Bundle BCU Quality, Safety and Experience Committee 2 July 2026

1 PRELIMINARY ITEMS

1.1 13:00 - QS26.88 Welcome & Apologies
Caroline Turner, Chair

1.2 13:01 - QS26.89 Declarations of Interest
Caroline Turner, Chair

1.3 13:02 - QS26.90 Minutes of the Previous Meeting - 7 May 2026
Caroline Turner, Chair
1.3 Unconfirmed Minutes 07.05.26

1.4 13:03 - QS26.91 Action Log
Caroline Turner, Chair
1.4 Public Action Log

1.5 13:05 - QS26.92 Patient Story
Angela Wood, Executive Director of Nursing & Midwifery
1.5 QSE Patient Story

2 INTERGRATED PERFORMANCE

2.1 13:25 - QS26.95 Integrated Quality Report
Angela Wood, Executive Director of Nursing & Midwifery
3.1 QSE Committee - Integrated Quality report

2.2 13:40 - QS26.96 Integrated Performance Report
Ed Williams, Deputy Director of Performance & Commissioning
3.2.1 IQPR Coversheet
3.2.2 IQPR QSE V2

2.3 13:50 - QS26.97 Clinical Services Plan Update
Dr Clara Day, Executive Medical Director / Paolo Tardivel, Executive Director of Transformation & Strategic Planning
3.3.1 CSP Report

3 STRATEGIC ITEMS

3.1 14:05 - QS26.93 Planned Care Report - Cancer Services
Tehmeena Ajmal, Chief Operating Officer
2.1 QSE Planned Care - Cancer services

3.2 14:25 - QS26.94 Urgent & Emergency Care Programme Update
Tehmeena Ajmal, Chief Operating Officer
2.2 UEC Programme Update V2

4 IMPROVING QUALITY, OUTCOMES & EXPERIENCE

4.1 14:40 - QS26.98 Maternity & Neonatal
Tehmeena Ajmal, Chief Operating Officer
5.1 QSE Maternity & Neonatal

4.2 15:00 - QS26.99 Nurse Staffing
Angela Wood, Executive Director of Nursing & Midwifery
5.2.1 Nurse Staffing Levels
5.2.2 Nurse Staffing

5 15:10 - BREAK

6 EFFECTIVE ENVIRONMENT FOR LEARNING AND SKILLS DEVELOPMENT

6.1 15:20 - QS26.100 Research, Development & Innovation
Dr Clara Day, Executive Medical Director
6.1 R&D paper

7 GOVERNANCE, RISK & ASSURANCE

7.1 15:30 - QS26.101 Corporate Risk Register
Pam Wenger, Director of Corporate Governance
7.1.1 QSE Corporate Risk Register Report
7.1.2 QSE CRR Appendix 1-3

7.2 15:40 - QS26.102 Corporate Governance Report
Pam Wenger, Director of Corporate Governance
7.2.1 Corporate Governance Report
7.2.2 forward workplan
7.2.3 cob

8 15:45 - FOR INFORMATION

8.1 QS26.103 Operational Delivery Group Chairs Report
Teresa Owen, Executive Director of Allied Health Professionals & Health Sciences
8.1 AAA Report MHODG

8.2 QS26.104 MHLD Advocacy Annual Report
Teresa Owen, Executive Director of Allied Health Professionals & Health Sciences
8.2 QSE Annual Statutory Advocacy report

8.3 QS26.105 Quality Governance Report - Audit Wales
Dr Clara Day, Executive Medical Director
8.3. BCU Quality Governance Report Final

9 15:50 - CLOSING BUSINESS

9.1 QS26.106 Agree items for Referral to Board / Other Committees
Caroline Turner, Chair

9.2 QS26.107 Review Meeting Effectiveness
Caroline Turner, Chair

9.3 QS26.108 Date of the Next Meeting - 3 September 2026
Caroline Turner, Chair

9.4 QS26.109 Resolution to Exclude the Press & Public
Caroline Turner, Chair

Betsi Cadwaladr University Health Board (BCUHB)
Unconfirmed Minutes of the Quality, Safety & Experience Committee
held in Public on 7 May 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
Emily Bebbington	Speciality Registrar in Public Health
Dr Clara Day	Executive Medical Director
Geoff Ryall-Harvey	Llais
Glesni Driver	Head of Statutory Compliance and Inquiries
Urtha Felda	Independent Member
Matthew Joyes	Deputy Director of Legal Services
Joanne Kendrick	Head of Quality
Mike Larvin	Independent Member (via teams)
Chris Lothian-Field	Independent Member (via teams)
Lois Lloyd	Chief Pharmacist (via teams
Jane Moore	Executive Director of Public Health
Teresa Owen	Executive Director of Allied Health Professionals & Health Sciences
Zoe Prince	Director of Nursing - Mental Health
Pam Wenger	Director of Corporate Governance
Ed Williams	Deputy Director of Performance & Commissioning (via teams)
Gareth Williams	Vice Chair, BCUHB
Angela Wood	Executive Director of Nursing & Midwifery
Committee Support	
Philippa Peake-Jones	Head of Corporate Governance
Harriet Abbott	Secretariat

PRELIMINARY MATTERS
QS26.58 Welcome and Apologies Apologies were received from Debbie Eyitayo, Stuart Keen, Carol Shillabeer, Paolo Tardivel.
QS26.59 Declarations of Interest No declarations of interest were received.
QS26.60 Unconfirmed Minutes of the Meeting held on 5 March 2026 The following amendments were requested: • QS26.37: abbreviation of DECLO to be included for clarity, “Designed Educational Clinical Lead Officer”.

- Clarified that the Llandudno Orthopaedic Centre referenced is the “North Wales Surgical Centre”.
- A small number of minor grammatical corrections to be shared with the secretariat for correction prior to publishing of the confirmed minutes.

It was agreed that, subject to the above amendments, the minutes of the meeting held on **5 March 2026** were a true and accurate record.

QS26.61 Matters Arising & Action Log

It was agreed that all due actions were completed.

It was resolved that the Committee:

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

[Zoe Prince, Pam Wenger & Gareth Williams joined the meeting].

QS26.62 Patient Story – This Too Will Pass

The Committee received the experience item.

[Tehmeena Ajmal joined the meeting].

In discussing the item, the Committee:

- Thanked Llais for their involvement in creation of the video, and shared thanks to the patient for sharing their story.
- Recognised the importance of sharing the story widely to challenge stigma and raise awareness, noting the patient’s wish to share their experience publicly, including a community screening at the Community Cinema in Porthmadog on 15 July, which will be followed by a question & answer session with Mental Health Learning Disabilities (MHLD) colleagues also in attendance.
- Emphasised the importance of respect, kindness and understanding of the lived experiences of individuals living with chronic conditions.
- Noted the impact of housing, social circumstances and community-based support on outcomes, as well as the relevance of the story for staff education and training.

It was resolved that the Committee:

- **NOTED** the report.

[Zoe Prince left the meeting and Ed Williams joined the meeting].

QS26.63 Service Presentation – Urgent & Emergency Care (UEC)

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

- The development of a refined 90-day Plan aligned with the Integrated Medium-Term Plan (IMTP) assumptions on key performance and quality metrics, and ensuring embedding of long-term changes.

- Tighter quality monitoring processes have been introduced, involving fortnightly performance and safety reviews with each IHC, which are focused on areas such as undesignated care areas, forward boarding, intentional rounding, as well as learning from complaints and significant incidents.
- There is recognition of the risks associated with long waits, ambulance handover delays and deconditioning.
- Reference was made to Community by Design, and how this can be utilised to improve UEC performance, including the role of social care and local authorities. A workshop is scheduled for 19 May with Local Authorities to identify enabling actions and expectations from partners.

[Dyfed Edwards joined the meeting].

In discussing the item, the Committee:

- Highlighted the need for clear trajectories and outcome measures to provide further assurance to the Board.
- Noted an upcoming Planning, Population Health & Partnership (PPHP) development session due to be held focusing on Community by Design for further awareness.

It was resolved that the Committee:

- **NOTED** the update.

[Tehmeena Ajmal left the meeting].

GOVERNANCE, RISK & ASSURANCE

QS26.64 Integrated Quality Report

The item was presented by the Executive Director of Nursing & Midwifery, Executive Medical Director and Deputy Director of Legal Services. Some overlap was noted between this item and the regulatory paper. It was agreed that future updates would be merged going forward, and the regulatory paper would not return as a stand-alone item as further detail is given through the integrated quality report.

The following points were highlighted:

- There was occurrence of two never events, with associated learning referenced within the report. An increase in events is noted. Whilst incidents are not associated, there can often be similar themes linked with following process.
- The report notes timeliness of investigations (a 75-day average), with acknowledgement of varying complexities impacting on timescale.
- Work is ongoing to reduce the number of incidents. Some progress has been seen, with further improvement still required.
- An increase in complaints has been seen. This was expected, following the implementation of the new Listening to People framework from 1 April 2026. Whilst an increase is noted, performance is still within trajectories with the resolution target met.

[Gareth Williams left the meeting].

In discussing the item, the Committee:

- Were advised regarding the one prevention of future death notice received, that this was initiated by the coroner to all Welsh Health Boards, but does not involve BCUHB directly. A response from BCUHB has been submitted.
- Emphasised the importance of understanding system pressures contributing to Never Events, to then enabling learning which can often require a whole system approach. Consideration was given to both the impact on patients as well as staff involved in regards to incidents.
- Raised concern over Welsh language compliance in some areas, highlighting the importance of ensuring staff are clear on legislation and expectations. Clarity is also needed in regards to expectation of care provided outside Wales, and the requirement to provide Welsh language service. It was suggested a Welsh language briefing be included for a future development session.
- Clarified that the concerns relating to insourcing are being addressed, and a reduction in incidents has been seen.
- Advised of a previous awareness session on the Listening to People Framework that took place in a recent development session. This was circulated to members for awareness.
- Requested a demonstration of the Quality Score Card referenced in 9.5.1 at a future development session.

The following actions were agreed:

- **Action QS26.64.1**: Regulatory paper to be merged with the Integrated Quality Report going forward.
- **Action QS26.64.2**: A Welsh language briefing be included at a future development session.
- **Action QS26.64.3**: a demonstration on the Quality Score Card to be given at a future development session.

It was resolved that the Committee:

- **NOTED** the current position.

QS26.65 Integrated Performance Report

The report was presented by the Deputy Director of Performance & Commissioning**.** The following points were highlighted:

- Improvement is noted on 11 out of 15 metrics, with one metric (Emergency Departments) seeing an increase in March.
- It was advised that areas will be reviewed by Executives and closely monitored and will be escalated to Committee as and when required.

In discussing the item, the Committee:

- Referenced the need to ensure alignment with the NHS Performance Framework for 2026/27, and ensuring metrics are linked with the IMTP around prevention.
- Emphasised the need of ensuring appropriate governance and assurance. It was clarified that the framework was referenced at Performance, Finance & Information Governance (PFIG) committee the previous week, following review at the Board in March, and will return to Board in May, which will set out reporting and governance

arrangements. In accordance with the framework, reporting will come through PFIG as a standard item, with a paper already expected at the next PFIG committee.

It was resolved that the Committee:

- **NOTED** the current position.

QS26.66 Regulatory Paper

The paper was presented by the Head of Quality. The following points were highlighted:

- Progress has been seen with recent Healthcare Inspectorate Wales (HIW) inspections. Sign off will not be given until HIW have assurance. A revisit is also expected after three months as follow up.
- There is a good ongoing relationship with the Ombudsman office, with implementation of the new complaint procedure strengthening this work.
- Further work is ongoing to strengthen organisational tracking and oversite, to ensure robust processes.

In discussing the item, the Committee:

- Were advised that implementation of the Commissioning Assurance Framework is being supported by governance and was previously presented at a PFIG Committee prior to discussion at May Board.
- Noted the spread of complaints across the region and queried how the resolution process. These are being explored by clinical executives and trends identified.
- Highlighted the need to consider staff wellbeing linked with regulatory demands.

It was resolved that the Committee:

- **NOTED** the report.

QS26.67 Nurse Staffing Act

The Executive Director of Nursing & Midwifery presented the item. The following points were highlighted:

- The item has to be presented to Committee on a six-monthly basis.
- A number of check and challenge meetings were undertaken with divisions in April, with outcomes of these reflected within the report.
- The previous review identified areas and wards requiring uplifts. The Nursing Staffing Act has been maintained, and no additional ward establishment uplifts are currently required based on acuity, harm and workforce review.

In discussing the item, the Committee:

- Requested a short paper be received at the next Committee meeting in relation to staffing ratios on the wards not covered by the Act for information.

The following actions were agreed:

- **Action QS26.67.1**: a short paper to be received at the next Committee meeting regarding staffing ratios of the wards not covered by the Act.

It was resolved that the Committee:

- **NOTED** the report.

[Ed Williams left the meeting].

QS26.68 Board Assurance Framework

The item was presented by the Director of Corporate Governance. The Board Assurance Framework maps strategic intent statements agreed by the Board. Overall progress is recognised, with further work ongoing to continue to strengthen.

It was resolved that the Committee:

- **NOTED** the report.

IMPLEMENTING THE QUALITY MANAGEMENT SYSTEM (QMS)

QS26.69 Clinical Services Plan (CSP)

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

- A launch day took place on 5 May with approximately 75 leaders across different professionals across BCUHB in attendance, which emphasised the need for collaboration. Strong engagement was fed back from the event, and advice was taken from Hywel Dda University Health Board following a previous similar event.
- Important factors for consideration include changes in population, workforce and medical practices, along with access to treatment and digital processes, as well as ensuring practices are cost effective.
- The CSP also links in with work relating to fragile services, Community by Design and the Foundation for the Future (FFTF) programme, with the need to focus on staff development and population health outcomes.

In discussing the item, the Committee:

- Noted the good attendance and engagement from the launch event.
- Referenced links with FFTF and the importance of ensuring engagement of clinical leads.
- Noted the positive engagement and shared learning with Hywel Dda University Health Board.
- Referenced recruitment aspects, and explored the potential of appointing to services specifically, and emphasised the need of ensuring clear expectation and skills for roles.
- Suggested the Clinical Services Plan be included as a topic on at a future development session for further information.

The following actions were agreed:

- **Action QS26.69.1**: the Clinical Services Plan be included as a topic on at a future development session for further information.

It was resolved that the Committee:

- **NOTED** the update.

IMPROVING QUALITY, OUTCOMES & EXPERIENCE

QS26.70 Challenged Services Update

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

- The services under the category were identified by Welsh Government previously. It is felt by BCU that Oncology and Plastics no longer meet within the defined criteria. From this year, the term "Fragile Services" has been adopted to references further services that are felt to need further review and rapid regionalisation, which are covered separately to the Challenged Services.
- A refresh of fragile services is underway, with the Chief Operating Officer meeting with IHC Directors to refresh operational ownership. An updated programme of work is expected prior to the next Committee meeting.

In discussing the item, the Committee:

- Noted universal difficulty regarding recruitment. It was advised that key influencers can be workforce planning and changing clinical practice, as well as high pressurised service areas.
- Referenced the hybrid facilities for vascular services at Ysbyty Glan Clwyd and the importance of ensuring relevant factors like this are emphasised to attempt to aid recruitment.

It was resolved that the Committee:

- **NOTED** the report.

[Zoe Prince rejoined the meeting].

QS26.71 Adult Mental Health & Learning Disabilities

The item was presented by Zoe Prince, Director of Nursing for MHLD. The following points were highlighted:

- An update was requested following several queries raised through the Expert Advisory Group (EAG) during the last committee meeting.
- Work is ongoing to align with Welsh Government's 10-year Mental Health strategy.
- The Operational Delivery Group (ODG) chaired by the Chief Executive provides a single point of accountability for Mental Health across the Health Board.
- The strategy is focused on reducing inpatient admissions and focusing on community-based care. A significant enabler for this improvement would be to move to a flexible access model, with the intention to reduce waits and provide earlier intervention. A new model is being developed in partnership with Welsh Ambulance Service Trust, which provides an opportunity to influence the national direction.
- Clarity was given regarding the care coordinator role, confirming that this has to be undertaken by a registered health or social professional.
- Further information was shared regarding part three and four of the Mental Health Measure. Part three, covers the right for service users to self-refer back into the service without the need to access primary care. A trend is seen both regionally and nationally, whereby patients often default back to Primary Care services. There is a

focus on information sharing with patients at discharge and strengthening relationships with primary care.
- Part four on the measure references the need to ensure advocacy is in place. An independent service is commissioned to provide this. Reporting on this part has changed from quarterly to annual reporting. The annual report will be shared with Committee once available. Feedback following the latest HIW visits to Hergest and Ablett stated that advocacy was visible and accessible to patients.

In discussing the item, the Committee:
- Added further that the care coordinator role does not have to be a separate standalone role in a patient's care, and could be an additional aspect to a clinician already involved.
- Emphasised the importance of continuity of care for patients through the same coordinator through an episode of care.
- Emphasised the need for clear communication between the clinician and patients, and ensuring awareness of rights and entitlement, including following discharge.
- Highlighted the importance of environment and the impact this can have on patients as well as staff, which can impact further on patient outcomes. It was noted that environment is often highlighted as part of Llais visits to inpatient facilities. It was advised that the Director of Environment & Estates has visited sites following the previous EAG item at the Board earlier this year. An update on this is expected at the ODG as a workstream. It was agreed for a chairs report from the ODG to be included on the standard QSE agenda item for information going forward.
- Noted an update on the new Mental Health Measure which will have significant changes and impact, with the expectation of shifting demand and complexity further into the community than currently. The importance of factoring in these changes through workforce planning was highlighted.
- Requested future updates include further data on the number of patients who have a designated care coordinator, highlighting any changes over time and trends.
- Requested the advocacy annual report be included for information at the next meeting.

The following action was agreed:
- **Action QS26.71.1**: a chairs report from ODG to be included on the QSE agenda for information going forward.
- **Action QS26.71.2**: future MHLD updates to include data on number of patients with designated care coordinators, highlighting any trends.
- **Action QS26.71.3**: The advocacy annual report to be included for information at the next QSE meeting.

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

[Zoe Prince left the meeting].

QS26.72 Mortality

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

- The paper covers population level data across a range of characteristics, covering death from physical causes as well as death by suicide.
- Regarding the Mental Health aspect, death by suicide is monitored in rolling years, and can only be defined following inquest, which can take several months. Figures around suspected suicide surveillance therefore gives a timelier figure.
- For every death that occurs, where the patient was under MHLD at the time, and the death was not linked to end-of-life care, the death is reported as unexpected and is investigated as per process.
- The importance of take situational circumstances into account when comparing health boards was highlighted.

[Chris Lothian-Field left the meeting].

In discussing the item, the Committee:

- Agreed that further work was required on premature mortality to ensure accurate reflection of health services.
- Noted that it was importance to acknowledge that BCUHB has the largest population number and area out of Welsh Health Boards, and the importance of considering this when reviewing data.
- Advised that the report would be shared with Gareth Williams, Vice Chair of the Board for awareness, as well as with EAG members as required.
- Requested future reports to include information from MHLD.
- Advised of a correction to papers, Prof Rob Atenstaed is a Consultant in Public Health and works for BCUHB rather than Public Health Wales as stipulated in the report.
- Sent thanks to the Interim Director MHLD for their continued work, ahead of upcoming retirement.

The following actions were agreed:

- **Action QS26.72.1**: the next mortality report to committee to include reference to MHLD data.

It was resolved that the Committee:

- **NOTED** the report.

FOR INFORMATION

QS26.73 Corporate Governance Report

The item was presented by the Head of Corporate Governance. The cycle of business is currently being reviewed to ensure alignment with the IMTP. In future reports, private items will require information as to why they are being received in private to ensure alignment with process.

It was resolved that the Committee:

- **NOTED** the report.

QS26.74 AAA Report – Mental Health Oversight & Development Group

It was resolved that the Committee:

- **NOTED** the report.

CLOSING BUSINESS

QS26.75 Agree Items for Referral to Board / Other Committees

It was agreed that the Patient story would be shared at the Board in May.

The chair advised updated regarding the All Wales Quality, Safety & Experience Meeting held with all Welsh Health Boards that met earlier this week. Items considered included the Neonatal Assurance Assessment and NHS Performance & Improvement on the national patient safety plan. It was advised that gap analysis has been undertaken on the report to understand the current position. Once complete, this will go through to Executive Committee and QSE Committee.

QS26.76 Review of Meeting Effectiveness

The Committee agreed to pilot a new approach from the next meeting whereby one executive and one independent member provide feedback at the close of each meeting.

The Committee commended the quality, clarity and depth of papers presented.

QS26.77 Date of next meeting

2 July 2026

QS26.78 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 24.06.26

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** Awaiting receipt of report. 05.03.26 – report not yet received. 26.03.26 – final version of report still outstanding. AW chasing. 29.04.26 – update from Rachel Wright - no further update on the draft un-paid carer strategy. Formal consultation ended on 13 April 2026. Approval expected after May 2026. 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	Sept 2026	**Remain Open** To be included at future development session.
3	QS26.38.1	05.03.26	**Learning Repository**	Exec Director of Nursing	Sept	**Remain Open**

			A demonstration of the system to be given in a future development session	& Midwifery	2026	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	Sept 2026	**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 future development session	Exec Director of Nursing & Midwifery	Sept 2026	**Remain Open** To be included at future development 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	Sept 2026	**Remain Open** To be included at future development session.
7	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	**Remain Open** 18.05.26 – next MHLD update due Jan 27 as per COB
8	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	Sept 2026	**Remain Open** Not yet due
				Suggest Close		

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	**Proposed for closure** 18.05.26 – added to draft cycle of business
3	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	**Proposed for closure** 18.05.26 – on July agenda.
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	**Proposed for closure** 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	**Proposed for closure** 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
Closed Actions (Closed at 07.05.26 meeting)						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
1	QS26.39.3	05.03.26	**Adult Mental Health & Learning Disabilities** percentages for figures to be included in future reports	Exec Director of Allied Health Professions & Health Sciences	May 2026	Closed 12.03.26 – to be included in reports going forward 07.05.26 – agreed to close at committee
2	QS26.07.03	15.01.26	**Integrated Quality Report** Redress change process to be item on the QSE development day	Exec Director of Nursing & Midwifery	March 2026	Closed 12.02.26 – Development Day scheduled for 16.03.26 with topic included 07.05.26 – agreed to close at committee
3	QS25.106.1	06.11.25	Cycle of Business to be reviewed ahead of the end of financial year	Director of Corporate Governance	May 2026	Closed 06.11.25 – referenced in 06.11.25

						meeting as further action QS25.106.1 07.01.26 – action ongoing 25.02.26 – COB reviewed and further amendment needed to aligned with IMTP as agreed at Chairs Advisory Group 12.03.26 – added to draft agenda for agenda setting for May meeting. 07.05.26 – agreed to close at committee
4	QS26.32.1	05.03.26	**Service Presentation (SMS)** a further briefing on unexpected deaths data to be presented at a future meeting.	Exec Director of Allied Health Professions & Health Sciences	May 2026	Closed 12.03.26 – to be included in MH update at next meeting. 07.05.26 – agreed to close at committee
5	QS26.33.1	05.03.26	**Integrated Quality Report** A report to come to the next Committee meeting regarding mortality with appropriate time allocated for discussion	Executive Medical Director	May 2026	Closed 12.03.26 – added to agenda for May 26.03.26 – advised action complete. 07.05.26 – agreed to close at committee
6	QS26.38.2	05.03.26	**Learning Repository** Update to be received at Audit Committee on implementation of the Learning Repository for assurance.	Head of Corporate Governance	May 2026	Closed 20.03.26 - Transferred to audit committee for action. 07.05.26 – agreed to close at committee

7	QS26.39.2	05.03.26	**Adult Mental Health & Learning Disabilities** future paper of MH to contain further information on Part 3 and 4 of MH measure.	Exec Director of Allied Health Professions & Health Sciences	May 2026	Closed 12.03.26 – referenced under item on agenda for May agenda 13.04.26 – agreed close. Information to be included in future reports. 07.05.26 – agreed to close at committee
8	QS26.39.1	05.03.26	**Adult Mental Health & Learning Disabilities** future briefing to clarifying regarding care coordinator role for inclusion for information at the next committee	Exec Director of Allied Health Professions & Health Sciences	May 2026	Closed 12.03.26 – for inclusion in future report. 13.04.26 – agreed close. Information to be included in future reports. 07.05.26 – agreed to close at committee
9	QS26.08.02	15.01.26	**Integrated Performance Report** Update on screening services to be given at a future meeting	Exec Director of Finance & Performance	May 2026	Closed Awaiting update. 05.03.26 – work is ongoing regarding updating the report. Action owner to be changed to the Executive Director of Finance & Performance. 12.03.26 – query added to draft agenda for May 29.04.26 – update to be given in May

						meeting by Deputy Director of Performance 07.05.26 – agreed to close at committee
10	QS24/121.1	24.10.24	**QS24/121 Integrated Performance Report** to speak to the Deputy Executive Medical Director to check the veracity of colonoscopy data provided in report, and to escalate concerns if required.	~~Exec. Dir. Allied Health Professionals & Health Science~~ ~~(**Teresa Owen**)~~ ~~Interim COO~~ **~~(Imran Devji)~~** Chief Operating Officer **– Tehmeena Ajmal**	~~17.12.24~~ May 2025	Closed **9.12.24** TO spoke with Deputy Executive Medical Director. Data/information is being checked by the team. **12.2.25** Jim McGuigan advised that Imran Devji was aware of this query and investigating. Update to be received at meeting 07.01.26 – awaiting update 05.03.26 – AW advised with Chief Operating Officer. Awaiting update. 13.04.26 – update requested. 29.04.26 – merged with action QS25/11.1. 07.05.26 – agreed to close at committee

Quality Safety & Experience Committee

Stori Bedydd Hari

Hari's Christening – A Patient Story

Dyddiad y Cyfarfod **Date of Meeting**	02 July 2026
Statws Cyhoeddi **Publication Status**	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad **Report Author name and title**	Hannah Hughes – People's Experience Manager
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol **Lead Executive Team Member name and title**	Angela Wood, Executive Director of Nursing and Midwifery

Pwrpas yr Adroddiad **Report Purpose**	For Noting

Crynodeb Gweithredol **Executive Summary**
A patient or carer story is presented to QSE to bring the voice of the people we serve directly into the meeting. The digital story will be played at the meeting. A short summary of the experience and actions undertaken in response to the story is included in the paper.

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**
Corporate Patient Experience Group	21-08-2025	Story shared and learning noted.
Various IHC/Directorate Patient Experience Groups	Various dates	Story shared and learning noted.

Acronymau / Rhestr Termau **Acronyms / Glossary of Terms**
Hari's Christening in ED Story - WELSH SUBTITLES.mov

1. Overview of story

The storyteller shares their experience of Ysbyty Gwynedd Emergency Department and the care provided for their loved one. The story highlights how the department went above and beyond to meet the family's religious beliefs, by organising a Christening in the Emergency Department for the patient's great grandson and a blessing for the patient.

Their account highlights the high-quality, compassionate, and coordinated care delivered by the Ysbyty Gwynedd Emergency Department and the Chaplaincy and Spiritual Care Service.

1.1 Key messages

- The family express sincere gratitude to staff, particularly from Ysbyty Gwynedd Emergency Department.
- The storyteller reflects positively on the support provided by staff in the Emergency Department to facilitate the christening, ensuring there was a quiet space, decorating the room and washing mum.
- Staff at Ysbyty Gwynedd Emergency Department can be described as 'thinking outside of the box', by organising a christening for the patient's great grandson, and a blessing for the patient, whilst the patient was being cared for in the department.
- The story demonstrates a strong working relationship between staff in the Emergency Department and the Chaplaincy and Spiritual Care Service; working together to make a positive difference.
- In particular, the Emergency Department is recognised for their professionalism, empathy, communication, kindness, and sensitivity, which ensured that all the family's needs were being considered. Staff looked beyond the clinical care to understand what mattered most to the family at that time.
- Staff demonstrated having a holistic understanding of the needs of the patient, by looking beyond clinical care to understand what was important to the patient and family at that time.

2. Summary of learning and improvement

The story has been shared with the Chaplaincy and Spiritual Care Service and Ysbyty Gwynedd Emergency Department.

The story was presented at the Patient and Carer Experience Group, and West IHC Patient and Carer Experience group by the Associate Director of Nursing, Integrated Health Community (West).

This story is being used as part of staff training for student nurses for learning purposes and good practice.

2.1 Chaplaincy and Spiritual Care Service

The Chaplain and Spiritual Care Service is a pan North Wales service with staff based at Ysbyty Gwynedd, Ysbyty Glan Clwyd and Wrexham Hospital, covering acute and community hospital settings.

From 1st April 2025 – 31st March 2026, a total of 957 referrals were made to the service. Out of the 957 referrals, 45 referrals were passed to an external faith group, while the remaining 912 referrals were fully managed by the Chaplaincy Service, showing that external escalation is rare and highly specific.

Christian-identifying patient referrals make up most chaplaincy related activity across the Health Board, with a very small number of non-Christian faith support. Smaller faith identity groups included; Muslim, Jewish, Hindu, Humanist, Buddhist, Pagan, Rastafarian, and Jehovah's Witnesses.

2.2 Responding to staff, patient and family feedback

As a result of staff feedback the Chaplaincy and Spiritual Care Service annually organise Iftar events across hospital sites to celebrate the breaking of Ramadam Fast. There is ongoing engagement with Kerala Nurses and the wider community to ensure their religious and spiritual beliefs are met.

The Chaplaincy and Spiritual Care Service work in partnership with services and families to organise annual memorial events to collectively remember, honour and celebrate a lost love one whilst providing emotional support to the bereaved. For example, baby memorial events held across North Wales in Bangor Cathedral, Marble Church and The Catholic Cathedral in Wrexham.

2.3 Service Developments

Examples of Chaplaincy and Spiritual Care service developments in 2025 – 2026 include:

- Introduction of an online staff referral form via QR code to increase service accessibility
- Updated SharePoint information page for staff
- Multi-faith trolley and resources based across hospital settings
- Supporting Palliative Care patients and patient in their homes
- Diversifying staffing with the recruitment of “On call” Iman from the Muslim Community
- Chaplaincy patient record keeping on WPAS and WNCR
- Representation at key Health Board meetings for example, Nutrition and Hydration meeting to ensure the consideration of people's religious dietary requirements

2.4 Service Priorities for 2026 – 2027

The Chaplaincy and Spiritual Care Service will continue to increase awareness of its service across Integrated Health Communities and Specialist Services, targeting wards/services with low numbers of referrals.

Ongoing staff training is being delivered to student nurses and teams to ensure spirituality is considered in ‘what matters’ conversations. The service will continue to recognise and share good practice when staff and teams go above and beyond to meet patients religious and spiritual needs.

Chaplain Officers are working in partnership with SWAN Bereavement Specialist Nurses to support the implementation of the SWAN end of life model of care, ensuring religious beliefs and spirituality is considered at the end of life for the patient and family.

The People’s Experience Team would like to thank the individual who shared their experience.

3. Recommendations

3.1 The Committee is asked to note this report.

ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol **Link to Strategic Priorities**	3. Improve Access, Outcomes and Experience
	4.Create a Modern, People Centred Healthcare System
Yr Egwyddorion Dylunio **Design Principles**	People First Consistency with Organisational Values
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd **Corporate Risks and Board Assurance Framework**	Not applicable

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:	Not applicable
Equality Act 2010 - Socio-economic Duty *Has BCUHB provided evidence of 'Due Regard' to compliance of ther Socio-economic Duty when making strategic decisions?*	Do/Yes: ☒	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not applicable
Have you completed an Integrated Equality Impact Assessment WP8a? *WP8a Template*	Canlyniad/Outcome: Do/Yes:	Naddo/No: ☒
	Os naddo, dylech gynnwys y rheswm:	Not applicable

	If no, please include rationale: Canlynaid/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not applicable
Human Rights Act *Have Human Right based concerns been addressed within WP8a*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	Not applicable
Compliance to the Welsh Language requirements? *Have you undertaken an Impact Assessment*	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Naddo/No: ☒
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not applicable
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
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:	Not applicable
Ansawdd *A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Galluogwyr Ansawdd **Enablers of Quality** 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:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Asesiad o Effaith ar Atal Twyll *A ydych chi wedi ystyried yr effeithiau ar atal twyll?* **Counter Fraud Impact** *Have you considered the counter fraud impacts*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Cyfreithiol **Legal**	There are no specific legal implications related to the activity outlined in this report.	
Enw Da **Reputational**	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith ar Adnoddau *(Pobl / Ariannol)* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

Quality Safety & Experience Committee

INTEGRATED QUALITY REPORT

Dyddiad y Cyfarfod **Date of Meeting**	02 July 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**	• Angela Wood, Executive Director of Nursing and Midwifery (Lead Executive) • 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**
This report provides the Committee with assurance, underpinned by analysis, on significant quality issues alongside longer-term data and information on the improvements underway.

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	Nationally 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
CHKS	Healthcare intelligence and quality improvement service
RAMI	Risk Adjusted Mortality index

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

3.1 **Never Events:** Two Never Events were reported this period; eleven recorded in the last 12 months. Full investigations are underway with system learning review planned.

3.2 **Increase in NRIs** this period (8 vs 20). Median completion time remains best in Wales (75 days), proportion open >90 days has decreased. Ongoing focus on investigation timeliness and quality.

3.3 **Patient Safety Incidents:**
Incident backlog remains high (5084 open; 59.3% overdue). Reduction target not achieved; refreshed recovery trajectories being agreed with IHCs and Divisions. Enhanced PST training and early-stage investigation improvements planned.

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

4.1 **HIW overdue actions and rising assurance requests** signal continued regulatory pressure, particularly in emergency departments.

4.2 **Attorney General for Northern Ireland [2026] UKSC 16**
This UK Supreme Court judgment handed down on the 2nd June 2026 is likely to have significant and important implications for health and social care practice.

4.3 **Wrexham Maelor Hospital has been identified as a 'borderline outlier'** for case mix adjusted mortality within the Sentinel Stroke National Audit, which benchmarks standardised mortality rate and other key performance indicators in centres across the UK.

4.4 **HIW Inspection – Emergency Department, YGC (5th to 7th May 2026)**
Immediate Actions received from HIW with initial improvement plan agreed.

5. ARGYMHELLION / RECOMMENDATIONS

5.1 The Committee is asked to take the report as assurance. All exceptions noted in this paper are being monitored and have management plans to track completion. These action plans are tracked through core quality forums.

ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol **Link to Strategic Priorities**	3. Improve Access, Outcomes and Experience
	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-SP18 and CRR-24-04 – Quality, Innovation and Improvement Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Equality Act 2010 Public Sector Equality Duty: Has BCUHB provided evidence of 'Due Regard' to compliance with the three parts of the Public Sector Equality Duty (General Duty): 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:	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: ☒
	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.
Human Rights Act *Have Human Right based concerns been addressed within WP8a*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	This report is purely administrative in nature and submitted for information only.
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?*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	n/a
	Os naddo, dylech gynnwys y rheswm:	This report is purely administrative in nature

Data Protection Impact Assessment *Have you undertaken a Data Protection Impact Assessment Screening?*	If no, please include rationale:	and submitted for information only.
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:	This report is purely administrative in nature and submitted for information only.
Cyfreithiol **Legal**	Yes (Include further detail below)	
	Safeguarding DoLs	
Enw Da **Reputational**	Yes (Include further detail below)	
	Please see report for 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.	

Patient Safety

1. Patient Safety Incidents

1.1 **Incidents**

There are currently 5084 open incidents of these, 59.34% are overdue, which is a consistent position to the previous reporting period. The number of closed incidents versus the number of opened incidents is a similar number each week.

1.2 Incident management performance continues to show variation across services. Some areas are demonstrating relatively strong timeliness, for example Mental Health and Learning Disabilities (21% overdue) and IHC East (43% overdue). However, other services, including Corporate Services (88% overdue) and Diagnostics and Specialist Clinical Support Services (76% overdue), indicate a need for significant improvement to achieve expected standards. Legacy and historical hierarchy cases (128 in total) remain 100% overdue, which continues to influence overall performance. To support a more consistent approach, the Patient Safety Team (PST) is engaging with all Integrated Health Communities (IHCs) and Divisions to review and refresh current trajectories. This work is focused on ensuring each area has a bespoke and achievable improvement plan, aligned to its operational context and supporting sustained improvement in incident management performance.

1.3 Capability and capacity building remain a key focus, with the Patient Safety Team providing monthly incident management training, bi-monthly Investigating Officer (IO) training, and weekly Nationally Reportable Incident (NRI) drop-in sessions delivered on a rolling basis. To date, 105 staff members have successfully completed the Investigating Officer training programme, demonstrating continued organisational commitment to strengthening investigation quality and resilience.

1.4 Throughout April 2026, the PST has also delivered weekly incident pathway workshops changing to fortnightly as of May 2026, with a particular focus on the timely completion and submission of Rapid Reviews alongside increased quality of reports produced via increased knowledge. These sessions have been well attended, with 155 staff participating to date, and early feedback has been positive, indicating improved understanding of processes and increased confidence in navigating incident pathways.

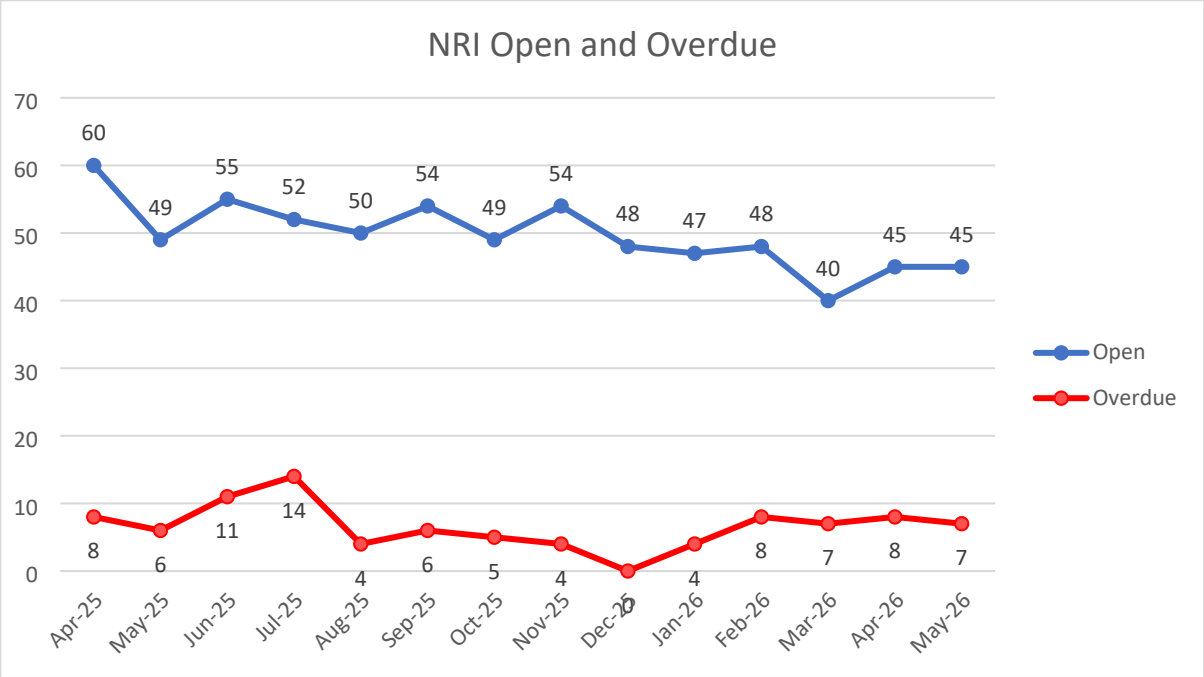
1.5 **Nationally Reportable Incidents**

From 01st April 2026 to 31st May 2026, there were 11 Nationally Reportable Incidents (NRIs) submitted (by incident date) compared with 30 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 time period.) These can be categorised as follows: -

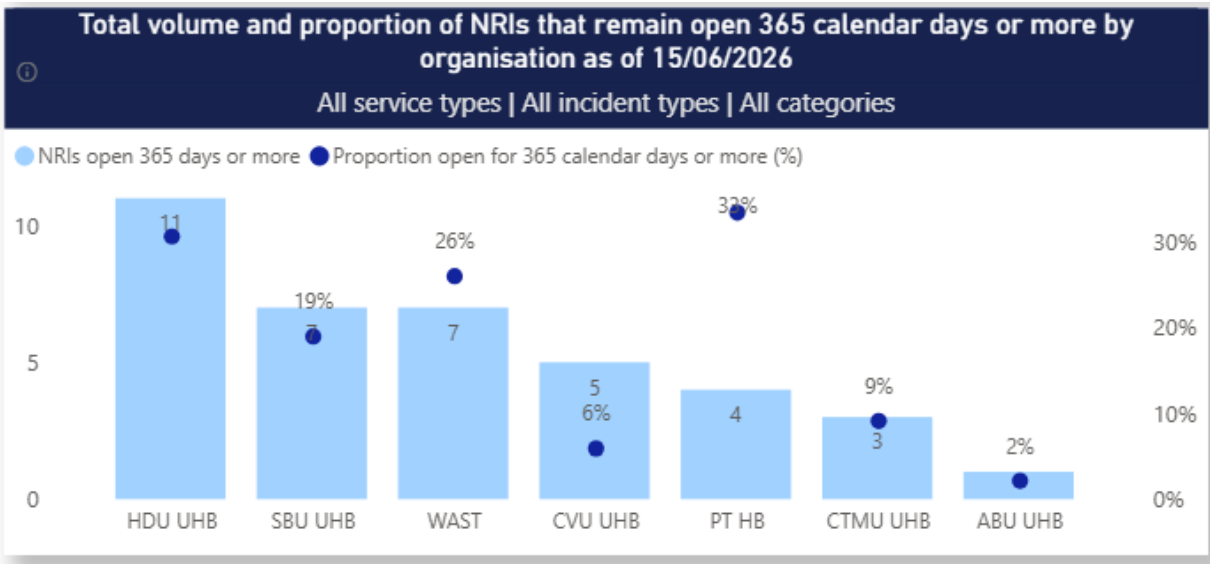
BCU UHB top 10 NRI categories occurring by volume (incident dates between Apr-26 and May-26) as of 15/06/2026

NRI category	Total
Diagnostic testing - Radiology	2
Neonate	2
Treatment or procedure issues	2
Assessing and recognising patient/service user deterioration	1
Healthcare Acquired Infection (community, primary care or hospital)	1
Infection outbreak / period of increased incidence	1
Medical devices	1
Monitoring errors	1

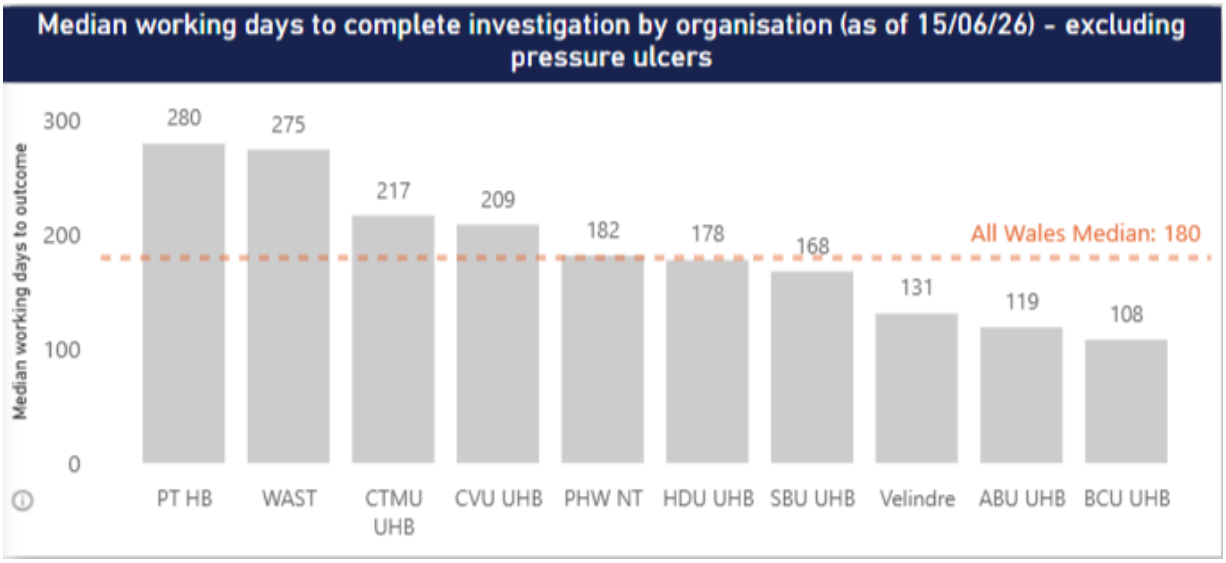
The total number of NRI investigations that were open as at the end of May 2026 was 45 with 7 overdue closures.



1.6 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 108 compared to the All-Wales median of 180 days.



1.7 A total of 37 NRI outcome forms were submitted to NHS Wales Performance and Improvement for closure during April 2026 and May 2026. Further detail and learning from a sample of these closures can be found in the confidential quality report.

1.8 **Never Events**

The BCUHB reported one Never Event occurring in the reporting period. This was relating to a retained swab. Additionally, there was another incident, which occurred in March 2026 but was not reported until April 2026 following histology, relating to wrong site surgery.

There were no Never Events reported in May 2026.

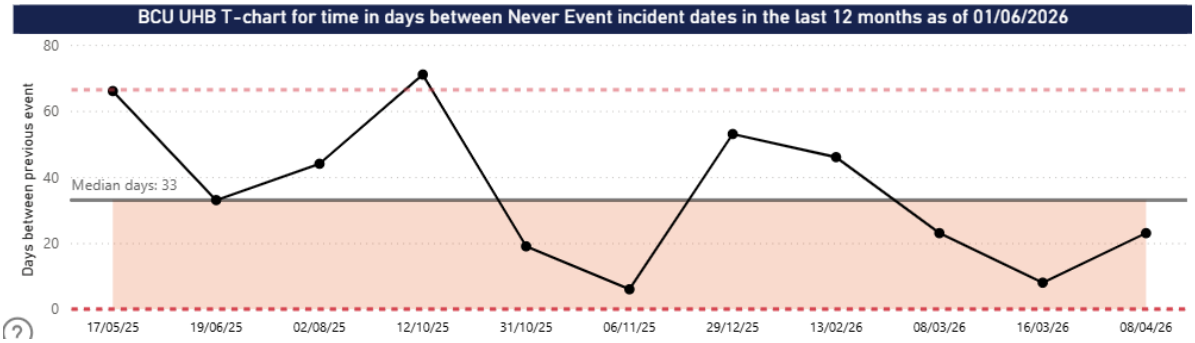
1.9 *Please note Beacon does not contain May 2026 data*

BCU UHB Never Events occuring (by incident date, May-25 to Apr-26) as of 01/06/2026

Year	2025								2026			
Never Event	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Administration of medication by the wrong route	1	0	0	0	0	0	0	0	0	0	0	0
Retained foreign object post procedure	0	0	0	1	0	0	1	0	0	0	0	1
Wrong implant/prosthesis	0	0	0	0	0	1	0	0	0	1	0	0
Wrong site surgery	0	1	0	0	0	1	0	1	0	0	2	0
Total Never Events	**1**	**1**	**0**	**1**	**0**	**2**	**1**	**1**	**0**	**1**	**2**	**1**

1.10 Never Events occurring within BCUHB continues to rise, with 11 Never Events reported in a rolling period, May 2025 to April 2026, with limited time between events, 33 median days.

1.11



1.12 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.

2. Patient Safety Alerts

2.1 The Patient Safety Team have circulated 3 pharmacy recalls, 5 pharmacy notifications, 2 field safety notices and 3 internal alerts. No new national alerts received.

2.2 **PSA019 Delayed administration of Rasbricase:** Approval for the revised process has been granted at the centralised Cancer Services Governance meeting. The documentation is currently with Pharmacy for final comments and is expected to be approved and distributed following the next meeting.

2.3 **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.

2.4 **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. Membership has been identified across East, West and Central, with corporate support from Patient Safety. IHC/service areas are producing a point-in-time position statement to establish a baseline of current practice, equipment, training, and risks. The next task and finish group is to convene on 1st July 2026.

2.5 **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.

A programme of work is in place to identify and review the affected patient cohort. This will be brought through quality governance routes for assurance.

3. High-level learning summary from Closed Nationally Reported Incidents

3.1 This case relates to delayed recognition of a patient's myocardial infarction and the learning identified. Further description of the incident is detailed in the confidential report.

3.2
- Patients with myocardial infarction (MI), particularly those with comorbidities like diabetes, may present with non-classical symptoms (e.g. vomiting, dysphagia, epigastric pain) rather than chest pain.
- An ECG and relevant blood tests (e.g. troponin) should be considered early in the assessment of high-risk patients—even when cardiac symptoms are not obvious—due to their low risk and high diagnostic value.
- Key investigations (ECG and troponin) were not performed at multiple stages, despite symptoms (including later chest pain) that should have triggered cardiac assessment. New or worsening symptoms (e.g. chest pain, clamminess) require prompt reassessment and escalation in line with clinical pathways.
- Reinforcement is required around recognising atypical acute coronary syndrome (ACS) presentations and ensuring appropriate investigation pathways are followed.
- Actions focus on improving adherence to protocols, strengthening communication processes, and sharing learning to prevent recurrence.

3.3 This incident was raised highlighting concerns regarding escalation of the deteriorating patient, lack of documentation and non-adherence to clinical pathways/guidelines. Further description of the incident is detailed in the confidential report.

3.4
- Managing oxygen therapy in Chronic Obstructive Pulmonary Disease (COPD) requires adherence to target saturation ranges, but also sensitivity to patient anxiety and perceived relief from oxygen delivery.
- Over-reliance on high-flow oxygen (NRB mask) can lead to oxygen levels exceeding safe limits in COPD patients, potentially causing harm.

- Incomplete recording of escalation, oxygen adjustments, and clinical decision-making can compromise continuity and safety of care.
- Deterioration must be clearly recognised, documented, and escalated in line with NEWS2 and clinical pathways. The launch and implementation of the deteriorating Patient programme is scheduled for 6th July 2026 with a view to increased learning from previous incidents as well as best practice guidelines.
- Ongoing training is needed in oxygen management, documentation, escalation processes, and end-of-life care planning to improve patient safety and experience.

Safeguarding and Public Protection

4. Deprivation of Liberty Safeguards (DoLS)

4.1 **Attorney General for Northern Ireland [2026] UKSC 16**
This UK Supreme Court judgment handed down on the 2nd June 2026 is likely to have significant and important implications for health and social care practice.

4.2 Background
Since the 2014 court decision in *Cheshire West*, a person has generally been treated as deprived of their liberty for the purposes of Article 5 of the European Convention on Human Rights (ECHR) where they lack capacity and are "subject to continuous supervision and control and are not free to leave" (the so-called "acid test"). This has underpinned the current Deprivation of Liberty Safeguards framework and has led to a large number of individuals in care settings being treated as requiring formal legal authorisation.

4.3 The Supreme Court considered this issue following a reference from the Attorney General for Northern Ireland concerning proposed changes to the NI DoLS guidance which would allow some individuals who lack capacity to consent to their care arrangements through "the expression of their wishes and feelings."

4.4 Outcome
The Supreme Court has expressly overruled *Cheshire West*. It has moved away from the "acid test" and confirmed that whether arrangements amount to a deprivation of liberty will instead require a broader, fact-specific assessment of the individual's situation in accordance with Article 5 principles.

4.5 This represents a material change in the legal framework and has potentially wide implications, particularly for community and continuing healthcare placements.

4.6 Position
The judgement is complex and requires detailed legal analysis. We will continue to operate in accordance with current statutory requirements, case law, and existing procedures. While implications of the Supreme Court judgement are being considered,

immediate changes to local practice will be implemented as agreed with BCUHB Legal and Risk services, existing statutory duties remain in force and UK and Welsh Government guidance has not yet been issued.

4.7 Next Steps

- Considering the Supreme Court judgement immediate advice has been taken on how to proceed to ensure patient safety and wellbeing remains paramount.
- A detailed governance and accountability framework will be developed.
- An immediate amendment to the Deprivation of Liberty Safeguards paperwork, to demonstrate the change in law.
- Managing Authorities will continue to submit DoLS applications as per the current process until further notice.
- The Supervisory Body will review all current, and future applications, and will prioritise only those cases where the Supreme Court judgement is valid.
- The Risk Register will be updated to reflect these changes.

Infection Prevention Control

5. Strategic Improvement Goals (2025-2027)

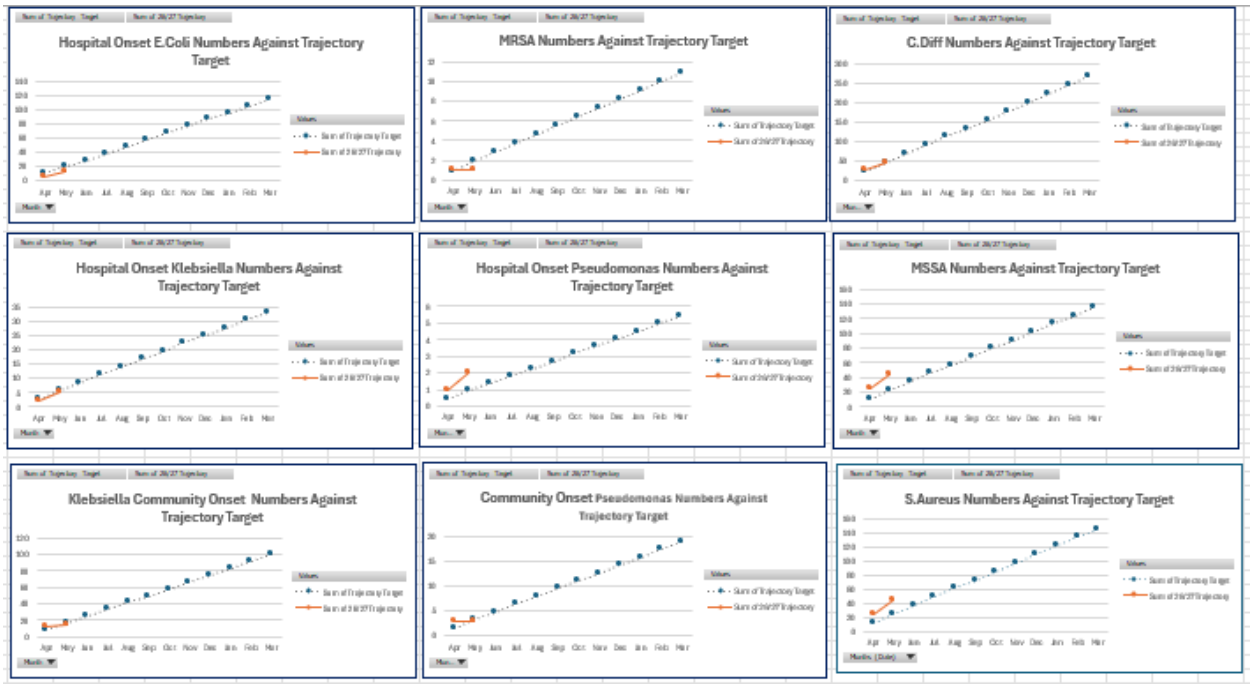
5.1 Performance against the HCAI improvement goals is mixed, with 4 organisms currently below trajectory, 3 exceeding their target trajectories and 2 on trajectory.

Goal Area	Target	Current Status vs. Trajectory
E. coli (Hospital-onset)	10% Reduction	Below trajectory (-6 cases)
MRSA	< Previous Year	Below trajectory (-1 case)
C. difficile	25% Reduction	On trajectory (at 44 cases)
Klebsiella (Hospital-onset)	10% Reduction	Below trajectory (-1 case)
Pseudomonas (Hospital-onset)	10% Reduction	Above trajectory (+1 case)
MSSA	20% Reduction	Above trajectory (+20 cases)

5.2 Additional expectations:

Goal Area	Target	Current Status vs. Trajectory
Klebsiella (community onset)	< Previous Year	Below trajectory (-2 cases)
Pseudomonas (community onset)	< Previous Year	On trajectory (+8 cases)
Staphylococcus aureus	< Previous Year	Above trajectory (20 cases)

5.3



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

5.5 The Q4 Primary Care data for 2025–26 published by AWTTC demonstrates that BCUHB has made excellent progress against the WHC antimicrobial targets. Overall antimicrobial use has shown a significant reduction, with BCUHB now ranked as the second lowest in Wales, behind Powys Teaching Health Board.

