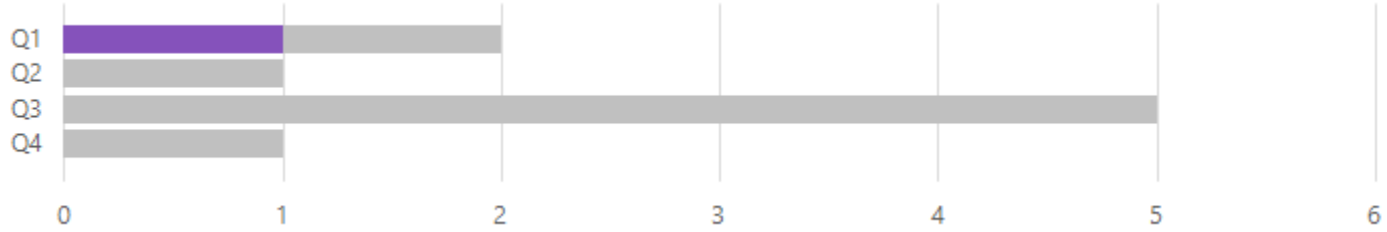
Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
3E.1	Early Help - Strengthen Early Intervention and Prevention. Develop and embed CAMHS Early Help	G5 G6	A4 A5	Chief Operating Officer	Q4

	systems and processes within the new model with partners across IHCs and regionally, to align with Flexible Open Access Mental Health Support and NYTH/NEST. Including: integration of schools in-reach, establishing reliable data reporting and measurement of impact, and establishing plans for secondary prevention that targets those at greatest risk of developing mental health problems.				**High Delivery Confidence**
3E.2	Improve access to CAMHS services by reducing and sustaining waiting times under the Mental Health Measure (MHM) and improving patient pathways to deliver better outcomes and experiences for Children and Young People (CYP). Including: exploring options for embedding Open Access principles, map and standardise pathways across the region using clinical guidelines and WG Community CAMHS service specification.	G1 G3	A1 A2	Chief Operating Officer	**Q3** **High Delivery Confidence**
3E.3	Deliver a transformed and sustainable crisis model through full implementation and embedding of the crisis enhanced service model. Including working with adult mental health and partners on plans for an Open Access North Wales demonstrator project, develop and initiate plans for further Alternative to Admission, operationalisation of the 24/7 regional crisis consultation and advice line.	G1 G3 G5	A1 A2 A5	Chief Operating Officer	**Q4** **High Delivery Confidence**
3E.4	Early Identification & Family Centred Support - Co-design new needs led model of care across children's neurodevelopmental (ND) services collaboratively with Children's Regional Partnership Board. Including: referral process review and improvement, roll out of standardised profile of need tool to be used prior to specialist ND referral is considered, ensure clear pathways and local points of access into ND services across all age groups, development of neuro affirmative communities.	G4 G5	A4 A5	Chief Operating Officer	**Q4** **High Delivery Confidence**

3E.5	Improved Access to Information, Guidance, and Assessment - Establish Clear, consistent access pathways in line with NEST/NYTH principles. Including streamline ND assessment prudent pathways to improve efficiency – introducing standard audit mechanisms and use of same day assessments for clear cases, enhance joint working across services and sectors - building links with education, CAMHS and third sector and piloting multi-agency ND input in schools.	G2 G3	A1 A3	Chief Operating Officer	**Q2 High Delivery Confidence**
3E.6	Improved post assessment/diagnostic support - Co-designed post-assessment support to ensure continuity, tailored interventions. Including: Map support offers regionally, align services to provide targeted post diagnostic support, ensure consistent signposting and referral pathways for support following diagnosis, develop ND transfer & transition protocols to provide seamless transition between child and adult services across agencies.	G3 G5	A4 A5	Chief Operating Officer	**Q4 High Delivery Confidence**

Priority:	**3F Children and Young People Services**			
Strategic Threat and Risks: There is a risk that the Health Board is unable to deliver timely, equitable and high-quality services for children and young people due to health inequalities, workforce capacity challenges, gaps in community and specialist provision, and delays in implementing integrated pathways and preventative models of care				
Accountable:	Chief Operating Officer			
Primary risk controls:	**Gaps in control:**	**Sources of assurance:**	**Gaps in assurance:**	**Assurance Rating**
Integrated Children's Services model (community, hospital and specialist services) Partnership working with Regional Partnership Board and Local Authorities Delivery of national programmes (Healthy Child Wales Programme, immunisation programmes)	G1: Health inequalities affecting outcomes and access to services G2: Workforce capacity constraints across specialist paediatric services G3: Gaps in community nursing provision for children with complex needs	**Management Assurance** Monitoring of IMTP deliverables (3F.1–3F.9) Performance reporting across child health indicators (immunisation, diabetes, etc.) Programme oversight for	A1: Limited assurance that inequalities will be reduced at pace A2: Insufficient independent validation of new service models A3: Limited data maturity	

Development of transition pathways from children to adult services Specialist service reviews (complex needs, palliative care, community nursing) Compliance with national guidance (NICE, WG frameworks) Performance monitoring (vaccination uptake, diabetes care, child health measures)	G4: Delays in access to specialist care and interventions G5: Incomplete development of integrated pathways across organisations G6: Limited progress in prevention and early intervention models	children's services and partnership delivery **Risk & Compliance Assurance** Compliance with national frameworks (Healthy Child Wales, NICE guidance) Monitoring of access, waiting times and service provision Internal governance and service reviews **Independent Assurance** Welsh Government oversight Regional Partnership Board scrutiny External inspections/reviews where applicable (e.g. HIW)	across children's services A4: Limited evidence of improved outcomes following interventions A5: Limited assurance of effective integration across partners A6: Insufficient clarity on long-term sustainability of service models	

Plans to improve control :					
					
Ref	**2026/2027 Deliverable**	**Improves Gaps in Control**	**Improves Gaps in Assurance**	**Executive Owner**	**Status of Action**

3F.1	Delivery of school age immunisation programme by immunisation team with targeted work in low uptake areas.	G1 G6	A1 A6	Chief Operating Officer	**Q4 High Delivery Confidence**
3F.2	Working with partners, undertake a gap analysis of the requirements to fully implement the Healthy Child Wales 2 Programme and submit proposals to the Health Board for implementation.	G1 G5 G6	A1 A2 A5	Chief Operating Officer	**Q3 (Moderate Delivery Confidence)**
3F.3	Undertake a review of specialist nursing team roles and delivery of care for children with complex needs.	G2 G3 G4	A2 A4	Chief Operating Officer	**Q1 High Delivery Confidence**
3F.4	Commence developing a service specification for delivery of community nursing care for children with complex care needs	G3 G4 G5	A2 A4	Chief Operating Officer	**Q3 High Delivery Confidence**
3F.5	Ensure that children with diabetes have timely provision of insulin pumps and CGM	G2 G4	A4	Chief Operating Officer	**Q2 High Delivery Confidence**
3F.6	Assess compliance with Diabetes NICE Guidance in readiness for the launch of the Type 1 diabetes screening programme for children	G2 G4	A2 A4	Chief Operating Officer	**Q3 High Delivery Confidence**
3F.7	Set out the proposal to the Health Board based on the service specification gap analysis related to the submitted Paediatric Palliative Care in Wales self-assessment, including specialist palliative care nursing.	G3 G4 G6	A2 A6	Chief Operating Officer	**Q3 (Moderate Delivery Confidence)**
3F.8	Work with the Partnership Transformation Programme to commence the development of a strategic plan for children with a learning disability, and reduce inequalities for consultation.	G1 G5	A1 A5	Chief Operating Officer	**Q1 (Complete)**
3F.9	Finalise and implement the Transition Pathways for children into adult services across all long-term conditions (respiratory, endocrine, cardiac and neurological conditions, cancer, CAMHS and Learning Disabilities).	G4 G5 G6	A2 A4 A5	Chief Operating Officer	**Q3 (Moderate Delivery Confidence)**

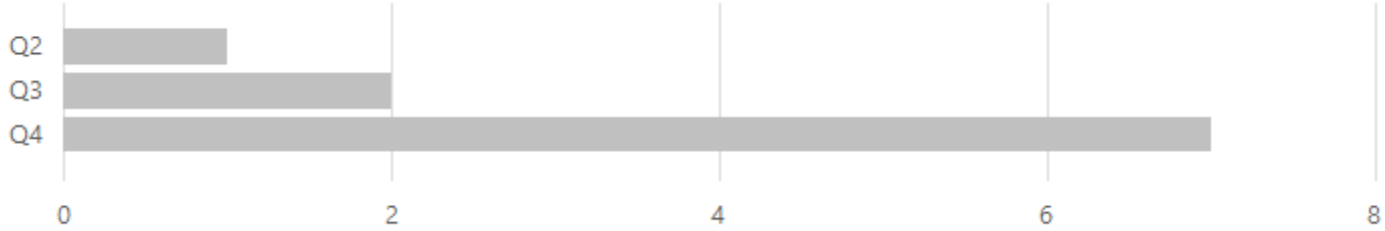
Priority:	3G Women's Health

Strategic Threat and Risks: There is a risk that the Health Board is unable to deliver equitable, safe & high-quality women's health services across the life course due to increasing demand, health inequalities, workforce & capacity constraints, & challenges in implementing national strategies, improving outcomes and reducing variation in access to services

Accountable:	Chief Operating Officer

Primary risk controls:	Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating
Implementation of NHS Wales Women's Health Plan (2025–2035) Delivery of Maternity and Neonatal Quality Statement (2025) Clinical Services Planning (CSP) for perinatal services Digital Maternity Cymru System rollout (electronic maternity record) Partnership working with HEIW and third sector organisations Local delivery of women's health pathways (menstrual health, menopause, contraception etc.) Expansion of Women's Health Hub model (e.g. Llandudno) Participation in national digital/data programmes (Women's Health Dashboard)	G1: Health inequalities impacting outcomes for women (especially deprived groups) G2: Workforce capacity and sustainability challenges in maternity and gynaecology G3: Variation in access and provision of key services (contraception, menopause, pelvic health) G4: Increasing complexity of care (e.g. diabetes, mental health in pregnancy) G5: Incomplete implementation of national strategies and frameworks G6: Limited maturity of digital and data systems across women's health pathways	**Management Assurance** Monitoring of IMTP deliverables (3G.1–3G.10) Programme oversight for Women's Health Plan delivery Maternity service performance reporting (incl. perinatal outcomes) CSP programme oversight for perinatal services **Risk & Compliance Assurance** Compliance with national quality standards (Maternity & Neonatal Quality Statement) Monitoring against national indicators (perinatal mortality, patient experience) Internal governance, audits and service reviews **Independent Assurance** Welsh Government oversight and performance reporting HEIW workforce planning and assurance	A1: Limited assurance improvements will reduce inequalities at pace A2: Insufficient independent validation of new models of care (e.g. Women's Health hubs) A3: Limited national data and KPIs currently defined (dashboard still emerging) A4: Limited evidence linking interventions to improved outcomes A5: Limited assurance of consistency across regions and pathways A6: Uncertainty around long-term sustainability (workforce, funding, infrastructure)	

		National programme boards (Women's Health, Maternity & Neonatal) External inspections/reviews (e.g. HIW)		

Plans to improve control :					
					
Ref	**2026/2027 Deliverable**	**Improves Gaps in Control**	**Improves Gaps in Assurance**	**Executive Owner**	**Status of Action**
3G.1	Progress the rollout of Phase 2 of the Digital Maternity Cymru System, with a focus on implementing maternity electronic health records to enhance the quality of care and improve communication for pregnant individuals.	G4 G6	A3 A4	Chief Operating Officer	**Q4 (Moderate Delivery Confidence)**
3G.2	Receive and analyse the findings of the Perinatal National Assurance Assessment Report (expected in Q4 2025/26), together with the key priorities outlined in the 2025 Quality Statement for Maternity and Neonatal Services, and develop a comprehensive proposal for local implementation inclusive of detailed costing.	G2 G5	A2 A4	Chief Operating Officer	**Q3 High Delivery Confidence**
3G.3	As part of the Clinical Services Plan, undertake a comprehensive review of the configuration of Pan–North Wales Perinatal Services to ensure the delivery of safe, high-quality and sustainable care.	G2 G5 G6	A2 A5	Chief Operating Officer	**Q4 High Delivery Confidence**

3G.4	Develop an implementation plan to deliver the outstanding commitments in the National Perinatal Engagement Framework (2025), including a paid Chair for Maternity and Neonatal Voices Partnership.	G3 G5	A2 A5	Chief Operating Officer	**Q2 (Moderate Delivery Confidence)**
3G.5	Collaborate with Health Education and Improvement Wales (HEIW) to prioritise year two service actions to ensure the Perinatal Strategic Workforce Plan is delivered within the Health Board.	G2 G6	A6	Chief Operating Officer	**Q4 High Delivery Confidence**
3G.6	Support the local delivery of the NHS Wales Women's Health Plan across North Wales, to include work on Menstrual Health, Endometriosis and Adenomyosis, Contraception – Postnatal Contraception and Abortion Care, Preconception Health, Pelvic Health and Incontinence, Menopause, Violence Against Women – Domestic Abuse and Sexual Violence, Ageing Well and Long-Term Conditions and strengthening community pathways.	G1 G3 G6	A1 A4 A5	Chief Operating Officer	**Q4 (Moderate Delivery Confidence)**
3G.7	Address variation in services such as Contraception, Menopause support and Pelvic Health.	G3 G5	A1 A5	Chief Operating Officer	**Q4 High Delivery Confidence**
3G.8	Deliver improvements to Women's Health prevention and early intervention, including preconception health and earlier identification of women's health conditions.	G1 G6	A1 A4	Chief Operating Officer	**Q4 High Delivery Confidence**
3G.9	Expand Women's Health service offering, currently focused via the Llandudno Womens Health Hub.	G3 G5	A2 A5	Chief Operating Officer	**Q4 (Moderate Delivery Confidence)**
3G.10	Participation in national digital and data development initiatives such as Women's Health Dashboard.	G6	A3 A4	Chief Operating Officer	**Q3 (Moderate Delivery Confidence)**

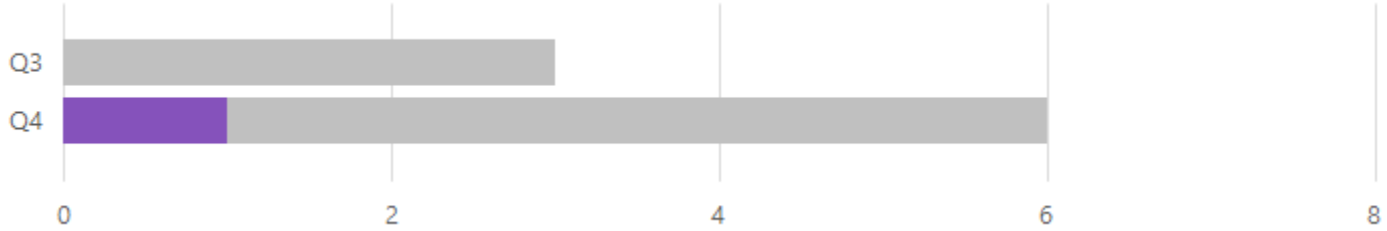
Priority:	3H Pharmacy and Medicines Management

Strategic Threat and Risks: There is a risk that the Health Board is unable to deliver safe, effective and sustainable pharmacy and medicines management services due to increasing demand, workforce capacity constraints, variation in prescribing practices, and challenges in implementing digital systems, optimising medicines use and supporting emerging therapies

Accountable:	Executive Medical Director

Primary risk controls:	Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating
Implementation of High Value Medicines programme Medicines optimisation through prescribing governance and NICE guidance Development of Transforming Access to Medicines (TrAMs) programme Expansion of Pharmacist Independent Prescribing Service (PIPS) Electronic Prescribing and Medicines Administration (ePMA) implementation Collaboration with HEIW and Bangor University to strengthen workforce pipeline Pharmaceutical Needs Assessment (PNA) and service planning Engagement with national genomics and advanced therapies programmes	G1: Workforce capacity and sustainability challenges G2: Variation in prescribing practice across primary and secondary care G3: Increasing demand and complexity of medicines use G4: Incomplete digital maturity (ePMA / prescribing systems) G5: Limited capacity to support emerging therapies and innovation G6: Challenges in medicines optimisation and cost sustainability	**Management Assurance** Monitoring of IMTP deliverables (3H.1–3H.9) Performance reporting on prescribing metrics (e.g. PIPS uptake, prescribing rates) Pharmacy programme governance (TrAMs, ePMA, Value & Sustainability Board) **Risk & Compliance Assurance** Compliance with NICE guidance and national prescribing standards Monitoring of high-value medicines and prescribing variation . Internal audit and medicines governance processes. **Independent Assurance** Welsh Government oversight National pharmacy and medicines optimisation programmes. All Wales Therapeutics and Toxicology Centre (AWTTC) reporting (where applicable). External regulatory oversight (e.g.	A1: Limited assurance that prescribing variation will reduce consistently A2: Insufficient independent validation of new service models (TrAMs, PIPS expansion) A3: Limited maturity of prescribing data and digital analytics A4: Limited evidence linking medicines optimisation to improved outcomes A5: Limited assurance of future workforce sustainability A6: Uncertainty around delivery of advanced therapies and innovation capacity	

		GPhC for education and workforce).		

