Bundle BCU Health Board 27 November 2025

1 09:30 - SUPPORTING PAPERS

1.1 09:30 - 25.205 Supporting Presentation for Major Change Programme: Focus - Value and Sustainability

25.205 Major Change Programme Focus - Value and Sustainability

1.2 09:30 - 25.219 Supporting Papers for Risk Management Report

25.219.1 RM01 Risk Management Framework

25.219.2 Health Board Corporate Risk Register Report November 2025 Public v2

1.3 09:30 - 25.220 Supporting Papers for Corporate Governance Report

25.220.1a Standing Orders Update

25.220.1b Welsh Health Circular 2025 Amendments to JCC SO's 5.3(1)

25.220.2 MWJC Update Report Oct 25 Final 031125

25.220.3a All Wales IPFR Policy

25.220.3b Appendix 1 - IPFR Policy - Final - July 2025

25.220.3c NHS Wales Prior Approval Policy - BCUHB FINAL July 2025

25.220.4 Board Protocol

25.220.5 FV - All Wales AC-Section 12 November 2025 Board report

25.220.5.1 Appendix 1 - Approved Clinicians Data - November 2025 Board report

25.220.5.2 Appendix 2 - Section 12(2) Doctors Data - November 2025 Board Report

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Gwerth a Chynaliadwyedd

Value & Sustainability

27 Tachwedd 2025

November 27th 2025

Mae Gofal Iechyd Seiliedig ar Werth yn Flaenoriaeth Allweddol i GIG Cymru

Beth yw Gofal Iechyd Seiliedig ar Werth (GISW)? Mae'n cynnwys canolbwyntio ar yr hyn sy'n bwysicaf i gleifion: canlyniadau a phrofiadau iechyd gwell, tra'n gwneud y defnydd gorau o adnoddau.

Pam mae'n bwysig? Yn hytrach na chyfrif faint o driniaethau neu apwyntiadau sy'n digwydd, mae Gofal Iechyd Seiliedig ar Werth yn edrych ar a yw'r triniaethau hynny mewn gwirionedd yn gwella bywydau pobl.

Beth yw'r nod cyffredinol? Dylai pob punt a wariwyd helpu pobl i fyw bywydau iachach, hapusach. Mae'n ymwneud ag ansawdd, nid maint.

Sut mae'n cyd-fynd â chynlluniau tymor hir GIG Cymru?
Mae adfywiad 2024-25 o 'Gymru Iachach' yn cyfarwyddo Byrddau Iechyd i ymgorffori Gofal Iechyd Seiliedig ar Werth "i sicrhau bod arian yn cael ei wario lle mae'n dod â'r budd mwyaf, yn cefnogi mynediad cyfartal ac yn helpu i gadw gwasanaethau fforddiadwy ac amgylcheddol gynaliadwy".

Value Based Health Care is a Key Priority for NHS Wales

What is Value Based Health Care (VBHC)?
It involves focusing on what matters most to patients: better health outcomes and experiences, while making the best use of resources.

Why is it Important?
Instead of counting how many treatments or appointments happen, Value Based Health Care looks at whether those treatments actually improve people's lives.

What is the overall aim?
Every pound spent should help people live healthier, happier lives. It's about quality, not quantity.

How Does it Fit With the Long Term Plans of NHS Wales?
The 2024-25 refresh of 'A Healthier Wales' instructs Health Boards to embed Value Based Health Care "to ensure money is spent where it brings the greatest benefit, supports equal access and helps keep services affordable and environmentally sustainable".

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

Gweithredu'r Rhaglen Genedlaethol

Mae Cynllun Gweithredu Cymru Iachach 2024–25 yn cyfarwyddo Bwrdd Gwerth a Chynaliadwyedd newydd i *"ymgorffori dull gofal iechyd sy'n seiliedig ar werth ledled Cymru, i ganolbwyntio ar sut rydym yn defnyddio ein hadnoddau yn ddoeth.* Mae'n cynnwys chwe ffrwd waith graidd.

1. Rheoli Meddyginiaethau
2. Gofal Iechyd Parhaus
3. Gweithlu
4. Heblaw Cyflogau, a Chaffael
5. Amrywiadau Clinigol
6. Gofal Iechyd Seiliedig ar Werth

Implementation of the National Programme

Exec Lead	Clara Day	Angela Wood	George Roberts	Russell Caldicott	Clara Day	
Programme	1. Medicines Management	2. Continuing Health Care	3. Workforce	4. Non-Pay & Procurement	5. Clinical Variation & Service Reconfiguration	6. Value-Based Health Care
Key Thematics	Generic v Branded Drugs	High Cost Placement Reviews	International Recruitment	Improved Contract Mgt	GIRFT Opportunities: Referral Mgt (incl Advice & Guidance)	High Value High Impact - Hip Arthroplasty
	Adoption of Biosimilars	Consistent Pricing	Nurse Staffing Levels	Improved Mgt of Non-Pay	GIRFT Opportunities: Optimal Pathways (One Stop, S2T)	High Value High Impact - Knee Arthroplasty
	Low Value Prescribing	Commissioned Care Planning	Agency Reduction		GIRFT Opportunities: Pre-Operative Assessment	High Value High Impact - Bone Health
			Sickness Reduction		GIRFT Opportunities: Theatres incl High Volume, Low Complexity Lists	High Value High Impact - Diabetes
					GIRFT Opportunities: Length of Stay incl Daycase/MOPs	PROMs Platform
					GIRFT Opportunities: UEC Flow/Transfer of Care Delays	Health Pathways
					Virtual Ward Models	Locally Funded Schemes
Additional National V&S Focus 25/25			Improved Job Planning & Rostering	Product Rationalisation & Standardisation	'Fragile' Services – Phase 2	HVHI – Heart Failure
			Standard Pay Rates for Additional Hours		Fit for Purpose Admin Estate	

The **2024–25 Healthier Wales** Action Plan instructs a new Value & Sustainability Board to *"embed a value-based health care approach across Wales, to focus on how we use our resources wisely.* It includes six core workstreams:

1. *Medicines Management*
2. Continuing Health Care
3. Workforce
4. Non-Pay & Procurement
5. Clinical Variation
6. Value-Based Health Care

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

Symud y Ffocws Tuag at Ansawdd (Canlyniadau a Phrofiad) / Shifting the Focus Towards Quality (Outcomes & Experience)

Er bod y cam cyntaf wedi canolbwyntio'n bennaf ar gyflawni gwelliannau costau, mae'r ffrydiau gwaith Amrywiad Clinigol a Gofal Iechyd Seiliedig ar Werth yn canolbwyntio ar y mesurau gwerth anariannol, sy'n seiliedig ar ansawdd, a fydd yn cael eu graddio ymhellach yn y cam nesaf.

Whilst the first phase has focused mainly on delivering cost improvements, the Clinical Variation and Value Based Healthcare workstreams focus on the non-financial, quality-based measures of value, which will be scaled further in the next phase.

Cynlluniau Gwerth a Ariennir ar gyfer 25/26	**Funded Value Schemes for 25/26**
Rhagsefydlu	• Prehabilitation
Lymffoedema	• Lymphoedema
Methiant y galon	• Heart Failure
Gwasanaethau Cludo Cleifion Mewn Achosion Nad Ydynt yn Rhai Brys	• Non-Emergency Patient Transport Services
Mesurau Adrodd ar Ganlyniadau Cleifion	• Patient Reported Outcome Measures
Endometriosis	• Endometriosis





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

Rhoi'r hyfforddiant a'r gefnogaeth sydd eu hangen ar ein staff

Meithrin Sgiliau a Gwybodaeth Craidd

- Gweithdai Rhagarweiniol - yn ymdrin ag egwyddorion gwerth
- Astudiaethau Achos - darparu enghreifftiau clinigol bywyd go iawn (Lean, Llwybr Twnnel Carpal Gwyrdd, Adsefydlu)
- E-Ddysgu – cynnwys rôl-benodol ar gyfer timau clinigol, rheoli ac ariannol

Ymgorffori Dysgu Parhaus (creu Mudiad Cymdeithasol)

- Datblygu Cymunedau Ymarfer - fforymau rheolaidd i rannu dysgu a mewnwelediad data
- Mentora a Hyrwyddwyr - nodi cefnogwyr gwerth ar draws pob disgyblaeth ac arbenigeddau clinigol
- Academi Gwerth - cyllid wedi'i neilltuo (yn amodol ar gymeradwyaeth) i ysgogi arloesedd
- Dysgu mewn darnau – fideos/ffeithluniau byr ar egwyddorion gwerth allweddol

Datblygiad Proffesiynol

- Partnerwch gyda'r Academi Iechyd a Gofal Seiliedig ar Werth (Prifysgol Abertawe) ar gyfer hyfforddiant achrededig
- Adeiladu i mewn i Fframweithiau Cymhwysedd Blynyddol ac Arfarniadau

Giving Our Staff the Training & Support They Need

Build Core Skills & Knowledge

- Introductory Workshops - covering value principles
- Case Studies - providing real-life clinical examples (Lean, Green Carpal Tunnel Pathway, Prehabilitation)
- E-Learning – role-specific content for clinical, managerial and financial teams

Embedding Continuous Learning (creating a Social Movement)

- Develop Communities of Practice - regular forums to share learning and data insight
- Mentorship & Champions - identify value supporters across all disciplines and clinical specialties
- Value Academy - ring-fenced funding (subject to approval) to incentivise innovation
- Bite-Sized Learning – short videos/infographics on key value principles

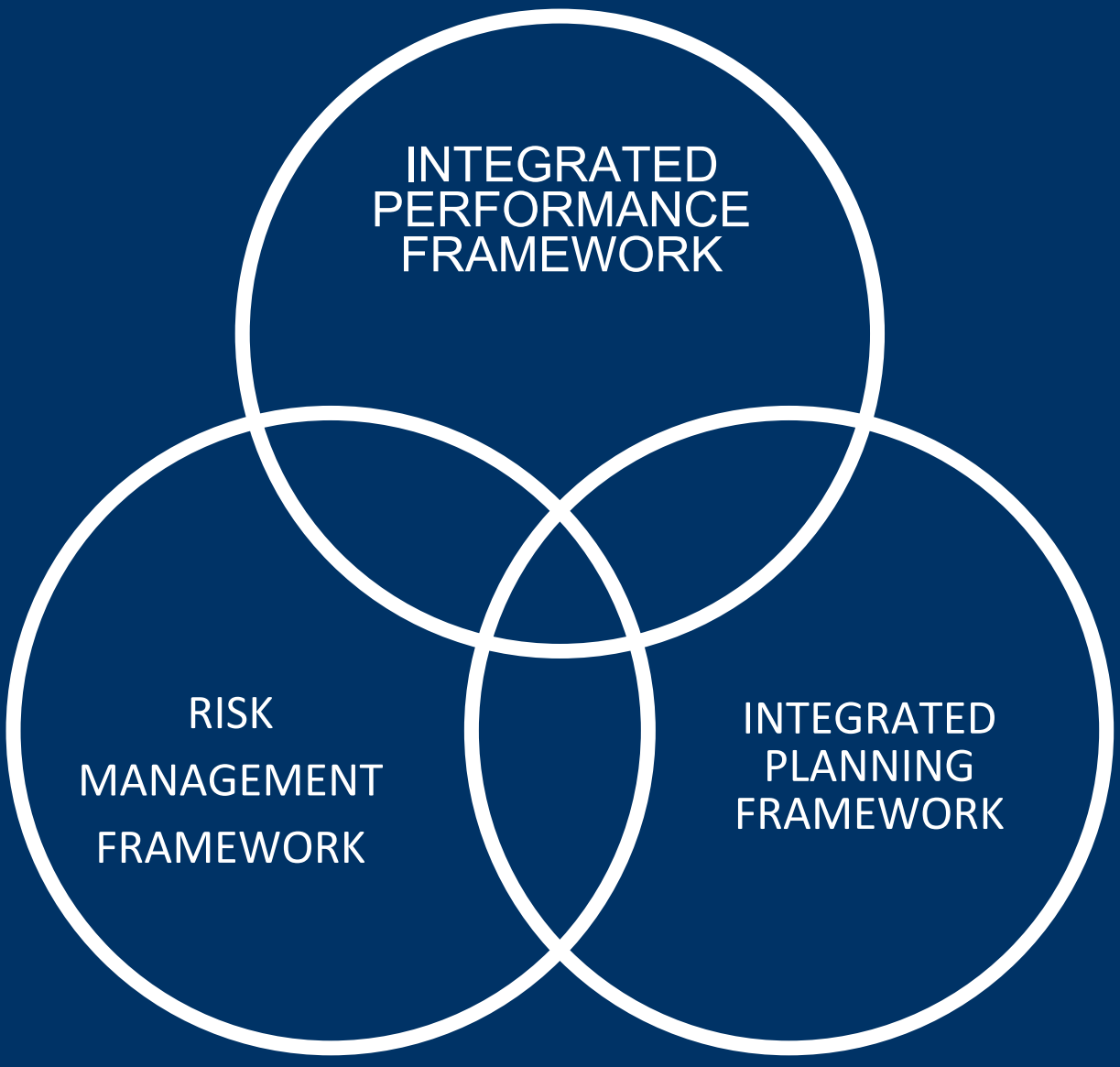
Professional Development

- Partner with the Value-Based Health & Care Academy (Swansea University) for accredited training
- Build into Annual Competency Frameworks and Appraisals

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

RISK MANAGEMENT FRAMEWORK

2025-27



Author & Title	Pam Wenger Director of Corporate Governance Dr Nesta Collingridge Head of Risk Management		
Responsible Department / Director:	Corporate Governance > Risk Management Carol Shillabeer Chief Executive		
Approved by:	Health Board – 27 November 2025 Audit Committee (AC) – 21 October Executive Committee 17 September 2025		
Date approved:	27 November 2025 ~~25 July 2024~~		
Date activated (live):	1 December 2025 ~~September 2024~~		
Documents to be read alongside this document:	Risk Management Procedures (RM02) Risk Management Training Procedures (RM03) Terms of Reference Risk Scrutiny Group BCUHB Integrated Performance Framework BCUHB Integrated Planning Framework Health and Safety Policy (HS01) Risk Assessment Guidance (HS03) Concerns Policy and Procedure (PTR01 and PTR01A) Information Governance Policy Health and Safety Policy		
Date of next review:	28 Sept 2027		
Date EqIA completed:	Sept 2023 (Original 2016)		
First Operational:	28 Sept 2023		
Previously reviewed:	Sept 2023	Health Board - 25 July 2024 Audit Committee (AC) - 18 July 2024 Executive Team 26 June 2024	Sept 2025
Changes made yes/no:	Yes - 28 Sept 2023 Approved at Board Major revisions made	Yes - Intermediate updates; as approved at: 18/07/2024 Audit Committee and 25/07/2024 Health Board Meeting– Formalisation of the Risk Scrutiny Group, and key updates to the Risk Framework and Procedures.	Yes - Intermediate updates- Escalation route

PROPRIETARY INFORMATION

This document contains proprietary information belonging to the Betsi Cadwaladr University Health Board. Do not produce all or any part of this document without written permission from the Health Board.

CONTENTS

GLOSSARY OF TERMS

Risk: A risk is the uncertainty that something could or may happen that will have an impact on the achievement of the Health Board's objectives and priority areas. Risk is expressed in terms of likelihood (probability of the risk occurring) and consequence (impact if the risks were to occur).

Distinguishing between a risk and an issue: A risk is an event that might occur and that could have an effect (can be positive but usually negative) upon the organisation and/or its stakeholders. A risk is characterised by uncertainty. An issue is something that has already happened or will definitely happen. An issue is a certainty. For example, 'we are short staffed' or 'lack funding to deliver a service', are issues (as these are already happening) and the risk will be the implications of staff shortage or the lack of funding to the successful delivery of our operational and strategic objectives. What these uncertainties (doubt) may cause, is what will constitute (give rise) to risks in both cases.

Assurance: This is a process to provide evidence that the controls in place are effective and working and that the Health Board is doing its best to appropriately reduce and manage risks to the achievement of its operational and strategic objectives.

Actions: Actions are the subsequent steps required following the application of controls to address or further mitigate residual (current) risk to as low as reasonably possible (target) level.

Board Assurance Framework: comprises of strategic risks developed by Board members from the Strategic Plans and Objectives that could prevent the Health Board's from fulfilling its strategic objectives/priorities.

Business Continuity: Business continuity is the capability of the Health Board to continue the delivery of products and services within acceptable timeframes at predefined capacity during a disruption. Business continuity is a temporary and alternative measure initiated during a disruption that ensures continuity of service provision whilst a permanent solution is found, or usual services/operations are resumed. The holistic process of business continuity management is an essential tool in ensuring an organisation's resilience.

Controls: These are measures or interventions implemented by the Health Board that reduce the likelihood of a risk and/or the impact/severity of a risk. The types of controls used in reducing risks include preventive, corrective, detective and directive controls. Gaps in control describe the weaknesses identified having put mitigation controls in place.

Corporate Risk Register: A corporate risk register is a repository used to record significant risks that could impact the strategic objectives and operations of the Health Board. Developed by services, corporate functions and members of the Executive Committee, the register provides a comprehensive overview of the key risks facing the organisation. It is a pivotal tool to help proactively strengthen risk oversight and management.

Risk Assessment: This is the overall process of risk identification, analysis and risk evaluation. This is achieved by identifying risks, examining the characteristics of each risk and comparing individual risks against the Health Board's risk appetite. Risk assessment techniques include questionnaires and checklists, workshops and brain storming sessions, and inspections and audits.

Risk Appetite: The amount and type of risk that an organisation is willing to seek or retain in its pursuit of its objectives.

Risk Framework: Set of activities that support the risk management process, i.e., the risk architecture, strategy and protocols.

Risk Management: Coordinated activities to direct or control risks within an organisation. These are management activities that deliver the most favourable outcome and reduce the volatility and variability of that outcome.

Risk Mitigation: This refers to the process of reducing risk exposure through minimising its likelihood and/or lessening the severity of its impact were it to materialise. Types of risk mitigations include the 5Ts (treat, tolerate, terminate, transfer or take opportunity).

Senior Information Responsible Risk Officer (SIRO): This may include the Director responsible for the Directorate or Executive Director or Deputy Executive Director or nominated Executive Sponsor.

Take Opportunity: The type of risk with potential to enhance the achievement of the organisation's objectives. Opportunity risk management is the approach that seeks to maximise on benefits of taking risks i.e., innovation, new systems, processes and procedures, services etc.

Terminate: Risk response that is appropriate when certain activities that give rise to risks are not necessary or worth doing and should be stopped. Also known as avoidance or elimination.

Tolerating: The decision to accept the risk and the impact should the following risk occur without taking any further steps to mitigate it. This is often to avoid significant investment or resources as the response would be disproportionate to the potential harm or gain. Also referred to acceptance or retention. Decision to tolerate any risks that are outside the risk appetite threshold for a particular domain of risk should be made at senior level proportionate to the level of risk.

Transfer: Risk response for risks outside the Health Board's appetite that the organisation wishes to transfer or share with other providers by way of contracts (outsourcing), insurance, joint venture etc. This option is particularly suited to mitigating financial risks or risks to assets.

Treat: Risk response by way of introducing cost effective controls to alter or reduce risk.

Target Risk: Ultimate level of risk that is desired by the Health Board when planned additional controls (see actions) have been implemented to address residual risk to as low as reasonably possible and/or within the Health Board's risk appetite.

RISK MANAGEMENT FRAMEWORK

- The Health Board endeavours to establish a positive risk and safety culture in the organisation, where unsafe practice (clinical, managerial, etc.) is not tolerated and where every member of staff is committed and empowered to identify/correct/escalate system weaknesses.
- The Health Board is committed to ensuring a robust infrastructure to manage risks ensuring an integrated approach, and where risks crystallise, to evidence improvement.
- The Health Board's intention is to ***minimise*** the risk to the delivery of quality services in the Health Board's accountability and compliance frameworks, ***maximise*** performance and is ***open*** to opportunity with considered risk taking.
- To deliver ***safe, quality*** services, the Health Board will encourage staff to work in collaborative partnership with each other and service users and carers to ***minimise*** risk to the greatest extent possible and promote patient well-being as a duty of care to the population.

The Board intends to demonstrate an ongoing commitment to improving the management of risk throughout the organisation by:

• Ensuring a dynamic approach to strategic risk management to support achievement of the Health Board's vision, aims, and strategic objectives;

• Promoting considered risk taking, within authorised and defined limits in-line with the Board's appetite for risk (see Appendix 1-Risk Appetite Statement);

• Adopting an integrated approach to risk management in order to facilitate a cross-functional collaboration of system-wide risks that includes risks related to: clinical care, health and safety, staff wellbeing, financial and business planning, workforce planning, corporate and information governance, performance management, project / programme management, research and development;

• Embedding effective risk management systems and processes within the organisation and promoting the ethos that risk management is everyone's business, with clearly defined roles and responsibilities;

• Creating an environment that is as safe as is reasonably practicable, by ensuring that risks are continuously identified, assessed and well managed, i.e. where possible eliminate, transfer or treat risks to an acceptable level;

• Fostering an organisational culture of openness and willingness to report risks, incidents and near misses to ensure organisation wide learning;

• Establishing clear and effective communication mechanisms that enable a comprehensive understanding of risks at all levels of the organisation by the use of directorate, specialist and organisational-wide risk registers; and

•Providing appropriate training to staff to ensure effective implementation of risk management arrangement

1. PURPOSE OF THIS FRAMEWORK

The Framework seeks to ensure:

- that the Health Board's risks in relation to the delivery of services (provided and commissioned) and care to patients are minimised;
- that the wellbeing of patients, staff and visitors is optimised;
- that opportunities are maximised;
- that the assets, business systems and finances of the Health Board are protected; and
- the implementation and ongoing management of a comprehensive, integrated (clinical and non-clinical) approach to the management of risk across the organisation.

2. SCOPE OF THE RISK MANAGEMENT FRAMEWORK

This framework applies to Board members; all staff of the Health Board; agency staff; contractors brought in to undertake work on behalf of the Health Board, for example capital and estates works; students; locums; volunteers; individuals employed on honorary contracts; and, other third parties engaged in Health Board business. It applies to all activities of the Health Board, including those related to the commissioning of services. Managers at all levels within the Health Board must take an active lead to ensure that risks are managed effectively and to support the development of a risk aware culture within the Health Board.

This framework will:

- Outline the risk management philosophy through our risk statement, identifying arrangements for embedding risk management;
- Explain the role, expectations and appetite of the Board in relation to risk and risk management;
- Detail the high-level roles and responsibilities for implementing and complying with this framework;
- Explain the arrangements for complying with all relevant legislation;
- Detail risk priorities for the present year;
- Detail the high-level Committee structure accountability in relation to risk, internal reporting requirements, assurance arrangements and external reporting controls;
- Signpost the specific policies, procedures and terms of reference and which the Health Board will publish to ensure that all staff understand what is required of them.

3. THE BOARD'S APPETITE FOR RISK

The Board recognises that risk is inherent in the provision and commissioning of healthcare services, and therefore a defined approach is necessary to articulate risk context, ensuring that the organisation understands and is aware of the risks it is prepared to accept in the pursuit of its aims and objectives.

Risks throughout the organisation will be managed within the Board's risk appetite, or where this is exceeded, action will be taken to reduce the risk. The Board is prepared to accept some financial risk and regulatory challenges if appropriate controls and defence strategies are in place. The Board support innovation despite potential short-term quality impacts and reputational risks, as long as there is potential for long-term rewards like improved outcomes for stakeholders and opportunities for staff recruitment, retention and development. The Board takes a holistic view of value for money, with price not being the sole determining factor.

The Health Board seeks to be innovative and will challenge current working practices and financial risk in terms of its willingness to take opportunities where positive gains can be anticipated. The Board's annual Risk Appetite, detailing acceptable levels of risk across five risk types (financial, regulatory/compliance, innovation, quality and reputational), is outlined in Appendix 1.

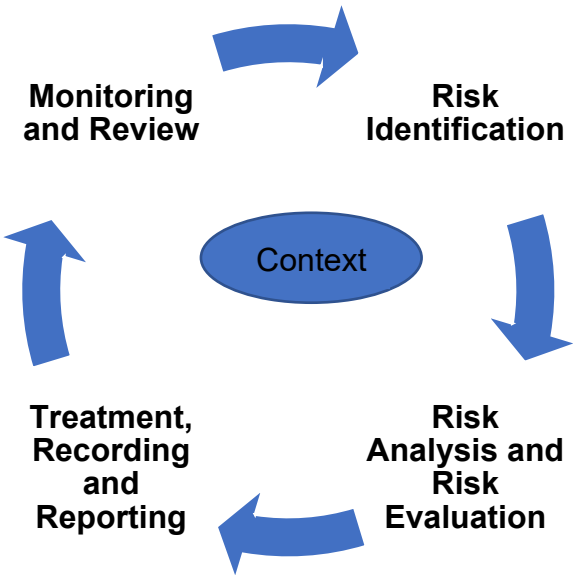
4. RISK MANAGEMENT PROCESS

Risk Management is the systematic application of management policies, practices and procedures to identifying, analysing, assessing, treating and monitoring risk in a way that will enable organisations to minimise losses and maximise opportunities.

The aim of risk management is not to remove risk altogether, but to manage risk to an acceptable level, considering the cost of minimising the risk and reducing risk exposure (the level of risk that the organisation is exposed to, either in regard to an individual risk or the cumulative exposure to the risks faced by the organisation).

The Board has adopted a structured approach to risk management, whereby risks are identified, assessed and controlled, and if appropriate, escalated or de-escalated through the governance mechanisms of the organisation. The process is defined in four key steps:

Figure 1 - Risk Management Process



1. RISK IDENTIFICATION

The Health Board cannot manage risk effectively unless it knows what the risks are. Risk identification is therefore vital to the success of the organisation's risk management process, and ultimately the safe delivery of care. This should be done within context.

2. RISK ANALYSIS AND RISK EVALUATION

Assessment and scoring of risk are used to determine the level of risk, using the Health Board's risk matrix to ensure a consistent approach is adopted across the organisation.

3. TREATMENT, RECORDING AND REPORTING

Treatment is how the risk will be managed, and what the required actions are to achieve an acceptable level of risk. All risks are recorded on a Datix risk register, which is a formal record of all risks raised, which makes up the Operational Risk Register.

4. MONITORING AND REVIEW

Part of managing risk is to continually review and update, and to capture the changes and progress of mitigation.

5. RISK ARCHITECTURE

The current enterprise risk architecture within the Health Board is shown below in a risk management model.

LEVELS OF RISK

The Risk Management Framework defines three levels of risk:

1. Strategic Risks – Risks that represent a threat to achieving the Health Board's strategic objectives or its continued existence. Strategic risks also include risks that are widespread beyond the local area, and risks for which the cost of control is significantly beyond the scope of the local budget holder.

2. Operational Risks – Risks that arise as a result of the day-to-day running of the Health Board and include a broad spectrum of risks comprising clinical risk (e.g., arising from incidents and complaints), financial risk (including fraud); legal risks (e.g., arising from employment law or health and safety regulation); regulatory risk; risk of loss or damage to assets or system failures; etc.

3. Project Risks – Risks that may impact on the delivery of a programme of work or project. All significant projects must be risk assessed before they are progressed, with each project required to have a separate risk register.

RISK REGISTERS

Board Assurance Frameworks, Corporate Risk Registers and Operational Risk Registers can work together in an integrated risk management model:

Board Assurance Framework (BAF)

- Focuses on the top <10 strategic risks that could impact achievement of the Health Boards objectives and priorities.
- Owned by the Board and tied directly to the strategic plan.
- Risks reflect external and internal issues affecting strategy.
- Regularly reviewed by Board and Executive Committee.
- Held by the risk team.

Corporate Risk Register (CRR)

- Consolidates key risks escalated up from the operational level based on the possible impact on Boards objectives and priorities. May include 10-40 major corporate-wide risks.
- Provides Executive Committee with enterprise view of significant operational and strategic risks.
- Enables corporate risk reporting, monitoring and oversight.
- Risk flows to BAF as appropriate.
- Overseen by the corporate risk team, maintained on Datix.

Operational Risk Registers

- Day to day operational risks which impact on service delivery. Includes clinical, financial, compliance, IT risks etc.
- Mandatory for all services to have a register on Datix.
- Service Risk Leads or Risk Champions responsible for maintaining and managing service risk register and escalates higher risks through Senior Responsible Officers and Corporate Risk Team for awareness and where appropriate consideration on the CRR.

Project Risks

- Project lead responsible for ensuring risks are captured and maintained.
- Acceptable for the project risk register to be held locally (not on Datix) but significant risks which could impact on day to day operations or have a wider impact on the Health Board should be escalated to a Datix risk register to allow for overview and consistency of reporting.
- Project team escalate higher risks through Senior Responsible Officers and Risk Scrutiny Group for awareness.

This model provides top-down and bottom-up connectivity to enable robust risk management at all levels and alignment to strategy.

All staff should be aware of the potential for risks to emerge which may affect the business of the Health Board and all staff should be prepared to identify and report risks as appropriate. When a possible risk is identified, staff should aim to discuss it first with their line manager. This is to avoid duplication of effort, as sometimes risks are identified which are already being managed but have perhaps been articulated differently. Once it is confirmed that a new risk has been identified, the details should be entered onto the Datix system. This will normally be achieved through a service risk lead/champion.

Once correctly identified and assessed, the risk should be logged on a risk register, depending on the seriousness of the risk. Where possible risks should be managed at the lowest level possible, proportionate to the level of exposure to which the risk.

Risks scored ≥15 should be sent to the Senior Information Responsible Risk Officer (SIRO) *(N.B. this may include the Director responsible for the Directorate or Executive Director or Deputy Executive Director or nominated Executive Sponsor)*, for awareness and consideration on the CRR, if critical/strategic in nature. Operational risks scored ≥20 should be sent to the most senior responsible person for management support and advice.

Risks scored 9>12, Risk owners are expected to ensure that there are appropriate processes, systems and governance arrangements in place to regularly review, scrutinise and effectively manage all risks within their areas. They will be required to

periodically present their Divisional risk register reports and assurance of robust risk arrangements to the Risk Scrutiny Group.