5.6 In relation to the target to shift prescribing towards shorter courses—aiming for 75% of doxycycline, amoxicillin, and clarithromycin prescriptions to be reduced from 7 to 5 days—within Primary Care BCUHB has successfully met the 75% target for both amoxicillin and doxycycline. For clarithromycin, BCUHB achieved 71.9%, making it the closest health board in Wales to reaching the 75% target. Engagement from practices across BCUHB has been very positive and represents an important step forward in embedding good antimicrobial stewardship (AMS) practice.

6. Outbreak Management

6.1 Outbreak activity reduced during April and May. There were 10 reported outbreaks due to C. diff (5), Norovirus (4), and CPE (1).

Impact:

- 1 full ward closures and 5 bay closures
- 78 total bed days were lost, with Norovirus accounting for 81% (63 days)

7. Key Improvement Initiatives

7.1 To address identified performance gaps and sustain progress, a comprehensive programme of work is underway across BCUHB. This programme combines targeted quality improvement activity, strengthened assurance processes, and a focus on cultural and behavioural change.

7.2
- **IPC Quality Statement Gap Analysis**
  A comprehensive gap analysis against the IPC Quality Statement (published February 2026) has been completed. The findings are informing BCUHB IPC Programme of Work for 2026–2028.

7.3
- **National *C. difficile* Collaborative**
  BCUHB continues to actively participate in the national C. difficile collaborative, delivering three Quality Improvement Projects with a strong Infection Prevention and Control (IPC) focus. These initiatives are underpinned by behavioural science principles to drive sustainable improvements in practice and compliance. This work is closely aligned with antimicrobial stewardship to reduce modifiable risk factors associated with infection.

7.4
- **Faecal Microbiota Transplant (FMT) Service**
  A nurse-led FMT service is established and operational, providing an effective treatment pathway for recurrent *C. difficile* infection. Plans are progressing to scale this service across all sites to improve equitable access and patient outcomes.

7.5
- **C. difficile Cohort Capacity and Estates Development**
  A temporary *C. difficile* cohort unit has been established at Wrexham Maelor Hospital to support effective isolation and management of cases. In parallel, project plans are being developed to secure a permanent cohorting solution through Targeted Estates Funding. This forms part of a wider estates strategy to improve IPC compliance, including increased single room capacity, improved patient flow, and enhanced environmental standards.

7.6
- **Pseudomonas Surveillance and Epidemiological Review**
  Following an earlier increase in *Pseudomonas* cases, it has been recognised that a significant proportion are not healthcare-associated and are therefore largely unavoidable. However, the Post-Infection Review (PIR) process has been strengthened to improve epidemiological understanding, identify any emerging trends or risk factors, and ensure that appropriate preventative and control measures are implemented where possible.

7.7
- **Enhanced Surveillance and Data-Driven Decision Making**
  Work is progressing to strengthen surveillance systems to support earlier

identification of trends, timely intervention, and more effective targeting of resources to high-risk areas. Data is increasingly being used to inform decision-making, monitor improvement, and demonstrate impact.

7.8 • **Workforce Development, Leadership and Culture**
Workforce development remains a key priority, with a focus on embedding behavioural science approaches to improve IPC compliance and organisational culture. This includes strengthening IPC leadership at ward and divisional level, supporting link practitioners and champions, and improving training compliance and competency assessment across the workforce.

7.9 • **Audit, Compliance and Triangulated Assurance**
The IPC audit programme continues to be strengthened, with expanded focus on key areas such as hand hygiene, environmental cleanliness, and isolation practices. A triangulated approach to assurance has been adopted, bringing together audit findings, surveillance data, incident reporting, and feedback to provide a more comprehensive and robust assessment of IPC performance.

7.10 • **High-Level Disinfection (HLD) Standardisation**
High-Level Disinfection technology has been standardised across BCUHB. Final stages of staff training are nearing completion to ensure full operational implementation and consistent practice.

7.11 • **Environmental Cleanliness and ATP Monitoring**
Adenosine Triphosphate (ATP) monitoring technology is now in use across BCUHB, providing quantitative assurance of cleaning standards and enabling targeted improvement where required.

7.12 • **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.

7.13 • **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.

7.14 • **Innovation and Sustainable Practice**
Opportunities to adopt innovative technologies and more sustainable IPC practices are being actively explored, supporting both quality improvement and environmental objectives.

8. Complaints

8.1 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.

8.2 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

8.3 The following table displays key complaints metrics as of 30th May 2026

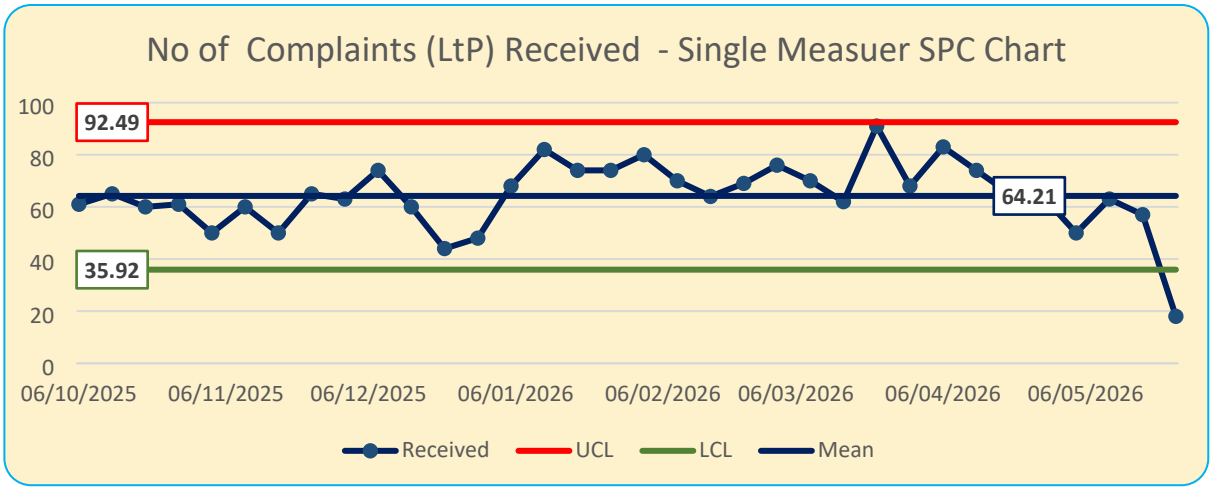
Metric	Status	Trend
Total Open Complaints	286	Decrease from 311
Number Overdue	83	Increase from 69
Overall Compliance (Target 75%)	70.89%	Decrease from 77.81%

8.4 As anticipated the overall compliance rate has decreased, driven by remaining legacy complaints under Putting Things Right (PTR). A sustained focus is underway to address all legacy complaints by the end of Quarter 1 2026/27.

Complaint Subtype	Total	Overdue	Compliance
Manged by PTR	56	56	0.00% (Target 75%)
LTP Early Resolution	14	2	88.24% (Target 40%)
LTP 30 WD	144	25	85.21% (Target 75%)
LTP 60 WD	38	0	100% (Target 75%)
LTP 90 WD	5	0	100% (Target 75%)
LTP 120 WD	1	0	100% (Target 75%)

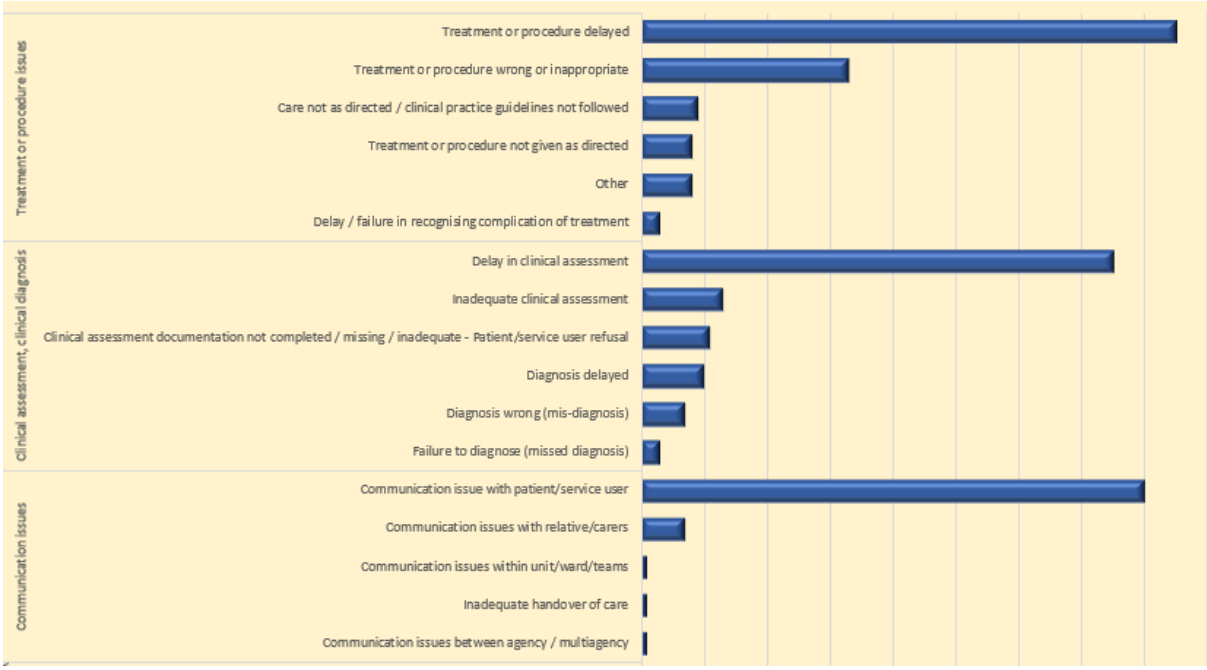
8.5 Between 1st April 2026 and 31st May 2026, BCUHB received 450 complaints, a reduction from 553 complaints in the previous quarter, and closed 515 complaints a positive variance of 65.

Complaints Received SPC chart



The top four themes and sub themes of complaints, areas follows

- Delay / Lack of Diagnosis
- Incorrect / Insufficient Treatment or Assessment
- Delay / Lack of Treatment or Assessment
- Communication



8.6 108 Complaint Early Resolutions (10 working days) have been attempted between 1st April 2026 and 31st May, with 72 being completed within the time (75%). It is anticipated performance will increase in the next reporting period, as new systems and processes fully embed. Early indications from both complainants and staff are that a person-centred approach to resolving concerns is ensuring people receive a timelier and more

satisfactory response to their concerns whilst also reducing the administrative burden of a full investigation. For assurance, in cases where there is harm alleged these are all subject to a full investigation.

8.7 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.

Overdue Complaints: BCUHB's performance on overdue complaints remains as the third best in Wales, and significantly better than other health boards of a comparable size. As of the 31st March 2026 (the latest Data available) BCUHB contribute just 61 complaints of the 1210 that are overdue nationally (5.04%)

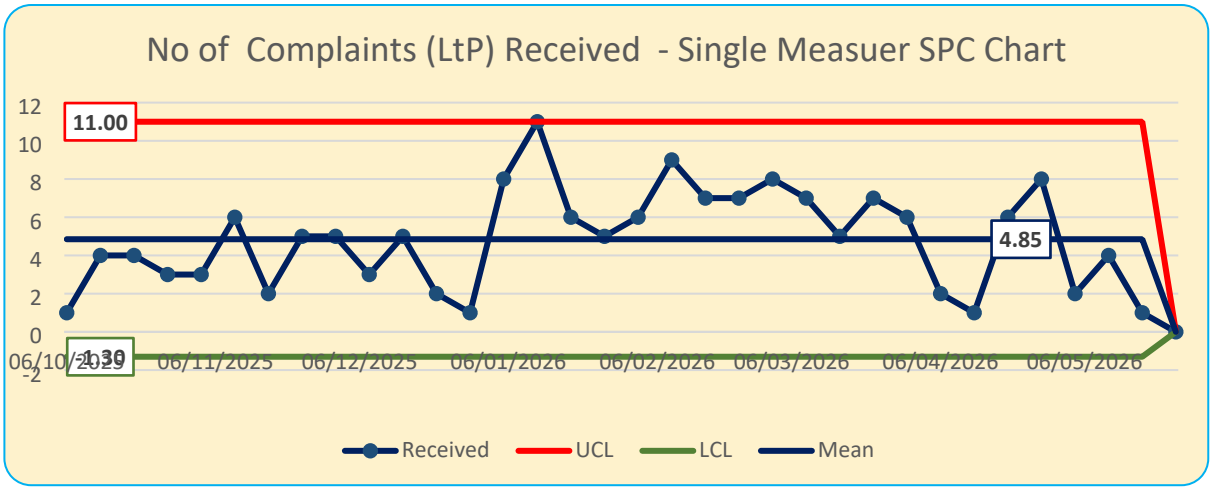
8.8 **Re-opened Complaints**: There is no data available nationally to benchmark re-opened complaints.

8.9 The Health Board currently has 41 re-opened complaints open of which 24 are overdue (over 30 working days) (Compliance 41.46%) with an average response time of 65.41 days, both below target, which is 75% of re-opened complaints to be resolved within 30 working days.

Note: However, an important distinction needs to be made that re-opened complaints are not to be regarded as directly related to dissatisfaction.

8.10 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.

8.11 Re-opened complaints SPC Chart

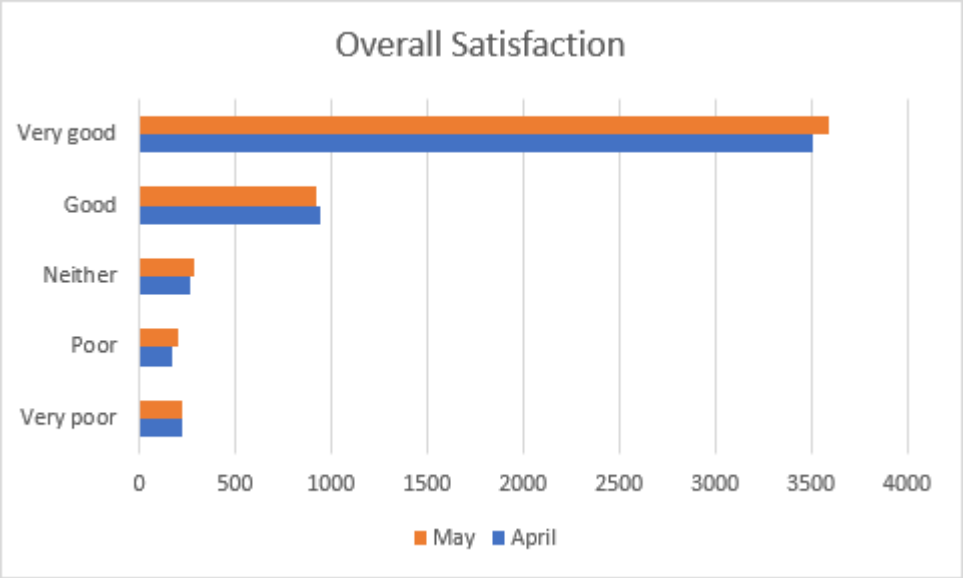


9 Patient Feedback

9.1 The People's Enquiry and Resolution Service (PEARS) supported the resolution of 939 enquiries between 1st April 2026 and 31st May 2026.

9.2 The top 3 enquiry themes included appointments, access to services, and test and investigation results. During this period, the service also received 100 written compliments praising general care and respect and 9 suggestions for improvement.

9.3 Findings from the All-Wales People's Experience Survey remain highly positive. Based on 10,617 responses, 86.97% of patients rated their overall experience as 'Good (18.09%)' or 'Very Good (68.88%)'. Satisfaction levels were high with people reporting they were 'Always' treated with dignity and respect (87.05%) and being able to communicate in a preferred language (90.80%) which exceeded the national benchmark of 85% satisfaction.



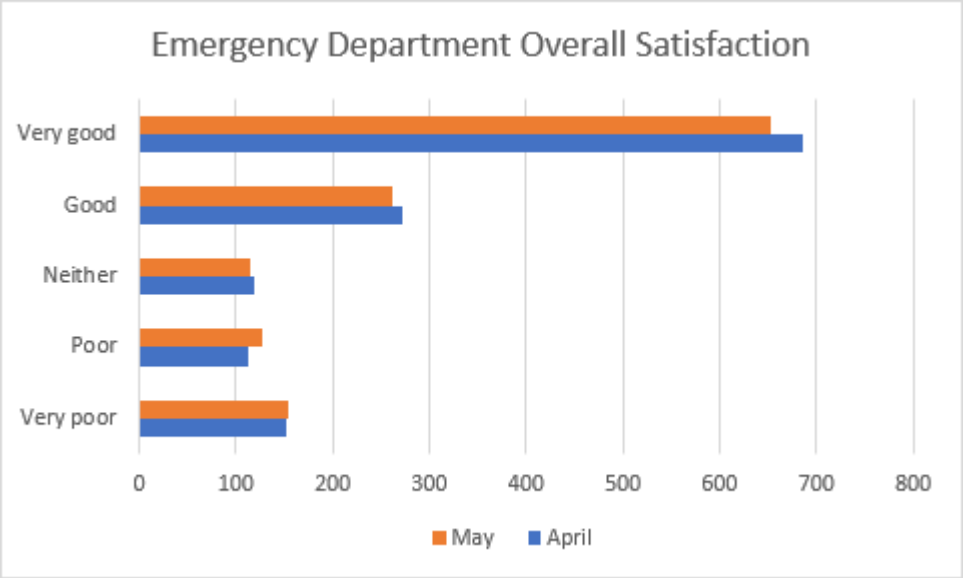
9.4 The following table displays key feedback metrics for the reporting period:

Survey Question	% of "always" response	Trend (vs. previous period)
Felt well cared for	75.49%	Increase from 75.06%
Felt listened to	79.38%	Increase from 78.46%
Involved in decisions about their care	77.76%	Increase from 76.51%
Explained in a way they could understand	82.04%	Increase from 80.27%

9.5 The Easy Read version of the NHS Wales People's Experience Survey also yielded positive results, with 89.51% of respondents sharing a positive experience (17.74% good and 71.77% very good).

9.6 **Emergency Department Feedback**

In total 2663 Emergency Department related All-Wales People's Experience Surveys were received. Based on 2663 responses, 74.22 % rated their overall experience as positive in April and falling to 70.08% in May.



9.7 Key Emergency Department feedback data:

- 57.79% “always” felt well cared for
- 68.06% “always” felt listened to
- 67.19% “always” were involved in decisions about their care
- 74.62% felt things were “always” explained in a way they could understand
- 90.82% of people ‘always” able to communicate in their preferred language
- 76.72% of people “always” treated with dignity and respect

9.8 **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.

10. Other Patient Experience Updates

10.1 The People’s Experience Service (PES) was established on 1 April 2026. Within the reporting period, People’s Experience Officers have visited 20 wards across acute and community hospitals in North Wales, to capture real-time patient experience through Care 2 Share Discovery. As part of this feedback process “You Said, We Did” learning was formulated with ward staff.

10.2 Key feedback themes:

- Friendly staff (positive)
- Communication (positive)
- Cleanliness (positive)

- Catering (negative)
- Delay in call bell answered (negative)

10.3 People's Experience Training was delivered to 184 members of staff including student nurses, and District Nurses studying at Wrexham University.

Clinical Effectiveness

11. Clinical Audit

11.1 During April and May (Quarter 1), there was one Tier 1 national clinical audit published, which is scheduled for reporting during July 2026.

11.2 **One National Audit report has been published in Quarter 1, all included BCU identifiable data.** The table below outlines the benchmarking information:

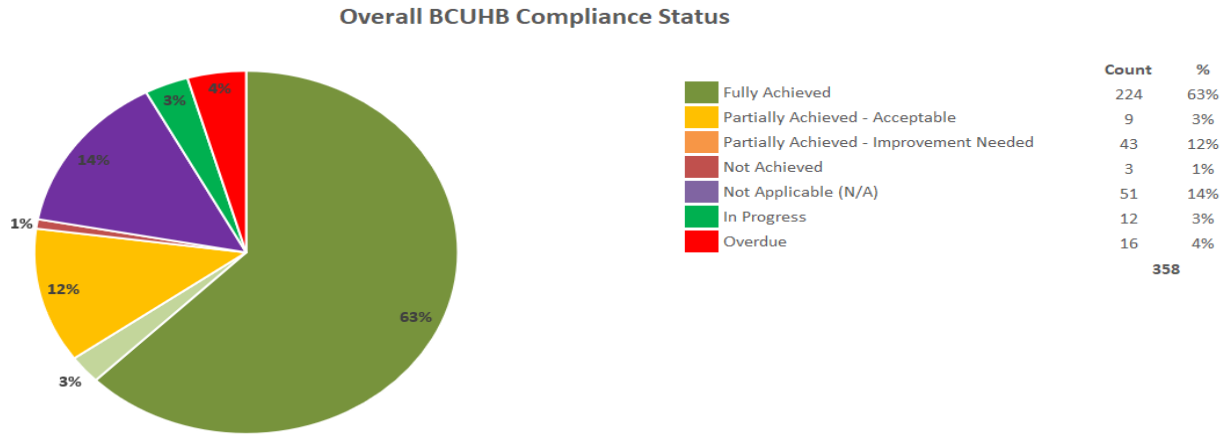
Tier 1 Project reference	Title	*Performance against*	
		National Benchmark	***Last BCU report***
NCAORP/ 2025-26-33	National Respiratory Audit Programme (NRAP): Primary Care Wales Audit: Clinical Audit report 2026 (2023-2025 audit period)	G	G

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

12. NICE Guidelines

12.1 BCUHB continues to make steady progress with improving the recording and monitoring of compliance with NICE guidance, although there are currently temporary staff resource issues within the Clinical Effectiveness Team (CET). This improvement reflects the ongoing support provided to clinical departments and the successful embedding of the Audit Management and Tracking (AMaT) system across services.

12.2 Below is the current position up to the end of May 2026 of NICE across BCUHB:

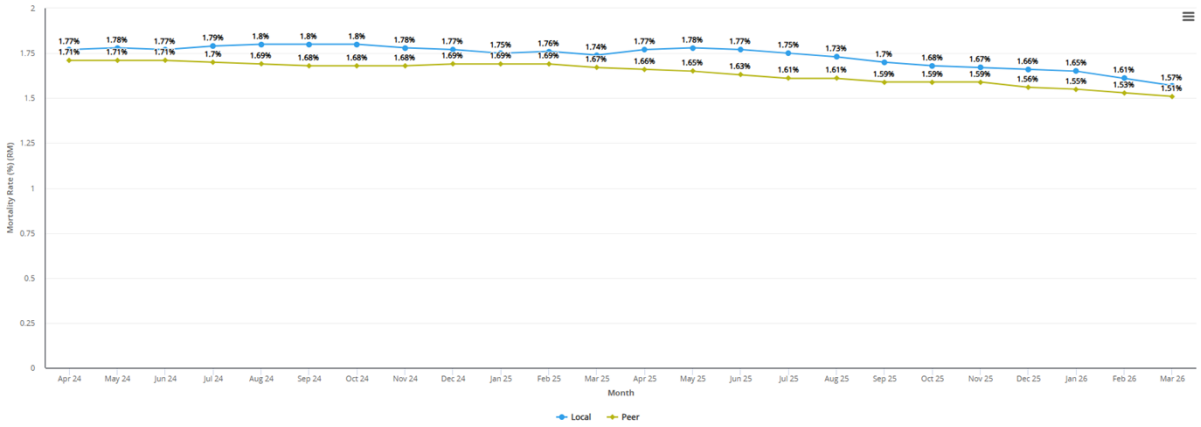


12.3 Instances of '**Not Achieved'** compliance (where the service **has not met the standards** that the National Institute for Health and Care Excellence (NICE) recommendations) are now being escalated monthly to Strategic Clinical Effectiveness Group (SCEG) to provide targeted support and drive improvements in compliance, which is starting to take effect. The responsible service must put together an action plan or Baseline Assessment Tool (BAT) to show how they are planning to meet the national standard in the near future and the timescale for this to be achieved. In a recent Internal Audit for NICE, it has been identified that this area needs to be improved further within services and targeted training is being put in place to achieve.

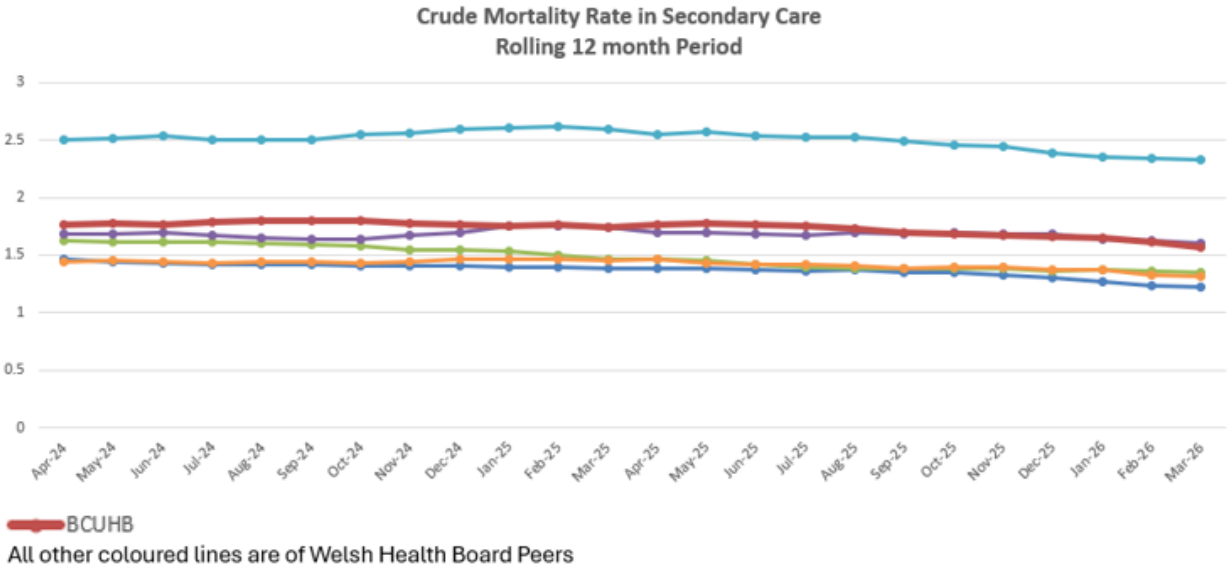
12.4 This internal audit had also highlighted that some clinical leads were able to bypass the full compliance review process by overriding their responses within AMaT. In response, AMaT is working on removing this functionality, and the Clinical Effectiveness NICE team will contact the clinical leads who have used the override to ensure the required compliance reviews are completed in full. A standardised message has also been prepared by the Clinical Effectiveness (CE) team and circulated across the Health Board to ensure that this is used correctly and only by the CE team if required until the problem is rectified. The Internal Audit review resulted in a Limited Assurance opinion, reflecting demonstrable progress in NICE compliance, alongside the need to enhance assurance through strengthened governance, oversight and reporting processes.

13. Mortality

13.1 **Review of Mortality Data taken from CHKS iCompare System (as of 22.05.2026):**
Crude Mortality Rate in Secondary Care 12-month rolling average - BCUHB vs Peer (All Other Welsh Health Boards excluding Powys):



13.2 Peer breakdown:



13.3 Crude mortality rate in BCUHB is consistently above the national average, although the gap has reduced in recent months. Crude mortality rates for other Welsh Health Boards are included in the graph above for comparison.

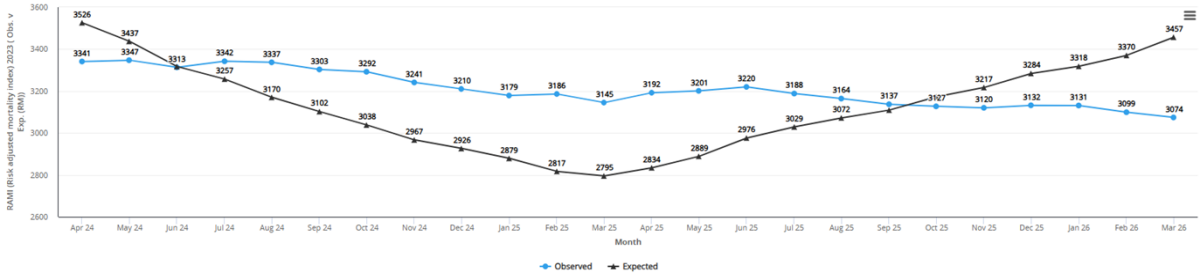
13.4 Crude mortality is not risk adjusted, and it can be affected by many factors. Population demographics including age, socioeconomic status, population health and rate of chronic disease will affect the crude mortality rate.

13.5 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 BCUHB and needs to be considered when making external comparison with other Welsh Health Boards.

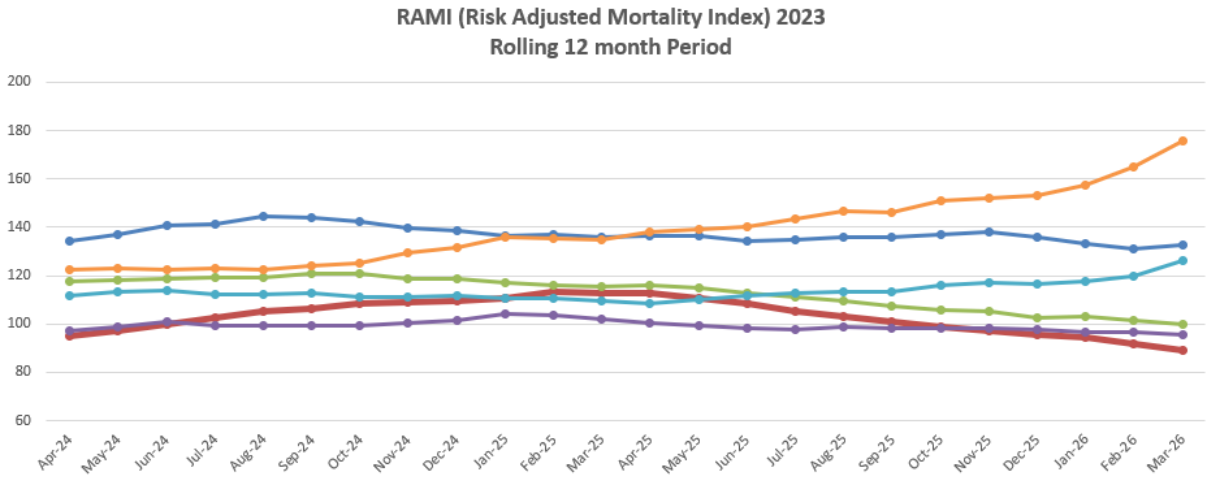
13.6 We continue to monitor risk adjusted mortality metrics. There has been a downward trend in Risk Adjusted Mortality Index (RAMI) in BCUHB since May 2025 associated with improved coding completion as previously discussed.

13.7 **RAMI Observed vs Expected Deaths 12-month Rolling Trend – April 2024-March 2026:**



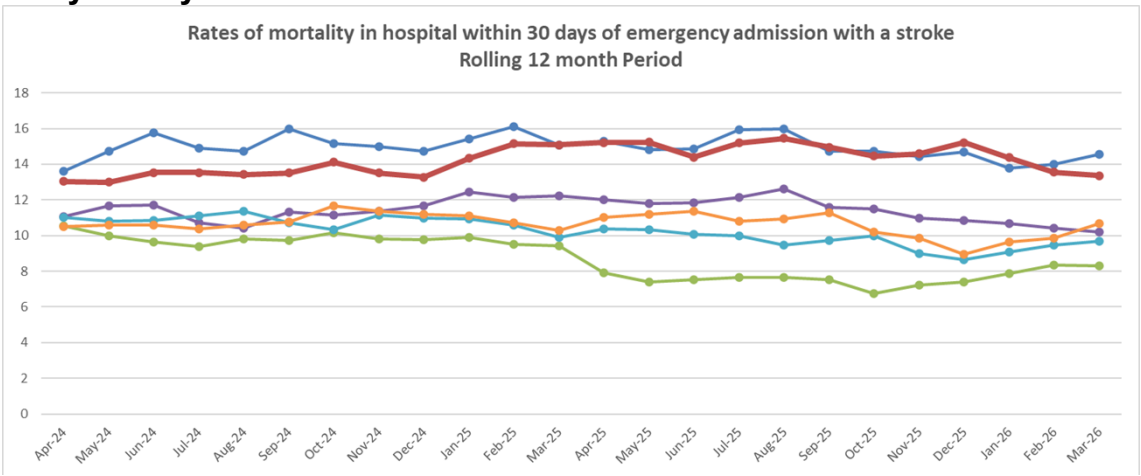
RAMI = Number of deaths observed / Number of deaths expected.

13.8 **RAMI (Risk adjusted mortality index) 2023 » Rolling 12-month period BCUHB vs Peers:**



– BCUHB
All other coloured lines are of Welsh Health Board peers

13.9 **Mortality 30 Day Post Stroke:**



BCUHB
All other coloured lines are of Welsh Health Board peers

13.10 Wrexham Maelor Hospital has been identified as a 'borderline outlier' for case mix adjusted mortality within the Sentinel Stroke National Audit, which benchmarks standardised mortality rate and other key performance indicators in centres across the UK. While no formal response from BCUHB is required, there is a need for a detailed review of this cohort. Methodology will be agreed following preliminary discussion with the SSNAP Audit Team. CHKS data also shows increased mortality within 30 days of admission with stroke. Advice from a provider who has performed a similar review will be taken.

13.11 Triangulation of mortality data with other key performance indicators will be essential and is reflected in the terms of reference for the newly formed BCUHB Stroke Clinical Governance Group which will be initially chaired by the Associate Medical Director for Mortality.

13.12 **Morbidity and Mortality (M&M) Form, Learning and Process:**
Clinical Governance and/or dedicated Mortality and Morbidity (M&M) meetings provide an effective forum for reflection, discussion and learning to inform service development and individual practice. This practice aligns with existing requirements for clinicians to reflect on concerns and other significant events within their annual appraisal. At present these are not consistently in place across BCUHB nor is a consistent and agreed methodology followed. A BCUHB wide approach is being introduced. This includes a Mortality and Morbidity Form which provides a structure for review and discussion including the development of accountable action plan. It ensures that an overall judgement is made about the quality of care provided to the patient. These forms will be collected by site Mortality Leads to ensure review is taking place and to allow shared learning.

13.13 **MCCD Completion Rate Update:**
MES dashboard data shows that BCUHB is performing well in comparison with other Health Boards: mean time to MCCD completion is currently 7.19 days.

13.14 **Learning**
The case presented by East IHC at the Reducing Avoidable Mortality Steering Group focussed on the care of a patient with Learning Disabilities. Learning included:

13.15 Secondary Care
- the importance of improving system capacity while strengthening the focus on personalised, equitable care for people with learning disabilities

Primary Care
- communication with families, delays in diagnosis and treatment, end-of-life care (particularly pain management) and care coordination issues

Actions are underway to share learning and deliver improvements including a learning lesson of the month for patients with Learning Disabilities.

Quality Assurance

14. Health Inspectorate Wales

14.1 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.

14.2 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.

14.3 **Inspection – Ysbyty Gwynedd Emergency Department (14–16 Apr 2025)**
- **Status**: Overdue
- **Recommendations**: 28
- **Actions**: 66 total; 65 completed (98%)
- **Outstanding**: 1 action remains
- **Closure Date**: TBC
- **Governance**: Continuous monitoring via Local HIW Review Meeting, Regulatory Assurance Group (RAG), and Executive Quality Delivery Group (EQDG).

14.4 **Inspection – Pantomime Ward, Ysbyty Maelor (14th to 16th October 2025)**
- **Status**: Complete
- **Recommendations**: 18
- **Actions**: 42 total; 42 completed (100%)
- **Closure Date**: 5th May 2026
- **Governance**: Progress monitored through the Local HIW Review Meeting, East Patient Safety Quality Delivery Group, Regulatory Assurance Group (RAG), which reports directly to the Executive Quality Delivery Group (EQDG).

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

- **Status:** Overdue
- **Recommendations:** 16
- **Actions:** 51 total, 19 completed (37%)
- **Outstanding:** 32 actions remain (one partially complete, overdue)
- **Closure Date:** TBC
- **Governance:** Continuous monitoring via Local HIW Review Meeting, Regulatory Assurance Group (RAG), and Executive Quality Delivery Group (EQDG).

14.6 **Inspection – Ablett Unit, YGC (27th to 29th April 2026)**
Improvement Plan not received as yet; no immediate assurances received.

14.7 **HIW Inspection – Emergency Department, YGC (5th to 7th May 2026)**
Immediate Actions outlined from HIW and escalated to Service Requiring Significant Improvement.
Concerns raised requiring Immediate Action include:

- 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.

An action plan detailing actions already taken and clear metrics to measure improvement has been submitted. This will be reviewed regularly with HIW. YG and YWM hospitals are also self-assessing against findings and will undergo peer review.

A full report is expected over the summer and a further action plan will be developed to address any additional concerns.

14.8 **Requests for Assurance**: BCUHB responded to requests for assurance from HIW concerning Nant Y Glyn, Community Mental Health Unit Conwy, Wrexham Community Mental Health Team and the Neonatal Unit in YGC

In each case the improvement actions were detailed and HIW were assured by the BCUHB responses.

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

- **Nant Y Glyn Community Mental Health Team (April 2026)**
  Assurance request from HIW following concerns received via a voicemail from the mother of an individual raising concerns about her mental health wellbeing and her safety.

14.10
- **Wrexham Community Mental Health Team (April 2026)**
  Assurance request from HIW highlighted concerns regarding a patient's dissatisfaction with the way their psychiatric assessment was managed. The email also mentions the patient's decision to discontinue their prescribed medication. There was an indication that the patient is a high risk to his personal safety and wellbeing.

14.11
- **Neonatal Department Ysbyty Glan Clwyd, IHC Central (April 2026)**
  Assurance request from HIW in relation to concerns received by Healthcare Inspectorate Wales in relation to the Neonatal Unit at Glan Clwyd hospital. The concerns received relate to safety, care standards and the working environment of the Unit, with concerns that some conditions are presenting an immediate risk to patient safety

15. Care Inspectorate Wales

15.1 Care Inspectorate Wales (CIW) inspections found no immediate concerns and improvement plans remain on track.

16. Public Services Ombudsman for Wales

16.1 BCUHB has maintained sustained compliance with Ombudsman requirements, with overall compliance against recommendations at 92%. Engagement with the Ombudsman's office has strengthened, supporting timely resolution and improved assurance.

16.2 BCUHB currently has 50 open Ombudsman cases.

Notification of New Full Investigations	2
Awaiting Draft Report	18
Draft Report Received	1
Awaiting Final Report	2
Final Report Received and working on action plans	9
Early Resolution Proposals	12
Further Info requested during investigation	5
Enquiries	3
Further evidence requested for Sign Off	1
Total Cases Open	**50**

16.3 **Public Interest Reports**

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

16.4 • **Final Public Interest Report 202301141**

The Ombudsman's investigation considered the following:
(a) Appropriate review and treatment of post-operative fluid collections and pelvic sepsis following proctectomy in 2019, including adequate gynaecological input.
(b) Sufficient time and information to understand and consider the risks of the surgical removal of post-operative fluid collections, and to give fully informed consent before surgery was carried out.
(c) Prompt and appropriate investigation and treatment for pain and reduced kidney function following surgery in March 2022
(d) Timely and appropriate information about the hysterectomy, including advice about post-operative recovery, the menopause and options for hormone replacement therapy.

This Public Interest Report remains open due to an outstanding action on the Commissioning Assurance Framework (CAF). A revised deadline of 31 January 2026 was agreed with the Ombudsman. The CAF has been approved through governance processes and the outstanding action will now progress for closure.

16.5 • **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.

The Final report was issued on 4 March 2026.

16.6 **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.

This was published on 17 June 2026.

17. Duty of Candour

17.1 Betsi Cadwaladr University Health Board (BCUHB) is committed to upholding the statutory Duty of Candour and ensuring compliance with all associated legislative and

regulatory requirements. The organisation continues to promote a culture of openness, transparency, and honesty in all aspects of care delivery, placing patients, families, and carers at the centre of its approach.

17.2 The Health Board provides assurance that systems and processes are in place to support the identification, reporting, and appropriate management of notifiable patient safety incidents. Duty of Candour is embedded within incident reporting, investigation, and concerns processes, ensuring that individuals affected by harm are informed in a timely, compassionate, and structured manner.

17.3 BCUHB recognises the importance of continuous improvement and learning. A dedicated Task and Finish Group is currently in place to review the organisation's compliance with Duty of Candour requirements. This group is actively assessing current practices, identifying any gaps in compliance, and overseeing the implementation of necessary improvements. This work ensures that Duty of Candour remains a strategic and operational priority across the Health Board.

17.4 Learning from incidents and concerns is a key component of this approach. The Health Board is committed to using insights from investigations and reviews to strengthen patient safety, improve service delivery, and reinforce a culture where staff feel supported to be open and honest.

17.5 Through these ongoing efforts, BCUHB aims to ensure that Duty of Candour is consistently applied, that patients and families are treated with dignity and respect, and that organisational learning drives meaningful and sustained improvement.

17.6 The task and finish group are currently reviewing the way Duty of Candour data is captured to be able to provide informative data for reporting. This is being undertaken with National forums to ensure it is aligned with other Health Boards across Wales.

18. Organisational Learning

18.1 The Mental Health Division has now contributed its first learning output to the Digital Learning Repository, with a second in development, marking a significant step in embedding the repository as a core mechanism for organisational learning. Their early engagement reflects growing confidence across services in using the platform to share high-quality, validated learning that supports a consistent approach to patient safety improvement. Work has also begun to strengthen quality-assurance and learning processes with commissioned services, ensuring that insights from across the wider system are captured and aligned to the BCUHB's organisational learning framework as this area develops further.

HealthCare Law

19. Coroner and Inquests

19.1 Prevention of Future Deaths (PFD) Reports
During the reporting period, there were no new PFD or responses to PFDs.

19.2 Response to other Coroner Concerns
A request for further assurance was received from the coroner following an inquest, seeking information on current waiting times for elective gallbladder surgery and the actions in place where extended waits may present a potential risk. In response, BCUHB has provided current waiting time data, recognising that in some cases waits are prolonged, and outlined the measures in place to manage and reduce these waits. These include strengthened waiting list management, optimisation of theatre capacity, validation processes, and the use of insourcing and outsourcing, supported by established governance and performance oversight arrangements.

20. Liability Claims

20.1 BCUHB continues to maintain focused oversight of Learning from Events Reports (LFERs) required by the Welsh Risk Pool. Based on the position at the end of the reporting period, there were 13 overdue LFERs.

20.2 Overall performance has improved year-on-year, with a sustained reduction in both the number of overdue submissions and the proportion of cases attracting penalties. 29 penalties were in the financial year 2025-2026, compared to 66 penalties in the financial year 2024/2025.

20.3 The majority of delays relate to WRP deferrals for further evidence or clarification, rather than non-submission, and primarily relate to Central and East IHCs.

20.4 Process improvements remain in place, including an earlier internal assurance deadline ahead of WRP submission, designed to strengthen quality and reduce avoidable deferrals.

21. Other Healthcare Legal Issues

21.1 As detailed in section 4 the Supreme Court issued (at the time of writing) a significant judgment overturning the legal test for deprivation of liberty; the implications for consent, capacity and safeguarding in health and social care are potentially wide-ranging, and Legal Services is working with Safeguarding and others to understand the practical impact and required response. This will be reported to the MHLC Committee.

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Quality Safety and Experience Committee

INTEGRATED QUALITY AND PERFORMANCE REPORT (IQPR)

Dyddiad y Cyfarfod **Date of Meeting**	02 July 2026
Statws Cyhoeddi **Publication Status**	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad **Report Author name and title**	Ed Williams Dirprwy Cyfarwyddwr Perfformiad Deputy Director for Performance Olivia Shorrocks Cyfarwyddwr Perfformiad Director of Performance
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol **Lead Executive Team Member name and title**	Russell Caldicott Cyfarwyddwr Gweithredol Cyllid Executive Director of Finance

Pwrpas yr Adroddiad **Report Purpose**	For noting

Crynodeb Gweithredol
Executive Summary

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

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

Members are asked to note the current position and assurance levels against key performance metrics.

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

Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	Dyddiad Date	Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data
Not applicable for this report		

INTEGRATED PERFORMANCE AND QUALITY REPORT

1.0 Y SEFYLLFA / SITUATION

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

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

2.0 Y CEFNDIR / BACKGROUND

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

- 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), Health Education and Improvement Wales (HIEW) and other formal recommendations

The integrated quality and performance report provides a clear assessment of organisational performance, outlining key achievements, areas of challenge, and the actions being taken to drive improvement against the domains of:

- Operational performance and access
- Quality, safety and patient experience
- Finance and sustainability

- People and places
- Population health and prevention

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

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

3.1 Performance and access

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

The health board is developing 90-day operational improvement plans to support further improvement. Cancer performance remains poor due to challenges in skin, breast, urology and colorectal. Across the organisation, there is a continued focus on operational delivery, productivity, validation, and targeted commissioning. A Recovery Director (interim) started mid-May with a focus on implementing planned care recovery plans from the start of quarter 2 (from July 2026).

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

3.2 Quality, safety and patient experience

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

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

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

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

3.3 Finance and sustainability

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

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

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

3.4 People and places

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

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

4.0 ASSESSMENT

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

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

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

5.0 ARGYMHELLION / RECOMMENDATIONS

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

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

MHLD	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, 02 July 2026

Trugaredd
Compassion

Agored
Openness

Parch
Respect

Quality, Safety and Experience Committee

Integrated Quality and Performance Report

Data Produced on 16.06.2026 on behalf of the Quality, Safety and Experience Committee by the Performance Directorate and partners

Table of Contents

Introduction

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

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

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

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

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

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

What is our data telling us?

Performance and access

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

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

Quality, safety and patient experience

Four new never events were reported between April and June 2026, with three of those occurring in June; twelve recorded in the last 12 months. There has been an Increase in **n**ational reportable incidents this period (20 vs 14). Median completion time remains the best in Wales (75 days), though the proportion open over 90 days has increased. Patient safety incident backlog remains high (4,976 open; 58.9% overdue). Reduction target not achieved; refreshed recovery trajectories being agreed with IHCs and Divisions. Progress noted against national patient safety alerts (PSA); some compliance timelines extended. There is a UK wide profemur hip recall affecting 821 patients in BCUHB with management plan and executive sponsorship in place. Complaints volume 311 (up from 291) and overdue cases, 69 (up from 49) have increased, though overall performance at 77.8% (down from 83.2%) remains among the best in Wales. Legislative transition to *Listening to People* successfully implemented.

Finance and sustainability

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

People and places

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

Executive Summary: Performance and access

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

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

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

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

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

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

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

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

Executive Summary: Quality, safety and patient experience

Key Performance Matters Three New Never Events were reported in June 2026, two concerned a 'retained object' post procedure and one administration of medication through incorrect route. These are still being investigated. A further new never event occurred in April 2026. This total's twelve in the last 12 months. In this reporting period, 20 Nationally Reportable Incidents (NRIs) have occurred (up from 14 in the last period), including two "never events," are under full investigation with clear actions in place to reduce recurrence. Investigation timeliness has improved to above the national average. Backlogs remain (4,976 open; 58.9% overdue) but are being actively reduced. Patient Safety Alerts (PSAs) and recalls are being managed effectively. Complaints have increased slightly with 311 open (up from 291). Although response times remains strong at 77.8% (down from 83.2%), 69 remain overdue (up from 49). Quality assurance processes continue to be strengthened.

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

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

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

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

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

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

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

Executive Summary: Finance and sustainability

Financial Plan

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

Financial Position

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

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

Savings and mitigations

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

Capital programme

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

Executive Summary: People and places

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

Executive Summary: Population health and prevention

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

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

Co-Producing an Anchor Charter for North Wales Building on the work established through the Well North Wales programme, the Regional Partnership Board (RPB) and Health Board have worked collaboratively with partners to co-produce a Regional Anchor Charter. The Charter incorporates seven Missions that enable North Wales to deliver on Marmot principles that tackle inequalities, deliver on the Ways of Working and Wellbeing Goals within the Wellbeing of Future Generations Act and take action to address the wider determinants of health, including housing, food, lifelong learning, and active & creative lifestyles.

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

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

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

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

Section 1
Performance and access

Scorecard : Performance and access (1 of 3)

Latest available validated data: May 2026

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

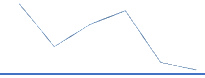
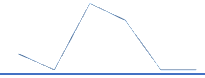
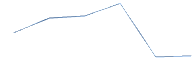
Scorecard : Performance and access (2 of 3)

Latest available validated data: May 2026

REF	Measure Description	Target Suite			Wales Benchmark	Actual Performance				Delivery Assurance	Action
		NT	SM	AP		Mar-26	Apr-26	May-26	Trend to Date		
3BP03	Number of patients waiting more than 26 weeks for a new outpatient appointment	0	N/A	TBC	N/A	15,694	16,575	16,955		No Assurance	Alert
3BP02	Number of patients waiting more than 52 weeks for a new outpatient appointment	0	0	6,785	8th from 8	5,858	5,922	5,385		Limited Assurance	Advise
3BP01	Number of patients waiting more than 104 weeks for referral to treatment	0	0	1,895	N/A	2,161	2,436	2,528		Limited Assurance	Alert
3BP14	Percentage of patients starting their first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)	75%	55%	55%	6th from 6	53.8%	52.6%	RIA		No Assurance	Escalate
3BP15	Reduction in number of patients on an active suspected cancer pathway after day 62	N/A	N/A	TBC	N/A	209	192	RIA		No Assurance	Escalate
3BP16	Number of patients (all ages) waiting more than 8 weeks for a specified diagnostic	0	N/A	TBC	7th from 7	13,778	12,386	10,461		Limited Assurance	Alert
NPF28	Percentage of R1 patient pathways, which have a target date allocated, waiting within their clinical target date or within 25% beyond their clinical target date for an outpatient appointment	95%	N/A	Improvement	5th from 8	56.10%	55.30%	54.90%		No Assurance	Alert
3BP04	Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%	92,455	N/A	TBC	7th from 7	123,259	128,079	131,031		No Assurance	Alert
3EP01	Percentage of Local Primary Mental Health Support Service (LPMHSS) assessments undertaken within (up to and including) 28 days from the date of receipt of referral for people aged under 18 years	80%	N/A	80%	5th from 7	88.90%	92.90%	RIA		Reasonable Assurance	Assure
3EP02	Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by Local Primary Mental Health Support Service (LPMHSS) for people aged under 18 years	80%	N/A	80%	5th from 7	85.40%	78.10%	RIA		Reasonable Assurance	Advise
3DP01	Percentage of Local Primary Mental Health Support Service (LPMHSS) assessments undertaken within (up to and including) 28 days from the date of receipt of referral for adults aged 18 years and over	80%	N/A	80%	5th from 7	87.18%	84.35%	RIA		Reasonable Assurance	Assure
3DP02	Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by Local Primary Mental Health Support Service (LPMHSS) for adults aged 18 years and over	80%	N/A	80%	5th from 7	91.55%	85.52%	RIA		Reasonable Assurance	Assure
3DP06	Material reduction in the number of adult mental health out of area placements	N/A	N/A	TBC	N/A	33	27	16		Limited Assurance	Alert
NPF18	Percentage of children and young people waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment	80%	N/A	12%	7th from 7	12.30%	12.20%	RIA		No Assurance	Alert
NPF19	Percentage of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health	80%	N/A	80%	3rd from 7	54.76%	50.62%	RIA		No Assurance	Alert
3BP05	Number of patients (all ages) waiting more than 14 weeks for a specified therapy	0	N/A	0	6th from 7	1,339	1,423	1,631		No Assurance	Alert
NPF30	Number of adults waiting more than 14 weeks for all audiology pathways (to include new and existing pathways for hearing aids, tinnitus and balance)	0	N/A	0	2nd from 7	13	20	31		Reasonable Assurance	Advise
NPF31	Number of children waiting more than 6 weeks for all audiology pathways (to include new assessment and intervention pathways)	0	N/A	0	6th from 7	594	678	695		Reasonable Assurance	Advise

Scorecard : Performance and access (3 of 3)

Latest available validated data: May 2026

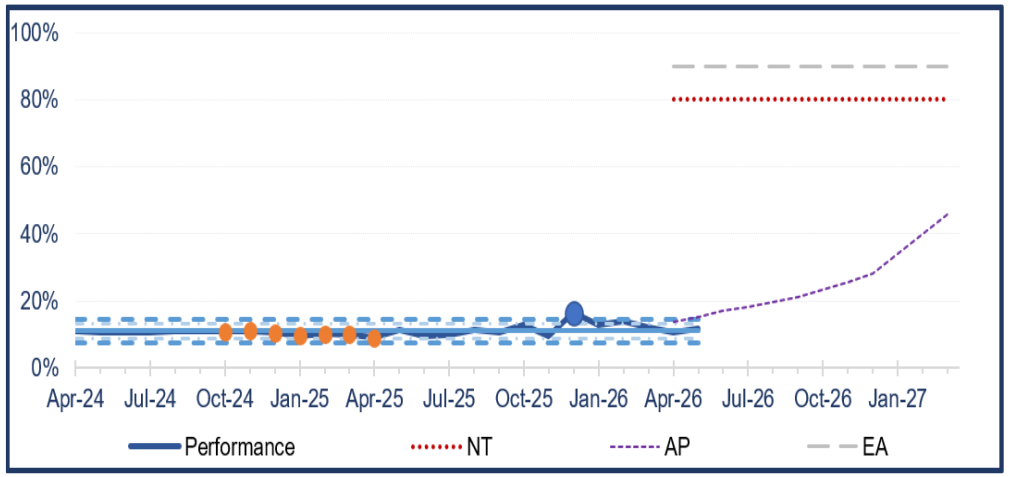
REF	Measure Description	Target Suite			Wales Benchmark	Actual Performance				Delivery Assurance	Action
		NT	SMDT	CMT		Mar-26	Apr-26	May-26	Trend to Date		
1BP02	Percentage of patients offered an index colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioner assessment appointment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

UEC: Ambulance Handover

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

Percentage of ambulance patient handovers within 15 minutes

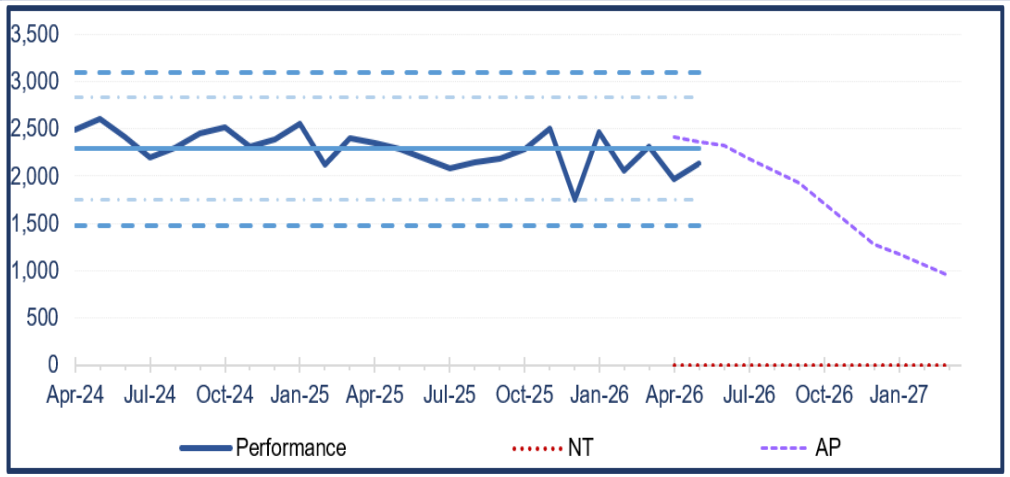
Latest Month	Profile	Actual	Status
May 2026	17%	11.6%	Escalate



Benchmark: BCU ranked as 6 of 6.

Number of ambulance patient handovers over 45 minutes

Latest Month	Profile	Actual	Status
May 2026	2,318	2129	Escalate



Benchmark: BCU ranked 6 of 6.