Plans to improve control :					
					
Ref	**2026/2027 Deliverable**	**Improves Gaps in Control**	**Improves Gaps in Assurance**	**Executive Owner**	**Status of Action**
3H.1	Commission and publish a Pharmaceutical Needs Assessment (PNA) and agree an action plan from this to ensure pharmaceutical services are aligned to population need, address gaps in provision, and support equitable, sustainable care delivery.	G1 G2 G6	A1 A5	Executive Medical Director	**Q3 High Delivery Confidence**
3H.2	Support General Pharmaceutical Council (GPhC) Step 4 accreditation for the Bangor University MPharm programme (confirming regulatory provisional accreditation to deliver the programme) and enrol Cohort 2 to strengthen the local pharmacy workforce pipeline and support sustainable service provision.	G1	A5	Executive Medical Director	**Q3 High Delivery Confidence**
3H.3	Launch and develop the North Wales Transforming Access to Medicines (TrAMs) programme, as one of three national transformation hubs, to modernise pharmacy technical services and strengthen regional collaboration, including scoping pharmacy	G3 G5	A2 A6	Executive Medical Director	**Q4 (Moderate Delivery Confidence)**

	provision to support advanced therapies within a national hub model.				
3H.4	Continue to work with Community Pharmacy Wales (CPW) and Health Education and Improvement Wales (HEIW) to support community pharmacy contractors to expand the number of Pharmacies offering the Pharmacist Independent Prescribers Service (PIPS), strengthening prescribing capacity and improving access to care.	G1 G2	A1 A5	Executive Medical Director	**Q4 (Moderate Delivery Confidence)**
3H.5	Ensure full implementation of the High Value Medicines Value & Sustainability Board programme by supporting clinicians to adopt best-value prescribing practices, optimising procurement and product selection, reducing low-value prescribing, and strengthening performance oversight to deliver sustainable financial and quality benefits.	G4 G6	A1 A4	Executive Medical Director	**Q4 (Complete)**
3H.6	Following completion of implementation, fully embed Electronic Prescribing and Medicines Administration (ePMA) by establishing clear pharmacy clinical ownership to lead safe prescribing configuration, formulary oversight, system optimisation and structured change control.	G4 G6	A3 A4	Executive Medical Director	**Q3 High Delivery Confidence**
3H.7	Work with primary care and community services, via the Local Enhanced Clinical Effectiveness Service, to support evidence-based patient reviews that reduce inappropriate gabapentinoid prescribing in line with NICE guidance, extend periods of treatment, and increase the use of low Global Warming Potential inhalers in line with the All-Wales respiratory treatment pathway.	G1 G2 G3 G4 G6	A1 A4	Executive Medical Director	**Q4 (Moderate Delivery Confidence)**
3H.8	Engage with national genomics leads and clinical networks to scope the potential role of pharmacogenomics in clinical pathways, explore opportunities to develop local champions, and raise awareness through shared learning and engagement.	G5	A2 A6	Executive Medical Director	**Q4 High Delivery Confidence**

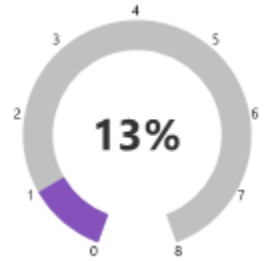
3H.9	Deliver the risk prioritised components of Electronic Prescribing Service (EPS) that sustain safe, reliable digital services, covering devices, network/telephony, core infrastructure, and clinical platforms.	G4	A3 A6	Executive Medical Director	**Q4 (Low Delivery Confidence)**

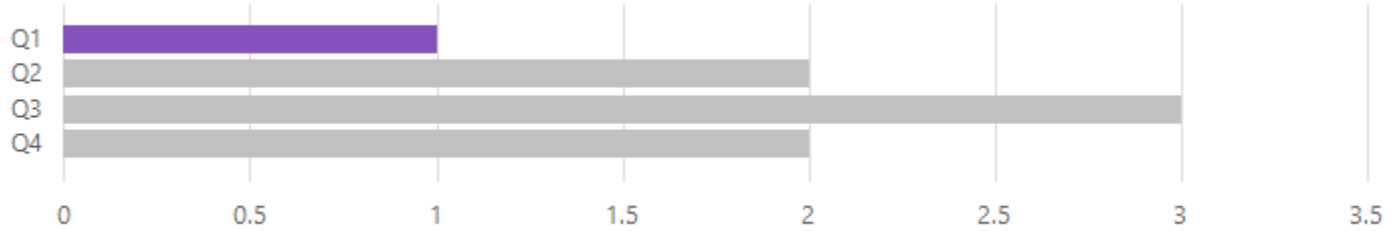
Priority:	**3I Dementia**
Strategic Threat and Risks: There is a risk that the Health Board is unable to deliver timely, equitable and high-quality dementia services due to increasing demand, workforce capacity constraints, delays in diagnosis and access to services, variation in care pathways, and challenges in delivering integrated care across health, social care and third sector partner	
Accountable:	Executive Director of Nursing

Primary risk controls:	**Gaps in control:**	**Sources of assurance:**	**Gaps in assurance:**	**Assurance Rating**
Implementation of the All-Wales Dementia Care Pathway of Standards Memory Assessment Services and diagnostic pathways Community dementia services and multidisciplinary teams Partnership working with Local Authorities and third sector organisations Dementia workforce training and development programmes Performance monitoring (diagnosis rates, waiting times) Carer support services and post-diagnostic support programmes	G1: Delays in diagnosis and access to memory assessment services G2: Workforce capacity and capability gaps G3: Variation in service provision and access across North Wales G4: Limited data quality and performance visibility G5: Lack of fully integrated system-wide pathways G6: Challenges in hospital flow and discharge for dementia patients	**Management Assurance** Monitoring of IMTP deliverables (3I.1–3I.8) Dementia programme governance and reporting. Performance monitoring (diagnostic rates, waiting times, service access). **Risk & Compliance Assurance** Alignment with All-Wales Dementia Standard.s Internal audits and service reviews. Monitoring compliance with national dementia pathways **Independent Assurance** Welsh Government oversight and performance reporting . Regional Partnership Board scrutiny.	A1: Limited assurance that diagnostic waiting times will improve at pace A2: Limited independent validation of service redesign A3: Data limitations impacting assurance reliability A4: Limited evidence of improved outcomes from interventions A5: Limited assurance of effective partnership integration A6: Limited assurance of workforce sustainability	

		External inspections (e.g. HIW where applicable)		

Plans to improve control :





Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
3I.1	Complete a review of existing dementia care provision within Emergency Departments to include benchmarking against areas of best practice.	G1 G3	A1 A2 A4	Executive Director of Nursing	**Q1 (Complete)**
3I.2	Review analyse and make recommendations to the Health Board on the requirements to implement a Dementia Care Pathway for Emergency Departments.	G1 G3 G5	A1 A2 A5	Executive Director of Nursing	**Q3 (Moderate Delivery Confidence)**
3I.3	Design and deliver bespoke dementia patient and carer experience review for ED.	G1 G3	A2 A4	Executive Director of Nursing	**Q3 High Delivery Confidence**
3I.4	Undertake a review and training needs analysis of existing dementia training approaches and align national guidance and best practice standards, informing the development of a training programme for the workforce, building on the work completed for the bitesize training.	G2	A5 A6	Executive Director of Nursing	**Q2 High Delivery Confidence**

3I.5	Design and implement a programme tailored to the needs of the workforce to enable a consistent service delivery through agreement of a core minimum standard of dementia education across the Health Board.	G2 G5	A5 A6	Executive Director of Nursing	**Q3 (Moderate Delivery Confidence)**
3I.6	Undertake environmental assessments to review the Health Board's current assessment of appropriate and suitable dementia friendly environments for all care settings and make proposals as appropriate.	G3 G6	A2 A4	Executive Director of Nursing	**Q2 (Moderate Delivery Confidence)**
3I.7	Recommendations and proposals collated and presented to the Health Board, working with Estates, to align any recommended improvements to Estates strategy and available budget.	G3 G6	A2 A6	Executive Director of Nursing	**Q4 (Moderate Delivery Confidence)**
3I.8	Design and implement a staff campaign to raise awareness of prevention as it affects dementia.	G1 G5	A1 A4	Executive Director of Nursing	**Q4 High Delivery Confidence**

4 **Create a modern, people-centred healthcare system that is future-focused**, maximising opportunities of digital care, research, innovation, and improvement, investing in workforce development and wellbeing and strengthening our role as an anchor institution for North Wales.

Principal risk (What could prevent us achieving this strategic objective)	**BAF 26 04 - Failure to deliver and create a modern, people centred heath care system that is future focused** There is a risk that the Health Board is unable to deliver a modern, people-centred and future-focused healthcare system due to capacity constraints, workforce pressures, financial and infrastructure limitations, dependency on national programmes and funding, and the scale and complexity of transformation required across digital, estates, workforce, planning, quality &governance. Failure to modernise the system risks unwarranted variation in care, reduced workforce sustainability and resilience, loss of public confidence, increased scrutiny, and delayed Special Measures de-escalation.		
Lead Commitee	Planning, & Population Health and Partnerships Committee Performance, Finance & Information Governance Committee Quality, Safety & Experience Committee	**Risk Type**	**Innovation**
Risk Lead	Executive Director of People Services & OD, Executive Director of Nursing , Executive Director of Transformation and Strategic Planning, Executive Medical Director, Chief Digital & Information Officer, Director of Corporate Governance, Director of Partnerships, Executive Director of Finance and Director of Estates	**Risk Appetite**	**<20**
Related Corporate Risks:	CRR25-02 – Future Demand & Sustainable Workforce, CRR25-04 – Modernising Digital Infrastructure to Enable Safe, Integrated Care, CRR25-05 – Strategic Change Impacting Care and Staff Delivery, CRR25-06 – Delivery of the 2026/27 Financial Plan & Financial Sustainability, CRR25-07 – Leadership and Operating Model, CRR25-08 – Non-Compliance with Regulatory & Legislative Requirements, CRR25-09 – Safe Environment, CRR25-10 – Health & Safety, CRR25-11 – ICT Failure & Cyber		

Risk Rating			**Review Dates**	
	Current Exposure	**Target**		
Consequence	**5**	**5**	**Initial assessment**	**July 2026**
Likelihood	**4**	**3**	**Last Committee review**	
Risk Rating	**20**	**15**	**Last Executive Review**	**July-Aug 2026**

Priority:	4E Research, Development and Innovation

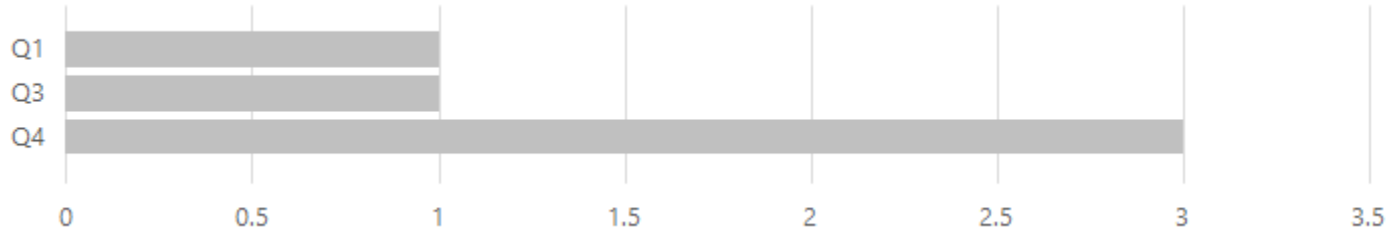
Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to effectively grow and sustain research, development and innovation (RD&I) activity due to limited pipeline of studies, insufficient capacity to support research delivery, and challenges in securing external funding. This may result in reduced research activity, missed opportunities for innovation, limited access to funding and partnerships, and an inability to improve patient outcomes, workforce development and organisational learning.