Risks scored 1-8 should be regularly reviewed, scrutinised, approved, reduced and managed at the service or departmental levels while those which score above 8 should be escalated in accordance with guidance and the approval of either the relevant quality and safety meeting and/or the triumvirate.

ESCALATION/DE-ESCALATION

Risks should be regularly reviewed and escalated or de-escalated to the appropriate risk register within the Committee or divisional meeting which reviews the risk. Before a risk is presented to a SIRO for approval, it should be quality assured by the Corporate Risk Team and take the assurance that robust action plans are in place.

For escalation of a risk on to the CRR the service risk lead should contact their Executive Director through the appropriate channels and the corporate risk team via their regional risk manager.

Figure 2 - Risk Management Meeting & Escalation/De-escalation

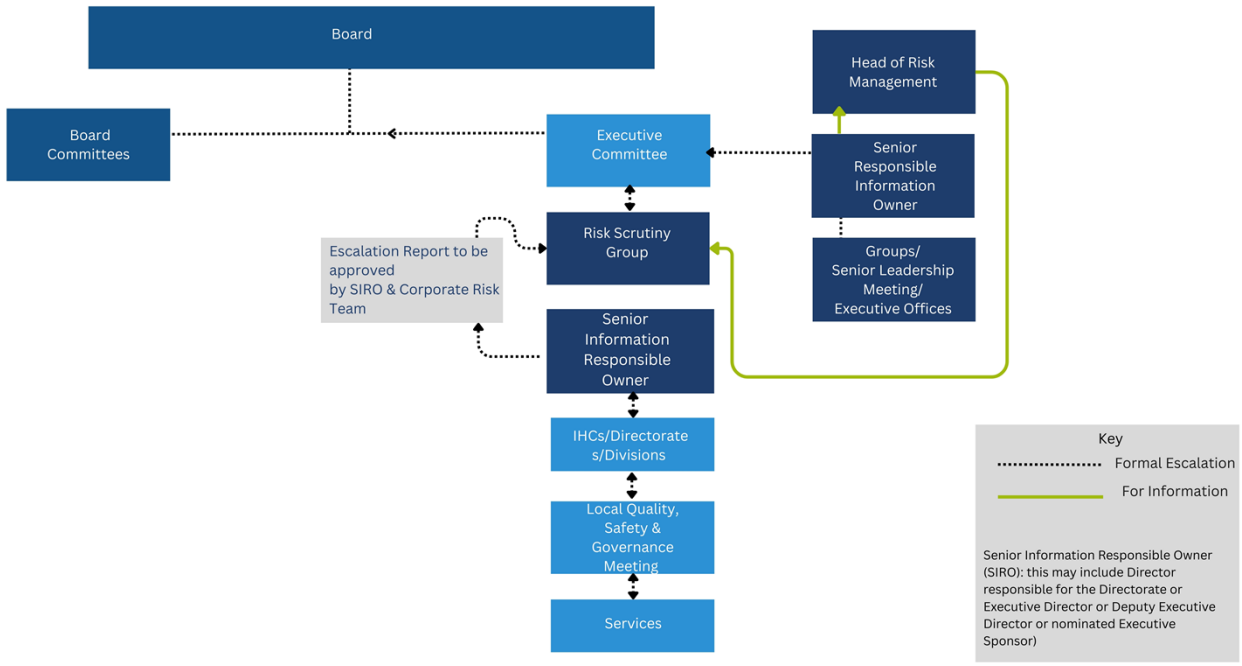
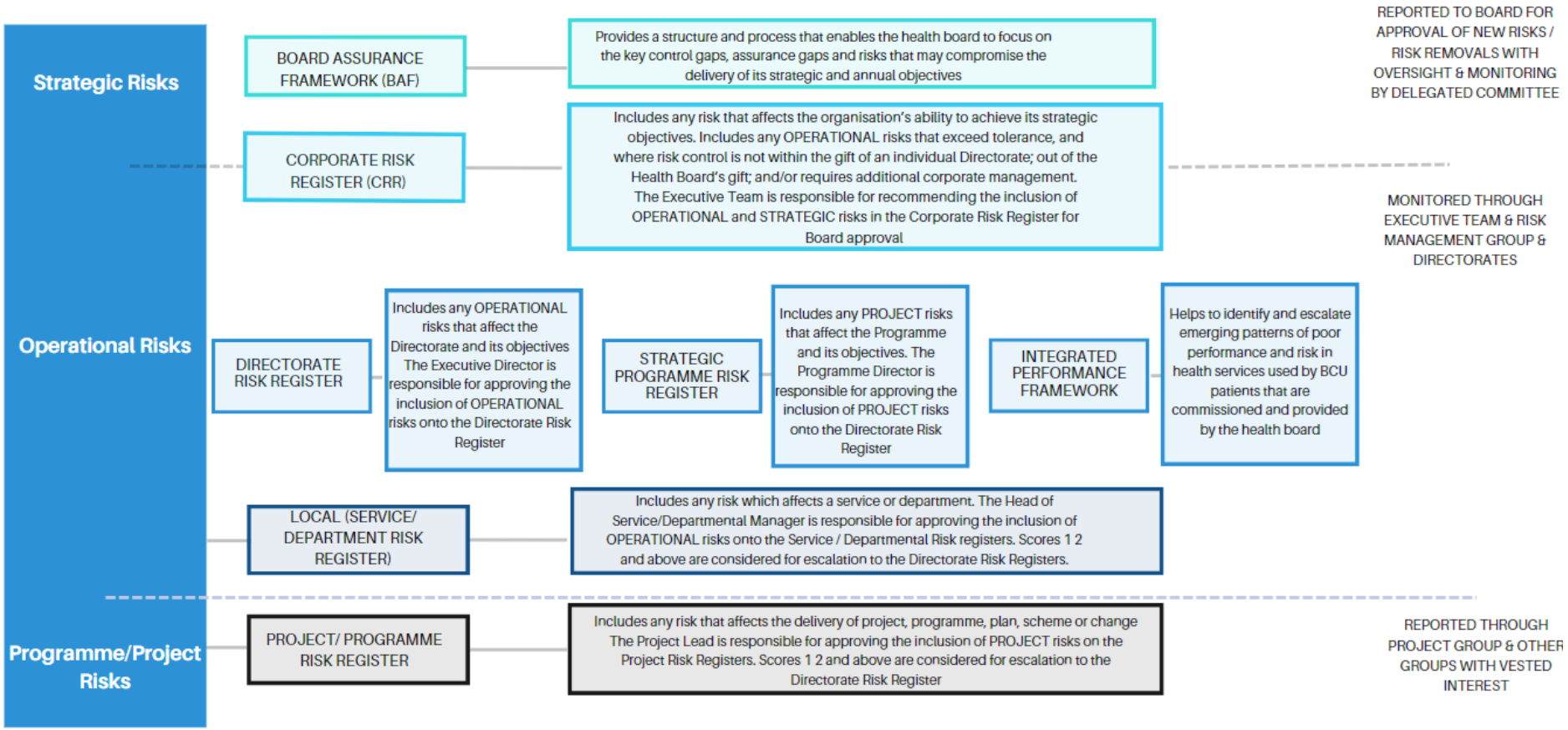


Figure 3 - Risk Management Register



6. RISK STRATEGY

To effectively manage risks, our organisation will take a comprehensive approach across several areas. This will include robust reporting mechanisms to keep leadership and the Board apprised of risks, using systems like risk registers to log and track risks, ensuring staff have adequate training and clear responsibilities, implementing standardised risk management processes, fostering a culture of openness around risks, and continuously monitoring and improving through quality assurance. Together these initiatives across reporting, systems, people, processes, culture and improvement will enable us to better anticipate, manage and mitigate the risks we face in alignment with our values and strategic objectives.

Reporting

- Services to provide their directorates on assurances over the management of the local service risk register.
- Risk Scrutiny Group to oversee risk processes in line with procedures to supports continuous improvement and monitoring of trends in relation to KPIs (outlined in RM02).
- Corporate risk report to Executive Committee and Board Committees on risk actions plans and updates. Terms of reference and cycle of businesses for all support risk as a standing agenda item.
- Board Assurance Framework (BAF) risk report to Board.

Figure 4 – Strategic Register Reporting Cycle

Register /Tier	Review	Formal Review	Approval Escalation/ De-	Committee Oversight	Board
Board Assurance Framework	Reviewed Bi-Monthly	Risk Scrutiny Group	Executive Committee Meeting	Quarterly	Bi-Annually (or any escalations via Audit Committee Chair's report)
Corporate Risk Register				Quarterly	Quarterly

Systems

- Datix to be used to log risks.
- Risk priorities will influence integrated planning.

Processes

- Process in relation to risk management procedures are detailed in RM02 'Risk Management Procedures' and throughout this framework as well as RM03 outlines 'Risk Management Training Procedures' and plans. Risk identification, assessment and treatment processes as detailed in section 4.
- Risk monitoring and review processes, risk reporting and escalation processes.

Culture

- The cultural tone is detailed in the statement and approach to risk as well as supported by the way in which processes are carried out, dynamic and diligence. Risk clearly noted as everyone's business and supported by detailing responsibilities.

People

- Risk management responsibilities are clear for all staff and have been further detailed in section 7.
- The Health Board is committed to continuous learning which applies across risks management. Training as a part of ensuring continuous improvement is crucial. Knowledge of good identification processes and how to manage risk is essential to the successful embedding and maintenance of effective risk management. To support this, a programme of training will be delivered as follows:

Staff Group	Training Need	Frequency
Board Members & Directors & Deputies	Strategic Risk Management Training	Every 2 years
Service managers/Risk owners/Service Risk Leads	Mandatory Operational Risk Management Training	Every 2 years
All staff	Basic awareness on corporate induction as well as a bespoke offer of face to face or virtual risk training	On starting and ad hoc offer as required (Patient safety mandatory module contains risk management

		awareness for clinical staff)

Strategic (BAF) Risks:

The ‘three lines of assurance’ have been outlined in relation to independent and objective audits and reviews of risk management practices ‘The three lines of assurance’ includes internal/external audit, regulators, professional body reviews and scrutiny. Provides assurance to senior management and Board on effectiveness of risk management.

The three lines of assurance also clarify roles for review and oversight:

First line of assurance: Reviews by operational management

Second line of assurance: Oversight by risk management/compliance functions

Third line of assurance: Independent assurance from audit/regulators

This model structures risk management oversight at the Risk Scrutiny Group Executive Committee, Board Committees and Board levels for the Health Board.

7. ROLES AND RESPONSIBILITIES

Effective risk management requires clear definition of the roles, responsibilities, and accountabilities across the organisation. This section outlines the duties and obligations relating to risk for the Board, relevant Committees, key groups and individuals within the Health Board.

THE BOARD:

The Board (Executives, Directors and Independent Members) being the governing body responsible for strategy, performance, governance, risk management, and ensuring statutory duties are met. The Board is accountable for effective oversight per NHS (Wales) Act and other healthcare regulations.

The cycle of business for the Board is set to receive the CRR and BAF on a quarterly/bi-annual basis. It is the duty of the Board to discuss and advise on the content and progress of action plans in the BAF. It is also the duty of the Board to appropriately monitor BCUHB’s significant risks noted in the CRR, associated controls and assurances outline as well taking a view on the overall decision of tolerating a risk or challenging the possible lack of progression.

The Board is responsible for ensuring that the Health Board consistently follows the principles of good governance; ensuring that the systems, policies and people are in place to manage risks and its effectiveness. The Board will be focused on key risks and driving the delivery of the Health Board’s strategic objectives. Gaining assurance demonstrates good oversight of effective risk identification and management; risk

architecture as well as due diligence including robust governance. It is a key principle of accountability.

The workplans for the Board and each of its Committees will be aligned to the BAF and CRR, ensuring appropriate focus on areas of risk. In the context of this Framework the Board will:

1. demonstrate its continuing commitment to risk management through the application and interest in the overall compliance with this Framework;
2. ensure, through the Chief Executive, that the responsibilities for risk management outlined in this document are communicated, understood and maintained;
3. take a proactive role in 'horizon scanning' for emerging threats/risks to the delivery of the Health Board's strategic objectives, and ensuring that controls put in place in response, manage risks to an acceptable level;
4. commit financial, managerial, technological and educational resources necessary to adequately control identified risks;
5. ensure that lessons are learned and disseminated into practice from complaints, claims and incidents, and other patient experience data;
6. oversee and participate in the risk assurance process;
7. allocate strategic risks to Committees for oversight;
8. ensure communication with partner organisations on problems of mutual concern including risks;
9. ensure that appropriate structures are in place to implement effective risk management; and
10. receive reports from the Committees of the Board in line with terms of reference and workplans of those committees.

AUDIT COMMITTEE (AC):

Provides assurance on governance, risk management, internal controls, financial reporting and internal/external audits. The Committee is responsible for points 1-5 as noted above.

The cycle of business for the Committee is set to receive the CRR and BAF in its entirety on a bi-monthly basis. The Audit Committee, on behalf of the Board, will be responsible for providing oversight of the adequacy and management of the CRR and BAF arrangements.

PERFORMANCE, FINANCE AND INFORMATION GOVERNANCE COMMITTEE (PFIG):

Oversees financial and operational performance, information governance, and delivery of plans/targets. The Committee is also responsible for points 1-5 as noted above. The cycle of business for the Committee is set to receive the section of the CRR and BAF to which it is accountable for on a bi-monthly basis.

QUALITY SAFETY AND EXPERIENCE COMMITTEE (QSE):

Reviews quality of care, patient safety issues, clinical effectiveness and outcomes, patient experience. The Committee is also responsible for points 1-5 as noted above. The cycle of business for the Committee is set to receive the section of the CRR and BAF to which it is accountable for on a bi-monthly basis.

~~**Risk Management Forum:**~~

~~The Risk Management Forum reports to the Risk Scrutiny Group and advises on any risk documentation ensuring the Framework and any other relevant policies and procedures are in place. The Forum will review the processes and report on any weaknesses identified to ensure that the Board has in place effective systems for the reporting of risk, and the management of risk registers (local, directorate and corporate) and the Board's Assurance Framework.~~

~~Specifically, the Forum is responsible for:~~

RISK SCRUTINY GROUP:

The Risk Scrutiny Group reports to the Executive Committee and advises on any risk management issues, including all significant risks arising from activities within the organisation. The Group is responsible for scrutinising the CRR and BAF ensuring appropriate escalation of operational risks. The Group will report on any weaknesses identified to ensure that the Board has in place effective systems for the reporting of risk, and the management of risk registers (local, directorate and corporate) and the Board's Assurance Framework.

Specifically, the Group is responsible for:

- Operationalising the objectives of the Risk Management Framework through the organisation's directorates, by embedding risk management and establishing local risk reporting procedures to ensure the effective integrated management of risk and assurance;
- Coordinating the escalation of all clinical and non-clinical risks, making recommendations to, and advising the Executive Committee and Board accordingly;
- Reviewing and monitoring the CRR and BAF;
- Advises on any risk documentation ensuring the Framework and any other relevant policies and procedures are in place
- Coordinating the achievement of the objectives of the Risk Management Framework through the organisation's directorates, by embedding risk management and establishing local risk reporting procedures to ensure the effective integrated management of risk and assurance;
- Reviewing high risk recommendations made by the Internal Audit Service, ensuring that where appropriate they are acted upon and recorded through risk registers and the BAF appropriately.

EXECUTIVE COMMITTEE

The Executive Committee holds accountability for individual risks listed on the BAF and CRR and plays a key role in the ongoing review of the risk register. They are responsible for identifying risks that require escalation or de-escalation, and for providing regular updates on the progress of action plans aimed at mitigating and managing the risks under their remit.

7.1 INDIVIDUAL RESPONSIBILITIES

All members of staff, and those working on behalf of the Health Board, have an individual responsibility for managing risk. They must understand and adhere to this Risk Management Framework. The following individuals have specific responsibility, accountability and authority for risk management, as part of their existing roles:

CHIEF EXECUTIVE (CEO)

The Chief Executive Officer (CEO) serves as the Accountable Officer for the Health Board, holding overarching responsibility for ensuring compliance with statutory and legal obligations, as well as adherence to governance guidance issued by the Welsh Government. This accountability extends across key areas including risk management, health and safety, financial and organisational controls, and overall governance. The CEO is ultimately responsible for

- ensuring the Health Board maintains an up-to-date Risk Management Framework endorsed by the Board;
- promoting a risk management culture throughout the Health Board;
- ensuring that there is a framework in place, which provides assurance to the Board in relation to the management of risk and internal control;
- ensuring that risk issues are considered at each level of business planning, from the corporate process to the setting of staff objectives;
- setting out their commitment to the risk management principles, which is a legal requirement under the Health and Safety at Work Act 1974. The Welsh Government requires the Chief Executive to sign a Governance Statement annually on behalf of the Board. This outlines how risks are identified, evaluated and controlled, together with confirmation that the effectiveness of the system of internal control has been reviewed.

EXECUTIVES & DIRECTORS

Executives and/or Directors have overall responsibility for the operational management of risks within their Directorates and are the named senior responsible officer for individual risks on the CRR and BAF.

They are also responsible for the effective allocation of resources to timely reduce risks within their remit, while ensuring prompt escalation and de-escalation of risks where appropriate. They shall also be responsible for ensuring that senior managers under their portfolio have effective risk management systems and processes in place in their directorates, divisions, sites, and services to demonstrate robust identification, assessment, mitigation and management of all risks.

They are responsible for ensuring that best practice in risk management and a positive risk-aware culture are fully embedded in their portfolio. Executives and Directors will work with the risk management team to ensure the appropriate use of the BAF and CRR.

Executives and Directors play a pivotal role in setting the expected cultural tone, one which is positive and encourages identification, risk is not to be considered as negative or to be avoided. The Executives and Directors will do so by ensuring communication is open, and transparent where all staff have the confidence to raise a risk. Executives and Directors will seek assurances that risk training is well attended for their regions and departments. Good risk awareness, awareness of roles and responsibilities, timely management of action plans, and a sense of accountability. Executives and Directors will seek assurances respective risk registers are maintained regularly, action plans are well managed, well communicated and actions which have blocks are escalated in a timely manner. Registers are expected to be agile and reflective of the service. Executives and Directors will foster a culture of continuous improvement supporting teams to engage with Better by Betsi, a community of continuous improvement, enhancing innovation with risk identification, mitigations strategies for their service. Executives will take a proactive identification approach to counter fraud risks.

In addition, Clinical Executive Directors (Executive Medical Director, Executive Director of Nursing & Midwifery, Executive Director of Therapies & Health Sciences, and the Executive Director of Public Health) have collective responsibility for clinical quality governance, which will include patient safety, incident management and patient experience, and will therefore have a responsibility to ensure that clinical risks are appropriately managed in-line with this Framework.

DIRECTOR OF CORPORATE GOVERNANCE

The Director of Corporate Governance is the delegated lead for risk management in the Health Board, and is accountable for leading on the design, development and implementation of the integrated BAF and Risk Management Framework.

The Director of Corporate Governance will:

▪ lead the embedding of an effective risk management culture throughout the Health Board;

▪ work closely with the Chair; Chief Executive; Chair of the Audit Committee; and, Executive Directors, to implement and maintain an appropriate Risk Management Framework and related processes, ensuring that effective governance systems are in place;

▪ develop and communicate the Board's risk awareness, appetite and tolerance;

▪ lead and participate in risk management oversight at the highest level, covering all risks across the organisation on a Health Board basis;

▪ lead the ongoing development of the Risk Scrutiny Group (established by the Executive Committee).

HEAD OF RISK MANAGEMENT

The Head of Risk Management is accountable to the Director of Corporate Governance, and in relation to risk management will specifically:

▪ provide specialist advice in relation to controls and assurances for a range of functions at all levels in the organisation to support the effective management of clinical and non-clinical risk and governance;

▪ ensure a central system is in place to collate risk registers across the Health Board, which link to the BAF;

▪ support the management and development of the BAF and Risk Management Framework;

▪ work with directorates and Heads of Service to ensure risks are escalated in accordance with the Risk Management Framework;

▪ compile the CRR and BAF, for Board;

▪ support the development and functioning of the Risk Forum and Risk Scrutiny Group; and

▪ provide training, information and advice to operational staff and corporate functions on risk management and risk registers, ensuring linkage to the BAF.

CORPORATE RISK TEAM

The corporate risk management team will facilitate and ensure effective risk management practices are in place throughout the organisation. The team will support the escalation of risks the CRR and BAF. The risk management team will support services by validating risk registers, including the adequacy of the risk descriptions, controls, and assurances and justification of the risk scoring and take a lead on assurances of compliance pan BCU.

They will advise all colleagues including Executives and Directors in managing their risks. The risk team will lead the development of procedures as required under this framework. They will ensure the delivery of training to staff who have responsibilities

under this policy. They will be responsible for the overall management of the risk module in Datix.

SENIOR MANAGERS

Senior managers will take the lead on risk management within their divisions, sites and areas and set the example through visible and exemplary leadership.

They are also responsible for supporting the effective allocation of resources in managing, escalating and de-escalating operational and strategic risks within their remit. The risk service lead and risk team will work with senior managers to ensure risks are articulated appropriately and described in line with procedures and will further support organisational wide learning.

The risk management team will provide healthy challenge and support to those risks that do not have adequate actions or action plans and have not progressed in a timely manner with a route to escalation to SIROs. Senior manager will provide SIROs with regular assurances around effective management of risk registers.

SERVICE RISK LEADS

Services are required to nominate a risk lead/champion on behalf of the service to ensure the risk register is well maintained and risk is championed throughout the service facilitating good identification processes. Service risk leads will support the operational management of their respective service risk register and will liaise with the risk management team around escalation or de-escalations of risks and will work on any feedback around the quality assurance of the risk register. Service managers and service risk leads will be responsible for ensuring activities and action plans within risks are regularly maintained. All leads and champions will have regular risk management training.

ALL STAFF

All staff including, Trade Union colleagues and contractors are required to comply with this Risk Management Framework, raise any issues of concern to the attention of their line manager and to appropriately minimise and manage risks to the best of their knowledge and ability. Controls and actions implemented in mitigating risks must be timely disseminated to all staff involved with the management of the risk. All staff are expected to share intelligence around any potential risks with contractors providing services within and on behalf of the Health Board. Risk is the responsibility of all staff of the Health Board; agency staff; contractors brought in to undertake work on behalf of the Health Board, for example capital and estates works; students; locums; volunteers; individuals employed on honorary contracts; and, other third parties engaged in Health Board business.

INDEPENDENT MEMBERS (IMs)

Independent Members have an important role in risk management in seeking assurance on the robustness of processes and the effectiveness of controls through

constructive, robust, positive and effective challenge to the Executives, Directors and senior management. IMs are expected to satisfy themselves that the Health Board`s risk management arrangements are effective, efficient and fit-for-purpose. IMs will provide healthy challenge on those risks that are not treated in a timely manner; the overall decision to tolerate the risk and/or the risks alliance to Health Board objectives.

IMs will challenge overall Board decision-making ensuring this is within the Boards risk appetite. In addition, IMs chair Board Committees and in line with the relevant Committee's terms of reference, should gain and provide assurance to the Board that risks within its remit are being managed effectively by the risk owners and report any areas of concern to the Board. IMs should seek assurance in ensuring a measured risk culture.

INTERNAL AUDIT

The relationship between risk management and Internal Audit is critical. Risk management is concerned with the assessment of risk and the identification of existing and additional controls, whereas Internal Audit's role is to evaluate these controls and test their efficiency and effectiveness. This is undertaken through the Internal Audit programme of work. Accordingly, the Head of Internal Audit will:

a. Provide an overall opinion each year to the Accountable Officer of the organisation's risk management, control and governance; to support the preparation of the Annual Governance Statement;

b. Focus the internal audit work on the significant risks as identified by management, and audit the risk management processes across the organisation;

c. Audit the organisation's risk management, control and governance through operational audit plans, in a way that affords suitable priority to the organisation's objectives and risks;

d. Provide assurance on the management of risk and improvement of the organisation's risk management, control and governance; by providing line management with recommendations arising from audit work.

LOCAL COUNTER FRAUD SERVICES

The Health Board's nominated Local Counter Fraud Specialist (LCFS) provides assurance to the Board regarding risks relating to fraud and/or corruption. The Health Board's Annual Counter Fraud Work Plan, as agreed by the Audit Committee identifies the arrangements for managing and mitigating risks as a result of fraud and/or corruption. Where such issues are identified they are investigated by the LCFS, and then reported to the Audit Committee as appropriate. The LCFS works with the Chief Executive, Executive Committee and Director of Corporate Governance to review any fraud or corruption risks. Such risks are referred to the relevant risk register for the Directorate concerned, and are then escalated through the Health Board's escalation process. The Executive Committee recognises that fraud, bribery, and corruption pose significant risks that require proactive

management. To protect the interests of our stakeholders, act ethically, and comply with counter fraud laws and regulations, we commit to proactively identify fraud risks and vulnerabilities across the Health Boards operations through audits, reviews of complaints and allegations, and risk assessments. Routinely assess changes that may impact exposure to fraud, bribery and corruption. This also includes effective controls tailored to the highest risk areas identified. This includes clear financial controls, investigation and response diligence, training, and ensuring robust channels for reporting concerns.

SENIOR INFORMATION RISK OFFICER

The Board will nominate an Executive or Director as the Senior Information Risk Officer (SIRO) with delegated responsibility by the Chief Executive for ensuring that information risks are treated as a priority for business outcomes.

8. MONITORING THE EFFECTIVENESS OF THE RISK MANAGEMENT FRAMEWORK

Compliance with this Framework is monitored by the Executive Committee and the Audit Committee. The Annual Governance Statement is signed by the CEO and sets out the organisational approach to internal control. This is produced at the end of the financial year and is scrutinised as part of the annual accounts process and presented to the Board with the accounts, as part of the Annual Accountability Report. The Corporate Risk Team and Risk Scrutiny Group will take a lead on seeking assurances and providing Committees and Board with an overview of the Health Board's effectiveness and compliance. The Head of Internal Audit will also provide an opinion together with the summarised results of the internal audit work performed during the year.

The Health Board's risk management arrangements are also subject to review annually, as part of the Audit Wales Structured Assessment process. The risk management framework draws from best practice standards ISO31000, policy, and legislative instruction such as the National Health Service (Wales) Act 2006, the Health and Safety at Work Act 1974 and the Management of Health and Safety at Work Regulations 1999. The Health Board understands that risk is inherent in every business and is committed to ensuring full compliance.

This document should be read in conjunction with the 'Risk Management Procedures' (RM02) and 'Risk Training Procedures' (RM03) which are supportive of this Framework and outline all the procedural requirements for managing a risk operationally through to escalation.

Appendix 1

RISK APPETITE

The Board set their risk appetite in a developmental session on the 27 August 2025 and is subject to annual review. The appetite session referenced the Good Governance Institute Appetite Risk Matrix for Sensitive Decision Making, for risk types in order to score appetite.

The output of the session detailed appetite across five risk types:

Quality Risk: There was willingness to be 'open' and consider all potential delivery options and choices while also providing an acceptable level of reward (and VfM). We are prepared to accept the possibility of short-term, managed risks to quality or safety where there is strong evidence that the change will deliver long-term improvement in patient outcomes. We will embed investigation and learning into all decisions, ensuring the duty of candour remains central to our approach. **<15**

Financial Risk: There was an agreed consensus on an 'open' appetite and consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM). There was an agreed consensus to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities. **<15**

Regulatory/Compliance Risk: There was an agreed consensus supporting an 'open' risk appetite to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM). Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences. **<15**

Reputational Risk: There was an agreed consensus to 'seek' some reputational risks and an eagerness to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk). We are willing to take bold decisions that may attract significant scrutiny if they are in the best interests of patient safety and service improvement. Reputation is actively managed through transparent, values-based communication, and we view public interest as an opportunity to demonstrate leadership. **<20**

Innovation: There was a clear consensus to 'seek' innovation, with eagerness to be forward-thinking and to pursue options offering potentially higher business rewards. We actively pursue innovations that challenge current practice while implementing controls to minimise risks to patient safety, where there is strong potential for substantial improvement in outcomes. Controlled trials, pilot programmes, and transparent stakeholder engagement remain integral to this approach. **<20**

Score tolerances are communicated for each risk domain and risks should be managed throughout the Health Board in line with domain scores.

EQUALITY IMPACT ASSESSMENT

The Health Board has undertaken an Equality Impact Assessment on the implementation of the Risk Management Framework and procedures to ensure that

it is inclusive and does not discriminate against any protected characteristics. The assessment has highlighted an equality impact concern regarding the availability of the documentation in a format to address any visual impairment disabilities. Any RAG ratings in Datix and other documents will have descriptors for those with colour blindness and RM01-03 will be available in Welsh as well as all risk training. Further support to understand the document is also available through bespoke support and training through the corporate risk team. Any other challenges to implement or apply these Risk Management documents can be communicated to the corporate risk team in order to ensure the Health Board to positively meet its responsibilities under the equalities and human rights legislation.

REFERENCES

AS/NZS ISO 31000:2018 (2018) Risk Management Guidelines. BSI Publication.

Bribery Act 2010. (c.23). London: The Stationery Office.

Cabinet Office. (2013). Functional Standard GovS013: Counter Fraud. [online] Available at: https://www.gov.uk/government/publications/counter-fraud-standards

Committee of Sponsoring Organizations of Treadway Commission (2017) Guidance on Enterprise Risk Management – Integrating with Strategy and Performance. Available at: https://www.coso.org/enterprise-risk-management

Criminal Finances Act 2017. (c.22). London: The Stationery Office.

Deloitte (2015) Enterprise Risk Management – A 'risk-intelligent' approach. Deloitte Advisory Publication.

Good Governance Institute (2018) Risk Appetite Matrix https://www.good-governance.org.uk/wp-content/uploads/2020/05/GGI_RiskAppetite_CHV19-version3.pdf

Fraud Act 2006. (c.35). London: The Stationery Office.