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

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

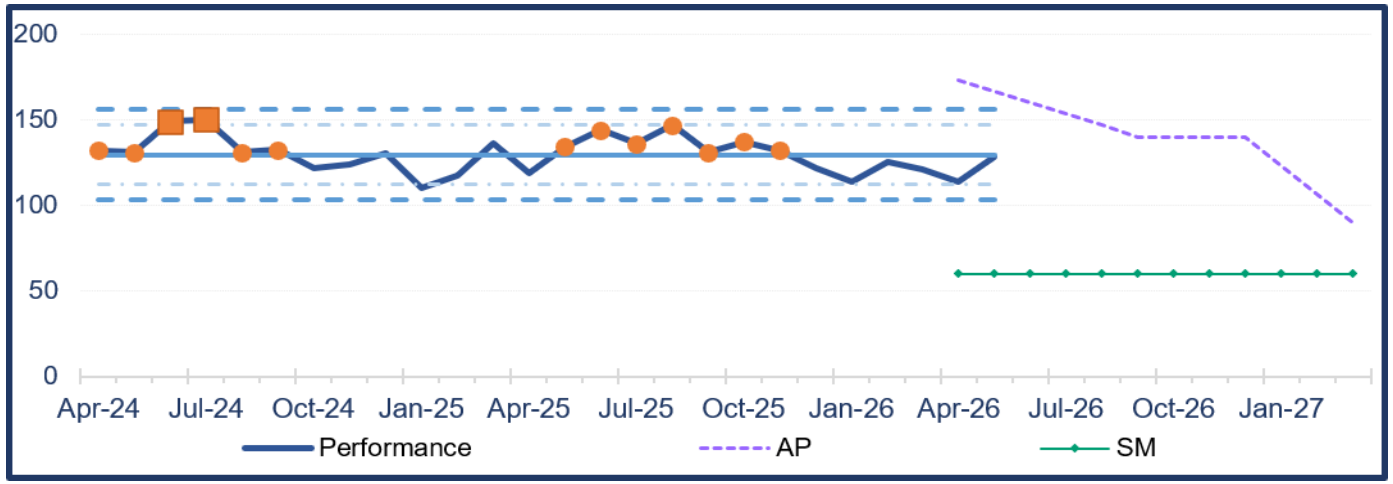
Expected impact upon forecasted performance –Performance against 15-minute handovers is not expected to meet the quarter 1 target and presents a significant delivery risk for Quarter 4. While performance for handovers exceeding 45 minutes is currently aligned with the quarter 1 trajectory, substantial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

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

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

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

Latest Month
May 2026
Profile
160
Actual
128
Status
Advise



Benchmark	BCU ranked 5 of 6.

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

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

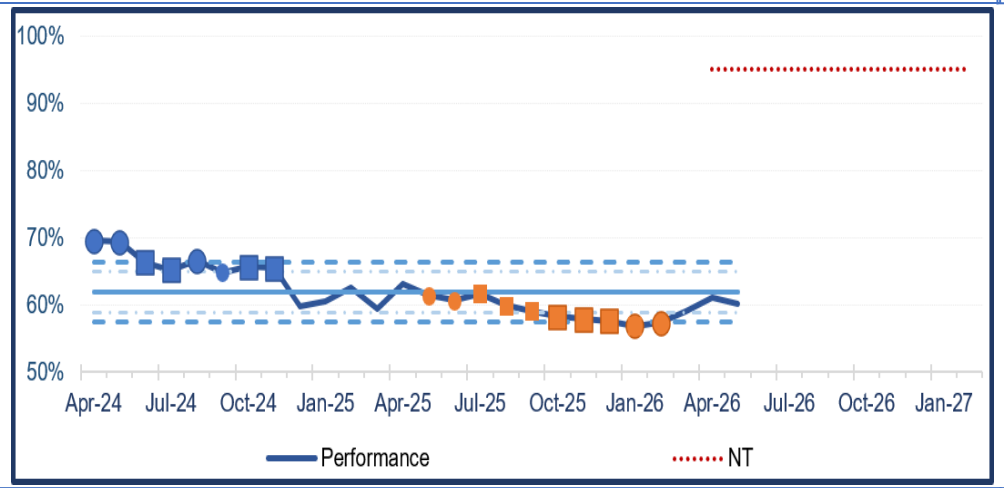
Expected impact upon forecasted performance – Based on current trend, median time to clinical decision maker is meeting the health board's internal trajectory and should achieve the required level by March 2027.

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

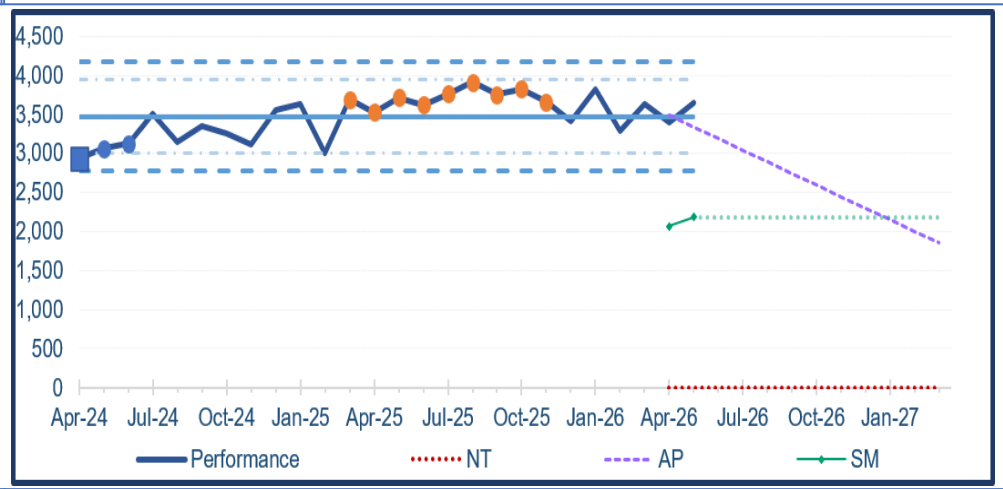
Percentage of patients who spend 4 hours or less in ED & MIU

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



Benchmark BCU ranked as 7 of 7.

Number of patients who spend 12 hours or more in ED & MIU



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

Benchmark BCU ranked as 7 of 7.

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

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

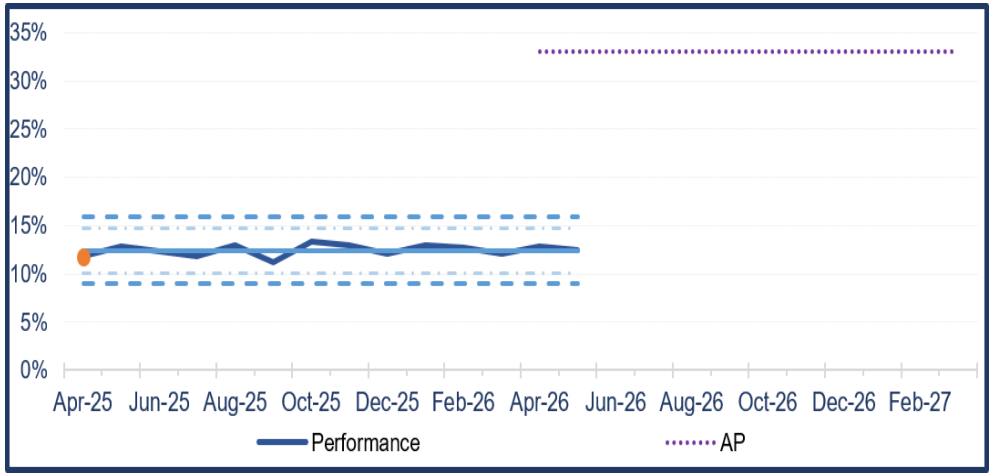
Expected impact upon forecasted performance – Based on current trend, both metrics will not meet the Q1 target. Further sustained improvements will be required as part of ongoing improvement plans

UEC: Discharges before midday

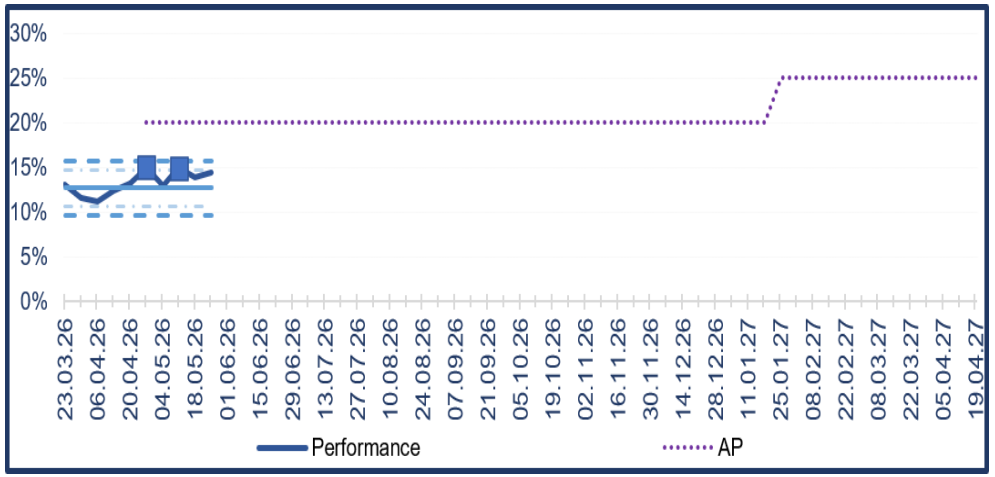
Metric Overview	ID	Metric	SM De-escalation	Planning / Performance Framework	Q1	Q2	Q3	Q4
	TPG-28	Discharges before midday - Weekday	N/A	33% of discharges by midday	33%	33%	33%	33%
	TPG- 29	Discharges before midday - Weekend	N/A	25% by the end of March 2027	15%	17%	20%	>25%

Discharges before midday - Weekday

Latest Month	Profile	Actual	Status	Benchmark
May 2026	33%	12.5%	Alert	N/A



Discharges before midday - Weekend



Latest Month	Profile	Actual	Status	Benchmark
May 2026	15%	14.4%	Alert	N/A

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

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

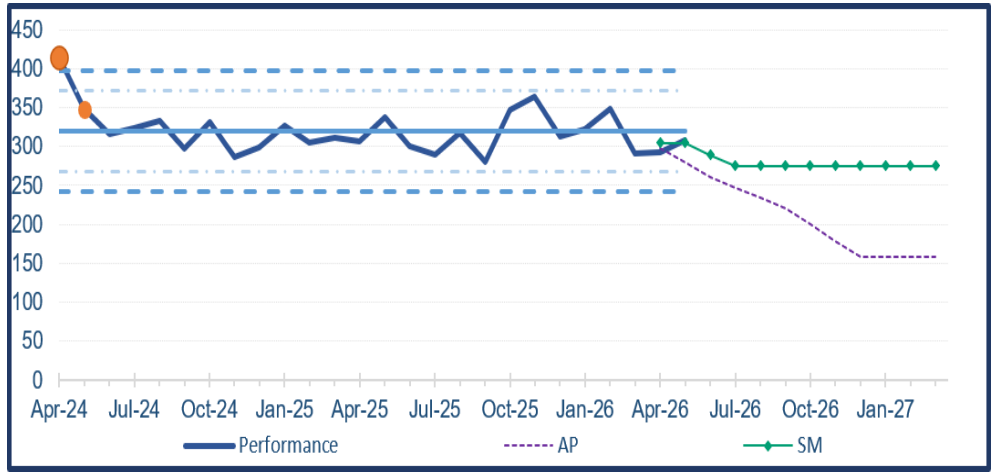
Expected impact upon forecasted performance – Based on current trend, overall discharges before midday is not expected to deliver the step up required during Q1.

UEC: Pathway of Care Delays (PoCD)

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

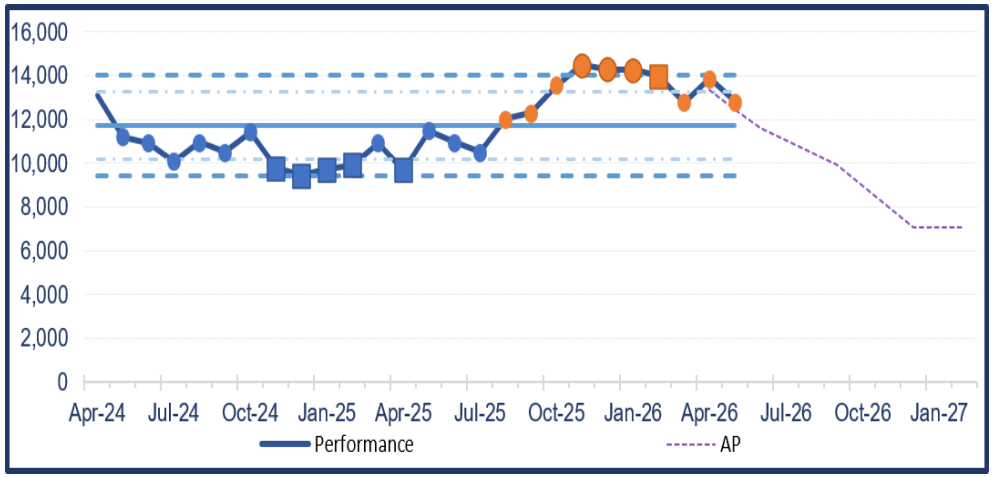
Number of patients on delayed pathways of care

Latest Month	Profile	Actual	Status
May 2026	260	308	Alert



Benchmark 8 of 8.

Number of bed days lost to delayed pathways of care



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

Benchmark N/A

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

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

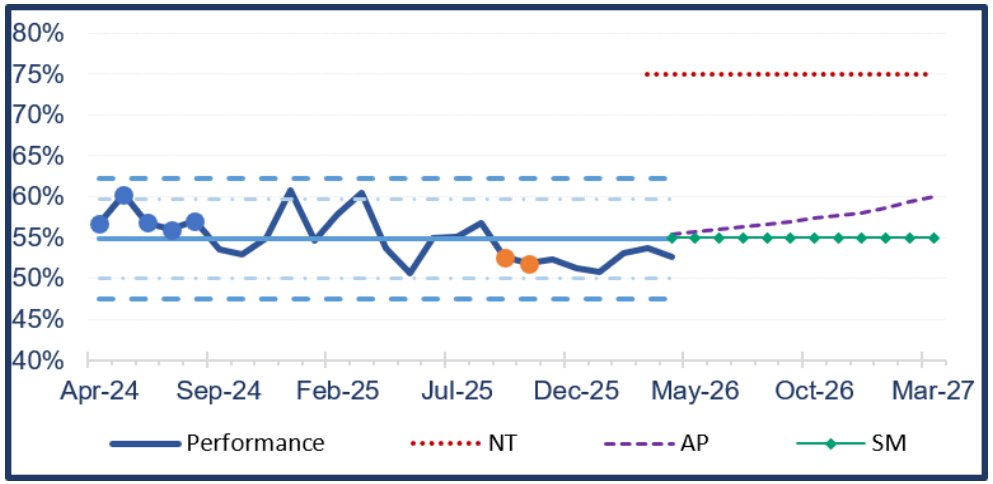
Expected impact upon forecasted performance –Significant improvement will need to be made over the next month to meet ongoing targets. Continual improvement in reducing the number of delays is predicted but reducing the days delays will require focused actions

Planned Care: Suspected Cancer Pathway Metric

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

Suspected cancer pathway 62 days wait

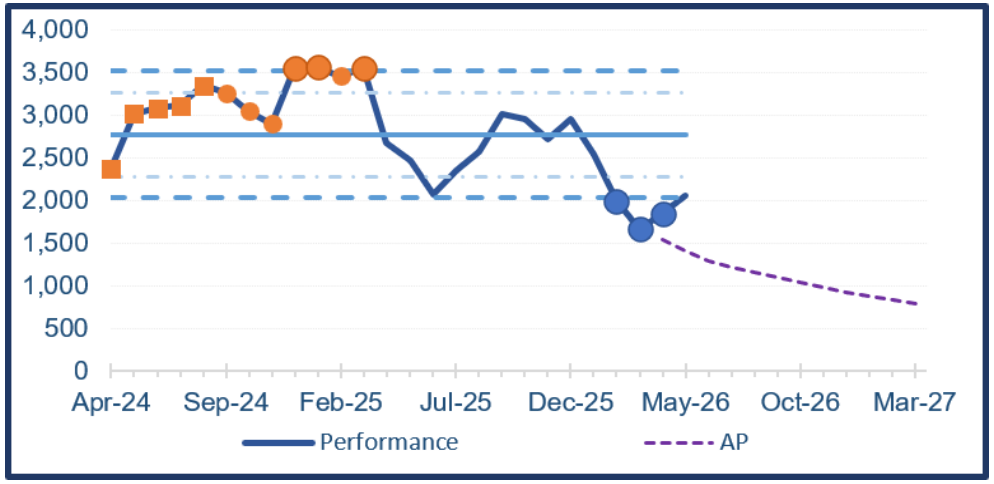
Latest Month	Profile	Actual	Status
Apr-2026	55%	52.6%	Escalate



Benchmark

6th of 6 (March 2026)

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



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

Benchmark

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

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

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

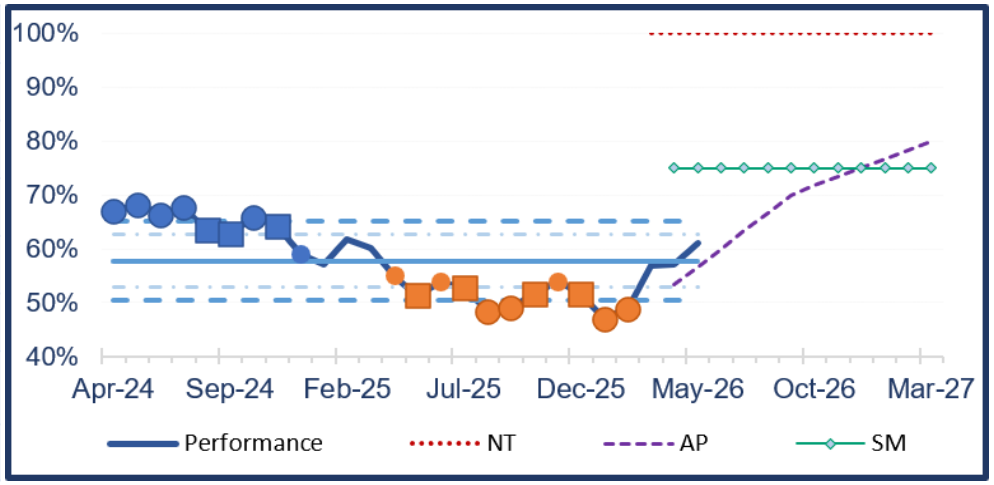
Expected impact upon forecasted performance – Timely mobilisation of actions is key to delivery recovery. The increase in number of patients on an active pathways after day 62 placing risk on delivery of targets at the end of quarter 1. Escalation required to address the issues.

Planned Care: 8-weeks Diagnostic Waits

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

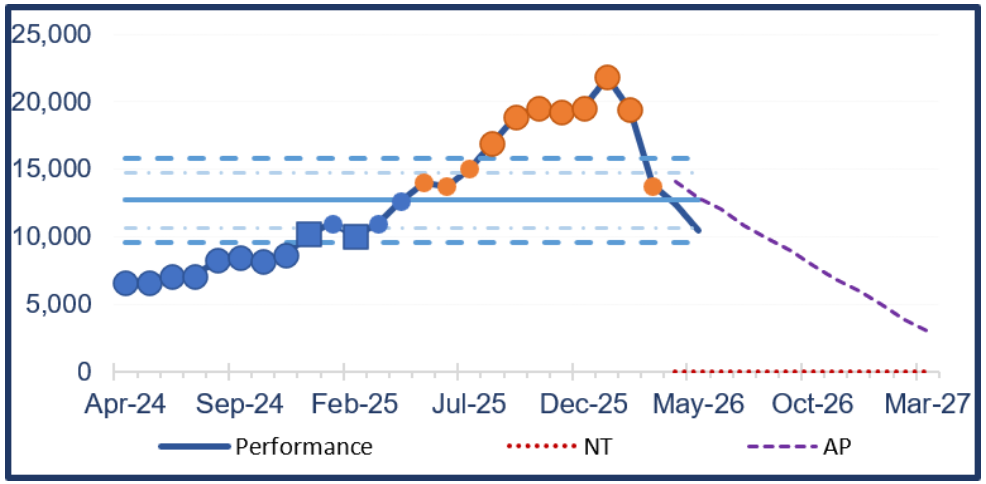
8 weeks diagnostic waits

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



Benchmark BCU ranked 7th of 7.

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



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

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

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

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

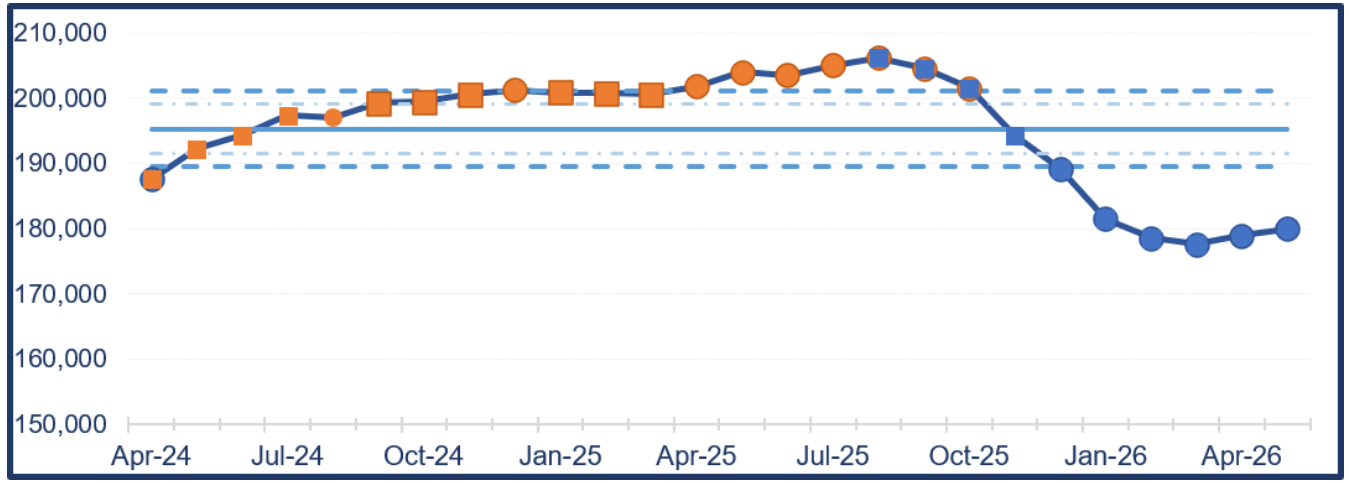
Expected impact upon forecasted performance – Current performance indicates that Q1 trajectory will be delivered for both metrics. Finalisation of plans beyond the end of the first quarter is key for continuation of improvement trajectory Q2 onwards. Sustainability remains a challenge.

Planned Care : Referral to Treatment Metrics

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

Total RTT Pathways

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



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

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

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

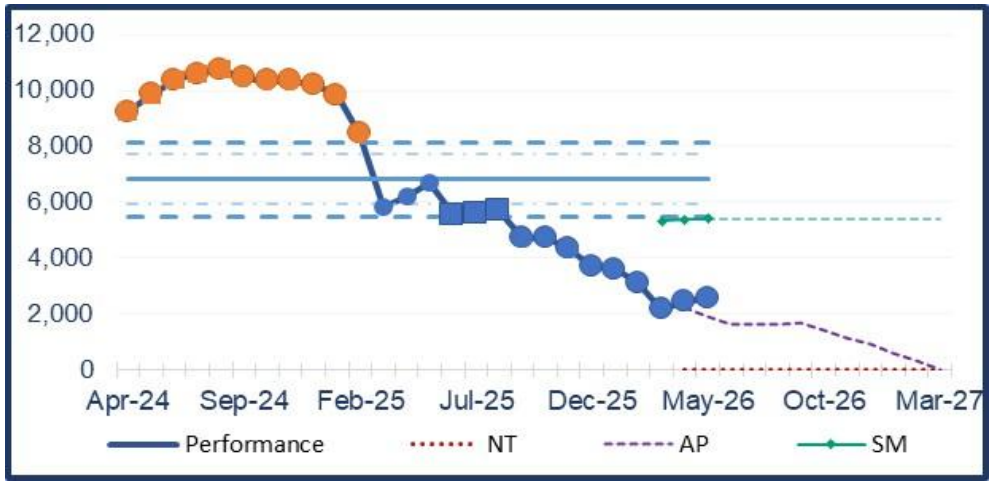
Expected impact upon forecasted performance – The overall waiting list should continue to fall as workstreams are mobilised as part of the operational improvement plans and the major change programme

Planned Care : Referral to Treatment Metrics

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

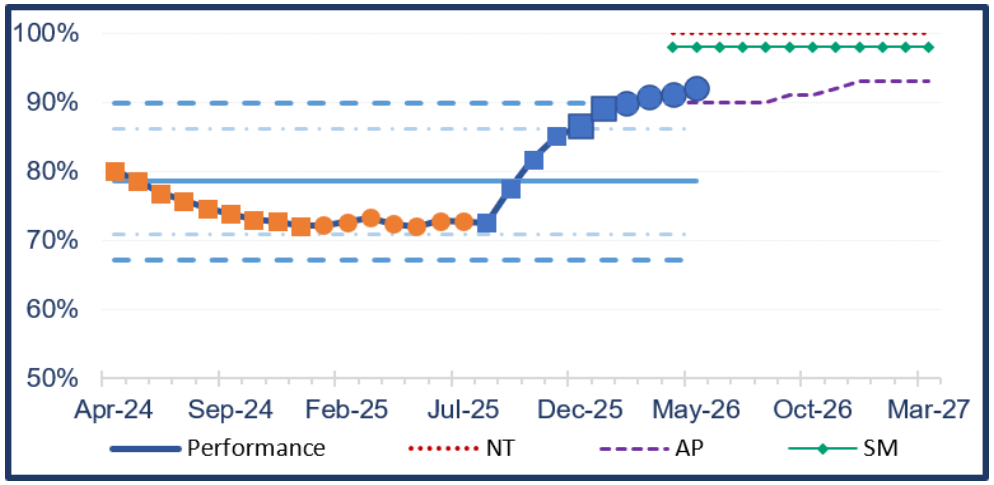
104 weeks for referral to treatment

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



Benchmark 8 of 8 at March 2026

Open outpatient pathways waiting < 52 weeks



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

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

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

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

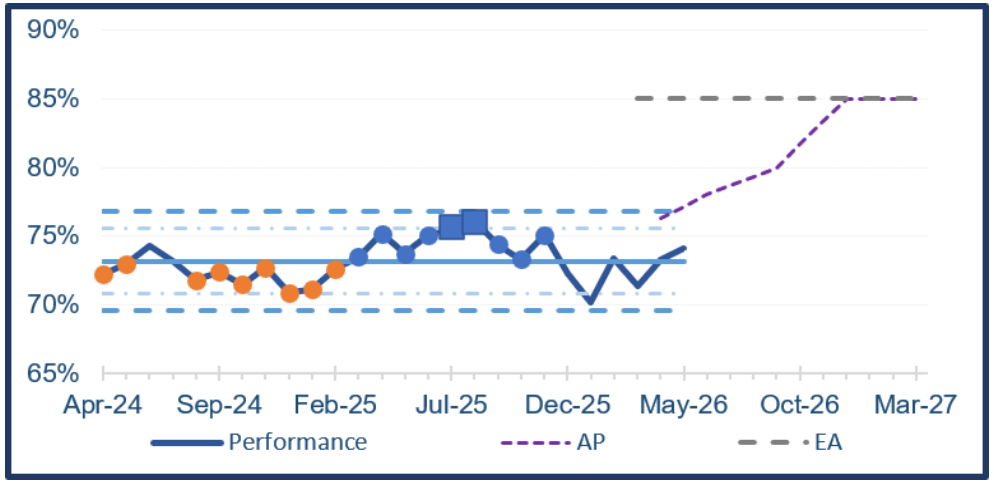
Expected impact upon forecasted performance – Forecast data indicates that the 104 weeks metric will not meet Q1 profile with current data indicating waits of c2,500 at quarter end.

Planned Care : Productivity / Utilisation

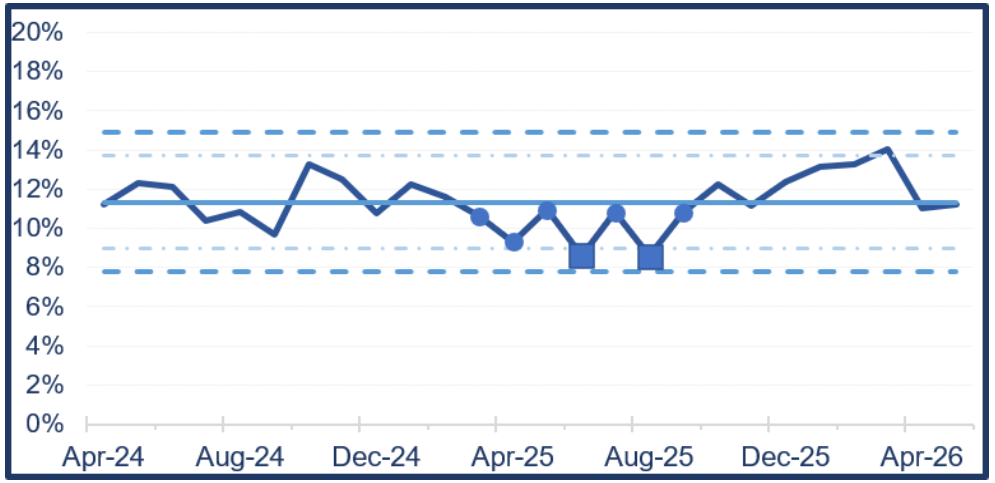
Metric Overview	ID	Metric	SM De-escalation	Planning / Performance Framework	Q1	Q2	Q3	Q4
	3BP13	Theatre session overall utilisation is reported as a key KPI to underpin the GIRFT standard	N/A	85%	78%	80%	85%	85%
	Local	Theatre Short Notice Cancellations	N/A					

Theatre Session Overall Utilisation

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



Theatre Utilisation – Short Notice Cancellations



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

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

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

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

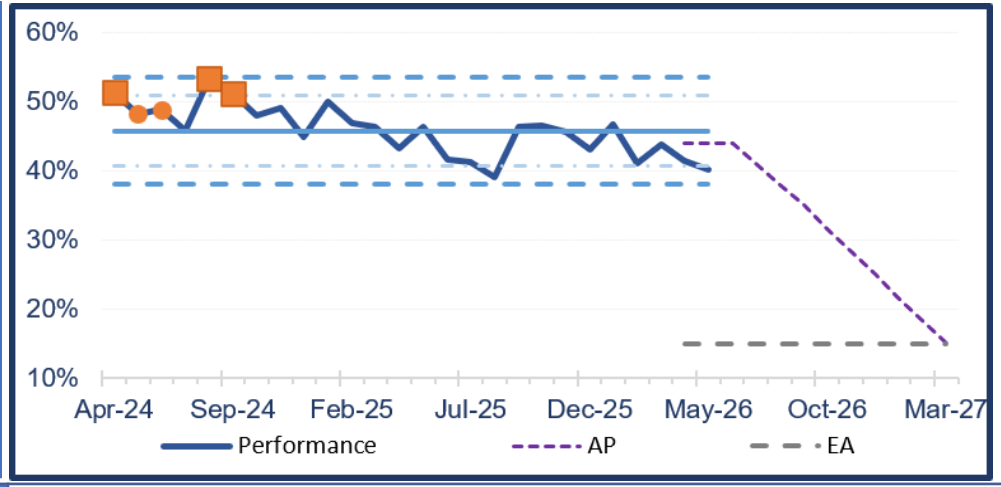
Area	CPS
West	2.0
Central	2.0
East	2.3
BCU	2.1

Planned Care : Productivity / Utilisation

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

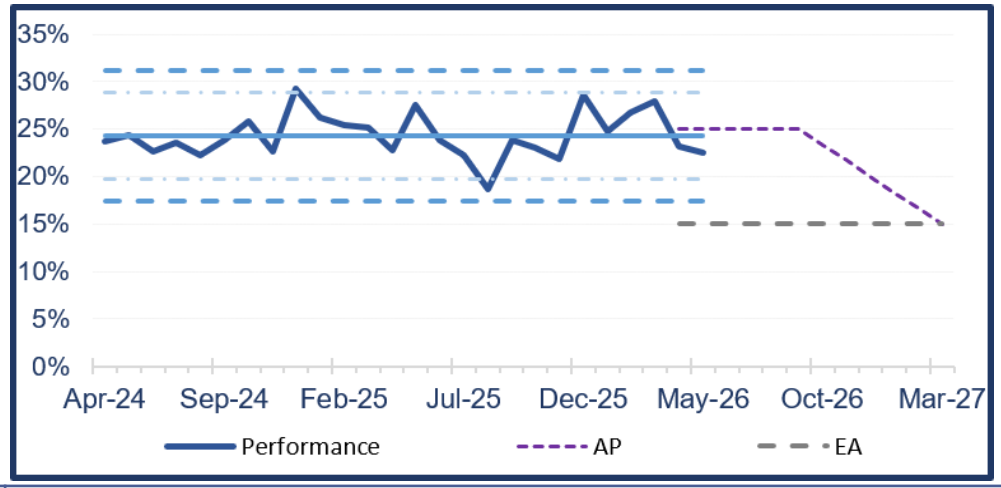
Theatre Utilisation – Late Start

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



Theatre Utilisation – Early Finish

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



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

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

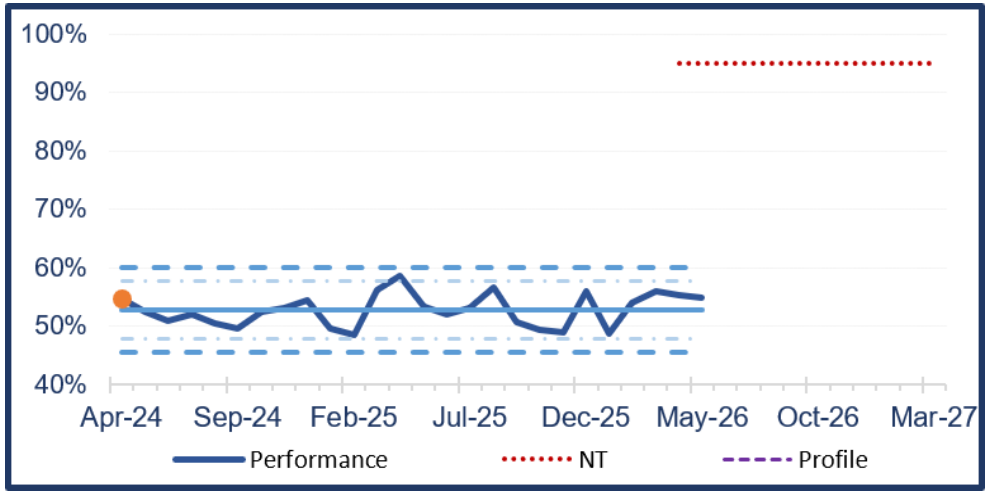
Expected impact upon forecasted performance – Levels of opportunity to increase theatre utilisation differ at specialty level dependent on procedure time.

Planned Care : Outpatient Activity

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

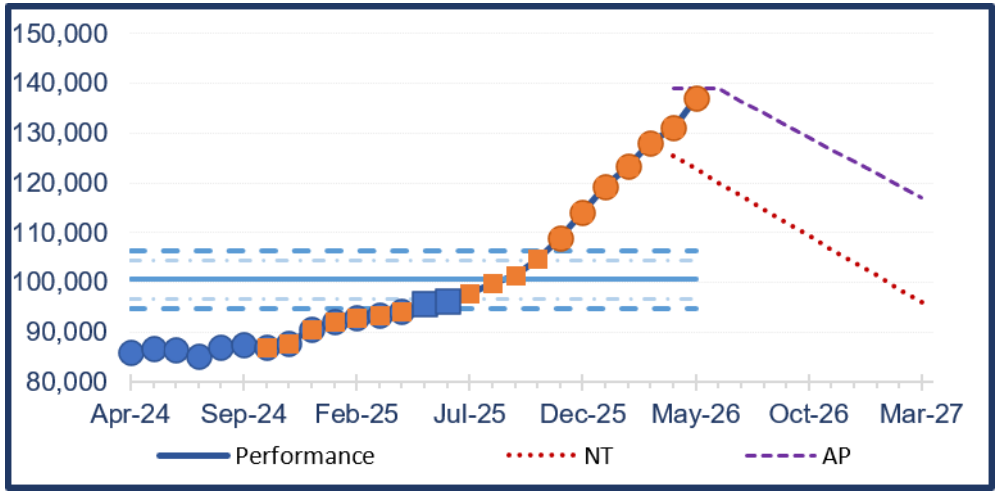
% R1 patient pathways waiting within or within 25% beyond clinical target date

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



Benchmark 5 of 8 at March 2026

Follow Up Delayed by over 100%



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

7 of 7 at March 2026 **Benchmark**

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

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

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

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

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

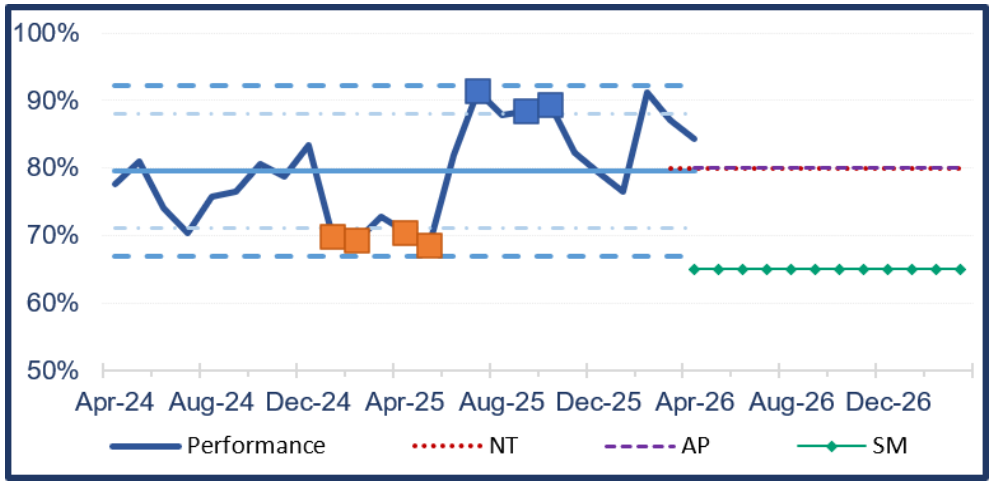
Expected impact upon forecasted performance – Actions are expected to significantly address follow up backlog volumes which will enable a re-balance of new to follow up ratio / clinical validation activity.

Adult Mental Health Measures

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

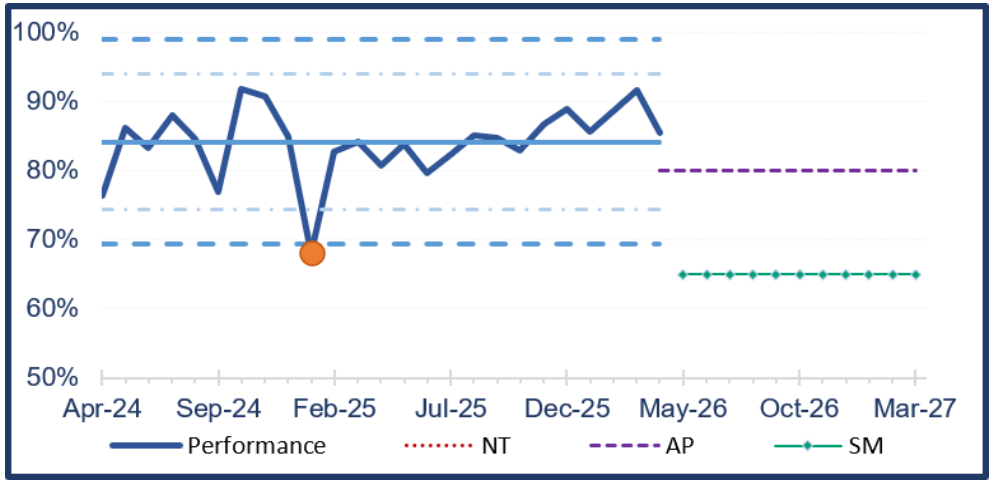
Mental Health Measure Part 1a - Assessments

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



Benchmark	5 of 7 at March 2026

Mental Health Measure Part 1b - 1st Intervention



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

5 of 7 at March 2026	Benchmark

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

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

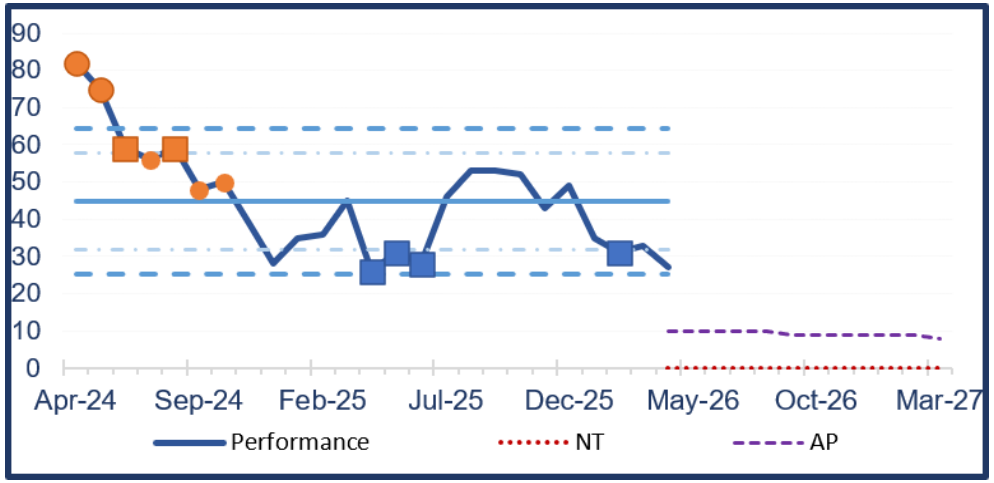
Expected impact upon forecasted performance Based on the current position, the health board is expected to remain above the 80% target in the short term if current delivery is maintained. However, sustained improvement over the next 6–12 months will depend on reducing long-wait cohorts, improving waiting-list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

Adult Mental Health Measures

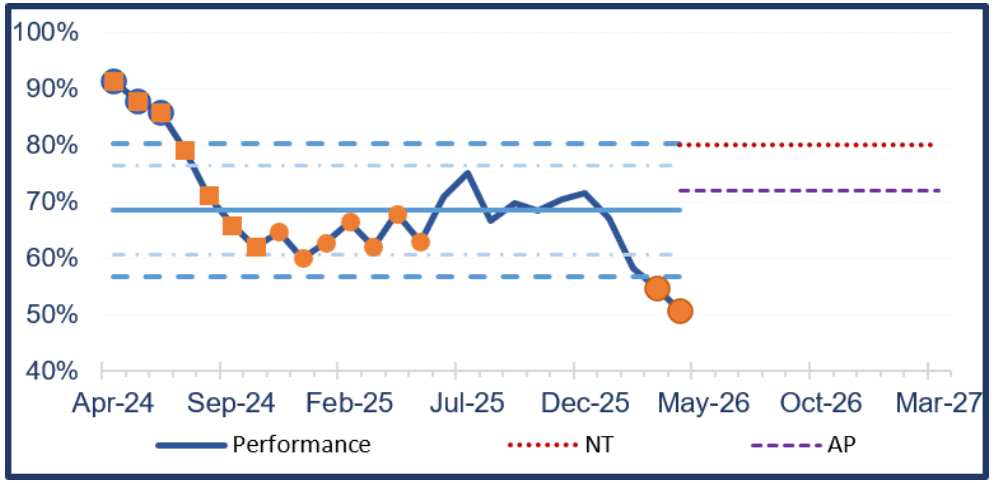
Metric Overview	ID	Metric	SM De-escalation	Planning / Performance Framework	Q1	Q2	Q3	Q4
	3DP06	Material reduction in the number of adult mental health out of area placements	N/A		10	9	9	8
	3BP05	Percentage of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental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

Out of Area Placements

Latest Month
Apr-2026
Profile
10
Actual
27
Status
Alert



Psychological Therapies



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

Benchmark	N/A	3 of 7 at March 2026	Benchmark

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

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

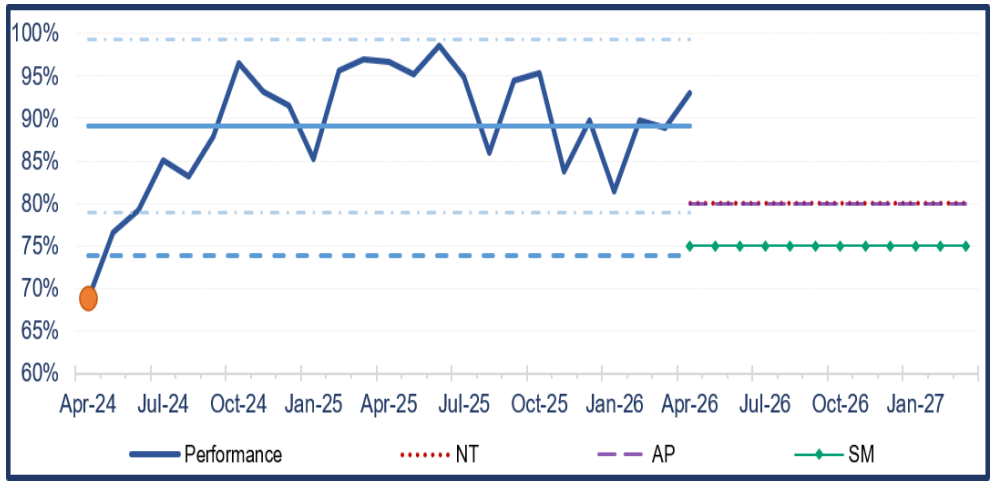
Expected impact upon forecasted performance Psychological therapy performance improvement relies upon the resolution of capacity, workforce and estates constraints. For out-of-area placements, if the April improvement is sustained, the health board should see continued reduction in placement days and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

Child and Adolescent Mental Health (CAMHs)

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

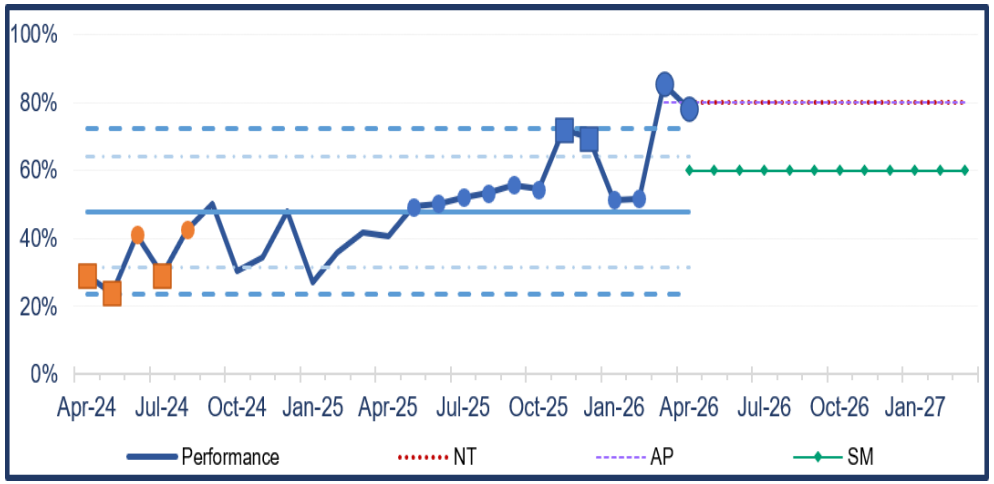
Measure – Part 1A (Assessments) – people aged under 18 years

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



Benchmark 5 of 7 at March 2026

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



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

Benchmark 5 of 7 at March 2026

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

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

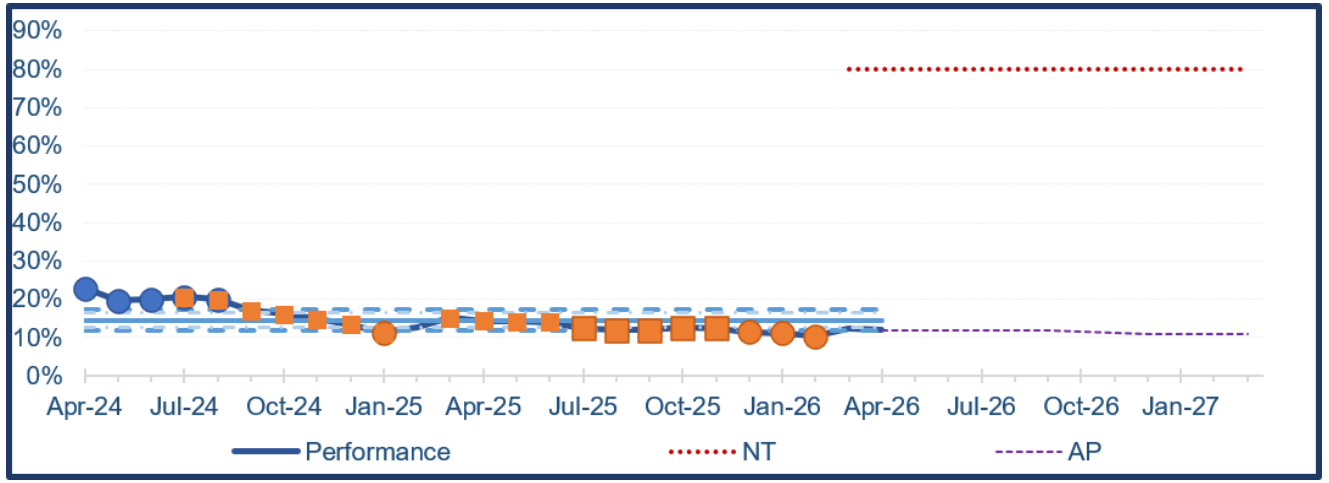
Expected impact upon forecasted performance – Performance against the assessment metric is expected to be maintained at or above the 80% framework threshold. For the interventions metric, the performance is expected to flux at or around the 78% - 80% rate during the next quarter as further work takes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

Neurodevelopment (ND)

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

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

Latest Month
Apr-2026
Profile
12%
Actual
12.2%
Status
Alert



Benchmark	BCU 7th of 7 (March 2026)

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

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

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

Section 2
Quality, safety and patient experience

Scorecard: Quality, safety and patient experience

Latest available validated data: May 2026

Quality, Safety and Experience

RIA = Reported in Arrears

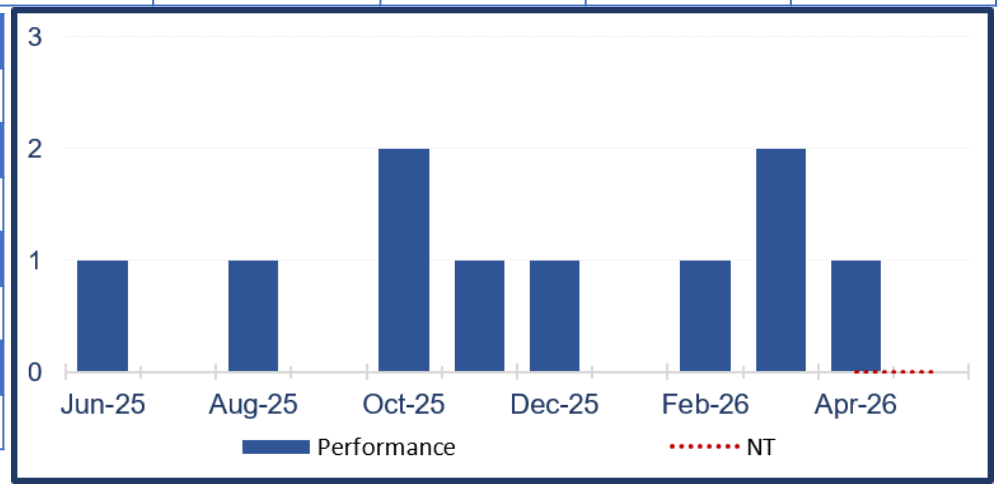
REF	Measure Description	Target Suite			Wales Benchmark	Actual Performance				Delivery Assurance	Action
		NT	SM	AP		Mar-26	Apr-26	May-26	Trend to Date		
NPF39	Percentage of episodes clinically coded within one reporting month post episode discharge end date	95%	N/A	95%	4th from 8	95.56%	RIA	RIA		Reasonable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

Quality: Never Events and National Reportable Incidents (NRIs)

Number of Never Events

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

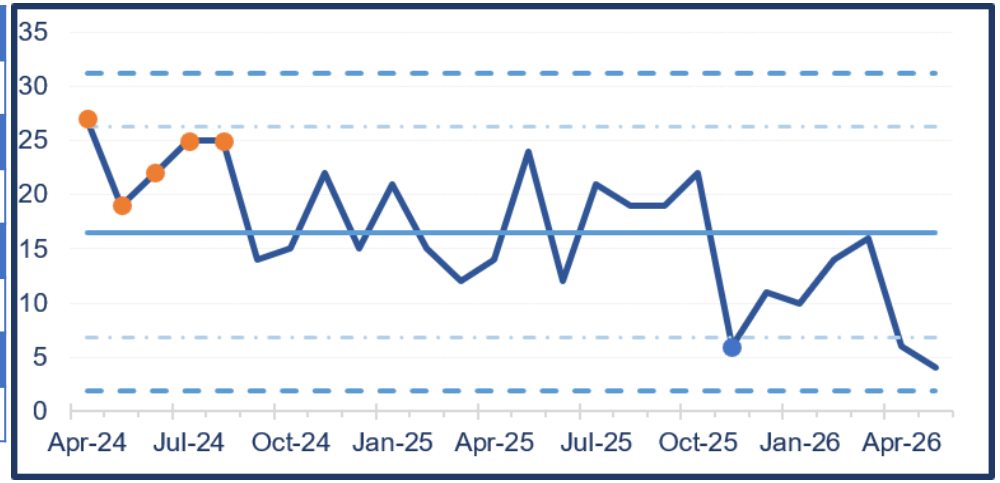
Latest Month
May-26
Profile
0
Actual
0
Status
Alert



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

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

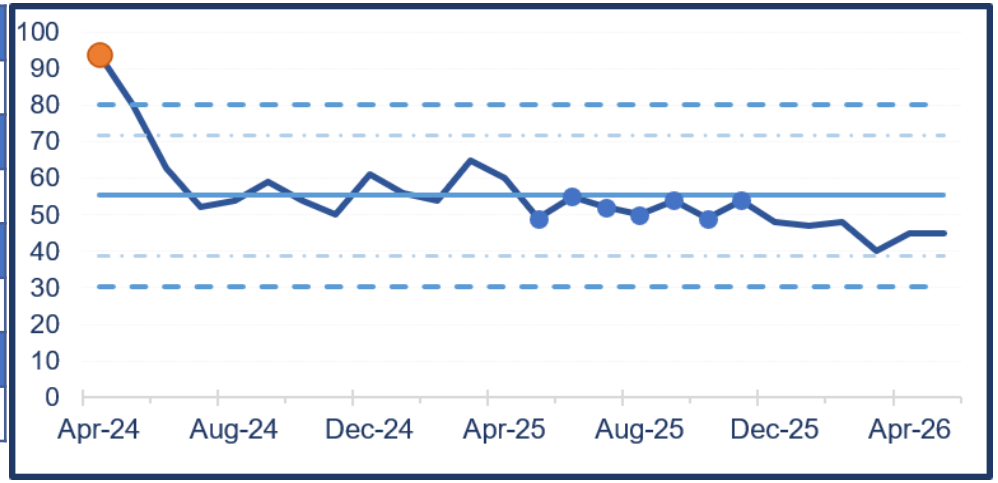
Latest Month
May-26
Profile
N/A
Actual
4
Status
Advise