Accountable:	Executive Medical Director

Primary risk controls:	Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating
Approval and delivery of RD&I strategic plan aligned to Health Board priorities and national expectations (4E.1) Development of proposals for an innovation centre in partnership with industry and academia (4E.2) Embedding research expectations into clinical roles, job plans and appraisals (4E.3) Increasing research study activity and recruitment through improved processes and engagement (4E.4) Strengthening academic partnerships and joint appointments to support research and innovation (4E.5)	G1: Limited pipeline of research studies and opportunities G2: Insufficient capacity (PI, workforce and support services) to deliver research activity G3: Limited capability and capacity for bid writing and securing external funding G4: Research and innovation not fully embedded as core part of clinical practice G5: Dependency on external partners and funding environment G6: Limited coordination and visibility of RD&I activity across the organisation	**Management Assurance** • External review through research networks and academic partners • Benchmarking against national research activity and funding metrics • Oversight and requirements from Welsh Government and Health and Care Research Wales **Risk & Compliance Assurance** • Alignment with Health and Care Research Wales and national policy requirements • Governance oversight of research activity and compliance processes • Monitoring of research performance metrics (recruitment to target, study delivery timelines) **Independent Assurance** • IMTP monitoring of 4E deliverables (4E.1–4E.5) • RD&I programme governance and reporting • Metrics on number of studies opened and recruitment levels	A1: Limited assurance on sustainability and growth of research pipeline A2: Limited visibility of capacity constraints impacting research delivery A3: Limited assurance over success rates for funding and bid quality A4: Limited evidence of impact of RD&I activity on patient outcomes and service improvement A5: Limited assurance that research is consistently embedded into clinical practice and workforce roles	

		• Monitoring of research funding applications and awards		

Plans to improve control :

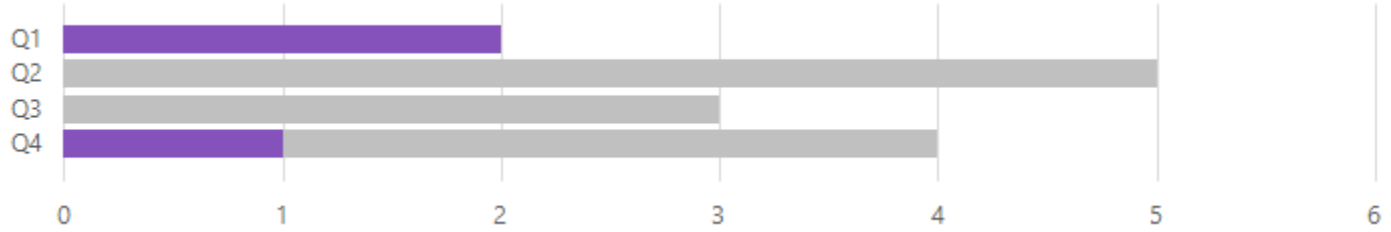


Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
4E.1	RD&I strategic plan and delivery plan approved, aligned to health board strategic intentions and national performance metric.	G4 G6	A1 A5	Executive Medical Director	**Q1 (Moderate Delivery Confidence)**
4E.2	Develop a proposal for a self-sustaining innovation centre, working with industry and academia, prioritising digital innovations and medical technology, aligned with the NHS Wales Technical Planning Guidance 2026-29 Digital and Innovation enabling plan, and Welsh Government's Innovation Strategy delivery plan.	G3 G5	A3 A4	Executive Medical Director	**Q3 High Delivery Confidence**
4E.3	Work with People Services colleagues to develop and implement a plan to normalise research as a core part of clinical practice by embedding research expectations within job descriptions, appraisal objectives, and job plans for identified priority staff groups, supported by guidance and manager training.	G2 G4	A2 A5	Executive Medical Director	**Q4 High Delivery Confidence**
4E.4	Increase the number of non-commercial and commercial research studies opened by the Health	G1 G2	A1 A2	Executive Medical Director	**Q4**

	Board and recruitment to those studies, through proactive engagement with sponsors and streamlined feasibility and approval processes.				**(Moderate Delivery Confidence)**
4E.5	Work with local academic partners to identify and implement to increase joint appointments and/or honorary contracts, closely working with the Academic Careers Community of Interest, ensuring that posts add value to research and innovation activity and support the above actions.	G2 G5	A2 A5	Executive Medical Director	**Q4 High Delivery Confidence**

Priority:	**4H Quality**				
Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to consistently deliver safe, effective and high-quality care due to challenges in embedding the Quality Management System (QMS), organisational change, and ongoing operational challenges particularly within UEC and Planned care , workforce and financial pressures . This may result in variability in care quality, increased patient harm, failure to meet statutory and regulatory requirements, and reduced confidence from patients, staff and stakeholders.					
Accountable:	Executive Director of Nursing				
Primary risk controls:		**Gaps in control:**	**Sources of assurance:**	**Gaps in assurance:**	**Assurance Rating**
• Development and implementation of a Quality Management System (QMS) and maturity framework (4H.1) • Development of a Health Board-wide Quality Accreditation Framework (4H.2) • Redesign and strengthening of quality governance framework including quality issues log (4H.3) • Implementation of audit programmes and NICE compliance improvements (4H.4–4H.5) • Delivery of national patient safety strategy and digital safety programmes (4H.6–4H.7) • Implementation of Listening to People Regulations and ward accreditation programmes (4H.8–4H.9) • Implementation of infection prevention and safety improvement plans (4H.10–4H.12)		G1: QMS not yet fully embedded across all services G2: Limited dedicated capacity to sustain QMS and quality improvements G3: Risk of reduced focus on quality during organisational change G4: Ongoing operational pressures particularly in UEC and planned care is impacting ability to prioritise quality improvement G5: Inconsistent application of quality governance processes across services G6: Limited integration of learning and improvement across the organisation	**Management Assurance** • IMTP monitoring of 4H deliverables (4H.1–4H.14) • QMS maturity metrics and reporting • Quality governance reporting and quality issues log • Audit programmes and compliance reporting • Performance indicators (infection rates, incidents, complaints, mortality data) Major change programme in place for both UEC and planned care improvement	A1: Limited assurance that QMS is fully embedded and consistently applied A2: Limited visibility of sustainability of quality improvements over time A3: Limited assurance of impact of organisational change on quality outcomes A4: Limited evidence linking quality improvement activity to patient outcomes A5: Limited assurance of consistency of quality governance and oversight across services A6: Limited assurance that	

• Development of organisational learning systems and repository (4H.13) • Oversight of national quality standards and best practice (4H.14)		CIVICA patient experience data measured and monitored **Risk & Compliance Assurance** • Compliance with national quality frameworks and standards (e.g. NICE, Patient Safety Strategy) • Monitoring against statutory requirements including Duty of Quality and Duty of Candour • Infection prevention and control performance reporting Integrated quality reports reported through QSE to Board **Independent Assurance** • Welsh Government oversight and Special Measures framework • Health Inspectorate Wales (HIW) inspections and reviews • External audit and regulatory reviews	organisational learning is embedded and driving improvement	

Plans to improve control :	
	

Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
4H.1	Develop a comprehensive organisational plan, aligned to Foundations for the Future, to embed the QMS into all core business processes and fully onboard every service to the QMS Maturity App, enabling systematic identification and response to fragile services.	G1 G2	A1 A2	Executive Director of Nursing	**Q2 (Low Delivery Confidence)**
4H.2	Develop and begin implementation of a Health Board–wide Quality Accreditation Framework aligned to QMS and regulatory standards, recognising and incentivising excellence.	G1 G5	A1 A5	Executive Director of Nursing	**Q4 (Moderate Delivery Confidence)**
4H.3	Re-design and implementation of quality governance framework to include implementation of quality issues log.	G5 G6	A5 A6	Executive Director of Nursing	**Q2 High Delivery Confidence**
4H.4	Deliver on findings of internal audit of NICE compliance by focussing on areas where NICE guidance not implemented with clear process of reviewing impact and addressing if significant risk.	G5	A2	Executive Director of Nursing	**Q1 (Complete)**
4H.5	Develop programme of Tier 2 audits based on current quality risks.	G5	A2	Executive Director of Nursing	**Q1 (Complete)**
4H.6	Develop programme of work to address priority programmes and actions within National Patient Safety Strategy including key performance indicators to measure improvement.	G4 G5	A4	Executive Director of Nursing	**Q4 (No Update provided during this reporting cycle)**
4H.7	Develop a programme of work and governance framework to address digital safety.	G5	A5	Executive Director of Nursing	**Q3 (No Update provided during this reporting cycle)**
4H.8	Refresh of NatSSIPs programme to address recent Never Events and reintroduce a revised ward	G5 G6	A4 A6	Executive Director of Nursing	**Q2**

	accreditation programme in line with the QMS methodology.				**High Delivery Confidence**
4H.9	Implement the new Listening to People Regulations and deliver on the 40% national performance target.	G4	A4	Executive Director of Nursing	**Q2 High Delivery Confidence**
4H.10	Meet the nationally set Infection Prevention trajectories and reduce the incidents of infections (including C-Diff and E.Coli) and associated harm, through implementation of the IPC improvement plan.	G4	A4	Executive Director of Nursing	**Q3 (No Update provided during this reporting cycle)**
4H.11	We will reduce severe and catastrophic incident numbers and monitor improvement and learning through the Integrated concerns Hub.	G6	A6	Executive Director of Nursing	**Q2 (Low Delivery Confidence)**
4H.12	We will reduce the number of avoidable falls and HAPU through continuing to implement the actions identified in the associated improvement groups.	G4	A4	Executive Director of Nursing	**Q3 High Delivery Confidence**
4H.13	We will fully implement the learning repository and have clear outcomes with regard to robust and sustained organisational learning and how it positively impacts outcomes.	G6	A6	Executive Director of Nursing	**Q4 (Complete)**
4H.14	Provide direction and oversight through the organisation's Quality governance for the application of appropriate best practice within the national Quality Statements - the ones not covered elsewhere in the plan are: Care of the critically ill, Respiratory Disease, Heart conditions, Kidney Disease, Liver Disease, Musculoskeletal health, Neurological conditions, Stroke, Infection prevention and control, Osteoporosis and bone health.	G5 G6	A5 A6	Executive Director of Nursing	**Q4 (Low Delivery Confidence)**

BAF Risk	Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range	Status of Actions at mapping	Strategic intent Priority	Mapped deliverable	BAF 26_01 – Failure to deliver improved population health and reduced inequalities	BAF 26_02 – Failure to deliver enhanced coordination of care for people with long term conditions and improve access	BAF 26_03 – Failure to Improve access, outcomes and experience	BAF 26_04 Failure to deliver and create a modern, people centred heath care system that is future focused
BAF24-02: Not Delivering Strategic Development and Digital Transformation	Senior Posts for reviewing Digital architecture and EHR. Funding for Architecture and EHR Teams is temporary and has been sourced from various non-recurrent budgets. Teams likely to have to stand down from April 2025 onwards and therefore progress halted (subject to budget setting process). NB. This is a 3-to-5-year piece of work. Activity which is required by 31st March 2025 will be completed. Senior Architecture posts in place but funded non-recurrently. These are resolving clinical system integration, which will also halt on the 31/03/2026 should recurrent funding not be secured.	Overdue	4D – Digital, Data & Intelligence 4C – Clinical Services Planning	• 4D.19 Review and update Digital Roadmap • 4D.15 Decommission legacy unsupported systems • 4D.16 Strategic Outline Case for digitisation of patient records • 4C.1–4C.4 CSP methodology & alignment of digital requirements				X
BAF24-02: Not Delivering Strategic Development and Digital Transformation	Roll-out of key priority EHR transformation projects. No funding from April 2025 onwards, to progress EHR Programme and other augmentation projects to improve the current digital environment. NB. This is a 3-to-5-year piece of work. The Electronic Health Record (EHR) – Acute and Community, Outline Business Case (OBC) first draft was handed over from the external consultants in March 25, the OBC has been updated following engagement with legal, finance, procurement and DDaT. Currently, there is no funding to progress this further, and Welsh Government have asked all Health Boards to pause while they agree a national approach. The Mental Health EHR is progressing with the procurement evaluation complete. Once assurance activities have been completed the next step will be to finalise the Full Business Case (FBC) and award contract following board approval. A strategic outline case for the scanning plan is being prepared, with anticipated submission for formal approval in April 2026 via the appropriate governance board.	Progressing	4D – Digital, Data & Intelligence 3D – Mental Health & Learning Disabilities	• 4D.19 Digital Roadmap alignment to 10-year Strategy & CSP • 4D.11–4D.12 Population Health Management datasets • 3D.9 Mental Health EHR transformation			X	X
BAF24-02: Not Delivering Strategic Development and Digital Transformation	Transformation of the DDaT Operating Model. Proposals for 2025/26 onwards are being progressed for consideration. Due to significant digital inflation, plans have been put forward and are currently being considered in line with other inflationary pressures. Bids for growth are being revised to align with IMTP Planning processes Anticipated position and due date will be 30th April 2026	Delayed	4D – Digital, Data & Intelligence 4A – Foundations for the Future	• 4D.1 Demand & capacity tools for digital • 4D.19 Digital Roadmap alignment • 4A.1–4A.7 Foundations for the Future: new operating model design				X
BAF24-02: Not Delivering Strategic Development and Digital Transformation	Proposals, (repeated from previous years) for 2025/26 onwards are being progressed for consideration. Cost Pressures and Growth proposals submitted to Executive Team for consideration. Only RIGA 1 additional funding resource received which doesn't take into consideration the required cost pressures or growth initiatives. Will continue to review funding gaps and available schemes.	Overdue	4K – Finance & Commissioning 4G – Value & Sustainability	4K.1 Financial control measures • 4K.2 Accountability agreements • 4G.12 Recurrent savings realisation • 4G.3 Address clinical variation & resource efficiency				X
BAF24-02: Not Delivering Strategic Development and Digital Transformation	Expand the implementation of the Digital Training Academy enhancing the skills and understanding of clinical and non-clinical systems and O365 tools.	Progressing	4D – Digital, Data & Intelligence	• 4D.13 Digital Skills Assessment • 4D.14 Data literacy & "Making Data Count" training offer				X
BAF24-02: Not Delivering Strategic Development and Digital Transformation	Implement and ensure Executive Decision and oversight of the Digital Prioritisation of projects and programmes in line with IMTP and Funding Arrangements.	Progressing	4D – Digital, Data & Intelligence 4B – Strategy & Planning	4D.19 Roadmap integration with Strategy & CSP • 4B.1–4B.3 Strategy Discovery & Design phases				X
BAF24-02: Not Delivering Strategic Development and Digital Transformation	Develop phase 2 of the Clinical Services Plan for implementation - a blueprint for services across North Wales	Progressing	4B – Strategy and Planning 4C - Clinical Services Planning	4B1, 2, 3 & 4B5 – 11 4C1, 2, 3, 4				X
BAF24-03: Not Achieving Long Term Financial Sustainability	Decarbonisation reporting of key objectives through to Committee (PPHP) completed, articulating goals and objectives through to Health Board. Revised NHS Wales decarb plan was published in 2025 and is currently under review. Health Board then to draft plan and an action plan.	Delayed	4I – Environment & Estates	• 4I.10 Development of BCUHB Climate Adaptation Plan • 4I.11 REFIT / carbon-reduction grant funding access • 4I.12 Renewable energy implementation (e.g., PV array) 4I.7 4I.5				X
BAF24-03: Not Achieving Long Term Financial Sustainability	Ongoing development of Estates strategy to be informed by completion of a reduced facet survey (to reflect unallocated budget), a register of assets and most importantly clinical strategies (this review of estates is likely to take 12 months) and will be used to drive estate utilisation and rationalisation. At present, this is delayed pending clinical service plans.	Delayed	4I – Environment & Estates 4C – Clinical Services Planning	• 4I.5 Revised Estates Strategic Plan aligned to 10-year Strategy & CSP • 4I.7 Estate utilisation & rationalisation improvements • 4C.1–4C.4 Clinical Services Plan methodology, prioritisation & alignment				X
BAF24-04: Not Establishing a Compassionate Culture, Leadership, Engagement and workforce capacity and capability	Prioritise implementing the workforce planning framework across the Health Board, with initial prioritisation for 'challenged services'. This action is on-going as services become familiar with the templates and the governance arrangements for the framework are embedded throughout 2026/27.	Overdue	4J – Workforce 4F – Education Partnerships	• 4J.7 Strategic Workforce Planning implementation • 4J.1–4J.4 Workforce productivity, job planning & sickness absence reduction • 4F.9–4F.10 Governance alignment of education & workforce planning				X