HM Treasury (2020) The Orange Book: Risk Management – Principles and Concepts.

IRM (2011) Risk Appetite & Tolerance Guidance Paper.

NHS Leadership Academy (2013) The Healthy NHS Board 2013 – Principles for Good Governance. Available at: www.leadershipacademy.nhs.uk

Public Interest Disclosure Act 1998. (c.23). London: The Stationery Office.

WHC (2000)13 – Corporate Governance in the NHS in Wales: risk management and organisational controls.

Included a desktop review of Welsh Health Boards Risk Frameworks

Corporate Risk Register

CORPORATE RISK REGISTER (AS AT END SEPTEMBER 2025)

1.0 PURPOSE

This report provides an update on the **Corporate Risk Register (CRR)** following a comprehensive review and refinement process.

1.1 Key Highlights

Two Executive Committee sessions were held on **16 July** and **20 August 2025** to review the CRR. It was agreed that the previous register of 26 risks should be consolidated into a more strategic format for Board oversight and committee governance.

Key Updates

- The revised CRR has been endorsed by Committees during their October cycles, with all requested refinements now incorporated.
- The **public CRR (Appendix 3)** now contains **nine strategic risks**, ensuring a sharper focus on organisational priorities.
- Operational risks have been de-escalated for management at Director level.
- Two sensitive risks remain restricted for private Committee and Board review due to their nature.

Risk Oversight

- The **Risk Scrutiny Group** continues its programme of deep dives on strategic risks.
    - September: CRR24-06 – *Value Delivery and Financial Sustainability*.
    - November: CRR25-09 – *Safe Environment* and CRR25-10 – *Health and Safety* (following postponement of the October session due to quoracy).

1.2 Changes in Score

Only 1 change in score has occurred for corporate risks within the past 12 months.

Within the Executive Committee Development Sessions held in July and August 2025, and the Audit Committee Development Session in November 2025, it was noted that actions within the Corporate Risk Register must demonstrably reduce the overall risk exposure and score, rather than solely describe ongoing activity.

- Action is therefore required by the Executive /Senior Responsible Officer (SRO) within the next six months to prioritise driving down risk scores through strengthened controls, enhanced accountability, and targeted interventions, particularly in areas such as financial sustainability, workforce resilience, estates safety, and regulatory compliance.

During this consolidation and review of the corporate risk register, the reduction of eight operational risks, on challenged services, have been identified as requiring enhanced oversight and scrutiny by the Chief Operating Officer, through inclusion and monitoring within the Operational Senior Leadership Team Meeting (OLT). The Corporate Risk Team will attend these meetings to monitor, ensuring that risk discussions are robust, actions are effective, and that clear evidence is available to demonstrate reduction in residual risk.
In addition, the Corporate Risk Team will undertake periodic risk maturity audit and reporting to the Risk Scrutiny Group, to provide assurance.

Risk Ref	Reduced Risks	Lead Exec Director	Previous Risk Score	Current Risk Score
CRR24-02	*Patient Safety*	Executive Direcor of Nursing	16	12

1.3 New Risks

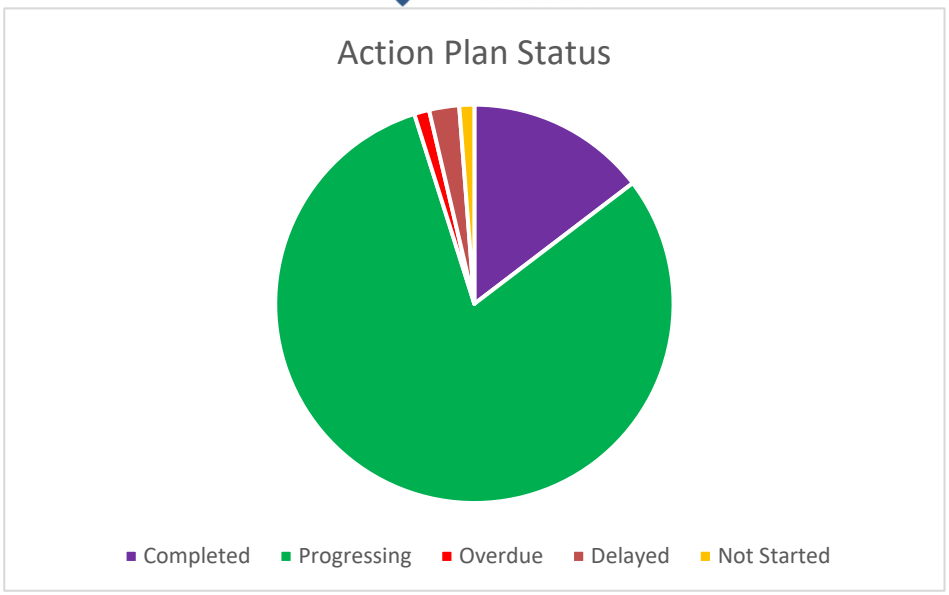
The risk(s) added to the Corporate Risk Register since the last update are:

Risk Ref	New Risks	Lead Exec Director	Current Risk Score (and IxL)
	2025: All 11 risks presented refined and consolidated		

1.4 Risks above Health Board 24/25 appetite

In 2024 the HB had eight risks reported to committee score **above** the tolerance range set in the appetite. Although some of these are now being managed operationally and remain above appetite. Ten corporate risks above tolerance are for the oversight of the Committees and Board.

1.5 Action Plan status of Corporate Risks



Of the 11 Corporate Risks, 82 actions have been developed to mitigate the risks 12 actions have been completed, 66 actions are progressing and on track, 1 action is overdue, 2 delayed actions (CRR25-03 Population Needs) rationale detailed within action update) and 1 action not started.

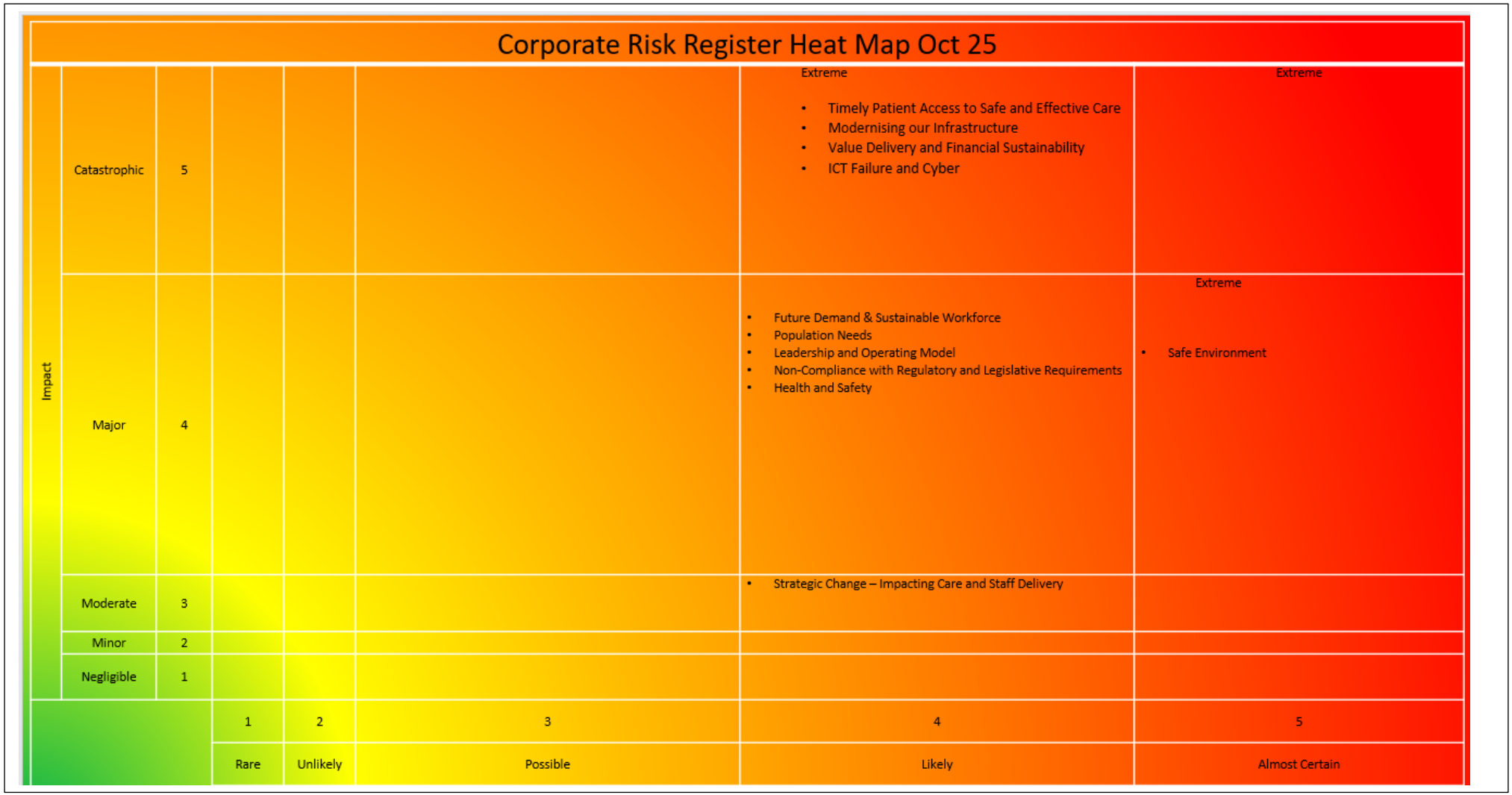
Next steps

1. Further scrutiny of all corporate risks by Executive Committee as per normal reporting cycle.

Appendix

1. Appendix 1 – Corporate Risk Register Heat Map September 2025.
2. Appendix 2 – Corporate Risk Register Dashboard September 2025.
3. Appendix 3 – Corporate Risk Register September 2025.

Appendix 1 – Corporate Risk Register Heat Map September 2025



Appendix 2 - Corporate Risk Register Dashboard September 2025

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	5	2	0	
EDoW	CRR25-02	Future Demand & Sustainable Workforce	4x4 16	8	Quality (<15) Above Tolerance	People & Culture Committee	8	1	0	
EDoPH	CRR25-03	Population Needs	4x4 16	12	Quality (<15) Above Tolerance	Planning, Population Health & Partnership Committee	13	0	2	
CDIO	CRR25-04	Modernising our Digital Infrastructure	5x4 20	12	Quality (<15) Above Tolerance	Planning, Population Health & Partnership Committee	9	1	0	*Removed from report, private
EDoTSP	CRR25-05	Strategic Change – Impacting Care and Staff Delivery	4x3 12	8	Quality (<15) In Tolerance	Planning, Population Health & Partnership Committee	6	0	0	

EDoF	CRR25-06	Value Delivery and Financial Sustainability	5x4 20	12	Financial (<15) Above Tolerance	Performance, Finance and Information Governance Committee	8	3	0	
EDoW	CRR25-07	Leadership and Operating Model	4x4 16	8	Quality (<15) Above Tolerance	People & Culture Committee	5	0	0	
DCG	CRR25-08	Non-Compliance with Regulatory and Legislative Requirements	4x4 16	8	Regulatory (<15) Above Tolerance	Quality, Safety and Experience Committee	8	1	0	
DoE	CRR25-09	Safe Environment	4x5 20	12	Regulatory (<15) Above Tolerance	Performance, Finance and Information Governance Committee	3	0	0	
DoE	CRR25-10	Health and Safety	4x4 16	8	Regulatory (<15) Above Tolerance	Performance, Finance and Information Governance Committee	8	0	1	
CDIO	CRR25-11	Cyber	5x4 20	15	Quality Above Tolerance	Planning, Population Health & Partnership Committee	9	4	2 (revised dates)	*Removed from report, private. Target score remains high.

Executive Lead	
Executive Director of Workforce	EDoW
Executive Director of Nursing & Midwifery	EDoN
Executive Director of Finance	EDoF
Chief Digital Information Officer	CDIO
Executive Director of Public Health	EDoPH
Director of Environment	DoE
Executive Medical Director	EMD
Chief Operating Officer	COO
Director of Corporate Governance	DCG
Executive Director of Therapies and Allied Health Professions	EDoTH
Executive Director of Transformation and Strategic Planning	EDTaSP

Appendix 3 – Corporate Risk Register October 2025

CRR 25-01	**Risk Title: Timely Patient Access to Safe and Effective Care**		**Date Opened:** 21/08/2025 *(version 2 refined from 2023)*
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 06/11/2025
Date Last Reviewed: 25/09/2025	**Director Lead:** Chief Operating Officer	**Link to BAF**: BAF24-07	**Target Risk Date:** 30/06/2027

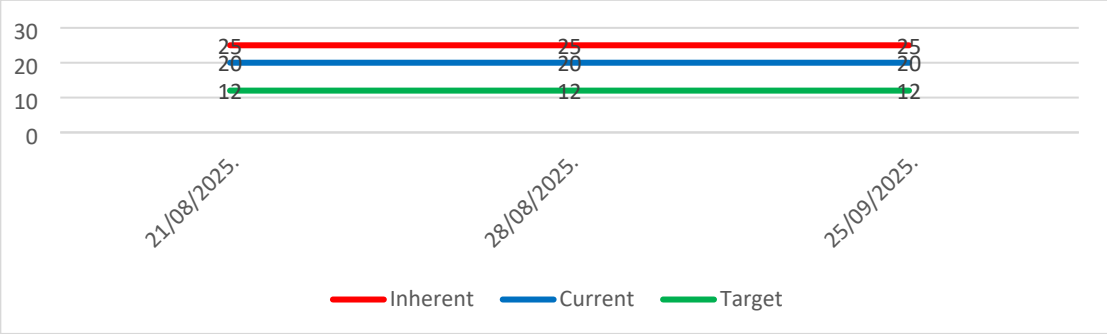
There is a risk that patients may not receive timely access to the care they need, which could lead to deterioration in health, poor patient experience, and poorer outcome.
This may be caused by lack of oversight of waiting lists, harm occurring on waiting lists, insufficient communication with clinicians, poor patient experience, and difficulties recruiting to specialist posts.
This may lead to extended waiting lists, patient harm due to delays, and reputational or regulatory consequences.

Mitigations/Controls in place	Additional Controls required
1. System Resilience Hub in place with hospital full protocols and winter/festive plans 2. 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. 3. Winter Resilience Plan complete evaluation and lessons learnt. 4. Revised Access policy to ensure standardised practice across the Health Board 5. Single Integrated Clinical Assessment Triage (SICAT) and GP Out of Hours (OOHs) joint model providing 24/7 triage and advice	a. Fragility of UEC and specialist workforce posts, reliance on locums' temporary posts. b. Fragility of social care provision causing delayed discharge and stranded patients c. Need for demand and capacity modelling and specialty-level trajectories d. Inadequate Neurodevelopment capacity to manage waiting list e. Outdated diagnostic IT systems causing inefficiencies in reporting and turnaround times with diagnostics.

6. Same Day Emergency Care (SDEC) services established at all acute sites 7. Routine clinical prioritisation of patients by risk in line with Referral to Treatment guidance 8. Outsourcing of radiology reporting and insourcing of CT, MRI, ultrasound 9. Diagnostic Quality Management System accreditation system embedded 10. Welsh Government short-term Neurodevelopment funding to support longest waiters, agency staff, overtime	

Actions	Action Owner	Due Date	Progression Analysis
a Complete recruitment of clinical leads and project management capacity to deliver sustainable specialty models. UEC clinical lead appointed to for 4 sessions a week commencing 1st October 2025 until March 2026.	Chief Operating Officer	30/03/2026	Progressing
b Complete demand and capacity analysis across Planned Care to inform forward activity planning As part of the planned care programme and major change programme. The Transformation improvement team have provided an allocation of project management and pathway re-design support to the planned care programme to be used flexibly across its delivery.	Danielle Edwards, Programme Director, Planned Care	31/03/2026	Progressing
d Implement new prudent ND assessment process to streamline and reduce wait times (ND Waiting List) Prudent assessment developed and agreed, to be rolled out across the teams from October 2025.Prudent assessment has been launched last week in September 2025	Louise Bell / Fiona Wright	31/07/2025	Completed
d Stratify ND waiting list to identify and prioritise high-risk children. Work undertaken to stratify the waiting list and identify high risk children. Stratification of Waiting Lists has taken place	Louise Bell / Fiona Wright	30/09/2025	Completed

e Update Failure to act on Diagnostics Procedure to be presented at divisional meeting for discussion on the 10/10/2025	David Fletcher, North Wales Managed Clinical Services	20/10/2025	Progressing



	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.

<table>
<tr><td rowspan="2">CRR 25-02</td><td colspan="2">Risk Title: Future Demand & Sustainable Workforce</td><td>Date Opened: 21/08/2025
(version 2 refined from 2023)</td></tr>
<tr><td colspan="2">Assuring Committee: People & Culture Committee</td><td>Date Last Committee Review: 16/10/2025</td></tr>
<tr><td>Date Last Reviewed:
25/08/2025</td><td>Director Lead:
Executive Director of People and Organisational Development</td><td>Link to BAF:</td><td>Target Risk Date: 31/03/2027</td></tr>
<tr><td colspan="4">There is a risk that the organisation will not have a sustainable workforce to meet future patient demand.
This may be caused by ongoing recruitment challenges (particularly in specialist roles), limited workforce planning to match future service</td></tr>
</table>

needs, and increasing operational pressures across teams and departments.
This may lead to staff burnout, reduced morale and retention, and an inability to consistently deliver safe, high-quality care placing additional strain on services and impacting patient outcomes.

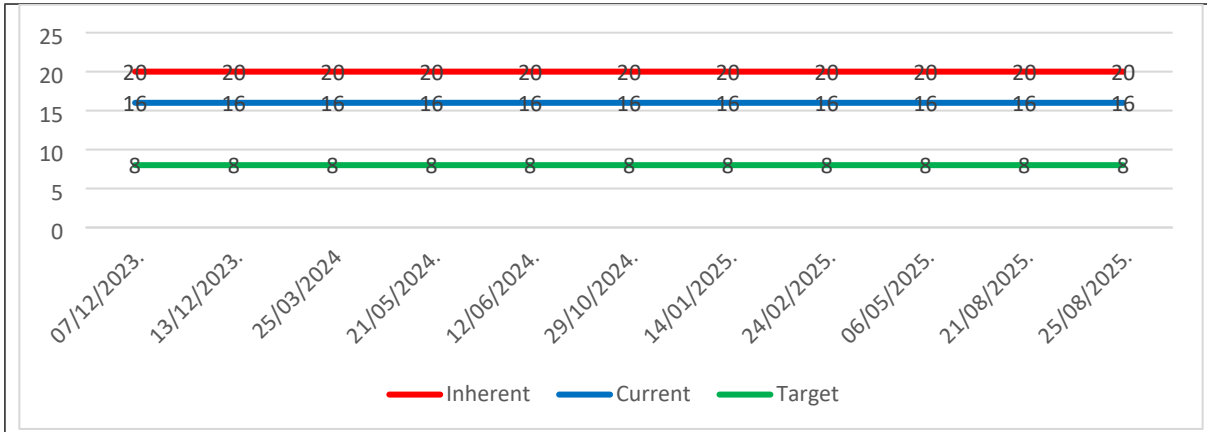
Mitigations/Controls in place	Additional Controls required
a) Strategic Recruitment Team supporting senior leadership, medical and dental consultant posts b) Local IHC resourcing teams delivering recruitment activity against divisional priorities. c) Recruiting Well / Joining Well programmes and recruitment campaigns. d) Nurse Retention Lead and retention plan. e) All-Wales Flexible Working policy implemented. f) Speak Out Safely Multi-Disciplinary Team and Work in Confidence platform in place for staff concerns. g) Workforce reviews underway in challenged specialties (ophthalmology, vascular, orthodontics, ND, diagnostics).	a) Implement a system-wide Workforce Planning Framework that aligns health and social care workforce requirements with service demand and capacity modelling. b) Medical and Dental workforce engagement and management not fully effective. c) Fragile workforce pipelines in specialist services (ophthalmology, vascular, orthodontics, ND, diagnostics) (cross-theme). d) Retention measures not yet delivering consistent impact. e) Absence and sickness management requires stronger controls (linked to new Absence risk created Feb 2025).

Actions	Action Owner	Due Date	Progression Analysis
Reintroduce Medical Staffing function within People Services The first stage of this is to recruit a new Band 7 Medical Staffing Policy and Practice specialist who will support key workstreams through the	Steven Gregg-Rowbury, Workforce & Organisational Development	30/06/2025	Completed

Value & Sustainability program and Medical Workforce Group. The individual starts in BCU on 1st October 2025. Any further implementation of a medical staffing resource will be dependent on the Foundations for the Future Program			
Deliver "Recruiting Well, Joining Well, Leaving Well" programme across staff journey Due to resource being allocated to the Foundations for the Future programme, the remaining workstreams within this action will continue to be worked on but the expected completion is delayed until later in 2025 a. The leaving well booklet b. Improving shortlisting timescales c. Advertising well in recruitment	Steven Gregg-Rowbury, Workforce & Organisational Development	31/03/2026	Progressing
Targeted management of sickness absence, linked to new Absence risk The Healthy Workforce group is in place and is overseeing the action plan to target reducing sickness absence rates, in line with the Welsh Government requirements by March 2026	Steven Gregg-Rowbury, Workforce & Organisational Development	31/03/2026	Progressing
Workforce modelling and specialty service plans for Ophthalmology, Vascular, ND and Orthodontics Workforce planning templates have been issued out to services and engagement is underway to support the completion. Vascular services are so far further along with this, having held an away day on 3rd	Nick Graham, Workforce & Organisational Development	31/03/2026	Progressing

September. There are challenges in service leads having time/capacity to work on their workforce plans			
Develop Vascular workforce strategy and Phase 2 Business Case	Jo Flannery, Vascular Services	31/03/2026	Progressing
Recruitment and workforce model development for Orthodontics Academy model	Chief Operating Officer	Ongoing	Progressing
ND workforce business case approval via Executive Team. Business case submitted to the Executive Team, decision on the case deferred pending a broader review of funding priorities	Fiona Wright, C&YP	31/12/2025	Progressing
Establish revised Radiology workforce model. Updated operational Diagnostic risk to be presented at divisional meeting to discuss on the 10/10/2025.	David Fletcher, Diagnostics	20/10/2025	Progressing

	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8



Risk Appetite	Quality <15	Not in Tolerance

Position & Intended Outcome for Risk

KPIs to that inform our risk in this area as at Oct 2025;

Overall Vacancy rate of 8.2%, slight improvement from 8.8% since the April 25. Clinical staff groups such as Registered Nursing, and Professional Scientific and Technical are seeing positive reductions in vacancy FTE over the last year, however, increases in Clinical Services, Admin and Clerical, Estates and Ancillary and Medical and Dental are causing the vacancy rate to remain fairly static.

Turnover stands at 7.7% and continues its downward trend from 10% in December 2022.

BCUHB continues to have the lowest reported sickness absence levels in Wales NHS, however, in August 2025 rolling sickness absence was 0.08% higher than during same period last year with Stress, anxiety and depression accounting for the largest proportion of absence.

CRR 25-03	**Risk Title: Population Needs**	**Date Opened:** 21/08/2025 *(version 2 refined from 2023)*

	Assuring Committee: Planning, Population Health & Partnership Committee		**Date Last Committee Review:** 06/11/2025
Date Last Reviewed: 25/08/2025	**Director Lead:** Executive Director of Public Health	**Link to BAF**: BAF24-06/07	**Target Risk Date:** 31/03/2028

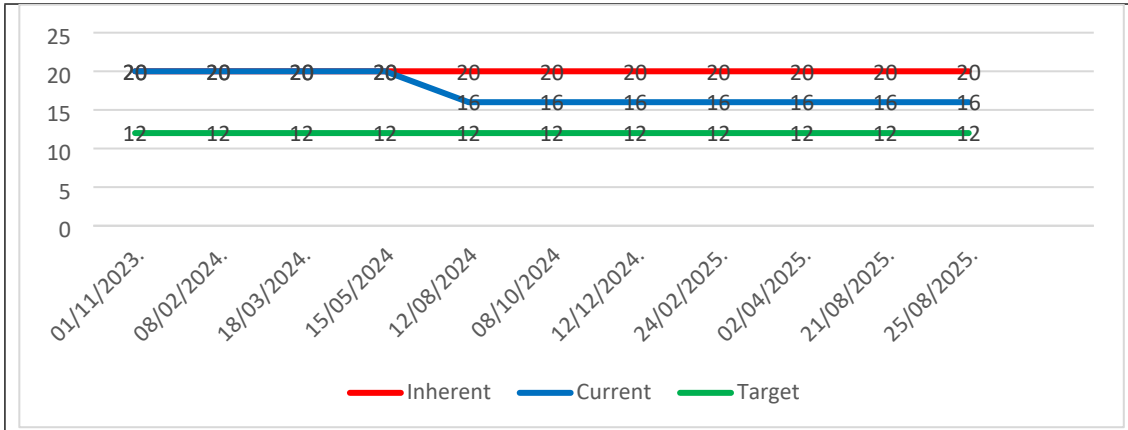
There is a risk that the organisation will fail to meet the health needs of the population and will not enable good health and wellbeing of the population.
This may be caused by a failure to take appropriate health prevention responses in areas such as immunisation, outbreak management and screening, failure to deliver interventions that improve people's health, increasing pressures in primary care, rising demand for chronic condition management, and insufficient capacity in children's, dental, and mental health services.
This may lead to unmet health needs, preventable and communicable diseases, poorer health outcomes and widening inequalities for the North Wales population.

Mitigations/Controls in place	Additional Controls required
1. Recurrent funding secured for Healthy Weight / Healthy Wales programmes 2. Diabetes "Case for Change" a structured, evidence-based mechanism to identify service gaps 3. Healthcare Public Health programmes support the integration of population health approaches within patient pathways 4. Approved Communicable Disease Plan in place with supporting procedures in place for some communicable diseases. 5. Primary Care Board and subgroups (dental, community pharmacy, optometry, GMS) provide cluster-level governance. 6. CHC teams and community escalation frameworks in place 7. Welsh Government ND transformation programme funding to support longest waiters 8. National referral pathways in orthodontics and Dentist with Enhanced Skills / Tier 2 provision.	a) Limited system-wide prevention leadership and prevention not consistently prioritised b) Inconsistent commissioning approach across community and primary care services. c) The plan in place for the management of communicable disease outbreaks (in and out-of-hours) within BCUHB requires testing / simulation and socialising to ensure effectiveness d) Diabetes Programme support to establish cross cutting delivery plan e) Insufficient digital integration for community and Neurodevelopment services f) Fragility of Neurodevelopment workforce and reliance on temporary funding g) Lack of restorative dentistry service and workforce pipeline h) Evidence to support the Health Inclusion offer.

Actions	Action Owner	Due Date	Progression Analysis

Complete Population Needs Assessment which informs the development and focus of Health Board Strategy	Gwyneth Page, Public Health	31/03/2026	Progressing
Identify population health focused priorities for Health Board delivery	Gwyneth Page, Public Health	31/03/2026	Progressing
Development of Population Health Management data and intelligence to ensure that Health Board is intelligence-led Delayed due to recruitment controls	Gwyneth Page, Public Health	31/03/2026	Delay
Develop a plan which addresses recommendations from the BCUHB Weight Management Service review	Gwyneth Page, Public Health	31/03/2027	Progressing
Communicable disease outbreak management plan is embedded within services with an agreed schedule of simulation events and schedule of review by the Board	Sam Lauder, Public Health	31/03/2026	Progressing
Contribute to co-design Prevention Framework for North Wales as part of the Regional Partnership Board	Gwyneth Page, Public Health	31/03/2026	Progressing
Achieve the ministerial priority BCUHB Integrated Vaccination & Immunisation Service – Increase vaccination rates against targets	Gwyneth Page, Public Health	31/03/2026	Progressing

Implement plan to target resources for the most vulnerable groups (e.g. – those experiencing homelessness, Gypsy, Roma and Traveller communities) which will contribute to reducing inequalities in healthy life expectancy	Gwyneth Page, Public Health	31/03/2026	Progressing
Establish Diabetes Change Programme providing programme management, milestones and delivery plan – in order to meet the Ministerial priorities (increasing the % receiving all 8 NICE Care processes) Delayed as clinical lead cover required and programme development	Gwyneth Page, Public Health	31/03/2026	Delay
Develop a Community and CHC Strategic Plan with Local Authorities (from CRR24-19)	Jane Trowman, CHC	31/03/2026	Progressing
Implement surge and escalation plans with Local Authority partners for community flow	Jane Trowman, CHC	Ongoing	Progressing
Management of CYP needs, ND workforce business case submitted to the Executive Team, decision on the case deferred pending a broader review of funding priorities	Fiona Wright, Child & Adolescent Health	31/12/2025	Progressing
Undertake a dental diagnostic deep dive to inform strategy	Rachael Page (amended from Gareth Evans)	31/03/2026	Progressing
	Impact	Likelihood	Score



Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	3	12
Risk Appetite	Quality <15		Not in Tolerance

Position & Intended Outcome for Risk

Life expectancy / healthy life expectancy is declining, and there are worsening health inequalities. This has significant impact on demand for services and potentially on the wider community due to the loss of people from the workforce, and through the subsequent economic impacts on our communities. Worsening health outcomes, increasing ill health and widening inequalities directly affects the Health Board's ability and capacity to deliver excellent healthcare services, meaning the Health Board's purpose must retain clear focus on prevention and early intervention to improve the health and wellbeing of the population

CRR 25-05	**Risk Title: Strategic Change – Impacting Care and Staff Delivery**		**Date Opened:** 21/08/2025 *(version 2 refined from 2023)*
	Assuring Committee: Planning, Population Health & Partnership Committee		**Date Last Committee Review:** 06/11/2025
Date Last Reviewed: 01/10/2025	**Director Lead:** Executive Director of Transformation and Strategic Planning	**Link to BAF**: BAF24-02	**Target Risk Date:** 31/03/2026

There is a risk that patients may not benefit from planned improvements in care, access, and outcomes if the HB does not effectively implement or develop its strategic change programmes.
This may be caused by a lack of momentum in delivering change, unclear or underdeveloped clinical strategy, competing ministerial priorities, and inconsistent transformation efforts across clinical services.
This may lead to inefficiencies, missed opportunities to modernise care, continued misalignment between service delivery and patient needs, and increased frustration or disengagement among staff tasked with delivering change.