All open NRIs

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

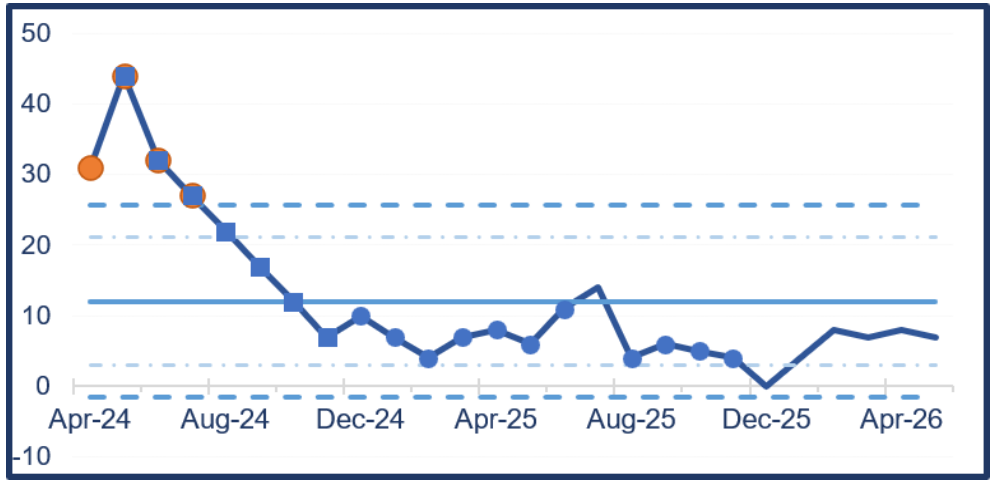
Latest Month
May-26
Profile
N/A
Actual
45
Status
Advise



All overdue NRIs

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

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

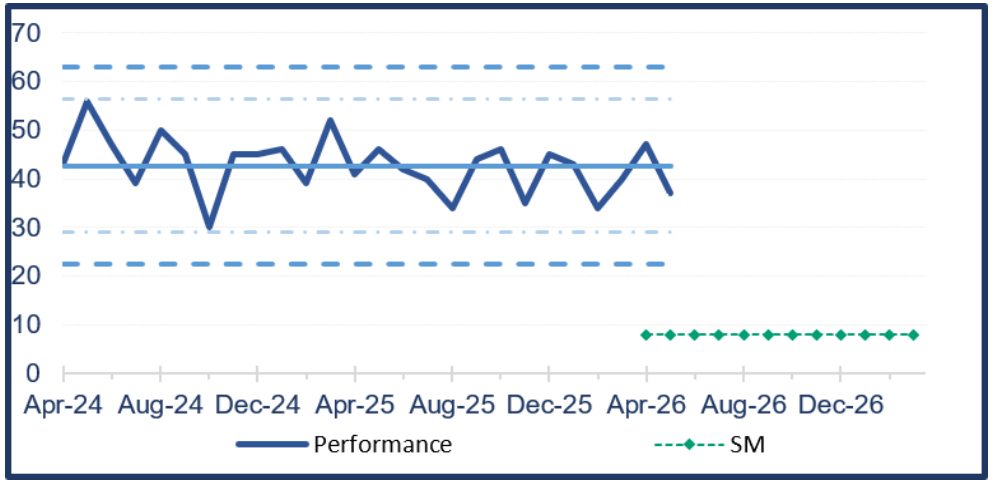


Quality: Infections

Number of hospital onset E-coli infections

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

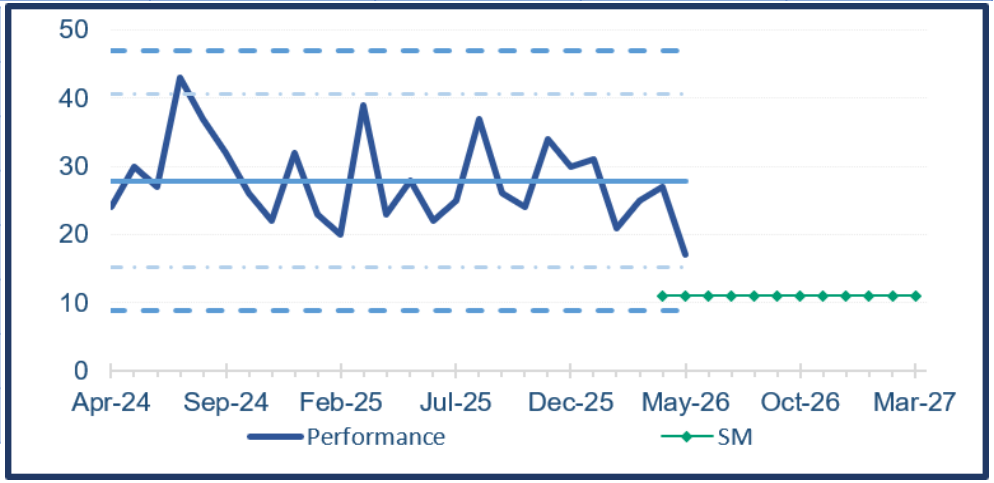
Latest Month
May-26
Profile
N/A
Actual
37
Status
Advise



Number of hospital onset C-Diff infections

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

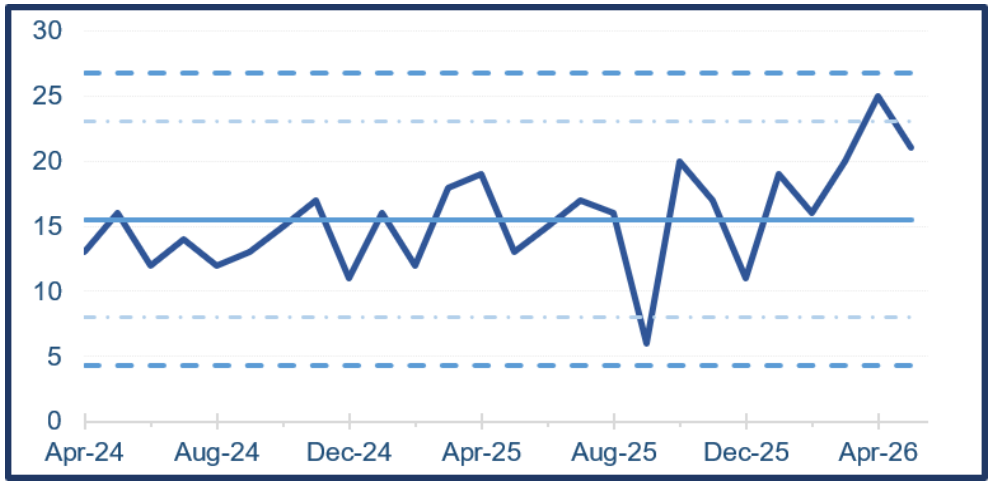
Latest Month
May-26
Profile
N/A
Actual
17
Status
Advise



Number of hospital onset MSSA infections

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

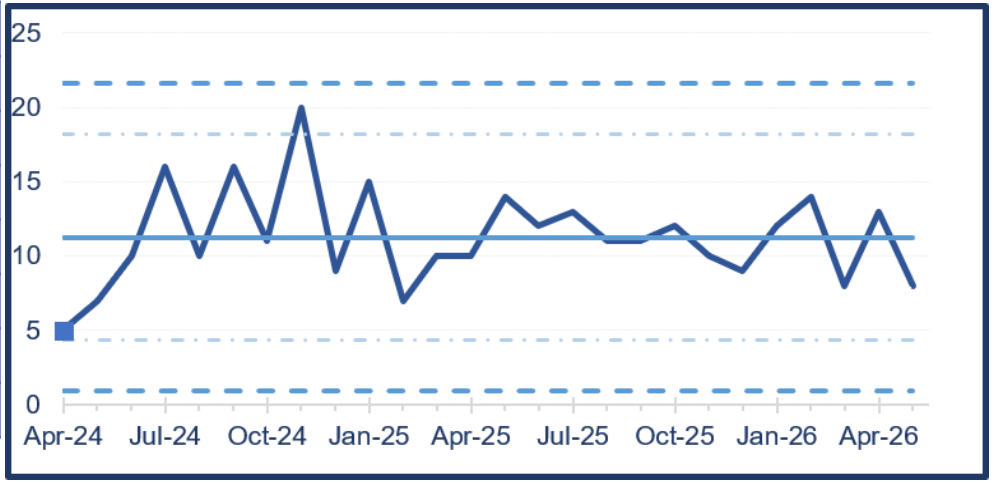
Latest Month
Mar-26
Profile
N/A
Actual
21
Status
Advise



Number of hospital onset Klebsiella infections

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

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

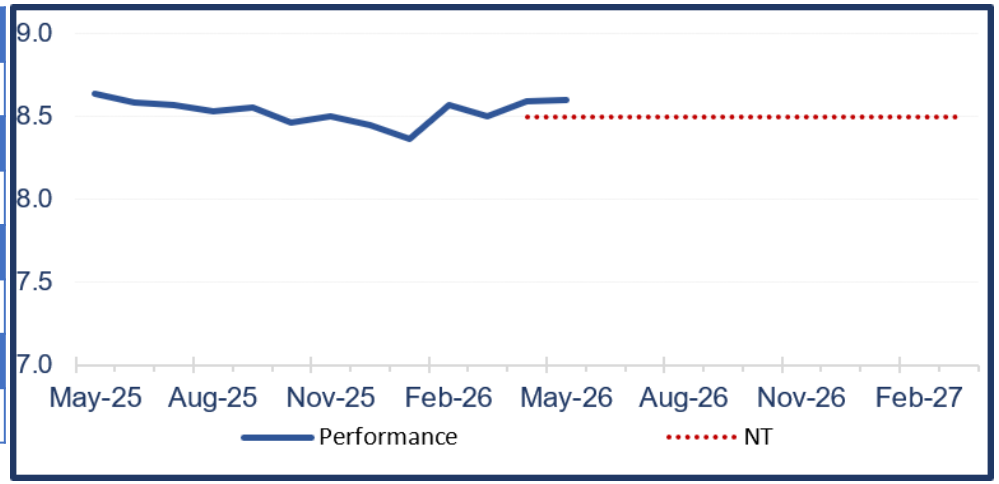


Quality: Patient Experience and Regulation 28 notices

Overall health board patient experience score

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

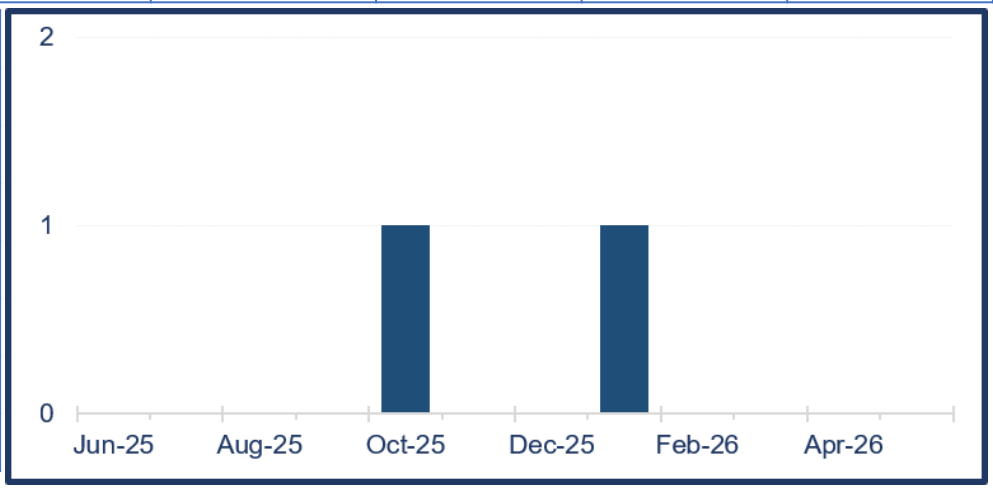
Latest Month
May-26
Profile
Actual
8.6
Status
Advise



Regulation 28 notices (Prevention of Future Deaths reports)

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

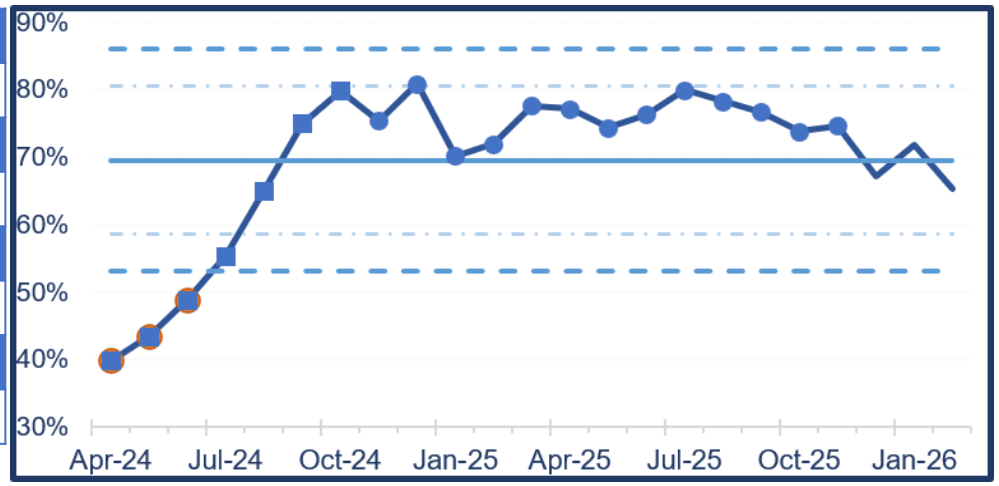
Latest Month
May-26
Profile
Actual
0
Status
Advise



Percentage of complaints closed within 30 days of date received

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

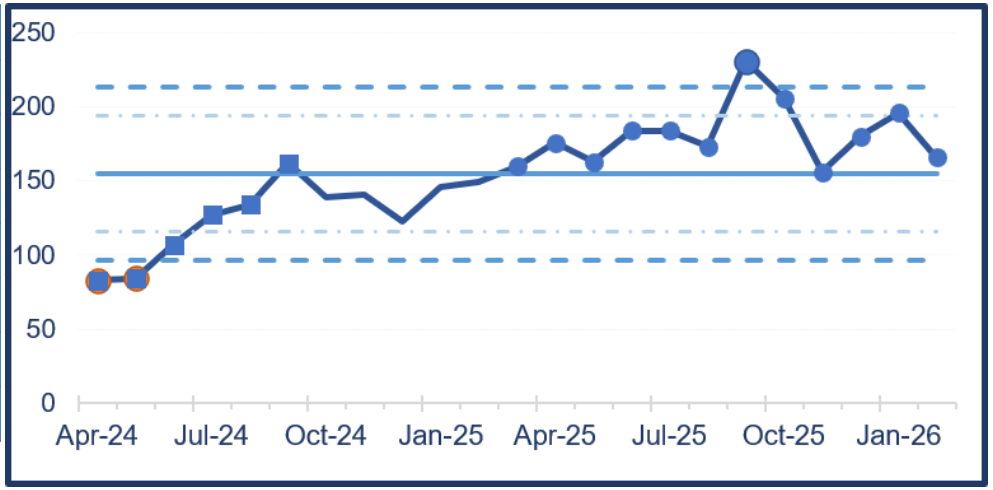
Latest Month
Feb-26
Profile
N/A
Actual
65.4%
Status
Assure



Number of complaints closed within 30 days of date received

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

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

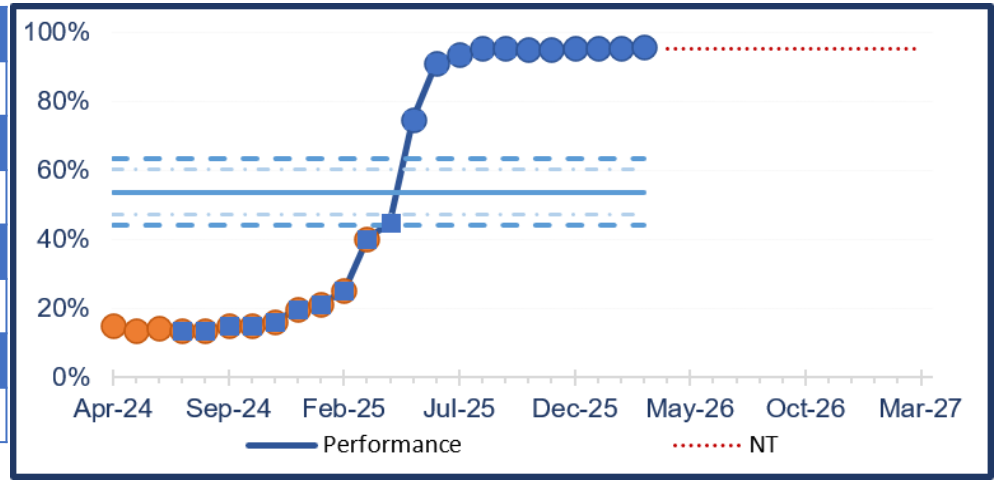


Quality: Clinical Coding

% of episodes clinically coded within one reporting month post episode discharge end date

SM De-Escalation	N/A	Framework	95%	Latest Benchmark	4 of 8

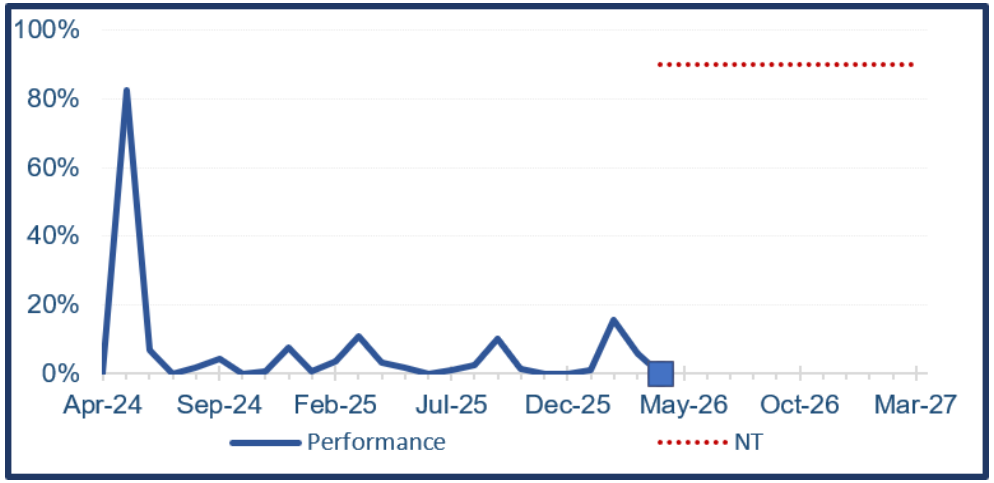
Latest Month
Mar-26
Profile
95%
Actual
95.6%
Status
Assure



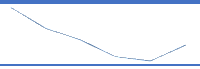
% of all classifications' coding errors corrected by the next monthly reporting submission following identification

SM De-Escalation	N/A	Framework	90%	Latest Benchmark	8 of 8

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



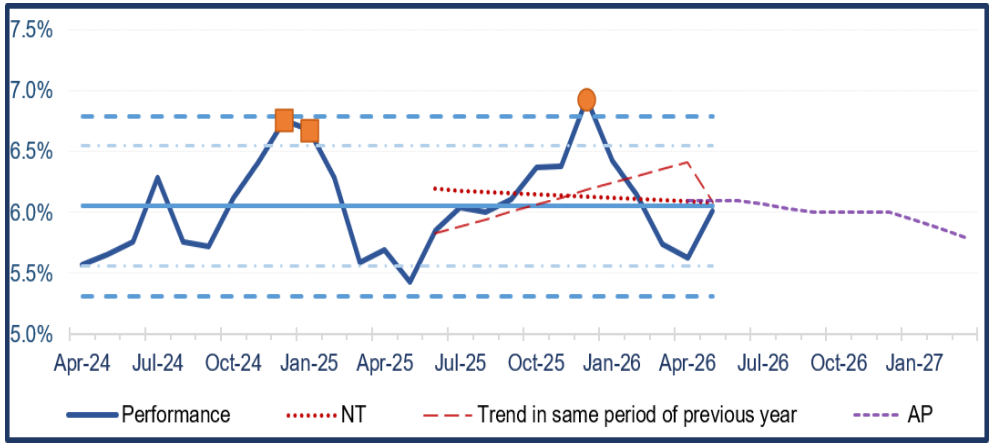
Section 3
People and places

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

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

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

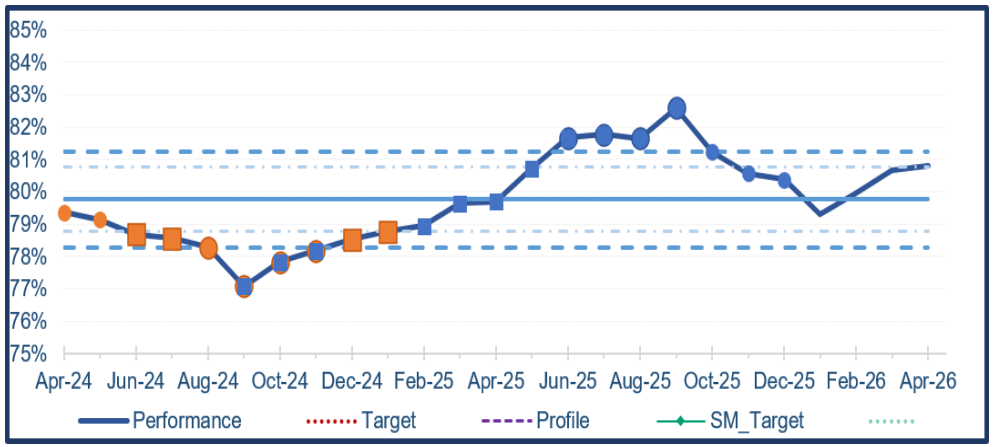
Latest Month	May-26
Profile	6.1%
Actual	6.0%
Status	Alert



Percentage of Performance Appraisal Development Reviews (PADRs) undertaken

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

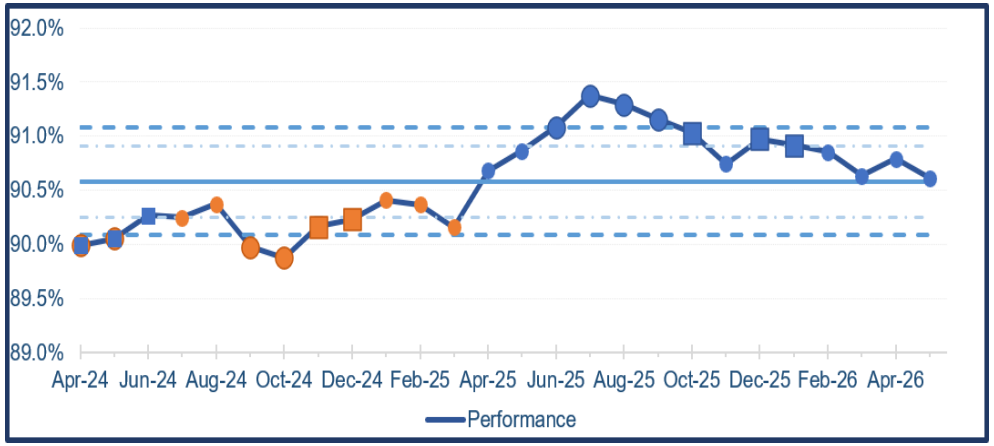
Latest Month	May-26
Profile	N/A
Actual	80.0%
Status	Advise



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

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

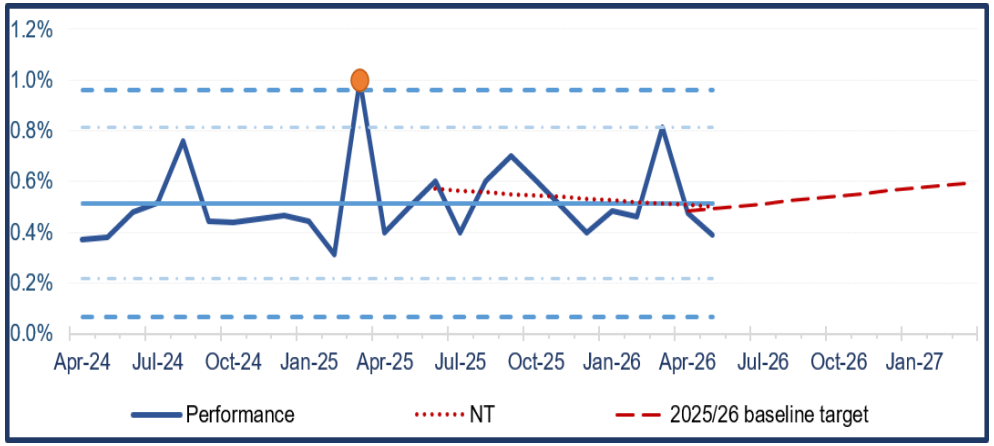
Latest Month	May-26
Profile	N/A
Actual	0.39%
Status	Advise



Turnover Rate of those leaving BCUHB (month by month data)

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

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



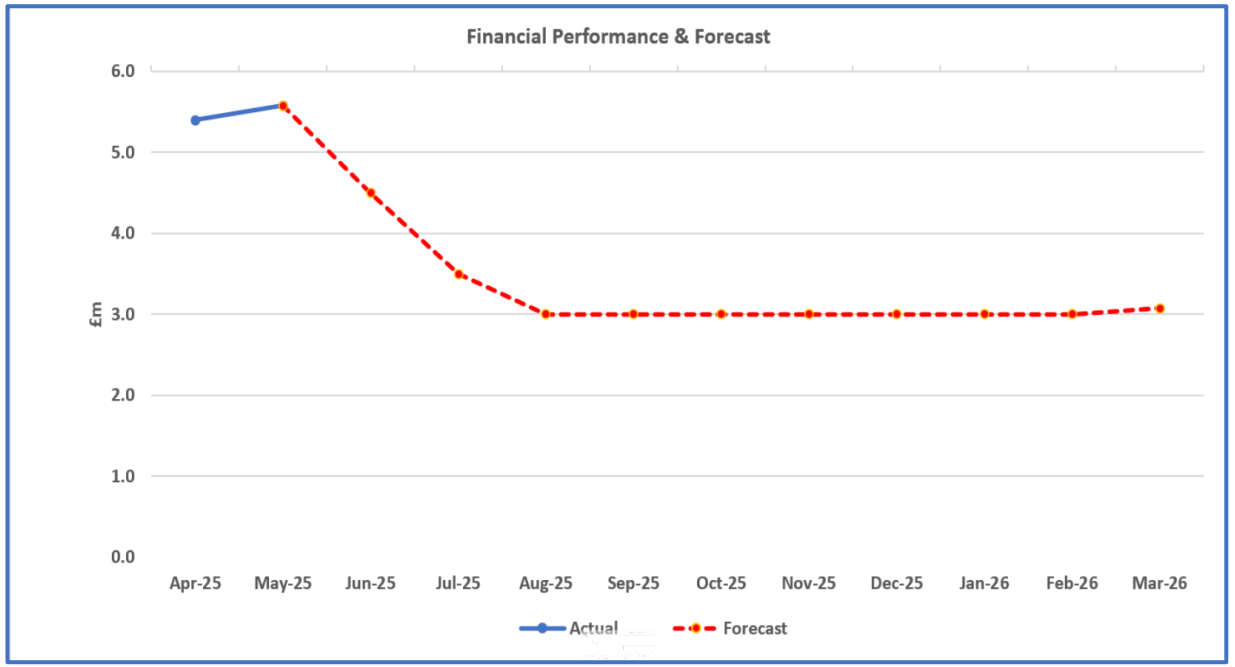
Section 4
Finance and sustainability

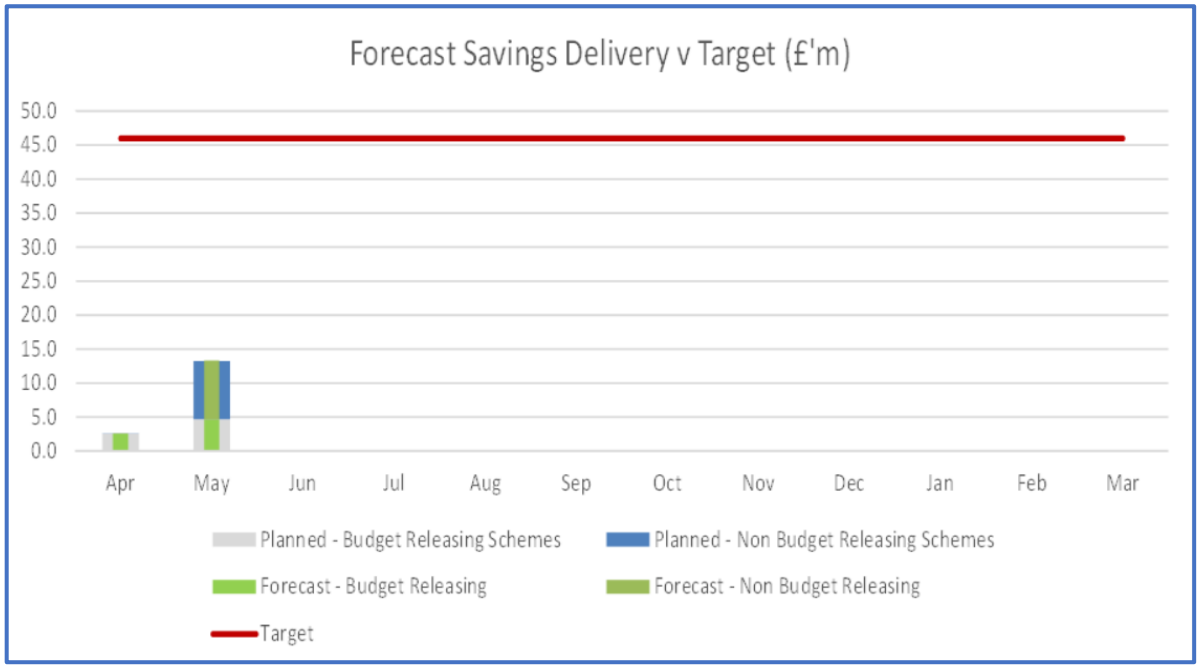
Scorecard: Finance and sustainability

Latest available validated data: May 2026

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

Scorecard: Finance and sustainability





Scorecard: Finance and sustainability

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

Section 5
Population health and prevention

Scorecard: Population health and prevention

Latest available validated data: Quarter 4 2025/26 or May 2025

Population Health

RIA = Reported in Arrears

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

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

Appendices

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

Interpreting Statistical Process Control (SPC) Charts

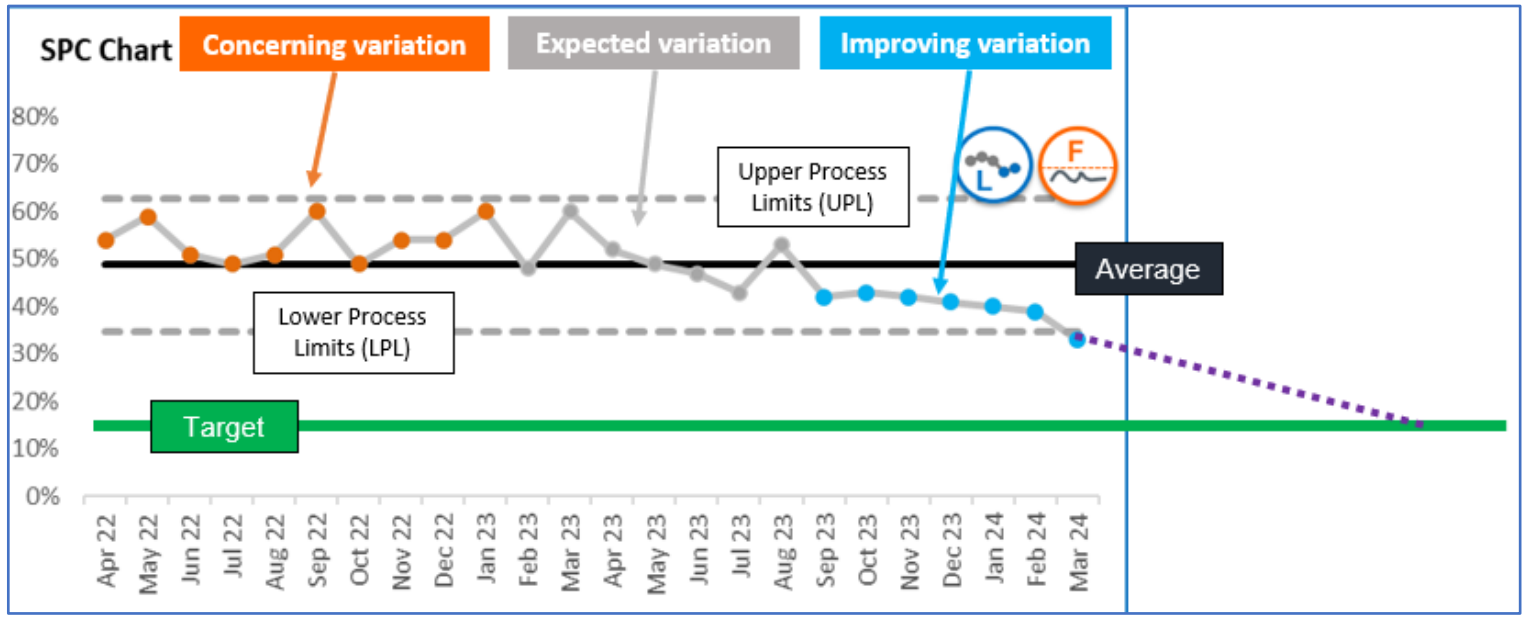
A statistical process control (SPC) chart is a useful tool to help distinguish between signals (which should be reacted to) and noise (which should not as it is occurring randomly).

The following colour convention identifies important patterns evident within the SPC charts in this report.

Orange – there is a concerning pattern of data which needs to be investigated and improvement actions implemented

Blue – there is a pattern of improvement which should be learnt from

Grey – the pattern of variation is to be expected. The key question to be asked is whether the level of variation is acceptable



The dotted lines on SPC charts (upper and lower process limits) describe the range of variation that can be expected.

Process limits are very helpful in understanding whether a target or standard (the **green** line) can be achieved always, never (as in this example) or sometimes.

SPC charts therefore describe not only the type of variation in data, but also provide an indication of the likelihood of achieving target.

Summary icons have been developed to provide an at-a-glance view. These are described on the following page.

Key

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

Action	**Escalate**	Escalate (Serious concerns, action required): There is no confidence that the actions taken in place will address performance issues. Executive level intervention is necessary to resolve the situation.
	Alert	Alert (may require discussion): There is a lack of confidence that any action in place is sufficient to address the issue satisfactorily and/or within the scope of the operational team or executive to resolve. Engagement, action or intervention required.
	Advise	Advise (to monitor): There are areas of concern where assurance has been taken on actions in place but requires close monitoring. An early warning of an emerging and potentially serious concern.
	Assure	Assure (to note): There is confidence that actions are robust and will be sufficient to address the issue or generally operating effectively. Routine monitoring.

How to interpret the Integrated Performance Scorecard

Diagram and description of Scorecard elements

Cyfarwyddiaeth Perfformiad
Performance Directorate

Target Suite:
NT = Natiuonally Mandated Target
SMDT = Special Measures De-escaltion Target
CMT = current Month Trajectory (where we planned to be at this point)

Actual Performance Window
Month: Actual position for previous 3 months to date
Trend to Date: Trend graph for previous 6 months
Variance & Assurance: SPC Indicators

Delivery Assurance:
Based on data, intelligence etc, what is our level of confidence that the stated performance inprovement will be delivered.

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

Measure Reference Numbers
Prefix
NPF = NHS Wales Performance Framework
LMU = Local Measure Urgent & Emergency Care
LMP = Local Measure Planned Care
LMQ = Local Measure Quality, Safety & Experience
LMW = Local Measure Workforce & Organisational Development
LMF = Local Measure Finance
LMPH = Local Measure Preventiuon & Population Health
All other Prefixes are from the Annual Delivery Plan

Full Measure Description

Benchmark of Performance compared to rest of Wales

BCUHB position compared to other Welsh NHS Organisations

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

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

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

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

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

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

Abbreviations

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

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

Additional Information

Integrated Quality and Performance Report
Betsi Cadwaladr University Health Board

Information on our performance can be found online at:

Our website www.bcu.wales.nhs.uk

Stats Wales https://statswales.gov.wales/Catalogue/Health-and-Social-Care

Regular updates on how we improve healthcare services for patients can be found on social media:

follow @bcuhb

http://www.facebook.com/bcuhealthboard

Quality Safety & Experience Committee

CLINICAL SERVICES PLAN PROGRESS REPORT

Dyddiad y Cyfarfod **Date of Meeting**	02 July 2026
Statws Cyhoeddi **Publication Status**	Open/ Public Not Applicable
Enw a theitl Awdur(on) yr Adroddiad **Report Author name and title**	Kamala Williams, Interim Assistant Director of Strategy Sophie Stevens-Jones, Strategy Programme Manager
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol **Lead Executive Team Member name and title**	Paolo Tardivel, Interim Executive Director of Transformation and Strategic Planning

Pwrpas yr Adroddiad **Report Purpose**	For Noting

Crynodeb Gweithredol
Executive Summary

The Clinical Services Plan (CSP) is a key component of the Health Board's strategic framework and will provide the roadmap for delivering safe, sustainable, high-quality healthcare services across North Wales.

The programme is within its mobilisation phase and is focused on establishing the foundations required to support clinically led service transformation. Progress has been made in engaging clinical leaders with a view to developing programme governance and establishing a structured methodology to support future service redesign.

A major clinical engagement event held in May 2026 provided a strong mandate for the programme and enabled clinicians from across the organisation to develop a shared understanding of current challenges, future ambitions, and priorities for service change. Follow-up engagement activity has continued to build momentum and strengthen clinical ownership.

Overall programme delivery is currently rated Amber. Whilst progress remains positive, delivery pace is affected by organisational capacity constraints, competing priorities and the need to embed a consistent methodology across a complex portfolio of service change activity.

The next phase will focus on embedding governance arrangements, finalising programme methodology, confirming priority service areas and progressing structured service assessments to support future service change proposals.

Ymgysylltu (mewnol/allanol) yr ymgymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp) **Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)**		
Pwyllgor / Grŵp / Unigolion **Committee / Group / Individuals**	**Dyddiad** **Date**	**Canlyniad, Tystiolaeth a Data** **Outcome, Evidence and Data**
Strategic Planning and Service Change Group	23 April 2026	Initial progress report considered and programme approach supported.
Clinical leadership event	5 May 2026	Broad clinical engagement undertaken. Consensus achieved regarding programme direction, principles, and future priorities.
Strategic Planning and Service Change Group	4 June 2026	Further progress update received and progress noted
Virtual focus groups	June 2026	Refined thinking of above
Strategic Planning and Service Change Group	24 June 2026	CSP Engagement Output Report approved for onward circulation

Acronymau / Rhestr Termau **Acronyms / Glossary of Terms**	
CSP	Clinical Services Plan

MEWNOSODWCH DEITL YR ADRODDIAD
INSERT REPORT TITLE

1. Y SEFYLLFA / SITUATION

1.1 Development of the Clinical Services Plan continues in line with the Health Board's strategic ambition to improve quality, outcomes, sustainability, and access to services across North Wales.

1.2 The programme is at the stage of completing mobilisation activity to establish programme governance, clinical engagement arrangements, and an emerging methodology to support clinically led service redesign.

1.3 Overall programme status is currently assessed as Amber. This reflects the early stage of programme maturity, the complexity of the transformation agenda, organisational capacity pressures, and the requirement to maintain alignment across multiple strategic programmes.

1.4 Despite these challenges, progress remains on track and there is increasing clinical engagement and organisational support for the programme.

2. Y CEFNDIR / BACKGROUND

2.1 The Clinical Services Plan forms a core component of the Health Board's strategic framework and will provide a coherent long-term approach to service transformation.

2.2 The purpose of the CSP is to:

- Deliver clinically led service redesign.
- Improve quality, safety, patient experience and outcomes.
- Support integrated, whole-system models of care.
- Embed prevention and population health approaches.
- Align long-term strategic ambitions with Integrated Medium Term Plan delivery requirements.
- Provide a credible basis for organisational, regulatory and public assurance regarding future service configuration.

2.3 The CSP is one of the organisation's key priorities and is intended to provide a structured mechanism for translating strategic priorities into sustainable service change.

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

3.1 **Progress to Date**

Significant progress has been achieved during the mobilisation phase, including:

- Delivery of a major clinical engagement event in May 2026 (See Appendix 1)
- Completion of follow-up focus groups and engagement activity.
- Production of the Clinical Services Plan Event Output Report.
- Establishment of clinical leadership as a core principle of programme delivery.
- Development of programme governance arrangements.
- Commencement of stakeholder mapping activities.

3.2 **Programme Development**

Work is progressing to establish a standardised methodology for service assessment and redesign. This methodology is intended to ensure that future service change proposals are evidence based, clinically led, quality focused, and capable of delivering sustainable improvements.

The programme approach will incorporate co-design principles, quality planning methodology, and phased delivery arrangements to ensure consistency and transparency.

3.3 **Next Phase Priorities**

Key priorities for the next three months include:

- Securing approval of the Programme Initiation Document.
- Fully implementing governance, reporting and accountability arrangements.
- Embedding risk management and benefits realisation processes.
- Finalising the CSP methodology.
- Confirming analytical and modelling support requirements.
- Identifying and agreeing Tranche 1 priority service areas.
- Commencing structured service assessments and option development.
- Maintaining clinical engagement and leadership arrangements.
- Strengthening alignment with IMTP development and wider organisational programmes.

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

4.1 **Clinical Engagement and Capacity**

The success of the CSP is dependent upon sustained clinical engagement. Competing operational pressures and workforce capacity constraints may reduce the ability of clinicians to participate fully in service redesign activity.

Mitigation includes maintaining visible clinical leadership, targeted engagement activity, and ensuring participants receive feedback demonstrating how their contributions influence programme outputs.

4.2 **Organisational Capacity and Alignment**

The Health Board is currently managing multiple transformation programmes and competing organisational priorities. There is a risk that fragmentation or duplication may reduce programme pace and effectiveness.

Mitigation includes strengthened governance arrangements, executive oversight, prioritisation of critical deliverables, and closer integration with IMTP development processes.

4.3 **Balancing Pace and Quality**

There is a risk that pressure to deliver rapid progress could compromise the robustness of service assessments and future decision-making.

Mitigation includes implementation of a structured methodology, phased programme delivery, quality management processes, and enhanced analytical support.

4.4 **Forward-Look Decisions**

Future committee and Board consideration will be required regarding:

- Agreement of CSP scope and ambition.
- Confirmation of Tranche 1 priority service areas.
  Endorsement of service redesign methodologies.
- Clinical leadership and programme capacity requirements.
- Alignment across major change programmes.
- Future service change proposals arising from the CSP process.

5. ARGYMHELLION RECOMMENDATIONS

The Committee is asked to:

NOTE the progress made in developing the Clinical Services Plan and outputs from the first phase of engagement activity

COMMENT on the proposed programme priorities and programme direction.

SUPPORT the continued development of the Clinical Services Plan and associated clinical engagement activity.

ENDORSE continued alignment between the Clinical Services Plan, the Integrated Medium Term Plan, and wider organisational transformation programmes.

APPENDIX 1

Shaping the future of sustainable healthcare services in North Wales
Clinical Services Plan Engagement Output Report – Phase One

1. Executive Summary

This report captures the outputs from an organisation-wide clinical engagement event focused on shaping the future of sustainable healthcare services in North Wales as part of the development of Clinical Services Plan for Betsi Cadwaladr University Health Board.

The event brought together clinical leaders to:

- Reflect on past and current experience
- Define what “good” looks like for a sustainable system
- Start to develop the principles that should guide future decisions
- Identify the key barriers and enablers to meaningful change

76 attendees gave their time on the day with a strong, consistent desire of being a patient-centred, collaborative and empowered healthcare system.

Event leads and facilitators welcomed open discussions of current experience which described a sense of frustration and fragility with inconsistent approaches alongside a sense of complex decision-making limiting progress at a local or service levels.

There was a strong call for strengthened trust and improved clinical involvement in shaping services with a sense of desire to improve the experience of people accessing services in North Wales and of those working in them.

There was clear recognition that the system is operating within significant financial and workforce constraints, requiring a more explicit and disciplined approach to prioritisation, with a clear need to ensure quality and safety is always placed first.

While there is broad agreement on what ‘good’ looks like, a recurring theme is the gap between ambition and delivery, with a need to move from high-level vision to practical implementation.

The event was one of the first steps in developing a Clinical Services Plan for North Wales. Further feedback has been sought at a series of follow-up focus groups and feedback will help to shape:

- A collective vision of what a sustainable North Wales system should look like
- A set of design principles

As well as identifying further opportunities and suggestions for improving clinical engagement in the development of the plan and subsequent services.

2. Event background

The event was designed as a structured, interactive workshop combining:

- Facilitated table discussions
- Plenary feedback
- A multi-round “gallery walk” exercise
- Prioritisation and synthesis activities
-

Organisers and facilitators sought honest reflection, active involvement and aimed to provide co-creation opportunities to what is a clinically-led, strategically supported programme.

The event was led by:

- Dr Clara Day, Executive Medical Director
- Paolo Tardivel, Interim Executive Director of Strategic Planning and Transformation
- Kamala Williams, Assistant Director – Health Strategy (Interim)
-

With support and facilitation from:

- Christopher Scrase, Clinical Oncologist
- Jane Moore, Executive Director of Public Health
- Jane Wild, Consultant Clinical Scientist and Head of Adult Audiology
- Liz Mckinney, Designated Education Clinical Lead Officer
- Naomi Holder, Director of Nursing – Central IHC
- Nesta McCluskey, East IHC AHP Director
- Sarah Dyer, Consultant in Respiratory Medicine and Clinical Director, East IHC
- Sarah Kingman, Head of Pharmacy for Primary Care and Community Service, West IHC
- Jim McGuigan, Deputy Executive Medical Director
- Karen Mottart, Integrated Health Community Medical Director, West

The event formed part of the development of the Clinical Services Plan with a focus on bringing people together to shape direction and prioritisation and support a sense of shared ownership for the future of the programme.

3. Learning from experience – at our worst and best

With a view to honestly describe peoples lived reality with no immediate fixing or defending, the activities opened with inviting the participants to describe what we as a Health Board, services and teams within them are like at our worst. Using Mentimeter to capture immediate reflections, feedback was consistent within the room; at our worst, the organisation is experienced not only as slow and fragmented, but as frustrating, exhausting and in danger of being harmful - for both staff and patients.

Some key themes of an organisation operating at its worst included:

- Poor culture, poor behaviours and a lack of psychological safety.
- Decision making that is disconnected from frontline reality.
- Bureaucratic with complex processes negatively impacting service and care delivery.
- Decisions led by financial constraints resulting in harm to care.
- Workforce fatigue impacting morale and engagement.
- Lack of transparency in decision-making processes.
- Unacceptable impacts on patient care – delayed pathways, delays and risk of harm.

Acknowledging concerns that people's current reality may be underrepresented when summarised, there was clear strength of feeling around operational pressures, financial constraints and workforce challenges.

Conversely, when asked to describe what we are like at our best, participants described strong performance emerging when culture, structures and behaviours align around trust, clarity, and shared purpose.

Again, a Mentimeter was used to capture initial thoughts ahead of a more detailed discussion within the room and on tables.

At our best, people described having genuine psychological safety. Individuals feel able to speak truth to power, challenge constructively, and admit uncertainty without fear. This creates an environment where openness, honesty, and learning are normal, and where staff feel respected, valued and proud of the work they do. Leadership is experienced as enabling; setting clear direction and trusting teams to act. Leaders in the room expressed a desire for delegated authority and autonomy within roles.

In summary, from the two angles emerged the themes of values, systems and behaviours; at our best these are aligned, at our worst, they are not.

4. Developing sustainable healthcare in North Wales

Through a “gallery walk” exercise split into key areas participants developed a vision of what a sustainable system would look like in practice, working together to challenge and build on each other’s thinking. Across all groups, there was strong consistency in themes.

Theme	What a Sustainable System Looks Like
People and Communities	Timely, accessible care close to home where appropriate; right care first time through simplified pathways and one-stop models; clear, honest communication and shared decision-making; safe, compassionate, patient-centred care; equitable access and

	outcomes; co-production with patients; single bilingual record; consistent standards with flexibility; strong leadership and community resilience.
Digital and Innovation	Digital as a clinical enabler with a single shared record; improved communication and reduced duplication; self-service tools (booking, triage) and AI to improve efficiency; virtual care and remote monitoring; patient access to data and feedback. Requires inclusive design, workforce support, and mitigation of digital exclusion risks. In a broader sense, embedding research and innovation as a core part of routine care delivery was highlighted as essential to improving outcomes and sustaining high quality services.
Workforce and Everyday Practice	Clear roles and purpose at all levels; psychologically safe, values-based culture; reduced bureaucracy with empowered, accountable teams; strong team identity and resilience; opportunities for learning, leadership and innovation; ability to deliver high-quality care without chronic overload.
Place, Geography and Rurality	Clear strategy for local vs central services; hub-and-spoke models balancing sustainability and access; local autonomy within consistent standards; effective use of virtual and physical infrastructure; outreach and mobile solutions; culturally and linguistically appropriate care; strong understanding of capacity and assets.
Future Models of Care	Clinically led, evidence-based, agile service models; prevention, primary and public health at the core; integrated pathways across sectors; sustainable workforce pipelines; use of data and technology for demand and capacity planning; balance of standardisation and personalisation; patient empowerment and innovation-led future-proofing.
Prevention and Population Health	Prevention embedded as core business; focus on high-impact interventions; realistic expectations of healthcare's role; strong partnerships across sectors to take into account the impact of employment, housing education and social factors; targeted action on inequalities; education and social prescribing; holistic, community-based models supported by sustainable investment.
Clinical Quality and Safety	Safe, timely, person-centred care with seamless pathways; clear communication of risks; consistent delivery of high standards ("getting the basics right"); continuous improvement culture; reliable data and outcomes; well-supported workforce; leadership at all levels; systems designed for safety by default.
Integration and Partnership	Shared system purpose and long-term strategy; genuine multi-agency collaboration; embedded patient and community voice; integrated digital records; reduced duplication through trusted assessor models; coordinated care, pooled resources and effective communication across partners.

There was a strong emphasis on being able to understand and respond to variation in population need across North Wales, as well as future service modelling.
Initial analysis has been carried out to develop the thinking further into the start of a clinical vision for healthcare in North Wales. This is overleaf and will be tested further.

DRAFT FOR FURTHER ENGAGEMENT

"To deliver high-quality, person-centred care that is safe, timely and accessible, ensuring every person in North Wales receives the right care, in the right place, at the right time — with a strong focus on prevention, equity and outcomes."

We will achieve this by:

- **Designing care around people and communities**, with services that are easy to access, close to home where appropriate, and shaped through genuine co-production and shared decision-making.
- **Delivering consistently high standards of clinical quality and safety**, where doing the basics well is the norm, care is evidence-based and seamless, and systems are designed so the "default" is the right thing to do.
- **Shifting from reactive care to prevention and population health**, embedding prevention across pathways, targeting inequalities, and working with partners to improve long-term health.
- **Empowering and valuing our workforce**, creating a culture of trust, psychological safety and clinical leadership, where staff are supported to innovate, improve and deliver compassionate care.
- **Working as one integrated system**, with strong partnerships across health, social care, third sector and communities, sharing responsibility for outcomes and reducing duplication.
- **Using digital and data as enablers of better care**, supporting access, coordination, quality and efficiency, while ensuring inclusion and reducing inequalities.
- **Adapting services to the needs of North Wales**, balancing local access with sustainable specialist care through hub-and-spoke models, innovation and flexible delivery approaches.

5. Key outputs: Designing the principles for sustainable healthcare

When asked the question, "What principles must guide decisions about service change?" conversations largely focused on patient and population outcomes, quality of care and experience, the development of clinical leadership and system collaboration.

"We need to design around real patient pathways, not structures"
"Equity has to mean something in practice"
"We need to listen properly to patients and staff"
"Safety and quality are non-negotiable"
"We need to measure what actually matters, not just activity"
"Value is about outcomes, not just cost"
System working has to be real, not just talked about"
"Boundaries get in the way of good care"
"We need data we can trust and actually use"
"We should expect to test, learn, and adapt — not get everything right first time"
"Prevention has to be real, not just a statement"
"We need to think long-term, even when under pressure"

Based on the discussions and feedback, one of the key outputs are the following design principles which have been developed for further testing. (See next page).

DRAFT FOR FURTHER ENGAGEMENT

Clinical Services Plan Design Principles

1. Improve patient outcomes and experience whilst reducing inequalities

- Care designed around patient need, experience, and outcomes
- Active co-production with patients, carers, and communities
- Reducing inequalities and unwarranted variation
- Clear communication and compassionate care

2. Quality, safety and value

- Safe, high-quality, evidence-based care as a baseline
- Focus on outcomes that matter to patients
- Value-based use of resources
- Reducing waste, duplication, and variation
- Clear prioritisation to deliver fewer priorities well

3. Integrated, whole-system care

- Services designed around whole pathways, not silos
- Joined-up working across organisations and teams
- Care delivered in the right place, at the right time
- Strong MDT and partnership approach

4. Clinically led, evidence-based decision-making

- Decisions led by clinicians with clear accountability
- Use of data, evidence, and population insight
- Transparency in how and why decisions are made and communicated
- Balancing clinical, population, and financial considerations

5. Builds sustainable services through workforce capability, culture and continuous improvement

- Supporting and valuing the workforce; allowing for protected time and capacity for clinical leadership
- Strong, positive, and accountable culture
- Continuous improvement as part of everyday practice
- Encouraging innovation, research, learning, and development

6. Build prevention and earlier intervention into service models wherever possible.

- Shift toward prevention and early intervention
- Focus on long-term outcomes, not just short-term pressures
- Sustainable use of workforce and resources
- Addressing wider determinants of health, including social, economic and environmental factors through partnership working.

6. From ambition to action: barriers and enablers

The group were asked two questions:

1. When we are developing plans for sustainable healthcare services in North Wales, what most often limits meaningful clinical input, involvement and ownership? (Barriers).
2. What small, realistic change would most improve clinical involvement in developing sustainable healthcare services? (Enablers).

Responses to each have been collated and mapped to form the following:

Theme	Barriers	Enablers	Required Shift
Leadership, Authority and Decision Making	Limited delegated authority; centralised or unclear decision-making; slow approvals; disconnect between executive and frontline	Clear delegation and ownership; defined decision frameworks; visible leadership; embedded clinical leadership; aligned accountability	From control and escalation to empowered, trust-based leadership
Culture, Trust and Behaviour	Risk aversion; blame and reputational fear; micromanagement; resistance and change fatigue	Compassionate, values-based leadership; psychological safety; learning culture; trust and autonomy; stopping low-value activity	From fear and compliance to learning and improvement
Capacity, Time and Workforce	Lack of time for change; operational pressures; limited resilience; gaps in leadership and improvement capability, low morale, fatigue and burnout.	Protected time; investment in capability; working at top of licence; resilient teams; clear prioritisation	From adding workload to creating space and reducing inefficiency
Strategy, Priorities and Focus	Competing or unclear priorities; ambition exceeding delivery; shifting goals; weak population planning	Clear shared direction; agreed priorities and trade-offs; focus on fewer priorities; population-based planning; system alignment	From competing priorities to clear, disciplined focus
Finance, Incentives and Value	Short-term financial focus; misaligned targets; historic funding models; finance driving decisions limiting flexibility and causing	Value-based decision-making; alignment of finance with outcomes; incentives for prevention/integration; long-term investment	From cost focus to value and outcomes focus

	priorities based on funds.		
Governance, Processes and Bureaucracy	Complex governance; excessive meetings/reporting; slow approvals; inconsistent processes, lack of transparency in decision-making.	Simplified governance; consistent principles; proportionate assurance; delegated authority; focus on pace and delivery	From process-heavy assurance to enabling governance
Systems, Integration and Digital	Fragmented services; poor pathway integration; weak digital infrastructure; inconsistent use of data	Integrated pathways; strong partnerships; improved digital/data sharing; routine use of data for decisions	From silos to whole-system working
From Ambition to Action	Lack of clear first steps; weak delivery discipline; unclear ownership; loss of momentum	Clear sequencing and early actions; defined ownership; delivery discipline; regular review and learning loops	From ambition to delivery and continuous learning
Service definition and prioritisation	Lack of clarity on core services vs discretionary activity	Clear definition of essential services and priorities	From implicit assumptions to explicit prioritisation.

Across all themes, feedback highlights that improving clinical involvement requires both removing structural barriers and enabling a fundamental shift in leadership, culture and delivery discipline.

Across all conversations, there was strong consensus that improving how clinicians are involved is critical to delivering sustainable change for the healthcare of North Wales.

Emerging priorities:

- Ensuring clinicians are involved at the earliest stages of planning and decision-making.
- Clearer decision-making and reduced bureaucracy
- Simplifying governance and clarifying accountability to enable pace and ownership
- Protected time and support for clinical leadership.