BAF24-04: Not Establishing a Compassionate Culture, Leadership, Engagement and workforce capacity and capability	Support the implementation of measures to aid reducing agency usage and improve value and sustainability of workforce. Progress has been made in some staff groups and now a particular focus on M&D agency is needed throughout 2026/27. The action end date will need to be extended to the end of Q4 (from 31/03/2026).	Delayed	4G – Value & Sustainability 4J – Workforce	• 4G.1–4G.12 Value & Sustainability (clinical variation, workforce efficiencies) • 4J.2–4J.3 Reduce agency spend & improve workforce sustainability • 4J.7 Strategic Workforce Planning implementation				X
BAF24-04: Not Establishing a Compassionate Culture, Leadership, Engagement and workforce capacity and capability	Implementing Values and Behaviours Framework. The V&B framework has been implemented, additional actions will be agreed to further embed and enhance its adoption, these will be added to the BAF in the coming weeks.	Overdue	4A – Foundations for the Future 4J – Workforce 4C – Clinical Leadership	• 4A.1 Culture, Leadership & Engagement programme • 4J.5–4J.6 Culture, engagement & behavioural improvement actions • 4C.9–4C.10 Interprofessional team working & leadership behaviours				X
BAF24-04: Not Establishing a Compassionate Culture, Leadership, Engagement and workforce capacity and capability	Embedding Integrated Leadership Development Framework. Three of the four programmes have already been written and launched. The remaining program pilot will be developed by the end of Q2 and the expected launch will be Q426/27. The ILDF framework will be reviewed by the Executive Committee in Q1 2026/27 to ensure it remains strategically aligned to the IMPT. The end date for action will be extended to end of September 2026 (from 31/03/2026).	Delayed	4C – Clinical Services Planning & Leadership 4A – Foundations for the Future 4J – Workforce	• 4C.5–4C.8 Clinical leadership roles, training & capability • 4A.1 Leadership culture & organisational development • 4J.5 Leadership & engagement improvement programme				X
BAF24-04: Not Establishing a Compassionate Culture, Leadership, Engagement and workforce capacity and capability	Developing Anchor Institute Framework – ongoing, draft Anchor Charter developed with partners and being formally discussed at regional wellbeing and anchor charter event on 19.03.26.	Overdue	1C – Health Inequalities / Anchor Institute Partnership & Regional Collaboration	• 1C.6 Anchor principles & missions implementation (Environment, Communities, Housing, Employment, Food, Learning, Creative & Active Lifestyles) • Section 5 – Working with Partners: strengthening regional collaboration & social value frameworks	X			
BAF24-04: Not Establishing a Compassionate Culture, Leadership, Engagement and workforce capacity and capability	Citizen Engagement Plan being reviewed – the draft principles and framework developed – Co-production, Engagement and Consultation Toolkit developed, Principles and Framework to be discussed at Executive Group Meeting before end of April 2026.	Progressing	3B – Citizen Engagement 4A – Foundations for the Future 4B – Strategy & Planning	• 4A.12 Partner engagement in operating model • 4B.1–4B.4 Embedding engagement into IMTP & Strategy processes			X	X
BAF24-04: Not Establishing a Compassionate Culture, Leadership, Engagement and workforce capacity and capability	Communications and engagement plan November 2025 to post Senedd election 2026 addressing progress to date and areas of Board focus in the months ahead – plan in development, overseen by the Chief Executive Officer.	Progressing	3B – Citizen Engagement 4A – Foundations for the Future 4B – Strategy & Planning	• 4B.2–4B.3 Strategic design & delivery – embedding public voice 4B.4, 4B7			X	X
BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Learning Repository Development – A Project Group oversees governance, strategic alignment, and accountability for the wider rollout by 31st April 2026. (Delayed from 31/11/2025)	Delayed	4H – Quality	• 4H.13 Implementation of learning repository & embedding organisational learning				X
BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Harms review process to be approved for planned care activity.	Overdue	3B – Planned Care 4H – Quality 4C – Clinical Services Planning	• 4H.1–4H.3 Quality Management System & governance framework development			X	X
BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Diabetes Pathway Programme – completion of case for change and next steps agreed - delay in appointing Clinical Lead however this has now gone out for expressions of interest. There have been some revisions to the plan as a result and also in keeping with wider priority programmes including Primary Care. Completion of the Diabetes Pathway Programme case for change has been completed however the overall implementation of the programme has been delayed in 25.26 due to dependencies, including the appointment of a Clinical Lead. The plan has been revised to align with wider priorities, and the completion date has moved from July 2025 to December 2026.	Delayed	1B – Disease Prevention 2A Primary Care 2B Community by Design 4G – Value & Sustainability 4C – Clinical Services Plan 4D – Population Health Management	• 1B.4–1B.7 Diabetes pathway (care processes, variation reduction, best practice) 2A.5 integrated primary & Community care 2B.1 -4 Community by Design (mapping, planning, delivery) • 4G.2 High Value/High Impact Diabetes Pathway • 4C.1-4 CSP alignment with disease pathways 4D.11-12 Population health intelligence	X	X		X
BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Deliver Primary Care based approaches to improving the compliance with NICE guidance. Awaiting update and revised date from Primary Care leads.	Overdue	2A – Primary Care 2B – Community by Design 1B – Disease Prevention 4H – Quality 4C – Clinical Services Plan	Incomplete improvement in NICE compliance; requires strengthened primary-community-secondary integration and clearer pathways.	X	X		X
BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Prevention embedded in Board Major Programmes.	Overdue	1A–1D – Prevention & Inequalities 4B – Strategy & Planning 4C – Clinical Services Plan 4G – Value Based Healthcare	• 1A–1D Prevention, Health improvement, Health Inequalities, Health Protection • 4B.1–4B.3 Strategy & IMTP alignment • 4C.1 CSP methodology – embedding prevention & PHM 4G.10 Respond to key population health intelligence	X			X

BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Development of Clinical Services Plan and Health Board Strategy recognises prevention as component part. Development of the Clinical Services Plan and Health Board Strategy, which incorporates prevention as a key component, has been delayed due to dependencies on preceding work. The completion date has moved from March 2025 to December 2026.	Delayed	1A-D Prevention & inequalities 4C – Clinical Services Planning 4B – Strategy & Planning 4D – Population Health Management 4I – Environment & Estates	1A-D Prevention, Health improvement, Health Inequalities, Health Protection • 4C.1–4C.4 Clinical Services Plan development & prioritisation • 4B.1–4B.3 10-year Strategy Discovery/Design/Delivery 4D.11-12 Population health intelligence • 4I.5 Estates Strategy alignment to CSP	X			X
BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Increased pathways with Primary care. Primary Care Service Transformation Delivery group has progressed with work completed outlining system challenges to inform next steps. On track but will be ongoing.	Delayed	3D MHLD 2A – Primary Care 4C – Clinical Leadership	• 3D.3 - Agree and develop with partners • 2A.5 Integrated primary & community pathways • 4C.9–4C.10 Interprofessional working		X	X	X
BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Electronic Health Record programme with MHLD as early adopter. Procurement concluded - assurance activity underway for award of contract. Implementation will be impacted by contract award timescales; this may impact the control completion date, but measures are being into place to mitigate this.	Overdue	4D – Digital, Data & Intelligence 3D – Mental Health & LD	• 4D.19 Digital Roadmap • 4D.6–4D.8 Coding, AI & data quality improvements • 3D.9 MHLD EHR programme rollout			X	X
BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Enhanced Savings plans. OOA/ CHC remain the well documented risks here for delivery, but plans are progressing well.	Overdue	3D MHLD 4G – Value & Sustainability 4K – Finance & Commissioning	3D.5 - Deliver a material reduction 4G.1–4G.12 Value & Sustainability Programme 4K.1–4K.3 Financial control & commissioning improvements			X	X
BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Capping OOA bed utilisation	Overdue	3D – Mental Health & LD 4G – Value & Sustainability	3D.5 Reduction in out-of-area placements • 4G.12 Financial sustainability & reducing unwarranted cost variation			X	X
BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Continued implementation of waiting list protocol to ensure patients are supported whilst waiting.	Progressing	3D MHLD	3D.3 agree & develop with partners a phrased open access MH service model			X	
BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Alignment with Learning Disabilities national programme- Improving Care Improving lives review.□ The LD transformation programme covers ECRS, Inpatient and Community Services and is fully aligned to the NHS P&I National improvement works. Improvements are project managed through service and divisional governance as well as the national programme. Progress to date includes successful roll out and uptake of Paul Ridd disability awareness training across BCU (not just LD services), introduction of the Health Equalities Framework (HEF) outcomes measure to support identifying health inequalities for people with a learning disability.	Overdue	3D – Mental Health & Learning Disabilities 4C – Clinical Services Planning & Interprofessional Leadership	3D.6–3D.7 MHLD improvement actions including health inequalities reduction, crisis response, • 4C.1–4C.4 CSP methodology & redesign of challenged services			X	X
BAF24-07: Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk	Use of data analytics to identify high-risk populations (completed) and optimise resource allocation, as a part of workstream one, needs aligning to enhanced community care Priorities agreed for primary and community transformation led by DPH, EMD and COO.	Overdue	4D – Digital, Data & Intelligence 1B – Proactive Strategies for Prevention	• 4D.1 Demand & capacity modelling tools • 4D.11–4D.12 Population Health Management intelligence • 1B.1–1B.3 Population health & prevention roadmap	X			X
BAF24-07: Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk	Deployment of live dashboards for real-time monitoring (complete) of performance and governance metrics. Standardise data collection and reporting processes to reduce variability in decision-making. Review of various dashboards to align input criteria and date. Data quality and alignment to data dictionary review ongoing. Dashboard designs work ongoing. Design phase to be complete by 31/07/2025. Once designed, build and deployment to take place with timescale tbc. Dashboard completed and information now used in UEC programme management, further work to continue moving forward as we develop SPoA This is on track. Due date extended to 30/09/2026 from June 2026.	Progressing	4D – Digital, Data & Intelligence	4D.13–4D.14 Digital & data skills improvement 4D.6–4D.8 Coding & data quality improvements 4D.19 Digital Roadmap alignment				X
BAF24-07: Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk	Strengthen digital capabilities to support service teams (such as e-triage, further roll out of home adaptations particularly rural areas, single patient tracking lists). Align digital plan to UEC plans. Alignment of plans consistent with revised prioritisation. Work underway to improve digital interface with UEC. WECDS has just been updated to enhance the data collection for ED's.	Overdue	4D – Digital, Data & Intelligence	4D.19 Digital Roadmap • 4D.15–4D.16 Legacy system reduction & digital records • 4D.5 RPA & automation opportunities				X
BAF24-07: Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk	Standardising care pathways across the Health Board. Current mapping exercise. Sits within clinical service strategy, community health pathways being rolled out for development in elective care. SPoA 'operational 'phase is commencing in Q1. There are clear performance metrics and expectations assigned to the developments into 2026/27	Overdue	3A – Urgent & Emergency Care 3B – Planned Care 4C – Clinical Services Planning	3A.4–3A.12 UEC care pathway redesign • 4C.1–4C.4 CSP methodology & service redesign 3B.2 Planned care 3B.5 Planned care			X	X

BAF24-07: Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk	Re-enforce specialty level planning cycle through service line demand and capacity plan across the Health Board. Reinforced with services, complete. To be evidenced in April 2026 through Plans. Demand & capacity (D&C) planning session held in April to review core demand and capacity planning across specialties within Q1 to confirm the position for 2026/27. A further session is scheduled in May with a specific focus on Cancer and Diagnostics to enable more detailed discussions on demand and capacity for 26/27. This will be supported by a 'planned care sprint' to improve booking of long waiters into core capacity and transfers of care to appropriate services	Overdue	Outstanding for update as at 22/05/2026	Outstanding for update as at 22/05/2026				
BAF24-07: Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk	Strengthened workforce planning for key areas linked to challenged services.	Overdue	4J – Workforce 4A – Foundations for the Future	• 4J.7 Strategic workforce planning • 4J.1–4J.4 Workforce productivity controls • 4A.1 Leadership, culture & engagement improvement				X
BAF24-07: Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk	Telehealth care to strengthen out of hospital care including home systems and video facilitated care forms workstream 1 or 4 for UEC.	Overdue	2A – Primary Care 1B – Prevention 4D – Digital, Data & Intelligence	2A.8 Digital innovation in primary care (NHS app, virtual care) • 1B.3 Preventive digital interventions • 4D.19 Digital Roadmap	X	X		X
BAF24-07: Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk	Continued efforts to further strengthen collaboration with local authorities and voluntary sectors for integrated care delivery models. Milestones to be reported. Operational workshop to be held in May with health & Social care partners to discuss development of a 12 month plan for implementation	Overdue		Outstanding for update as at 22/05/2026				
BAF24-07: Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk	Incorporate public health needs analysis to service planning (such as deprivation links to access for UEC, Planned Care, CAMHS and Womens services).	Overdue	1B.1–1B.3 PHM intelligence • 4B.1–4B.3 Strategy Discovery/Design/Delivery • 3A.1–3A.3 UEC prevention & falls pathways 4C.1-4C.4	• 1B – Population Health 4B – Strategy & Planning 4C Clinical Services Plan 3A – UEC	X		X	X
BAF24-07: Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk	Regional improvement approach for Child and Adolescent Mental Health (CAMHS)and Childrens Neurodevelopmental Services. CAMHS Improvement Plan revised for 2026/27 to sustain delivery of the Mental Health Measure access targets which the HB achieved in 2026/27 for assessment and intervention. The Childrens ND 3-year improvement plan has been agreed with RPB to implement a needs-led Childrens ND delivery model across health, social care and education. Confirmation of WG funding allocation (£2m) 26-27 for ND assessments, received in April. Approval from Exec Committee & PFIG subsequently confirmed for the continued use and extension of the private provider contract for children's ND assessments to support delivery against WG expectations for 2026/27.	Overdue	3E – CAMHS & ND 3D – MHLD 4C – Clinical Leadership & CSP 1A - Preventative Approaches to Health & Wellbeing 4B - Strategy & Planning	3E.1–3E.6 CAMHS & ND redesign • 3D.9 EHR for MHLD • 4C.3 CSP alignment with challenged services 1A.3 Deliver approved Grant Funded Programmes of work (WSA) 4B.5 Draw on support for NHS P&I colleagues	X		X	X
BAF24-08: Not Implementing Evidenced Based Improvement and Innovation	Develop a model for Cancer Referrals and activity for single modality. Work is continuing with cancer services looking at breast pathways. Stage 1 demand for all tumour sites has been assessed against ringfenced capacity to incorporate into Referral to Treatment demand and capacity work, linked to workstream 6 of the Planned Care Programme. Due to operational challenges and the complexity of cancer pathways and associated data, current focus is on short term operational forecasting and we will with colleagues from NHS Performance & Improvement to develop longer term (annual and beyond) forecasting tools for the cancer pathways. Revised due date 30/06/2026 from 30/11/2025)	Delayed	3B – Planned Care, Cancer & Diagnostics 4D – Digital, Data & Intelligence	• 3B.7–3B.15 Cancer pathway optimisation & diagnostics modernisation • 4D.1 Demand & capacity modelling • 4D.10 Transition to cloud analytics			X	X
BAF24-08: Not Implementing Evidenced Based Improvement and Innovation	Strengthen collaborative research projects with university partners. Draft 'Research Strategy on a Page' developed with Bangor University for consideration by the BU & BCUHB Strategic Steering Group which is due to meet on 8th May 2026. Action delayed from 31/03/2025 to 31/05/2026	Delayed	4E – Research, Development & Innovation	• 4E.1–4E.5 Research, Development & Innovation strategic plan, joint appointments & academic partnerships				X
BAF24-08: Not Implementing Evidenced Based Improvement and Innovation	Strengthen academic career pathways with universities Academic Careers Community of Interest Working Group has been established and draft framework developed. The community of Interest is to be established during 2026/27. The development of this is to be supported by focus groups and workshops approach. A paper for the consideration of Executive Committee was considered on 4th March 2026 and agreement reached regarding support pending a further paper with a business case approach describing anticipated benefits and costs. Delayed from 31/03/2025 to 31/05/2026.	Delayed	4F – Education Partnerships & Academic Careers	• 4F.7–4F.11 Academic careers framework; governance for strategic education planning; HEI partnerships				X