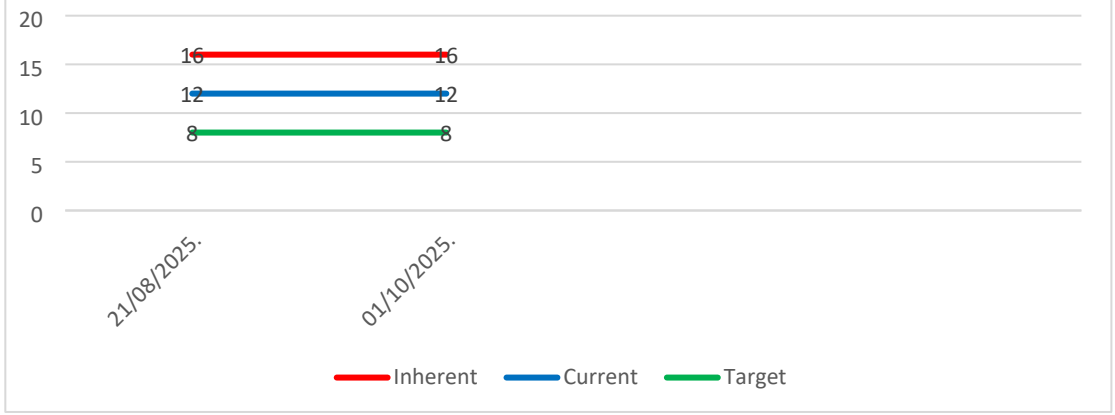
Mitigations/Controls in place	Additional Controls required
1. Scrutiny and oversight of strategy development work by the Strategic Planning and Service Change Group (SP&SC Group a sub-group of the Executive Committee), Planning Population Health and Partnerships (PPHP) Board Committee and the Health Board to ensure robust governance arrangements and timely escalation; which are important for enabling foundations for successful delivery of strategic change and co-production of the 1) Strategic Intent for North Wales with partners, 2) 10 Year Strategy for the Health Board, 3) Clinical Services Plan 2. Priority change programmes in place for the organisation 1) Major Change Programmes (Planned Care; Urgent and Emergency Care; Value and Sustainability; and Foundations For The Future), 2) Key Programmes (grouped into: Mental Health; Llandudno Planned Care hub; Improving safety,	a. Completion of the strategy development work, moving into the execution phase. b. Continued development of the portfolio management and reporting approach for all priority change programmes, including monthly monitoring of high risks across all priority programmes. c. Mobilisation of the Challenged Services oversight group that will report into the SP&SC Group. d. Organisational approach to change management to be developed and implemented.

efficiency and effectiveness through digitisation; Diagnostics improvement; and Health and Well-being Hubs), 3) Challenged Services (Dermatology, Ophthalmology, Vascular, Urology, Oncology, Plastics, Orthopaedics, Orthodontics). 3. Change programmes controls in place and monitored by the Transformation and Improvement team to ensure they are run consistently and best practice project, programme and portfolio management is applied. As well as providing an objective and independent assessment of progress and areas of risk. 4. Oversight and scrutiny of the Major Change Programmes tracking progress, risks, and dependencies by the Executive Committee, relevant Board Committee and Health Board. The Key Programmes reports into SP&SC Group, PPHP and Health Board. 5. The Challenged Services report into SP&SC Group for review and oversight, Quality, Safety and Experience Committee (QSE) and Health Board. 6. External oversight and scrutiny is provided by Welsh Government via IQPD and JET as well as quarterly Challenged Services review meetings. 7. Terms of References for all groups with clear routes to escalation. 8. Legal and policy compliance including adherence to Welsh Government (WG) service change guidance.	

Actions	Action Owner	Due Date	Progression Analysis
Complete Strategic Intent for North Wales with partners, presenting to Health Board for approval	Kamala Williams, Transformation	31/01/2026	Progressing

	& Strategic Planning		
Complete the diagnosis phased of the Health Board's 10 Year Strategy, including an implementation plan for the remaining programme of work	Kamala Williams, Transformation & Strategic Planning	31/03/2026	Progressing
Complete preparations for phase 2 of the Clinical Services Planning work, including an implementation plan	Kamala Williams, Transformation & Strategic Planning	31/03/2026	Progressing
Implement changes to portfolio management and reporting based on feedback on early iterations of reporting across all the priority programme areas, including monthly monitoring of high risks across all priority programmes.	Geraint Parry, Transformation & Strategic Planning	31/12/2025	Progressing
Mobilise the Challenged Services oversight group that will report into the SP&SC Group	Geraint Parry, Transformation & Strategic Planning	31/12/2025	Progressing
Organisational approach to change developed as one of the enabling products within Foundations For The Future programme	Geraint Parry, Transformation & Strategic Planning	31/03/2026	Progressing

	Impact	Likelihood	Score
Inherent Risk Rating	4	4	16
Current Risk Rating	4	3	12



Target Risk Score	4	2	8
Risk Appetite	Quality <15		In Tolerance

Position & Intended Outcome for Risk

CRR25-06	**Risk Title: Value Delivery and Financial Sustainability**		**Date Opened:** 21/08/2025 *(version 2 refined from 01/04/2024)*
	Assuring Committee: Performance, Finance and Information Governance Committee		**Date Last Committee Review:** 22/10/2025
Date Last Reviewed: 25/09/2025	**Director Lead:** Executive Director of Finance	**Link to BAF**: BAF24-03	**Target Risk Date:** 31/03/2026

There is a risk that the Health Board is unable to secure current non-recurrent (one off) allocations in future financial years, these allocations conditional on attainment of financial plans. If this reosurce is not secured then services will be required to deliver within a reduced envelop of funds and as a consequence patients may experience reduced access to high-quality, timely and innovative care. The objective is to achieve long-term financial sustainability or maximise value from its spending.
The key risks centre upon cost overruns from out of area referrals for mental health patients and patient flow out of the Hospital resulting in cost exposure from requiring additional capacity areas to remain open and additional costs within Emergency Care front of house, combined with an inability to deliver savings plans, reduced investment in transformation.

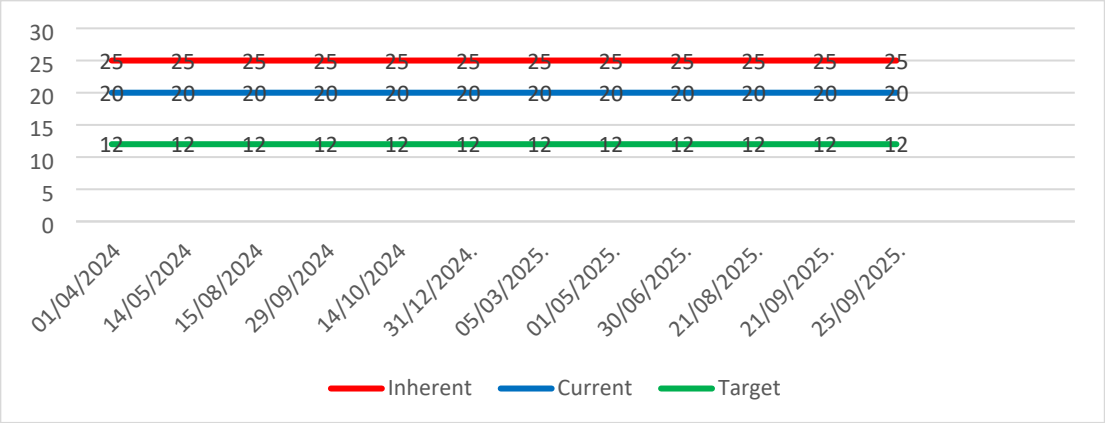
Mitigations/Controls in place	Additional Controls required
1. Core Savings targets for IHCs, Non-IHC Directorate and Corporate functions have been issued and performance to be challenged at Integrated Performance Executive Delivery Group – chaired by the Chief Executive. 2. Value and Sustainability programme approach to 2025/26 savings has been endorsed by the Executive and Board. Executive Leads have been assigned and a flow chart issued setting out the governance process for sharing of costed savings opportunities and Divisional delivery. 3. Accountability Agreements to be issued to the budget managers for sign off in support of funding and deliverables required for each financial year. The signing off for these agreements monitored for review by Internal Audit and performance reported through Committees of the Health Board 4. Continuation of the Enhanced Establishment Control Group (executive approval before advertising) to review all requests for A&C posts and all Band 7+ posts, moratorium on requests for Permanent recruitment to Band 8B and above where	a. Prior year and current year financial performance material deterioration and therefore additional actions are required to control the run rate and reduce the deficit to a balanced position. These have been previously endorsed for implementation through the Integrated Performance – Executive Delivery Group. b. Health Board delegation to Executive to produce a recovery plan, Health Board working group formed to provide Board oversight with Performance, Finance and Information Governance Committee to mitigate against the year-to-date deficit and

potentially affected by Foundations for the Future but excluding any clinical posts and minimising interim staff appointments. 5. Expansion of EEC to be utilised for acting up and any increase in hours to be managed through the Enhanced Establishment Control process. 6. Cease use of agency in line with Ministerial Actions by end of September 2025 with the exceptionality of sign off by Executive Director of Nursing for all Agency nursing requests which are deemed clinically necessary beyond 31 October. This exceptionality for nursing requests is for all areas excluding Mental Health. Mental Health to be included from December 2025. 7. Non-Pay – all discretionary, non-catalogue, non-clinical expenditure directed to the office of the Executive Director of Finance for scrutiny prior to approval 8. Internal scrutiny by Central Finance Team, of the Divisional financial assumptions, overspends and forecasts. 9. Financial reporting throughout the Health Board and to Welsh Government on a monthly basis, the Monthly Monitoring Return. 10. Early identification of emerging issues through horizon scanning and trends in run rate and alerting Operational Management to changes to regularity requirements. 11. Monitoring the adequacy and effectiveness of internal control, accuracy and completeness of financial reporting and forecast, compliance with laws and timely remediation of deficiencies through conformance reporting to Audit Committee and reporting through local finance reports to services 12. Reviewing of SORD in place in September 2025 which was implemented in October 23 with a view to providing clarity of authority moving towards earned autonomy	risk to attainment of target break even whilst assessing impact on patient safety and quality c. Performance is reported and scrutinised through the IP-EDG monthly meetings where officers are held to account for delivery. A 1% cost benefit and savings ask delivery is required as a minimum d. Gaps in delivery of savings targets are to be mandated to be met on a recurrent basis e. Escalation meetings where improvements are not realised will continue to be held with leadership teams by the Chief Executive. In these forums support is offered to improve performance and trajectories supported for improvement. f. Ongoing prioritisation exercise involving £42m transformation funding received on a conditionally recurrently basis to the end of 2025/26

Actions	Action Owner	Due Date	Progression Analysis
Health Board receiving a report on need for additional financial oversight, delegating Executive to develop a recovery plan building on the measures deployed and key asks of officers from the Integrated performance executive Delivery Group. A representation of the	Director of Finance (DoF)	30/11/2025	Progressing

Health Board to support development of the recovery plan and Performance, Finance and Information Governance Committee to provide Health Board oversight			
The Integrated Performance – Executive Delivery Group (IP-EDG) endorsed implementation of expenditure controls within the areas and directorates (from November 2024) as a measure to cease the run rate deterioration above plan and recover the year to deficit, to attain the forecast control total deficit for the financial year as agreed with Welsh Government. These measures were expanded to cover controls over expenditure discretionary expenditure (non-patient related) in January 2025 within IP-EDG. In 2025/26, a further target 1% reduction of total spend has been provided to services in September 2025 with a view to reduce the year to date overspend and mitigate any further movement of the financial position. The total target is c£20m. Action completed: As at Month 6 reporting the risk to attaining breakeven was reported at £40m.In November 2025 following discussion at Finance Oversight Group (FOG) it was agreed that the total spend reduction target be increased to 1.5% equating to c£30m alongside an acceptance that services and corporate directorates achieve the full amount of their own savings target. An assessment of the additional savings and mitigation submitted by 7th November will be presented to the next FOG meeting for assessment against the presented risks to breakeven.	DoF	31/10/2025	Complete
Enhanced 'Check and Challenge' discussions with Chief Finance Officers, on a monthly basis, to ensure the forecast expenditure is robust. Escalation of Out of Area Mental Health Placements, through the Chief Executive Officer. Maintain increased controls.	DoF	31/03/2026	Progressing
Continued oversight and holding to account via the Integrated Performance Executive Delivery Group, and holding to account against expenditure control reductions identified for the remainder of the financial year.	Chief Executive Officer (CEO) / DoF	Monthly	Progressing
Strengthen application of SORD decision-making framework across all directorates /Decision Making Framework to be developed and shared with stakeholders (completed). Decision Making Framework to be progressed to January 2026 Board (progressing).	DoF / Director of	31/10/2025	Complete

	Corporate Governance		
Programme of work initiated to review how the Health Board spends its money, visibility of IHC performance and national benchmarks to ensure value outcomes (Patient Related Outcome Measures) are developed to support Allocative Efficiency moving forwards (cost / activity / outcomes)	DoF	30/09/2025	Complete / Ongoing
Examine and explain clinical variation with a view to benchmarking opportunities internally initially with a view to ensuring financial sustainability	DoF	30/09/2025	Complete / Ongoing
Directorate teams to review medical devices capital replacement plans. Directorate teams are linking with Capital to update their replacement plans.	Susan Brierley-Hobson, Therapies & Health Science	15/12/2025	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score	4	3	12
Risk Appetite	Financial/VfM <15		Not in Tolerance

Position & Intended Outcome for Risk

CRR25-07	**Risk Title: Leadership and Operating Model**		**Date Opened:** 21/08/2025 *(version 2 refined from 2023)*
	Assuring Committee: People & Culture Committee		**Date Last Committee Review:** 16/10/2025
Date Last Reviewed: 25/08/2025	**Director Lead:** Executive Director of People and Organisational Development	**Link to BAF**: BAF25-04	**Target Risk Date:** 31/03/2027

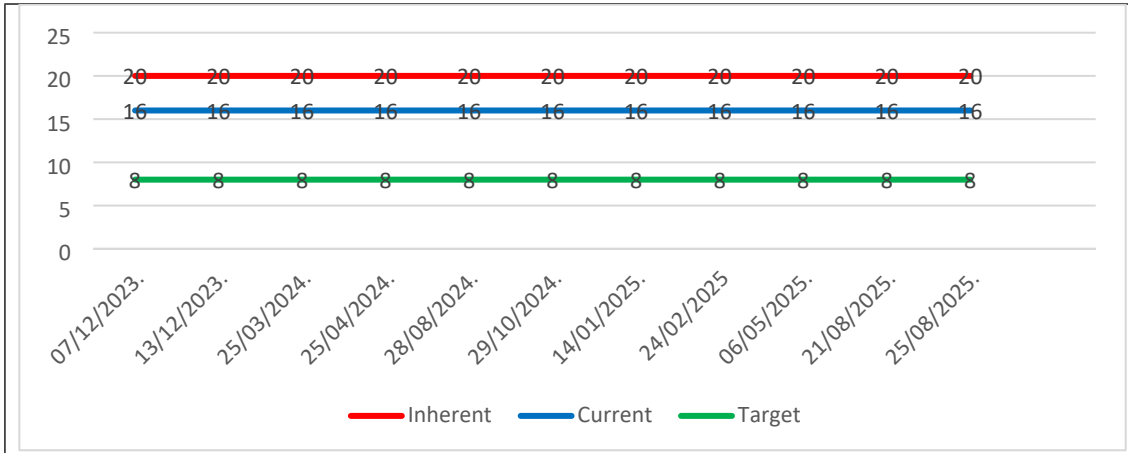
There is a risk that patients may experience delays, reduced quality of care, or fragmented services if the organisation does not have an operational model to deliver its strategic objectives
This may be caused by fragile management structures, workforce shortages, leadership capabilities and competence and rising demand in high-need areas.
This may lead to diminished organisational resilience, reduced capability to deliver foundations for the future, low staff morale, and risks to safe, high-quality care.

Mitigations/Controls in place	Additional Controls required
a) Strategic Recruitment team for senior leadership, medical and dental consultant posts b) Local IHC resourcing teams driving recruitment priorities c) Recruiting Well and Joining Well programmes d) All-Wales Flexible Working policy implemented e) Speak Out Safely MDT and Work in Confidence platform for staff to raise concerns	a) Need for further embedding of workforce planning function b) Leadership development pathways not fully integrated c) Engagement and operational effectiveness with Medical and Dental workforce inconsistent d) Absence management requires stronger controls Compassionate leadership adoption requires measurable indicators across organisation

f) Organisational Culture Change Plan and Behaviours Framework approved by Board g) Integrated Leadership Development Framework (ILDF) with measurement metrics h) Increased nurse retention i) Clear top-down commitment reinforced leadership culture that prioritises staff wellbeing, inclusion, and psychological safety (Pledge signed) j) 60% senior staff trained in leadership through conferences and masterclasses			
Actions	**Action Owner**	**Due Date**	**Progression Analysis**
Implement Employee Engagement Plan with suite of indicators The actions underway listed below are part of the 2025-26 plan for culture and engagement. The 2025 staff survey result will be used to assess the impact these actions have had. It is expected the result will be available in early 2026. • Embedded new engagement listening approach including staff stories being shared at People and Culture Committee, Local Partnership Forum and more widely to support organisational understanding and learning • Refreshed reward and recognition activity to introduce monthly recognition awards 'Seren Betsi' with Executive involvement, improved annual staff achievement awards event (26.9.25) and currently reviewing approach to the celebration of long serving colleagues while holding ceremonies for those who have reached 25 years service in October 2025 • Involved local teams and introduced new local responsibility for actions in response to the 2024 NHS Wales Staff Survey to prepare the ground for the 2025 survey (goes live 6.10.25) • As of August 2025, two members of staff joined the team, bringing additional capacity to proceed with work to further develop and deliver employee	Katie Sargent - Corporate Office	31/03/2026	Progressing

engagement and experience-related improvements which will include mechanisms for both improving engagement and measuring engagement such as Pulse surveys			
Further embed ILDF and measure effectiveness HEIW will release a Management Competency Framework due to be launched September 25. This will be used to inform the mid-level management ILDF leadership courses / resources design.	Rebecca Testa Workforce & Organisational Development	31/03/2026	Progressing
Roll out Compassionate Leadership resources and embed into development programmes	Director of People and Organisational Development	Ongoing	Progressing
Deliver Culture Change Plan with Comms and Engagement rollout The synthesis report has been submitted to the Executive Committee (EC) and pulls together the findings from the Discovery phase of the Culture & Leadership Programme and staff feedback from other sources including the NHS Wales Staff Survey 2024 and the Foundations for the Future programme engagement work. This report includes a series of proposals for the EC to agree that will form the work program to improve culture and leadership in the organisation,	Nia Thomas Workforce & Organisational Development	31/12/2025	Progressing
Quarterly Culture, Leadership & Engagement Plans finalised and monitored	Nia Thomas Workforce & Organisational Development	Ongoing	Progressing

	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20



Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	Quality <15		Not in Tolerance

Position & Intended Outcome for Risk

KPIs to that inform our risk in this area as at April 2025;
Staff retention is 90.6% In April 2025 compared to 90.2% last year.
PADR compliance showed improvement increasing to 9.6%

The number of Grievance cases has dropped in the previous three months to 3, from a spike of 17 in July 2024.

The percentage of stress & anxiety absences remains high at 1.6% although has dropped 0.2% since January. Avoidable turnover has dropped from 5.9% to 4.5% compared to January 2023.

Speak out safely cases have dropped from 9 to 6 since the last report in January 2025

CRR 25-08	**Risk Title: Non-Compliance with Regulatory and Legislative Requirements**		**Date Opened:** 21/08/2025 *(version 2 refined from 2023)*
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 06/11/2025
Date Last Reviewed: 01/10/2025	**Director Lead:** Director of Corporate Governance	**Link to BAF**: BAF24-01	**Target Risk Date:** 30/06/2027

There is a risk that the organisation 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, insufficient policy management, managing changes in legislation at pace, insufficient operational assurance across estates, health and safety, and medical devices, and failure to deliver climate/net zero requirements.
This may lead to enforcement action, financial penalties, and loss of public and stakeholder confidence.

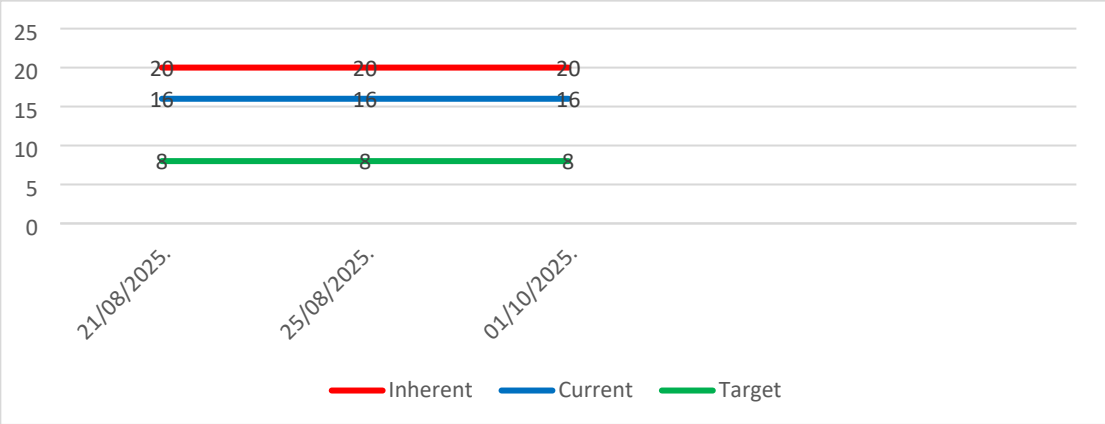
Mitigations/Controls in place	Additional Controls required
1. Training, induction and mandatory requirements for staff for highlights legislation and compliance. 2. Monitoring of regulations and legislation by various groups exist such as: Medical Devices Governance & Assurance Group oversees procurement, selection, risk management and safety communication Estates and Health & Safety Committee oversee areas of non-compliance and tracking of action plans.	a) Improved escalation routes, governance, oversight and monitoring of non-compliance. Governance and regulatory Executive Delivery Group (EDG) group to be in place to ensure HB wide oversight of all regulatory activity and inspections (not just clinical) and tracking non-compliance with a clear route for escalation of non-compliance to the EDG and route of escalation. b) Creation of an electronic system to capture all legislative and regulatory requirements, to capture information in relation to accountability and

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) 3. Various External peer review programmes e.g. Finance, Counter Fraud, Pharmacy, Imaging and Pathology reporting areas of non-compliance with legislation. 4. Regulatory compliance around Health Inspectorate Wales and Care Inspectorate Wales reported to QSE, and to Audit Committee (via the Statutory Compliance Report)	responsibility for the different elements, to enable the sharing of information, monitoring of progress and production of monitoring reports as necessary c) The Quality Management system is yet to be fully embedded and will highlight external peer reviews which cite any areas of non-compliance for better oversight by the EDG. d) Lack of consistent medical device training and local governance e) Inadequate workforce capacity in Pharmacy aseptic units; >80% capacity utilisation f) Quality assurance and regulatory compliance gaps in Pharmacy services g) Net zero / climate compliance delivery plan not embedded (consolidated) h) Core Emergency Preparedness policies, templates, and guidance documents are still under review, such as the Business Continuity Operational Response Framework.

Actions	Action Owner	Due Date	Progression Analysis
A) Governance and regulatory EDG to be set up to oversee non-compliance (strategic actions from this to be added here going forward)	Glesni Driver, Corporate Office	01/12/2025	Progressing
B)Creation of an electronic system to capture legislative and regulatory information and requirements. Not started due to resource constraints anticipated start date Q1 25/26.	Glesni Driver, Corporate Office	01/11/2026	Not Started

D)Complete audit of medical devices readiness of services. Post-market surveillance audit completed August; three services who make or modify devices need support to ensure compliance. Meetings scheduled with those services, Head of Clinical Engineering and ADAHPS in September / October to facilitate next steps. The audit was circulated widely across the Health Board, prioritising services/pathways most likely to make or modify devices. As there may be other services who fit these criteria, the engagement team have supported ongoing communication into the organisation for awareness. National benchmark audit completed June 2025. Benchmark summary received August 2025. Head of Clinical Engineering working with services to progress improvements. The National audit remains live so we can update as required.	Susan Brierley-Hobson, Therapies & Health Science	16/12/2025	Progressing
A)Review local medical devices groups governance & membership. A proposal was written re these groups being reformed in April 2025. EDAHPHS Teresa Owen and COO Tehmeena Ajmal in discussion re way forward.	Susan Brierley-Hobson, Therapies & Health Science	16/03/2026	Progressing
E)In order for compliance in pharmacy (aseptic production, QA and regulatory staff) Workforce Expansion is required. The delay in initial progress has been due to annual leave in July and August, responding to external audit findings and responding to out of specification environmental monitoring results. Work has restarted but completion will be delayed until end of Nov 2025.	Lois Lloyd , Corporate Office	31/11/2025	Progressing
E) Strengthen pharmacy QMS and regulatory compliance roles	Lois Lloyd , Corporate Office	31/05/2025	Completed
A)Prevent Fraud legislation. Compliance task and finish group to be set up with risk leads appointed to ensure compliance across the HB. Areas of non-compliance or not progressing in a timely manner to be monitored by Finance and EDG.	Danielle Timmins, Finance	31/12/2025	Progressing
Review and update business continuity plans for Pharmacy Technical Services. The Cancer Division have set up a working group to develop and implement a demand and capacity SACT Dashboard, multi-disciplinary group meeting monthly.	Lois Lloyd, Corporate Office	31/12/2025	Progressing

h) A number of Business Continuity Plans (BCP) have been identified as in place however scoping is required to identify all outstanding BCPs (possibility of over 100 BCP, however scoping is required to determine). Continue support is required for the IHCs/ Womens and MH/LD to obtain denominators for accurate reporting, monitoring and compliance rates. The scoping exercise to identify all required BCPs will be completed by March 2026.	Sharon Scott	31/03/2026	Progressing
h) Business Continuity dashboard has been established, a RAG system has been introduced and a % compliance indicator, to be a control once uptake and communicated out.	Sharon Scott	31/12/2025	Progressing



	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 non-compliance and all operational aspects. This risk to be developed to be more strategic following the group and to report areas of non-compliance to the Executive Committee. Compliance to be tracked and risks mitigated.

CRR 25-09	**Risk Title: Safe Environment**		**Date Opened:** 04/01/2024
	Assuring Committee: Performance, Finance and Information Governance Committee		**Date Last Committee Review:** 22/10/2025.
Date Last Reviewed: 25/08/2025	**Director Lead:** Director of Environment and Estates	**Link to BAF**: BAF 24-03	**Target Risk Date:** 31/03/2027

There is a risk that patients may be exposed to unsafe, uncomfortable, or unsuitable care environments if the organisation's estates and infrastructure are not maintained to appropriate standards.
This may be caused by ageing estate, backlog maintenance, and gaps in fire safety, health and safety compliance, and alignment with the estates strategy.
This may lead to safety incidents, non-compliance with statutory duties, and barriers to service modernisation.

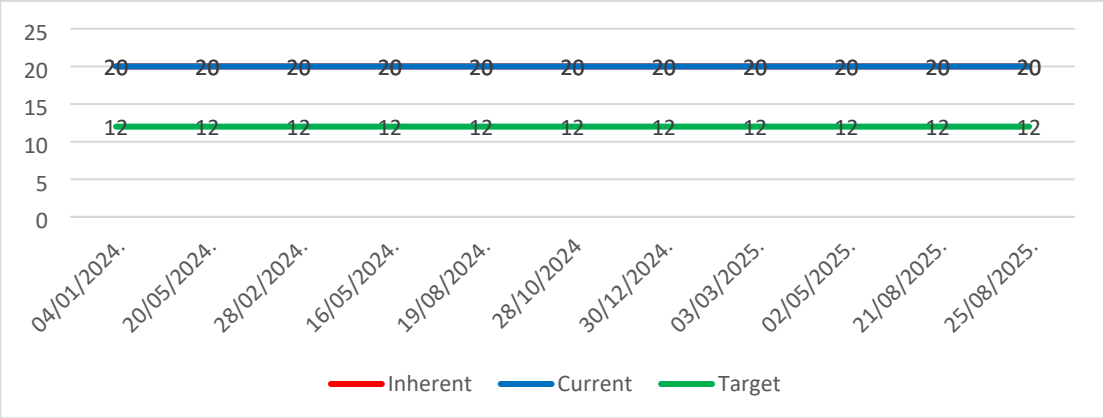
Mitigations/Controls in place	Additional Controls required
1. Estates Strategy developed and approved by the Health Board in January 2023. 2. Internal Governance for capital allocation in place within the Health Board. 3. Business Cases to Welsh Government to resolve major infrastructure issues in line with the Estates Strategy 4. Priority bids against Welsh Government Estates Funding Advisory Board (EFAB) for the allocation and prioritisation of funding in relation to infrastructure funding, decarbonisation, fire and Mental Health and Learning Disability.	a) 6 facet survey to be undertaken to obtain an updated report of the condition of the Estate' this will inform the risk status by site, which will be assessed against the controls currently in place. Additional mitigation or strengthening of controls will also be considered. b) Standardised approach by the Health Board in relation to management of Estates and Capital between the Integrated Health Community IHC's) and other services and the Estates/Capital teams – linked to the changes to the Operating Model.