7. Key Insights

The event was an important first step in the development of a Clinical Services Plan for North Wales. Engagement on the day demonstrated a high degree of alignment across clinical leaders on both the challenges facing services and the characteristics of a sustainable future system. A core barrier is not a lack of vision, but a persistent gap between ambition and delivery. Participants consistently articulated a clear understanding of what “good” looks like; however, felt that current organisational complexity, unclear accountability and limited pace of decision-making continue to hinder delivery. As such, the Clinical Services Plan must prioritise how change is implemented, not just what change is required.

There is also a clear need to more explicitly acknowledge the financial and workforce context in which services are being delivered. Participants highlighted that meaningful change must be grounded in the reality of constrained resources, requiring clear prioritisation and being clear about potentially difficult decisions.

A consistent theme throughout all discussions was the critical role of culture and leadership in enabling improvement. Psychological safety, trust and empowered leadership were identified as the conditions under which teams perform at their best. Conversely, blame culture, risk aversion and micromanagement were seen as barriers to progress. This indicates that sustainable transformation depends as much on cultural and behavioural change as on structural redesign.

There is also a clear call to move clinical engagement to genuine co-ownership. While there is strong willingness among clinicians to contribute to service design, frustration exists around previously-felt tokenistic involvement and lack of authority to influence decisions. It is felt that embedding clinical and professional leadership within governance structures, with clear delegated authority, will be essential to unlocking both pace and ownership of change. It is felt that clinicians need protected time to lead service change where necessary as well as being involved from the earliest stages, as well as being directly involved in decision-making.

Complexity across systems, processes and pathways emerged as a constraint on both staff experience and patient care. Fragmentation, duplication and bureaucratic burden were widely reported, often leading to delays and inefficiencies. Simplification of governance, pathways and digital systems was repeatedly raised as enabling staff to focus on delivering high-quality care.

The need for a whole-system approach was another core theme. Organisational boundaries and siloed working were seen as significant barriers to integrated care. Participants highlighted the importance of shared purpose, aligned incentives and genuine partnership working across health, social care and the third sector. The Clinical Services Plan must therefore operate at a system level, with integrated pathways and collective accountability.

Workforce pressures are currently limiting the ability to engage in and sustain change. High operational demand, combined with limited time and capacity for improvement work, means that transformation is often perceived as additional rather than integral. Creating space through prioritisation, reducing low-value activity and investing in leadership and improvement capability will be critical enablers.

Finally, there is strong consensus that the system must shift towards prevention and population health, supported by long-term thinking, partnership working and aligned incentives. There is a concern that there is an imbalance in system focus, with secondary care often felt to dominate organisational attention when there is a need to strengthen the role of primary, community and preventative services in both planning and delivery.

A recurring theme was the need for a more explicit and disciplined approach to prioritisation. Participants consistently highlighted that the organisation cannot deliver everything and must focus on a smaller number of priorities aligned to population need and outcomes.

Overall, there is a strong foundation of shared intent, clarity and engagement to build upon.

8. Next steps

The outputs from this event and the subsequent focus groups will:

- Inform the development of the Clinical Services Plan (CSP)
- Be refined and tested through further engagement
- Shape targeted workstreams and analysis
- Contribute to a shared clinical vision for North Wales.

There has been some uncertainty regarding how the Clinical Services Plan aligns with existing planning frameworks, including the Integrated Medium-Term Plan (IMTP). Greater clarity is required on the role of the CSP as a strategic framework for clinical services and how it will translate into delivery. This will be addressed as well as broader clinical engagement being sought as future forums and opportunities are identified.

By the end of June 2026, a programme structure and approach to governance and delivery must be established that supports clinical engagement in the identification of priority areas of focus; culminating in the production of the Clinical Services Plan.

ASSESSMENT	
Link to Strategic Priorities	
	2. Developing strategy and long-lasting change
	If more than one applies, please list below:
Design Principles	Choose an item. All apply
Corporate Risks and Board Assurance Framework	*N/A*
Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales
	If more than one applies, please list below:

IMPACT ASSESSMENTS		
Equality Act 2010 **Public Sector Equality Duty: Has BCUHB provided evidence of 'Due Regard' to compliance with the three parts of the Public Sector Equality Duty (General Duty):** Public Sector Equality Duty [HTML] | GOV.WALES	Yes: ☐	No: ☒
	Outcome:	Provide details of the findings following the review
	If no, please include rationale:	An impact assessment has not been undertaken as this report is administrative and submitted for information only. It does not propose any changes to services, policy, or resource allocation. Equality and wider impacts will be considered as part of subsequent service design and option

IMPACT ASSESSMENTS		
		appraisal stages within the CSP
Equality Act 2010 - Socio-economic Duty *Has BCUHB provided evidence of 'Due Regard' to compliance of ther Socio-economic Duty when making strategic decisions?*	Yes: ☐	No: ☒
	Outcome:	Provide details of the findings following the review
	If no, please include rationale:	An impact assessment has not been undertaken as this report is administrative and for information only. It does not propose any changes to services, policy, or resource allocation.
Have you completed an Integrated Equality Impact Assessment WP8a? *WP8a Template*	Canlyniad/Outcome: Do/Yes:	Naddo/No:
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale: Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	An impact assessment has not been undertaken as this report is administrative and for information only. It does not propose any changes to services, policy, or resource allocation.
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:	An impact assessment has not been undertaken as this report is administrative and for information only. It does

IMPACT ASSESSMENTS		
		not propose any changes to services, policy, or resource allocation.
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:	An impact assessment has not been undertaken as this report is administrative and for information only. It does not propose any changes to services, policy, or resource allocation.
Quality *Have you undertaken a Quality Impact Assessment Screening?*	**Enablers of Quality** All Apply	**Domains of Quality** All Apply
	If more than one applies, please list below:	If more than one applies, please list below: Quality considerations are embedded within the CSP methodology and will be formally assessed as part of service redesign
	Please list other Enablers of Quality in here	*Please list other Domains of Quality in here*
Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales	
	All apply	
Environmental /Sustainability Impact (5Rs)	No - Not Applicable	
	If more than one applies, please list:	
	If no, please include rationale:	An impact assessment has not been undertaken as this report is administrative and for information only. It does not propose any changes to services, policy, or resource allocation.
Data Protection Impact Assessment	Yes: ☐	No: ☒
	Outcome:	Provide details of the findings following the review

IMPACT ASSESSMENTS		
Have you undertaken a Data Protection Impact Assessment Screening?	If no, please include rationale:	The paper is administrative and informational in nature and does not involve the processing of personal data, or introduce any new data flows or changes that would trigger DPIA requirements.
Counter Fraud Impact Assessment *Have you considered the counter fraud impacts*	Yes: ☐	No: ☒
	Outcome:	Provide details of the findings following the review
	If no, please include rationale:	The paper is administrative and informational in nature and does not propose any changes to financial processes, resource flows or operational arrangements that would warrant consideration of counter fraud implications
Legal	There are no specific legal implications related to the activity outlined in this report.	
	If yes, include further details in here	
Reputational	Yes (Include further detail below)	
	The absence of a CSP presents a significant reputational risk for BCUHB, potentially signalling a lack of clear direction, organisational grip, and a credible long-term approach to delivering safe and sustainable services. This may undermine confidence among Welsh Government, regulators, partners, staff and the public, weaken system relationships, increase scrutiny, and create uncertainty across the workforce at a time when clear progress and robust planning are essential.	
Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	
	If yes, include further details in here	

Quality Safety & Experience Committee

PLANNED CARE REPORT - CANCER SERVICES

Dyddiad y Cyfarfod **Date of Meeting**	02 July 2026
Statws Cyhoeddi **Publication Status**	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad **Report Author name and title**	Caroline Williams, Network Manager, Cancer
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol **Lead Executive Team Member name and title**	Tehmeena Ajmal, Chief Operating Officer

Pwrpas yr Adroddiad **Report Purpose**	For Noting

Crynodeb Gweithredol
Executive Summary

This paper provides an update on planned care with a specific focus on cancer services in north Wales, following on from discussions at the March Health Board meeting.

While there is clear evidence of development and innovation across multiple tumour sites, cancer services as a whole continue to face significant pressures. These are largely driven by workforce shortages, diagnostic capacity constraints, and an ongoing reliance on temporary service models.

Delivery of the emerging Clinical Services Plan, alongside targeted investment in workforce and diagnostic capacity, will be essential to ensure services are resilient, effective, and able to meet increasing demand in the years ahead.

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**
Summary of discussions at Cancer Partnership Board	8th May 2026	

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

CANCER SERVICES REPORT

1. SITUATION

At the March 2026 Health Board it was agreed that the Quality, Safety and Experience Committee would receive an update report on cancer services and report back to a future Board meeting.

This update paper is based on discussions held at the North Wales Cancer Partnership Board meeting in May 2026.

2. BACKGROUND

The North Wales Cancer Partnership Board oversees the strategic development of cancer services in north Wales in line with the Roadmap for Cancer Services 2024-2029, approved by the Health Board's Executive Committee in 2024. The Cancer Partnership Board comprises managerial and clinical leads from across the Health Board, the third sector and patient representatives.

Cancer remains a leading cause of morbidity and mortality worldwide, and is the leading cause of premature death in north Wales. Cancer incidence across Wales has increased by approximately 31% over the past two decades. Cancer incidence is approximately 20% higher in the most deprived areas in Wales compared to the least deprived areas in Wales. North Wales experiences higher incidence rates than the all-Wales average, primarily reflecting the older population profile.

Survival rates have improved over the past two decades but progress has plateaued in recent years. The combined effect of rising incidence and improved survival is a growing population of people living with and beyond cancer, placing sustained pressure on health services across the country.

In 2025, approximately 5,600 people from across north Wales were treated for cancer. Each month, approximately 4,000 people are assessed and found to have no evidence of cancer.

3. SPECIFIC MATTERS FOR CONSIDERATION

While there is clear evidence of development and innovation across multiple tumour sites, cancer services as a whole continue to face significant pressures. These are largely driven by workforce shortages, diagnostic capacity constraints, and an ongoing reliance on temporary service models.

At a strategic level, the Health Board's *Foundations for the Future* programme is reshaping the organisational operating model, with direct implications for the governance and delivery of cancer services. Alongside this, a draft oncology clinical strategy is in development and, together with emerging work on a robotic-assisted surgery strategy, will form a key component of the wider Clinical Services Plan. The focus on robotic surgery reflects the recognition that this approach will become standard practice in the coming years and will be essential for maintaining service quality as well as attracting and retaining a skilled workforce.

Service transformation is also being driven through stronger integration with primary care, supported by targeted education initiatives and improved referral pathways. These developments aim to enable earlier diagnosis and ensure that patients are directed to the most appropriate part of the system in a timely manner.

Operationally, there has been significant progress in improving pathway efficiency. Innovative models, such as nurse-led triage, particularly within colorectal services, and the expansion of self-management follow-up pathways across multiple tumour sites, are being embedded. These approaches are helping to reduce unnecessary outpatient activity, streamline patient flow, and maintain timely access back into services when clinically required. Additionally, the use of Rapid Diagnosis Clinics and teledermoscopy, in skin cancer services, has enhanced diagnostic efficiency, with a significant proportion of patients now discharged or redirected to treatment without the need for traditional outpatient appointments.

Despite these improvements, operational pressures remain significant. Diagnostic capacity continues to represent one of the most critical constraints across the system, particularly within endoscopy services and image-guided biopsy provision. While additional capacity has been introduced, waiting times for key diagnostic tests remain a concern, and demand continues to exceed sustainable levels in several pathways.

Workforce challenges represent the most significant risk to service stability. A number of specialties, including dermatology and gastroenterology, remain heavily reliant on insourced provision and locum staff. Although this has enabled services to be maintained in the short term, it is not a sustainable long-term solution.

In parallel, gaps in clinical leadership present additional challenges. Key roles, including Cancer Advisory Group (CAG) chairs for skin and urology, remain vacant. Although interim arrangements are in place, these gaps reduce the Health Board's ability to drive consistent improvement and maintain strong, coordinated clinical leadership.

Across individual tumour sites, the position remains mixed, with clear areas of good practice alongside ongoing risks.

- Breast services are progressing well with pathway redesign, including the development of a community-based breast pain service to reduce unnecessary referrals, and the introduction of self-management follow-up pathways for low-risk patients. However, the absence of a coordinated management role continues to present a concern.
- Colorectal services have demonstrated improvement through the rollout of a nurse-led triage model, with early evidence showing reduced delays and improved direct access to diagnostic testing. However, these gains are limited by ongoing pressures within endoscopy capacity.
- Gynaecology services are responding proactively to nationally set priorities, with work underway to implement new pathways for post-menopausal bleeding, alongside the adoption of patient-initiated follow-up models.
- Haematology services have focused on improving referral pathways and are piloting the use of the Rapid Diagnosis Clinic model in the East to support earlier diagnosis.
- Head and neck cancer services face a significant gap in allied health professional support, as identified through audit work, which impacts their ability to meet the complex needs of this patient group.
- Lung cancer services are preparing for the introduction of a national screening programme from 2028, which is expected to increase demand further, particularly for diagnostic services such as image-guided biopsy, where capacity is already constrained.
- Skin cancer services have demonstrated innovation through the expansion of teledermoscopy and the introduction of new minor operating facilities at Connah's Quay Medical Centre. These developments have contributed to reduced waiting times and more efficient use of outpatient capacity. However, these improvements remain dependent on temporary workforce solutions, highlighting the need for a more sustainable service model.
- Urology services are progressing through collaboration with external partners, particularly Wirral University Teaching Hospital, to deliver specialist surgery and develop services closer to home. Nevertheless, reliance on external providers, combined with the absence of a CAG chair, continues to highlight underlying fragility within the service.

The Cancer Partnership Board received a detailed update on the specialist prehabilitation service, which is delivering clear and demonstrable improvements in patient outcomes. Evidence shows reductions in post-operative complications, length of stay, and mortality, alongside improvements in patient wellbeing. However, provision remains limited to Wrexham, resulting in issues with access across the region. A hub-and-spoke model is being explored; however, expansion is dependent on securing sustainable funding and improving accessibility, particularly for those patients who are unable to travel.

Communication between primary and secondary care has been identified as a significant system-wide issue affecting both patient safety and experience. The continued reliance on paper-based communication means that GPs are not always informed of diagnoses or treatment plans in a timely manner, resulting in fragmented care. The Cancer Partnership Board felt that this represents a fundamental requirement for safe and effective care and supported a local initiative to improve this issue.

Feedback from the Cancer Patient Forum further highlighted areas of unmet need and variation in patient experience. Key concerns include delays in phlebotomy services, limited access to cancer-specific fatigue services, gaps in menopause support for cancer patients, and insufficient psychological support, particularly in the West. While some mitigating provision exists through third-sector organisations, this is not consistently accessible across north Wales and does not replace the need for specialist services. Work is ongoing to review these gaps and explore options to improve equity, particularly in relation to psychological support.

Performance against the cancer waiting times target (the Suspected Cancer Pathway target) remains below the national target, with BCUHB achieving 54% in March 2026 against the 70% target. The most significant pressures are within breast and skin cancer pathways, where demand continues to exceed available capacity. While national intervention support is in place, sustainable improvement will depend on addressing the underlying workforce and diagnostic challenges.

Performance in national audits is strong, particularly in relation to treatment outcomes, survival, and adherence to clinical guidelines. Notable areas of good practice include lung and bowel cancer services, where key performance indicators are consistently meeting All-Wales benchmarks. However, some pathway-specific issues remain, such as higher emergency presentation rates in ovarian cancer and ongoing concerns regarding access to CT-guided biopsy in lung pathways. This positive position is tempered by ongoing challenges with data quality and reporting systems. The recent introduction of e-forms to replace the national cancer data system has created additional administrative burden, with limitations in system design, integration, and data capture affecting reliability and completeness of submissions. Combined with an increase in audit requirements, this is placing further pressure on cancer services teams.

Finally, updates on screening and prevention highlighted continued progress in population health initiatives, including efforts to improve uptake and reduce inequalities. However, challenges remain, particularly in relation to endoscopy capacity for bowel screening, where performance remains significantly below national standards. Future developments, including the introduction of cervical self-sampling and the planned rollout of lung cancer screening, are expected to increase demand further, requiring careful planning to ensure the system is sufficiently prepared.

While there is a strong foundation for future improvement, cancer services are not yet operating within a stable or sustainable model. Delivery of the emerging Clinical Services Plan, alongside targeted investment in workforce and diagnostic capacity, will be essential to ensure services are resilient, effective, and able to meet increasing demand in the years ahead.

4 KEY RISKS / MATTERS FOR ESCALATION

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

- **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.

- **Workforce Fragility and Unsustainable Models** - Services are heavily reliant on insourcing and locum provision, particularly in dermatology and gastroenterology.

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

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

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

5. RECOMMENDATIONS

The Committee is asked to **SUPPORT** the Cancer Partnership Board in continuing its work programmes to lead improvements within cancer services.

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	Simplify, Standardise, and Adopt Best Practices
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd **Corporate Risks and Board Assurance Framework**	Cancer performance is identified on the Health Board risk register

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:	n/a
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:	n/a
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:	n/a

	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:	n/a
Ansawdd *A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Do/Yes: ☐	Naddo/No: ☐
	Canlyniad/Outcome:	n/a
	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:	n/a
Asesiad o Effaith ar Ddiogelu Data *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?* **Data Protection Impact Assessment** *Have you undertaken a Data Protection Impact Assessment Screening?*	Do/Yes: ☐	Naddo/No: ☐
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	n/a
Asesiad o Effaith ar Atal Twyll *A ydych chi wedi ystyried yr effeithiau ar atal twyll?* **Counter Fraud Impact** *Have you considered the counter fraud impacts*	Do/Yes: ☐	Naddo/No: ☐
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	n/a
Cyfreithiol **Legal**	There are no specific legal implications related to the activity outlined in this report.	
Enw Da **Reputational**	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith ar Adnoddau *(Pobl / Ariannol)* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	As outlined in report	

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Quality Safety & Experience Committee

URGENT & EMERGENCY CARE PROGRAMME UPDATE

Dyddiad y Cyfarfod Date of Meeting	02 July 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Tehmeena Ajmal, Chief Operating Officer

Pwrpas yr Adroddiad Report Purpose	For Assurance

**Crynodeb Gweithredol
Executive Summary**

This report provides the 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 actively managed through daily, weekly and monthly performance grip.

2. Executive Summary

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

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

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

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

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

UEC services across BCUHB remain under significant pressure. This aligns to the Health Board's UEC strategic direction: 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.

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

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

URGENT & EMERGENCY (UEC) CARE UPDATE

1. Y SEFYLLFA / SITUATION

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

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

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

2. Y CEFNDIR / BACKGROUND

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

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

2.3. Trend analysis over time shows:

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

2.4. In the period since the last Board report, the Health Board has been supported by the Intensive Support Team to undertake a series of diagnostics focused on Emergency Department processes and management, site management and flow, and discharge processes. Work continues to establish performance metrics and further required improvements.

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

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

3.1. Quality and Safety

3.1.1. The current operational position within UEC represents a sustained period of elevated clinical risk. There is a clear association between overcrowding, prolonged waits and delayed decision making with increased risk of clinical deterioration, delayed treatment, avoidable harm and poorer outcomes. The Health Board continues to triangulate incident data, patient experience, workforce feedback and performance indicators to understand and mitigate these risks.

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

3.1.3. Key safety risks identified through incident review and operational oversight include:

3.1.3.1. Delayed recognition and treatment of time critical conditions (e.g. sepsis, cardiac events, stroke) associated with prolonged time to assessment
3.1.3.2. Increased risk of patient deterioration in waiting areas and during corridor care, including falls, delirium and unmet fundamental care needs.
3.1.3.3. Reduced ability to maintain privacy, dignity and infection prevention standards in overcrowded environments
3.1.3.4. Increased clinical risk associated with high cognitive load, interruptions and staffing pressures.
3.1.3.5. Risks arising from multiple handovers and unclear clinical ownership during periods of escalation.

3.1.4. Oversight of defined quality metrics is held fortnightly as part of the Executive Integrated Concerns Oversight Panel (EICOP). Each IHC

reports in a structured manner outlining performance, incidents (including defined 'must report' incidents) and complaints. In addition, IHCs report daily forward waiting data, episodes of boarding in extremis, numbers receiving care in undesignated areas, and a now standardised audit of intentional rounding for those in undesignated areas.

3.1.5. A focused set of safety indicators is being tracked weekly to provide early warning of harm, including:
- 3.1.5.1. Incidents of moderate and severe harm originating in UEC pathways
- 3.1.5.2. Cardiac arrest calls within ED and assessment areas
- 3.1.5.3. Unplanned ICE admissions from ED
- 3.1.5.4. Falls and pressure damage in ED and admission areas
- 3.1.5.5. Time to critical interventions (e.g. antibiotics for sepsis

3.1.6. Trends remain under review through EICOP with escalation where thresholds are breached.

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

3.1.8. Incidents within the UEC pathways meeting the criteria for review in EICOP continue to be reviewed at rapid review stage. Learning has included:
- 3.1.8.1. The need for review of falls assessments and management in emergency care
- 3.1.8.2. Prompt review and clarity of ownership by specialist teams
- 3.1.8.3. Provision of access to digital systems for all non-substantive staff
- 3.1.8.4. Learning around chest drain placement and care
- 3.1.8.5. Clear communication with forward waiting patients (patients moved to a ward area pending a planned discharge)

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

3.1.10. An ED business case has been approved to ensure appropriate substantive nursing and middle grade medical staffing is in place in each of the three departments.

Patient Experience

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

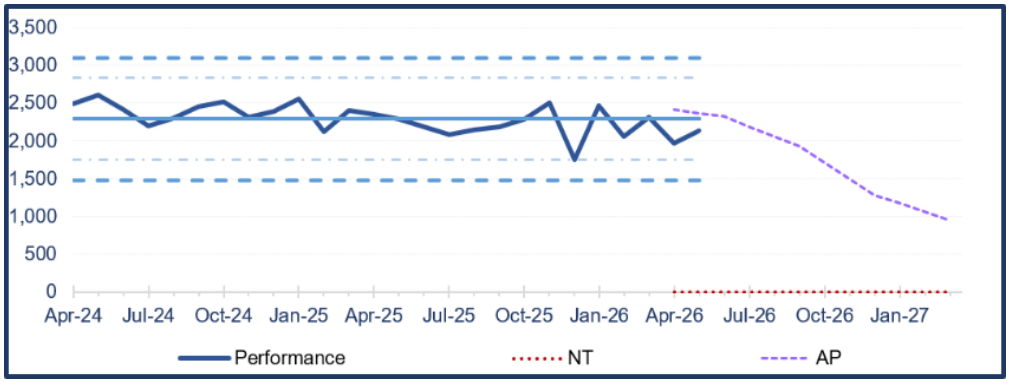
3.2. **Performance**

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

3.3. Number of ambulance patient handovers over 45 minutes

3.3.1. Performance against this metric at the start of the emergency pathway are in line with previous months activity but fall short of national expectations. Performance relating to ambulance handovers exceeding 45 minutes has improved and is ahead of the health board's trajectory, which is positive but remains above the Welsh Government expectation of zero. Prolonged ambulance handovers present a direct patient safety risk, as patients remain in vehicles or handover areas without full access to ED clinical teams, delaying definitive assessment and treatment.

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



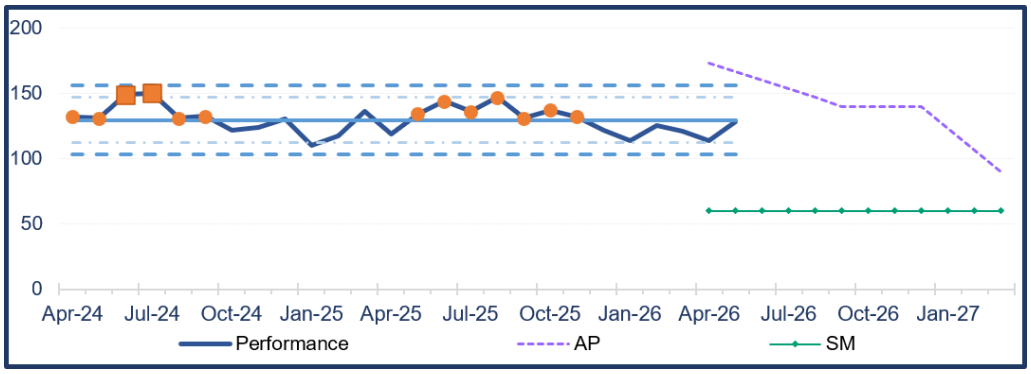
3.4. Median time to assessment by clinical decision maker in less than 60 minutes

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

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

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

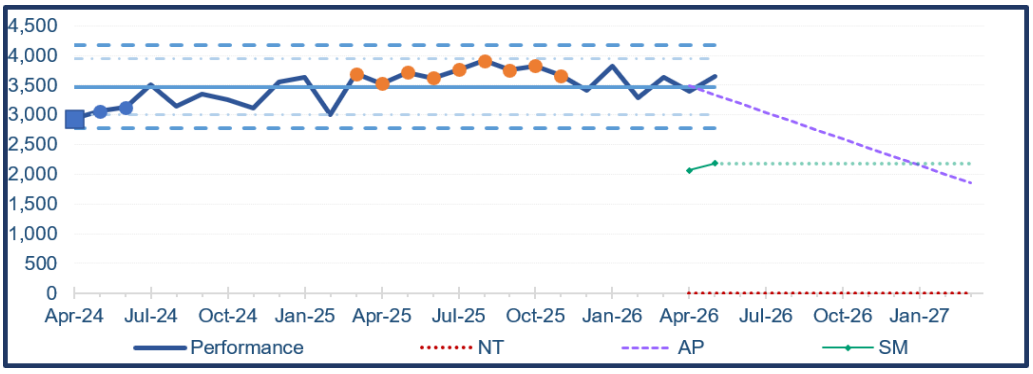
3.4.4. Based on current trend, median time to clinical decision maker is meeting the health board's internal trajectory and should achieve the required level by March 2027.



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

3.5.1. 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

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

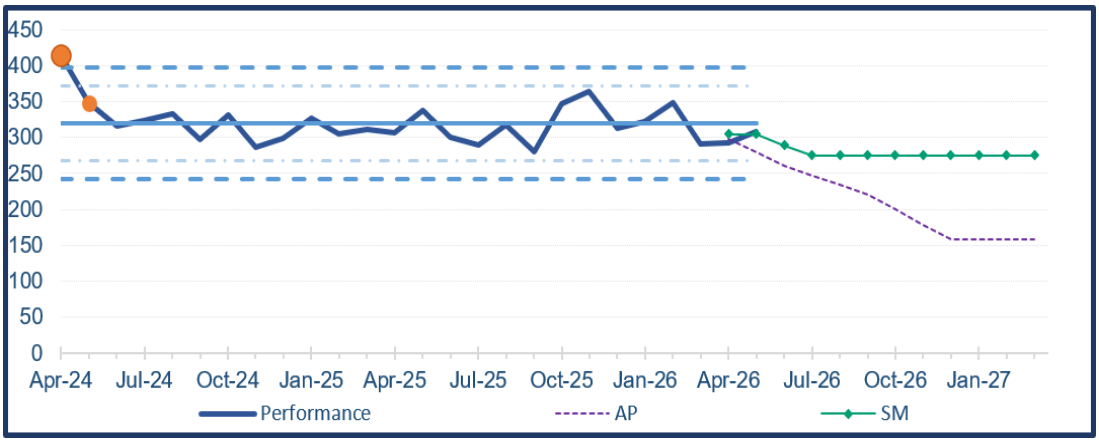


3.6. Pathway of Care Delays (PoCD)

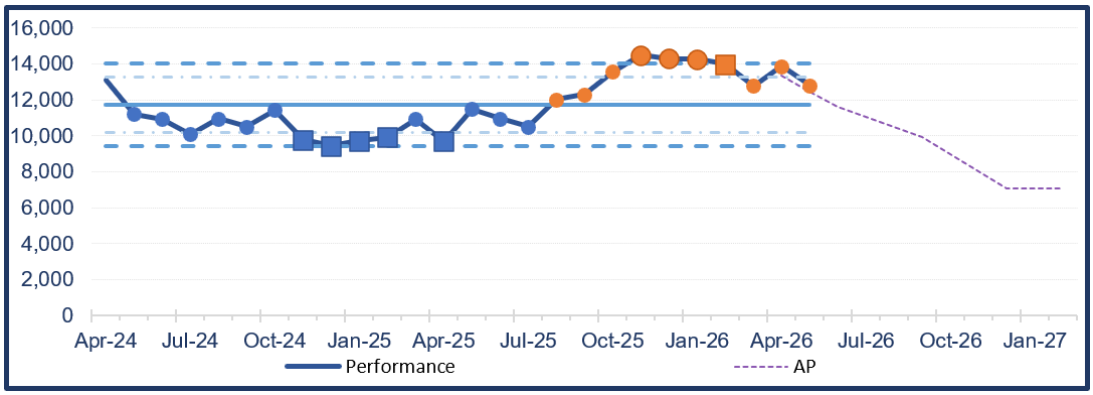
3.6.1. Prolonged inpatient delays increase the risk of deconditioning, hospital acquired infection, falls and loss of independence, particularly in frail cohorts.

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

Number of patients on delays pathways of care



Number of bed days lost to delayed pathways of care



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

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

3.7.1.1. Ambulance handover – maximum 45 minutes (WAST): 68% of patients not handed over within 45 minutes (Mar 2026). Daily handover huddles, HALO/WAST liaison and IHC-level accountability are in place. Improvement trajectory required by Q1 exit.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.7.4.5. New data dashboard to highlight POCD delays, driving joint work with local authorities, utilised as part of the reset fortnight

3.7.4.6. Implementation of criteria-led discharge pathways, including to virtual wards/Hospital at Home and hot clinics

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

3.7.5.1. SDEC and ambulatory pathways remain under-utilised across BCUHB. The following actions are being progressed:

3.7.5.2. Strengthening SDEC First streaming to reduce avoidable ED attendance and exit block

3.7.5.3. Expanding SDEC access to cover medicine, surgery, frailty and gynaecology as a minimum, available at least 12 hours per day, seven days per week

3.7.5.4. Developing the frailty service pathway, with a target of 80% of frailty patients remaining in hospital fewer than eight hours

3.7.5.5. Scaling virtual ward/Hospital at Home capacity to support both step-up and step-down pathways

3.7.5.6. Strengthening the Urgent Community Response service as an integral part of ‘Call Before Convey’ via Single Point of Access (SPoA)

3.8. **Staff Experience**

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

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

3.11. 82.9% of survey respondents agree we are compassionate towards patients/service users. This is a small reduction of 0.41% from 2024 and just beneath the NHS Wales Health Board average of 83.3%

3.12. We are the lowest scoring Health Board in the 'We are all able to speak up' theme at 63.9%. This is a reduction of 1.85% and below the NHS Wales Health Board average of 65.6%

3.13. Our score in the Staff Engagement theme has fallen by 2.88% to 55.9%, compared to an NHS Wales Health Board average of 57.7%

3.14. 2024 saw a 6.7% improvement in our Patient Safety theme score, and this has pretty much held in 2025, with a decline of just 0.47 % to 58.6%. This is just over 1% off the NHS Wales Health Board average. Some responses to questions within the survey connected to this are concerning, including a drop of 2.51% on 2024 and 10.9% below the NHS Wales Health Board average of 55.3%

4. System Risk Position (Quality & Safety)

4.1. 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.

4.2. Risk is 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.

4.3. 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.

5. **90-Day Improvement Plans**

5.1. 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.

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

6.1. 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.

6.2. 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.

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

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

6.5. 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.

6.6. 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.

6.7. 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.

6.8. 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.

7. ARGYMHELLION / RECOMMENDATIONS

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

7.1.1. **NOTE** progress and current quality, safety and risk position within the UEC 90-Day Improvement Planning
7.1.2. **TAKE ASSURANCE** that robust governance and mitigations are in place and align with HIW, GIRFT and Board Assurance expectations
7.1.3. **SUPPORT** continued delivery of the UEC Programme aligned to the IMTP 2026–2029
7.1.4. **ACKNOWLEDGE** the critical role of workforce investment in sustaining improvement and triangulation assurance with incidents, data and experience.
7.1.5. **ENDORSE** ongoing monitoring and review through Board and Committee structure

ASESIAD / ASSESSMENT		
Cysylltiad â'r Bwriadau Strategol **Link to Strategic Intentions**	3. Improve Access, Outcomes and Experience	
	If more than one applies, please list below:	
Yr Egwyddorion Dylunio **Design Principles**	Equity and Accessibility	
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd **Corporate Risks and Board Assurance Framework**	CRR25-01 Timely Access to Care BAF24-07	
ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Equality Act 2010 **Public Sector Equality Duty: Has BCUHB provided evidence of 'Due Regard' to compliance with the three parts of the Public Sector Equality Duty (General Duty):** https://www.gov.wales/public-sector-equality-duty-htmlPublic Sector Equality Duty [HTML] | GOV.WALES	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Equality Act 2010 - Socio-economic Duty *Has BCUHB provided evidence of 'Due Regard' to compliance of ther Socio-economic Duty when making strategic decisions?*	Do/Yes: ☒	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Have you completed an Integrated Equality Impact Assessment WP8a? *WP8a Template*	Canlyniad/Outcome: Do/Yes:	Naddo/No: ☒
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale: Canlynaid/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	

Human Rights Act *Have Human Right based concerns been addressed within WP8a*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
Compliance to the Welsh Language requirements? *Have you undertaken an Impact Assessment*	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Naddo/No: ☒
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Compliance to giving 'Due Regard' to the principles of the Armed Forces Covenant *Have the principles of the Armed Forces Covenant been addressed within WP8a*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Ansawdd *A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Galluogwyr Ansawdd Enablers of Quality Choose an item. Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals	Choose an item.	
Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	

	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Asesiad o Effaith ar Ddiogelu Data *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?* **Data Protection Impact Assessment** *Have you undertaken a Data Protection Impact Assessment Screening?*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Asesiad o Effaith ar Atal Twyll *A ydych chi wedi ystyried yr effeithiau ar atal twyll?* **Counter Fraud Impact** *Have you considered the counter fraud impacts*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Cyfreithiol **Legal**	There are no specific legal implications related to the activity outlined in this report.	
Enw Da **Reputational**	Yes (Include further detail below)	
	There is a reputational risk to the Health Board of lengthy delays and potential harm	
Effaith ar Adnoddau *(Pobl / Ariannol)* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Quality Safety & Experience Committee

MATERNITY SERVICES
QUALITY, OUTCOME AND EXPERIENCE

Dyddiad y Cyfarfod **Date of Meeting**	02 July 2025
Statws Cyhoeddi **Publication Status**	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad **Report Author name and title**	Emma Adamson, Consultant Midwife Karen Roberts, Head of Midwifery
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol **Lead Executive Team Member name and title**	Tehmeena Ajmal – Chief Executive Officer

Pwrpas yr Adroddiad **Report Purpose**	For Noting

Crynodeb Gweithredol / Executive Summary

The NHS Wales Planning Framework (December 2025) sets out Ministerial Delivery Expectations for Women's Services, including the expansion of the Women's Health Hub model by March 2027 and improvements in maternity service quality, specifically reducing perinatal mortality rates. While expectations are clear, there is currently limited detail on defined targets or key performance indicators for measuring improvement in maternity outcomes.

In response, BCUHB Maternity Services has strengthened its approach to performance monitoring and data transparency in line with the Quality Statement. A Perinatal Surveillance Dashboard has been developed, capturing 16 key indicators relating to serious maternal and neonatal outcomes, alongside Datix-reported harm incidents. This provides robust, timely data accessible from floor to Board level.

Additionally, the phased implementation of the BadgerNet Digital Maternity System (from March 2026) is enhancing data quality and enabling improved identification of trends, supporting service improvement and population health assessments.

Progress continues against wider national priorities, including engagement with the All-Wales Perinatal Engagement Plan, alignment with Bliss Baby Charter standards, workforce planning with Health Education and Improvement Wales (HEIW), expanding choice of place of birth, and maintaining bereavement care pathways. However, some areas remain dependent on further national guidance and resource allocation.

A baseline assessment against the National Perinatal Assurance Assessment (NPAA) has identified areas of strength and ongoing improvement, alongside challenges linked to workforce and financial capacity. National work is progressing to support this agenda through the establishment of a National Perinatal Team and Strategic Oversight Board.

The Committee is asked to **NOTE** the progress made to date.

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**	
NPAA	National Perinatal Assurance Assessment
HEIW	Health Education and Improvement Wales
MBRRACE	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries

Improving Quality, Outputs and Experience
Maternity & Neonatal

1. Y SEFYLLFA / SITUATION

1.1 Included within the NHS Wales Planning Framework, issued in December 2025, are a set of Ministerial Delivery Expectations. For Women's Services this includes:

1.1.1 Further expansion of the Women's Health Hub model in each health board area by March 2027 (aligned to the Women's Health Plan)

1.1.2 Improving the quality of our maternity services by reducing peri-natal mortality rates

1.2 Note that there are a number of recommendations made within the Planning Framework to support the expansion of the Women's Health Hub Model, however detail is not provided with regards to expected targets / key performance indicators to monitor improvements in the quality of maternity services.

1.3 However, as per two of the seven Key Actions of the Quality Statement, BCUHB Maternity Services have developed mechanisms of more timely, robust performance data.

1.4 The first of these is via the development of a *Perinatal Surveillance Dashboard*, which in the absence of an agreed national set of standardised metrics, collects a data set as per the example dashboard provided as part of the MatNeo SSP Discovery Phase Report (2023).

1.5 There are 16 items linked to the most serious maternal and neonatal outcomes, and data relating to Datix reportable incidents of harm which are moderate and above, and those which are nationally reportable. This dashboard is accessed via Iris and provides floor to board transparency.

1.6 The following table illustrates the dataset for March 25 – May 2026, noting for some items there is a lag in reporting, which demonstrates the month-on-month performance of Maternity Services. Whilst there are no associated targets for these key performance indicators, each individual instance is subject to an in-depth local review by maternity and neonatal services, to identify immediate safety issues, themes and trends, and opportunities for learning. Those outcomes related to maternal death, stillbirth or neonatal death are also subject to the MBRRACE Perinatal Mortality Reporting Tool, which supports objective, robust and standardised local reviews of care when a baby dies from 22 weeks' gestation onwards.

Perinatal / Maternal Morbidity and Mortality

Metric	5	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Total
Maternal and sphincter injury - 3rd/4th degree tear following Instrumental Delivery		0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →		0
Maternal and sphincter injury - 3rd/4th degree tear following Normal Delivery		0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →		0
Maternal haemorrhage >1500mls		10 ↓	10 →	15 ↑	15 →	21 ↑	20 ↓	12 ↓	21 ↑	9 ↓	12 ↑	19 ↑	10 ↓	17 ↑	14 ↓		274
Maternal readmission within 28 days		8 ↑	4 ↓	4 →	5 ↑	6 ↑	5 ↓	8 ↑	11 ↑	3 ↓	6 ↑	6 →	7 ↑	9 ↑	7 ↓		95
New-born readmission within 28 days		6 ↑	7 ↑	10 ↑	9 ↓	9 →	5 ↓	7 ↑	0 ↓	0 →	1 ↑	7 ↑	4 ↓	4 →	2 ↓		78
Number of HIE cases (maternity)		0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0
Number of maternal deaths		0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →		0
Number of reported 'never events'		0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0
Number of stillbirths 17-23+6 weeks (excluding Termination of Pregnancy)		0 ↓	0 →	0 →	1 ↑	0 ↓	0 →	1 ↑	0 ↓	0 →	0 →	0 →	2 ↑	0 ↓	0 →	0 →	5
Number of women needing ICU (level 3)		0 →	0 →	0 →	0 →	0 →	1 ↑	0 ↓	1 ↑	2 ↑	2 →	1 ↓	0 ↓	0 →	1 ↑	1 →	9
Number of intrapartum stillbirths >24 weeks		0 →	0 →	0 →	0 →	0 →	0 →	1 ↑	0 ↓	1 ↑	0 ↓	0 →	0 →	0 →	1 ↑	0 ↓	3
Number of neonatal deaths (0-6 days)		0 →	1 ↑	0 ↓	1 ↑	0 ↓	1 ↑	1 →	0 ↓	0 →	0 →	0 →	4 ↑	0 ↓	0 →	0 →	9
Number of neonatal deaths (7-28 days)		0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	1 ↑	0 ↓	0 →	0 →	1 ↑	0 ↓	0 →	2
Number of stillbirths >= 24 weeks (excluding Termination of Pregnancy)		2 ↑	1 ↓	1 →	0 ↓	0 →	4 ↑	3 ↓	2 ↓	2 →	2 →	1 ↓	4 ↑	1 ↓	1 →	1 →	33
Total number of perinatal deaths		2 →	1 ↓	1 →	1 →	0 ↓	4 ↑	4 →	2 ↓	2 →	2 →	1 ↓	6 ↑	1 ↓	1 →	1 →	38
Women with existing MH condition		0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →	0 →		0

1.7 The service produces an annual report on the thematic analysis of stillbirths, the findings of which inform the stillbirth action plan. The 2026 analysis of data up to and including 2025 demonstrated an improvement in the stillbirth rate in BCUHB in 2020 and 2021, with a slight increase in 2022. The data for 2023 shows that the stillbirth rate for that year decreased to 2.25 a drop of 1.15 per 1000 live births. In 2024 the rate was 3.04 showing a slight increase (0.79) for that year and for 2025 there was a decrease of 0.37n from 3.04 to 2.67.

1.8 The comparative data for BCUHB relating to 2024 published by MBRRACE in March 2025 is:

All deaths

1. Your stabilised & adjusted stillbirth rate is **2.94 per 1,000 total births**. This is around the average for similar Trusts & Health Boards.
2. Your stabilised & adjusted neonatal mortality rate is **1.20 per 1,000 live births**. This is more than 5% higher than the average for similar Trusts & Health Boards. Your stabilised & adjusted neonatal mortality rate has worsened by two RAG categories since the previous MBRRACE-UK report.
3. Your stabilised & adjusted extended perinatal mortality rate is **4.18 per 1,000 total births**. This is more than 5% higher than the average for similar Trusts & Health Boards.

Excluding deaths due to congenital anomalies

1. Your stabilised & adjusted stillbirth rate excluding deaths due to congenital anomalies is **3.03 per 1,000 total births**. This is more than 5% higher than the average for similar Trusts & Health Boards.
2. Your stabilised & adjusted neonatal mortality rate excluding deaths due to congenital anomalies is **0.72 per 1,000 live births**. This is around the average for similar Trusts & Health Boards.
3. Your stabilised & adjusted extended perinatal mortality rate excluding deaths due to congenital anomalies is **3.66 per 1,000 total births**. This is more than 5% higher than the average for similar Trusts & Health Boards.

1.9 The second element is the implementation of a *Digital Maternity System*, the first phase of which took place in March 2026.

1.10 The adopted system, BadgerNet, once fully implemented, further supports the collection of accurate data to enable timely identification of themes and trends, and areas for improvement, particularly with regards to population health needs assessments.

1.11 Appropriate progress is being made against the remaining actions, as follows:

1.11.1 Working in partnership with NHS Executive to devise an implementation plan to deliver the All-Wales Perinatal Engagement Plan – a local initial baseline assessment against the commitments within the plan was completed and immediate actions identified, whilst awaiting further national steer. A National Implementation Phase working group has been established with an initial meeting taking place on 22nd June

1.11.2 Neonatal care to be delivered in line with Bliss Baby Charter Principles and to work towards accreditation – All BCUHB Neonatal Units actively working towards accreditation

1.11.3 Collaborate with HEIW to prioritise year 1 actions of Perinatal Strategic Workforce Plan – Baseline assessment against HEIW and NHS Performance and Improvement Strategic Workforce plan complete, await national steer

1.11.4 All health boards to ensure choice of place of birth is offered to include all settings, noting this may be in an alternative health board – Draft service specification developed to support women from North Wales to access freestanding midwifery unit in Powys; shared with PTHB for review

1.11.5 Ensure that 4 of the 5 national bereavement pathways are ratified within 1 year – publication of national pathways remains outstanding, however BCUHB Women's Services continue to use the well-embedded Bereavement ICPs. Work also in progress to determine training opportunities to gynaecological nurses supporting women and families who experience early pregnancy loss

1.12 A baseline assessment against the recommendations made within the *National Perinatal Assurance Assessment* (NPAA) was carried out by maternity, neonatal and other stakeholder groups involved in the care of women, babies and families during the perinatal period, to identify areas of good practice, those where improvement work is already in progress and those which require consideration. However, a number of identified actions are limited by workforce and financial capacity, therefore further detail is awaited in terms of potential national resource allocation and priorities for action. The establishment of a National Perinatal Team and a National Strategic Oversight Board is in progress.

2 Y CEFNDIR / BACKGROUND

2.1 In 2025 Welsh Government published the Quality statement for maternity and neonatal services. The statement builds on the 5-year vision for the future of maternity care in Wales (2019) and provides a framework for health boards to support improvement in each unit, focusing on high quality care across Wales.

2.2 Contained within the statement are 33 Quality Attributes, which health boards were required to assess themselves against, aligned to Maternity and Neonatal Safety Support Programme (MatNeo SSP) and consider as part of ongoing improvement plans. There are also 7 Key Actions set by Welsh Government and the NHS Wales Executive, a number of which health boards were expected to deliver by end of March 2026.

2.3 The MatNeo SSP and the quality statement both informed the National NPAA which was conducted by an expert and independent panel across Wales in 2025, following a request from the Cabinet Secretary. The report '*The Path to Safer Beginnings in Wales'* published in February 2026, highlights many strengths in Welsh maternity and neonatal services, but also identified important vulnerabilities in some of the key conditions required for safe and reliable care and a number of recommendations were made to address these vulnerabilities.

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

3.1 Delivery of the priorities outlined above is progressing; however, there remain a number of risks that may impact the pace, consistency, and overall success of implementation. These risks are largely associated with capacity, dependencies on national direction, and the complexity of delivering transformation alongside ongoing service pressures.

Workforce capacity and sustainability

3.2 Delivery of improvement actions and service expansion is constrained by workforce availability, including recruitment, retention, and the ability to release staff for training and transformation activity.

Financial constraints

3.3 Limited financial resources may restrict the pace and scale of implementation, particularly where investment is required to support service redesign, digital maturity, or workforce growth.

Lack of national clarity on performance measure

3.4 The absence of clearly defined national targets and key performance indicators for maternity quality creates a risk of variation in how improvement is measured and evidenced. The Perinatal Surveillance Quality Dashboard implemented locally in March 2026 collects maternal and perinatal metric for the most adverse outcomes, and whilst this can be utilised to compare against outcomes in other health boards / trusts, however in the absence of nationally agreed targets for these KPIs there is limited ability to indicate how effectively the service is achieving objectives.

Dependence on national direction and timelines

3.5 Progress in several areas (e.g. Perinatal Engagement Plan, workforce planning, bereavement pathways) is reliant on further national guidance, which may delay local implementation. In the absence of national directives, BCUHB Maternity Service continue to use strategic recommendations to assess and identify potential actions for local service provision.

Digital system implementation risks

3.6 While BadgerNet offers significant benefits, there are risks associated with system adoption, data quality during transition, staff training, and realisation of anticipated benefits.

Data maturity and consistency

3.7 Although local dashboards have been developed, variation in data definitions and the absence of standardised national metrics may impact benchmarking and assurance.

Ability to deliver service transformation alongside operational pressure

3.8 Ongoing service demand and performance pressures may limit capacity to progress strategic transformation initiatives at pace.

Interdependencies with partner organisation

3.9 Delivery of some actions, such as cross-border pathways and choice of place of birth, relies on collaboration with other health boards, which may introduce delays or complexity.

4 ARGYMHELLION / RECOMMENDATIONS

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

- **NOTE** progress to date
- **NOTE** the associated risks to delivery

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**	Not applicable	
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:	Where applicable a local EqIA screening is carried out for individual programmes of work
	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:	Not applicable

Ansawdd *A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	**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:
		All domains of quality apply to the implementation of a Digital Maternity System The Perinatal Engagement Framework supports the domain of equity
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant **Wellbeing of Future Generations Act – Wellbeing Goals**	A More Equal Wales	
Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	Yes - Reduce	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	The Digital Maternity System supports sustainability by reducing the use of paper documents and the requirement to transport paper notes between locations
Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog: **Armed Forces Covenant Due Regard Duty**	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not applicable

Have you considered the Armed Forces Covenant Due Regard Duty?		
Asesiad o Effaith ar Ddiogelu Data *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?* **Data Protection Impact Assessment** *Have you undertaken a Data Protection Impact Assessment Screening?*	Do/Yes: ☒	Naddo/No: ☐
	Canlyniad/Outcome:	Data Protection Impact Assessment carried out during the planning phase of the digital maternity system implementation
	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:	Not applicable
Cyfreithiol **Legal**	There are no specific legal implications related to the activity outlined in this report.	
Enw Da **Reputational**	Yes (Include further detail below)	
	There may be reputational risk associated with the inability to maintain the activity of Women's Hub	
Effaith ar Adnoddau *(Pobl / Ariannol)* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	A number of the outlined programmes of work are known / expected to require a workforce change, specifically implementation of the actions as a result of the HEIW / NHS P & I Workforce strategies and the Perinatal Engagement Framework. In addition, future development phases of the Digital Maternity System will require financial investment, as per business plan.	

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Quality Safety & Experience Committee

NURSE STAFFING LEVELS - SECTION 25A WARDS

Dyddiad y Cyfarfod Date of Meeting	02 July 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 & Experience Committee on Betsi Cadwaladr University Health Board (BCUHB) progress towards compliance with Section 25A of the Nurse Staffing Levels (Wales) Act 2016. This paper has been prepared in response to the Committee's request for further assurance regarding arrangements for Section 25A areas.

The accompanying Nurse Staffing QSE Presentation demonstrates the outputs of the reviews that BCUHB has undertaken in regard to its responsibilities under Section 25A of the Act.

The responsibility for meeting the requirements of the Act applies to staff at all levels from the ward to the Board, with the Board and Chief Executive Officer being ultimately responsible for ensuring the health boards'/trusts' compliance with the Act.

When exercising their responsibilities, the Board must consider and have due regard to the duty on them under section 25A of the Act to have sufficient nurses to allow the nurses time to care for patients sensitively wherever nursing services are provided.

The paper also highlights risks that limit full assurance, including the sustained reliance on escalation capacity that are often dependant on the availability of the temporary workforce. These issues present ongoing operational, workforce, financial, and regulatory risk, requiring continued Board oversight and timely decision-making.

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 In line with these requirements, for wards pertaining to Section 25B bi-annual nurse staffing calculations are undertaken in spring and autumn using the nationally mandated triangulated methodology.

1.3 The outcome of the Section 25B spring 2026 review was presented to the Committee in May 2026. The committee requested further assurance regarding the processes in place for Section 25A areas.

1.4 This paper summarises work undertaken in relation to Section 25A, supported by the Nurse Staffing QSE Presentation (Appendix 1), and provides an overview of progress to date. While the Committee is not currently able to take full assurance on compliance, it is asked to note the ongoing work and the risks that currently limit full assurance.

2 Y CEFNDIR
BACKGROUND

2.1 Under the Nurse Staffing Levels (Wales) Act 2016, nurse staffing calculations must be approved by a designated person authorised to act on

[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.

behalf of the Chief Executive Officer. In Welsh Health Boards, this role is undertaken by the Executive Director of Nursing.

2.2 The approved calculation establishes the nurse staffing level, expressed as the required establishment to support a planned roster that enables nurses to meet all reasonable patient care requirements.

2.3 All areas providing care to patients are expected to undertake nurse staffing calculations, and whilst these are not legally mandated for areas pertaining to section 25A, 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.

2.4 The Nurse Staffing Levels (Wales) Act: Post-legislative Scrutiny undertaken in 2024 identified the need for clear operational guidance to support the consistent application of section 25A, including the need to ensure a triangulated approach to nurse staffing level calculations. This work is ongoing at a national level under the auspices of the All-Wales Nurse Staffing Programme.

2.5 Whilst national guidance is in development the process to undertake nurse staffing calculations is operationalised in BCUHB through the NU28 - Nurse Staffing Levels Act - Governance and Compliance Policy and the associated NU53 - Calculating and Maintaining Nurse Staffing Levels SOP.

2.6 Nursing workforce and nurse staffing arrangements across BCUHB are monitored in line with NU43 - Nursing & Midwifery Workforce Optimisation Standards SOP which supports ensuring substantive nursing establishments and internal bank are optimised through effective rostering and deployment; and subject to ongoing monitoring and learning.

2.7 Section 25C of the Act describes the triangulated method of calculation that must be used for calculating the nurse staffing levels. The triangulated methodology involves collecting, reviewing and interpreting data relating to:

- Professional Judgement
- Patient Acuity
- Quality Indicators

2.8 During the process of calculating the nurse staffing levels using the triangulated approach there is no pre-determined hierarchy in terms of the evidence with equal weighting given to all the information that informs this process.

2.9 A rolling programme of nurse staffing reviews is in place.

3 MATERION PENODOL I'W HYSTYRIED
SPECIFIC MATTERS FOR CONSIDERATION

3.1 The HCSW Skill Set Assessment process, undertaken in accordance with the NHS Wales Collective Agreement Framework, is currently in progress. Upon completion, the findings will require detailed analysis to determine the implications for future workforce configuration, including the optimal Band 2 / Band 3 skill mix. This will inform subsequent recruitment planning and any associated changes required to ensure a safe and sustainable staffing model.

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

4.1 The risks outlined below each impact the organisation's ability to provide full assurance on statutory compliance, workforce sustainability, and safe care delivery and therefore require continued Board oversight.

4.2 Nurse staffing level calculations across Section 25A wards identified a number of previously known practices that had not been formally addressed, contributing to discrepancies between required and funded establishments. It was also identified that earlier reviews, conducted before the Executive Director of Nursing & Midwifery took post, did not follow a formal process to ensure appropriate budget and roster adjustments to support the delivery of timely, sensitive care. Reviews confirmed a system-wide gap between funded and required establishments, driven by historic inconsistencies in applying the nurse staffing process.

4.3 In summary, the required establishment exceeds the funded establishment, resulting in a system-wide gap. This misalignment between agreed staffing levels and allocated financial resources presents a material and ongoing risk to compliance with the Act.

4.4 From a governance perspective, this issue limits the organisation's ability to provide full assurance to the Board regarding statutory compliance, workforce sustainability, and the delivery of safe and effective care.

4.5 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.

4.6 From a governance perspective, the persistent reliance on unfunded and variably staffed escalation areas presents a material risk to organisational compliance with statutory nurse staffing requirements, quality standards, and financial control. The inability to consistently staff these beds within

approved establishments increases exposure to patient safety incidents, undermines the organisation's ability to provide robust assurance to the Board, and contributes to recurrent financial pressures.

4.7 Until a sustainable approach to managing escalation capacity is established, including clarity on funding, workforce availability, and operational triggers, the Board will continue to carry elevated operational, quality, and regulatory risk.

5 ARGYMHELLION RECOMMENDATIONS

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

- Note the collective risks outlined in the report, including those relating to unfunded escalation capacity and support timely decisions on the associated staffing and budget requirements. These risks should remain visible on the corporate risk register and under strengthened oversight until mitigations are fully implemented.
- Receive the presentation demonstrating the output of the reviews that BCUHB has undertaken in regard to its responsibilities under Section 25A of the Act, while noting the risks and limitations to full assurance as outlined in the report.
- Support the recommendations contained within the presentation including those necessary to address identified staffing, operational, and financial risks.

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**	There are several risks associated with the subject and scope of this paper, including workforce, financial and operational risks related to staffing deficits, unfunded escalation capacity, and the need for timely decisions on nurse staffing establishments.

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** *Have you considered the counter fraud impacts*	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 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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Presentation of the Nurse Staffing Levels: Section 25A Wards

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Introduction / Background

- All patient care areas are expected to undertake nurse staffing calculations, however these are not legally mandated for Section 25A areas.
- Reviews should be undertaken routinely and triggered in response to changes in patient acuity/dependency; service model or delivery; or when concerns are raised.
- The **Post-Legislative Scrutiny (2024)** identified the need for clear operational guidance to support the consistent application of section 25A, including the need to ensure a triangulated approach to nurse staffing level calculations. This work is ongoing at a national level under the auspices of the All Wales Nurse Staffing Programme.
- Whilst national guidance is in development, the processes in BCUHB are governed by:
  - **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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Ward / Department Level

Data Collection & Review

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.