BAF24-08: Not Implementing Evidenced Based Improvement and Innovation	Strengthen collaboration with Higher and Further Education partners across North Wales Memoranda of Understanding have been developed with Bangor and Wrexham Universities as well as Group Llandrillo Menai and College Cambria. Signing is complete apart from CC which is expected to take place in April/May. Strategic Steering Groups are in place with Bangor, Wrexham and GLIM with arrangements to follow with CC in April/May. The collaborative partnerships will progress and mature during the course of 2026/27.	Progressing	4F – Education Partnerships & Academic Careers	• 4F.1–4F.6 HE/FE partnerships; Medical School & Dental School collaboration; MoU implementation				X
BAF24-08: Not Implementing Evidenced Based Improvement and Innovation	Increase R&D collaboration with industry and academic institutions. MoUs have been developed as described above. Collaborations with industry have resulted in a number of joint bid applications to i4i, Contracts for Innovation and NIHR. BCU staff have presented nationally at events such as BioWales London, Cancer innovation.	Overdue	• 4E.2–4E.5 Innovation Centre development; external funding; research activity expansion	4E – Research, Development & Innovation				X
BAF24-08: Not Implementing Evidenced Based Improvement and Innovation	Secure additional funding for healthcare innovation projects. A number of grant applications are being developed or are awaiting decision from funders. To date funding has been secured from Welsh Government Innovation and from Contracts for Innovation.	Overdue	• 4E.2 Innovation Centre & funding model • 4E.4 Growth of research studies and income	4E – Research, Development & Innovation				X
BAF24-08: Not Implementing Evidenced Based Improvement and Innovation	Increase the number of joint appointments between the Health Board and academic institutions. A number of honorary appointments have been awarded, and a joint research fellow post has been appointed to. A joint research fellow post in cardiology is in progress. We are awaiting decision regarding readvertising the joint post in cancer services.	Overdue	• 4F.7–4F.11 Academic careers pathways & joint roles • 4E.3–4E.5 Embedding research into clinical roles	4F – Academic Careers 4E – Research, Development & Innovation				X

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Quality Safety & Experience Committee

CORPORATE GOVERNANCE REPORT

Dyddiad y Cyfarfod **Date of Meeting**	03 September 2026
Statws Cyhoeddi **Publication Status**	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad **Report Author name and title**	Philippa Peake-Jones, Head of Corporate Governance
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol **Lead Executive Team Member name and title**	Pam Wenger, Director of Corporate Governance

Pwrpas yr Adroddiad **Report Purpose**	For Noting

Crynodeb Gweithredol
Executive Summary

The Committee is asked to:

- **NOTE** the summary of business considered in private session to be reported in public
- **NOTE** the Committee Annual Report
- **NOTE** the Committee Self-Assessment
- **NOTE** the Committee Cycle of Business
- **ENDORSE** the Committee Terms of Reference for Board Approval

Ymgysylltu (mewnol/allanol) yr ymgymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp)
Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

Pwyllgor / Grŵp / Unigolion **Committee / Group / Individuals**	**Dyddiad** **Date**	**Canlyniad, Tystiolaeth a Data** **Outcome, Evidence and Data**
Not applicable for this report		

Acronymau / Rhestr Termau

Acronyms / Glossary of Terms	

CORPORATE GOVERNANCE REPORT

1. **Y SEFYLLFA**
SITUATION

1 The Health Board is required to act according to its Standing Orders. This report contains information to allow the Health Board to conform to this.

2 It is essential that the Board has robust arrangements in place for Corporate Governance and failure to do so could have legal implications for the Health Board.

3 **Y CEFNDIR**
BACKGROUND

3.1 The purpose of this report is to provide the Committee with an update on key corporate governance matters.

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

4.1 **Summary of Business Considered in Private**

4.1.1 Standing Order 6.5.3 requires the Board to formally report any decisions taken in private session to the next meeting of the Board in public session. This principle is also applied to Committee meetings.

4.1.2 The below items were considered in private at the meeting held on 2 July 2026:

Agenda Item	Subject (including narrative)	Committee Resolution	Rationale for item in Private
QS26.114	Integrated Quality Performance Report	The Committee: • **NOTED** the report	Identifiable Information
QS26.115	Draft Annual Quality Report – *Item Withdrawn*		
QS26.116	Controlled Drug & Accountability Report	The Committee: • Provided **ASSURANCE** on the report.	Business Sensitive

Agenda Item	Subject (including narrative)	Committee Resolution	Rationale for item in Private
QS26.117	HIW Report – Ysbyty Glan Clwyd	The Committee: • **ENDORSED** the report for Board Approval	Legally Privileged
QS26.118	Ombudsman Public Interest Report	The Committee: • **NOTED** the report	Business Sensitive
QS26.119	Quality Delivery Chairs Report	The Committee: • **NOTED** the report	Identifiable Information

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 2 July 2026 Committee.
- **NOTE** the draft Cycle of Business for comment prior to approval
- **NOTE** The Committee Terms of Reference
- **NOTE** the Committee Annual Report
- **NOTE** the Committee Self-Assessment

ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol **Link to Strategic Priorities**	 1. Building an effective organisation
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Yr Egwyddorion Dylunio **Design Principles**	Simplify, Standardise, and Adopt Best Practices Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:

Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd **Corporate Risks and Board Assurance Framework**	BAF24-01 Building an Effective and Accountable Organisation CRR-16 – Leadership/Special Measures

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Cydraddoldeb *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)* **Equality** *Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report
Asesiad o'r Effaith Economaidd-gymdeithasol *A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?* **Socio-Economic Impact Assessment** *Have you undertaken a Socio-Economic Impact Assessment*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report
Ansawdd *A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	**Galluogwyr Ansawdd** **Enablers of Quality** All Apply	**Meysydd Ansawdd** **Domains of Quality** All Apply
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant **Wellbeing of Future Generations Act – Wellbeing Goals**	Not Applicable	

Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog: **Armed Forces Covenant Due Regard Duty** Have you considered the Armed Forces Covenant Due Regard Duty?	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report
Asesiad o Effaith ar Ddiogelu Data *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?* **Data Protection Impact Assessment** *Have you undertaken a Data Protection Impact Assessment Screening?*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report
Asesiad o Effaith ar Atal Twyll *A ydych chi wedi ystyried yr effeithiau ar atal twyll?* **Counter Fraud Impact Assessment** *Have you considered the counter fraud impacts*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report
Cyfreithiol **Legal**	There are no specific legal implications related to the activity outlined in this report.	
Enw Da **Reputational**	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	

Effaith ar Adnoddau *(Pobl / Ariannol)* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

QUALITY, SAFETY AND EXPERIENCE COMMITTEE

Annual Report 2025-26

FOREWORD

I am pleased to present the 2025-26 Annual Report of the BCUHB Quality, Safety and Experience Committee, which outlines the Committee's activity during the period 1 April 2025 to 31 March 2026. During the year, the Committee discharged its delegated responsibilities on behalf of the Board by scrutinising quality, safety, patient experience, clinical effectiveness, challenged services and associated strategic risks. In doing so, the Committee sought assurance that appropriate governance arrangements, controls, performance oversight and improvement plans were in place to support the delivery of safe, effective and compassionate care.

The Committee maintained oversight of quality governance arrangements, patient experience, complaints and concerns, safeguarding, challenged services, commissioned services, quality management systems and relevant risks within the Board Assurance Framework and Corporate Risk Register. Through constructive scrutiny and challenge, the Committee sought assurance that areas of concern were being actively managed and that improvement actions were progressing as intended.

Through its work, the Committee was able to provide assurance to the Board in a number of key areas whilst identifying matters requiring continued oversight during 2026-27. These include challenged services, workforce sustainability, organisational culture, patient experience, quality governance and the effective management of strategic risks.

The remainder of this report summarises the assurance received, the scrutiny undertaken by Committee members and the areas requiring ongoing attention.

Dr Caroline Turner
Chair of the Quality, Safety and Experience Committee

Annual Report 2025 - 2026

1. Introduction

1.1 This report provides the Board with an annual summary of the assurance received by the Quality, Safety and Experience Committee during 2025-26. It describes how the Committee discharged its delegated responsibilities on behalf of the Board and identifies the key areas of oversight, assurance and ongoing focus for 2026-27.

1.2 The Committee's work during the year was guided by its Terms of Reference and Cycle of Business, which supported the systematic consideration of key matters within its remit. The Committee considered reports and updates relating to quality governance, patient safety, patient experience, challenged services, complaints and concerns, safeguarding, commissioned services, workforce matters impacting quality and safety, quality management systems, strategic service developments and associated Board Assurance Framework and Corporate Risk Register risks.

1.3 Through its work, the Committee sought assurance that effective governance arrangements, quality management systems, performance oversight arrangements and improvement mechanisms were in place to support the delivery of safe, effective and compassionate healthcare services and to promote continuous improvement across the organisation

2. Role and Responsibilities

2.1 The primary purpose of the Committee is to act on behalf of the Board to:

2.1.1 scrutinise, assess and seek assurance in relation to the patient experience, safety, impact, quality and health outcomes of the services provided by the Health Board.

2.1.2 provide evidence-based and timely advice to the Board to assist it in discharging its functions and meeting its responsibilities with regard to the quality and safety of health care provided and secured by the Health Board.

2.1.3 provide assurance that the Health Board has an effective strategy and delivery plan(s) for improving the quality and safety of care patients receive, commissioning quality and safety impact assessments where considered appropriate. This includes consideration of the Annual Plan/Integrated Medium Term Plan (IMTP).

2.1.4 provide assurance that the organisation, at all levels, has the right governance arrangements and strategy in place to ensure that the care planned or provided is of a high standard.

3. Agenda Planning Process

3.1 The Chair of the Committee, in conjunction with the Executive Lead and Meeting Secretary develops the final agenda for the Committee meetings.

3.2 The venue, location and other administrative arrangements are organised a year in advance where possible.

3.3 The secretariat for the meeting is provided by Harriet Abbott.

3.4 The agenda and papers are disseminated to Committee members prior to the date of the meeting. Where appropriate all papers are accompanied by a cover sheet which provides an executive summary and guidance to the Committee on the action required.

4. Operating Arrangements

4.1 The Committee reviewed its Terms of Reference and operating arrangements during the year. A minor amendment was made to ensure the Committee's remit remained clear, current and aligned to the Board's assurance requirements.

4.2 The Committee also reviewed its Cycle of Business, which provided a structured framework for ensuring that key matters within the Committee's remit were scheduled for consideration during the year. The agenda remained sufficiently flexible to allow the Committee to consider emerging issues and areas requiring additional scrutiny.

5. Membership, Frequency and Attendance

5.1 The Terms of reference of the Committee state that the Committee should consist of a minimum of three members of the Board.

5.2 During the year the Committee met on six occasions with member attendance as follows:

Name	Attendance
Caroline Turner, Committee Chair	Five out of six meetings
Chris Lothian-Field, Committee Vice Chair	Four out of six meetings
Prof Mike Larvin	Six out of six meetings
Urtha Felda	Five out of six meetings

5.3 The Committee requires the attendance of other Health Board Officers for advice, support and information routinely at meetings. It may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

6. Committee Activity

6.1 During 2025-26, the Committee considered a wide range of reports and updates aligned to its delegated remit. Through detailed scrutiny and challenge, the Committee sought assurance regarding the quality, safety and experience of services provided by the Health Board, the effectiveness of governance arrangements, and the management of risks within its areas of responsibility. The Committee's activity can be summarised under the following assurance themes.

a) Quality Governance and Improvement
The Committee maintained oversight of the Health Board's quality governance arrangements, including the implementation and development of the Quality Management System, nurse staffing levels and the findings of annual assurance reports. The Committee sought assurance that appropriate systems and processes were in place to support continuous improvement, learning and the delivery of safe and effective care. The Committee also monitored relevant corporate and Board Assurance Framework risks to ensure appropriate mitigation and management actions were in place.

b) Patient Experience and Organisational Learning
The Committee regularly received Patient Stories to ensure that the patient voice informed discussions and organisational learning. It scrutinised complaints performance, the Putting Things Right Annual Report and the Llais Annual Report, seeking assurance that feedback, concerns and complaints were being appropriately managed and that learning was being used to drive service improvement and enhance patient experience.

c) Safeguarding and Professional Standards
The Committee maintained oversight of safeguarding arrangements through consideration of the Safeguarding and Public Protection Annual Report and the Designated Educational Clinical Lead Officer Annual Report. Scrutiny focused on compliance with statutory responsibilities, organisational learning, workforce capability and the effectiveness of arrangements to protect vulnerable individuals receiving Health Board services.

d) Clinical Quality, Safety and Service Sustainability
A significant area of the Committee's work focused on challenged services and areas of clinical performance requiring enhanced oversight. The Committee received reports relating to Urology, Vascular, Dermatology, Plastics, Oncology and Ophthalmology services, together with updates on Urgent and Emergency Care, Colonoscopy Performance, Children's Services, Women's, Maternity and Gynaecology Services and Learning Disability Services. Through this scrutiny, the Committee sought assurance regarding quality, safety, service sustainability, performance improvement and the delivery of recovery plans.

e) Strategic Service Development and Transformation
The Committee considered the development of the Clinical Services Plan and updates relating to commissioned services and the East Integrated Health Community. It also monitored progress against improvement actions arising from the Royal College of Psychiatrists Invited Assessment. This work enabled the Committee to assess the extent to which strategic developments and service transformation initiatives were supporting the delivery of high-quality, sustainable healthcare services.

f) Assurance and Risk Oversight
Throughout the year, the Committee maintained oversight of risks within its remit through review of the Corporate Risk Register and Board Assurance Framework. The Committee scrutinised the adequacy of controls, mitigating actions and assurance sources, seeking assurance that key quality, safety and experience risks were appropriately identified, monitored and managed.

7. Committee Effectiveness & Performance

7.1 The Committee regularly reviews its own performance by completing this report on an annual basis, reviewing the cycle of business which provides the Committee with the basis on which it will monitor its progress during the year and also provide clarity for all of those who contribute to the agenda as to the expectations of them.

7.2 A Committee effectiveness questionnaire will be issued in July 2026, the outcome of which will be reported to the Committee in respect of recommendations and subsequent actions in response to areas identified for improvement.