5. Discretionary Capital Allocation of £17m for 25/26 approved by Welsh Government with an allocation of approximately £3.45m aligned to improvements within the Estates. Prioritisation is based on Operational Estates Risk Register 6. Regular Welsh Government /Health Board Capital Meetings – which provides a direct link with Welsh Government to raise concerns regarding the funding available to effectively manage the condition of the estate and ensure safety of patients and staff. 7. Operational Estates Safety Groups in place to provide assurance, the safety groups are as detailed below and oversee risks relevant to the groups: a. Fire Management b. Asbestos Management c. Water Safety, d. Ventilation Safety e. Electrical Safety 8. Welsh Government Capital Resource Meetings in place to provide route for escalation. 9. Estates and Facilities Performance Management System (EFPMS) reporting template and recording of backlog maintenance 10. Capital Allocation from Welsh Government – additional capital funding of allocated to the Health Board to focus on Backlog Maintenance 11. The Health Board submitted the Major Capital prioritisation plan to Welsh Government (WG) to identify required investment. The end date is dependant of how much capital investment is provided to the Health Board from WG. The 10 year capital investment requests aligns with the capital prioritisation form that we will submit to Welsh Government.	c) Ensure that the Health Board has an Estates rationalisation programme in place that will support the capital prioritisation programme and reduce backlog maintenance. d) Internal Audit review of Fire Safety – Agreed Management Action Plan being implemented and being managed through the Fire Safety Management Group e) Timely progression of major Capital Schemes which address Estates Safety such as Wrexham Maelor Continuity Plan – Phase

12. Updated agreed protocol for use of Annual Discretionary Slippage in place for developing Business Justification Cases (BJC) for essential estates works and discretionary capital schemes that could be aligned with in-year additional Capital Funding provided by WG. 13. Review of Reinforced Autoclaved Aerated Concrete (RAAC) completed by the Health Board's approved structural engineers – Curtins and a report will be presented at the Strategic Occupational Health and Safety Group 14. Targeted Estates Funding (TEF) approved by Welsh Government and allocation of £15.390m awarded over a 2-year period (2025-2026 / 2026/2027) to progress the national programme of capital schemes for Fire, Infrastructure, Decarbonisation, Mental Health, Infection Prevention Control and Decontamination 15. Assurance around the Capital Prioritisation Plans that it is aligned with both the Estates strategy and the Clinical strategy. This forms part of the T.O.R of the Capital Investment Group	

Actions	Action Owner	Due Date	Progression Analysis
Undertake action to deliver a Health Board Estates Rationalisation Programme. Estates Rationalisation Programme being developed and in draft format. The Draft will be submitted to a multi-disciplinary group for initial comment, with a final version to be ratified by Capital Investment Group. Health Board Rationalisation Programme to be presented to CIG on 12th September 2024. Estate's rationalisation plan is being reviewed and updated taking into account disposal that have been approved in 2024-2025 and opportunity for disposals in 2025-2026 as part of rationalisation of our estates that supports the Caledfryn Project.	Arwel Hughes, Estates	31/03/2026	Progressing

Undertake actions to deliver a 6 facet survey across the Health Board over the next 5 years. The 6 Facet survey contract is currently being procured through the SBS framework via mini-competition, the contract is due to be awarded by January 2025. A Phase 1 approach for the Acute Hospitals, is expected to be completed by 30/09/26. The completion of the full survey has been brought forward from the original 5 year time frame to a 2 year programme. A review of the 6 facet survey programme has been undertaken with support from Director of Environment and Estates and a plan has been agreed to utilise Ysbyty Gwynedd as a pilot site to conduct a 6-facet survey, it is anticipated that the pilot will be completed by 31st March 2026	Arwel Hughes, Estates	31/03/2027	Progressing
Develop a standardised Terms of Reference to be considered and endorsed by Capital Investment Group. New Terms of Reference for IHC Capital Groups will be reviewed as part of the Foundation for the Future Programme.	Arwel Hughes, Estates	31/03/2026	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	3	4	12
Risk Appetite	Regulatory/Compliance <15		Not in Tolerance

Position & Intended Outcome for Risk

	Current Risk score of 20 aims to be reduced to a 12 by April 2035 as a part of a wider Estates strategy. Backlog maintenance is the cost to bring estate assets that are below acceptable standards (either physical condition or compliance with mandatory fire safety requirements and statutory safety legislation) up to an acceptable condition. Total 2021/22 backlog costs for all BCUHB properties was £348.4m. Cost to achieve physical condition B is c. £213m. Cost to achieve condition B for fire and safety statutory compliance is c. £136m. Total risk adjusted backlog is c. £240m. The majority (73%) of backlog relates to the 3 acute hospitals. Backlog for MH&LD, Community and Local Hospitals, and Community Facilities each comprise c.10% of total backlog. The estate is facing significant risks and challenges and severe limitations on expected future funding. The current estate is not sustainable or viable in the long term and will not support the implementation of key BCUHB strategies and is a significant risk to the Board. To aid with supporting a Capital Programme the Health Board will commence with a programme to deliver a 6 facet survey for the Estates, these surveys will commence in 2024 focussing on Acute sites and then community hospitals with a target to complete within 2 years. This will be a significant part of the estates portfolio and backlog maintenance cost. As sites are completed the

	cost associated with backlog maintenance will be identified and capital funding requested. The end date is dependant of how much capital investment is provided to the Health Board from Welsh Government. The 10 year capital investment requests aligns with the capital prioritisation form that we will submit to Welsh Government. In addition, significant works have been undertaken on the fire project at Ysbyty Gwynedd which will result in approx £2M being invested and works completed by March 2025. Wrexham Resilience Programme has undertaken a risk-based approach to address key findings of the original Business Case. The Health Board has disposed of 2 sites (Ala Road and Cilan) this financial year which were vacated as 'not being fit for purpose', approval has also been received to dispose of Rossett HC and Ruthin HC which have been vacated due to condition of the Estate and these are expected to progress to auction in early 2025. Both sites are currently being disposed of with Ruthin HC awaiting completion of contract.

CRR 25-10	**Risk Title: Health and Safety**		**Date Opened:** 21/08/2025
	Assuring Committee: Performance, Finance and Information Governance Committee		**Date Last Committee Review:** 22/10/2025
Date Last Reviewed: 25/08/2025	**Director Lead:** Director of Environment and Estates	**Link to BAF**: BAF24-03	**Target Risk Date:** 31/03/2026

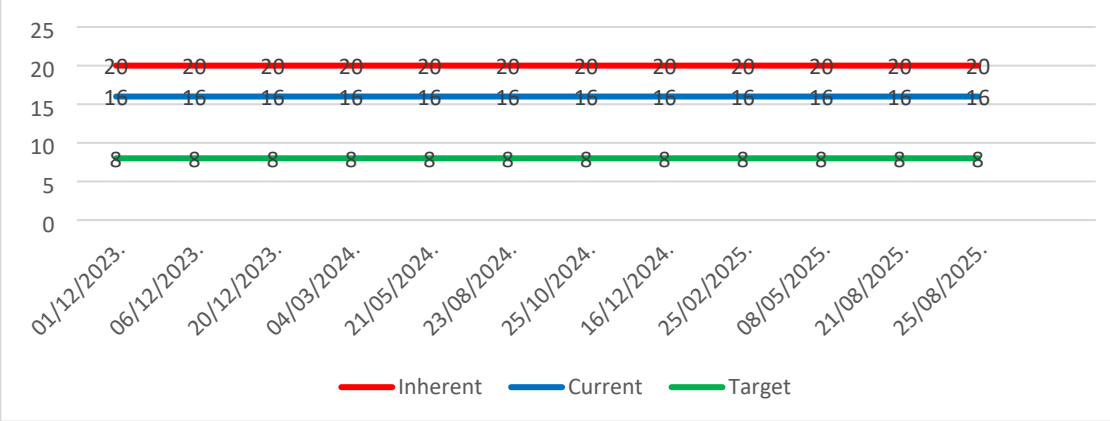
There is a risk that the organisation will not maintain a safe environment for staff and patients in line with health and safety legislation. This may be caused by inadequate oversight of health and safety risks, gaps in estates and equipment compliance, and insufficient resources to address safety priorities.
This may lead to patient and staff harm, enforcement action, reputational damage, and increased legal claims

Mitigations/Controls in place	Additional Controls required
1. Three-year Occupational Health, Safety and Security strategy. 2. Health and Safety Policies report into the Strategic Occupational Health & Safety Group (SOSHG). 3. Health and Safety eLearning and short courses in place. 4. Gap Analysis has been reviewed. Strategy and plan to March 2026. 5. Health and Safety Policies and Procedures are on BetsiNet. 6. Programme of Health and Safety Reviews are in place. 7. Programme of Health and Safety Self-Assessments are in place for completion twice yearly. 8. Health and Safety presentation delivered to Board members in February 2025, to raise awareness of requirements.	a) NHS Employer Health and Safety Standards are being developed b) A review of resources required following the internal audit. c) BCUHB Executive Team and Board of Directors to complete health and safety training. d) The business model aligned to the NHS Manual Handling Passport Scheme to be reviewed e) Investment in training venues is required for manual handling training delivery. f) Senior Leaders to nominate staff to support with Divisional delivery of manual handling refresher training. g) Review of health and safety policies within the next 12-24 months.

	h) A Health and Safety Risk Assessment and Management Framework needs developing. i) A pan BCUHB Health, Safety and Security Training Needs Analysis is required. j) Utilise the Violence Prevention and Reduction Standards to provide a framework for a safer environment. k) Intranet pages for Health, Safety and Security Services require development.

Actions	Action Owner	Due Date	Progression Analysis
Develop a Health Board Health and Safety Management Framework. The introduction of the NHS Employer's Health and Safety Standards will provide an indication of Health & Safety performance, and be a mechanism to monitor the Health Board Health & Safety management framework and will be used to formulate strategy moving forwards. Key service objectives will be monitored going forward.	Lynne Bushell, Workforce & Organisational Development	31/12/2025	Progressing
In-house security service model not being pursued. 22/01/2025: Extension of current Security SLA and Technical specification awaiting sign off. Existing security SLA being extended to the 31/03/2026 to allow for a formal tender process.	Director of Estates	31/03/2026	Progressing (revised date from 31/07/2025)
A process to monitor and review department self-assessments is under development and will be issued in readiness for the April Self-Assessment Cycle.	Director of Estates	31/12/2025	Progressing
A review of resources within the Health, Safety and Security Service is required following the internal audit findings.22/01/2025: Structure reviewed and remodelled. A business case to be developed.	Director of Estates	31/12/2025	Progressing
The BCUHB business model aligned to the All-Wales NHS Manual Handling Passport Scheme 2020 to be reviewed. Following meeting with DDoNs and Service Leads, further meetings scheduled to discuss bespoke service requirements. Work is progressing, with current target date not being met due to lack of engagement with	Director of Estates	31/07/2025	Overdue

some services. Those services that have engaged work will commence to update ESR with the agreed changes.			
An electronic document management system (EDMS) for reporting of health and safety compliance and risk management pan BCUHB. Risk Management software approved. Implementation 2026 which will improve transparency of all H&S risks and reduce non-compliance around visibility and sharing of key documentation.	Director of Estates	01/01/2027	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	Regulatory/Compliance <15		Not in Tolerance

Position & Intended Outcome for Risk

There is an inherent risk that the failure of Health & Safety management systems could lead to RIDDOR Reportable. Specified Injuries to Workers. Patient mismanagement, long-term effects. Death or significant irreversible harm which will result in prosecution by the Health and Safety Executive consequently leading to loss of reputation and financial penalties. The risk is extenuated by Non-compliance with national standards with significant risk to patients/public. An unacceptable

	level or quality of treatment/service. Gross failure of patient safety leading. Inquests and Coroners reports. Low staffing level that reduces the service quality. Low staff morale. Poor staff attendance for mandatory/key professional training. Uncertain delivery of key objective/ service due to lack/loss of staff within the Health and Safety team. Structural changes implemented in summer 2024, with Health and Safety moving from Workforce Directorate to a new role of Director of Environment, reporting directly to CEO.

Agenda Item
CORPORATE GOVERNANCE REPORT

Joint Commissioning Committee

Joint Commissioning Committee Standing Orders

Dyddiad y Cyfarfod / Date of Meeting	27 November 2025
Statws Cyhoeddi / Publication Status	Open/ Public
Awdur yr Adroddiad / Report Author	Aaron Fowler, Committee Secretary
Cyflwynydd yr Adroddiad / Report Presenter	Aaron Fowler, Committee Secretary
Noddwr yr Adroddiad / Report Sponsor	Aaron Fowler, Committee Secretary

Pwrpas yr Adroddiad / Report Purpose	For Approval

Engagement (internal/external) undertaken to date (including receipt /consideration at Committee/Group)		
Committee/Group/Individuals	**Date**	**Outcome**
NWJCC (NHS Wales Joint Commissioning Committee) Joint Committee Meeting	25/11/2025	Approved

1. SITUATION/BACKGROUND

in January 2025, the Local Health Boards, NHS Trusts and Special Health Authorities (Constitution, Membership and Procedures) (Miscellaneous Amendments) (Wales) Regulations 2024 ("the Regulations") came into force. These regulations resulted in revisions to the Model Standing Orders and Reservation and Delegation of Powers for Local Health Boards, NHS Trusts and Special Health Authorities using the Welsh Ministers power of direction in accordance with Section 12(3), Section 19(1) and Section 23(1) of the National Health Service (Wales) Act 2006.

Unfortunately, the Regulations did not mandate that revisions to section 7 of the standing orders (Committee Meetings: Notifying the public and others) should apply to the NWJCC. To rectify this oversight the Cabinet Secretary for Health and Social Care has written to our Chair to confirm that the NWJCC's Standing Orders are to be updated to adopt the same approach to committee meetings as Health Boards, NHS Trusts and Special Health Authorities.

2. Standing Orders

The detail of the proposed amendments is shared below but can also be found within WHC (2025) 45, a copy of which is attached as appendix 1:

Standing Orders - Section 7
Committee Meetings: Notifying the public and others

The NWJCC is required to amend the text in green within the following paragraph, from:

7.12 Except for meetings called in accordance with SOs, at least 10 calendar days before each meeting of the Joint Committee, a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed bilingually (in English and Welsh) as follows:

- *Each LHBs website shall link to the JCC website, where the papers supporting the public part of the agenda will be available; as well as*
- *Through other methods of communication as set out in the Joint Committee's communication strategy.*

When providing notification of the forthcoming meeting, each LHB shall set out when and how the agenda and the papers supporting the public part of the agenda may be accessed, in what language and in what format, e.g., as Braille, large print, etc.

To:

7.12 Except for meetings called in accordance with SOs, at least 10 calendar days before each meeting of the Joint Committee, a public notice of the time and place of the meeting shall be displayed bilingually (in English and Welsh):

- *On the JCC's website;*
- *Each LHBs website shall link to the JCC website; as well as*

- *Through other methods of communication as set out in the JCC's communication strategy.*

  When providing notification of the forthcoming meeting, the committee shall set out when and how the agenda and the papers supporting the public part of the agenda may be accessed, in what language and in what format, e.g., as Braille, large print, etc. The agenda and papers will be made available to the public at least 5 clear days before each meeting of the Committee.

3. Assessment

It is not anticipated that the amendments to the Standing Orders will result in any operational or functional impact to the NWJCC nor Local Health Boards, NHS Trusts and Special Health Authorities and the updated NWJCC standing orders were approved at the NWJCC Joint Committee meeting of the 25th November 2025.

It is recommended that the Board approve the updated NWJCC Standing Orders, attached as appendix 2 for inclusion within Betsi Cadwaladr University Health Board
Standing orders at Schedule 4.

4. RECOMMENDATIONS

The Board is asked to:

- Approve the **updated NWJCC** Standing Orders **for inclusion at Schedule 4 of Betsi Cadwaladr University Health Board** standing orders.

Objectives / Strategy	
Dolen i Nod(au) Strategol BIP CTM /Link to JCC Strategic Goal(s)	Not Applicable
	If more than one applies, please list below:
Dolen i Feysydd Strategol BIP CTM /Link to JCC Strategic Areas	Not Applicable
	If more than one applies, please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	A Healthier Wales
	If more than one applies, please list below:
Dolen i Hwyluswyr Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / **Link to Enablers of Quality** (Duty of Quality Statutory Guidance (gov.wales))	Leadership
	If more than one applies, please list below:
Dolen i Feysydd Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / **Link to Domains of Quality** (Duty of Quality Statutory Guidance (gov.wales))	Effective
	If more than one applies, please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies, please list below:

Impact Assessment		
Ansawdd Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /	Yes: ☐	No: ☒
	Outcome:	Consideration has been given to the Duty

Quality Have you undertaken a Quality Impact Assessment Screening?		of Quality as set out in section 1A of the NHS (Wales) Act 2006 ("the 2006 Act") as it applies to the Welsh Ministers. The Duty of Quality places Ministers under an additional duty to exercise their functions in relation to the health service with a view to securing improvement in the quality of health services. The establishment of the new JCC arrangements will support the delivery of the Duty of Quality requirements.
Cydraddoldeb Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? / **Equality** Have you undertaken an Equality Impact Assessment Screening?	Yes: ☐	No: ☒
	Outcome:	A Regulatory Impact Assessment is contained with the Explanatory Memorandum to The National Health Service Joint Commissioning Committee (Wales) Regulations 2024.
Cyfreithiol / Legal	National Health Service Joint Commissioning Committee (Wales) Directions 2024 National Health Service Joint Commissioning Committee (Wales) Regulations 2024	
Enw da / Reputational	There is no direct impact on the reputation of the Local Health Boards or the Joint Committee as a result of the activity outlined in this report.	
Effaith Adnoddau (Pobl /Ariannol) / **Resource Impact** (People / Financial)	There is no direct impact on resources as a result of the activity outlined in this report.	
	There is not expected to be an additional cost as costs associated with the establishment of the new NHS Wales Joint Commissioning	

	Committee will be borne out of existing budgets of WHSSC, EASC, NCCU and costs relating to any other commissioning functions transferred into the new Joint Commissioning Committee.

WHC (2025) 045

WELSH HEALTH CIRCULAR

Status: Compliance

Category: Governance

Title: Revisions to the Standing Orders for the NHS Wales Joint Commissioning Committee.

Date of Expiry / Review: Not applicable

Action by:
Chair & Committee Secretary and Deputy Director of Corporate Services of the NHS Wales Joint Commissioning Committee (JCC)
For information to:
Chairs & Chief Executives of Local Health Boards
Directors of Corporate Governance/ Board Secretaries

Required by: In accordance with Committee timetable.

Sender:
Llinos Henry, NHS Governance, HSCEY

Welsh Government Contacts:
llinos.henry001@gov.wales

Introduction and Background:

NHS bodies in Wales must agree Standing Orders (SOs). This, together with a set of Standing Financial Instructions (SFIs) and a scheme of decisions reserved to the Board; a scheme of delegations to officers and others; and a range of other framework documents set out the arrangements within which the Board, its Committees, Advisory Groups and NHS staff make decisions and carry out their activities. The Standing Orders should be based upon the model determined by the Welsh Government.

The NHS Wales Joint Commissioning Committee (JCC) is a joint committee of each Health Board in Wales, established under the NHS Wales Joint Commissioning Committee (Wales) Directions 2024.

The previous Cabinet Secretary agreed the new Model Standing Orders and Reservation and Delegation of Powers for the NHS Wales Joint Commissioning Committee prior to its establishment on 1 April 2024.

In January 2025, the Cabinet Secretary agreed to the amendments to the Model Standing Orders (SOs), Reservation and Delegation of Powers for Local Health Boards, NHS Trusts and Special Health Authorities following amendments to Regulations for NHS bodies. It is proposed that the JCC is to adopt same approach in committee proceedings to ensure consistency across NHS boards.

The JCC's Standing Orders are based upon the model determined by the Welsh Government.

The Welsh Government has made amendments to the following document:

- Standing Orders - NHS Wales Joint Commissioning Committee (JCC)

The latest version of the standing orders for the JCC have been published and can be accessed here:

JCC Model SOs

A summary of the amendments can be found in the enclosures.

Enclosures:

Letter to Chairs of Local Heath Boards and letter to Chair of the NHS Wales Joint Commissioning Committee.

Jeremy Miles AS/MS
Ysgrifennydd y Cabinet dros Iechyd a Gofal Cymdeithasol
Cabinet Secretary for Health and Social Care

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref: MA/JMHSC/2472/25

Chair of the NHS Wales Joint Commissioning Committee (JCC)

Copy:
Chairs of Local Health Boards
Chief Executives of Local Health Boards
Committee Secretary and Deputy Director of Corporate Services of the JCC

14 October 2025

Dear Chair,

As you are aware, in January, the Local Health Boards, NHS Trusts and Special Health Authorities (Constitution, Membership and Procedures) (Miscellaneous Amendments) (Wales) Regulations 2024 came into force.

These regulations resulted in revisions to the Model Standing Orders and Reservation and Delegation of Powers for Local Health Boards, NHS Trusts and Special Health Authorities using the Welsh Ministers power of direction in accordance with Section 12(3), Section 19(1) and Section 23(1) of the National Health Service (Wales) Act 2006.

It has been agreed that the NHS Wales Joint Commissioning Committee (JCC) are to adopt same approach in committee proceedings (where appropriate) to ensure consistency across NHS boards.

The proposed amendment to the Standing Orders (SOs) of the JCC relate to the timing of publication of public papers for committee meetings (see Doc 1).

These amendments supersede those issued on 18 March 2024 and as confirmed in Welsh Health Circular WHC2024/019. A new WHC will be published to confirm this.

The JCC is required to incorporate and adopt this latest review into your committee's Standing Orders. The NHS Wales Joint Commissioning Standing Orders form part of Schedule 4 of the Local Health Board Model Standing Orders.

Yours sincerely,

Jeremy Miles AS/MS
Ysgrifennydd y Cabinet dros Iechyd a Gofal Cymdeithasol
Cabinet Secretary for Health and Social Care

Bae Caerdydd • Cardiff Bay
Caerdydd • Cardiff
CF99 1SN

Canolfan Cyswllt Cyntaf / First Point of Contact Centre:
0300 0604400
Gohebiaeth.Jeremy.Miles@llyw.cymru
Correspondence.Jeremy.Miles@gov.wales

Rydym yn croesawu derbyn gohebiaeth yn Gymraeg. Byddwn yn ateb gohebiaeth a dderbynnir yn Gymraeg yn Gymraeg ac ni fydd gohebu yn Gymraeg yn arwain at oedi.

We welcome receiving correspondence in Welsh. Any correspondence received in Welsh will be answered in Welsh and corresponding in Welsh will not lead to a delay in responding.

Doc 1

Amendments to the Standing Orders of the NHS Wales Joint Commissioning Committee

Section 7 – Committee Meetings: Notifying the public and others

Amend the highlighted text within the following paragraph, from:

7.12 Except for meetings called in accordance with SOs, at least 10 calendar days before each meeting of the Joint Committee, a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed bilingually (in English and Welsh) as follows:

- Each LHBs website shall link to the JCC website, where the papers supporting the public part of the agenda will be available; as well as
- Through other methods of communication as set out in the Joint Committee's communication strategy.

When providing notification of the forthcoming meeting, each LHB shall set out when and how the agenda and the papers supporting the public part of the agenda may be accessed, in what language and in what format, e.g., as Braille, large print, etc.

To:

7.12 Except for meetings called in accordance with SOs, at least 10 calendar days before each meeting of the Joint Committee, a public notice of the time and place of the meeting shall be displayed bilingually (in English and Welsh):

- On the JCC's website;
- Each LHBs website shall link to the JCC website; as well as
- Through other methods of communication as set out in the JCC's communication strategy.

When providing notification of the forthcoming meeting, the committee shall set out when and how the agenda and the papers supporting the public part of the agenda may be accessed, in what language and in what format, e.g., as Braille, large print, etc. The agenda and papers will be made available to the public at least 5 clear days before each meeting of the Committee.

END

Cyd-bwyllgor Iechyd a Gofal y Canolbarth ar gyfer Iechyd a Gofal / **Mid Wales Joint Committee for Health and Care**	
***Cadeirydd Arweiniol* / Lead Chair**	Dyfed Edwards, Chair, Betsi Cadwaladr University Health Board
***Prif Weithredwr Arweiniol* / Lead Chief Executive**	Prof. Phil Kloer, Chief Executive, Hywel Dda University Health Board
Cyfarwyddwr y Rhaglen* / *Programme Director:	Keith Jones, Director of Operational Planning and Performance, Hywel Dda University Health Board
***Dyddiad y Cyfarfod Diwethaf* / Date of Last Meeting**	13th October 2025
***Cyfnod Adrodd* / Reporting Period:**	April to October 2025

***Penderfyniadau allweddol a Materion a ystyriwyd gan y Cyd-bwyllgor* / Key Decisions and Matters considered by the Joint Committee**

Mid Wales Priorities and Delivery Plan 2025/26

The Mid Wales Planning and Delivery Executive Group (MWPDEG) leads on the development and implementation of the Mid Wales Priorities and Delivery Plan. The Mid Wales Joint Committee (MWJC) received the latest update report from the MWPDEG on the Mid Wales Priorities and Delivery Plan 2025/26 for the period 1st April to September 2025. For 2025/26 the Mid Wales priorities are as follows:

Mid Wales priorities 2025/26	
Priority	**Strategic Objective**
Urology	Complete the review of prostate cancer Prostate-Specific Antigen (PSA) and Trial Without Catheter (TWOC) pathways and flows for patients residing in Mid Wales, identify any current gaps in provision and opportunities for the future provision of services across Mid Wales.
Ophthalmology	Increase capacity and access to ophthalmology services across the Mid Wales area through the development of a regional and a whole system pathway (primary, community and secondary care) approach supported by the establishment of operational and service links between Health Boards.
Cancer	Identify opportunities for increasing provision and improving access to cancer services across Mid Wales.
Community Dental Services	Identify what improvements can be made to general NHS dental services provision across Mid Wales.
Strategic service change programmes	Identify the impact on the Mid Wales population of pathway changes proposed via strategic service change programmes being progressed by individual organisations.
Cross Border workforce arrangements	Develop solutions to cross organisational border health and social care workforce arrangements across Mid Wales.
Colorectal	Establish a sustainable colorectal services pathway for Mid Wales, which ensures a Mid Wales focus on service delivery and creates opportunities for the provision of outreach services across the Care Hubs in Mid Wales.
Dermatology	Identify opportunities for increasing provision and improving access to Dermatology services across Mid Wales.

The Joint Committee noted the summary overview of the progress and current status of the Mid Wales priorities and its workstreams (see below) and a plan on a page for each priority which detailed the actions undertaken to date and actions planned for October to December 2025.

MWJC Priorities – Progress / Status Overview					
Priority	**Workstreams**	**Blue (Completed)**	**Red (Late)**	**Amber (Off Track)**	**Green (On Track)**
Urology	2		1	1	
Ophthalmology	4				4
Cancer	2	1			1
Community Dental Services	2			2	
Strategic service change programmes	4				4
Cross Border Workforce arrangements	3	1			2
Colorectal	1			1	
Dermatology	1				1

For those workstreams whose status is currently Red (Late) and Amber (Off Track) the Joint Committee noted the summary exception report highlighting the issues which have impacted progress and the current actions being progressed to get the workstream status back on track.

Mid Wales Clinical Advisory Group (MWCAG)

The MWCAG has revised its terms of reference with the membership reduced to a core group and meetings focusing on a specific service area / pathway with relevant organisational representatives invited to attend in addition to the core group. This new approach will support the delivery of the Mid Wales Priorities and Delivery Plan with the MWCAG providing clinical support and advice either as identified by the group or as commissioned by the MWPDEG. This includes those organisational strategic service change programmes and proposals for service areas / pathways where there are potential implications for the Mid Wales population.

Stroke Services

In response to a request from MWPDEG to consider the proposed changes for stroke services across the region, the MWCAG established a Mid Wales Stroke Steering Group with its membership comprising relevant clinical and planning leads from across Mid Wales. The group's two main objectives are to:

i) Respond to the service changes across the region and highlight the risks and challenges for the Mid Wales population.
ii) Outline a robust stroke pathway for Mid Wales.

The MWCAG has asked the Mid Wales Stroke Steering Group to draft a summary appraising the work undertaken to date for sharing with MWCAG and the Hywel Dda University Health Board (HDdUHB) Clinical Service Plan (CSP) programme team. The MWCAG has also agreed that there is a need to for a mechanism to ensure the Mid Wales Stroke Steering group be kept

informed of the public feedback received by HDdUHB from its CSP consultation on stroke services and the alternative ideas that these are generating.

Mid Wales Strategic Commissioning Group (MWStCG)
The MWStCG group has identified areas of work which would benefit a collaborative approach across Mid Wales, in addition to the Mid Wales priorities already agreed for the year. Dermatology and Colorectal services have now been incorporated within the Mid Wales Priorities and Delivery Plan.

The MWStCG was originally established for the three Mid Wales Health Boards (BCUHB, HDdUHB, PTHB) to fulfil their commissioning role collaboratively for the population of Mid Wales. The group is directly accountable to the three Health Boards, with reports on its work provided to the MWPDEG. Following consideration of its original terms of reference, members felt that the group was not fulfilling its core purpose and it was unclear as to whether the group is reflected within the governance structures of the respective Health Boards. A review of the role and purpose of the group and its current reporting arrangements is to be undertaken.

Mid Wales Social Care Group (MWSoCG)
A review of the role and purpose of the MWSoCG is currently being undertaken. The three Directors of Social Services are to meet jointly to consider the future of the group and how social care can be taken forward within the MWJC work programme. The Director of Social Services for Ceredigion County Council will provide feedback to the MWJC Programme Director on the outputs of the tripartite meeting for considering the next steps that need to be taken.

Mid Wales Strategic Intent
In 2018, the MWJC agreed the Mid Wales Strategic Intent for 2018 to 2021 which outlined the vision for health and care services provided to the population of Mid Wales and supported a joined up approach to the planning and delivery of health and care services across Mid Wales. Although the Strategic Intent covered the three year period up until 2021, the vision has continued to be relevant and appropriate for health and care services in Mid Wales.

The Mid Wales Health Boards are in the process of updating and refreshing their strategic plans and the opportunity will be taken to review the Mid Wales Strategic Intent in order to ensure that the strategic direction for Mid Wales continues to be aligned to and reflects the organisational strategies for health and care organisations for the region. The final revised Mid Wales Strategic Intent will be considered by the MWPDEG at its meeting on 30th March 2026 and subsequently by the MWJC at its Spring meeting in April 2026. The revised Mid Wales Strategic Intent, which will cover the 3 year period 2026/27 to 2029/2030, will support the future development of the MWJC programme of work.