Health Board Wide Multi-site, Service Specific Reviews

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.

Review & Approval by Designated Person

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.

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Section 25A BCUHB Staffing Reviews

BCUHB nursing services which have undertaken/commenced reviews of their nurse staffing levels using the triangulated method of calculation are:

- 24/7 medical & surgical wards who do not pertain to Section 25B of the Act
- Emergency quadrant wards and departments
- Community hospital wards
- Mental Health and Learning Disability wards
- Mental Health Community Mental Health Teams
- District Nursing Teams

Nurse Staffing Levels Summary

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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.

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ED Staffing Requirements

Nurse staffing level reviews by the Executive Director of Nursing & Midwifery supported the September 2025 Emergency Departments (ED) business case. This presented the requirement to revise the current nursing establishment within the 3 ED departments, with the overall FTE requirements summarised in the table below:

IHC	Current Estabished Staffing Ratio (RN: HCA)	Proposed Established Staffing Ratio (RN: HCA)	Current Establishment (FTE)		Recommended Establishment (FTE)		Variance (FTE)	
			RN	HCA	RN	HCA	RN	HCA
West - Ysbyty Gwynedd	10 RN:3 HCA (24/7)	12 RN: 6 HCA (24/7)	54.74	19.03	68.22	34.11	13.48	15.08
Centre - Ysbyty Glan Clwyd	15 RN:5 HCA (Mon - Fri) 15 RN:4 HCA (Sat & Sun)	16 RN: 6 HCA (24/7)	81.66	24.4	87.17	32.69	5.51	8.29
East - Wrexham Maelor Hospital	13 RN:5 HCA (Early) 15 RN: 5 HCA (Late) 12 RN :5 HCA (Night)	15 RN: 7 HCA (Early) 16 RN: 8 HCA (Late) 1 RN: 1 HCA (Twilight) 14 RN: 8 HCA (Night)	77.73	31.49	86.22	45.6	8.49	14.11
Totals			**214.13**	**74.92**	**241.61**	**112.4**	**27.48**	**37.48**

The additional establishment and staffing figures above are inclusive of a 26.9% headroom.

Unfunded / Escalated Beds

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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

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To mitigate identified risks and support progress towards compliance with Section 25A, the committee is asked to support the following:

- Continue to review the impact of nurse staffing levels within the clinical areas, observing workforce and quality metrics.
- Following approval by the Executive Director of Nursing & Midwifery, as the nominated Designated Person, within Section 25A wards and departments:
  - Support the alignment of funded establishments with approved nurse staffing levels, recognising the current system-wide gap between required and funded establishments.
  - Amend planned roster templates within E-Rostering to reflect the approved nurse staffing levels.
  - Enable recruitment of nursing staff in line with approved nurse staffing levels
- Ensure continued Board oversight of nurse staffing risks, including funded establishment gaps and escalation capacity, through the corporate risk register.
- Support the continuation of the rolling programme of nurse staffing reviews across remaining Section 25A services.
- Continue to work with the All Wales Nurse Staffing Programme to support development of national operational guidance for Section 25A.

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Diolch / Thank you

Any questions?

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Quality Safety & Experience Committee

ADOLYGIAD ALLANOL O YMCHWIL, DATBLYGU AC ARLOESI EXTERNAL REVIEW OF RESEARCH, DEVELOPMENT AND INNOVATION

Dyddiad y Cyfarfod Date of Meeting	02 July 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Dr JR McGuigan Deputy Executive Medical Director
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Dr Clara Day Executive Medical Director

Pwrpas yr Adroddiad Report Purpose	For Noting

**Crynodeb Gweithredol
Executive Summary**

This paper provides an update on the commissioning of an external review of Research, Development and Innovation (RDI) at BCUHB.

Following a number of concerns, the Executive Medical Director identified the need for an external review as a planned reinforcement of RDI governance and leadership. The Welsh Government Annual R&D review meeting on 29/04/26 and the Internal Audit advisory review of the Centre for Mental Health and Society (BCU-2526-44) have emphasised this requirement.

The presented scope is drawn from the draft Terms of Reference, which are currently being socialised with external stakeholders prior to finalisation.
On the advice of Health and Care Research Wales (HCRW), the review is likely to utilise the specialist expertise of the UK Research and Development (UKRD) network.

The Executive Committee has approved the commissioning of this review, and this paper is presented to the Quality, Safety and Experience Committee for noting and assurance of the proposed scope and approach.

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 annual R&D review meeting Draft ToR being socialised with key external stakeholders. Executive Committee	29/04/26 18/06/26	Draft Actions issued by Welsh Government (Annex A); Approved

Acronymau / Rhestr Termau **Acronyms / Glossary of Terms**	
BCUHB	Betsi Cadwaladr University Health Board
RDI / RD&I	Research, Development and Innovation
EMD	Executive Medical Director
ToR	Terms of Reference
UKRD	UK Research and Development (network)
HCRW	Health and Care Research Wales
CRF	Clinical Research Facility
NWMS	North Wales Medical School
HRA	Health Research Authority
REC	Research Ethics Committee
CfMHaS	Centre for Mental Health and Society

EXTERNAL REVIEW OF RESEARCH, DEVELOPMENT AND INNOVATION

1. Y SEFYLLFA / SITUATION

1.1 This paper provides an update on the commissioning of an external review of Research, Development and Innovation (RDI) and sets out the agreed scope, assurance arrangements and next steps for noting by the Quality, Safety and Experience Committee.

1.2 Following a number of concerns, the Executive Medical Director had identified the need for an external review of research activity as a planned reinforcement of RDI governance and leadership arrangements. The Welsh Government Annual R&D review meeting on 29/04/26 and the Internal Audit advisory review of the Centre for Mental Health and Society (BCU-2526-44) have emphasised this requirement.

1.3 The scope of the review is set out below and is drawn from the draft Terms of Reference (ToR) developed within the Office of the Medical Director, structured around the national framework 'Research Matters: what excellence looks like in NHS Wales '(HCRW, July 2023). The draft ToR is currently being socialised with external stakeholders, including Bangor University, Welsh Government and the Health and Care Research Wales (HCRW) Support and Delivery Centre, prior to being finalised.

1.4 On the advice of HCRW, the review is likelyto utilise the highly specialist expertise of the UK Research and Development (UKRD) network. Therefore, this review will be sole-sourced by single tender waiver.

1.5 Welsh Government correspondence is appended at Annex A; the National Research Framework for Wales is reproduced at Annex B.

2. Y CEFNDIR / BACKGROUND

2.1 The requirement for an external review was identified by the Executive Medical Director as a planned measure, not a reactive one. It forms part of the wider strengthening of RDI governance now underway, alongside the new governance structure and a proposed associated External Review Steering Group.

2.2 The case for review is reinforced by several converging drivers:

- Welsh Government annual R&D review meeting (29/04/26) and the subsequent actions issued by the Science, Research and Evidence Division (received in draft, awaiting offical letter: Annex A).

- A number of incidents within the RDI function, reinforcing the need for independent assurance of research governance, leadership and delivery.
- Internal Audit advisory review of the Centre for Mental Health and Society (BCU-2526-44), Key Finding 7, recommending a whole-system R&D review to assure compliance with WHC/2023/026.
- Welsh Government concerns regarding commercial research delivery and associated reputational risk, utilisation of national support, and demonstration of research impact (Annex A, Actions 3 and 4).

2.3 The review will assess BCUHB against the national framework Research matters: what excellence looks like in NHS Wales (HCRW, July 2023, Annex B), which defines research excellence across ten pillars and is designed for organisational self-assessment and peer review. Assessing BCUHB against this framework directly meets the Welsh Government expectation (Annex A, Action 1) that the review define what research excellence should look like for the organisation.

2.4 The review will likely utilise the specialist expertise of the UKRD network, a recognised peer network of NHS R&D leaders offering a sector-specific external review methodology, which has been used previously in other Health Boards.

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

3.1 The scope of the review is drawn from the draft ToR and is summarised below.

Domain	Coverage
Governance, leadership & accountability	RDI governance and oversight architecture; accountability and decision rights; the R&D Office; sponsor and research-governance function; risk management; compliance with the UK Policy Framework, HRA and HCRW expectations.
Clinical safety	Research-related clinical safety; incident reporting and management; learning and improvement; safety oversight of sponsored and hosted studies.
Financial performance & sustainability	HCRW core funding; commercial income; grant income; cost recovery; value for money; financial sustainability of the RDI function and its infrastructure.

Commercial activity	Commercial study pipeline; sponsor and contract performance; study set-up and approval timelines; costing, contracting and income recovery; commercial partnerships; the service offer to industry. Immediate commercial-recovery actions are being progressed separately and ahead of the review; the review provides the longer-term commercial research strategy and assurance.
Non-commercial activity	Non-commercial, grant and own-account research; portfolio balance and performance; recruitment; equity of access for the North Wales population.
Research impact & value for money	How research impact and benefit to the North Wales population are defined, measured, evidenced and reported — outputs, outcomes, benefit realisation and value for money; reflecting Key Findings 6 and 7 of the CfMHaS advisory review (BCU-2526-44).
Research pipeline & infrastructure	The Clinical Research Facility (CRF) and MAUMSS; capacity, utilisation, staffing and infrastructure; how each interlocks with the core R&D function; duplication/gaps; conversion of feasibility/basic-science activity into adopted clinical studies.
Workforce & academic partnership	Research workforce, including research team and support services; protected time; clinical academic posts; the NWMS/Bangor and Wrexham University interfaces.
Innovation (research-adjacent)	Innovation arising from BCUHB/partner research activity (IP, spin-out, commercial development from study findings) and its boundary with digital, transformation and QI programmes.
Public involvement, communications & engagement	Public involvement and participation in the design and delivery of research, including the UK Standards for Public Involvement, budget and recognition for public contributors, and inclusive representation across the North Wales population; communications and engagement to raise the profile of research among staff and the public, adoption of the national HCRW approach, engagement with under-represented communities, and representation on the HCRW Public Involvement and Communications Alliances.

Centre for Mental Health and Society (CfMHaS)	The matters raised within the CfMHas advisory review (BCU-2526-44) which will be published in due course, will be considered as part of the wider review of Research and Development arrangements, including compliance, partnership working, value for money, and alignment with the Health Board's overall R&D governance framework.

3.2 The review will not address:

- Decisions on individual research applications, sponsorship of individual studies, or research ethics approvals — these remain with the R&D Office, sponsor function and external REC architecture;
- Quality improvement and clinical audit activity that does not meet the UK Policy Framework definition of research;
- Operational delivery of individual studies, which remains with Chief and Principal Investigators and the R&D Office;
- Matters reserved to other Board Committees (remuneration, audit opinion, statutory Caldicott decision-making);
- Re-performance of the Internal Audit advisory review (BCU-2526-44) — this review takes those findings as a defined input, not as a subject for re-audit.

3.3 Assurance on the commissioning, conduct and findings of the review will route from the External Review Steering Group, through the Executive Medical Director, to the Quality, Safety and Experience Committee.

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

4.1 The principal risk of not proceeding is that BCUHB fails to provide the independent assurance now expected by Welsh Government and Internal Audit, with consequent reputational and regulatory risk to the Health Board's research standing.

4.2 Welsh Government has set timescales of 30/06/26 and 31/07/26 for related actions (Annex A). Delay in commissioning risks BCUHB being unable to demonstrate the agreed engagement and oversight approach within those timescales.

4.3 The incidents within the RDI function have heightened the need for timely independent assurance. Commissioning the review is the proportionate mitigation, consistent with the Health Board's position under Special Measures.

4.4 The cost of the review will be met from the RD&I budget.

5. ARGYMHELLION

RECOMMENDATIONS

5.1 It is recommended that the Committee:

- **notes** that an external review of Research, Development and Innovation (RDI) has been commissioned as a planned reinforcement of governance and leadership arrangements;
- **notes** the proposed scope of the review as set out in the draft Terms of Reference, which are currently being finalised following engagement with key stakeholders;
- **notes** the assurance arrangements through which progress, conduct and findings of the review will be reported to the Committee.

ANNEX A – WELSH GOVERNMENT CORRESPONDENCE

The following email was received from the Science, Research and Evidence Division, Welsh Government, following the annual R&D review meeting of 29/04/26, it is expected to form the official letter following the review. It is reproduced in full for the record:

> Dear colleagues,
>
> Sent on behalf of Gareth Cross, Deputy Director of Science, Research and Evidence Division, Welsh Government.
>
> Thank you for a productive meeting on 29th April. As discussed, we have prepared some actions, and we would be grateful if you can review over the next two weeks and indicate you are content before we issue a formal letter.
>
> 1. We recognise that plans are in place to commission an external review to strengthen governance and leadership arrangements within BCUHB. This review is expected to define what excellence in research, development and innovation should look like for the organisation. We noted that its findings should directly inform the development of the next BCUHB RD&I Strategic Plan and the accompanying Implementation Plan.
>
>   We recommend that a formal engagement approach with Welsh Government and the Health and Care Research Wales Support and Delivery Centre is agreed, that includes oversight of review plans as they develop, including the agreed priorities, key deliverables, milestones, and timescales, to support oversight and alignment. We expect this work to be completed by 31 July 2026.
>
> 2. We welcome the actions being taken to strengthen governance arrangements within BCUHB, including clearer leadership, accountability, and escalation processes.
>
>   We suggest formal quarterly reviews on the new governance structure be undertaken that will assess effectiveness of the structure and impact on research delivery and oversight. In addition, any risks, issues or required adjustments to the structure will be reviewed to ensure they are operating as intended. A format of the review will be agreed in due course, and an initial meeting will be organised during September 2026.
>
> 3. As discussed at the meeting, we have significant concerns regarding the delivery of commercial research and the associated reputational risk for BCUHB. We therefore ask that BCUHB takes stock of its current approach to the delivery of commercial studies, to ensure quality and performance is prioritised and that the service offered to industry is of a consistently high standard.

We would like to see the development of a commercial research recovery plan that sets out: (a) the key issues affecting commercial research delivery; (b) the actions being taken to address these issues; and (c) a clear and articulated summary of BCUHB's service offer to industry aligned to the Health and Care Research Wales offer. This work should be developed in close collaboration with the Health and Care Research Wales Support and Delivery Centre and demonstrate how reliability and consistency will be improved ahead of any future growth. We expect this work to be completed by 31 July 2026.

4. We discussed the national support available through the Health and Care Research Wales Support and Delivery Centre and noted some uncertainty as to whether BCUHB is fully maximising the support on offer.

   We would like BCUHB to provide a clear overview of the support currently being accessed, and an assessment of where additional or different support is required. We expect this to be completed by the end of 30 June 2026. In parallel, we will ask the Health and Care Research Wales Support and Delivery Centre to meet with you to systematically identify any gaps, reduce duplication and ensure that the full breadth of national support is being actively and effectively utilised to strengthen delivery and performance.

5. We noted that Welsh Government will undertake a critical friend role as new developments progress. We encourage proactive and timely engagement with us at key stages, where our input can add value, provide challenge and support effective decision making.

Thanks, Claire

Claire Bond, Science, Research and Evidence (Gwyddoniaeth, Ymchwil a Thystiolaeth), Welsh Government (Llywodraeth Cymru).

ANNEX B – NATIONAL FRAMEWORK: RESEARCH MATTERS (HCRW, JULY 2023)

The Health and Care Research Wales national framework Research matters: what excellence looks like in NHS Wales (July 2023) is reproduced in full on the following pages. The framework sets out the ten pillars and six cross-cutting themes against which the scope of this review (Section 3) is structured and against which BCUHB will be assessed.

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

Ariennir gan Lywodraeth Cymru
Funded by Welsh Government

Research matters
What excellence looks like in NHS Wales

Background

Improving health and care services in Wales using evidence-based approaches is fundamental to improving the quality of care and putting the public at the heart of everything. It is widely known that research makes a real difference to improving health outcomes and to the lives of patients and people in our communities. Health and care research and innovation are critical to the delivery and development of the NHS and NHS organisations in Wales, who have a critical role to play to support research.

Research in the NHS is funded through a variety of sources. A key funder is Health and Care Research Wales – which is funded by Welsh Government (WG) to coordinate and facilitate health and social care research across Wales and provide resources to stimulate and support research. Health and Care Research Wales includes both policy (Research & Development Division, Welsh Government) and the various parts of the Health and Care Research Wales funded infrastructure which include research centres and units, faculty, Wales evidence centre, the support and delivery centre and NHS R&D.

The NHS also attracts research funding from a wide variety of sources including non-commercial funders through research grant income from government departments, research councils and charities, as well as commercial income for research from industry partners. These various funding streams work together to strengthen the NHS' capacity and capability. In addition, the NHS supports research through the provision of resources such as accommodation and facilities, as well as providing support for the day-to-day activities of NHS staff who support the research specialists on the ground.

This document has been developed through a co-creation process with key stakeholders facilitated by Health and Care Research Wales. It outlines what 'research excellence looks like' within NHS organisations in Wales where research is embraced, integrated into services, and is a core part of the organisation's culture.

To drive excellence, NHS organisations should have a positive culture of continuous improvement through research. This aligns with the *Duty of Quality* which came into force in April 2023 as part of the Health and Social Care Act 2020.

Research capacity and capability will differ between organisations and this document has been created to be relevant to all NHS organisations in Wales. There are seven local health boards and three NHS trusts which make up the NHS in Wales, as well as two special health authorities and a shared services partnership; and all these organisations support research.

As the NHS is part of a wider ecosystem, it is vital that Health and Care Research Wales and NHS organisations build on existing activities and work together across the features outlined in this document to support the NHS to strengthen its research and development (R&D) function. This is particularly important now to ensure that research plays its crucial role in supporting the NHS to evolve and adapt to future demands.

Why should research matter to the Welsh population and to the NHS?

Research provides the opportunity for patients and service users to access new treatments and services, that will improve their health and well-being and contribute to reducing health inequalities in the general population.
NHS organisations that are actively involved in research see improved health outcomes and lower mortality rates, not just for those patients participating in research, but for everyone.
Research creates evidence-based services, provides evidence for NHS standards and helps organisations to find new and better ways of delivering health and social care, including better health economic outcomes.
Research provides opportunities for staff development and enhanced job roles which helps with recruitment and retention, as well as developing leaders and critical thinkers.
Research leads to economic benefits by attracting non-commercial funding and commercial income that can build the research capacity of frontline and other support services, as well as providing access to novel treatments and technologies received for free.
Research is an essential pillar of securing and maintaining University (Health Board) status and a key enabler for NHS Wales to deliver '*A Healthier Wales.*'

Who is this document for?

Research is a fundamental component of everyday health and care and is critical to the development of all aspects of NHS Wales. This document is therefore relevant to all those involved in the design, management, and delivery of healthcare in the Welsh NHS including the NHS boards and all executives, those with responsibility for strategy development, clinical leads, professional leads, heads of services, operational managers as well as dedicated research staff such as R&D Directors and leads, research managers and the research workforce.

This framework is also relevant to the public as recipients of health and care services from NHS Wales.

It is also relevant for key stakeholders working in partnership with NHS Wales who have aligned vision for research and joint R&D strategies as part of the whole ecosystem which enables health and care research through collaborative effort. This includes but is not limited to government departments, higher education providers, research agencies and funders, third sector organisations, public sector organisations, life science companies and their representative bodies.

What research does it cover?

This document covers health research across all specialties and sectors which is within the responsibility of NHS Wales as part of the whole ecosystem, including but not limited to:

- primary care, secondary care, public health, community services, health research in social care settings and integrated care;
- commercial and non-commercial research, including clinical trials, observational studies, discovery science and experimental medicine, public health, translational and applied research; and
- research to support policy making, academic research in clinical areas and research into NHS services and care pathways.

How should this document be used?

- To provide guidelines on the core content of NHS R&D and/or R&D and innovation strategies and implementation plans.
- To provide a framework for organisational self-assessment and peer review to establish the maturity of an organisation in respect of its arrangements and approach to supporting high quality and impactful research.
- To support better alignment between the national and local infrastructure for R&D, including identifying ‘once for Wales’ opportunities in the context of the national strategy, and/or sharing local good practice.
- To support broader strategic discussions between the Research and Development Division (RDD), Welsh Government (WG) and NHS organisations at performance meetings.
- To provide one document that can be used consistently across a range of national guidance and activities to simplify reporting processes for example the NHS planning framework (and associated workplans such as Integrated Medium-Term Plan- IMTPs), Welsh Health Circulars publication, and the NHS Executive.

- To provide the basis for a work programme to achieve the ambitions within this document, taking a partnership approach with Health and Care Research Wales and NHS organisations working collaboratively.

Features of a research supportive NHS organisation

The features of a research supportive NHS organisation have been organised under ten pillars, which are summarised in Diagram 1. Supportive NHS organisations will work to embrace every pillar and the features they contain together, as they all play an important part in ensuring that research is integrated into services and is contributing to the whole system, thereby achieving excellence.

Diagram 1:
The ten pillars outlining the features of a research supportive NHS organisation

There are also several cross-cutting themes which underpin the ten pillars which include the statutory requirements to be addressed and considered when developing policy and implementation plans. These cross-cutting themes are highlighted in diagram 2 where those most relevant to the research agenda have been identified.

The Duty of Quality is a recent addition and reinforces the importance for research supportive organisations to adopt a system-wide way of working to provide safe, effective, person-centred, timely, efficient, and equitable health care in the context of a learning culture.

Diagram 2:
Cross-cutting themes which underpin the ten pillars of a research supportive NHS organisation

Each of the ten pillars is detailed below, along with the features of a research supportive NHS organisation.

1. Strategy:

Supportive organisations:

1.1. Have clear vision for research and ambitious R&D strategies, with aligned implementation plans and continuous progress monitoring. Strategies will:
- be coproduced with the public and key stakeholders to ensure they are patient/ public centred;
- outline a clear vision;
- demonstrate a clear connection to wider organisational strategies and service plans;
- demonstrate alignment with the opportunities presented by national and UK wide R&D strategies;
- be signed off by the Board, alongside a time bound implementation plan;
- be widely promoted to staff and the public.

1.2. Demonstrate a clear connection between their strategy and implementation plans and key local and national indicators for research performance.

1.3. Ensure R&D has full representation and visibility within the NHS organisations Integrated Medium-Term Plan (IMTP).

2. Governance and Leadership

Supportive organisations:

2.1. Demonstrate clear board commitment to research, with evidence of members contributing to agenda setting, assessing performance, and impact.

2.2. Appoint an independent board member/ champion for research, to act as an ambassador and to champion R&D at the board and across the organisation.
2.3. Support research at all levels by raising awareness among NHS directors, executives, deputies, senior and operational managers to secure commitment and by promoting research through existing committee structures.
2.4. Have a dedicated Executive Lead for research and a dedicated R&D Director, who have dedicated time to oversee the R&D strategy and provide strategic leadership.
2.5. Have a dedicated committee wired into the NHS organisation's governance where research is frequently discussed, with representatives from across the organisation and public members, to plan, oversee and report on research.
2.6. Annually report on progress against the organisation's R&D strategy, including reporting progress for a public facing audience for example, through a public facing annual report outlining R&D activities and income.

3. Partnership and Collaboration

Supportive organisations:

3.1. Establish strong interdisciplinary working within the organisation between departments and specialisms; across primary, secondary and community care; and evidenced connections across research, training and education, service improvement and innovation.
3.2. Establish cross-sector partnerships across Wales, the UK and internationally to increase the reach, level and impact of research. Specifically, there will be evidence of alignment of vision, joint R&D strategies, memorandums of understanding, deliverable plans and regular progress reviews with:
- Higher education providers, collaborating to maintain integrated partnership working between the NHS and academia including, where relevant, as part of the research and development pillar for University Health Board status
- Research agencies and funders (including research councils and third sector organisations)
- Public sector organisations, by working across organisational boundaries and adopting flexible approaches to enable easier movement of staff. This may include working with other NHS organisations, Digital Health and Care Wales, Health Education and Improvement Wales, and the Regional Innovation and Improvement Coordination Hubs.

- Life science companies and representative bodies as part of Wales and UK wide industry collaboration plans, whilst developing efficient systems to support commercial research.

3.3. Establish partnerships with external expert advisory boards and key international opinion leaders to bring fresh insight and perspective; act as critical friends and collaborative partners; and help NHS researchers to benchmark against internationally leading research within their fields.

4. Research Support

Supportive organisations have:

4.1. R&D offices and/or departments to support researcher development, research governance and the set-up, delivery, and quality assurance associated with studies.

4.2. Support for research within departments and directorates including support for staff time and NHS support services for research such as radiology, pathology, pharmacy, finance, and workforce and organisational development (W&OD).

4.3. The ability to assess organisational capacity and capability to undertake research so that studies can be hosted or sponsored.

4.4. Access to well-equipped physical and digital library services, where staff can access information on research outcomes to inform best practice.

4.5. Access to suitable space, facilities, and equipment for the conduct of research, with ongoing development enabled through the organisation's facilities and estates strategy.

4.6. An effective and efficient Information Management & Information Technology (IM&IT) infrastructure and systems to support research, with evidenced alignment to organisational digital strategies and national strategies, including those produced by Health and Care Research Wales for example supporting data and software that adheres to the FAIR (Findable, Accessible, Interoperable, and Reusable) principles to allow full repeatability, reproducibility, and reuse.

4.7. Processes in place to contribute to the availability of health data for research purposes, increasing data resources for secure access data via trusted research environments and supporting more diverse research enabled by data driven services.

4.8. A commitment to embracing emerging technologies and to research enabled by data and digital tools, leveraging the strength of NHS Wales and UK health data assets to allow for more high-quality research to be developed and delivered, whilst adhering to data protection obligations in relation to conducting research.

5. Research delivery

Supportive organisations:

5.1. Implement UK and Wales wide research delivery support programmes in partnership with the Health and Care Research Wales.

5.2. Adopt One Wales approaches (where Welsh organisations operate as a national collective) to research delivery to enable streamlining, reduce duplication and consistency across Wales including national approaches for research approvals, rapid study setup and delivery.

5.3. Strategically manage the NHS organisation's research portfolio, to lead and participate in a wide range of research, capitalising on local strengths and research groups, organisational priorities and research capacity and capability.

5.4. Support research with high policy relevance which aligns with priorities at a national and regional level, and the NHS organisation's local population health needs.

5.5. Set realistic study delivery targets, ensure research delivery to time and target as agreed with sponsors and monitor the performance of individual studies, ensuring study management data is accurately recorded and monitored frequently.

5.6. Regularly review the organisation's track record in research delivery across the portfolio, understanding the context with local intelligence and benchmarking with UK peers.

6. Finance

Supportive organisations:

6.1. Secure adequate funding from Health and Care Research Wales to establish a sustainable R&D function covering research development and delivery and manage the funding transparently, in line with the Health and Care Research Wales R&D Finance Policy.

6.2. Include R&D within the organisation's financial strategies and plans.

6.3. Have financial plans for R&D with good forecasting, timely invoicing, and proportionate risk management.

6.4. Have a commitment to generate research income for non-commercial studies (i.e. from research funders, research councils and third sector organisations) and commercial studies (i.e. from industry partners) to facilitate capacity building.

6.5. Help existing and prospective researchers secure grants from a wide range of funding sources to advance their studies leading to high quality and impactful outcomes and peer-reviewed international journal publications.

6.6. Ensure financial support is provided to advise on and monitor all costs relating to commercial and non-commercial research.

7. NHS Workforce Capacity and Capability

Supportive organisations:

7.1. Promote R&D in the organisation's W&OD strategy to facilitate research and recognise the benefits of being a research supportive NHS organisation in attracting talented staff.

7.2. Deliver NHS workforce plans where research is a key component which will include plans to:

- raise awareness of research and research careers through a variety of mechanisms to attract more people into research careers, whilst providing role variety, job enhancement and facilitating staff retention (e.g. through staff induction and mandatory training).
- build research capacity and capability for all staff by supporting the professional development of research knowledge and skills (e.g. through PADRs, mentoring, and signposting to national training opportunities provided through Health and Care Research Wales and other training providers across Wales and the UK).
- ensure that all NHS staff have the opportunity to support research by including research in all NHS job descriptions and have protected time for research for NHS staff through job planning and PADRs.
- maintain support for research in the NHS workforce during times of clinical crises such as urgent public health emergencies and winter pressures, where research activity should be focussed toward the clinical needs.
- enhance research delivery capacity amongst the workforce, including the capability to support clinical trials, ensuring good clinical governance and best practice.
- adopt national polices enabling agile regional and national mobilisation of the R&D workforce across NHS organisation boundaries and adopt flexible approaches to staff contracts with partner organisations to promote cross-organisational working.
- facilitate access to support for staff at all levels who wish to undertake research, advising on how to navigate the R&D environment and signposting to internal and external sources of information (e.g. on funding streams, protocol development, writing funding applications, statistical support, research design and methods).
- explore opportunities for investment in joint clinical academic roles in specialties and disciplines aligned to local and national plans, in partnership with universities.

8. Public Involvement and Participation

Supportive organisations:

8.1. Have an evidenced commitment to proactive public involvement and participation in the development and delivery of research studies where the public's experience is valued and where they can play a variety of roles adding significant value to research e.g. strategy development, setting research priorities, study steering group member, as a research participant and in shaping plans to share the findings of research.

8.2. Allocate sufficient budget to public involvement, ensuring that public contributors are acknowledged and recognised for their time, lived experience and contribution, in the form of monetary payment or other methods of reward and recognition in line with best practice guidelines.

8.3. Ensure that all research supported by the NHS organisation is people centred, supporting research to make it easier for patients, service users and members of the public to access research of relevance to them and be involved in its design, learning directly from public experience.

8.4. Adopt the national approach to promote research opportunities to staff and the public, including working in partnership with key stakeholders such as third sector organisations to promote research opportunities to communities of people with lived experiences; and signpost access to the organisation's and NHS Wales' research portfolio to enhance participation.

8.5. Ensure that the public involved in the NHS organisation's research represents the population it serves with equality, diversity and inclusion being key drivers, and develop flexible approaches to involvement to enable inclusive representation e.g. addressing barriers to involvement and participation through language barriers and literacy levels etc.

8.6. Adopt the UK Standards for Public Involvement, enabling good practice in public involvement.

8.7. Facilitate access to national training on public involvement for research active staff, to raise awareness on how to effectively involve the public in research.

8.8. Have active representation on the Health and Care Research Wales Public Involvement Alliance.

9. Communications and Engagement

Supportive organisations:

9.1. Include research in the NHS organisation's communications and engagement plans to demonstrate the value and importance of research, celebrating successes and raising the profile amongst staff and the public.

9.2. Adopt the national approach to communications and engagement for research in Wales to ensure there is clear and consistent messaging.

9.3. Have active representation at the Health and Care Research Wales Communications Alliance.
9.4. Develop plans to raise awareness of the importance of research among local diverse communities, collaborating with researchers and ensuring proactive engagement with underrepresented groups, including working in partnership with third sector organisations and their local communities.
9.5. Include research in the NHS organisation's equality, diversity and inclusion plans with a strong commitment to active engagement with specific groups to address health inequalities through research.
9.6. Adopt national research campaigns and link local research with national Health and Care Research Wales research to maximise impact.

10. Research Impact

Supportive organisations:

10.1. Have a commitment to open access publishing for research findings, including a commitment to ensure that researchers follow the open access policies of those funding their work, to ensure that research outcomes are freely available and encourage the use of research findings.
10.2. Have systems in place to enable research from Wales, the UK and beyond to influence practice and service delivery on an ongoing basis to improve and enhance the quality of services.
10.3. Develop plans to ensure research is supported during service redesign and informs the design of new models of service delivery based on outcomes from national, UK wide and international research.
10.4. Work with Health and Care Research Wales to develop mechanisms for measuring the economic and societal value associated with research and its impact.

Implementation of this document

This document will be used for the purposes described in the introduction.

A strong partnership approach will be taken with Health and Care Research Wales and NHS organisations working collaboratively to achieve the features of research supportive organisations.

Programmes to support implementation and monitor progress will provide the basis for a work programme to achieve the key features set out across the ten pillars.

July 2023

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**	Simplify, Standardise, and Adopt Best Practices Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd **Corporate Risks and Board Assurance Framework**	Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)
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?* **Socio-Economic Impact Assessment**	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	

Have you undertaken a Socio-Economic Impact Assessment		
Ansawdd *A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	**Galluogwyr Ansawdd** **Enablers of Quality** All Apply	**Meysydd Ansawdd** **Domains of Quality** All Apply
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant **Wellbeing of Future Generations Act – Wellbeing Goals**	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	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	

A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data? **Data Protection Impact Assessment** *Have you undertaken a Data Protection Impact Assessment Screening?*	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Asesiad o Effaith ar Atal Twyll *A ydych chi wedi ystyried yr effeithiau ar atal twyll?* **Counter Fraud Impact Assessment** *Have you considered the counter fraud impacts*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Cyfreithiol **Legal**	Yes (Include further detail below)	
Enw Da **Reputational**	Yes (Include further detail below)	
	Welsh Government and Internal Audit now expect independent assurance of RDI governance, leadership and delivery. Failure to commission the review would carry reputational and regulatory risk to the Health Board's research standing, heightened by the incidents within the RDI function and the timescales set out in Annex A. -	
Effaith ar Adnoddau *(Pobl / Ariannol)* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	The cost of the review will be met from within the Office of the Medical Director / RDI resource. There are no direct workforce implications arising from commissioning the review.	

Quality Safety & Experience Committee

CORPORATE RISK REGISTER

Dyddiad y Cyfarfod **Date of Meeting**	02 July 2026
Statws Cyhoeddi **Publication Status**	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad **Report Author name and title**	Anthony Hughes, Risk Assurance Manager Jody Evans, Assistant Head of Risk Management
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol **Lead Executive Team Member name and title**	Pam Wenger, Director of Corporate Governance

Pwrpas yr Adroddiad **Report Purpose**	Endorse for Board Approval

Crynodeb Gweithredol
Executive Summary

The Committee is asked to **receive assurance** of the two updated Corporate Risks and will fall under the remit and oversight of the Quality, Safety and Experience Committee:

- CRR25-01 'Timely Patient Access to Safe and Effective Care '
- CRR25-08 'Non-Compliance with Regulatory and Legislative Requirements'

No changes to risk scores are proposed. Both risks currently exceed the risk tolerance levels set within the Board's risk appetite.

While progress has been made, further refinement is required to ensure actions are sufficiently targeted to drive a reduction in overall risk scores, particularly for risk ***CRR25-01***. A series of risk-specific meetings with Executive Leads are therefore being scheduled to review each risk in detail. This will include consideration of whether risks should be further segmented, alongside strengthening existing controls and actions. These sessions will focus on ensuring that action plans are outcome-focused and clearly aligned to delivering a measurable reduction in risk scores within the agreed risk appetite.

Action Progress

A total of 15 actions have been developed across the two corporate risks.

- 4 actions are complete
- 10 actions are progressing
- One action remains due to commence within 'CRR 25-08 'Non-Compliance with Regulatory and Legislative Requirements' following completion of an additional action.

The Committee is asked to:

- Review the current risks and level of assurance provided.
- Provide feedback to support further refinement ahead of submission to the Board.

Ymgysylltu (mewnol/allanol) yr ymgymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp) **Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)**		
Pwyllgor / Grŵp / Unigolion **Committee / Group / Individuals**	**Dyddiad** **Date**	**Canlyniad, Tystiolaeth a Data** **Outcome, Evidence and Data**
Executive Committee (EC)	20/05/2026	Full CRR presented to the Executive Committee.
Risk Scrutiny Group (RSG)	12/05/2026	Following review by the Risk Scrutiny Group (RSG) on the 12th May 2026, minor further amendments to the template were agreed, alongside the need to present action details in a more succinct and consistent manner in future iterations of the cycle.
Deep Dive – CRR25-01 – Timely Patient Access to Safe and Effective Care	01/04/2026	Deep Dive undertaken at Informal Executives Meeting.
Deep Dive – CRR25-08 - Non-Compliance with Regulatory and Legislative Requirements'	18/03/2026	Deep Dive undertaken at Informal Executives Meeting.

Acronymau / Rhestr Termau **Acronyms / Glossary of Terms**	
CRR	Corporate Risk Register
RSG	Risk Scrutiny Group
BAF	Board Assurance Framework

CORPORATE RISK REGISTER

1. **Y SEFYLLFA**
SITUATION

The purpose of this report is to provide an update to the Committee on the most significant risks to which the committee has overall accountability and oversight of.

Two consolidated Corporate Risks will fall under the remit and oversight of the Quality, Safety and Experience Committee:

- CRR25-01 'Timely Patient Access to Safe and Effective Care'
- CRR25-08 'Non-Compliance with Regulatory and Legislative Requirements'

2. **Y CEFNDIR**
BACKGROUND

The Committee is asked to scrutinise and endorse three Corporate Risks within its remit prior to submission to the Board.

All risks have been mapped over to the newly approved Corporate Risk Register template. This provides improved clarity and consistency in the articulation of risk position, and strengthens the alignment between identified control gaps, mitigating actions and intended outcomes.

The Committee is invited to review the risks in their current form and provide feedback to support further refinement ahead of Board consideration.

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

Overdue/Delayed Actions

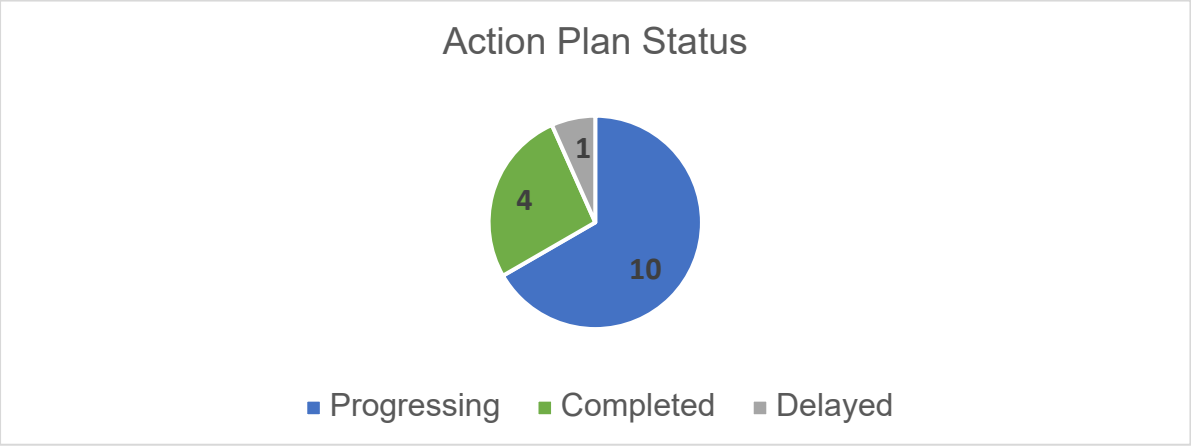
CRR25-08 'Non-Compliance with Regulatory and Legislative Requirements' – One action remains due to commence within 'CRR 25-08 'Non-Compliance with Regulatory and Legislative Requirements' following completion of an additional action.

Risks above Health Board 24/25 appetite

Both risks reported to committee score outside the tolerance range set in the appetite.

Risk Ref	Risks	Lead Exec Director	Current Risk Score	Risk Tolerance Range in Appetite Score
CRR25-01	Timely Patient Access to Safe and Effective Care	Chief Operating Officer	**20**	Quality <15
CRR25-08	Non-Compliance with Regulatory and Legislative Requirements	Director of Corporate Governance	**16**	Regulatory <15

Action Plan status of Corporate Risks



Out of the 2 corporate risks, 15 actions have been developed to mitigate the risks, with 10 open actions progressing and on track. 4 actions have been completed with 1 delayed action.

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

- All risks have been reviewed and updated by the relevant service, with no proposed changes in risk scoring. The risks have current risk scores which sits outside the risk tolerance level set within the risk appetite.

- While progress has been made, further refinement is required to ensure actions are sufficiently targeted to drive a reduction in overall risk scores, particularly for risk ***CRR25-01***. A series of risk-specific meetings with Executive Leads are therefore being scheduled to review each risk in

detail. This will include consideration of whether risks should be further segmented, alongside strengthening existing controls and actions. These sessions will focus on ensuring that action plans are outcome-focused and clearly aligned to delivering a measurable reduction in risk scores within the agreed risk appetite.

5. ARGYMHELLION RECOMMENDATIONS

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

- **Review and scrutinise** the corporate risks set out in the report, including consideration of the current risk position, existing controls, and identified gaps.
- **Endorse** the risks for submission to the Board, noting that the risks remain above the Health Board's risk appetite and therefore represent a continued exposure.
- **Endorse** for Board submission with recognition that risks remain above appetite and require continued Executive oversight and action acceleration

6. CAMAU NESAF NEXT STEPS

1. Approved Corporate Risks to be monitored as business as usual by senior risk leads, Executives, the Risk Scrutiny Group and the Executive Committee
2. Submission of Corporate Risks to Board.

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

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

Compliance to the Welsh Language requirements? *Have you undertaken an Impact Assessment*	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	No impacts identified – administrative report
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	No impacts identified – administrative report
Compliance to giving 'Due Regard' to the principles of the Armed Forces Covenant *Have the principles of the Armed Forces Covenant been addressed within WP8a*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	No impacts identified – administrative report
Ansawdd *A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	No impacts identified – administrative report
	Galluogwyr Ansawdd **Enablers of Quality** Whole-systems Perspective Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales	
Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	Choose an item.	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Asesiad o Effaith ar Ddiogelu Data	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	

A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data? **Data Protection Impact Assessment** *Have you undertaken a Data Protection Impact Assessment Screening?*	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	No impacts identified – administrative report
Asesiad o Effaith ar Atal Twyll *A ydych chi wedi ystyried yr effeithiau ar atal twyll?* **Counter Fraud Impact** *Have you considered the counter fraud impacts*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	No impacts identified – administrative report
Cyfreithiol **Legal**	There are no specific legal implications related to the activity outlined in this report.	
Enw Da **Reputational**	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith ar Adnoddau *(Pobl / Ariannol)* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	As per detail relating to resources within risk and actions.	

Corporate Risk Register

Quality, Safety and Experience Committee – July 2026

GIG CYMRU NHS WALES

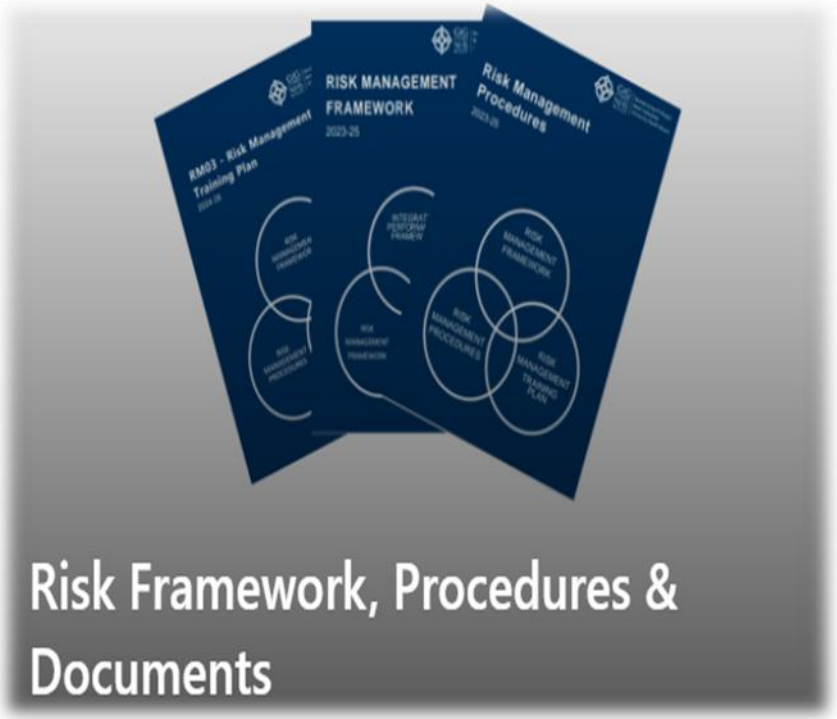
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Corporate Risk Register

This report provides the Quality, Safety and Experience (QSE) Committee with an update on the Corporate Risk Register (CRR) risks within its remit, specifically:

- CRR25-01 ‘Timely Patient Access to Safe and Effective Care’
- CRR25-08 ‘Non-Compliance with Regulatory and Legislative Requirements’

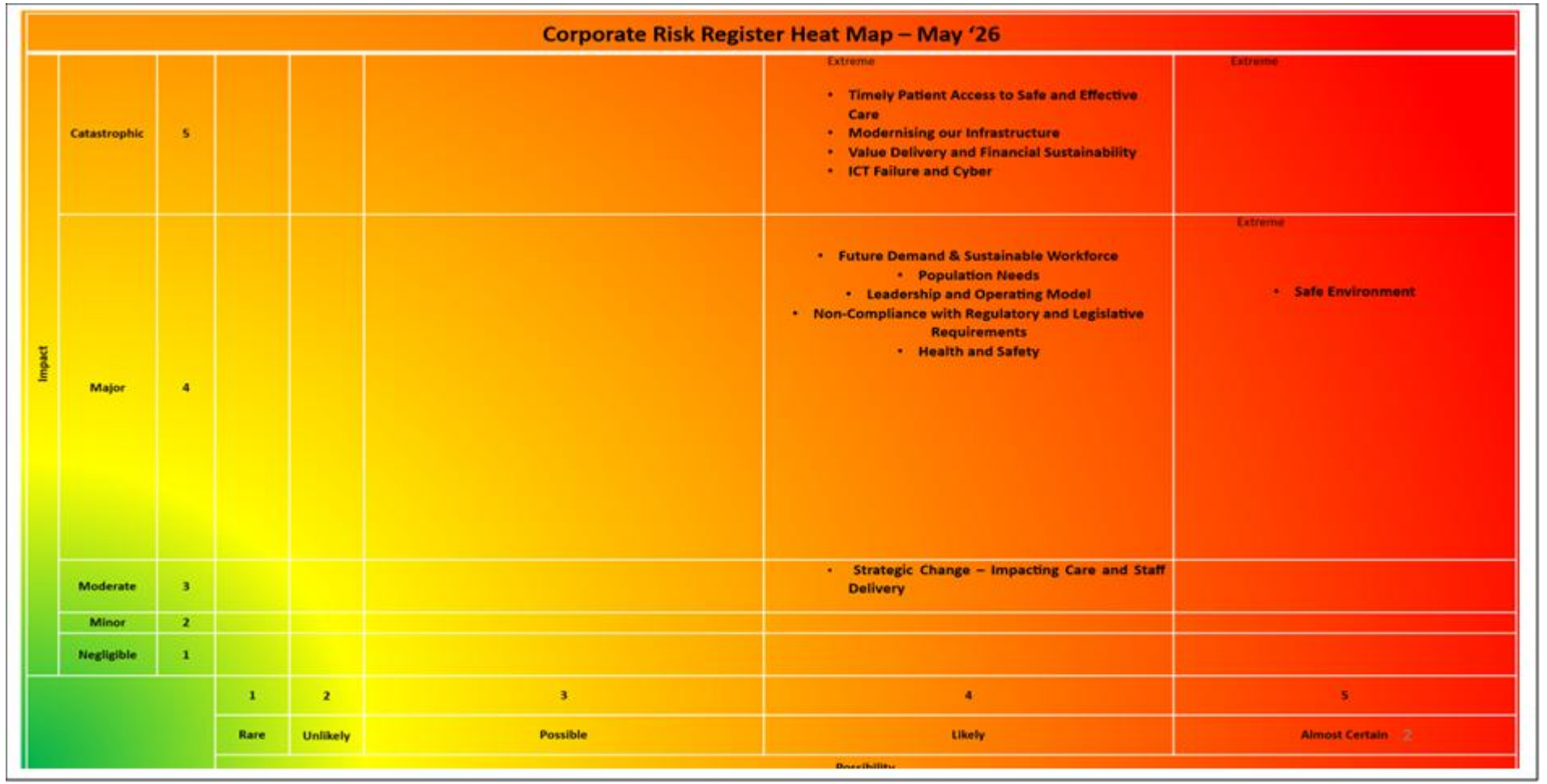
Each risk sets out the current position, including progress against the delivery of associated mitigating actions.



Appendix 1 - Dashboard

Lead	Ref	Risk Title	Current Score (Impact x Likelihood)	Risk Target Score	Appetite Main Risk Type Appetite Level	Lead Board Committee	Action Progression			Risk Management Commentary
							Total	Completed	Delayed or Overdue	
COO	CRR25-01	Timely Patient Access to Safe and Effective Care	5x4 20	12	Quality (<15) Above Tolerance	Quality, Safety and Experience Committee	11	4	0	Four actions now completed Deep Dive undertaken at Informal Executive Committee. Action plan to be reviewed following feedback.
DCG	CRR25-08	Non-Compliance with Regulatory and Legislative Requirements	4x4 16	8	Regulatory (<15) Above Tolerance	Quality, Safety and Experience Committee	4	0	1	One action remains due to commence upon completion of an additional action. Deep Dive undertaken at Informal Executive Committee.

Appendix 2 - Heatmap



Appendix 3

CRR REF: 25-01 - Timely Patient Access to Safe and Effective Care		
Director Lead: Chief Operating Officer		**Date Opened:** 21/08/2025
Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 05/03/2026
Date Last Reviewed: 30/04/2026	**Link to BAF**: BAF24-07	**Target Risk Date:** 30/06/2027

Risk Detail:

There is a risk that patients may not receive timely access to the care they need; for planned care this may lead to a delay in definite treatment, deterioration in health or harm occurring whilst waiting, poor patient experience, and poorer outcome. In the unscheduled care pathway, patients may experience harm whilst waiting for ambulances in the community, may have prolonged waits for specialist medical care, this could lead to patient harm and poor patient experience.

This may be caused by capacity and demand mismatch, lack of oversight of waiting lists, lack of validation, the need to transform services and service models and delays due to waiting for diagnostic tests in the unscheduled arena it may be caused by poor flow through the health and social system, poor discharge practices, lack of appropriate residential and nursing placement.

This may lead to extended waiting lists, patient harm due to delays, and reputational or regulatory consequences.

Mitigations/Controls in place

1. System Resilience Hub in place with hospital escalation protocols, daily and weekend plans, and winter/festive plans. Daily Hub + rapid review + weekly executive oversight panels
2. 6 week rapid improvement plan with clinical and operational executive oversight
3. Quality, professional and operational standards
4. Major change programmes for Urgent and Emergency Care (UEC) and planned care aligned to the Six Goals for UEC framework and national objectives (such as timely access to care and building community capacity). Governance structure completed, all workstreams now all aligned.

5. Winter Resilience Plan complete evaluation and lessons learnt.
6. Revised Access policy to ensure standardised practice across the Health Board
7. Single Integrated Clinical Assessment Triage (SICAT) and GP Out of Hours (OOHs) joint model providing 24/7 triage and advice
8. Same Day Emergency Care (SDEC) services established at all acute sites
9. Routine clinical prioritisation of patients by risk in line with Referral to Treatment guidance
10. Outsourcing of radiology reporting and insourcing of CT, MRI, ultrasound
11. Diagnostic Quality Management System accreditation system embedded
12. Welsh Government short-term Neurodevelopment funding to support longest waiters, agency staff, overtime

Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G1 Fragility of UEC (Urgent Emergency Care) and specialist workforce posts, reliance on locums' temporary posts.	A UEC clinical lead has been appointed as part of the UEC programme team as well as other clinical leads specifically focusing on the priorities of the 6 goals plan within specific workstreams.	UEC Programme Director	Complete	Complete

	ED staffing business case for medical and nursing requirements including whole time equivalent and costings to be drafted for Executive Committee endorsement. Task & Finish group to be established to progress at pace with key leads including clinical, nursing, workforce and transformation and progress through HB governance. **Outcome:** A stable, sustainable UEC and frailty workforce with reduced reliance on locums, improved service continuity, and consistent delivery across all sites. **Metric:** Reduction in locum usage and vacancy rates in UEC and frailty posts, **Impact on risk:** Likelihood of risk will reduce as permanent posts are filled with further reduction expected as locum reliance decreases and workforce stability improves	Chief Operating Officer	Q1 2026/27 – 30/06/2026	Progressing

Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G2 Fragility of social care provision causing delayed discharge and stranded patients	Implement reset 'sprint' fortnight 8-22 December focusing on improving number and timeliness of discharges, delivering 45-minute ambulance handover, and improve ED performance Second 'Sprint' undertaken 22 January – 4 February, supported by 3 diagnostics to target ongoing actions Action update: Further to competed actions, above, MADE events have been held on each site and further interventions have been identified including: >21-day length-of-stay reviews / 6As audits scheduled during March / April across all sites – findings will inform immediate and longer-term actions that strengthen discharge processes and system-wide UEC flow – supported by external improvement and intensive support team.	Chief Operating Officer	8/12/2025	Complete
Gaps in Controls	**Action**	**Action Owner**	**Due Date**	**Progression Analysis**
	Deliver December "Discharge Fortnight" - Intensive cross-sector focus to maximise discharge, unblock flow, reduce LOS, and significantly improve bed availability.	Chief Operating Officer	31/01/2026	Complete

	Action update: Fortnightly regional realignment meetings in place with BCU / LA to maintain focus on discharges to support flow and patient outcomes			
Gaps in Controls	**Action**	**Action Owner**	**Due Date**	**Progression Analysis**
G3 Need for demand and capacity modelling and specialty-level trajectories	Complete demand and capacity analysis across Planned Care to inform forward activity planning 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 **Outcome** Clear understanding of specialty level- demand and capacity, enabling improved activity planning, reduced long waits, and more efficient use of core capacity	Chief Operating Officer	30/06/2026	Progressing (revised date from 31/03/2026)

	Metric Reduction in number of long waiting patients (aligned to IMTP trajectory) **Impact on Risk:** Likelihood decreases as clearer planning reduces backlog risk and improves ability to meet demand.			
Gaps in Controls	**Action**	**Action Owner**	**Due Date**	**Progression Analysis**
G4 Inadequate Neurodevelopment (ND) capacity to manage waiting list	Eradicate all >3 year waits by end March 2026. Ministerial priority. At the end of March 2026 there were 646 over three year waits due to the private provider being unable to complete their contract assessment numbers. These referrals have now been allocated to another private provider for completion by the end of Quarter 1, families and schools have been updated. Additionally there will be 2,358 C&YP that will have waited over 3 years in 26/27, WG have allocated £2m to BCUHB to address the >3 year waiters, however this will be insufficient with a shortfall of approximately 490 assessment. WG are to be informed of this residual gap and options to manage reviewed	Associate Directors Childrens	Qtr 1 2026/27 – 30/06/2026	Progressing

	Confirmation of funding allocation (£2m) from WG re 26-27 for ND funding for assessments, was received in April. Approval from Exec Committee & PFIG subsequently confirmed in April 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. **Outcome** The capacity gap has reduced significantly, supported by a 63% increase in assessment activity in 2025/26. This has been achieved through a prudent delivery approach alongside commissioning of independent providers. Allocated funding will support backlog reduction for waits exceeding 3 years in Q1 26/27, whilst also contributing to longer term service sustainability. **Metric** Ministerial milestone. Deliver and sustain no >3 year waits at the end of March. **Impact on Risk** Failure to maintain increased assessment capacity and targeted backlog reduction may result in continued waits exceeding three years into 2026/27. This would lead to non-delivery of the ministerial milestone, prolonged delays for neurodevelopmental (ND)			

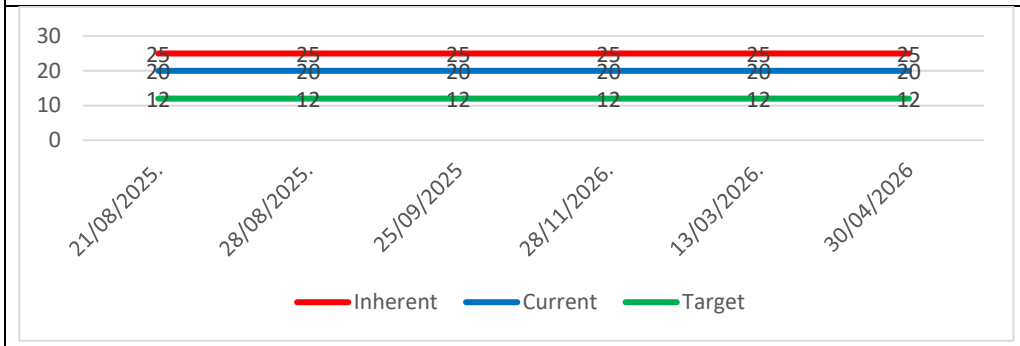
	assessments, increased demand pressures on services, and potential deterioration in patient outcomes and experience			
Gaps in Controls	**Action**	**Action Owner**	**Due Date**	**Progression Analysis**
G5 Outdated diagnostic IT systems causing inefficiencies in reporting and turnaround times with diagnostics.	• Strengthen and enhance monitoring of reportable diagnostics through implementation of upgraded systems including: - RISP (radiology) – completed RISP radiology system September 2025 completed. - LIMs 2.0 (pathology) – ongoing roll out to be completed by end Q3 • Ensure existing services have mechanisms in place to report urgent and unsuspected findings, including Welsh Clinical Portal (WCP). Enhanced / divisional monitoring of reportable diagnostics as a byproduct of planned care backlog recovery programmes. This will develop further with diagnostics division throughout 2026-27 to include UEC and urgent suspected cancer diagnostics	Associate Director, North Wales Managed Clinical Services	30/06/2026 30/06/2026	Progressing

	Update Failure to act on Diagnostics Procedure to be presented at divisional meeting for discussion on the 10/10/2025 (NB: This action is delayed due to service focus on 8-week backlog reduction and supporting OPD programme. Proposed revise due date to Q1 2026-27) **Outcome:** improved oversight and strengthened reporting of findings / responsive actions **Metric:** reporting turnaround times maintained / improved, with outliers identified earlier for intervention **Impact on Risk:** overall reduction in likelihood of delayed diagnostic results to service users			
Gaps in Controls	**Action**	**Action Owner**	**Due Date**	**Progression Analysis**
G6 Variation in acute medicine, SDEC (Same Day Emergency Care), frailty pathways across sites, No standardised model yet	• Complete pan BCUHB- baseline and gap analysis to inform a standardised frailty service model, develop unified Acute (front door) Frailty Services pathways aligned with SDEC and community services (Q2), Baseline and gap analysis completed • Finalise financial and workforce modelling required to deliver the national AFS model (Q1).	UEC Programme Director	30/09/2026 30/06/2026	Progressing

Workforce recruitment impacted by non-recurrent (6 Goals) funding	**Outcome** A consistent, standardised frailty model across all acute sites, improving early assessment, flow, and access to same-day and community alternatives **Metric** Completion of baseline & gap analysis. Agreement of standardised AFS model for each site. Progress against recruitment to frailty workforce roles. **Impact of Risk** Risk reduces as variation decreases and standardised models strengthen service reliability and pathway consistency through pan BCU standardised approach.			
Gaps in Controls	**Action**	**Action Owner**	**Due Date**	**Progression Analysis**
G7 Consistent application of "Our Next Patient Please" flow model.	• Patient flow improvements: Implement “Our Next Patient Please” Move patients to wards ahead of predicted discharges; reduce ED congestion. Completed – Our next patient (forward waiting) is now BAU	Chief Operating Officer	31/01/2026	Completed

	• Develop draft Single Point of Access for alternative pathways & Primary Care redirection. Reduce unnecessary ED attendance; strengthen community pathways. **Outcome** Improved patient flow through earlier ward moves, reduced ED congestion, and strengthened use of alternative pathways and community services—leading to fewer unnecessary ED attendances and more efficient system-wide flow. **Metric** Reduction in ED congestion metrics (4 hour / 12 hour / time to triage / ambulance handover) • Reduction in LoS / POCD **Impact on Risk** Risk decreases as improved flow reduces system pressure, ED overcrowding, and delays in urgent and emergency care—lowering the likelihood and impact of service failure Action update: • Your Next Patient / Forward Waiting SOP developed	Chief Operating Officer	31/03/2027	Progressing

	• Accelerated Boarding in Extremis SOP developed			
Gaps in Controls	**Action**	**Action Owner**	**Due Date**	**Progression Analysis**
G8 Health Board improvement goal for Colostrum Difficile Infection (CDI) reductions in 2025/2026 to reduce the number of cases within the Health Board.	Implementation of Health Board improvement goal for CDI (Colostrum Difficile Infection) reductions in 2025/2026 This action to reduce CDI is now based on the WHC Improvement Goals for 2025 – 2027. The Health Board has until March 2027 to reduce CDI by at least 25% against the 2024/2025 counts **Outcome** Reduced incidence of Clostridioides difficile infection across the Health Board through strengthened infection prevention-, antimicrobial stewardship, and system-wide adherence to improvement measures. **Metric** CDI incidence rate per 100,000 population **Impact on Risk** Risk decreases as CDI rates fall, demonstrating improved infection control and reduced harm as performance moves towards the 2025/26 reduction target.	Deputy Director of Nursing Infection Prevention and Decontaminati on	31/03/2027	Progressing (revised date from 31/03/2026)



	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score	4	3	12
Risk Appetite	Quality <15		Not in Tolerance

Position & Intended Outcome for Risk

The number of Prevention of Future Death (PFD) / Regulation 28 Notices issued to BCUHB were: 23 in 2023-24; 7 in 2024-25; 3 in 2025-26 to date. In 2023 the Health Board was an outlier and 9 cases directly related to the impact of delays in the health and social care system on the timeliness of responses by the HB and Welsh Ambulance Service and ongoing work is required to resolve the underlining delays to treatment. The goal being to be in line with WG targets.