8. Reporting the Committee's Work

8.1 The Committee Chair reports the key issues discussed at each of its meetings by way of a 'AAA Report' to the Board.

8.2 These reports are supported by the relevant and more detailed Committee minutes. Committee papers, including minutes are routinely published on the Health Board's website.

9. Reporting the Committee's Work

9.1 During 2025-26, the Quality, Safety and Experience Committee discharged its responsibilities in accordance with its Terms of Reference and approved Cycle of Business, providing Board oversight of matters relating to quality, safety, patient experience, clinical effectiveness, challenged services, safeguarding, quality governance and strategic risks within its remit. The Committee considered a

broad range of reports and assurance information designed to support effective scrutiny, oversight and continuous improvement.

9.2 Through the reports received, the scrutiny undertaken and the challenge provided by Committee members, the Committee was able to gain **reasonable assurance** that appropriate governance arrangements, controls and improvement actions were in place across the majority of areas within its remit. The Committee also maintained oversight of areas requiring enhanced scrutiny, including challenged services, performance improvement, patient experience, workforce-related quality issues and strategic risks, seeking additional assurance where necessary.

9.3 The Committee recognises that continued focus is required in a number of areas and will therefore maintain oversight of challenged services, workforce sustainability, patient experience, quality governance and associated strategic risks during 2026-27. The Committee will continue to seek assurance that improvement actions are being effectively implemented, risks are being appropriately managed and that services continue to support the delivery of safe, effective and compassionate care.

10. Conclusion and way forward

10.1 The Committee is very grateful to all those involved in the work of the Committee for their support over the past 12 months, and for the constructive and positive way in which they have contributed to the activity.

10.2 The Committee will continue to ensure that it conducts its business in accordance with legislation and best practice.

10.3 It will provide the assurance that the Committee has in place the appropriate governance arrangements and resources to ensure success in achieving its objectives.

11. Further Information

Please visit the Health Board's websites for further information as outlined below:
Committees and Advisory Groups - Betsi Cadwaladr University Health Board

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QUALITY, SAFETY & EXPERIENCE COMMITTEE SELF ASSESSMENT

2025-2026 Results Summary

Quality, Safety & Experience Committee Self Assessment 2025-26: Headline Feedback

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- Overall feedback is positive, with all responses agreeing or strongly agreeing across most core governance and meeting-effectiveness questions.
- Clear strengths include the Terms of Reference, annual review arrangements, Cycle of Business, meeting culture, chairing, scrutiny and secretariat support.
- Areas for attention are awareness of the Annual Report, visibility of internal assurance review, audit action monitoring and consistent Executive Director attendance.
- The results indicate a well-established Committee, with focused opportunities to strengthen assurance visibility and member development.

Composition, Establishment and Duties

- All respondents confirmed that written Terms of Reference are in place, reviewed annually and supported by an established Cycle of Business.
- Authority and resources were rated positively by all respondents; two respondents did not know whether an Annual Report is prepared.

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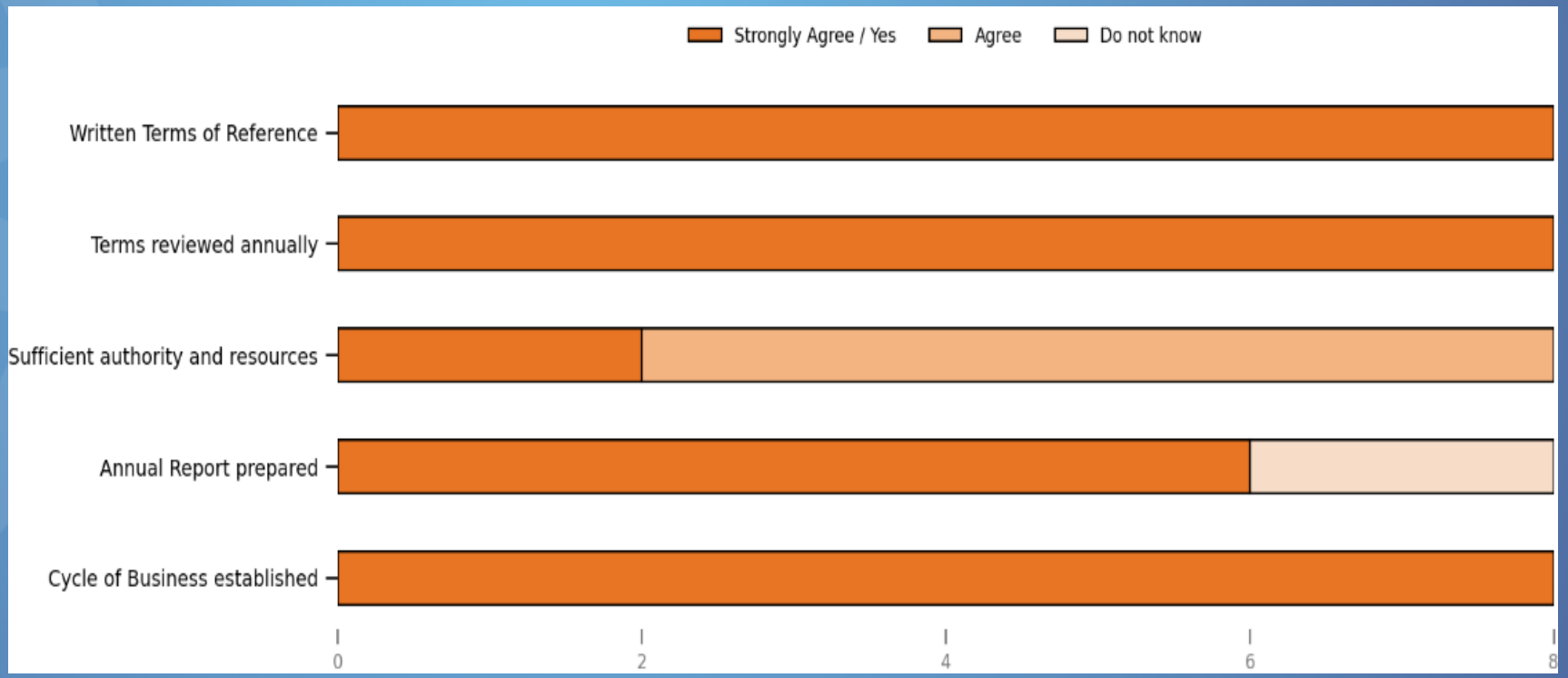

Meeting Culture and Effectiveness

- All respondents agreed that meetings are sufficiently frequent, allow time for discussion and support open, productive debate.
- Courtesy and professionalism were rated particularly strongly; one respondent selected “do not know” regarding the use of private meetings.

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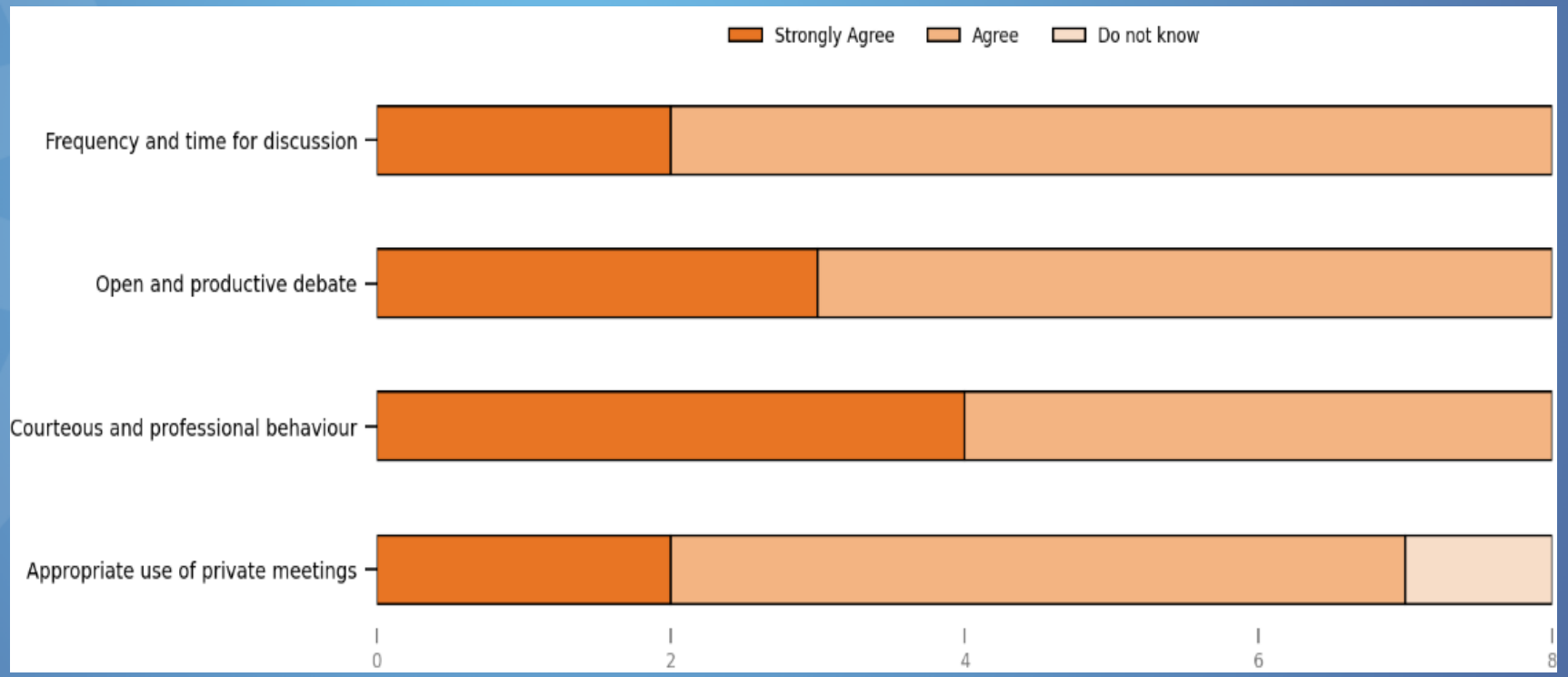

Internal Controls, Risk Management and Assurance

- Risk oversight was rated positively by all respondents, and reports were considered timely and appropriately formatted.
- The greatest uncertainty related to review of the internal assurance system; audit action monitoring also attracted one “do not know” response.

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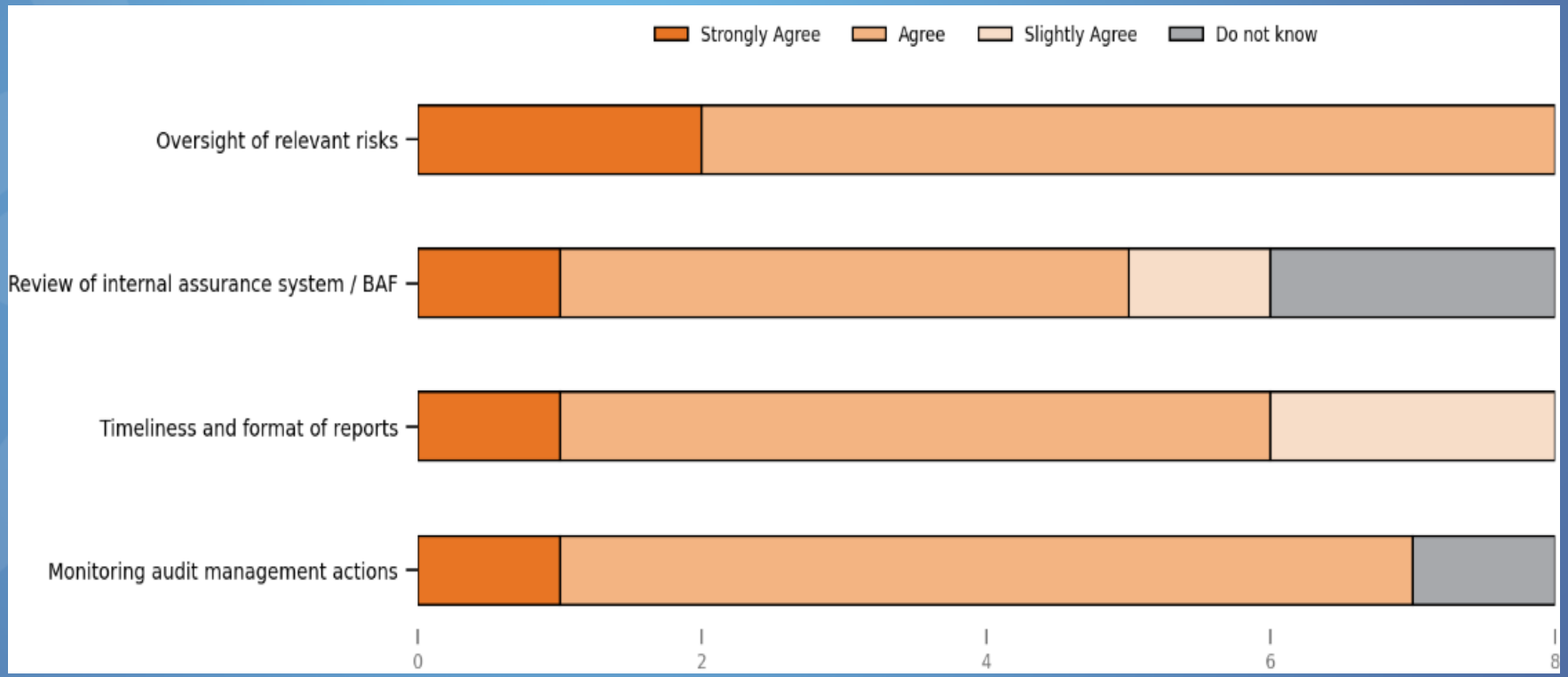

Committee Leadership and Support

- Chairing, Board reporting, secretariat support, alignment to organisational priorities and assurance-based scrutiny were rated positively.
- Executive Director support and closure of agenda items included some “slightly agree” responses; two respondents did not know whether outcomes influence Board decisions.