MWJC Governance arrangements
The MWPDEG noted the proposed reviews of the role and purpose of the MWStCG and MWSoCG, and that a number of other elements also needed consideration. As such the scope of work has been expanded to a review of the MWJC governance arrangements. The review will include consideration of the following:

- A number of priorities and their workstreams have been carried forward from previous years. In order to strengthen organisational support for the priorities and its workstreams, a Senior Responsible Officer (SRO) for each priority/workstream should be identified and agreed by MWPDEG.
- Outputs from the review of the Mid Wales Strategic Intent.

- Outputs of the reviews of the MWStCG and MWSoCG.
- Formal governance structure for the Joint Committee between HDdUHB and Swansea Bay University Health Board and this links and works with the MWJC governance structure.

The Mid Wales Programme Director will lead on the review with the final Mid Wales Governance arrangements to be presented to the MWJC meeting in April 2026.

Process for setting Mid Wales priorities

The process for setting the Mid Wales priorities has been revised and will now commence earlier in the financial year in November, rather than January as in previous years. This will allow more time for the MWPDEG and its sub-groups to fully consider what priorities are appropriate for the upcoming year and for Mid Wales organisations to include and report the proposed priorities within their own individual plans for internal consideration by committees and Board prior to submission to the Welsh Government. The process will also consider those areas, identified by Mid Wales organisations during their individual planning exercises, which may benefit a joint approach across Mid Wales.

Rural Health and Care Wales (RHCW)

The Joint Committee received the latest update on the RHCW work programme for 2025/26 and the RHCW Stakeholder Group. The annual RHCW conference, for which the theme this year is "Innovation and Improvement – advances in the delivery of rural health, care and wellbeing services," will be held on 11th and 12th November 2025 at the Royal Welsh Showground, Builth Wells.

Materion sydd angen eu cytuno new trafod ymhellach gan y Bwrdd / **Items to be referred to the Board for agreement or discussion**
The Board is asked to **NOTE** the work of the Mid Wales Joint Committee.

Dyddiad y Cyfarfod Nesaf / **Date of Next Meeting**	Time and date of next meeting to be confirmed for April 2026

Agenda, papers and minutes of the Mid Wales Joint Committee meeting are available on its website: English - https://mwjc.nhs.wales, Welsh - https://cbbc.gig.cymru

Acronyms / Glossary of Terms	
BCUHB	Betsi Cadwaladr University Health Board
CSP	Clinical Services Plan
HDdUHB	Hywel Dda University Health Board
MWCAG	Mid Wales Clinical Advisory Group
MWJC	Mid Wales Joint Committee
MWJSG	Mid Wales Joint Scrutiny Group
MWPDEG	Mid Wales Planning and Delivery Executive Group
MWSoCG	Mid Wales Social Care Group
MWStCG	Mid Wales Strategic Commissioning Group
PTHB	Powys Teaching Health Board
RHCW	Rural Health and Care Wales

GIG CYMRU NHS WALES | Cyd-bwyllgor Comisiynu Joint Commissioning Committee

Agenda Item
CORPORATE GOVERNANCE REPORT

Joint Commissioning Committee

All Wales Individual Patient Funding Request (IPFR) Policy

Dyddiad y Cyfarfod / Date of Meeting	29/05/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Aaron Fowler, Committee Secretary JCC Iolo Doull, Medical Director JCC
Cyflwynydd yr Adroddiad / Report Presenter	Pam Wenger Director of Corporate Governance
Noddwr yr Adroddiad / Report Sponsor	Iolo Doull, Medical Director

Pwrpas yr Adroddiad / Report Purpose	For Approval Choose an item.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
NWJCC – Joint Committee Meetings	20.05.2025 25.11.2025	Endorsed Updated draft endorsed

1. SITUATION/BACKGROUND

The purpose of this report is to present the outcomes from the engagement process with key stakeholders to review the All Wales Individual Patient Funding Request (IPFR) Policy and to seek approval for the proposed changes to the policy.

1.1 All Wales IPFR Policy

The All Wales IPFR Policy is an NHS Wales policy owned by each of the seven HBs who have statutory responsibilities in relation to IPFR decisions. Each Health Board (HB) has its own HB IPFR Panel.

In December 2021, a request for a judicial review (JR) was made in the case of Maria Rose Wallpott (MW)– v- (1) Welsh Health Specialised Services Committee (WHSSC -hosted by Cwm Taf Morgannwg University Health Board (CTMUHB)) & (2) Aneurin Bevan UHB (ABUHB) when the JR was allowed and the decision of the WHSSC IPFR panel to refuse funding for treatment was quashed by the court. Subsequently, legal advice indicated the IPFR policy was being interpreted in such a way that was contrary to the original policy intention and the IPFR policy would need to be updated if its original and intended meaning was to be reinstated. This was in accordance with the subsequent advice from appointed Kings Counsel that the judicial review had changed the intended meaning on the Policy and if the original meaning was to be returned then the wording of the Policy would need to be revised.

On 28 July 2022 the Chief Pharmaceutical Officer (CPO), Welsh Government (WG) wrote to WHSSC setting out a proposal for addressing the issues raised in relation to the operation of the WHSSC IPFR Panel and the review of the NHS Wales Policy Making Decisions on Individual Patient Funding Requests (IPFR) ("The IPFR Policy"). WG requested that WHSSC lead a process of engagement for a de-minimis review of the Policy wording and that a review of the WHSSC IPFR panel Terms of Reference (ToR) be undertaken with key stakeholders including the All Wales Therapeutics & Toxicology Centre IPFR Quality Assurance Advisory Group (AWTTC QAG), HB Medical Directors and the Board Secretaries of each of the HBs and Velindre University NHS Trust (VUNHST).

1.2 Stakeholder Engagement Exercise

On the 8 November 2022, the JC approved the methodology for WHSSC to embark on an engagement process and were assured that the process adhered to the specific request from Welsh Government for a specific and limited review of the All Wales IPFR Policy engagement on the WHSSC IPFR panel ToR.

The stakeholder engagement process took place between the 10 and the 22 December 2022. The consultation documentation was issued to a broad range of stakeholders including the WHSSC IPFR panel, the AWTTC QAG, the NHS Wales IPFR Policy Implementation Group (PIG), Medical Directors and Board Secretaries of each of the HBs, Welsh Government and Velindre University NHS Trust

(VUNHST). Additionally, a stakeholder engagement workshop was held on the 2 December 2022 in Cardiff with a number of additional engagement briefings also held.

1.3 Independent Legal Advice

David Locke KC was tasked with reviewing the wording of the IPFR policy and revising if appropriate. He noted that the text of the policy was contradicted by the accompanying Decision Making Guide (DMG).

He highlighted the important distinction in the policy between IPFR submissions where there was a relevant policy or guideline e.g. NICE or AWMSG (Part A), or if there was no relevant policy or guideline (Part B).

Part A - There is policy/guidance in place, requires three criteria:

1) that the patient is significantly different from others with the same condition
2) that the patient will gain significantly more clinical benefit
3) that the intervention offers value for money.

Part B – Where there is no policy/guidance, requires only 2 criteria:

1) that the patient will gain significantly more clinical benefit
2) that the intervention offers value for money.

Unfortunately, the DMG could be interpreted as contradicting this distinction. David Locke emphasised the primacy of the 2017 policy, that the DMG was legally problematic and recommended the removal of the DMG from the policy.

There was initial resistance from the Policy Implementation Group (PIG) to the removal of the DSG, but through an iterative process in consultation with HBs, the IPFR PIG, the IPFR Quality Assurance Group (QAG) and WHSSC a revised policy (V10) was proposed where the DMG became an accompanying appendix to the policy.

Subsequently, Welsh Government highlighted a potential conflict between the NHS Wales Putting Things Right (PTR) policy and the IPFR policy and wanted clarity that raising of a complaint under the PTR arrangements related to the care provided before or after an IPFR decision, and not the process of making the IPFR decision.

2.ASSESSMENT

In 2024, the NWJCC convened a meeting of the chairs of the HB IPFR panels, the chair of the JCC IPFR panel, the IPFR QAG, the IPFR PIG and observers from Welsh Government. All wished to follow David Locke’s advice.Through an iterative process minor changes were made to the policy (including a rewording of the DMG) until all were content (V12).

Finally, NWSSP Legal and Risk Services advice was sought, and final minor revisions were made based on their recommendations (V14).

On the 20th May 2025 the IPFR Policy was approved by the NHS Wales Joint Commissioning Committee. Notwithstanding this, further minor amendments to Appendix 1 (Decision Making Factors) of the IPFR Policy were requested by the IPFR PIG and HBs.

The updated policy will be shared for approval at the Joint Committee meeting of the NHS Wales Joint Commissioning Committee on the 25th November 2025. A copy of the revised IPFR Policy, with changes highlighted in yellow, is attached as Appendix 1.

Subject to approval of the revised IPFR Policy by the Joint Committee on the 25th November 2025, HB Board approval of the IPFR Policy is sought, with adoption of the Policy to be adopted from the 1st December 2025.

Objectives / Strategy	
Dolen i Amcan (au) Strategol CBC / Link to JCC Strategic Objectives(s)	Maximise Value
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	A More equal Wales
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Whole-systems Perspective
Dolen i Feysydd Ansawdd	Equitable
	Effective Efficient

(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Patient centred
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☒	No: ☒
	Outcome:	Access to IPFR has the potential to increase quality
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	Access to IPFR has the potential to increase equality of access
Cyfreithiol / Legal	Yes (Include further detail below)	
	The document is based on advice from counsel David Locke KC and Welsh Legal Services.	
Enw da / Reputational	There is no direct impact on the reputation of the Joint Committee as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

1. RECOMMENDATIONS

The Board is asked to:

- **Note** the report,
- **Approve** the updated All Wales Individual Patient Funding Request (IPFR) policy for adoption from the 1st December 2025.

NHS WALES POLICY
MAKING DECISIONS ON INDIVIDUAL PATIENT FUNDING REQUESTS (IPFR)

Reference Number	Policy Reference (as per individual Health Board)	**Version Number**	FINAL July 2025
Linked Documents	Health Board Policies on Interventions Not Normally Undertaken (INNU)		

Classification of Document: Clinical Policy

Area for Circulation: Health Boards and Primary Care providers across Wales

NHS Wales Joint Commissioning Committee (JCC)
Public Health Wales (PHW)
Public Domain via Internet Sites

Policy Development: All Wales IPFR Policy Implementation Group
NHS Wales Joint Commissioning Committee

Consultation: Legal Advice from Welsh Health Legal & Risk Services
NHS Wales Medical Directors Stakeholder groups

Approved: TBC

Date of Publication: TBC

Date of Next Review July 2028

Lead Health Board Contact: Contact details as per individual Health Board

Table of Contents

1 INTRODUCTION

1.1 Background

In 2010, the Director General, Health and Social Services, Chief Executive, NHS Wales requested that Health Boards would work together with the Welsh Health Specialised Services Committee (WHSSC) and Public Health Wales (PHW) to develop an All-Wales policy and standard documentation for dealing with individual patient funding requests (IPFR) for treatment. This policy has been in place since September 2011.

1.1.1 In October 2013, The Minister for Health and Social Services announced a review of the IPFR process in Wales. An independent review group was established to explore how the current process could be strengthened.

1.1.2 In April 2014, the "Review of the IPFR process" report was published. The report concluded that the IPFR process in Wales is comprehensive and supports rational, evidence-based decision making for medicine and non-medicine technologies which are not routinely available in Wales. The review group also made a number of recommendations to strengthen the IPFR process.

1.1.3 In September 2016, following the 2014 review and implementation of its recommendations, the Cabinet Secretary for Health, Well-being, and Sport agreed the time was right for a new, independent review of the IPFR process. The panel would be independent of the Welsh Government and encompass a range of expertise and knowledge.

The "Independent Review of the Individual Patient Funding Requests Process in Wales" report was published in January 2017.

1.1.4 Following a Judicial Review in December 2021, the Welsh Government in July 2022 agreed that a specific and limited review would be undertaken to put beyond doubt how the policy should be interpreted. In 2024 the commissioning responsibilities of WHSSC were transferred to the NHS Wales Joint Commissioning Committee (JCC).

1.2 Purpose of this Policy

1.2.1 To ensure an open, transparent, fair, clearly understood and easily accessible process is followed, the NHS in Wales has introduced this Policy on decision making for IPFR's. It describes both the principles underpinning how decisions are made to approve or decline individual patient requests for funding and the process for making them.

1.2.2 Continuing advances in technology, changing populations, better information and increasing public and professional expectations all mean that NHS Health Boards have to agree their service priorities for the application of their financial and human resources. Agreeing these priorities is a complex activity based on sound research evidence where available, sometimes coupled with value judgments. It is therefore important to be open and clear about the availability of healthcare treatments on the NHS and how decisions on what should be funded by the NHS are made.

1.2.3 A comprehensive range of NHS healthcare services are routinely provided

locally by primary care services and hospitals across Wales. In addition, the JCC, working on behalf of all the Health Boards in Wales, commissions a number of more specialist and highly specialist services at a national level. However, each year, requests are received for healthcare that fall outside this agreed range of services. We refer to these as Individual Patient Funding Requests (IPFR).

1.2.4 Each Health Board in Wales has a separate Policy called 'Interventions Not Normally Undertaken' (INNU) setting out a list of healthcare treatments that are not normally available on the NHS in Wales. This is because:

- There is currently insufficient evidence of clinical and/or cost effectiveness; and/or
- The intervention has not been reviewed for the indication under consideration by the National Institute for Health and Care Excellence (NICE) or the All-Wales Medicines Strategy Group (AWMSG); and/or One Wales Medicines process or Health Technology Wales.
- The intervention is considered to be of relatively low priority for NHS resources.

1.2.5 The INNU policy should be read together with this policy on making decisions

1.2.6 The challenge for all Health Boards and JCC is to strike the right balance between providing services that meet the needs of the majority of the population in the geographical area for which it is then given responsibility, whilst having in place arrangements that enable it to accommodate people's individual needs. Key to this is having in place a comprehensive range of policies and schedule of services that the Health Board and/or JCC has decided to fund to meet local need within the resource available. To manage this aspect of the Health Board and JCC's responsibilities, there will always need to be in place a robust process for considering requests for individual patient funding within the overall priority setting framework. Demand for NHS services is always likely to exceed the resources available and, as a result, making decisions on IPFR are some of the most difficult a Health Board or JCC will have to make.

1.2.7 In line with the requirements of the Equality Act 2010 and the Welsh Government guidance 'Inclusive Policy Making' issued in May 2010, a detailed equality impact assessment has been completed to assess the relationship between this policy and the duties of the Act.

1.3 Explaining Individual Patient Funding Requests (IPFR)

1.3.1 IPFRs are defined as requests to a Health Board or JCC to fund NHS healthcare for individual patients who fall outside the range of services and treatments that a Health Board or JCC has arranged to routinely provide, or commission. This can include a request for any type of healthcare including a specific service, treatment, medicine, device or piece of equipment.

Such a request will normally be within one of the three following categories.

- a patient and NHS clinician have agreed together that they would like treatment that is either new, novel, developing or unproven and is not within the Health Board's routine schedule of services and treatments for example, a request to use a cancer drug that has yet to be approved by the Health Board for use in that particular condition).

- a patient and NHS clinician have agreed together that they would like treatment that is provided by the Health Board in certain clinical circumstances but is not eligible in accordance with the clinical policy criteria for that treatment (for example, a request for treatment for varicose veins for cosmetic reasons alone).

- a patient has a rare or specialist condition that falls within the service remit of the JCC but is not eligible in accordance with the clinical policy criteria for treatment (for example, a request for plastic surgery where the indication is personal preference rather than medical need).

1.3.2 IPFRs should not be confused with requests for packages of care for patients with complex continuing healthcare needs – these are covered by separate Continuing Healthcare arrangements. Further information can be obtained from the Health Board's Nursing Department.

1.3.3 IPFRs should also not be confused with treatments that have already been provided or administered outside of NHS funded care. Requests **will not** be considered for retrospective funding.

1.3.4 If the clinical circumstances for the specific individual patient have changed, an IPFR application form describing / explaining / justifying:

i. why the patient is likely to gain significant clinical benefit from the proposed intervention; and
ii. demonstrating that the value for money of the intervention for that particular patient is likely to be reasonable,

then a case may be submitted to the Health Board or JCC for consideration for further prospective funding. For example, if a patient funds a treatment themselves and their clinician believes they can demonstrate that the patient has gained significantly more clinical benefit from the intervention than would normally be expected for that treatment, an IPFR can be submitted for consideration.

1.3.5 The three categories of treatment described in 1.3.1 will only potentially be funded in specific clinical circumstances. It is important to note that the NHS in Wales does not operate a blanket ban for any element of NHS healthcare but equally the granting of funding in one case does not mean that funding will be provided for the same treatment for other patients. We will consider each IPFR on its individual merits and in accordance with the arrangements set out in this policy. We will determine if the patient should receive funding based on the significant clinical benefit expected from the treatment and whether the cost of the treatment is in balance with the expected clinical benefits.

1.3.6 In this policy, the words "significantly different to the general population of patients" means that the patient's condition does not have substantially the same characteristics as other members of that population. For a patient to be significantly different, their particular clinical presentation is unlikely to have been considered as being part of the population for which the policy was made.

1.3.7 In practice, it is not always practical to determine the "benefit" of an intervention in numerical terms in the same way, for example as NICE or the AWMSG. In these situations, a description of the benefit should be used to

enable IPFR panels to compare the description of the incremental clinical benefit likely to be obtained.

In general, the clinician should compare the benefits of the intervention being requested with what he or she considers to be the next best alternative, which may in some cases be best supportive care.

1.3.8 Whether an intervention provides "value for money" is assessed conceptually in terms of the incremental cost per incremental quality-adjusted life year (QALY) of benefit. Whilst "reasonable" value for money is to be interpreted in the same way that "cost-effective" is used in the Health Technology Appraisal (HTA) process operated by NICE, AWMSG and HTW.

1.3.9 Recognising that it can never be possible to anticipate all unusual or unexpected circumstances, this policy aims to establish a clear guide to making decisions on IPFRs to determine whether the evidence that the patient is likely to gain a significant clinical benefit, and the value for money of the intervention for that particular patient is likely to be reasonable, has been presented.

Please refer to the decision-making factors in Appendix one. These are factors the panel may consider when looking at the significant clinical benefit expected by the treatment, and whether the cost of the treatment is in balance with the expected benefits.

2 THE LEGAL CONTEXT OF THIS POLICY

2.1 Health Boards exercise functions delegated to them by the Welsh Ministers under various statutes and in particular under the National Health Service (Wales) Act 2006 and under secondary legislation made under that Act.

2.2 In addition to specific statutory obligations, Health Boards are public bodies, which are required to comply with their legal obligations to act in accordance with the rights of individuals under the European Convention of Human Rights as defined in the Human Rights Act 1998 and under common law.

2.3 Health Boards must therefore be able to demonstrate that their decisions are within their powers and comply with their legal obligations. In terms of the exercise of their powers, they must show that they have considered all relevant issues in the decision-making process, giving them appropriate weight and that those decisions are rational, logical, lawful and proportionate.

Careful consideration needs to be given in relation to all decisions; particular care may need to be given in the following circumstances:

- when evidence is not clear or conclusive.
- when the issue is controversial and may not have the support of NICE, AWMSG or HTW.
- when life or death decisions are involved.
- when limiting access to specific services or treatments.
- when setting priorities.
- when other Health Boards or JCC may have used their discretion to make a different decision on a specific topic.

2.4 It is lawful for JCC and Health Boards to adopt policies about which treatments will, and which will not, be routinely funded. It is also lawful for JCC and Health Boards to adopt this policy to define the circumstances in which a decision can be made to fund an intervention for a patient where the patients are lawfully

2.5 denied funding for the same intervention as a result of policies or as a result of an absence of a policy approving funding for that intervention.

2.6 Consistency in policy and approach, together with clarity about clinical criteria for treatment and a consistent approach to dealing with IPFR requests should reduce the need for patients to go through a review or appeal process at any level. This should be the desirable outcome as far as it is possible.

3 PRINICIPLES UNDERPINNING THIS POLICY

The principles underpinning this policy and the decision making of the Health Board are divided into five areas - the NHS Core Values, the Prudent Healthcare Principles, Evidence-based Considerations, Ethical Considerations and Economic Considerations.

3.1 NHS Core Values are set out by the Welsh Government as;

- Putting quality and safety above all else: providing high value evidence-based care for our patients at all times.
- Integrating improvement into everyday work and eliminating harm, variation and waste.
- Focusing on prevention, health improvement and inequality as key to sustainable development, wellness and wellbeing for future generations of the people of Wales.
- Working in true partnerships with partner organisations and with our staff
- Investing in our staff through training and development, enabling them to influence decisions and providing them with tools, systems, and environment to work safely and effectively.

3.2 Prudent Healthcare Principles

- Achieve health and wellbeing with the public, patients and professionals as equal partners through co-production.
- Care for those with the greatest needs first, making the most effective use of all skills and resources.
- Do only what is needed, no more, no less; and do not harm.
- Reduce inappropriate variation using evidence-based practices consistently and transparently.

3.3 Evidence-Based Considerations

3.3.1 Evidence-based practice is about making decisions using quality information, where possible, and recognising areas where evidence is weak. It involves a systematic approach to searching for and critically appraising that evidence.

3.3.2 The purpose of taking an evidence-based approach is to ensure that the best possible care is available to provide interventions that are sufficiently clinically effective to justify their cost and to reduce inappropriate variation using evidence-based practices consistently and transparently.

NICE issue Technology Appraisals and the All-Wales Medicines Strategy Group and Health Technology Wales issue guidance which Health Boards and JCC are required to follow.

3.3.3 Additionally, a central repository for evidence-based appraisals is available which provides support for clinicians making an application. This is located on the shared database. Users are able to upload and access the information

available which will continue to be developed over time as evidence /new reports are produced.

3.3.4 It is also important to acknowledge that in decision making there is not always an automatic "right" answer that can be scientifically reached. A "reasonable" answer or decision therefore has to be reached, though there may be a range of potentially reasonable decisions. This decision is a compromise based on a balance between different value judgements and scientific (evidence-based) input. Those vested with executive authority have to be able to justify, defend and corporately "live with" such decisions.

3.4 Ethical Considerations

3.4.1 Health Boards and JCC are faced with the ethical challenge of meeting the needs of individuals within the resources available and meeting their responsibility to ensure justice in the allocation of these resources ('distributive justice'). They are expected to respect each individual as a person in his or her own right.

3.4.2 Resources available for healthcare interventions are finite, so there is a limit to what Health Boards and JCC can routinely fund. That limitation is reasonable providing it is fair, and not arbitrary. It must be based on the evidence both about the effectiveness of those interventions and their cost. A cost-effective intervention is one that confers a great enough benefit to justify its cost. That means policies must be based on research, but research is carried out in populations of patients, rather than individual patients. That leaves open the possibility that what is true for patients in general is not true about a specific individual patient. Fairness therefore also requires that there must be a mechanism for recognising when an individual patient will benefit from a particular intervention more than the general population of patients would. Identifying such patients is the purpose of the IPFR process.

3.4.3 Welsh Government communications set out six ethical principles for NHS organisations and these underpin this policy. They are:

- treating populations and particular people with respect.
- minimising the harm that an illness or health condition could cause.
- fairness.
- working together.
- keeping things in proportion; and
- flexibility

3.5 Economic Considerations

3.5.1 It is a matter for Health Boards and JCC to use its discretion to decide how it should best allocate its resources. Such resources are finite and difficult

balancing decisions have to be made. Health Boards and JCC must prioritise the services that can be provided whilst delivering high-quality, cost-effective services that actively avoid ineffective, harmful, or wasteful care that is of limited benefit. The opportunity cost associated with each decision has also to be acknowledged i.e., the alternative uses to which resources could be put.

4 MAKING DECISIONS ON IPFR

4.1 In line with the principles set out earlier in this document, Welsh Government communications set out the key factors for 'good decision making'. These are:

- openness and transparency.
- inclusiveness.
- accountability.
- reasonableness.
- effectiveness and efficiency.
- exercising duty of care.
- lawful decision making; and
- the right to challenge and appeal

This policy aims to ensure that the Health Board and JCC has a clear and open mechanism for making decisions that are fair, open, and transparent. It enables those responsible for decision making to demonstrate that they have followed due process, considered the above factors, and have been both rigorous and fair in arriving at their decisions. It also provides a clear process for challenge and appeal.

4.2 In accordance with Welsh Government communications, NICE definitions, and the criteria set out in this policy, Health Boards and JCC should make decisions on IPFRs based on; the evidence presented to demonstrate the expected significant clinical benefit, and the evidence presented outlining the patient's individual clinical circumstances. Decisions should be undertaken whilst taking into reasonable account the evidence base, and the economic and ethical factors below:

- **evidence-based considerations** – clinical and cost effectiveness; service and policy implications.
- **economic considerations** – opportunity cost; resources available; and
- **ethical considerations** – population and individual impact; values and principles; ethical issues.

Non-clinical factors (such as employment status) will not be considered when making decisions on IPFR.

This Policy does not cover healthcare travel costs. Information on patients' eligibility for healthcare travel costs to receive NHS treatment under the care of a consultant can be found on the Welsh Governments' healthcare costs website.

4.3 The following criteria must be used by all Health Board and JCC IPFR Panels when making IPFR decisions. It is the responsibility of the referring clinician to ensure that sufficient information is placed before the panel to allow the panel to be able to determine whether the criteria are satisfied.

A patient will only be entitled to NHS funding for the requested intervention or drug if the panel conclude that the criteria under **either (a) or (b)** below are satisfied:
(a) If guidelines (e.g. from NICE or AWMSG) recommend NOT using the intervention/drug, or the clinical access criteria of an applicable policy are not met: I. The clinician must demonstrate that the patient's clinical circumstances are significantly different to other patients for whom the recommendation is not to use the intervention. II. The clinician can demonstrate that the patient is likely to gain significantly more clinical benefit from the intervention than would normally be expected from patients for whom the recommendation is not to use the intervention, and III. The IPFR panel must be satisfied that the value for money of the intervention for that particular patient is likely to be reasonable.
(b) If the intervention has NOT been appraised (e.g. in the case of medicines, by AWMSG or NICE), and there is no applicable policy in place: I. The clinician can demonstrate that the patient is likely to gain significant clinical benefit, and II. The IPFR panel must be satisfied that the value for money of the intervention for that particular patient is likely to be reasonable.

4.4 An IPFR panel is required to decide whether the application fulfils Part A or Part B and then consider the application against the relevant criteria. A panel may only approve applications which meet all of the applicable criteria above. It is however the responsibility of the requesting clinician to demonstrate the clinical case for the patient in respect of the criteria outlined.

4.5 Considerations under Part A

4.5.1 Where a recommendation has been made not to use an intervention, the panel is required to consider whether the patients' clinical circumstances are significantly different to other patients for whom the recommendation is made not to use the intervention'. That process will usually require a comparison between the patient for whom treatment is being requested, and other patients with the same medical condition who could have been offered the requested intervention if the relevant guidance and/or applicable policy allowed.

4.5.2 The panel next should consider whether there is a significant difference between the clinical circumstances of the patient for whom funding is being requested, and the comparator group, and whether the patient is likely to gain significantly more clinical benefit from the intervention than would normally be expected for patients for whom the recommendation has been made not to use the intervention. If, but only if, both of these criteria are

met on the facts of an individual Part A case, the panel will then consider whether the intervention is deemed value for money as described at paragraph 4.7 below.

4.6 Considerations under Part B

4.6.1 In the absence of any appraisal or applicable policy, the panel need to consider whether the referring clinician has provided sufficient evidence to conclude that the patient is likely to gain significant clinical benefit from the intervention requested. If this criterion is met on the facts of an individual Part B case, the panel will then consider whether the intervention is deemed value for money as described below.

4.7 Value for money

4.7.1 The assessment as to whether the intervention provides "value for money" is a matter of judgement for the panel. The panel should reach a decision exercising its broad discretion to decide whether the value for money of an intervention for a particular patient is likely to be reasonable.

4.7.2 The panel should consider the likely overall costs to the NHS of the requested intervention compared with the next best alternative treatment that is routinely funded on the NHS. The panel should in a similar way consider the overall benefit (effectiveness) of the intervention compared with the next best alternative treatment that is routinely funded on the NHS. If the requested intervention is estimated to be more effective and less costly (than the alternative treatment) then it is likely to represent value for money. If the treatment is less effective and more expensive, then it is unlikely to be deemed value for money. If the treatment is more effective and more costly or less effective and less costly then the panel will need to make a judgement as to whether the treatment is likely to represent value for money. For any scenario, other factors may affect treatment choice, and these should be documented as part of the discussion.

4.7.3 Where presented as part of the evidence, an incremental cost effectiveness ratio ("ICER") and quality- adjusted life year (QALY) may be considered by the panel provided this is relevant to the individual case and there is appropriate expertise by the group to do so. When assessing this evidence, the panel should consider relevant thresholds in relation to NICE and AWMSG when considering if the intervention is a cost-effective option.

4.8 When making decisions, the panel are entitled to have regard to the factors set out at Appendix 1 to this policy, if the panel consider that addressing those issues may assist the panel in coming to decisions on the criteria set out at paragraph 4.3 above. The panel is not obliged to consider all the factors set out Appendix 1 to this policy and may consider that some of the factors are not relevant to the facts of an individual case or do not assist the panel in coming to its decision on those criteria.