Intended Outcome:
By 2027, patients consistently receive timely, effective, and safe care, evidenced by:

- Reduction in long-wait patients (>104 weeks) and breaches of national access standards.
- Fewer harm events linked to delayed care.
- Improved quality metrics including length of stay, readmission rates, and patient-reported outcome measures (PROMs).
- Reduction in regulatory and legal cases associated with delayed access.
- A demonstrable shift in focus from access process metrics to sustained improvement in patient safety, experience, and outcomes.

CRR REF: 25-08

Risk Title: Non-Compliance with Regulatory and Legislative Requirements

Director Lead: Director of Corporate Governance		**Date Opened:** 21/08/2025
Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 06/11/2025
Date Last Reviewed: 27/04/2026	**Link to BAF**: BAF24-01	**Target Risk Date:** 31/03/2027

Risk Detail:

There is a risk that the Health Board may fail to comply with regulatory and legislative requirements, which could directly or indirectly impact the safety, quality, and accessibility of patient care.

This may be caused by inefficiencies in managing regulatory complexities and changes at pace, ineffective relationship management with regulators and statutory bodies, inadequate monitoring and reporting of actions and progress, including escalation, and insufficient operational assurance.

This may lead to enforcement action, impact patient safety, financial penalties, impact on workforce, and loss of public and stakeholder confidence.

Mitigations/Controls in place

1. Internal and external audit reviews identifying and reporting areas of non-compliance with legislation and regulation.
2. Report on progress on some regulatory compliance submitted to the Regulatory Assurance Group, Executive Quality and Delivery Group, and Quality, Safety and Experience Committee via the Integrated Quality Report.
3. An update on progress on some regulatory compliance from the Integrated Quality Report also included in the Statutory Compliance Report to Executive Committee and Audit Committee.
4. Monitoring of regulations and legislation by various groups, such as:
   - Medical Devices Governance & Assurance Group oversees procurement, selection, risk management and safety communication
   - Estates and Health & Safety Committee oversee areas of non-compliance and tracking of action plans.
   - Pharmacy Technical Services and monitoring of compliance in relation to Controlled Drugs. Regulatory Assurance Group for some clinical regulations. (Oversight and gap analysis of all groups required and reflected in the action plan/gaps in controls)

Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G1 The Health Board currently lacks a complete and consolidated picture of its regulatory and statutory relationships, leading to limited visibility over roles, responsibilities, and engagement practices.	**Capture current relationship management practices and arrangements around Health Board regulators and statutory bodies** Complete a structured mapping exercise of all regulators and statutory bodies across the Health Board to identify lead Executive Team member, operational lead, and current relationship with these bodies Update 23/04/2026: A list of all Health Board regulators, statutory and professional bodies has been captured. Following a review of the information received to date by the Head of Statutory Compliance and Inquiries, the requested detail was incomplete across the majority of areas. As this work relies on information provided by others from across the Health Board, strict deadlines for were responses put in place, but these were not met. Further requests have been made for the additional information. Due to this, this work around capturing our relationship with these regulators, and our internal processes has not been completed, and the due date extended to enable further engagement across the Health Board. **Outcome** • A clear, consolidated view of how the Health Board currently manages relationships with regulators and statutory bodies • A baseline understanding that supports improved coordination, compliance, and strategic engagement • Clarity, visibility, and baseline understanding.	Head of Statutory Compliance and Inquiries	29/05/2026	Progressing

	Metric • Confirmation from each Executive Team member that details of all regulators and statutory bodies under their portfolio have been captured **Impact on Risk** • Increased visibility of current relationship management practices with its regulators and statutory bodies across the Health Board • Increased visibility of the current reporting and monitoring practices relating to regulator and statutory body information across the Health Board • Increased visibility of roles and responsibilities relating to regulators and statutory bodies.			
Gaps in Controls	**Action**	**Action Owner**	**Due Date**	**Progression Analysis**
G2 There is no fully reliable or validated register of regulatory relationships and statutory obligations, creating uncertainty around ownership, assurance, and compliance oversight	**Review of regulatory and statutory body relationship management, reporting and monitoring arrangements** Update 23/04/2026: An initial review of the information received has been undertaken by the Head of Statutory Compliance and Inquiries, however the requested detail was incomplete across the majority of areas. As this work relies on information provided by others from across the Health Board, strict deadlines have been put in place, but these were not met. Further requests have been made for the additional information. Due to this, this work has not been	Head of Statutory Compliance and Inquiries	30/06/2026	Not Started (Above action to be completed prior to this action being started)

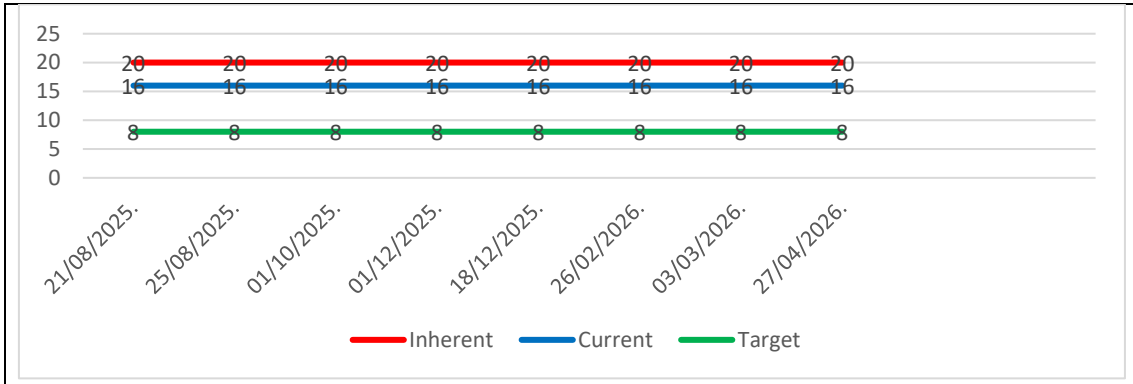
	completed, and the due date extended to enable further engagement across the Health Board. Review the Relationship Management Matrix. **Outcome** • A strengthened, authoritative information set that can be used confidently by the Board, Executive Team Members, and operational teams • Identification of strengths, gaps, inconsistencies, and duplication in governance practices • An assessment of whether the existing information is sufficient to support assurance, compliance oversight, and regulatory engagement • A foundation for designing a more consistent, risk-aligned regulatory engagement framework **Metric** • Completeness — proportion of regulators/statutory bodies for which full information exists • Clarity of ownership — proportion of entries with clearly assigned responsible officers or teams. **Impact on Risk** When the information is complete and reliable: • Regulatory risk decreases because the Health Board has a clear, accurate understanding of all obligations and expectations • Ability to identify gaps in the improvements required to strengthen our processes			

	• A verified, up-to-date record of all regulatory relationships and obligations, with inaccuracies corrected and gaps identified.			
Gaps in Controls	**Action**	**Action Owner**	**Due Date**	**Progression Analysis**
G3 There is no formalised executive-led forum providing consistent oversight, coordination, and escalation of governance, statutory compliance, and regulatory issue .	**Executive Governance and Regulatory Group** Formalise a multi-disciplinary Governance and Regulatory Group to provide routine scrutiny, coordination, and escalation Update 23/04/2026: A meeting between the Director of Corporate Governance, Executive Medical Director and Interim Executive Director of Transformation and Strategic Planning was held on 16/04/2026 to discuss the groups agenda and reporting requirements. Following this, a request was submitted to the Executive Team members for nomination(s) to attend the Group, and also to provide a list of their top 3 regulators for the Group's initial focus over the next 6-12 months. This included information as to the parent committee (e.g. QSE, PFIG), and details of any operational group that currently receives updates relating to these regulators. This will assist to form the attendee list for the Governance and Regulatory EDG, to map the reporting structures to and from the Group, and provide focus for the Group over the coming months. The deadline for responses was 24th April 2026, but only one response received by that date. A further reminder for responses was submitted on 27th April 2026.	Head of Statutory Compliance and Inquiries	31/04/2026	Progressing (revised date from 31/03/2026)

	Meeting with Executive Director of Allied Health Professions and Health Science, Executive Director of Nursing and Midwifery, Director of Environment and Estates and Acting Director of Digital, Data and Technology is also required, with work ongoing to coordinate schedules for this meeting to take place. **Outcome** A formalised, multi-disciplinary Executive Led Group to ensure consistent oversight, aligned decision-making, and timely escalation across governance, statutory compliance, and organisational assurance domains **Metric** • Group established with agreed terms of reference • Clear, defined and documented reporting and escalation processes • Attendance and representation across disciplines. **Impact on Risk** Formalising this Group will have a material positive impact on organisational risk exposure, the key improvements include: • Clearer escalation routes ensure strategic risks receive timely executive attention • More coordinated oversight supports consistent compliance across operational divisions • Improved accountability reduces drift, variability, and unmanaged exposures • Systematic monitoring ensuring the Health Board maintains compliance with statutory duties and regulatory frameworks			

	• Provides clearer lines of sight for Board Committees			
Gaps in Controls	**Action**	**Action Owner**	**Due Date**	**Progression Analysis**
G4 The Health Board lacks a centralised system to record, monitor, and assure compliance with legislative and regulatory requirements, resulting in fragmented and inconsistent oversight.	**Compliance Management System** Implement a centralised compliance management system to capture and enable the monitoring of Health Board-wide legislative and regulatory requirements Update 27/04/2026: Following receipt of tenders, the Health Board has determined that a review of the specification and re-engagement of the market is necessary to ensure its needs are fully met and that value for money is achieved. A procurement process will be completed during Q1-Q3 of 2026/27 in line with public procurement law and Health Board SFIs. **Outcome** Implementation of a centralised electronic system provides a single source of information for all legislative, statutory, and regulatory requirements, linked directly to named accountabilities and real-time assurance. **Metric** • System procured • System live by agreed date **Impact on Risk**	Head of Statutory Compliance and Inquiries	31/03/2027	Progressing

	Implementation of the system will have a significant positive effect on reducing organisational risk in multiple categories. • Ensures the organisation maintains a live, accurate register of all legislative and regulatory duties • Strengthens evidence trails for external inspections (for example Health Inspectorate Wales, Audit Wales, Health and Safety Executive) • Clear ownership of responsibilities reduces operational ambiguity and the risk of requirements being missed • Real-time visibility enables early escalation of compliance risks before becoming significant failures • Moves the Health Board from reactive to proactive compliance management • Reduces inconsistencies across directorates, improving confidence in assurance processes • Supports Board Committees by providing reliable, validated, accessible assurance information • Demonstrates to regulators and external stakeholders a systematic, robust approach to compliance • Automated reporting reduces human error, version-control issues, and information gaps • Ensures a clear audit trail for decisions, updates, accountability, and evidence.			



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	Regulatory/Compliance <15		Not in Tolerance

Position & Intended Outcome for Risk

Governance and regulatory EDG to be set up to oversee compliance, and to track non-compliance to ensure risks are mitigated, reporting areas of non-compliance to the Executive Committee. This risk has been developed into a more strategic risk, which will encompass overarching compliance to statutory requirements across the Health Board.

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Quality Safety & Experience Committee

CORPORATE GOVERNANCE REPORT

Dyddiad y Cyfarfod Date of Meeting	02 July 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Philippa Peake-Jones, Head of Corporate Governance
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Pam Wenger, Director of Corporate Governance

Pwrpas yr Adroddiad Report Purpose	For Noting

Crynodeb Gweithredol Executive Summary
Members are asked to: • **NOTE** the matters considered in Private at the 7 May 2026 Committee. • **NOTE** the draft Cycle of Business for comment prior to approval • **NOTE** The Committee forward workplan

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

Acronymau / Rhestr Termau Acronyms / Glossary of Terms	

CORPORATE GOVERNANCE REPORT

1. **Y SEFYLLFA**
SITUATION

1 The Health Board is required to act according to its Standing Orders. This report contains information to allow the Health Board to conform to this.

2 It is essential that the Board has robust arrangements in place for Corporate Governance and failure to do so could have legal implications for the Health Board.

3 **Y CEFNDIR**
BACKGROUND

3.1 The purpose of this report is to provide the Committee with an update on key corporate governance matters.

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

4.1 **Summary of Business Considered in Private**

4.1.1 Standing Order 6.5.3 requires the Board to formally report any decisions taken in private session to the next meeting of the Board in public session. This principle is also applied to Committee meetings.

4.1.2 The below items were considered in private at the meeting held on 7 May 2026:

Agenda Item	Subject (including narrative)	Committee Resolution	Rationale for item in Private
QS26.83	Integrated Quality Performance Report	The Committee: • **NOTED** the report	Identifiable Information
QS26.84	Maternity & Neonatal Report	The Committee: • **NOTED** the update	Business Sensitive
QS26.85a	Gastroenterology – Rapid Quality Review	The Committee: • **NOTED** the current position	Legally Privileged
QS26.85b	Barrett's Oesophagus Surveillance Look Back Review	The Committee: • **NOTED** the current position	Legally Privileged

Agenda Item	Subject (including narrative)	Committee Resolution	Rationale for item in Private
QS26.86	Public Interest Report	The Committee: • **NOTED** the report	Commercially Sensitive
QS26.57	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 7 May 2026 Committee.
- **NOTE** the draft Cycle of Business for comment prior to approval
- **NOTE** The Committee forward workplan

ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol **Link to Strategic Priorities**	 1. Building an effective organisation
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Yr Egwyddorion Dylunio **Design Principles**	Simplify, Standardise, and Adopt Best Practices Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd **Corporate Risks and Board Assurance Framework**	BAF24-01 Building an Effective and Accountable Organisation CRR-16 – Leadership/Special Measures

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS

Cydraddoldeb *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)* **Equality** *Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report
Asesiad o'r Effaith Economaidd-gymdeithasol *A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?* **Socio-Economic Impact Assessment** *Have you undertaken a Socio-Economic Impact Assessment*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report
Ansawdd *A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	**Galluogwyr Ansawdd Enablers of Quality** All Apply	**Meysydd Ansawdd Domains of Quality** All Apply
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals	Not Applicable	

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

	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog: **Armed Forces Covenant Due Regard Duty** 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.	

Quality Safety and Experience Committee – Non-Routine Committee Business Forward Plan - PUBLIC

(1 April 2024 – onwards)

This forward plan is only to be used for one-off Adhoc items that do not require inclusion as routine business on the Annual Committee Cycle of Business.

Date of Request	Origin of Request	Requestor	Item Summary / Title	Nature of Request	Lead Officer	Executive Lead	Intended Meeting Date	Status
24.06.26	Verbal	Exec Director of Nursing & Midwifery	Service Presentation - Palliative, End of Life & Bereavement Care	Deferred to next meeting in absence of Exec Director of Nursing & Midwifery	Angela Wood / Chris Lynes	Angela Wood	Sept 2026	
26.05.26	Email	Helen Stevens-Jones / Pam Wenger	100 Stories Project	Stories to be shared from event	Pam Wenger / Helen Stevens Jones	Pam Wenger / Helen Stevens Jones	Sept 2026	26.05.26 – query from Pam to Caroline as whether to include on July agenda 24.06.26 – further discussion still required. Review at Sept agenda setting
14.05.26	MHL Committee	MHL Committee	Delayed packages of care	The Committee agreed that the emerging risk relating to delayed packages of care impacting the appropriate application of Mental Health Act powers should be escalated to the Quality, Safety & Experience Committee for system-level oversight.	Teresa Owen	Teresa Owen	Sept 2026	Agreed to report through MHLC update when scheduled in Sept 26.
18.05.26	Originally PFIG	PFIG Committee	Performance – Follow Up Appointments	QSE to look at evidence of harm as a result of delays to follow up appointments	Ed Williams	Russell Caldicott	~~July 2026~~ Sept 2026	Previous added to performance report, but further information needed on discussion 18.5.26 – included on July draft agenda under performance report item. 20.05.26 – advised in agenda setting for this be reviewed with chairs of PFIG and QSE

								separately with PW to ensure appropriate committee.
11.05.26	PFIG 28.4.26	PFIG Committee	Contracts & Commissioning	Quality, Safety & Experience to consider the draft Commissioning Framework to ensure quality and safety are given sufficient weight in procurement activity.	TBC	Clara Day	~~July 2026~~ Sept 2026	18.5.26 – included on draft agenda for July under "Quality of Commissioned Services Item" 19.05.26 – agreed by CD/PPJ to defer to next meeting due to number of items on agenda
21.04.26	Audit Committee	Chair of Audit Committee	Commissioned Services	Monitoring the quality of commissioned services	TBC	Clara Day	Sept 2026	06.05.26 – emailed PPJ to query exec lead 18.05.26 – included on draft agenda (was on forward workplan) 19.05.26 – agreed to defer to next meeting due to number of items on agenda
13.03.26	QSE Agenda Setting	Chair of QSE	QMS update	QMS update	Exec Director of Nursing & Midwifery / Exec Medical Director	Exec Director of Nursing & Midwifery / Exec Medical Director	~~July 2026~~ Sept 2026	18.05.26 – added to draft agenda for July 19.05.26 – agreed by CD/PPJ to defer to next meeting due to number of items on agenda
04.03.26	Email Request	Chairman	Patient Experience Item	Patient Experience item on Emergency Departments	Rachel Wright	Angela Wood	~~July 2026~~ Sept 2026	04.03.26 – request from chairman. To be included on May agenda setting. 12.03.26 – on may draft agenda for agenda setting 13.03.26 – agreed in agenda setting to defer to July

								meeting due to number of items, and another patient experience item already scheduled. A short film and covering paper to be requested in addition. 12.05.26 – presenter now unable to attend. Defer to next meeting. 03.06.26 – confirmation from Rachel Wright for patient to attend Sept meeting date.
18.12.25	PFIG Meeting 18.12.25	Chair of PFIG	Paper Update on 100% overdue follow ups	Paper update requested during PFIG meeting 18.12.25	Chief Operating Officer / Executive Medical Director	Chief Operating Officer/ Executive Medical Director	~~July 2026~~ Sept 2026	To be added to March agenda 29.1.26 – QSE review evidence of harm as a result of delays to follow up appointments. 05.03.26 – data included in IQPR item for meeting 13.03.26 – advised at May agenda setting by EMO, a further cycle is needed before a paper update can be received by the committee. Review in July agenda setting. 20.05.26 – advised in agenda setting

								for this be reviewed with chairs of PFIG and QSE separately with PW to ensure appropriate committee.
07.05.24	Transfer Log AC24.60.1.8	Audit Committee		Quality, safety and commissioned services. The Committee agreed to a 6-month deferral requesting that the review take place before the end of the current financial year - it was agreed to inform the QSE of this decision and for the QSE committee to drive progress on recommendations from the May 23 report.	Director of Governance / Head of Corporate Governance	Director of Corporate Governance	~~Jan 2026~~ Sept 2026	This matter has been escalated 01.12.25 – added to draft agenda May 2026 - Links with above and item on agenda? (this item now deferred to Sept 26)

Completed items

10.12.24	Email from Executive Director of Nursing & Midwifery re Action from Oct – Deep Dive on Complaints – Duty of Care.	Executive Director of Nursing & Midwifery	PTR guidance update for Development Session	Once Welsh Government releases new PTR guidance, to return to a Development Session.	Executive Director of Nursing & Midwifery	Executive Director of Nursing & Midwifery	March 2026	**17.3.25** Leon Marsh confirmed that guidance still in draft, with no further updates. Current schedule being embedded is Dec 25. Covered in March 2026 development session
2.12.25	COB and moved to forward work plan at agenda setting.	Executive Medical Director	Controlled Drugs Accountable Officer Report	Item came from COB	Executive Medical Director	Executive Medical Director	July 2026	Consider for March 26 meeting. 20.01.26 – to be included on Jul 26 agenda to align with last years reporting schedule 18.05.26 Included on Committee COB
03.03.26	Verbal Request	Phil Meakin	Mental Health Strategic Update –	Follow up from Board meeting in January 2026,	Teresa Owen	Teresa Owen	May 2026	03.03.2026 – PM to discuss with TO

			include under MHLD item.	including case study of EAG. Board will be receiving a report on Mental Health in July.				and advise of any further information. For inclusion on agenda for May. 12.03.26 – on may draft agenda for agenda setting covered on may agenda.
23.02.26	Email Request	Chairman	Experience Item	Discussion on MHLD patient story item video.	Teresa Owen	Teresa Owen	May 2026	Include in agenda setting for May meeting. 12.03.26 – on may draft agenda for agenda setting – included on may agenda.
19.01.26	Board Meeting 27.11.25	Board Meeting	Urgent & Emergency Care	Update to be received at QSE regarding safety elements	Chief Operating Officer	Chief Operating Officer	Mar 2026	20.01.26 – included on March agenda 05.03.26 – update received in march meeting
06.01.26	Verbal Request	Executive Medical Director	Medical Education	Update - deferred from January 26 meeting	Executive Medical Director	Executive Medical Director	Mar 2026	20.01.26 – included on March agenda 05.03.26 – update received in march meeting
30.12.25	Email Request	Head of Corporate Governance	DECLO-ALNET Act annual report	Annual Report update	DECLO (Liz McKinney)	Executive Director of Allied Health Professions & Health Science	Mar 2026	To be added to March agenda 20.01.26 – included on March agenda 05.03.26 – update received in march meeting
28.11.25	Email Request	Director of Corporate Governance	JCC Highlight Report	Highlight report from recent JCC meeting/s	Director of Corporate Governance	Pam Wenger	Jan 2026	To be added to next agenda

								Will come as part of the corporate governance report. On January agenda
05.11.25	Email Request	Chairman/ Director of Corporate Governance	Child Practice Review Briefing	A briefing capturing the recent report and underlining the steps being taken as a Health Board	Angela Wood/Helen Stevens-Jones	Pam Wenger	January 2026	This came to Committee in October and the briefing has been shared
30.10.25	Verbal request	Head of Corporate Governance	NHS Wales JCCQC Chair's Report	Item deferred from Nov 25 meeting to Jan 26 as update not available. To be added "for information" section.	Director of Corporate Governance (Pam Wenger)	Pam Wenger	January 2026	To be added to next agenda This will come via the Corporate Governance Report
30.01.25	Board Meeting 30.01.25	Chair	25/15.1 Improving Quality Report	QSE Committee to review patient feedback data and discuss how this can be addressed to provide longer term solutions to improve performance.	Head of Corporate Governance	Director of Corporate Governance	May 2025	The Performance Framework is being reviewed and due to return to Board Complete
2.12.25	COB and moved to forward work plan at agenda setting.	Executive Director of Allied Health Professions & Health Science	Adult Mental Health & Learning Disabilities • Mental health crisis • Perinatal and Eating Disorder Service	Item came from COB	Executive Director of Allied Health Professions & Health Science	Executive Director of Allied Health Professions & Health Science	To be advised	Item scheduled as per COB
2.12.25	COB and moved to forward work plan at agenda setting.	Executive Director of Nursing & Midwifery	Children & Young People • Childrens Charter • Youth Board	Item came from COB	Executive Director of Nursing & Midwifery	Executive Director of Nursing & Midwifery	To be advised	On COB
2.12.25	COB and moved to forward work plan at agenda setting.	Executive Director of Nursing & Midwifery	Pharmaceutical Services • Independent Review of Hospital Clinical	Item came from COB	Executive Medical Director	Executive Medical Director	To be advised	On COB

			• Pharmacy Services • Radiopharmacy Services					
21.04.26	Board 26.03.26	Board (action 26.52.1)	Cancer Services	QSE to receive Cancer Services as an agenda item at a future meeting to consider how this area of work can be taken forward following discussion at the March Board and report back to a future meeting of the Board. How can areas of this work be embedded as part of Health Board vision to develop services.	Caroline Williams	Tehmeena Ajmal	July 2026	21.05.26 – added to agenda for July under planned care item.

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.

			~~Stephen Powell (~~

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		⚑		⚑		⚑		⚑		⚑		⚑		⚑
Matters Arising and Action Log	Executive Director of Nursing & Midwifery	All Regular Meetings		⚑		⚑		⚑		⚑		⚑		⚑		⚑
Patient Story	Executive Director of Nursing & Midwifery	All Regular Meetings		⚑		⚑		⚑		⚑		⚑		⚑		⚑
Service Presentation	Varied	All Regular Meetings		⚑		⚑		⚑		⚑		⚑		⚑		⚑
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		⚑		⚑		⚑		⚑		⚑		⚑		⚑
~~Regulatory Paper~~ Now included in IQPR bi annually		~~Bi-Annually~~														
Integrated Performance Report	Executive Director of Finance	All Regular Meetings		⚑		⚑		⚑		⚑		⚑		⚑		⚑
Controlled Drugs Accountable Officer Report	Executive Medical Director	Bi-Annually				⚑						⚑				
Strategic Item 1D – Implementing the Quality Management System (QMS)																
Quality Management System	Executive Director of Nursing & Midwifery	Bi-Annually						⚑						⚑		
Strategic Item 4 – Improving Quality, Outcomes and Experience																
Adult Mental Health & Learning Disability ~~(4F)~~	Executive Director of Allied	Bi-monthly		⚑				⚑				⚑		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~~				~~⚑~~				~~⚑~~				~~⚑~~		
~~CAMHS (4G)~~ • ~~Alternative to Admissions~~ • ~~Schools in Reach~~	~~Chief Operating Officer~~	~~To be agreed~~														
~~Neurodevelopment (4H)~~	~~Chief Operating Officer~~															
Dementia Services ~~(4I)~~ TBC	Executive Director of Allied Health Professions & Health Science	To be agreed														
Currently 'Challenged Services' ~~(4J)~~ • Urology • Vascular • Dermatology • Plastics • Oncology • Ophthalmology • Orthodontics	Chief Operating Officer	~~To be~~ agreed Now coming to each Committee		⚑		⚑		⚑		⚑		⚑		⚑		
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				⚑						⚑				
~~Children & Young People (4L)~~ • ~~Childrens Charter~~ • ~~Youth Board~~ Not required – not a quality issue ***Check to see if Childrens Outcomes needs to go to PPHP – Check with TA***	~~Chief Operating Officer~~											⚑				

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
Pharmaceutical Services (4M) • Independent Review of Hospital Clinical Pharmacy Services • Radiopharmacy Services	~~Chief Operating Officer~~ Executive Medical Director	TBC														
Palliative, End of Life, ~~and~~ Bereavement Care and Diterition (4N) • Strategic Delivery Plan • Quality Improvement Strategy (End of Life Care)	Executive Director of Nursing & Midwifery and Executive Medical Director	Annually				X								~~P~~		
Strategic Item 5 - Effective Environment for Learning and Skills Development																
Research, Development & Innovation (5B)	Executive Medical Director	TBC														
Medical Education	Executive Medical Director	Annually														
~~Learning Organisation (5E)~~ ~~Learning from Incidents –~~ comes in quality report	~~Executive Director of Nursing & Midwifery~~															
Quality of Commissioned Services Twice per year – timing to be confirmed	Executive Medical Director & Executive Director of Finance & Performance	TBC														
Annual Responsible Officer Report - TBC	Executive Medical Director	TBC														
ANNUAL REPORTING																
Annual Quality Report	Executive Director of Nursing & Midwifery	Annually *(For onward submission to Board)*														
Nurse Staffing Act	Executive Director of Nursing & Midwifery	Bi-Annually *(For onward submission to Board)*														
Duty of Candour Annual Report	Executive Director of Nursing & Midwifery	Annually *(For onward submission to Board)*														
Putting Things Right Annual Report	Executive Director of Nursing & Midwifery	Annually *(For onward submission to Board)*														

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
Ombudsman Annual Letter	Executive Director of Nursing & Midwifery	Annually								⚑						
Research & Development Annual Report	Executive Medical Director	Annually *(For onward submission to Board)*				⚑				⚑				⚑		
Adoption of Corporate Policies (TBC)	Director of Corporate Governance	As Required														
ALN DECLO Annual Report	TBC	Annually												⚑		
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		⚑		⚑		⚑		⚑		⚑		⚑		⚑
Committee Cycle of Business	Director of Corporate Governance	Annually		⚑												
Committee Terms of Reference	Director of Corporate Governance	Annually		⚑												
Committee Self-Assessment	Director of Corporate Governance	Annually		⚑												
Committee Annual Report	Director of Corporate Governance	Annually		⚑												
Corporate Risk Register Report	Director of Corporate Governance	Quarterly				⚑				⚑				⚑		
Board Assurance Framework Report	Director of Corporate Governance	Quarterly		⚑				⚑				⚑				
FOR INFORMATION																
NHS Wales JCCQC Chairs	Director of Corporate Governance			⚑		⚑		⚑		⚑		⚑		⚑		
Llais Annual Report / Experience Paper	Llais															
Quality Delivery Chairs Report	Executive Director of Nursing & Midwifery			⚑		⚑		⚑		⚑		⚑		⚑		
Operational Delivery Group (ODG) Chairs Report	Exec. Director of Allied Health Professionals					⚑		⚑		⚑		⚑		⚑		
CLOSING BUSINESS																
Agree Items for Referral to Board / Other Committees	Chair	All Regular Meetings		⚑		⚑		⚑		⚑		⚑		⚑		⚑

Item of Business	Executive Lead	Reporting period	Q1			Q2			Q3			Q4			2027-28	
			April 2026	May 2026	June 2026	July 2026	Aug 2026	Sep 2026	Oct 2026	Nov 2026	Dec 2026	Jan 2027	Feb 2027	Mar 2027	April 2027	May 2027
Review of Meeting Effectiveness	Chair	All Regular Meetings		🏳		🏳		🏳		🏳		🏳		🏳		🏳
Date of Next Meeting	Chair	All Regular Meetings		🏳		🏳		🏳		🏳		🏳		🏳		🏳
Resolution to Exclude the Press and Public	Chair	All Regular Meetings		🏳		🏳		🏳		🏳		🏳		🏳		🏳

Health Board Key Issues Report				
Committee Date		02/07/2026 Quality Safety Experience Committee 01/07/2026 Executive Committee		
Date of Committee		01/06/2026	**Report of:**	Mental Health Oversight and Development Group
Quoracy met:		No. The 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. Although the former was satisfied, the attendance was just below the required level. It was noted that discussions will be documented but this requires ratification at a subsequent quorate meeting.		
1	Agenda	The Mental Health Oversight and Development (MHODG) group met on 1st June 2026. The Committee was chaired by Vice Chair, Executive Director of Allied Health Professionals and Health Science 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 work continues on the previously reported formation of a Ligature Reduction Programme Board; the inaugural meeting will take place before the next MHODG meeting and a report will be considered at the July committee. The plan remains for all Health Safety Executive (HSE) actions to 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 five MHODG workstreams and associated deliverables have been communicated to appropriate Executive Leads and the importance of the workstreams and associated deliverables were re-iterated in the meeting (and are summarised in Appendix 2). A subsequent cycle of business is being formulated for the meeting based on the work plan. Each of the workstreams has an Executive Director Lead and a senior lead from MHLD division aligned to them and will continue to be socialised. 2. The Quality Statement for Mental Health (published by the Welsh Government 20th March 2026) was considered. It outlines outcomes/ standards that define high quality, person focused services across health and social care ensuring that these ambitions are delivered consistently across Wales. It provides a single, nationally mandated definition of what “good” mental health care looks like. It applies across the life course and across the whole system, recognising that responsibility for mental wellbeing extends beyond specialist mental health services to include; primary care, social care, education, housing, justice and the third sector. The Quality Statement is a core mechanism for delivering Wales’ Mental Health and Wellbeing Strategy 2025–2035 and is required to inform strategic and operational planning through the National Clinical Framework. Discussion focused on the approach to delivering on the quality statement through existing structures and functions including the Quality Management System (QMS).		

		3. The Mental Health Patient Safety Programme implementation was discussed. This is a key part of the National Strategic Programme for Mental Health and is a priority within the Annual Delivery Plan to ensure it is prioritised and progressed. Work will be undertaken to map the mental health programme against the broader patient safety work, led by the governance team, to ensure alignment and consistency organisationally.
2c	Advise	The MHODG wish to **advise** members of Executive Committee and QSE Committee that: 1. The intended plan for continually developing a compassionate and supportive culture will be progressed with a paper to be considered at the next meeting based on work undertaken within MHLD division to date. This includes the establishment of 29 culture champions and improvements noted from the latest staff survey. 2. The Mental Act 2025 legislation was referenced for information following discussions at Mental Health Legislation Committee (MHLC). 3. The National Dementia strategy consultation was also referenced for information, whilst the final version is awaited from Welsh Government.
2d	Review of Risks	1. Need for assurance on establishment of ligature programme board.
2e	Sharing of learning	1. Wider organisational learning is being sought to ensure the mental health patient safety programme can be implemented consistently and recognising the duality of physical and mental health.
3	Actions to be considered by the Executive Committee	MHODG agreed: • The MHODG work plan to be shared again with key leads to ensure traction. • That the Quality statement should be considered throughout MHODG work and developments. • That the Ligature Reduction Programme Board should continue to progress at pace. • To ensure the mental health patient safety progresses in line with the organisational established approach and for alignment to be drawn.

APPENDIX 1

Mental Health Oversight and Development Group

Date	**01/06/2026**
Time	**2.00 - 4:00pm**
Location	**Teams**
Chair	**Carol Shillabeer, Vice Chair- Teresa Owen**

Item Ref		Time	Paper	Lead	Ask	Notes
1	**PRELIMINARY ITEMS**					
1.1	ODG26.18	2.00	Welcome, Introductions and Apologies for Absence and Declarations of Interest	Chair	Note	
1.2	ODG26.19	2.05	Minutes of the Previous Meeting (13.04.2026) and Action Log	Chair	Approve	
1.3	ODG26.20	2.15	Work We Are Proud Of	All	Note	Discussion
1.4	ODG26.21	2.25	MHODG Workstreams and Key Deliverables	Head of Integrated Strategy and Development- MHLD	Note	A reminder of the workstreams and key deliverables agreed.

2	**STRATEGIC PLANNING, OUTCOMES AND SERVICE MODEL**					
2.1	ODG26.22	2.35	The Quality Statement for Mental Health Wales	Medical Director-MHLD	Note	The Quality Statement for Mental Health | GOV.WALES
3	**CLINICAL STANDARDS AND SERVICE PERFORMANCE**					
3.1	ODG26.23	2.50	Patient Safety Programme	Executive Director of Allied Health Professionals and Health Sciences/ Director of Nursing-MHLD	Note and support development	Patient Safety Programme Paper
4	**ESTATES AND ENVIRONMENT**					
4.1	ODG26.24	3.10	Ligature Programme Board Update	Director of Environment and Estates	Note and Oversight	Verbal
5	**CULTURE LEADERSHIP AND OD**					
5.1	ODG26.25	3.25	Health Board plan for continually developing a compassionate and supportive culture	Executive Director for Workforce and Organisational Development/ Director of Operations MHLD	Note and support development	Verbal
6	**GOVERNANCE OF MH ODG**					
6.1	ODG26.26	3.35	Next Steps Draft MHODG Workplan	Associate Director of Governance	Note	Verbal

7	**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.					
7.1	ODG26.27	3.40	Mental Health Act 2025	Executive Director of Allied Health Professionals and Health Sciences	Note	
7.1	ODG26.28	3.45	Dementia Strategy Consultation	Executive Director of Allied Health Professionals and Health Sciences/ Director of Nursing- MHLD	Note	Draft dementia strategy for Wales 2026 to 2036 | GOV.WALES
8	**CLOSING BUSINESS**					
	ODG26.29	3.50	Any Other Business and Date and Time of next Meeting 16 July 2026 2pm-4pm	Chair		

Appendix 2

Mental Health Oversight and Delivery Group (MHODG) Workstreams and Deliverables Summary

Workstreams	**Deliverables include:**
Strategic Planning Outcomes and Service Model	- Mental Health Outcomes framework - Effective plan to deliver on the strategic programme for Mental Health
Clinical Standards and Service Performance	- Plan to continually improve standards of clinical practice – aligning with Health Board Quality Management System (QMS),
Patient and Carer Engagement and Experience	- Agreed strategy and implementation plan for patient and carer engagement
Estates and Environment	- Agreed estates and physical environment plan - Ligature reduction programme
Culture, Leadership and Organisational Development	- An effective MHLD leadership and OD model, reflecting the Health Board Approach - A plan for continuously developing compassionate and supportive culture in MHLD

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Quality Safety & Experience Committee

ANNUAL 2025/26 STATUTORY ADVOCACY (IMHA) REPORT

Dyddiad y Cyfarfod **Date of Meeting**	02 July 2026
Statws Cyhoeddi **Publication Status**	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad **Report Author name and title**	Joanne Janes Commissioning Manager - Mental Health and Learning Disability Division Zoe Prince Director or Nursing – Mental Health and Learning Disability Division Carole Evanson Director of Operations – Mental Health and Learning Disability Division
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol **Lead Executive Team Member name and title**	Teresa Owen- Executive Director of Allied Health Professionals and Health Science

Pwrpas yr Adroddiad **Report Purpose**	For Noting and assurance

Crynodeb Gweithredol
Executive Summary

This report provides an overview and evidence of BCUHB's provision of Independent Mental Health Advocacy (IMHA) services across North Wales in line with the request made by the Quality, Safety and Experience Committee on the 20th May 2026

The service is delivered by Conwy and Denbighshire Mental Health Advocacy Service (CADMHAS), which operates across a range of healthcare settings to ensure consistent access for eligible individuals.

The purpose of the IMHA service is to support qualifying patients in understanding their rights and the legal frameworks that apply to their care, particularly under the

Mental Capacity Act 1983, as amended by the Mental Health (Wales) Measure 2010.

Part 4 of the Mental Health Measure establishes a statutory entitlement for all eligible inpatients in Wales who are receiving assessment or treatment for a mental disorder to request support from an Independent Mental Health Advocate (IMHA). This provision extends the Independent Mental Health Advocacy arrangements set out under the Mental Health Act 1983 and applies to a wider group of patients.

The entitlement covers both:

- individuals subject to compulsory measures under the Mental Health Act 1983; and
- individuals receiving assessment or treatment in hospital on a voluntary basis.

Eligibility applies across a range of inpatient settings, including specialist mental health hospitals, independent hospitals, and general hospitals where treatment for a mental disorder is being provided.

Regulations may specify the circumstances under which an individual may act as an IMHA, the conditions attached to the role, and the approval process required. This ensures consistency, quality, and safeguarding within the advocacy service.

A fundamental principle of Part 4 is that Independent Mental Health Advocacy must, as far as practicable, be provided by someone who is independent of those professionally involved in the patient's medical treatment. This independence is central to the purpose of IMHA and ensures that patients can receive impartial support to understand their rights, express their views, and engage in decisions about their care without conflict of interest. The legislation is clear that advocacy undertaken under specific statutory arrangements, such as the Mental Capacity Act 2005, does not compromise this independence.

Key assurance findings (appendix 1)

Appendix 1 is a quarterly assurance proforma and the following key assurance findings summarise the performance, quality, and statutory compliance of the IMHA service across BCUHB during 2025/26:

- There was high demand for advocacy services, with 1,300 patients supported during the year 25/26 (compared to 1258 24/25), predominantly compulsory patients (78%).

- Full statutory compliance achieved, with 100% of patients seen within 5 working days and no breaches recorded.
- Comprehensive service coverage, with IMHA provision available across 100% of BCUHB hospital settings.
- Strong service throughput, with 1,289 discharges closely aligned to new referrals, indicating effective case flow and capacity management.
- There was a sustained caseload, with 191 patients actively supported at year end, reflecting ongoing demand.
- Activity appropriately concentrated in mental health inpatient settings (87%), while maintaining access across independent and community-based settings.
- Workforce capacity and capability in place, with 11 WTE IMHAs, all meeting required standards.
- Quality assurance in place, with the provider holding a recognised advocacy quality performance mark. The provider reports that Welsh language needs are assessed as part of initial contact, with arrangements in place to provide advocacy support in Welsh where required.

Conclusion

Overall, the current IMHA contract is performing effectively and is compliant with statutory requirements. There are no immediate risks identified in relation to service delivery, access, or workforce capacity.

Committee Members should note that IMHA provision may be subject to future change following legislative reform to the Mental Health Act, which received Royal Assent in December 2025. The Health Board will continue to monitor these developments and assess any implications for service delivery and commissioning arrangements.

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**	
CADMHAS	Conwy and Denbighshire Mental Health Advocacy Service
IMHA	Independent Mental Health Advocacy
MCA	Mental Capacity Act – legislation that provides a framework for decision-making on behalf of individuals who lack capacity.
MH	Mental Health
MHLD	Mental Health and Learning Disabilities
Mental Health (Wales) Measure 2010 – Part 4	Welsh legislation that establishes a statutory right to Independent Mental Health Advocacy for eligible individuals in Wales.
SORD	Scheme of Reservation and Delegation
BCUHB	Betsi Cadwaladr University Health Board

ANNUAL 2025/26 STATUTORY ADVOCACY (IMHA) REPORT

1. Y SEFYLLFA
SITUATION / BACKGROUND

1.1 All Health Boards have a statutory duty to instruct and make available an Independent Mental Health Advocacy (IMHA) service. The Mental Health Act 1983, as amended by the Mental Health (Wales) Measure 2010, requires all Health Boards to ensure the provision of independent Mental Health advocacy for qualifying compulsory and informal patients in Wales.

1.2 Under the Act the following people over the age of 16 are legally entitled to have an IMHA advocate.

i) People who are detained under the Mental Health Act 1983, except where:

- They have been detained in an emergency under Section 4
- They have been detained under Section 5 holding powers
- They have been taken to a place of safety under Section 135 and 136 of the Mental Health Act

ii) People who are "liable to be detained" including:

- Where people are on leave of absence from hospital
- Where people are absent without leave from hospital
- Where a court order or application for admission has been made
- Where people are subject to a community treatment order (CTO)
- Where people are subject to guardianship
- Where people are a conditionally discharged restricted patient
- where people are a voluntary/informal patient and certain treatments, including neurosurgery, are being considered for them

1.3 The purpose of the IMHA service is to provide assistance to qualifying patients to ensure that they understand the legal procedures of the Act and the rights and safeguards to which they are entitled.

1.4 This may include assistance in obtaining information about any of the following:

- The patient's rights under the Act
- The provision of the Act under which the patient qualifies for an IMHA
- Any conditions or restrictions to which the patient is subject

- The medical treatment the patient is receiving, or which is being proposed or discussed, and the reasons for this
- The legal authority for providing such treatment
- The requirements of the Act which apply in relation to treatment

1.5 The responsibility for commissioning and managing the service sits with the Mental Health and Learning Disabilities Division (MHLD), and Conwy and Denbighshire Mental Health Advocacy Service (CADMHAS), who are commissioned to deliver the regional Independent Mental Health Advocacy service. The contract has been in place since February 2022 and runs until 31st March 2027.

2 MATERION PENODOL I'W HYSTYRIED
SPECIFIC MATTERS FOR CONSIDERATION

2.1 The dataset represents the BCUHB statutory return and includes all qualifying patients for whom the Health Board is responsible, across NHS, independent and other settings.

2.2 The Health Board can provide assurance that the statutory duties under Part 4 of the Mental Health (Wales) Measure 2010 are being met and are summarised in the tables below

IMHA Quantitative Performance Summary – BCUHB (2025/26)

Measure	Compulsory Patients	Informal / Voluntary Patients	Total
New patients accepted into IMHA services	1,018	282	**1,300**
Patients in receipt of IMHA at year end (caseload)	168	23	**191**
Patients discharged from IMHA services	1,012	277	**1,289**
Patients seen within 5 working days	1,018	282	**1,300 (100%)**
Patients waiting over 5 working days	0	0	**0 (0%)**

Service Capacity and Coverage – BCUHB

Metric	Number
Total number of hospital settings	27
Hospitals with IMHA provision	27 (100%)
Total WTE IMHAs	11
Fully qualified IMHAs	8
IMHAs in training	3
IMHAs with additional qualifications	3
Quality performance mark	Yes

Activity by Setting – BCUHB Patients

Setting	New Patients	% Of Total Activity
NHS Mental Health Hospitals	1,137	87%
Independent Hospitals	104	8%
Other NHS Settings	28	2%
Other Settings (e.g. CTO/guardianship)	31	2%
Total	**1,300**	**100%**

IMHA Qualitative Summary – BCUHB (2025/26)

2.4 Qualitative feedback from the provider and patient experience data indicates that the IMHA service is delivering meaningful benefits for patients i.e. ensuring patients are fully heard, explaining, fully, issues to both parties in an understandable way and removing perceived barriers to enable effective therapeutic relationships. For example, an autistic patient detained under Section 3 presented challenging behaviour and limited communication. Through adapted communication, the IMHA increased engagement, improved family contact, and reduced challenging behaviour. Advocacy support is consistently reported to improve patients' understanding of their rights and treatment, enabling greater involvement in care planning and decision-making.

2.5 Patients particularly value the independence of the advocacy role, which supports them to express their views and raise concerns, especially during periods of detention or vulnerability. IMHAs also play an important role in

facilitating engagement with services and supporting resolution of concerns where they arise.

2.6 These qualitative insights complement the quantitative performance data, providing assurance that the service is not only meeting statutory requirements, but is also impactful, patient-centred, and supporting improved experience and outcomes

2.7 Annual and quarterly advocacy reports will be routinely presented to the Mental Health and Learning Disabilities (MHLD) Divisional Senior Leadership Team, where they are subject to review, scrutiny, and provide assurance on service performance and compliance

2.8 The advocacy reports will also be incorporated into the governance framework of the Health Board, specifically feeding into the Mental Health Act Legislation Group. This will ensure that advocacy provision is subject to ongoing oversight, aligns with statutory requirements, and contributes to broader assurance in relation to compliance with mental health legislation, quality of practice, and patient rights

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

The continued high demand and challenging time requirements puts pressure on the provider and its staff. The value of the contract has remained static for the last 3 years with a small 1% increase. This puts the service at risk due to staff retention. Conversations are ongoing at a national level to address this.

As above the rising costs of delivering the service may impact on the ability of the service to continue to train staff, raised during National negotiations about the service.

4. ARGYMHELLION
RECOMMENDATIONS

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

- Note the content of the Advocacy report

Appendix 1 – Mental Health Measure (Part 4) Annual Submission Proforma

Mental Health Measure (Part 4) - quarter 4 Submission Proforma

Local Health Board BCUHB	Select HB:	Summary

Indicator			Data relating to: 2025/26
1	Total number of all hospitals within the Local Health Board [end of March census snapshot]		27
2	Total number of all hospitals which have arrangements in place to ensure advocacy is available to qualifying patients? [end of March census snapshot]		27
3	Total number of WTE Independent Mental Health Advocates (IMHAs) in the Local Health Board at the end of March [end of March census snapshot]		11
4	What is the qualification status of the IMHAs in the Local Health Board (see indicator 3) [end of March census snapshot]	Number of WTE IMHAs who satisfy appointment requirements	11
		Number of WTE IMHAs who are working towards the IMHA diploma	3
		Number of WTE IMHAs who have successfully completed the IMHA diploma	8
		Number of WTE IMHAs who have any additional qualifications	3
5	Does your advocacy provider have or is working towards a recognised advocacy quality performance mark (select from drop down list)?		Yes
6	Number of new qualifying patients accepted into IMHA services during the year: [annual count]	Compulsory patients	1018
		Informal/voluntary patients	282
		Total number of new qualifying patients accepted into IMHA services during the year	1300
7	Number of qualifying patients currently in receipt of IMHA services at the end of the year - i.e. the caseload: [end of March snapshot]	Compulsory patients	168
		Informal/voluntary patients	23
		Total number of qualifying patients currently in receipt of IMHA services at the end of the year	191
8	Number of qualifying patients discharged from IMHA services during the year: [annual count]	Compulsory patients	1012
		Informal/voluntary patients	277
		Total number of qualifying patients discharged from IMHA services during the year	1289
9	Of the qualifying compulsory patients who had their first contact with an IMHA during the year, how many had waited: [annual count]	Up to and including 5 working days following their request for an IMHA	1018
		6 working days or more following their request for an IMHA	0
		Total number of qualifying compulsory patients who had their first contact with an IMHA during the year	1018
10	Of the qualifying informal/voluntary patients who had their first contact with an IMHA during the year, how many had waited: [annual count]	Up to and including 5 working days following their request for an IMHA	282
		6 working days or more following their request for an IMHA	0
		Total number of qualifying informal/voluntary patients who had their first contact with an IMHA during the year	19

Mental Health Measure Part 4

Local Health Board	Select HB:

Indicator			Data relating to: 2025/26
1	Total number of all hospitals within the Local Health Board [end of March census snapshot]		27
2	Total number of all hospitals which have arrangements in place to ensure advocacy is available to qualifying patients? [end of March census snapshot]		27
3	Total number of WTE Independent Mental Health Advocates (IMHAs) in the Local Health Board at the end of March each year [end of March census snapshot]		11
4	What is the qualification status of the IMHAs in the Local Health Board (see indicator 3) [end of March census snapshot]	Number of WTE IMHAs who satisfy appointment requirements	11
		Number of WTE IMHAs who are working towards the IMHA diploma	3
		Number of WTE IMHAs who have successfully completed the IMHA diploma	8
		Number of WTE IMHAs who have any additional qualifications	3
5	Does your advocacy provider have or is working towards a recognised advocacy quality performance mark (select from drop down list)?		Yes

Mental Health Measure (Part 4) - quarterly Submission Proforma

Local Health Board	Select HB:	NHS Mental Health Hospitals

Indicator			Data relating to:
			2025/26
6	Number of new qualifying patients accepted into IMHA services during the year: [annual count]	Compulsory patients	874
		Informal/voluntary patients	263
		Total number of new qualifying patients accepted into IMHA services during the year	**1137**
7	Number of qualifying patients currently in receipt of IMHA services at the end of the year - i.e. the caseload: [end of March snapshot]	Compulsory patients	136
		Informal/voluntary patients	19
		Total number of qualifying patients currently in receipt of IMHA services at the end of the year	**155**
8	Number of qualifying patients discharged from IMHA services during the year: [annual count]	Compulsory patients	863
		Informal/voluntary patients	261
		Total number of qualifying patients discharged from IMHA services during the year	**1124**
9	Of the qualifying compulsory patients who had their first contact with an IMHA during the year, how many had waited: [annual count]	Up to and including 5 working days following their request for an IMHA	874
		6 working days or more following their request for an IMHA	0
		Total number of qualifying compulsory patients who had their first contact with an IMHA during the year	**874**
10	Of the qualifying informal/voluntary patients who had their first contact with an IMHA during the year, how many had waited: [annual count]	Up to and including 5 working days following their request for an IMHA	263
		6 working days or more following their request for an IMHA	0
		Total number of qualifying informal/voluntary patients who had their first contact with an IMHA during the year	**0**

Mental Health Measure (Part 4) - quarterly Submission Proforma

Local Health Board	Select HB:	Independent Mental Health Hospitals

Indicator			Data relating to:
			2025/26
6	**Number of new qualifying patients accepted into IMHA services during the year:** **[annual count]**	Compulsory patients	93
		Informal/voluntary patients	11
		Total number of new qualifying patients accepted into IMHA services during the year	**104**
7	**Number of qualifying patients currently in receipt of IMHA services at the end of the year - i.e. the caseload:** **[end of March snapshot]**	Compulsory patients	21
		Informal/voluntary patients	2
		Total number of qualifying patients currently in receipt of IMHA services at the end of the year	**23**
8	**Number of qualifying patients discharged from IMHA services during the year:** **[annual count]**	Compulsory patients	97
		Informal/voluntary patients	11
		Total number of qualifying patients discharged from IMHA services during the year	**108**
9	**Of the qualifying compulsory patients who had their first contact with an IMHA during the year, how many had waited:** **[annual count]**	Up to and including 5 working days following their request for an IMHA	93
		6 working days or more following their request for an IMHA	0
		Total number of qualifying compulsory patients who had their first contact with an IMHA during the year	**93**
10	**Of the qualifying informal/voluntary patients who had their first contact with an IMHA during the year, how many had waited:** **[annual count]**	Up to and including 5 working days following their request for an IMHA	11
		6 working days or more following their request for an IMHA	0
		Total number of qualifying informal/voluntary patients who had their first contact with an IMHA during the year	**11**

Mental Health Measure (Part 4) - quarterly Submission Proforma

Local Health Board	Select HB:	Other NHS

Indicator			Data relating to:
			2025/26
6	Number of new qualifying patients accepted into IMHA services during the year: [annual count]	Compulsory patients	26
		Informal/voluntary patients	2
		Total number of new qualifying patients accepted into IMHA services during the year	**28**
7	Number of qualifying patients currently in receipt of IMHA services at the end of the year - i.e. the caseload: [end of March snapshot]	Compulsory patients	7
		Informal/voluntary patients	1
		Total number of qualifying patients currently in receipt of IMHA services at the end of the year	**8**
8	Number of qualifying patients discharged from IMHA services during the year: [annual count]	Compulsory patients	28
		Informal/voluntary patients	3
		Total number of qualifying patients discharged from IMHA services during the year	**31**
9	Of the qualifying compulsory patients who had their first contact with an IMHA during the year, how many had waited: [annual count]	Up to and including 5 working days following their request for an IMHA	26
		6 working days or more following their request for an IMHA	0
		Total number of qualifying compulsory patients who had their first contact with an IMHA during the year	**26**
10	Of the qualifying informal/voluntary patients who had their first contact with an IMHA during the year, how many had waited: [annual count]	Up to and including 5 working days following their request for an IMHA	2
		6 working days or more following their request for an IMHA	0
		Total number of qualifying informal/voluntary patients who had their first contact with an IMHA during the year	**2**

Mental Health Measure (Part 4) - quarterly Submission Proforma

Local Health Board	Select HB:	Any other setting

Indicator			Data relating to:
			2025/26
6	Number of new qualifying patients accepted into IMHA services during the year: [annual count]	Compulsory patients	25
		Informal/voluntary patients	6
		Total number of new qualifying patients accepted into IMHA services during the year	**31**
7	Number of qualifying patients currently in receipt of IMHA services at the end of the year - i.e. the caseload: [end of March snapshot]	Compulsory patients	4
		Informal/voluntary patients	1
		Total number of qualifying patients currently in receipt of IMHA services at the end of the year	**5**
8	Number of qualifying patients discharged from IMHA services during the year: [annual count]	Compulsory patients	24
		Informal/voluntary patients	2
		Total number of qualifying patients discharged from IMHA services during the year	**26**
9	Of the qualifying compulsory patients who had their first contact with an IMHA during the year, how many had waited: [annual count]	Up to and including 5 working days following their request for an IMHA	25
		6 working days or more following their request for an IMHA	0
		Total number of qualifying compulsory patients who had their first contact with an IMHA during the year	**25**
10	Of the qualifying informal/voluntary patients who had their first contact with an IMHA during the year, how many had waited: [annual count]	Up to and including 5 working days following their request for an IMHA	6
		6 working days or more following their request for an IMHA	0
		Total number of qualifying informal/voluntary patients who had their first contact with an IMHA during the year	**6**

N.B. For clarity, whilst the title references a quarterly report, the content presented relates to the annual 2025/26 statutory advocacy report.