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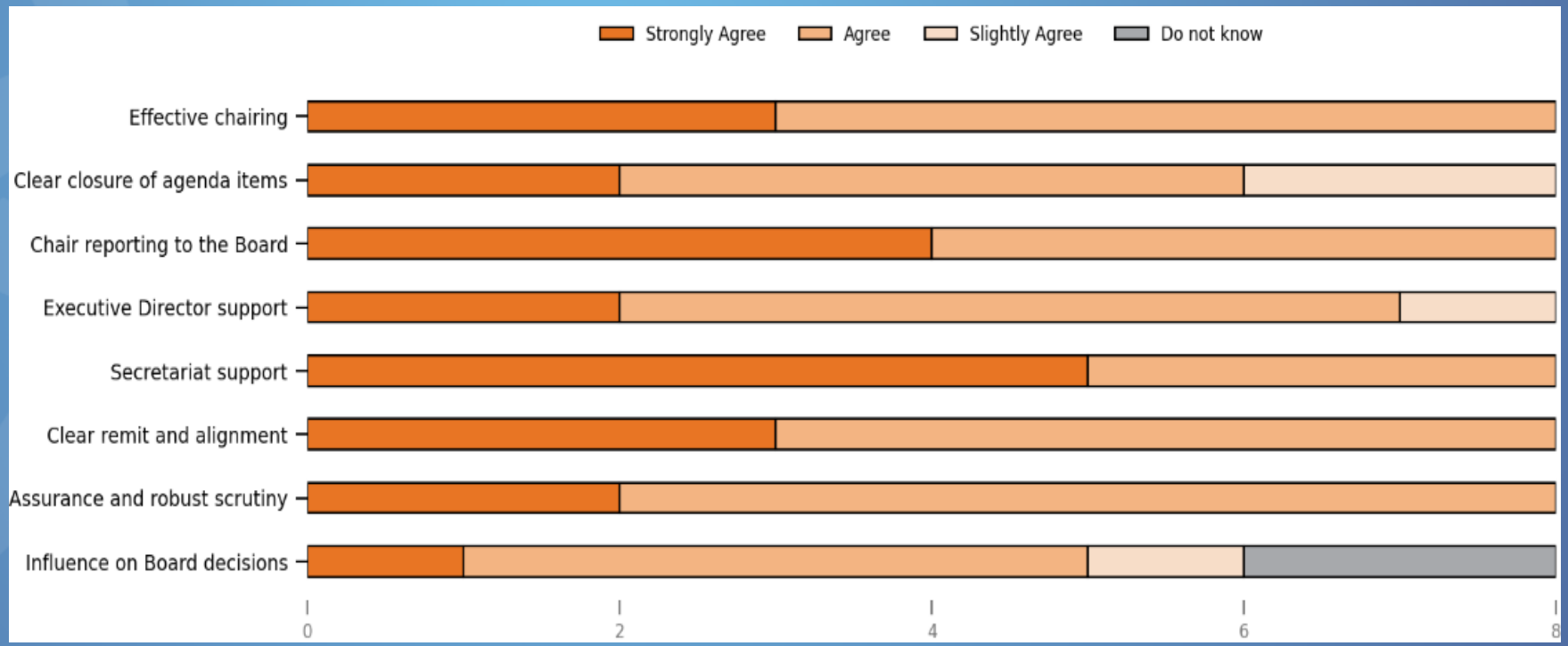

Overall Summary

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Overall Position:

- Strong governance foundations: Terms of Reference, annual review arrangements and Cycle of Business.
- Positive meeting culture, professional behaviour and constructive debate.
- Effective chairing, clear Board reporting and strong secretariat support.
- Clear focus on assurance, scrutiny and organisational priorities.
- Overall, the Committee is operating positively, with targeted opportunities to strengthen assurance visibility and support.

Key areas for improvement:

- Increase awareness of the Committee Annual Report and its purpose.
- Improve visibility of review of the internal assurance system and Board Assurance Framework.
- Maintain clear monitoring of audit management actions.
- Support consistent Executive Director attendance and address the identified training need.
- Continue improving papers and maintain clear closure of agenda items.

Betsi Cadwaladr University Health Board
Quality, Safety and Experience Committee

Cycle of Business DRAFT

(1 April 2026 – 31 March 2027)

Betsi Cadwaladr University Health Board should, on an annual basis, receive a cycle of business that identifies the items which will be regularly presented for consideration. The annual cycle is one of the key components in ensuring that the Health Board is effectively carrying out its role.

The Committee Cycle of Business cover the period 1 April 2025 to 31 March 2026.

The Committee Cycle of Business has been developed to help plan the management of Health Board matters and facilitate the management of agendas and Health Board business. The Annual Cycle of Business will be complemented by a "Non-Routine Board Business (Forward Work Plan)" for 'one-off' Ad-hoc items raised during the course of meetings.

The role of the Quality, Safety and Experience Committee is set out in the Terms of Reference which is available here: [Insert here]

Committee Chair Caroline Turner **Committee Vice Chair** Christopher Lothian-Field	**Independent Members** Urtha Felda Mike Larvin	**Executive Members** Angela Wood (Executive Director of Nursing & Midwifery) – Exec Lead Jane Moore (Executive Director of Public Health) Teresa Owen (Executive Director of Allied Health Professions & Health Science) Clara Day (Executive Medical Director)	**In Attendance** Tehmeena Ajmal (Chief Operations Officer) ~~Stephen Powell (Director of Performance & Commissioning)~~ Stuart Keen (Director of Environment & Estates) Executive Director of Workforce and Organisation **Other BCUHB Senior Managers as required by the Chair** Chair of Healthcare Professionals Forum (Associate Board Member) Llais Representative

QUALITY, SAFETY AND EXPERIENCE COMMITTEE CYCLE OF BUSINESS 2026-27

Item of Business	Executive Lead	Reporting period	Q1			Q2			Q3			Q4			2027-28	
			April 2026	May 2026	June 2026	July 2026	Aug 2026	Sep 2026	Oct 2026	Nov 2026	Dec 2026	Jan 2027	Feb 2027	Mar 2027	April 2027	May 2027
PRELIMINARY MATTERS																
Minutes of the Previous Meeting	Executive Director of Nursing & Midwifery	All Regular Meetings		Π		Π		Π		Π		Π		Π		Π
Matters Arising and Action Log	Executive Director of Nursing & Midwifery	All Regular Meetings		Π		Π		Π		Π		Π		Π		Π
Patient Story	Executive Director of Nursing & Midwifery	All Regular Meetings		Π		Π		Π		Π		Π		Π		Π
Service Presentation	Varied	All Regular Meetings		Π		Π		Π		Π		Π		Π		Π
STRATEGIC ITEMS																
Major Change Programmes																
Planned Care	Chief Operating Officer	As Required														
Urgent and Emergency Care	Chief Operating Officer	As Required														
Clinical Services Plan	Chief Operating Officer	As Required														
INTEGRATED PERFORMANCE																
Integrated Quality Report	Executive Director of Nursing & Midwifery / Executive Medical Director	All Regular Meetings		Π		Π		Π		Π		Π		Π		Π
~~Regulatory Paper~~ Now included in IQPR bi annually		~~Bi-Annually~~														
Integrated Performance Report	Executive Director of Finance	All Regular Meetings		Π		Π		Π		Π		Π		Π		Π
Controlled Drugs Accountable Officer Report	Executive Medical Director	Bi-Annually				Π						Π				
Strategic Item 1D – Implementing the Quality Management System (QMS)																
Quality Management System	Executive Director of Nursing & Midwifery	Bi-Annually						Π						Π		
Strategic Item 4 – Improving Quality, Outcomes and Experience																
Adult Mental Health & Learning Disability ~~(4F)~~	Executive Director of Allied	Bi-monthly		Π				Π				Π		x		

Item of Business	Executive Lead	Reporting period	Q1			Q2			Q3			Q4			2027-28	
			April 2026	May 2026	June 2026	July 2026	Aug 2026	Sep 2026	Oct 2026	Nov 2026	Dec 2026	Jan 2027	Feb 2027	Mar 2027	April 2027	May 2027
	Health Professions & Health Science															
~~Royal College of Psychiatry (RCPsych) Review~~	~~Associate Director of Governance~~	~~Alternate Meetings~~				~~Π~~				~~Π~~				~~Π~~		
~~CAMHS (4G)~~ • ~~Alternative to Admissions~~ • ~~Schools in Reach~~	~~Chief Operating Officer~~	~~To be agreed~~														
~~Neurodevelopment (4H)~~	~~Chief Operating Officer~~															
Dementia Services ~~(4I)~~	Executive Director of Allied Health Professions & Health Science	To be agreed														
~~'Challenged Services'~~ ~~(4J)~~ Fragile Services • Urology • Vascular • Dermatology • Plastics • Oncology • Ophthalmology • Orthodontics	Chief Operating Officer	All Regular Meetings		Π		Π		Π		Π		Π		Π		
Maternity and Neonatal ~~Women's Services (4K)~~ • Women's Health Hub • Preconception Strategy • Perinatatal • Specialist Infant Feeding • Still birth • Maternal Mortality • Infant Mortality • Incidents	Chief Operating Officer	Bi-Annually				Π						Π				
Pharmaceutical Services (4M) • Independent Review of Hospital Clinical Pharmacy Services • Radiopharmacy Services	~~Chief Operating Officer~~ Executive Medical Director	Annually										Π				
Palliative, End of Life, ~~and~~ Bereavement Care (4N) • Strategic Delivery Plan	Executive Director of	Annually				Π										

Item of Business	Executive Lead	Reporting period	Q1			Q2			Q3			Q4			2027-28	
			April 2026	May 2026	June 2026	July 2026	Aug 2026	Sep 2026	Oct 2026	Nov 2026	Dec 2026	Jan 2027	Feb 2027	Mar 2027	April 2027	May 2027
• Quality Improvement Strategy (End of Life Care)	Nursing & Midwifery and Executive Medical Director															
Strategic Item 5 - Effective Environment for Learning and Skills Development																
Research, Development & Innovation (5B)	Executive Medical Director	To be agreed at agenda setting														
Medical Education	Executive Medical Director	Annually												Π		
Mortality	Executive Medical Director	Annually		Π												Π
Quality of Commissioned Services Twice per year – timing to be confirmed	Executive Medical Director & Executive Director of Finance & Performance	Bi-annually						Π						Π		
Annual Responsible Officer Report	Executive Medical Director	TBC														
ANNUAL REPORTING																
Annual Quality Report	Executive Director of Nursing & Midwifery	Annually *(For onward submission to Board)*		Π												
Nurse Staffing Act	Executive Director of Nursing & Midwifery	Bi-Annually *(For onward submission to Board)*		Π						Π						
Duty of Candour Annual Report	Executive Director of Nursing & Midwifery	Annually *(For onward submission to Board)*						Π								
Putting Things Right Annual Report	Executive Director of Nursing & Midwifery	Annually *(For onward submission to Board)*						Π								
Ombudsman Annual Letter	Executive Director of Nursing & Midwifery	Annually								Π						
Research & Development Annual Report	Executive Medical Director	Annually *(For onward submission to Board)*				Π				Π				Π		
Adoption of Corporate Policies (TBC)	Director of Corporate Governance	As Required														

Item of Business	Executive Lead	Reporting period	Q1			Q2			Q3			Q4			2027-28	
			April 2026	May 2026	June 2026	July 2026	Aug 2026	Sep 2026	Oct 2026	Nov 2026	Dec 2026	Jan 2027	Feb 2027	Mar 2027	April 2027	May 2027
ALN DECLO Annual Report	Executive Director of Allied Health Professionals & Health Science	Annually												Π		
GOVERNANCE, RISK AND ASSURANCE																
Corporate Governance Report *(Including summary of business to be reported from private and forward workplan)*	Director of Corporate Governance	All Regular Meetings		Π		Π		Π		Π		Π		Π		Π
Committee Cycle of Business	Director of Corporate Governance	Annually		Π												
Committee Terms of Reference	Director of Corporate Governance	Annually		Π												
Committee Self-Assessment	Director of Corporate Governance	Annually		Π												
Committee Annual Report	Director of Corporate Governance	Annually		Π												
Corporate Risk Register Report	Director of Corporate Governance	Quarterly				Π				Π				Π		
Board Assurance Framework Report	Director of Corporate Governance	Quarterly		Π				Π				Π				
Quality Governance Report (Audit Wales)	Director of Corporate Governance	Bi-Annually				Π						Π				
FOR INFORMATION																
NHS Wales JCCQC Chairs	Director of Corporate Governance	As Required		Π		Π		Π		Π		Π		Π		
Llais Annual Report / Experience Paper	Llais	As Required														
Quality Delivery Chairs Report	Executive Director of Nursing & Midwifery	All Regular Meetings		Π		Π		Π		Π		Π		Π		
Mental Health Oversight Operational & Development Group Chairs Report	Exec. Director of Allied Health Professionals	All Regular Meetings				Π		Π		Π		Π		Π		
CLOSING BUSINESS																
Agree Items for Referral to Board / Other Committees	Chair	All Regular Meetings		Π		Π		Π		Π		Π		Π		Π
Review of Meeting Effectiveness	Chair	All Regular Meetings		Π		Π		Π		Π		Π		Π		Π
Date of Next Meeting	Chair	All Regular Meetings		Π		Π		Π		Π		Π		Π		Π

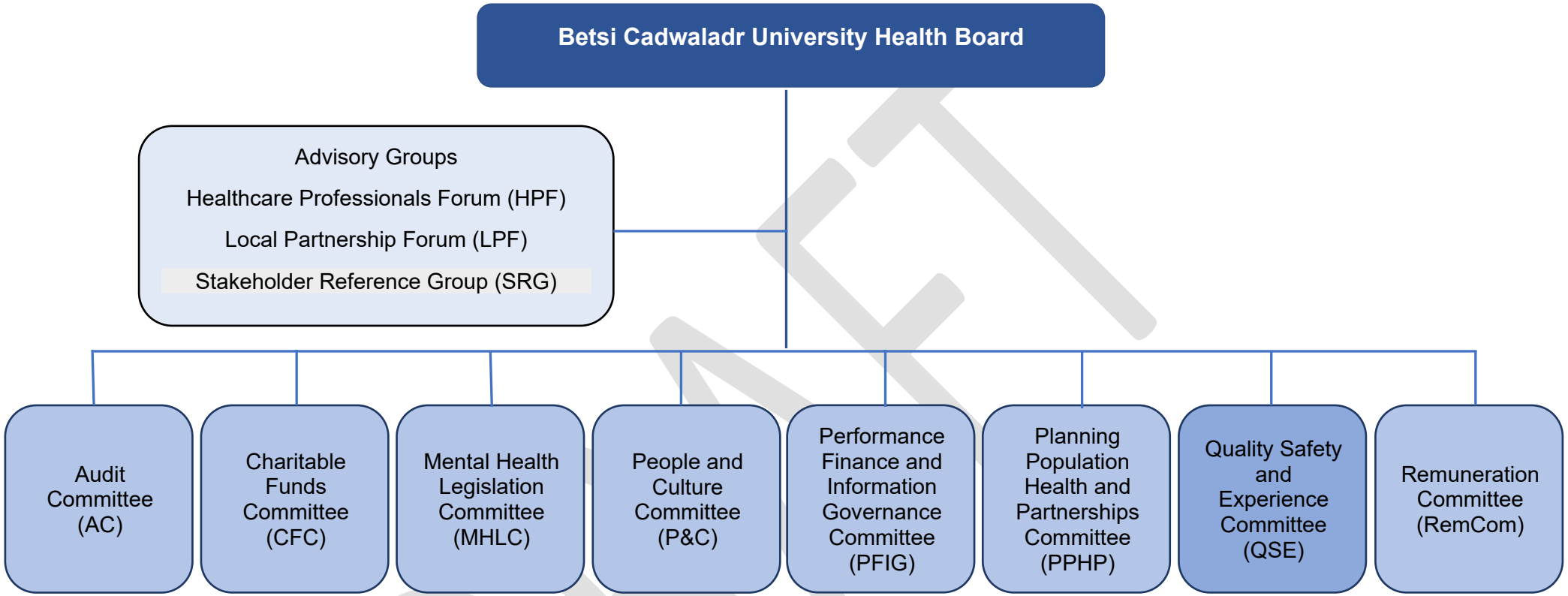
Item of Business	Executive Lead	Reporting period	Q1			Q2			Q3			Q4			2027-28	
			April 2026	May 2026	June 2026	July 2026	Aug 2026	Sep 2026	Oct 2026	Nov 2026	Dec 2026	Jan 2027	Feb 2027	Mar 2027	April 2027	May 2027
Resolution to Exclude the Press and Public	Chair	All Regular Meetings		Π		Π		Π		Π		Π		Π		Π

QUALITY, SAFETY AND EXPERIENCE COMMITTEE

Terms of Reference & Operating Arrangements

(Schedule 3.5 of the Standing Orders)

Date approved by Health Board:



Version Control

Version	Issued to	Date	Comments
V0.01	Quality, Safety & Experience Committee	01.05.25	Endorsed for approval at the May Board
V1.0	Board	29.05.25	
V1.01	Quality, Safety & Experience Committee	03.09.26	Seek endorsement for submission to the Board

TERMS OF REFERENCE

1 INTRODUCTION

1.1 The Betsi Cadwaladr University Health Board (BCUHB) Standing Orders provide that "The Board may and, where directed by the Welsh Government must, appoint Committees of the Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees

1.2 In accordance with Standing Orders (and the BCUHB scheme of delegation), the Board shall nominate annually a committee to be known as the Quality, Safety and Experience Committee. The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set in this document.