5 HOW TO MAKE A REQUEST FOR FUNDING UNDER THIS POLICY

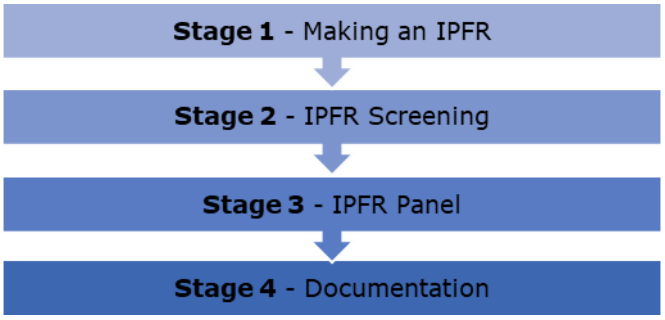
5.1 Information on how to make an IPFR

A patient leaflet is available explaining how an individual patient funding request (IPFR) can be made. These can be downloaded from the Health

Board, JCC or AWTTC website. Further information can be obtained from the IPFR Coordinator.

Copies of this policy and the IPFR application forms can also be obtained via the website, or by contacting the IPFR Coordinator.

5.2 Summary of the IPFR Process



5.3 Stage 1 Making an IPFR

The patient and their NHS clinician (agree together that a request should be made). The IPFR application form is completed by the clinician on the patient's behalf. This will ensure that adequate clinical information is provided to aid the decision-making process.

The requesting clinician must sign the application form to indicate that the patient is aware and agrees with the submission of the request. In doing so, the clinician is providing confirmation that the patient is fully informed of the treatment request and all its associated implications.

Ideally, applications for specialised and tertiary services should be completed by the patient's secondary care clinician, unless extenuating circumstances dictate otherwise. This is to ensure that all pertinent information is included in the form thereby avoiding the delay that will arise from the need to request further information before the application can be processed. All IPFR applications should demonstrate support from the relevant clinical lead, head of department or multi-disciplinary team (MDT). Where relevant, advice may also be sought from the internal clinical team.

It is necessary for clinicians to provide their contact details as there may be times when additional clinical information is required during a panel meeting to aid a decision.

The application form is sent to the IPFR Coordinator electronically or in hard copy so that the authorised consent of the clinician is recorded.

The IPFR application form must be completed in full to enable the IPFR Panel to reach a fully informed decision.

Should the IPFR Coordinator receive an application form which has not been completed sufficiently enough to determine whether or not the request can be screened out or taken to the IPFR Panel, or if the incorrect form is completed, the form should be returned to the requesting clinician **within three working days**.

The requesting clinician is responsible for completing and re-submitting the application form **within ten working days**. Should this time elapse, a chaser letter will be sent providing a **further ten working days** to make a submission.

Where the information has still not been provided in the time set, the case shall be closed, and the requesting clinician notified accordingly.

5.4 Stage 2 Screening of the IPFR

The IPFR application will be considered by the IPFR Senior Officer to determine whether the application needs to be screened out because:

a) The request meets pre-agreed criteria for a service already commissioned/provided and can automatically be funded
b) an alternative and satisfactory clinical solution is found
c) The request represents a service development which needs to be passed to the relevant Division or Directorate for action.

The IPFR Senior Officer should then communicate the outcome of the screening stage to the requesting clinician using a standard letter, **within five working days** of the decision being made. This letter will also include reasons for the decision and information on any further courses of action required.

5.5 Stage 3 Considerations by the IPFR Panel

Requests that are not screened out will be considered at a meeting of the IPFR Panel. The IPFR Coordinator will ensure that the panel has all of the information needed to reach a decision and will ensure that each case is anonymised before each meeting.

Panels will convene at least once per month in order to ensure that applications are dealt with in a timely manner. The volume and urgency of applications may require panels to meet more frequently as and when required.

The panel will consider each IPFR on its own merits, using the criteria set out in paragraph 4.3 of the Policy. Where possible, they should set out their assessment of the likely incremental clinical benefit and their broad estimate of the likely incremental cost so that their judgements on value for money are clear and transparent. The IPFR Coordinator or Senior Officer will complete a record of the panel's discussion on each IPFR, including the decision and a detailed explanation for the reason for that decision.

A standard decision letter should be prepared to communicate the decision to the requesting clinician. Correspondence will also be sent to the patient to inform them that a decision has been made, and their clinician will contact them within 5 working days to discuss. If this has not happened, patients are encouraged to contact their clinician.

These letters will be sent **within five working days** of the panel's decision and will also include information on how to request a review of the process where a decision has been made to decline the request.

5.6 Who will sit on the IPFR Panel?

The Health Board will appoint core members of the IPFR Panel which will comprise:

- Executive Public Health Director (or deputy – Public Health Consultant)
- Executive Medical Director (or deputy - Associate/Assistant Medical Director)
- Executive Director of Nursing (or deputy – Assistant Director of Nursing)
- Director of Therapies & Clinical Science (or deputy - Assistant Director of Therapies)
- Director of Pharmacy and / or Chief Pharmacist or deputy; and
- Two lay representatives.

The Chair of the Panel will be selected from the group of core members and must have a clinical background (with the exception of JCC – see Terms of Reference at Appendix 3).

Each organisation may also wish to appoint up to a further two Panel members at the discretion of the Chair of the Panel, for example a member of the Ethics Committee, Primary Care Director, or Director of Planning.

Please refer to the Terms of Reference at Appendix 2 and 3 for details of the Health Board and JCC IPFR Panel.

5.7 What about clinically urgent cases?

The IPFR Policy and process allows for clinically urgent cases, as deemed by the requesting clinician, to be considered outside of the normal screening and panel processes. In these circumstances, the Chair or Vice Chair of the IPFR panel is authorised to make a decision outside of a full meeting of the panel, within their delegated financial limits. Any such decisions will be made in line with the principles of this policy, considering the clinical urgency of the request outlined in the application form by the clinician. Those marked urgent will be considered within 24-48 hours (working days only) as per the application form.

5.8 Can patients and clinicians attend the IPFR Panel?

Patients are not permitted to attend IPFR Panels. The reasons are that it would make the process less fair because it would draw to the attention of panel members characteristics of the individual patient that should not influence their decision-making. The IPFR process is anonymous therefore allowing patients to attend would jeopardise this level of scrutiny. The IPFR Panel will normally reach its decision on the basis of all of the written evidence provided, including the IPFR application form and other documentary evidence which is provided in support. Patients and clinicians are able to supply any written statements they feel should be considered by the Panel**. Any information provided which relates to non-clinical factors will not be considered.** Local Llais teams are able to support patients in making such statements if required.

The IPFR Panel may, at its discretion, request the attendance of any clinician to provide clarification on specific issues and/or request independent expert clinical advice for consideration by the panel at a future date. The Chair of the IPFR Panel, may also contact the referring clinician to get more clarification in respect of an individual referral.

The provision of appropriate evidence to the IPFR Panel will be entirely at the Chair of the IPFR Panels discretion.

5.9 Documentation

The IPFR Coordinator will maintain a confidential electronic record of all requests. A separate, confidential hard copy file may also be maintained. This information will be held securely in compliance with Data Protection requirements and with Caldicott Guidance.

The IPFR Administration Team retains a record of the IPFR application and subsequent decision and any outcome data that is provided by the clinician. Data will be retained to help inform future planning requirements by identifying patient cohorts both at a local and national level. Data will also be used for the production of an annual report on IPFR's every year as required by the Welsh Government. This will not include any identifiable data and will use aggregated data.

In addition, a central repository for clinical evidence will be available and will develop over time as and when new evidence reports are produced / become available.

Any information will be held in line with the NHS Information Governance Retention Policy

6 HOW TO REQUEST A REVIEW OF THE PROCESS

If an IPFR is declined by the panel, a patient and their NHS clinician have the right to request information about how the decision was reached. If they are unhappy with the decision the NHS clinician on behalf of the patient can either:

Resubmit an IPFR application, but only if there is either significant new clinical information or a significant change in clinical circumstances, or

If the patient and their NHS clinician feel the process has not been followed in accordance with the IPFR policy, a review hearing can be requested (see below).

The review process for an application for funding under the IPFR policy does not conflict with a patient's ability to make a complaint about the care that has been arranged in relation to a IPFR funding decision. This is best achieved through the Health Boards or JCC's Putting Things Right process which can be found at

https://www.gov.wales/nhs-wales-complaints-and-concerns-putting-things-right (see section 9).

6.1 The 'review period'

There will be a period of **25 working days** from the date of the decision letter during which they may request a review by the review panel ('the review period").

The letter from the Health Board or JCC that accompanies the original

decision will state the deadline for any review request. In calculating the deadline, Saturdays, Sundays, and public holidays in Wales will not be counted.

6.2 Who can request a review?

A review can be requested either (a) by the original requesting clinician on the patient's behalf or (b) by the patient with the original requesting clinician's support. **The review request form must be completed by the clinician**. Both the patient and their clinician must keep each other informed of progress. This ensures the patient is kept informed at all times, that the clinician/patient relationship is maintained, and review requests are clinically supported. Patients are able to access advocacy support at any stage during this process.

6.3 What is the scope of a review?

It does not constitute a review of the merits of the original decision. It has the restricted role of hearing review requests that fall into one or more of three strictly limited grounds. A review request on any other ground will not be considered.

The 3 grounds are:

Ground One: *The Health Board or JCC has failed to act fairly and in accordance with the All Wales Policy on Making Decisions on Individual Patient Funding Requests (IPFR).*

Health Boards and JCC are committed to following a fair and equitable procedure throughout the process. A patient who believes they have not been treated fairly by the Health Board or JCC may request a review on this ground. This ground relates to the procedure followed and not directly to the decision and it should be noted that the decision with which the patient does not agree is not necessarily unfair.

Ground Two: *The Health Board or JCC has prepared a decision which is irrational in the light of the evidence submitted*

The review panel will not normally entertain a review request against the merits of the decision reached by the Health Board or JCC. However, a patient may request a review where the decision is considered to be irrational or so unreasonable that no reasonable Health Board or JCC could have reached that conclusion. A claim that a decision is irrational contends that those making the decision considered irrelevant factors, excluding relevant ones, or gave unreasonable weight to particular factors.

Ground Three: *The Health Board or JCC has not exercised its powers correctly.*

Health Boards and JCC are public bodies which carry out its duties in accordance with the Statutory Instruments under which it was established. A patient may request a review on the grounds that the Health Board or JCC has acted outside its remit or has acted unlawfully in any other way.

6.4 How is a review request lodged?

A review request form should be completed and logged with the IPFR Coordinator of the Health Board or JCC within the review period. The review request form must include the following information:

- The aspect(s) of the decision under challenge and
- The detailed ground(s) of the review request

The review request form should be sent to the IPFR Coordinator so that the signatures of both the patient and their clinician are recorded. A scanned version sent electronically will also be acceptable as long as signatures are present.

If the patient signature cannot be obtained in a timely manner or at all, the requesting clinician can sign to indicate that the patient is aware and agrees with the submission of the request. In doing so, the clinician is providing confirmation that the patient is fully informed of the treatment request and all its associated implications.

6.5 Initial scrutiny by the IPFR Senior Officer

The review documents lodged will be scrutinised by the IPFR Senior Officer who will look to see that they contain the necessary information. If the review request does not contain the necessary information or if the review does not appear to the IPFR Senior officer to fall under any one or more grounds of review, they will contact the referrer (patient or their clinician) to request further information or clarification.

A review will only be referred to the review panel if, after giving the patient and their clinician an opportunity to elaborate or clarify the grounds of the review, the Chair of the review panel is satisfied that it falls under one or more of the grounds upon which the review panel can hear the review.

The Chair of the review panel may refuse to consider a review that does not include all of the above information.

6.6 What is the timescale for a review to be heard?

The review panel will endeavor to hear a review **within 25 working days** of the request being lodged with the Health Board. The date for hearing any review will be confirmed to the patient and their clinician in a letter.

This review process allows for clinically urgent cases, as deemed by the referring/supporting clinician, to be considered outside of the panel process by the Health Board's Chair together with a clinical member of the review panel. Any such decisions will be made in line with the principles of this policy.

6.7 Who will sit on the Review Panel?

The Health Board will appoint members of the review panel. The panel will comprise (see Terms of Reference at Appendix 4 for full details);

- Health Board Independent Board Member – Lay (Chair of the Review Panel)
- Health Board Independent Board Member (with a clinical background)
- Health Board Executive Director, or deputy (with a clinical background)

- Representative from Llais
- Chair of the Local Medical Committee, or deputy
- JCC Representative at Director level (where applicable)

The Health Board will intend to inform the patient and their clinician of the membership of the review panel as soon as possible after a review request has been lodged. None of the members of the review panel will have had any prior involvement in the original submission.

In appointing the members of the review panel, the Health Board will endeavor to ensure that no member has any interest that may give rise to a real danger of bias. Once appointed, the review panel will act impartially and independently.

6.8 Can new data be submitted to the review panel?

No, because should new or additional data become available then the IPFR application should be considered again by the original panel in order to maintain a patient's right to review at a later stage.

6.9 Can patients attend review panel hearings?

At the discretion of the panel, patients and/or their unpaid representative may attend review panel hearings as observers but will not be able to participate. This is because the purpose of a review hearing is to consider the process that has been followed and not to hear new or different evidence.

If new or different evidence becomes available, the case will automatically be scheduled for reconsideration by the IPFR Panel. Patients and/or their unpaid representatives are able to make their written representations to this IPFR Panel in order for their views to be considered.

It is important for all parties to recognise that review panel hearings may have to discuss complex, difficult and sensitive information in detail and this may be distressing for some or all of those present. Patients and/or their unpaid representatives should be aware that they will be asked to retire at the end of the review panel discussion in order for the panel to make their decision.

6.10 The decision of the review panel hearing

The IPFR Senior Officer will complete a record of the review panel's discussion including the decision and a detailed explanation for the reason for the decision. They will also prepare a standard decision letter to communicate the decisions of the panel to the patient and referring/supporting clinician. The review panel can either;

- uphold the grounds of the review and ask the original IPFR Panel to reconsider the request; or
- not uphold the grounds of the review and allow the decision of the original IPFR Panel to stand.

There is no right to further review unless new and relevant circumstances emerge. Should a patient be dissatisfied with the way in which the review panel carried out its functions, they are able to make a complaint to the Public Services Ombudsman for Wales.

6.11 After the review hearing

The Chair of the review panel will notify patients and their clinicians of the review panel's decision in writing. This letter should be sent **within five working days** of the panel and will also include information on how to make a complaint to the Public Services Ombudsman for Wales www.ombudsman-wales.org.uk.

6.12 How will JCC undertake a review?

As the JCC is a collaborative committee arrangement to support all Health Boards in Wales, it will not be able to constitute a review panel. JCC will therefore refer any requests it receives for a review of its decisions to the Health Board in which the patient resides. A JCC representative who was not involved in the original panel will become a member of the review panel on these occasions.

The Health Boards IPFR Senior Officer will be present at these review hearings to advise on proceedings as per their governance role. In the interests of transparency, and not to confuse the applicant, the JCC Senior IPFR Officer will be responsible for circulating the review documentation to review panel members, clerking the hearing, and preparing the standard decision letter to communicate the decision of the review panel to the patient and clinician.

7 QUALITY ASSURANCE

The IPFR Quality Assurance Advisory Group was established in 2017 to monitor and support all IPFR panels to promote quality in decision making and consistency across Wales. The Group meets quarterly to assess anonymised random sample IPFR reports in relation to their completeness, timeliness, and efficiency of communication in line with the NHS Wales IPFR policy process.

8 REVIEW OF THIS POLICY

8.1 This Policy should be reviewed every 3 years or as required to reflect changes in legislation or guidance. The review will be undertaken by the All-Wales IPFR Policy Implementation Group. Any changes made will be undertaken in line with the groups Terms of Reference (see appendix 5) and authorised by the responsible Health Board and JCC Committee. Any delay in conducting a review will not prevent JCC or a Health Board from being able to rely on this policy.

8.2 Any of the following circumstances will trigger an immediate review of the linked INNU Policy:

- an exemption from a treatment policy criterion has been agreed.
- new scientific evidence of effectiveness is published for all patients or sub- groups.
- old scientific evidence has been re-analysed and published suggesting previous opinion on effectiveness is incorrect.
- evidence of increased cost effectiveness is produced.

- NHS treatment would be provided in all (or almost all) other parts of the UK.
- a National Service Framework recommends care.

9 MAKING A COMPLAINT

9.1 Making an IPFR does not conflict with a patient's ability to make a complaint through the Health Boards or JCC's Putting Things Right process, details of which can be found at https://www.gov.wales/nhs-wales-complaints-and-concerns-putting-things-right

9.2 If it is not possible to resolve a concern through local resolution the person raising the concern can refer the matter to the Public Services Ombudsman for

Wales (PSOW). Further information is available on the Ombudsman's website www.ombudsman-wales.org.uk.

Patients are able to access advocacy support at any stage during this process.

APPENDIX 1: DECISION MAKING FACTORS

Panels may find it useful to consider these factors, but they are not required to look at every factor set out in the table. Furthermore, there may be factors in the table that are not relevant to the individual case. The factors in the table are optional and cannot change the meaning of the criteria under paragraph 4.3 of the Policy.

IPFR Panel Decision-Making Factors	**IPFR Panel Evidence for Consideration in Decision-Making**
PART 9A - SIGNIFICANTLY DIFFERENT AND SIGNIFICANT CLINICAL BENEFIT	
Is the clinical presentation of the patient's condition significantly different in characteristics to other members of that population for whom the recommendation is not use the intervention? Does this presentation mean that the patient will derive a greater clinical benefit from the treatment than other patients with the same condition at the same stage and for whom the recommendation is not to use the intervention?	Consider the evidence supplied in the application that describes the specific clinical circumstances of the IPFR: • What is the clinical presentation of this patient? • Is evidence supplied to explain why the clinical presentation of this patient is significantly different to that expected for this disease and this stage of the disease? This is in context of the population for whom the treatment is not recommended. • Is evidence supplied to explain why the clinical presentation means that the patient will gain a significantly greater clinical benefit from the treatment than another patient with the same disease at the same stage? This is in context of the population for whom the treatment is not recommended.
PART 9B - SIGNIFICANT CLINICAL BENEFIT	
Does the presentation of the patient's condition mean they are likely to gain significant clinical benefit from the intervention requested?	Consider the evidence submitted in the application that describes the specific clinical circumstances of the IPFR: • What is the clinical presentation of this patient? • Does the evidence provided explain why this patient is likely to gain a significant clinical benefit when compared to next best alternative for this patient, which may in some cases be best supportive care?
EVIDENCE BASED CONSIDERATIONS	
Does the treatment work? What is the evidence base for clinical and cost effectiveness?	Consider the evidence supplied in the application, and supplementary evidence (where applicable) supplied by professional advisors to the Panel: • What does NICE recommend or advise? • What does the AWMSG recommend or advise? • What does the Scottish Medicines Consortium recommend or advise? • What does Public Health Wales advise? • Is there advice available from the One Wales Medicines process or Health Technology Wales? • Is there peer reviewed clinical journal publications available? • What information does the locally produced evidence summary provide? • Is there evidence from clinical practice or local clinical consensus? • Has the rarity of the disease been considered in terms of the ability for there to be comprehensive evidence base available? • Does the decision indicate a need to consider policy or service change? If so, refer to service change processes.
ECONOMIC CONSIDERATIONS	
Is it a reasonable cost? What is the cost of the **treatment** and is the cost of the treatment likely to be reasonable? Is the cost of the treatment in balance with the expected clinical benefits?	Consider the evidence supplied in the application, and supplementary evidence (where applicable) supplied by professional advisors to the Panel: • What is the specific cost of the treatment for this patient? • What is the cost of this treatment when compared to the alternative treatment they will receive if the IPFR is declined? • Has the concept of proportionality been considered? (Striking a balance between the rights of the individual and the impact on the wider community), in line with Prudent Healthcare Principles. • Is the treatment reasonable value for money?

ETHICAL CONSIDERATIONS	
How has the decision been reached? Is the decision a compromise based on a balance between the evidence-based input and a value judgement?	Having considered the evidence base and the cost of the treatment requested, are there any ethical considerations that have not been raised in the discussions? • Is the evidence base sufficient to support a decision? • Is the evidence and analysis of the cost sufficient to support a decision? • Will the decision be made on the basis of limited evidence and a value judgement? If so, have you considered the values and principles and the ethical framework set out in the policy? • Have non-clinical factors been excluded from the decision? • Has a reasonable answer been reached based on the evidence and a value judgement after considering the values and principles that underpin NHS care?

APPENDIX 2

TERMS OF REFERENCE – INDIVIDUAL PATIENT FUNDING REQUEST PANEL (Health Board)

PURPOSE

The Health Boards IPFR Panel is constituted to act as a Committee of the Health Board and holds delegated Health Board authority to consider and make decisions on requests to fund NHS healthcare for patients who fall outside the range of services and treatments that a Health Board has agreed to routinely provide.

The IPFR Panel will normally reach its decision on the basis of all of the written evidence which is provided to it, including the request form itself and any other documentary evidence which is provided in support of the application.

The IPFR Panel may, at its discretion, request the attendance of any clinician to provide clarification on any issue or request independent expert clinical advice for consideration by the Panel at a further date. The provision of appropriate evidence to the Panel will be entirely at the Panel Chair's discretion.

SCHEME OF DELEGATION REPORTING	MEMBERSHIP AND ATTENDANCE
The IPFR Panel cannot make policy/commissioning decisions for the Health Board. Any policy proposals arising from the panels considerations and decision will ultimately be reported to the Health Board's Quality & Patient Safety Committee for ratification. Financial authorisation is as follows: - The Panel's authorisation limit will be set at the delegated financial limit as per the individual Health Board structure. - Any decisions resulting in a financial cost in excess of this must be reported to the Health Board Chief Executive for budget authorisation.	• Executive Public Health Director or deputy • Executive Medical Director or deputy • Executive Director of Therapies and Health Science or deputy • Director of Pharmacy and/or Chief Pharmacist or deputy • Executive Director of Nursing or deputy • Two Lay Representatives A further two panel members may be appointed at the discretion of the panel Chair, for example a member of the Ethics Committee, Primary Care Director, or Director of Planning. In Attendance: • IPFR Coordinator • Finance Advisor (if required) • Senior Pharmacist (if required)

PROCEDURAL ARRANGEMENTS

Quorum: Chair or Vice Chair plus 2 panel members with a clinical background.

Meetings: The IPFR Panel will normally be at least once per month, either virtually, face to face or a combination of both.

Urgent Cases: Provision will be made for occasions where decisions may need to be made urgently. In these circumstances, the Chair or Vice Chair

of the IPFR Panel is authorised to make a decision outside of a full meeting of the Panel, within their delegated financial limits.

Recording: The IPFR Coordinator will document the meetings to ensure panel discussions and decisions are appropriately recorded.

Training: All Panel members will receive a local induction.

Panel members should have the opportunity to attend a separate annual refresher session to ensure all members maintain the appropriate skills and expertise to function effectively.

Panel Interest: At the start of the meeting members must declare any personal or prejudicial interests relating to the discussions of the panel.

Consensus: IPFR panel members will seek to achieve decisions by consensus where possible. If the panel is equally split the Chair of the Panel will make the final decision

APPENDIX 3

TERMS OF REFERENCE – INDIVIDUAL PATIENT FUNDING REQUEST PANEL (JCC)

PURPOSE

The NHS Wales Joint Commissioning Committee's IPFR Panel is managed by NHS Wales Joint Commissioning Committee and holds delegated authority to consider and make decisions on requests to fund NHS healthcare for patients who fall outside the range of services and treatments that a Health Board has agreed to routinely provide.

The IPFR Panel will act at all times in accordance with the All-Wales IPFR Policy taking into account the appropriate funding policies agreed by JCC.

The IPFR Panel will normally reach its decision on the basis of all of the written evidence which is provided to it, including the request form itself and any other documentary evidence which is provided in support of the application.

The IPFR Panel may, at its discretion, request the attendance of any clinician to provide clarification on any issue or request independent expert clinical advice for consideration by the Panel at a further date. The provision of appropriate evidence to the Panel will be entirely at the Panel Chair's discretion.

SCHEME OF DELEGATION REPORTING	**MEMBERSHIP AND ATTENDANCE**
The IPFR Panel cannot make policy/commissioning decisions for the Health Boards. Any policy proposals arising from the Panel's considerations and decisions will be reported to the JCC for ratification. Financial authorisation is as follows: **Individual Patient Packages** The JCC scheme of delegation states that financial approval is required for individual NHS patient treatment charges outside of LTS's and SLA's concerning one off treatment costs exceeding £750,000. Therefore, any approved IPFR treatment exceeding £750,000 needs to be reported to the Joint Committee. **Lifetime costs** The JCC scheme of delegation states that financial approval is	• Independent Chair (from open recruitment) • 2 Lay representatives** • Health Board nominated clinician or clinician deputy. • 2 Vice Chairs (appointed from within the panel membership) • JCC Medical Director or nominated deputy. • JCC Director of Nursing or nominated deputy. A further two panel members from the NHS in Wales may be appointed at the discretion of the Chair of the Panel in conjunction with the JCC Medical and/or Director of Nursing, for example a member of an ethics committee. In attendance from JCC • IPFR Coordinator • Finance Advisor (if required) • Governance Advisor (if required) • Other JCC staff as and when required to clarify on policy/commissioning arrangements/evidence evaluation For particularly complex cases the IPFR Panel may invite other individuals with clinical, pharmacy or commissioning expertise and skills, unconnected with the requesting provider to support decision making.

required for individual NHS patient treatment charges outside of LTS's and SLA's for lifetime costs exceeding £100,000,000. Therefore, any approved IPFR exceeding £1,000,000 needs to be reported to the Joint Committee. Any decisions resulting in a financial cost in excess of these limits must be reported to the Chief Commissioner for authorisation and the relevant Health Board for information and if over £1 million to the Joint Committee for approval or ratification (if a Chairs action was undertaken).	

** **Definition: Not registered as a healthcare professional, either lay (not currently healthcare worker) or lay plus (no healthcare experience ever) (Health Research Authority 2014) will be eligible.**

PROCEDURAL ARRANGEMENTS

Quorum: The Panel will be quorate with 4 of the 7 Health Boards representatives, 1 JCC Clinical Director or deputy and the Chair or Vice Chair.

Meetings: The IPFR panel will normally be held as a minimum once per month, either virtually, face to face or a combination of both.

Urgent Cases: Provision will be made for occasions where decisions may need to be made urgently.

Where possible, a virtual panel will be held to consider urgent cases. If this is not possible due to the urgency of the request, or availability of panel members, then the Chief Commissioner with either the Medical Director or Director of Nursing and Quality and the Chair of the JCC Panel (or a vice chair) are authorised to make a decision outside of a full meeting of the Panel, within their delegated financial limits, on behalf of the Panel.

	Urgent cases will be reported at the next scheduled IPFR panel. An electronic National IPFR database of all cases will be maintained by AWTTC.
Recording:	The IPFR Coordinator will document the meetings to ensure panel discussions and decisions are appropriately recorded.
Training:	All Panel members will receive a local induction programme. Panel members should have the opportunity to attend a separate annual refresher session to ensure all members maintain the appropriate skills and expertise to function effectively.
Members Interest:	At the start of the meeting members must declare any personal or prejudicial interests relating to the discussions of the panel.
Consensus:	IPFR Panel members will seek to achieve decisions by consensus where possible. If the panel is equally split the Chair of the Panel will make the final decision.
Reporting:	The IPFR Chair shall: Report formally, regularly and on a timely basis to the Collaborative Commissioning Leadership Group (CCLG) on IPFR activities. Bring to the CCLG's attention any significant matters and ensure appropriate escalation arrangements are in place.
Review of the TOR:	The Terms of Reference of the JCC Panel will be reviewed in line with the All-Wales IPFR Policy.

APPENDIX 4

TERMS OF REFERENCE – REVIEW PANEL

PURPOSE

The IPFR Review Panel are constituted to act as a Committee of the Health Board and holds delegated Health Board authority to review (in line with the review process outlined in this policy) the decision-making processes of the Individual Patient Funding Request (IPFR) Panel.

The Review Panel may uphold the decision of the IPFR Panel or, if it identifies an issue with the decision-making process, it will refer the issue back to the IPFR Panel for reconsideration.

The Review Panel will normally reach its decision on the basis of all of the written evidence which is provided to it and will not receive any new information.

SCHEME OF DELEGATION REPORTING	**MEMBERSHIP AND ATTENDANCE**
The Review Panel has delegated authority from the Board to undertake reviews, limited to the purpose set out above. In exceptional circumstances, the Review Panel may also wish to make a recommendation for action to the Board. The action can only be progressed following its ratification by the Board (or by its Chief Executive in urgent matters).	• Independent Board Member – Lay (Chair of the Review Panel) • Independent Board Member (usually with a clinical background) • Executive Director or deputy (with a clinical background) • Representative from Llais • Chairman, Local Medical Committee, or deputy • JCC representative at Director level (as required) In Attendance: • IPFR Senior Officer (governance advisor) • JCC IPFR Senior Officer (as required)

PROCEDURAL ARRANGEMENTS

Quorum: As a minimum, the Review Panel must comprise 3 members (one of whom must have a clinical background, one must be an Independent Board Member, and one must be a Health Board Officer).

Meetings: As required.

Urgent Cases: It is recognised that provision must be made for occasions where reviews need to be heard urgently and before a full panel can be constituted. In these circumstances, the Health Board's Chair can undertake the review together with a clinical member of the Review Panel. This ensures both proper accountability of decision making and clinical input.

Recording: The IPFR Senior Officer will clerk the meetings to ensure a proper record of the review discussion and outcome is made.

See detail under section 6.12 on how JCC will undertake a review.