Archwilio Cymru
Audit Wales

Review of Quality Governance

Betsi Cadwaladr University Health Board

April 2026

We have prepared and published this report under section 61(3) (b) of the Public Audit Wales Act 2004

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Contents

Audit snapshot

What we looked at

1 Our 2022 Quality Governance Review examined how Betsi Cadwaladr University Health Board's (the Health Board) manages service quality. We looked at culture and behaviours, quality strategy, and governance structures. We made 12 recommendations focussing on:

- quality and patient safety priorities;
- risk management;
- clinical audit; mortality reviews and complaint handling;
- sharing learning and good practice;
- values and behaviours; and
- governance and oversight.

2 This follow on review assesses the extent to which the Health Board's arrangements support high quality and safe services. As part of this, we have assessed progress on our 2022 review recommendations. Our work also looked at the delivery of the Duties of Quality and Candour requirements, and related oversight and scrutiny.

Why this is important

3 Quality should be at the 'heart' of all aspects of healthcare and 'putting quality and safety' above all else is one of the core values underpinning the NHS in Wales. Poor quality care can be costly in terms of waste and unjustifiable variation in services but most importantly it can result in harm and poor outcomes for patients.

4 In February 2023, the Welsh Government escalated the Health Board to Level Five (Special Measures)[1].The Welsh Government set out the actions that it expects the Health Board to achieve, which includes:

- improvement in complaints response times;
- progress on the implementation of and compliance with the Duties of Quality and Candour;
- effective response to external reviews; and
- the use of national clinical audit and Value in Health dashboards to support quality improvement.

What we have found

5 The Health Board is taking steps to strengthen its quality governance arrangements, but there remain weaknesses which it needs to address. It has put in place key parts of a digital Quality Management System (QMS) and updated several governance frameworks. But the Health Board needs to agree clear quality priorities, with strong leadership and accountability across and throughout the organisation to deliver them.

6 Early work to implement the Duties of Quality and Candour is underway, but significant gaps remain in quality leadership, staff training and reporting. The Health Board has a new learning system, but it is not always demonstrating that lessons are learnt. Complaints response timeliness has improved. However, rising complaint volumes is placing pressure on teams. The volume of re-opened cases also suggests the quality of investigations needs strengthening.

[1] NHS Wales escalation and intervention arrangements | GOV.WALES

7 The Health Board could further strengthen quality oversight at Board and committee levels. It has not yet done enough to strengthen its focus and oversight of the quality of commissioned services following concerns raised by the Public Services Ombudsman for Wales. Similarly, despite improvements in national clinical audit reporting, the local clinical audit programme is not risk-based. As a result, there is a missed opportunity to provide the QSE Committee with targeted assurance on areas of concern.

8 The Health Board's progress on the 2022 audit recommendations is mixed. It has taken actions to strengthen arrangements for mortality reviews, culture, and patient feedback, but it has made less progress on other areas.

What we recommend

9 We have made nine new recommendations to the Health Board, which focus on:

- Establishing clear quality priorities;
- Strengthening assurance and learning systems;
- Improving organisational training and awareness of quality governance systems and process; and
- Enhancing corporate oversight of commissioned care and complaints.

Key facts and figures

3,000	monthly average number of patient safety incidents. This equates to approximately 100 per day.
4,900	open patient safety incidents, with 58.6% overdue for investigation.
291	open complaints with an average of 20 working days to resolve complaints. The Health Board's performance is currently the best in Wales.
41	new contacts with the Public Services Ombudsman for Wales in November 2025, the highest number for a year. The PSOW decided **not** to investigate 29 (71%) of these.
£57,000	in financial penalties for overdue Learning from Events Reports between April 2024 and February 2026, a reduction of 67% compared to the £172,500 penalties received in 2024-25.
9	Number of never events recorded during 2025-26, compared to five in 2024-25.

Source: Integrated Quality Performance Report to the Quality Safety and Experience Committee, January 2026

Our findings

Quality plans and planning

The Health Board's approach to quality improvement planning is not yet sufficiently robust

Quality plans and priorities

10 The Health Board needs to do more set out clear quality priorities and a coordinated programme to deliver them. At the time of our work the Health Board did not have a stand-alone quality plan. It has not updated its previous Quality Strategy (2017-20), with a preference to integrate quality into existing plans including the Integrated Medium-Term Plan (IMTP). This approach does not appear to be driving enough of emphasis on quality improvement. It also leaves some gaps.

11 The Health Board's IMTP 2025-28 is its primary plan for improving quality, supported by the Quality Management System (QMS) and Quality Management Framework. It sets out how the Health Board will deliver its five strategic objectives. The IMTP includes several delivery priorities linked to the objective of 'Improving Quality, Outcomes and Experience'. However, these priorities mainly link to operational targets. Examples include reducing waiting times for planned care and urgent and emergency care. As a result, the IMTP takes a narrow view of quality. It places a greater weight on performance than on other aspects of patient safety, clinical effectiveness, and patient experience.

12 The Health Board's IMTP 2026–29 gives more visibility to quality than the previous IMTP (2025-28). Our review of the IMTP 2025-28 found that the Health Board's quality priorities mainly linked to operational performance targets. The plan also did not have actions for concerns such as infection prevention, sepsis, or pressure damage reduction. Our review of the IMTP 2026-29 found that it includes a wider range of actions to improve patient safety, outcomes and experience.

13 Even with this improvement, the IMTP 2026–29 does not give the Health Board a clear overall plan for how it will manage and improve quality. In particular, the plan does not set out a small number of shared quality priorities, supported by consistent measures and a clear approach to assurance. For example, while the IMTP includes measures such as complaint response times, these are presented as individual actions within specific service areas.

14 There is a risk that the lack of a clear quality plan and priorities affect staff understanding of quality aims. While the Health Board is developing a QMS, it is not yet well implemented. The Quality Management Framework provides structure and processes. However, the Health Board does not translate this into a set of agreed quality priorities, standards, or outcomes for staff and services to work towards.

15 Our work found that staff could consistently identify performance priorities, such as complaints timeliness, emergency department and planned care waits. But they struggled to describe wider quality improvement priorities. This suggests that staff understanding of quality is shaped by what is quantified in performance reports rather than broader quality improvement plans.

16 The Welsh Government has set out in some detail its quality improvement expectations at the Health Board. At present, our view is that the IMTP is not providing a sufficiently robust mechanism to drive the quality improvements needed. There is a clear need for a stand-alone quality plan. This plan should set out quality priorities, the leadership, resources and programme to deliver it. This is particularly important to demonstrate a joined-up response to Welsh Government escalation requirements.

Responding to the Duties of Quality and Candour

The Health Board is taking steps to meet the duties, yet gaps in leadership roles, training oversight and reporting limit assurance over its delivery

Roles and responsibilities

17 The Quality and Engagement Act guidance requires NHS bodies to establish clear lines of accountability for discharging the Duties of Quality and Candour. This includes ensuring that leadership roles are defined at all levels.

18 The Health Board has clearly delegated the strategic lead for both the Duty of Quality and the Duty of Candour to the Executive Director of Nursing and Midwifery. However, wider responsibilities for other executive, operational and clinical leaders are unclear. We understand that this is a result of past and ongoing gaps in management and clinical leadership.

19 Several interviews raised concerns about the visibility and cohesiveness of quality leadership more broadly. This includes clear responsibilities and leadership embedded across quality groups.

20 The Health Board is currently reviewing its organisational structures as part of its Foundations for the Future programme. This work is ongoing and will continue throughout 2026. As it progresses, the Health Board should ensure that it defines clear accountability for discharging both duties.

Training

21 The Health Board has taken steps to brief Board members on the duties of quality and candour. However, it needs to do more to provide assurance that it is sufficiently training operational staff. Executives and Independent Members have had updates on the Duties of Quality and Candour, with a session in 2024 and another planned for spring 2026.

22 There is currently no assurance that operational staff are receiving required training on the duties of quality and candour. Internal Audit's June 2025 review of the Duty of Quality gave a reasonable assurance rating but identified key gaps. This includes the absence of a structured training programme and the inability to verify training uptake. The Health Board completed a training needs analysis in August 2025. Since then, neither the People and Culture Committee nor the QSE Committee has received reports showing progress. The Integrated Concerns Policy also sets clear training requirements for the Duty of Candour, including mandatory training for investigators. However, the Health Board does not report compliance rates.

Quality Management System (QMS)

23 The Health Board's development and implementation of the QMS and Quality Management Framework is not yet well progressed. To help meet the requirements of the Quality and Engagement Act, the Health Board started its journey to develop its QMS with a presentation to the Board in May 2024 which set out high level principles. The more recent Board development session in February 2026 started to explore:

- Board roles and responsibilities for a QMS;
- creating the conditions and organisational enablers for a QMS; and
- using data in the Board as part of a QMS.

24 The QMS should provide a structured, organisation-wide model that supports quality planning, monitoring, assurance and improvement. It should aim to improve learning, transparency, and support data-led decision-making across all services. Yet the QMS approach is not yet well developed nor well-embedded with limited progress in implementing the approach across services. While not the sole reason for delay, there has been a pause while the Foundations for the Future programme is developing.

25 The QMS approach is supported by a high-level Quality Management Framework. This Framework provides limited detail on the implementation of the QMS. It does provide the reader with a summary of the aims of the QMS and how it aligns with the Board's Strategic Objectives. The Quality Management Framework notes further development is needed across all the quality domains and an implementation plan will be developed. This was not completed at the time of our review.

26 The Health Board's Quality Dashboard provides real time service data. The dashboard supports performance monitoring, escalation and incident reporting. It brings together data from both the Datix system[2] and the Audit Monitoring and Tracking system. A November 2025 Internal Audit review of complaints management found no evidence on Datix to show that the Health Board had completed or closed Learning and Improvement Plan actions. The audit also found no routine validation of completed actions.

27 As of March 2026, the Health Board assessed its maturity in responding to the Duty of Candour as 'Yellow/Operationalising'. This shows that it recognises the need to do more before it fully meets the duty. The Health Board is working on an improvement plan to address the remaining gaps during 2026. This includes embedding organisational learning. In June 2025 Internal Audit gave a reasonable assurance opinion on the Duty of Quality. However, it highlighted the need to approve the Quality Regulatory Policy, improve staff training and provide guidance on how to use the QMS.

Monitoring and oversight of response to the duties

28 Statutory guidance for the Quality and Engagement Act sets out explicit expectations for how NHS organisations must implement, evidence, and report on the duties during the year and through annual public reporting.

[2] Datix is a cloud-based software tool within NHS Wales, which has multiple modules, including systems for logging handling patient safety, health and safety and complaint records.

29 The Health Board is improving its reporting approach, but it not yet fully meeting the reporting requirements set out in the Act. The QSE Committee receives a reasonably comprehensive suite of regular quality, safety and experience reports. Routine reporting includes the:

- Integrated Quality Report;
- Integrated Quality & Performance Report;
- regulatory inspection findings; and
- national audit outputs.

30 These reports contain extensive quality performance data and supporting narrative. But they do not explicitly frame this information through the lens of the statutory duties. For example, reports do not describe quality impact consistently in relation to the six quality domains and six enablers set out in statutory guidance nor do they provide information on the number of candour cases and compliance with the candour procedure. These elements are prescribed within the statutory guidance for the duties.

31 We saw similar scope to improve the Health Board's Annual Quality Report. It last published this report in September 2025. The 2024–25 report clearly sets out work to improve patient experience and care outcomes. It highlighted several service-level improvements, such as reduced waiting times through the Planned Care Hub. But it says little about how quality evidence guided big choices, such as changes to the organisation or decisions around financial recovery.

32 The Annual Duty of Candour Report 2024-25 clearly sets out the Duty's requirements and the steps the Health Board is taking. But the report would be stronger if it included more detail on what the Health Board learned from candour cases and what it subsequently improved. In 2024–25, the narrative focuses on arrangements rather than assurance about actions and difference that the Health Board is making.

Learning from service quality feedback

The Health Board is improving how it learns from service quality feedback, though it needs to better demonstrate that learning has been affectively adopted

Listening to staff

33 In 2022, we recommended that the Health Board strengthens how it addresses and learns from staff concerns about bullying, harassment and abuse, which was a theme in the 2022 staff survey. The Health Board has taken several steps to address these concerns, as follows:

- In August 2023, it introduced a culture dashboard, to track organisational culture. The dashboard includes measures such as sickness absence, vacancies, staff turnover and Speaking Up Safely concerns which the Health Board presents in a Culture Synthesis Report.
- In September 2023, the Health Board established a Culture and Leadership Programme, aimed at all levels of leadership across the organisation.
- In September 2024, the Health Board introduced a new ‘Speaking up Safely’ approach. Its aim is to make sure all staff can raise concerns safely and confidently. The approach is supported by a network of Freedom to Speak Up Guardians, an anonymous digital reporting system, and clear guidance and communications material.
- In November 2024, the Health Board approved a new Values and Behaviours Framework. Officers developed the Framework through wide staff engagement and it sets out expectations for how all staff should work, behave, and interact with service users, colleagues and partners.

34 These actions show that the Health Board is committed to responding to concerns about bullying and harassment. We therefore consider our 2022 recommendation to be complete.

35 However, we note that there will be a need to continue to improve against, and closely monitor, metrics related top bullying and harassment in the annual NHS staff survey, which will demonstrate whether the Health Board is implementing the correct actions and learning from staff concerns. The results of the 2025 NHS staff survey were not yet available at the time of our review but are expected to report in Spring 2026.

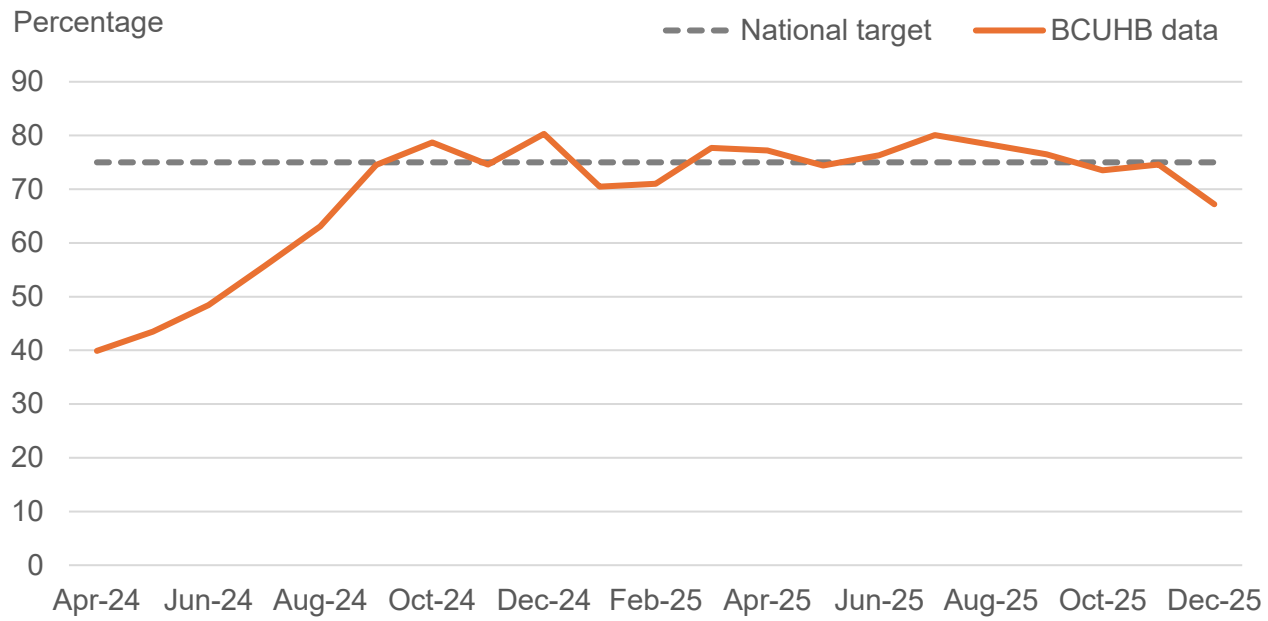
Complaints

36 The Health Board's Integrated Concerns Policy, adopted in September 2024, aligns with the national Putting Things Right Regulations and gives staff clear guidance and procedures for identifying, responding to and learning from complaints, concerns, and mortality reviews. The Patient and Carer Experience Group is the primary operational group for overseeing complaints. It works together with other relevant operational groups to report information on complaints to the Executive Quality Delivery Group. Interviews indicated that this process works well.

37 The QSE Committee provides corporate oversight of complaints. It receives regular updates through the Integrated Quality and Performance Report and considers more detailed analysis in the Integrated Quality Report. This includes the number of new, open, and overdue complaints, along with the main themes. In March 2026, the most common themes still related to long waiting times and poor experiences in emergency departments.

38 Reports demonstrate significant improvements to the timeliness of its responses to complaints in recent months, as shown in **Exhibit 1**. Benchmarking data provided within the Integrated Quality Report also shows how this performance consistently compares well against other Welsh health boards.

Exhibit 1: Percentage of complaints closed within 30 days, April 2024 – December 2025



Source: Integrated Quality and Performance Reports between August 2024 and March 2026.

39 Although the Health Board has improved complaint response timeliness, the number of complaints continues to rise at a pace that may become difficult to manage. In 2024-25, it recorded 2,412 complaints, up 17.7% from 2,049 in the previous year. By March 2026, the Health Board was receiving an average of 66 complaints each week and closing 60. To address this growing demand, it plans to focus more on early resolution and on using learning and improvement to reduce the need for people to complain.

40 Alongside a rise in new complaints, the Health Board has also seen a 43% increase in re-opened cases, from 131 in 2023-24 to 229 in 2024-25. This may suggest that some people are not satisfied with the first response. However, cases can be reopened for several reasons. For example, people may ask new questions, share more information, or want further explanation. Currently, QSE Committee does not have clear sight of these issues. It would benefit from receiving the annual Patient Experience & Complaints Review Reports. These reports provide useful insight into longer-term trends and effectiveness of complaints handling.

41 The high number of re-opened complaints also points to gaps in staff training. We first raised this issue in our 2022 review. Since then, there has been little progress, and the Health Board is still not monitoring training completion well enough. For these reasons, we consider that progress against this recommendation remains ongoing.

42 The Welsh Government has introduced a new 'Listening to People[3]' Process which replaces the existing Putting Things Right arrangements from April 2026. The revised framework introduces three key changes:

- a strengthened early resolution stage extended from 2 to 10 working days;
- a mandatory listening conversation with every complainant; and
- an expanded redress threshold with shortened investigation timescales.

43 As a result of these new requirements, the Health Board is anticipating a significant increase the volume of work handled by frontline teams, given the requirement for clinical and operational services to support decisions under the new Process. In response, it is redesigning its concerns-handling model. It plans to replace its Patient Advice and Liaison Service with a new Patient Enquiry, Advice and Resolution Service which will function as a single point of contact, manage enquiries, close lower grade complaints, and facilitate listening conversations. A new People's Experience Team will focus on broader patient-experience work and embedding learning.

[3] Listening to People - Improvements to be made to NHS Wales complaints system

Responding to patient feedback

44 Patient feedback is a valuable source of intelligence on the quality of services. The Health Board uses real-time data and information from the Patient Advice and Liaison Service to collect patient feedback. The Patient and Carer Experience Group reviews this feedback, brings the findings together, and reports to the QSE Committee every two months. However, the Health Board does not track how teams evaluate learning from patient experience feedback or how they use it to improve quality. The Patient Experience and Complaints Review for 2024-25 shows only small improvements in patient experience across all areas.

45 Our 2022 review found that less than half of the staff surveyed felt they received regular updates on patient feedback in their work area. We subsequently recommended that the Health Board address this issue. The Health Board has since strengthened its arrangements for sharing patient feedback with staff routinely. For example, feedback is shared with frontline staff by displaying results on ward boards. An October 2025 Internal Audit review of Patient Experience also provided a substantial assurance rating. We therefore consider the Health Board to have completed our 2022 recommendation in this area.

46 The Health Board is planning to further strengthen its arrangements in responding to the new Welsh Government ‘Listening to People’ Process. It plans to improve the sharing of patient feedback to staff to support ward-level learning. However, we note that the delivery of this plan is contingent on finding investment for additional staff.

Learning from mortality reviews

47 In 2013, the Chief Medical Officer for NHS Wales advised that every hospital death should have a mortality review. The Health Board's Integrated Concerns Policy clearly explains the roles of clinicians and committees in this process. A clinician-led Mortality Review Team carries out the reviews and reports the findings to the Strategic Clinical Effectiveness Group. This group includes staff from therapy, pharmacy, and research and development. A Learning from Mortality Forum then looks at the findings, identifies lessons, and shares them across services.

48 In our 2022 review, we recommended that the Health Board set up a system so staff from different professions take part in mortality reviews as a matter of routine. With more structured multidisciplinary oversight now in place, we consider this recommendation complete.

49 Our 2022 review also recommended that the Health Board ensure its QSE Committee receives quarterly mortality review reports that highlight learning. Our recent review found that the QSE Committee now receives regular mortality review updates through the bi-monthly Integrated Quality Report. In early 2024, the Health Board had a large mortality review backlog of around 500 cases. By late 2025, this had reduced, with cases pending scrutiny falling from around 450 in November to about 390 in December, investigations reducing from around 140 to 65, and no significant backlog remaining in the West Integrated Healthcare Community.

50 Themes from mortality reviews continue to centre on concerns about clinical treatment, patient care, and the recording and use of Do Not Attempt CPR decisions. The Health Board has begun a programme to address these recurring issues. The QSE Committee should review the impact of this work to determine whether learning has been implemented as intended.

Embedding learning from internal and external reviews

51 The Health Board has three key groups in place to support organisational learning from internal and external sources:

- the Integrated Concerns Oversight Panel, a weekly executive forum that reviews urgent internal safety issues and escalates concerns through the Health Board's governance structure;
- the Regulatory Assurance Group which meets monthly to oversee how the Health Board responds to external regulatory reports and inspections; and
- the Organisational Learning Forum which meets monthly to share learning and encourage improvement across the organisation.

52 These groups provide oversight of learning from incidents, concerns, external reviews and regulatory findings. Each group reports to the Executive Quality Delivery Group, which then escalates key issues to the QSE Committee through assurance reports. However, the purpose of these groups, and the policies and processes that support them, need strengthening. An Internal Audit review of Learning from Regulatory Reporting in December 2025 gave a limited assurance opinion. The audit highlighted major gaps in the Health Board's regulatory learning processes, including:

- no overarching regulatory assurance policy;
- no central register of regulators or reporting routes;
- the Regulatory Assurance Group reviewing only a small number of regulators and therefore not meeting its remit;
- no formal or consistent process for extracting, sharing or tracking wider learning from regulatory reports; and
- no system to check whether actions are carried out or whether they are effective.

53 In response, the Health Board has introduced a Regulatory Assurance Policy. However, three of the five high-priority actions have long-term deadlines running to March 2027, suggesting greater priority is needed.

54 The Health Board's response to Healthcare Inspectorate Wales (HIW) inspections shows that it acts on regulatory findings to deliver improvement, although the improvements are not always sustained.

55 In June 2023, it improved arrangements including audit and governance in vascular services. This led HIW to remove the "Service Requiring Significant Improvement" status. At Ysbyty Glan Clwyd, the Emergency Department resolved the main patient safety concerns that HIW found in 2022. HIW recognised the improvements and learning and de-escalated the service in 2024. However, some problems continue to appear in HIW reports. This includes concerns about pressure injury checks, falls risk assessments, equipment checks, corridor care and record keeping.

56 Overall, HIW reports show that the Health Board can improve individual services after inspections. But it struggles to embed these changes. This is most clear where change needs strong leadership, clear roles, and shared responsibility beyond the service under review.

57 These challenges in regulatory learning are mirrored in the Health Board's broader approach to organisational learning, including its management of Learning From Events Reports. Learning From Events Reports are mandatory submissions to the Welsh Risk Pool after the Health Board settles clinical negligence, redress or personal injury cases. To receive reimbursement for the costs of redress, the Health Board must show clear learning, identify causes, set out corrective actions and explain how it will prevent the issue from happening again.

58 Over the past two years, performance on LFERs has improved: the number of overdue LFERs reduced from around 105 in September 2024 to 79 by January 2025, and further to 18 by January 2026 following targeted intervention. This improvement has led to a reduction in financial penalties, from 69 penalties (£172,500) in 2024–25 to 23 penalties (£57,500) between April 2025 and February 2026.

59 However, despite the reduction in overdue reports, many cases remain deferred because the Health Board has not yet provided sufficient evidence of learning to close them. This shows that while the backlog has reduced, underlying weaknesses in evidencing learning, assurance processes, and organisational learning systems continue may limit the Health Board's ability to demonstrate timely and robust learning from events.

60 The Health Board also continues to report a high number of never events, with nine recorded in 2025-26. This compares to five which were recorded in 2024-25. Some of these events are very similar in nature. This raises concern about whether the Health Board is effectively learning from serious incidents and using that learning to prevent the same problems happening again. Repeated never events of a similar type suggest that learning is not yet being embedded consistently across services.

61 Our 2022 review raised concerns about the system for supporting staff learning from quality improvement projects. In 2025, the Health Board introduced a new 'Learning Repository' to support the Organisational Learning Forum. The Repository sits within the Quality Management System and brings together learning from incidents, complaints, audits and feedback in one consistent, reliable library.

62 The Pharmacy team is testing the new system, and early results are positive. The Health Board is now expanding the rollout during 2026. If the Health Board delivers the new approach well, the Repository could strengthen thematic learning and help teams share lessons more easily. As this work is still underway, we consider our 2022 recommendation to be in progress.

Quality governance, assurance and oversight

Quality governance arrangements are improving but significant weaknesses remain in oversight of risk, clinical audit and commissioning.

Corporate oversight of quality

63 The Quality, Safety and Experience Committee receives clear and structured information. There is a well-established agenda supported by integrated quality and performance reporting. The level of detail and analysis varies between meetings. However, most papers allow the committee to challenge and scrutinise performance effectively. They usually include trend data, benchmarking, and focused deep dives. These deep dives cover key areas of concern, such as patient safety incidents and complaints. But as highlighted elsewhere in this the report there are opportunities for improvement. This includes scrutiny of the quality of commissioned services and target local clinical audit.

64 We found differences in the Health Board's reporting of Nationally Reportable Incidents (NRIs). The numbers given to the QSE Committee during 2025-26 do not match the numbers in the draft annual performance report. For example, the QSE Committee was told there were 14 NRIs in June-July and 26 in August-September, but the performance report says there were two incidents in each of those periods. This makes it harder to trust the data and to get a clear picture of patient safety issues.

65 Our 2022 review raised concerns about how information flowed from operational sub-groups to the quality group responsible for escalating risks to the QSE Committee. At the time, the highlight reports used, known as 'Triple A' reports, varied in quality and detail, and we recommended that the Health Board provide clearer guidance to report authors.

66 Operational groups now submit Quality Highlight and Escalation Reports to the Executive Quality Delivery Group instead of Triple A reports. Although no formal written guidance has been issued, Executive Quality Delivery Group members provide regular verbal feedback to authors on how well their reports have covered the key issues, and our review found that submissions now consistently cover all five key domains with an appropriate level of detail. Based on this, we consider the previous recommendation to be met.

67 However, our review found some duplication in reports sent to the Executive Quality Delivery Group by sub-groups. These included the Patient Safety Group, Regulatory Assurance Group, and Clinical Effectiveness Group. This overlap could lead to mixed or conflicting messages. It also suggests that roles and responsibilities between these groups are not always clear and may overlap in unhelpful ways.

Arrangements for managing quality risks

68 We considered whether services effectively identify and manage quality and patient safety risks. Service teams use local risk registers to record service-level risks. Staff often identify new risks during daily patient safety and incident huddles using information from the Quality Dashboard and Datix reports. Risk escalation processes appear to work well. The weekly Integrated Concerns Oversight Panel provides support and challenge on operational risks and escalates concerns to the Executive Quality Delivery Group when needed.

69 The November 2025 Rapid Quality Review of Emergency Departments found that teams in Emergency Departments were identifying risks and taking action to manage them. However, the review did not provide assurance that officers were managing these risks effectively. It reported that major risks still remained and that the Health Board needs better systems, clearer reporting and improved patient flow. The review also highlighted specific weaknesses that show mitigating actions have had limited impact. Given that the Health Board has other high-risk services, it should consider using this type of review more widely. Currently, the Health Board does not plan to carry out similar reviews in other pressured services.

70 At corporate level, the QSE Committee oversees quality and patient safety risks through the Corporate Risk Register and the Board Assurance Framework, reviewing them in turn each meeting. However, the risks recorded are very high level, with only two quality risks on the Corporate Risk Register and one on the Board Assurance Framework. Given current service pressures, this results in many controls and actions spread across several services and performance areas, making oversight and scrutiny difficult. It also raises questions about how effective corporate risk management is. All three risks remain above tolerance and have not reduced for several months.

71 Our 2022 review found that operational staff needed better risk management training. Internal Audit raised the same concern again in April 2025 during its review of the Board Assurance Framework and risk management. Although Internal Audit gave a reasonable assurance rating, it identified clear gaps. These included limited access to risk management training and a lack of clarity about how many staff were expected to complete it.

72 In response, the Health Board updated its Risk Management Framework, and the Board approved the new version in November 2025. The revised Framework explains roles and responsibilities more clearly and sets out training needs for three levels of staff. The operational Risk Scrutiny Group now checks training rates each month for each group. Current rates are still below target, but the Health Board plans more training and targeted communications to improve uptake. As additional training is still needed we consider our 2022 recommendation to be ongoing.

Clinical audit assurance

73 Local and national clinical audits play an important role in quality assurance. Our 2022 review recommended that the Health Board focus its clinical audit programme on high-risk specialties and patients waiting longest for treatment. Internal Audit raised the same issue in April 2025 and gave a limited assurance rating, partly because the Tier Two[4] audit plan did not reflect the Health Board's key risks. It also identified that 75% of Tier Three audits were not completed on time and lacked updated completion dates, clear ownership, or escalated when progress stalled.

74 In response, the Health Board developed a Clinical Audit Improvement Plan in May 2025. The plan aims to improve action planning, learning, escalation to the Executive Team and reporting across quality groups and committees. While the plan sought to strengthen risk-based clinical audit planning through the Strategic Clinical Effectiveness Group, the updated Clinical Audit Forward Plan still does not show a robust risk-based approach in its Tier Two programme. As a result, we consider our 2022 recommendation to remain ongoing.

75 Our recent review also found a lack of clarity in the approval process for the 2025–26 Clinical Audit Forward Plan. We found no evidence to clearly indicate who had approved the clinical audit plan.

76 Papers to the QSE Committee provide a clear overview of Tier One clinical audit activity, including the number of national audits published in-period and benchmarking results. Reports highlight areas of strong performance which, included clinical audits on bowel cancer and diabetes as well as areas requiring targeted action, such as vascular pathways. Reports provide some assurance that the Health Board is taking action where national audits have highlighted risk or under-performance. In March 2026 for example, a national vascular audit had prompted the Health Board to initiate reviews of specific pathways.

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[4] Tier One refers to National and / or mandatory audits; Tier Two refers to service level audits based on local priorities and risk; Tier Three refers to clinician/team initiated audits

77 The QSE Committee does not receive information on Tier Two or Tier Three audits, and it does not receive a full overview of progress against the wider Clinical Audit Forward Plan. It has no information on how many of these clinical audits the Health Board has completed, overdue or are yet to start, and no assessment of whether the overall programme is on track. As a result, although the Committee has good visibility of national audit outputs, it cannot judge whether the Health Board is delivering its wider clinical audit programme effectively or in line with expectations.

Assurance on commissioned services

78 The Health Board commissions a substantial range of services on behalf of the patients of north Wales across primary, community and secondary care from other NHS providers. The latest Monthly Monitoring Return to Welsh Government indicates that the Health Board is forecasting spend on services from other NHS providers to reach nearly £400 million in 2025-26. Given the volume of treatment and the expenditure involved it is essential that there are effective quality oversight arrangements in place.

79 The Health Board does not currently have a Commissioning Assurance Framework. A draft Commissioning Assurance Framework was developed in July 2024, but this Framework has not progressed to a final, agreed version as of the time of writing. In its absence, there are significant gaps in governance for these services. Our review found that the Quality Management Framework and Integrated Concerns Policy do not set out expectations for commissioned services. The Health Board's arrangements also lack clarity on how it will meet its responsibilities under the Duties of Quality and Candour in relation to outsourced patient care.

80 Our 2022 review recommended that the Health Board develop quality measures to reflect commissioned services across primary, community and secondary care. Similarly, Public Service Ombudsman for Wales (the Ombudsman) reviews[5] and Internal Audit Reviews highlight the absence of effective quality assurance arrangements for commissioned services. This included a 'No Assurance' rated Internal Audit review of Contracted Patient Service in 2022. When Internal Audit followed up progress in May 2025, none of the four high priority recommendations had been implemented resulting in a repeated 'No Assurance' rating. Those recommendations related to significant weaknesses in contracting of patient services, including:

- absence of a robust Commissioning Assurance Framework, policy or relevant Standard Operating Procedure, with lines of escalation, roles, responsibilities and requirements for oversight unclear;
- absence of controls and oversight to ensure commissioned providers are adhering to contractual agreements;
- weaknesses in contractual quality measures, and in escalation procedures for quality issues; and
- weaknesses in review and scrutiny of NHS provider quality, supported by performance data.

81 The Ombudsman raised concerns that the Health Board's contract monitoring of commissioned care placed financial reporting ahead of patient safety and service quality. As a result, the Ombudsman recommended that the Health Board complete and implement a Commissioning Assurance Framework within six months. The Health Board first committed to doing this by 30 September 2025. It later extended the deadline to January 2026. At the time of our fieldwork, the Health Board was seeking another extension because work on the Framework was still ongoing.

[5] The Investigation of a Complaint against Betsi Cadwaladr University Health Board: A Report by the Public Services Ombudsman for Wales, Case 202301141, April 2025 and An Own Initiative Investigation issued under s23 of the Public Services Ombudsman (Wales) Act 2019, August 2021

82 Due to limited progress on a clear Commissioning Assurance Framework, the Health Board's routine performance reports to the QSE Committee still lack quality metrics for externally commissioned services or wider assurances on the quality or safety of care delivered through commissioned services. We noted an isolated improvement in March 2026, when the QSE Committee received a paper on the national insourcing programme. However, we understand that this is an exception rather than a systematic approach.

Recommendations

83 Based on the findings of our follow-up review, we have issued nine new recommendations.

Develop and monitor standalone quality plan

R1 The Health Board should develop and implement a standalone, multi-year Quality Plan that clearly sets out its quality priorities, intended outcomes, leadership accountability, and the resources required to deliver sustained improvement **(paragraphs 10-16)**.

R2 The Health Board should ensure that the quality priorities, metrics, and expected benefits of its quality plan are regularly monitored through Executive Quality Delivery Group and QSE Committee, with progress routinely reported using meaningful indicators **(paragraphs 10-16)**.

Training Oversight for Risk Management

R3 The Health Board should monitor and report workforce training for each risk-management level on a regular (e.g. quarterly basis) and take action where training rates remain below targets. **(paragraphs 68-72)**.

Demonstrating lessons are learnt and shared

R4 The Health Board should ensure that quality and performance reports include clear evidence of learning, improvements achieved, and measurable change over time particularly:

- outcomes of mortality-related improvement work;
- actions from complaints, incidents, and thematic reviews; and evidence of learning from external regulatory intelligence **(paragraphs 47-61).**

Improve the reliability of NRI reporting

R5 The Health Board should investigate and reconcile the discrepancies between Nationally Reportable Incidents contained within its committee reports and annual report for 2025-26 and strengthen arrangements to ensure that future reporting is reliable **(paragraph 64).**

Strengthen quality oversight of commissioned services

R6 The Health Board should implement a commissioning oversight framework to fully address the Public Services Ombudsman for Wales' recommendation **(paragraphs 78-82)**.

R7 Develop clear and routine assurance reporting to the QSE Committee on the quality of commissioned services includes quality metrics, patient experience information, and risk assessments for care delivered through commissioned and outsourced services **(paragraphs 78-82)**.

Improve staff understanding and engagement with quality systems

R8 Building on the Culture & Leadership programme, the Health Board should provide progress and evaluation reporting on the implementation of the QMS to the Executive Quality Delivery Group **(paragraphs 23-27)**.

Strengthen complaints oversight and escalation

R9 The Health Board should enhance QSE Committee reporting on complaints by:

- regularly highlighting re-opened complaints as an emerging risk;
- providing analysis of root causes and quality of investigations; and
- monitoring compliance with complaint-handling training requirements **(paragraphs 36-43).**

Appendices

1 About our work

Scope of the audit

We have assessed whether:

- the Health Board's quality governance arrangements support high quality, safe and effective services;
- the Health Board has implemented previous audit recommendations arising from our 2022 review of its quality governance arrangements and is realising the intended outcomes and benefits of those recommendations; and
- there is a sound corporate approach to oversee and scrutinise the quality and safety of services in line with the Duty of Quality and Duty of Candour requirements.

Audit questions and criteria

Questions

Our audit addressed the following questions:

- Does the Health Board have clear and well-understood plans and priorities relating to quality?
- Are roles and responsibilities relating to quality clearly set out and understood?
- Does the Health Board have effective arrangements to support the Duties of Quality and Candour?
- Does the Health Board consistently and effectively demonstrate learning from internal and external assurance sources, including mortality reviews, patient and staff feedback and external regulators?

- Does the Health Board have a strong approach to risk management in relation to quality and patient safety?
- Does the Health Board have an up-to-date and risk-based clinical audit plan, which is approved and monitored by the Audit Committee?
- Does the Health Board have good oversight over the quality of its commissioned services?
- Is there regular and well-informed oversight for quality and patient safety at operational and corporate levels?

Criteria

In gathering evidence against the above questions, we were looking for the Health Board to demonstrate that it:

- Had effective governance arrangements support high quality, safe and effective services, specifically in relation to risk, complaints, staff culture and learning;
- Had made the expected progress in implementing our 2022 audit recommendations (set out in **Appendix 2**) to address the issues and concerns identified in the original audit; and
- Was implementing the requirements of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 (the Act) in respect of the Duties of Quality and Candour.

Methods

We undertook our audit work between September 2025 and January 2026.

We reviewed the following documents:

- The Integrated Quality Management Framework
- The Integrated Concerns Policy
- Relevant Internal Audit reports
- Public Services Ombudsman for Wales Public Interest Reports

- Committee and operational group reports, including Quality, Safety and Experience Committee papers, Executive Quality Delivery Group reports
- Relevant annual reports, including Clinical Audit Plan, Duty of Quality, Duty of Candour and Putting Things Right Reports
- Corporate and Service Risk Registers

We interviewed the following:

- Executive Medical Director
- Interim Executive Medical Director
- Executive Director of Nursing & Midwifery
- Chair of the Quality, Safety & Experience Committee
- Executive Director of Allied Health Professionals & Health Science
- Executive Director of Finance
- Deputy Director for Legal Services
- Head of Quality
- Head of Risk Management
- Directors of Integrated Health Communities
- Head of Patient Experience
- Head of Patient Safety
- Director of Women's Services
- Head of Midwifery and Gynaecology
- Director of Operations Mental Health & Learning Disabilities
- Interim Executive Director of People's Services and organisational Development
- Associate Director, Diagnostic and Specialist Clinical Support

2 Previous recommendations

We made the following recommendations in 2022 following our review of the Health Board's quality governance arrangements. The Health Board has demonstrated partial progress in implementing previous audit recommendations. We have highlighted the status of these recommendations based on our follow up review.

Recommendation	Audit Wales Assessment of progress
Recommendation 1 We found that the Health Board did not formally review its quality improvement priorities in light of the consequences of COVID-19. The Health Board should ensure its new Quality Improvement Strategy sets out how the Health Board will manage and mitigate the potential harms associated with the COVID-19 pandemic. **Original target completion date**: September 2022	**Superseded**

Recommendation	Audit Wales Assessment of progress
Recommendation 2 We found that not all operational staff are trained to record clinical and nonclinical risks and compile risk registers. The Health Board should ensure staff have adequate levels of risk management training so that they can confidently contribute to the risk identification and escalation process. **Original target completion date**: Completed	**In Progress** **(see paragraph 71)**
Recommendation 3 The Health Board's Quality Improvement Hub (BCUQI) has developed a quality improvement database to allow staff to share, adopt and learn from existing quality improvement projects. However, we found that the database is not well used. The Health Board should promote and encourage routine use of the database by setting targets for participation, by keeping the level of engagement under regular review and by taking action if engagement is too low. **Original target completion date**: Completed	**In Progress** **(see paragraph 62)**

Recommendation	Audit Wales Assessment of progress
Recommendation 4 The Health Board has restarted clinical audits after most activity was paused during the pandemic. The Health Board should look to use its programme of clinical audit work to focus on the risk of harm as a result of the pandemic. For example, to better understand the consequences of long waits or exacerbation of chronic conditions. The audits could be targeted at high-risk specialities. **Original target completion date**: June 2022	**In Progress** **(see paragraphs 73 - 74)**
Recommendation 5 We found that mortality reviews are not reported to the QSE Committee in a timely manner. The Health Board should ensure the QSE committee receives a quarterly mortality review report, which highlights learning and what action has been taken. **Original target completion date**: July 2022	**Complete** **(see paragraph 48)**

Recommendation	Audit Wales Assessment of progress
Recommendation 6 We found that, generally, mortality reviews are medically led, but there is an appetite for multidisciplinary mortality reviews. The Health Board should look to establish a system where a multidisciplinary mix of staff are routinely involved in mortality reviews. **Original target completion date**: October 2022	**Complete** **(see paragraph 49)**
Recommendation 7 The Health Board recognises that it does not yet have a process to systematically share learning across the organisation. The Health Board should use the new integrated governance framework and the Quality Improvement Hub (BCUQI) as tools to support organisational learning and sharing good practice across the organisation. **Original target completion date**: October 2022	**In progress** **(see paragraph 61)**

Recommendation	Audit Wales Assessment of progress
Recommendation 8 Only 37.9% of Health Board staff responding to the NHS staff survey agreed or strongly agreed that the organisation takes effective action when bullying harassment or abuse occurred. The Health Board should review its systems for managing, addressing, and learning from the concerns of staff in relation to bullying, harassment, or abuse. **Original target completion date**: Completed	**Complete** **(see paragraphs 33-35)**
Recommendation 9 We found that operational teams did not know what proportion of staff had been trained to investigate complaints, incidents, and root cause analysis. The Health Board should review levels of complaints handling training across the organisation. If this shows shortfalls, the programme of training should be expanded. **Original target completion date**: Completed	**In progress** **(see paragraphs 40-42)** **(see paragraph 41)**

Recommendation	Audit Wales Assessment of progress
Recommendation 10 Less than half (42%) of respondents responding to our survey agreed or strongly agreed that they receive regular updates on patient feedback for their work area. Whilst patient feedback is shared with wards monthly, the Health Board needs to ensure all ward staff are aware of this feedback and that it is easily accessible to staff. **Original target completion date**: October 2022	**Complete** **(see paragraphs 44-45)**
Recommendation 11 The Health Board introduced a new reporting format (triple A) to improve the flow of quality assurance. But we found some variation in the levels of detail provided in the reports. To reduce the risk of quality and safety issues being missed or not correctly escalated the Health Board should provide staff with guidance on using the new template, especially setting out how much detail is expected and how to agree which issues are escalated. **Original target completion date**: July 2022	**Complete** **(see paragraphs 64-65)**

Recommendation	Audit Wales Assessment of progress
Recommendation 12 We found that whilst the measures in the integrated performance report aligns with the NHS delivery framework, there are no locally agreed quality measures or wider measures such as for community services. Through the new Quality Improvement Strategy, the Health Board should review current quality measures with a view to developing measures that reflects the services it provides and commissions across primary, community and secondary care. **Original target completion date**: October 2022	**No Progress** **(see paragraphs 78-82)**

3 Key terms in this report

Term	Description
Clinical Audit	The process that looks to improve patient care and outcomes through systemic review of care against explicit criteria and the implementation of change
Duty of Candour	The Duty of Candour is a legal requirement for Welsh NHS organisations to be open and honest with service users when harm occurs during their care. This includes communicating with the patient
Duty of Quality	The Duty of Quality is a legal obligation on Welsh NHS Organisations to continually improve the quality of healthcare services and outcomes for the people of Wales. The Duty requires a focus on quality in all strategic decisions and ongoing monitoring of progress in quality improvement
Executive Quality Delivery Group	A senior executive group responsible for overseeing the delivery of quality, safety and clinical governance priorities
Foundations for the Future	A major organisational change programme at aimed at aligning the Health Board's structures, systems, processes, culture, and strategy to support long-term improvement and sustainability as part of its special-measures recovery.
Integrated Concerns Policy	The formal policy for managing complaints, claims and patient safety incidents under the Putting Things Right regulations.

Term	Description
Learning From Events Reports	Formal reports submitted to the Welsh Risk Pool that describe the learning and improvement actions taken by NHS Wales bodies following clinical negligence, redress, or personal injury cases. They are scrutinised by the Learning Advisory Panel, which ensures that learning has been implemented to prevent recurrence before the Welsh Risk Pool reimburses claim costs.
Listening to People	The new NHS Wales complaints system that replaces Putting Things Right. It focuses on compassionate, clear, and timely handling of concerns, using listening discussions, early resolution, and a two-stage process with potential redress up to £50,000. Its aim is to ensure people feel heard and that the NHS learns from complaints.
Never Events	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.
Organisational Learning Forum	The Health Board forum where leaders and staff share learning and improvement insights.
Patient & Carer Experience Group	A sub-group to support the work of the Executive Quality Delivery Group and to raise the profile and visibility of patient and carer experience and to provide assurance that the Health Board is listening and learning from patient and carer feedback.

Term	Description
Patient Safety Group	A sub-group of the Executive Quality Delivery Group responsible for co-ordinating and overseeing patient safety activity.
Public Services Ombudsman for Wales	An independent body that investigates public complaints about maladministration, service failures, and injustice by Welsh public services, including NHS bodies and local authorities.
Putting Things Right	A statutory NHS Wales process for handling concerns, complaints, patient safety incidents, and redress, ensuring issues are investigated fairly, openly, and in a timely manner under the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. It provides a clear route for raising concerns and requires NHS bodies to learn from mistakes and take corrective action.
Quality Governance	The combination of structures, processes and behaviours used by an organisation, particularly its board, to lead on and ensure high-quality performance, including safety, effectiveness and patient experience.
Quality Management Framework	A framework document which is intended to explain how health boards will adopt their Quality Management System.
Quality Management System	The organisation-wide framework that NHS Wales bodies are required to implement to ensure they continuously, reliably, and sustainably meet the needs of the population, in line with the Duty of Quality under the Health and Social Care (Quality and Engagement) (Wales) Act 2020.

Term	Description
Speaking Up Safely	The NHS Wales framework that ensures all staff can raise concerns safely, confidentially, and without fear of victimisation, and that organisations listen, respond, and learn from those concerns to improve the quality and safety of care
Strategic Clinical Effectiveness Group	A senior clinical governance group that oversees and promotes clinical effectiveness, ensuring care is aligned with the Health Board's quality improvement and strategic priorities. It supports wider organisational efforts to improve clinical outcomes, quality, and patient experience.
Welsh Risk Pool	The Welsh Risk Pool is part of the NHS Shared Service Partnership Legal and Risk service. It provides the means by which all Trusts and Health Authorities in Wales are able to indemnify against risk. The role of the Welsh Risk Pool is to have an integrated approach towards risk assessment, claims management, reimbursement and learning to improve.

4 Management Response Form

Recommendation		Commentary on planned actions	Completion date	Responsible officer
Develop and monitor standalone quality plan				
R1	The Health Board should develop and implement a standalone, multi-year Quality Plan that clearly sets out its quality priorities, intended outcomes, leadership accountability, and the resources required to deliver sustained improvement **(paragraphs 10-16).**	The Health Board will develop and agree a clearly defined set of organisation-wide quality priorities document which will be reported, aligned to the Duty of Quality and IMTP, with measurable outcomes, named executive and clinical leads, and defined governance oversight through Executive Quality Delivery Group and QSE Committee.	September 2026	Clinical Directors

Recommendation		Commentary on planned actions	Completion date	Responsible officer
R2	The Health Board should ensure that the quality priorities, metrics, and expected benefits of its quality plan are regularly monitored through Executive Quality Delivery Group and QSE Committee, with progress routinely reported using meaningful indicators **(paragraphs 10-16).**	Progress will be monitored through the Executive Quality Delivery Group and reported six monthly to the QSE Committee, supported by an enhanced suite of quality indicators and assurance metrics.	March 2027	Clinical Directors
Training Oversight for risk management				
R3	The Health Board should monitor and report workforce training for each risk-management level on a regular (e.g. quarterly basis) and take action where training rates remain below targets **(paragraphs 68-72).**	Arrangements will be strengthened to include defined compliance targets, routine reporting, and escalation where performance falls below agreed levels, providing improved assurance to the Board on workforce capability in risk management.	December 2026	Director of Corporate Governance

Recommendation	Commentary on planned actions	Completion date	Responsible officer
Demonstrating lessons are learnt and shared **R4** The Health Board should ensure that quality and performance reports include clear evidence of learning, improvements achieved, and measurable change over time particularly: • outcomes of mortality-related improvement work; • actions from complaints, incidents, and thematic reviews; and • evidence of learning from external regulatory intelligence **(paragraphs 47-61).**	Work is underway to strengthen how learning is captured, evidenced, and reported. This will include: • Embedding the Learning Repository within the Quality Management System in addition to exploring and implementing effective mechanism of spreading learning within all layers of the organisation; • Enhancing reporting to demonstrate clear links between incidents, complaints, and subsequent improvements; and • Introducing measures to evidence impact over time, including outcome-based indicators. Future reports to the QSE Committee will place greater emphasis on demonstrable change and assurance that learning has been embedded.	December 2026	Clinical Directors

Recommendation	Commentary on planned actions	Completion date	Responsible officer
Improve the reliability of NRI reporting			
R5 The Health Board should investigate and reconcile the discrepancies between Nationally Reportable Incidents contained within its committee reports and annual report for 2025-26 and strengthen arrangements to ensure that future reporting is reliable **(paragraph 64).**	An immediate review will be undertaken to reconcile discrepancies in NRI reporting across Board and committee reports.	June 2026	Executive Director of Finance and Executive Director of Nursing and Midwifery
Strengthen quality oversight of commissioned services			
R6 The Health Board should implement a commissioning oversight framework to fully address the Public Services Ombudsman for Wales' recommendation **(paragraphs 78-82)**.	Completion and implementation of a Commissioning Assurance Framework will be prioritised, addressing previous audit and Ombudsman findings.	September 2026	Executive Director of Finance

Recommendation		Commentary on planned actions	Completion date	Responsible officer
R7	Develop clear and routine assurance reporting to the QSE Committee on the quality of commissioned services includes quality metrics, patient experience information, and risk assessments for care delivered through commissioned and outsourced services **(paragraphs 78-82).**	Routine reporting to the QSE Committee will be enhanced to include quality, safety, and patient experience information relating to commissioned services.	September 2026	Executive Medical Director
Improve staff understanding and engagement with quality systems				
R8	Building on the Culture & Leadership programme, the Health Board should provide progress and evaluation reporting on the implementation of the QMS to the Executive Quality Delivery Group **(paragraphs 23-27).**	The implementation of the QMS will be accelerated as a key component of the Foundations for the Future programme. This will include: • Clear governance and accountability for QMS delivery; • Phased implementation across services; and	September 2026	Executive Director of Nursing and Midwifery

Recommendation	Commentary on planned actions	Completion date	Responsible officer
	• Regular progress and evaluation reporting to Executive Quality Delivery Group.		
Strengthen complaints oversight and escalation			
R9 The Health Board should enhance QSE Committee reporting on complaints by: • regularly highlighting re-opened complaints as an emerging risk; • providing analysis of root causes and quality of investigations; and • monitoring compliance with complaint-handling training requirements **(paragraphs 36-43).**	Arrangements for complaints oversight will be strengthened through: • Enhanced reporting of trends, including reopened complaints as a specific risk indicator; • Improved analysis of root causes and quality of investigations; and • Monitoring and reporting of training compliance for staff undertaking investigations.	December 2026	Executive Director of Nursing

About us

The Auditor General for Wales is independent of the Welsh Government and the Senedd. The Auditor General's role is to examine and report on the accounts of the Welsh Government, the NHS in Wales and other related public bodies, together with those of councils and other local government bodies. The Auditor General also reports on these organisations' use of resources and suggests ways they can improve.

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Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.