2 PURPOSE

2.1 The purpose of the Committee is to act on behalf of the Board to:

2.2 scrutinise, assess and seek assurance in relation to the patient experience, safety, impact, quality and health outcomes of the services provided by the Health Board;

2.2 provide evidence-based and timely advice to the Board to assist it in discharging its functions and meeting its responsibilities with regard to the quality and safety of health care provided and secured by the Health Board;

2.3 provide assurance that the Health Board has an effective strategy and delivery plan(s) for improving the quality and safety of care patients receive, commissioning quality and safety impact assessments where considered appropriate. This includes consideration of the Annual Plan/Integrated Medium Term Plan (IMTP); and

2.4 provide assurance that the organisation, at all levels, has the right governance arrangements and strategy in place to ensure that the care planned or provided is of a high standard.

3 DELEGATED POWERS

With regard to its role in acting on behalf of the Board, and in providing advice and assurance to the Board, the Quality, Safety and Experience Committee will comment specifically upon:

3.1 provide advice to the Board on the adoption of a set of key indicators of quality of care against which the Health Board's performance will be regularly assessed and reported on;

3.2 seek assurance on the management of principal risks within the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) allocated to the Committee and provide assurance to the Board that risks are being managed effectively and report any areas of significant concern;

3.3 ensure the right enablers are in place to promote a positive culture of quality improvement based on best evidence;

3.4 seek assurance on delivery against planning objectives aligned to the Committee, considering and scrutinising the processes that are developed and implemented, supporting and endorsing these as appropriate;

3.5 provide assurance that all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality and safety of care provided and, in particular, that sources of internal assurance are reliable, there is capacity and capability to deliver and lessons are learned from patient safety incidents, complaints and claims;

3.6 provide assurance to the Board in relation to improving the experience of patients, including those services provided by other organisations or in a partnership arrangement. Patient stories will feature as a key area for patient experience and lessons learnt;

3.7 provide assurance to the Board in relation to its responsibilities for the quality and safety of mental health, primary and community care, public health, health promotion, prevention and health protection activities and interventions in line with the Health Board's strategies. This includes consideration of those health and safety matters which fall under the responsibilities of this Committee;

3.8 ensure that the organisation is meeting the requirements of the NHS Concerns, Complaints and Redress Arrangements (Wales) Regulations;

3.9 approve the required action plans in respect of any concerns investigated by the Ombudsman;

3.10 agree actions, as required, to improve performance against compliance with incident reporting;

3.11 provide assurance that the Central Alert Systems process is being effectively managed with timely action where necessary;

3.12 provide assurance on the delivery of action plans arising from investigation reports and the work of external regulators;

3.13 approve the annual clinical audit plan, ensuring that internally commissioned audits are aligned with strategic priorities;

3.14 provide assurance that a review process to receive and act upon clinical outcome indicators suggesting harm or unwarranted variation is in place and is operating effectively with concerns escalated to the Board;

3.15 consider advice on clinical effectiveness and, where decisions about implementation have wider implications with regard to prioritisation and finances, prepare reports for consideration by the Executive Team which will collectively agree recommendations for consideration through relevant Committee structures;

3.16 provide assurance in relation to the organisation's arrangements for safeguarding vulnerable people, children and young people;

3.17 approve policies and plans within the scope of the Committee, having taken assurance that the quality and safety of patient care has been considered within these policies and plans;

3.18 assure the Board in relation to its compliance with relevant national practice, mandatory guidance, healthcare standards and duties, including Duty of Quality, Duty of Candour,

Quality Standards and Quality Management ensuring the Board is supported to make strategic decisions from a quality perspective;

3.19 develop a work plan which sets clear priorities for improving quality, safety and experience each year, together with intended outcomes, and monitor delivery throughout the year;

3.20 refer quality and safety matters which impact on other Board Committees and receive referrals from other Committees; and

3.21 agree issues to be escalated to the Board with recommendations for action.

4 AUTHORITY

4.1 The Committee may investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any:

- Employee - and all employees are directed to cooperate with any legitimate request made by the Committee; and
- Other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

4.2 It may also obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

5 SUB-COMMITTEES

5.1 The Committee may, subject to the approval of the Health Board, establish sub-committees or task and finish groups to perform specific aspects of Committee business.

6 MEMBERSHIP

6.1 Formal membership of the Committee shall comprise of the following:

MEMBERS
Independent Member (Chair)
2 x Independent Members (one of whom will be designated as Vice Chair)

6.2 The following should attend Committee meetings:

IN ATTENDANCE
Executive Director of Nursing and Midwifery (Executive Lead)
Executive Medical Director
Executive Director of Allied Health Professionals and Health Science
Other Executive Directors as required by the Chair including:
Chief Operating Officer
~~Director of Performance and Commissioning~~
Executive Director of People and Organisational Development
Other BCUHB Senior Managers as required by the Chair and
Chair of Healthcare Professionals Forum (Associate Board Member)
Representative of Llais

6.3 The attendance of the Committee shall be determined by the Board, based on the recommendation of the Health Board Chair, taking into account the balance of skills and expertise necessary to deliver the Committee's remit, and subject to any specific requirements or directions made by the Welsh Government.

6.4 Other Directors/Officers will attend as required by the Committee Chair, as well as any others from within or outside the organisation whom the Committee considers should attend, taking into account the matters under consideration at each meeting.

5. COMMITTEE MEETINGS

5.1 Quorum

- A quorum shall consist of no less than two of the membership, and must include as a minimum the Chair or Vice Chair of the Committee.

5.2 Frequency of meetings

- The Committee will meet bi-monthly and an annual schedule of meetings will be determined by the corporate calendar.

- Any additional meetings will be arranged under exceptional circumstance and shall be determined by the Chair of the Committee in discussion with the Executive Lead.

5.2 Withdrawal of individuals in attendance

- The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

5.3 Meeting arrangements

- The agenda and papers will be distributed/published seven days in advance of the meeting.

- The Director of Corporate Governance is to hold an agenda setting meeting with the Chair and/or Vice Chair and the Executive Director of Nursing and Midwifery at least six weeks before the meeting date.

- The agenda will be based on the Committee work plan, identified risks, matters arising from previous meetings, issues emerging throughout the year, and requests from Committee members.

6. REPORTING AND ASSURANCE ARRANGEMENTS

The Committee, through its Chair and members, shall work closely with the other Committees to provide advice and assurance to the Board through joint planning and co-ordination of Board and Committee business including sharing information.

6.1 The Committee Chair, supported by the Committee Secretary, shall:

- Report formally, regularly and on a timely basis to the Board on the Committee's activities;
- Bring to the Board's specific attention any significant matter under consideration by the Committee; and

- Ensure appropriate escalation arrangements are in place to alert the Health Board's Chair, Chief Executive and/or Chairs of other relevant Committee, of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

6.2 The Committee will undertake an annual review on the effectiveness of its arrangements and responsibilities. The Director of Corporate Governance will oversee this review.

7. RELATIONSHIP WITH THE BOARD AND ITS COMMITTEES/GROUPS

Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these Terms of Reference, it retains overall responsibility and accountability for these matters.

7.1 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference.

7.2 The Committee, through its Chair and members, shall work closely with the Board's other committees, including joint (sub) committees and groups to provide advice and assurance to the Board through the:

~ Joint planning and co-ordination of Board and Committee business and
~ Sharing of information

In doing so, it will contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

7.3 The Committee will consider the assurance provided through the work of the Board's other committees and sub groups to meet its responsibilities for advising the Board on the adequacy of the Health Board's overall system of assurance.

7.4 The Committee shall embed the Health Board's corporate standards, priorities and requirements, e.g. equality and human rights through the conduct of its business.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in the Health Board's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

• Quorum

9. REVIEW

These Terms of Reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board.

10. CHAIR'S ACTION ON URGENT MATTERS

10.1 There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate,

may deal with the matter on behalf of the Board – after first consulting with **all** Members of the Committee. The Secretariat must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

10.2 Chair's action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

Health Board Key Issues Report				
Committee Date		03/09/2026 Quality Safety Experience Committee 26/08/2026 Executive Committee		
Date of Committee		16/07/2026	**Report of:**	Mental Health Oversight and Development Group
Quoracy met:		Quoracy requires the Chair and/or Vice Chair of the Group to be present with two members of the Mental Health and Learning Disability (MHLD) Senior Leadership Team and a minimum of 50% of the core membership present. The group was quorate on this basis.		
1	Agenda	The Mental Health Oversight and Development (MHODG) group met on 16th July 2026. The Committee was chaired by the Chief Executive and considered an agenda which is attached at Appendix 1.		
2a	Alert	The MHODG wish to **alert** members of the Quality Safety Experience (QSE) Committee that although the inaugural meeting of the planned Ligature Reduction Programme Board has not been held, imminent plans are in place as it forms a significant priority for the Health Board. This will report back to MHODG Committee in its September meeting. The commitment remains to ensure that all Health Safety Executive (HSE) actions, relating to ligature, can be progressed through the new governance structures, led jointly by Estates and the MHLD division. This will ensure MHODG have strategic oversight of ligature reduction progress and therefore strengthen existing governance arrangements for important quality and safety issues.		
2b	Assurance	The MHODG wish to **assure** members of QSE Committee that: 1. The Draft Mental Health Outcomes framework was considered and supported for further development and onward consideration at Board. This is a coproduced framework based on over 1000 insights from service users and their family members and forms a key deliverable of the MHODG. It is hoped this will provide a blueprint for a wider Health Board approach to an outcomes framework that is person centred and ensures delivery of care that focuses on what patients want and need, from their own perspective, and not that of the service. Next steps are to test the outcomes framework for further iteration. 2. The BCUHB Open Access Model (OAM) demonstrator programme, led by Adult Mental Health (AMH), under the Strategic Programme for Mental Health led by NHS Performance and Improvement (NHSPI) was considered and is progressing favourably. BCUHB were successful in an application to become a demonstrator site for this work at the end of 2025. MHLD Divisional Clinical, Operational and Service Transformation leads have worked collaboratively with Welsh Ambulance Service Trust (WAST) and other partners to develop a proposal focused on redefining the front door, seamlessly connecting people to the right level of care using the Open Access Model and to community services. Plans are being developed to implement and evaluate this approach to inform the national evidence base. 3. The MHLD approach to delivering culture, leadership and organisational development was considered and supported the direction of travel but that further work is required to ensure organisational alignment. 4. A clear and detailed work programme has been developed in line with identified MHODG objectives and deliverables. This was agreed.		

2c	Advise	The MHODG wish to **advise** members of Executive Committee and QSE Committee that: 1. A supplier for the MHLD Electronic Health Record (EHR) has been identified following a successful tender exercise. A full paper will be considered at the September MHODG with regards plans for implementation. 2. A recent HIW inspection of the Ablett unit has taken place with positive feedback received. 3. The acute out of area patient numbers have significantly reduced to just one as at 16/07/26 with work ongoing to repatriate this patient at the earliest opportunity. 4. A suitable BCUHB chair-person is required for the developing Suicide and Self harm review group and this will be followed up.
2d	Review of Risks	1. Need for assurance on establishment of ligature programme board.
2e	Sharing of learning	1. The draft Mental Health Outcomes framework provides an opportunity for learning for the wider Health Board by providing a template for adaptation.
3	Actions to be considered by the Executive Committee	MHODG agreed: • The MH Outcomes framework draft to progress for Board consideration. • The developing Open Access Model (OAM) model and proposed next steps with further detail on timescales to be considered at a future meeting. • That the Ligature Reduction Programme Board should progress at pace. • That MHLD Division has made progress with establishing a comprehensive approach to delivering culture, leadership and organisational development but that further work is required to ensure organisational alignment. • That a chair for the developing Suicide and Self harm review group be considered further with key BCU leads. • The detailed forward work programme for MHODG.

Mental Health Oversight and Development Group

Date	**16/07/2026**
Time	**2.00 - 4:00pm**
Location	**Teams**
Chair	**Carol Shillabeer**

Item Ref		Time	Paper	Lead	Ask	Notes
1	**PRELIMINARY ITEMS**					
1.1	ODG26.30	2.00	Welcome, Introductions, Apologies for Absence and Declarations of Interest	Chair	Note	
1.2	ODG26.31	2.05	Minutes of the Previous Meeting (01.06.2026) and Action Log	Chair	Approve	
1.3	ODG26.32	2.15	Health Board Mental Health Work We Are Proud Of	All	Note	Discussion
2	**STRATEGIC PLANNING, OUTCOMES AND SERVICE MODEL**					
2.1	ODG26.33	2.30	Draft Mental Health Outcomes Framework	Head of Integrated Strategy and Development- MHLD	Note and Approve	
2.2		2.45	Delivering on the Strategic Programme for Mental Health- Open Access Model	Head of Integrated Strategy and Development- MHLD	Note	

3	**ESTATES AND ENVIRONMENT**					
3.1	ODG26.34	3.00	Ligature Programme Board Update	Director of Environment and Estates	Note and Oversight	
		3:15	Ablett Update	Director of Environment and Estates	Note	
4	**CULTURE LEADERSHIP AND OD**					
4.1	ODG26.35	3.20	Work plan Objective: An effective MHLD leadership and OD model, reflecting the Health Board Approach	Executive Director for Workforce and Organisational Development/ Director of Operations MHLD	Note and support development	
5	**GOVERNANCE OF MH ODG**					
5.1	ODG26.36	3.40	MHODG Cycle of business aligned to Workstreams and Key Deliverables	Associate Director of Governance/ Head of Integrated Strategy and Development- MHLD	Note	
6	**CONSENT ITEMS** The MH ODG is asked to approve the items listed under the consent agenda. These items are considered routine and non-controversial, and supporting documentation has been circulated in advance. Any member may request that an item be withdrawn from the consent agenda for separate discussion prior to meeting. If no such requests are made, all items will be approved as presented.					
6.1	ODG26.37	3.50	Suicide and Self Harm Review Group development	Medical Director- MHLD	Note	
7	**CLOSING BUSINESS**					
	ODG26.38	3.55	Any Other Business and Date and Time of next Meeting September 17/09/2026 2pm-4pm	Chair		