APPENDIX 5

NHS Wales Individual Patient Funding Request (IPFR) Policy Implementation Group

Terms of reference

1. Purpose of the Group

The purpose of the NHS Wales IPFR Policy Implementation Group (PIG) is to facilitate the commitment made by Health Boards and the Joint Commissioning Committee (JCC) to adhere to the NHS Wales IPFR Policy, providing and developing assurances systems and guidance to aid the decision making process. This includes areas relating to IPFR's, requests for routine treatment out of area, Interventions Not Normally Undertaken (INNU) and requests for treatment in other parts of the European Economic Area (EEA). The group will:

- Provide strategic leadership for the development and implementation of the IPFR policy and supporting documentation across all Health Boards and the JCC.
- Share good practice across all Health Board areas and promote continuous improvement.
- Review all policies that refer to IPFR to ensure that the policies are up to date, consistent and coherent.
- Provide a forum in which to share advice, support and assistance to ensure deliverance of a consistent process across Wales.
- Explore opportunities to ensure the IPFR process is widely understood by patients and clinicians, providing support on the process and application of IPFR's.
- Use best efforts to ensure the quality of data collection is in line with local and national reporting requirements.
- Monitor identified and emerging risks and advise on their prevention, mitigation and management.
- Work with and support the All Wales Therapeutics and Toxicology Centre on the development of the annual report in relation to IPFR's.
- Utilise the IPFR process to help inform key issues relating to possible future regional and / or national commissioning opportunities.
- Ensure active participation of key stakeholders when and where appropriate.

2. Membership of the Group

The IPFR network group will comprise of;

- A senior IPFR co-ordinator or nominated deputy from each Health Board and JCC.
- A senior member or nominated deputy from the AWTC

Other members may be included in the group as and when required.

3. Chair

The group will be chaired by an appointed member of the group.

The Chair will provide direction on the implementation of all decisions made by the group in relation to the development of the All-Wales policy, related guidance and assurance mechanisms.

All activities carried out under the auspices of the IPFR Policy Implementation Group are to be undertaken with prior agreement from the group members.

4. Frequency of Meetings

The group will meet bi-monthly. However, due to the nature of the work, the group may be required to meet more frequently on occasions, with additional work being done between meetings via email whenever possible.

The Terms of Reference will be reviewed periodically and amended accordingly.

5. Quorum

The quorum will be made up of any 5 members of the IPFR Policy Implementation Group.

NHS WALES PRIOR APPROVAL POLICY

Reference Number	Policy Reference (as per individual Health Board)	**Version Number**	FINAL July 2025
Linked Documents	Individual Patient Funding Request (IPFR) Policy Health Board Policies on Interventions Not Normally Undertaken (INNU)		

Classification of Document: Clinical Policy

Area for Circulation: Local Health Boards and Primary Care Providers across Wales
NHS Wales Joint Commissioning Committee (NWJCC)
Public domain via Internet sites

Development Group: All Wales IPFR Policy Implementation Group

Consultation: Commissioning / Planning Managers
IPFR Panel Members
NHS Wales Medical Directors

Date of Publication: July 2025

Lead Health Board Contact: IPFR Team, Betsi Cadwaladr University Health Board
BCU.IPFR@wales.nhs.uk
Tel : 03000 846880
Block 22, Glan Clwyd Hospital,
Sarn Lane, Bodelwyddan. LL18 5UJ

Review Date July 2028

1.0 INTRODUCTION

1.1 Background

1.1.1 In September 2016, following the 2014 review and implementation of its recommendations, the Cabinet Secretary for Health, Well-being and Sport agreed the time was right for a new, independent review of the Individual Patient Funding Request (IPFR) process. The review panel would be independent of the Welsh Government and encompass a range of expertise and knowledge.

1.1.2 The "Independent Review of the Individual Patient Funding Requests Process in Wales" report was published in January 2017 and made a number of recommendations to support the IPFR process. This includes the development of a clear and consistent national process for dealing with requests to access routine services outside of Local Health Board's existing arrangements (including those of the NHS Wales Joint Commissioning Committee)

1.2. Purpose of this policy

1.2.1 Continuing advances in technology, changing populations, better information and increasing public and professional expectations all mean that NHS Health Boards have to agree their service priorities for the application of their financial and human resources. Agreeing these priorities is a complex activity based on sound research evidence where available, sometimes coupled with value judgments. It is therefore important to be open and clear about the availability of healthcare treatments on the NHS and how decisions on what should be funded by the NHS are made.

1.2.2 Health Board's in Wales have a statutory responsibility to provide healthcare that meets the needs of their local populations in accordance with the NHS (Wales) Act 2006, the Well-being of Future Generations (Wales) Act 2015, Social Services and Wellbeing (Wales) Act 2014 and Cross Border Healthcare Services (April 2013). They achieve this by either directly providing healthcare or by commissioning healthcare from other service providers. In addition, the NHS Wales Joint Commissioning Committee (NWJCC), working on behalf of all Health Board's in Wales, commissions a number of more specialised services at a national level. The use of the term 'Health Board' throughout this policy includes NWJCC unless specified otherwise.

1.2.3 Consequently, patients should not be able to access healthcare services elsewhere unless **all** treatment options available within locally provided services or those commissioned by Health Boards have been exhausted and it is **clinically appropriate** to do so.

1.2.4 Each Health Board in Wales has a separate policy setting out a list of healthcare treatments that are not normally available on the NHS in Wales. This is because: -

- There is insufficient evidence of clinical and/or cost effectiveness

- The intervention has not been reviewed by the National Institute for Health and Care Excellence (NICE) or the All-Wales Medicines Strategy Group (AWMSG)'
- The intervention is considered to be of relatively low priority for NHS resources

The relevant policy for the patients' Health Board titled 'Interventions Not Normally Undertaken' (INNU) should be read together with this policy.

1.2.5 For the purpose of this policy, a prior approval is normally defined as a request for a patient to receive routine treatment outside of local services or established contractual arrangements. Such a request will normally fall within one of the following categories: -

- Second opinion
- Lack of local/commissioned service provision/expertise
- Clinical continuity of care (considered on a case-by-case basis)
- Transfer back to the NHS following self-funding in the private sector
- Re-referral following a previous tertiary referral
- Students
- Veterans

Further detail is provided in Section 5.

Requests **will not** be considered for retrospective funding.

1.2.6 This policy sets out to deliver the national context and provide clarity for referring clinicians and patients. Additional policy processes outlining specific commissioning, contractual and additional prior approval requirements may be in place and will vary across each Health Board.

1.2.7 For instances where funding is required for NHS healthcare for individual patients who fall outside the range of services and treatment that a Health Board has arranged to routinely provide, the Individual Patient Funding Request (IPFR) policy should be followed. Such a request would normally fall within one of the following categories: -

- A patient requires a treatment which is new, novel, developing or unproven and is not within the Health Board's routine schedule of services and treatment,
- A patient requires a treatment which is outside of existing clinical policy criteria,
- A treatment is required for a patient with a rare or specialist condition and is not eligible for treatment in accordance with the clinical policy criteria.

2.0 AIMS AND PRINCIPLES

2.1 Health Board's in Wales have a responsibility to secure services for their patients. Patients registered with a GP in Wales who are resident in Wales do not have a statutory right to choose which hospital they are referred to. The Welsh Governments view is that in general, Health Boards can best organise services to meet the needs of their patients when such services

are provided in Wales. This ensures equity in terms of access, convenience, and affords each Health Board the opportunity to strengthen and improve the quality of their local services thus providing a net gain for the whole community.

2.2 However, patients who are registered with a Welsh GP but are resident in England, or patients who are resident in Wales but registered with an English GP (Cross Border Patients) may have a specific right to choose their secondary care provider. The cross-border arrangements are specific to those Health Boards that share a border with England i.e. Betsi Cadwaladr University Health Board, Powys Teaching Local Health Board and Aneurin Bevan University Health Board the detail of which can be found in the Responsible Body Guidance for the NHS in Wales.

2.3 Each Health Board aims to ensure the establishment of simple uniform arrangements based around high quality, sustainable local services for their patients. Where these cannot be provided by the Health Board's own services for reasons such as resource, expertise or capacity, the Health Board will look to plan and secure necessary services with other appropriate NHS providers through its agreed care pathways. Where the service cannot be provided by the Health Board or contracted provider, the Health Board will plan to secure services from other appropriate providers.

The principles underpinning this policy include: -

2.4 **NHS Core Values** – set out by the Welsh Government as;

- Putting quality and safety above all else; providing high value evidence-based care for our patients at all times.
- Integrating improvement into everyday working and eliminating harm, variation and waste.
- Focusing on prevention, heath improvement and inequality as key to sustainable development, wellness and wellbeing for future generations of the people of Wales.
- Working in true partnerships with partner organisations and with our staff; and
- Investing in our staff through training and development, enabling them to influence decisions and providing them with the tools, systems and environment to work safely and effectively.

2.5 **Prudent Healthcare Principles**

- Achieve health and wellbeing with the public, patient and professionals as equal partners through co-production.
- Care for those with the greatest needs first, making the most effective use of all skills and resources.
- Do only what is needed, no more, no less; and do no harm.
- Reduce inappropriate variation using evidence-based practices consistently and transparently.

2.6 **Cross Border Healthcare Arrangements**

- Enable Cross Border patients to exercise their right of choice to a secondary care provider either in England or within the Health Board.

3.0 SCOPE OF THE PRIOR APPROVAL POLICY

3.1 This policy applies to: -

- The registered population within the geographical catchment area of the Health Board to whom it has a statutory responsibility for arranging services as outlined in the Local Health Boards (Directed Functions) (Wales) Regulations 2009. (*The Who Pays? Determining Responsibility for payments to providers in August 2013 states that although the Health Board has commissioning responsibility for English resident Welsh registered patients, they are the legal responsibility of the relevant CCG*)
- Secondary Care referrals only made by General Practitioners, Consultants and other clinically qualified health professionals with referral rights within the Health Board area.
- Tertiary referrals only made by consultants and clinical gatekeepers.

Please note - it is the clinician's responsibility to complete the application form. This ensures that adequate clinical information is provided to aid the decision-making process.

4.0 EXCLUSIONS

4.1 This policy does not apply to the following services: -

- Emergency Treatment
- Urgent suspected cancer referrals. All referrals for urgent suspected cancer must be **referred by e-referral** into the appropriate Health Board's respective tumour sites which have been set up in accordance with NICE guidelines. If a Cross Border patient has requested to be referred to a local hospital in England, then the referral will be made.
- Community based services such as district nursing.
- Looked After Children
- Requests for treatment in countries of the European Economic Area.
- The specialised services pathways established as part of the arrangements under The National Health Service Joint Commissioning (Wales) Regulation 2024.
- Requests which are judged to fall under IPFR or INNU.
- Reimbursement for private treatment

4.2 This policy does not apply to the following cohorts of patients: -

- Patients diagnosed with HIV/AIDS as outlined in the Welsh Governments HIV Actions Plan for Wales 2023-2026.

4.3 This policy does not apply to the following factors: -

- Non-clinical factors (such as employment status) will not be considered when making decisions on prior approval requests.
- Waiting time factors will not be considered when considering prior approvals as this will theoretically prioritise some patients over others who are in the same clinical position.
- Patient choice. The NHS in Wales does not operate a system of patient choice. However, cross border patients may be able to choose their secondary care provider.

4.4 This policy does not cover healthcare travel costs. Information on patient eligibility for healthcare travel costs to receive NHS treatment under the care of a consultant can be found on the Welsh Government's 'healthcare costs' website.

4.5 Referrals related to **participation (or potential participation) in a clinical trial**

No Prior Approval, or Individual Patient Referral Funding (IPFR) application is required if the purpose of the referral is clinical trial related i.e. if a patient wishes to participate (or explore potential participation) in an 'interventional' research study outside of Wales i.e. studies where the research protocol includes a treatment or intervention not otherwise available to the patient outside of a trial. There should be no barrier to a patient being seen by the trial site for this purpose, and no funding needs to be exchanged or be provided for the site to accept the referral.

The UK Policy is that costs associated with the referral are a research cost and as such must be met by the trial site (via the study grant for non-commercial studies, or by the commercial Sponsor for industry funded studies). This includes visits to the trial site at pre-screening stages prior to commitment or recruitment to the trial being confirmed, including where referrals that are more speculative for a range of potential trials open at the provider site, and includes the consultation costs and associated travel costs. The referring clinician will need to be assured that the patient at least broadly meets (or has potential through further screening/assessment to meet) the eligibility criteria for one or more trials that are open to recruitment at the provider organisation before a referral is made.

Note: If any support is required to expedite the referral, or if provider site requires more information on the UK Policy position, please escalate to Research-FundingSupport@wales.nhs.uk

5.0 GUIDING PRINCIPLES AND CRITERIA

5.1 **Second Opinion**

If a second opinion is required for routine treatment out of area, the requesting clinician must demonstrate that the patient has exhausted all local options where possible. The patient should first receive a second opinion from a consultant colleague within the same Health Board and then from a Health Board or English NHS Trust with whom a contractual agreement is held.

Please note; if a second opinion is approved, this does not automatically mean that funding will be provided for additional appointments and/or treatment.

5.2 **Lack of local service provision/expertise**

The NHS secondary care consultant or other care provider, for example a GP or dentist, with the support of an NHS secondary care consultant where available, needs to demonstrate that all local and locally commissioned service provision has been exhausted in order for an external referral to be considered for an 'expert' opinion. In addition, for reasons due to lack of local expertise, the clinician must demonstrate that the referral being made is to an 'expert' within that specific clinical speciality.

5.3 **Clinical continuity of care**

Whilst the Health Board understands the importance of continuity, we must endeavour to deliver the patient's care locally. Where comparable services are available locally, the patient will be referred to those services in the first instance. Clinical advice will be sought to ensure local services meet the needs of the patient's clinical condition.

Consideration for a patient to remain with an existing provider will only be given if their specific clinical condition warrants continuity of care and that there are circumstances, which if unaddressed, are likely to have a serious impact on the patient's continuing health and wellbeing.

Before funding on this basis can be considered, a comprehensive report/letter from the existing clinician highlighting the specific clinical reasons why the patient should remain under their care would be required.

If a patient moves into a Health Board's area, they will be expected to access local services. However, in some instances, patients may request to remain with an existing care provider based on 'continuity of care'. As outlined above, clinical information will be required to support the reasons for this.

5.4 **Transfer back to the NHS following self-funding in the private sector**

If a patient has self-funded their own referral/treatment in the private sector, the Health Board cannot be expected to fund ongoing treatment in the private sector. To ensure equity, all such referrals will be declined and the clinician advised to refer the patient to local or commissioned NHS services.

If, however, there is no local or locally commissioned service provision for the proposed treatment, the request for a referral to an external NHS consultant will be considered, based on the clinical information provided. The patient will be expected to receive all treatment with an NHS provider and should be added to the appropriate waiting list accordingly.

5.5 **Re-referral following a previous tertiary referral**

If a service is not available locally or within existing commissioned services, the Consultant/Clinical Gatekeeper may wish to refer a patient to a specialist centre for clinical advice and/or potential treatment. Following

the assessment/treatment, and when clinically appropriate, the patient should be discharged back to local services.

Patients frequently request to return to the same specialist centre for a 'new episode of care' based on 'clinical continuity'. When comparable services are available locally, patients will be expected to access the local services.

5.6 **Students**

Students who register with a GP in Wales where they are receiving further or higher education become the responsibility of the Local Health Board in that area and should be treated in accordance with the principles outlined with the Responsible Body Guidance for the NHS in Wales.

5.7 **Veterans**

The treatment of veterans should be undertaken in accordance with the principles outlined within WHC (2023) 022 Armed Forces Covenant – Healthcare Priority for Veterans

6.0 PROCESS UNDERTAKEN WHEN CONSIDERING A PRIOR APPROVAL REQUEST

6.1 Prior approval requests can be sent to BCU.IPFR@wales.nhs.uk

6.2 All prior approval requests are considered on their own merits using the guiding principles and criteria outlined in this document. Decisions are based on the clinical circumstances of the individual patient. It is therefore important to ensure that adequate clinical information is provided to aid the decision-making process.

6.3 Where the patient does not meet the guiding principles outlined above, the prior approval request will be declined.

6.4 Should an application be received which has not been completed sufficiently enough to determine whether or not the request meets the guiding principles and criteria, or the incorrect form has been completed, the form will be returned to the requesting clinician within five working days of receipt.

6.5 Prior approval requests made directly by a patient, or a patient representative will not be accepted. If a direct request is received, the patient will be advised to contact their GP or Hospital Consultant. Requests for referrals will not be accepted to private providers. The NHS cannot pay for or subsidise private hospital treatment.

6.6 A formal process will be held on a regular basis to ensure that correctly submitted and completed applications are considered in a timely manner. The volume and urgency of applications may require a decision more frequently as and when required.

6.7 A standard decision letter notifying the requesting clinician of the decision will be sent.

7.0 HOW TO REQUEST A REVIEW OF THE PROCESS

If a prior approval request is declined, a patient and/or their NHS clinician have the right to request information about how the decision was reached. If the patient and their NHS clinician feel the process has not been followed in accordance with this policy, they can ask for that decision to be reviewed.

8.0 WHAT IS THE SCOPE OF A REVIEW

There will be a period of 25 working days from the date of the decision letter during which a review may be requested.

The request for a review form should be completed clearly outlining the grounds for the review and sent to the Prior Approval team. The review panel will endeavour to meet within one month of the request being logged by the Health Board. Following the review, a decision letter will be issued to notify the patient and their clinician of the review panel's decision.

If new or additional information becomes available, the application will be reconsidered.

9.0 REVIEW PANEL MEMBERSHIP

The review panel should comprise: -

- Chair
- Senior Clinical Representative
- Senior Management Representative

10.0 CONFIDENTIALITY AND INFORMATION GOVERNANCE

In operating the prior approval policy, the Health Board will have due regard to the need to ensure that patient confidentiality is maintained at all times.

Each Health Board must comply with the requirements of the Data Protection Act and Caldicott Principles of Good Practice.

11.0 REVIEW OF THIS POLICY

This policy will be reviewed every 3 years or as required to reflect changes in legislation and guidance.

12.0 MAKING A COMPLAINT

Making a request for a prior approval does not conflict with a patient's ability to make a complaint to the Public Services Ombudsman for Wales. Further information is available on the Ombudsman's website www.ombudsman-wales.

Protocol: Board Visits

Version: 1.0

Date drafted: November 2025

Approved:

DRAFT

Board Visits Protocol

Foreword

"When we visit our services across North Wales, we are reminded that governance is ultimately about people. It is about understanding the realities of care through the eyes of those who deliver and receive it. As Board Members, these visits give us a deeper connection to the workforce and the communities we serve. They help us see beyond data and dashboards, bringing context and compassion to our assurance role. Each visit reinforces our collective ambition to build a culture that listens, learns, and continuously improves."

1. Purpose

This protocol sets out the arrangements for Board Visits within Betsi Cadwaladr University Health Board (BCUHB). It describes how members of the Board, both Executive and Independent, will engage directly with staff, patients, and service users to strengthen organisational culture, demonstrate visible leadership, and gain authentic assurance about the quality of care being delivered. The visits are designed to complement formal Board reporting and committee oversight, offering structured opportunities for members to experience services first-hand and to hear from those delivering and receiving care.

2. Scope

This protocol applies to all Board members, Independent and Executive, and to deputies or senior officers attending on their behalf. It covers visits across all areas of BCUHB's operations: acute hospitals, community and primary care services, mental health and learning disability services, and partnership arrangements. The Corporate Governance team are responsible for coordinating the visit programme, maintaining records, and ensuring findings and actions are reported into the appropriate governance forums.

3. Underpinning Principles

Board visits should embody the values and behaviours expected of all Health Board leaders. They should be purposeful, respectful and collaborative, focused on learning and engagement rather than inspection. Each visit should promote openness, curiosity, and mutual respect, reinforce the organisation's commitment to its cultural context, support a just and compassionate culture, and create a clear link between lived experience and the Board's formal assurance systems.

4. Governance Alignment

The Board Visits Programme forms part of the Health Board's wider governance and improvement framework. It complements systems for quality and safety oversight, workforce and culture development, and performance monitoring. Each visit is aligned with one or more IMTP strategic objectives, ensuring that insight contributes directly to understanding progress against priorities. Themes may include quality and safety, workforce wellbeing, mental health transformation, community and primary care, digital transformation, or estates and infrastructure. Each theme will have a designated Executive Lead accountable for planning, hosting, and follow-up.

5. Visit Process

The Health Board will maintain an annual rolling programme of Board Visits, developed collaboratively by the Corporate Governance Team, the Chair, and Executive Directors. The

DRAFT

programme will ensure that visits are spread fairly across the geography of North Wales and the full range of services.

Visits will normally be planned at least one quarter in advance. They will usually take place during the first week of each month, with additional themed visits linked to Board development sessions. Each visit will include a balanced team, typically one or two Independent Members, an Executive Director or their deputy, and a clinical representative (if relevant), to ensure diversity of perspective and expertise. Cancellations should be avoided wherever possible; if unavoidable, the visit must be rescheduled promptly and the reason recorded.

Before each visit, participants will receive a short briefing pack about the service. This will include background information, key performance or quality data, and a summary of the IMTP objective to which the visit relates. The Executive Director/Corporate Governance team will inform the workforce of upcoming visits to reinforce their purpose as supportive and learning-focused. Each service will nominate a local lead to greet the visiting team and confirm local arrangements for infection control and confidentiality.

On the day of the visit, the team will introduce themselves and explain the purpose of the visit. The tone should be informal and open, encouraging staff and service users to speak freely. Visits may involve a walkaround of clinical or community environments or a structured discussion with staff, depending on the context and preferences of the service. Board members should respect operational pressures, maintain confidentiality, and comply with local infection-control requirements. Any immediate safety concerns must be raised with the senior manager on duty before leaving the area.

After each visit, the team will hold a short debrief to agree key messages, reflections, and actions. One member will complete the standard visit record or online form, and a short thank-you note will be sent to the service summarising the discussion and any agreed actions. All visit records will be logged in the central Board Visits Tracker. Themes and learning will be triangulated with other sources of intelligence, such as incidents, complaints, compliments, and performance data and summarised for the Board.

6. Communications and Visibility

The purpose of communication around Board Visits is to promote openness and visibility without formality or fanfare. The intention is not to create a “red-carpet” feel or give the impression of inspection, but to support an ongoing conversation between the Board and staff.

On the day, visits should be informal and minimally disruptive. Photography and social-media activity should be limited and only used when there is clear value in showcasing good practice or thanking teams.

After the visit, the local service lead and the visiting members may agree a brief follow-up message, typically a few sentences for BetsiNet, local bulletins, or the “You Said, We Did” update, highlighting learning, positive practice, or actions being taken. Messages should focus on people, listening, and learning rather than on individuals attending.

The Communications and Corporate Governance Teams will work together to ensure consistency of tone and to maintain an archive of visit summaries for reference and transparency.

7. Evaluation and Continuous Improvement

The effectiveness of the Board Visits Programme will be evaluated through quantitative and qualitative measures, including the number and range of visits, staff and service feedback, and evidence of improvement. Reflections from Independent Members and Executives will be collated to capture learning and influence future decision-making. An annual summary report will highlight key themes and recommendations for the next cycle.

8. Review

This protocol will be reviewed annually by the Director of Corporate Governance, with input from the Chair. Feedback from participants and any changes to national policy will be considered, and updates will be approved through the appropriate governance route.

DRAFT

Board Visits – Appendices

Appendix A – Question Prompts

These prompts are designed to support open, honest conversations with staff, patients, and carers during Board Visits. They are not a checklist but a guide to help Board Members explore culture, quality, and lived experience in a respectful and curious way.

1. For Staff

Culture and Teamwork:

- How would you describe the culture in your team?
- Do you feel supported and listened to by your line manager and senior leaders?
- How do you and your colleagues celebrate success or recognise good practice?
- What gets in the way of delivering excellent care, and what would help most?

Safety and Improvement:

- How do you know your area is safe for patients and staff?
- Can you share an example of a recent improvement or learning from an incident?
- How confident do you feel that concerns are acted upon?

Wellbeing and Support:

- How are you and your colleagues supported to look after your own wellbeing?
- What one change would make the biggest positive difference to you at work?

Welsh Language and Inclusion:

- How is the Welsh language supported in your service?
- Are staff and patients able to use their language of choice in day-to-day care?

2. For Patients and Service Users

- Do staff introduce themselves and explain what will happen during your care?
- How well do staff listen to you and involve you in decisions?
- Do you feel safe and respected here?
- How easy is it to access information or communicate in Welsh or English?
- Is there anything that could make your care experience better?

3. For Carers and Relatives

- Do you feel welcome and involved in your loved one's care?
- Are you kept informed and able to raise concerns easily?
- Have staff offered information or support for carers?
- How flexible and responsive are visiting arrangements?

DRAFT

Appendix B – Visit Observation and Feedback Form

To be completed within seven days of the visit and submitted to the Governance Team.

Date of Visit:	
Service / Site:	
Service Lead Contact:	
IMTP Objective/Theme:	
Visiting Team: (Independent Member, Executive Lead, Clinical Representative)	
Section 1 – Overview	
Purpose of Visit:	
Key Staff / Groups Met:	
Section 2 – Observations and Reflections	
Positive Practice and Strengths Observed:	
Challenges or Concerns Identified:	
Notable Comments from Staff or Service Users:	
Welsh Language and Cultural Observations:	
Overall Impression of Culture and Morale:	
Section 3 – Agreed Actions and Follow-Up	
Action / Recommendation:	
Responsible Lead:	
Target Date:	
Follow-Up Outcome:	
Section 4 – Reflections for Board Reporting	
How does this visit align with the IMTP and Board priorities?	
What learning should be shared across the organisation?	

DRAFT

Are there issues that require escalation or wider review?	
Completed by:	
Date Submitted:	
Submitted to: Director of Governance / Improvement Team	

DRAFT

Appendix C – "You Said, We Did" Template

To provide feedback to staff and services after a Board Visit, showing how their input has led to action or recognition.

Theme / Topic
What You Told Us
What We Did / Plan to Do
Outcome / Impact

Example:

Theme / Topic
Staff Wellbeing
What You Told Us
Staff reported limited access to rest areas on night shifts.
What We Did / Plan to Do
Estates Team reviewed rest spaces; improvements scheduled for Q3.
Outcome / Impact
Staff reported improved morale and access to rest facilities.

DRAFT

Appendix D – Annual Visit Tracker (Aligned to IMTP)

A tracker maintained by the Corporate Governance Team to record visits, ensuring coverage across IMTP themes and geographical areas.

Date	Service / Site	Strategic Objective	Executive Lead	Independent Member	Key Learning / Issues	Actions Logged	Status (Open/Closed

DRAFT

Appendix E – Independent Member Reflection Form

To capture individual reflections from Independent Members following a visit, ensuring personal learning is integrated into collective Board understanding.

Date of Visit:

Service / Site:

IMTP Objective:

1. What struck you most about what you saw and heard?

2. What did you learn about the people delivering care and the culture of the service?

3. How does this connect to what you see in Board papers or reports? Did it challenge or reinforce your understanding?

4. What, if anything, should the Board pay more attention to as a result of this visit?

5. How will this experience influence your contribution at future Board or Committee meetings?

Signed: _____ Date: _____

DRAFT

Teitl adroddiad: ***Report title:***	Mental Health Act 1983 as amended by the Mental Health Act 2007. Mental Health Act 1983 Approved Clinicians (Wales) Directions 2018. **Update of Registers of:-** **1.** Approved Clinicians (All Wales) **2.** Section 12(2) Doctors (All Wales). Reporting Period: **3rd September 2025 – 5th November 2025**.
Adrodd i: ***Report to:***	Betsi Cadwaladr University Health Board
Dyddiad y Cyfarfod: ***Date of Meeting:***	27th November 2025
Crynodeb Gweithredol: ***Executive Summary:***	This report provides assurance of compliance with Mental Health Act legislation, policy, and process. The Board is asked to note the report's contents and formally ratify approvals granted through weekly action letters submitted by the Approval Team to the Executive Medical Director and their nominated deputy. The details presented are a summary of approvals for Approved Clinicians and Section 12(2) Doctor approvals across Wales. The report ensures governance records comply with the Mental Health Act 1983 (as amended 2007) and the Welsh Government Guidance Document. Approval is sought via Action Letters submitted to the Executive Medical Director, with final ratification by the Board. A bi-monthly approval process ensures transparency, as detailed in Appendices 1 and 2. The Board is asked to: **Note** the report's contents. **Ratify** approvals in line with Welsh Government Guidance and NHS Wales Mental Health Act Directions.
Argymhellion: ***Recommendations:***	The Board is recommended to: **Formally ratify** approvals delegated to the Executive Medical Director, in accordance with the All Wales Approval Panel recommendations
Arweinydd Gweithredol: ***Executive Lead:***	**Dr Clara Day** – Executive Medical Director, Office of the Medical Director.
Awdur yr Adroddiad: ***Report Author:***	**Meryl Roberts,** All Wales Approvals Manager for Approved Clinicians and Section 12(2) Doctors.

Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒

Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☒ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Betsi Cadwaladr University Health Board successfully bid to take over the function of the Welsh Ministers for the Approval Process in 2009 on behalf of all former Local Health Boards. Betsi Cadwaladr University Health Board (BCUHB) acting in its capacity as the main Approving Board for Wales, has continued to effectively undertake the delegated function of the Welsh Ministers for the approval of Approved Clinicians and Section 12(2) Doctors on behalf of all the Health Boards in Wales. The Approving Board and Process of Approval continue to fully meet all objectives.
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	The approval process meets Approved Clinician regulatory requirements set out in the Mental Health Act 1983 (as amended) and the 2008 No.1204 Mental Health (Mutual Recognition) Regulations 2008. The Health Board continues to ensure an effective approval, re-approval, suspension and termination of approval processes for Approved Clinicians and Section 12(2) Doctors in Wales is in place.
Yn unol â WP7 (sydd bellach yn cynnwys WP68), a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 (which now incorporates WP68) has an EqIA been identified as necessary and undertaken ?***	The approval process does not impact patient demographics or service provision. No disparities have been identified in the approval rates of different clinician groups. If future assessments indicate an impact, an EqIA will be undertaken.
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)***	There is currently a lack of Section 12(2) Wales Directions – which is recorded on Datix Risk Register (ID: 4134). The Approval Team and the All Wales Chair of the Approval Panel worked with Welsh Government to draft Section 12(2) Directions for Wales. Welsh Government advised the draft legislation would then be subject to legal review. We await the Directions to be legally reviewed and have not yet been provided with a timeline for this. The Approval Team and Panel Chair continue to seek engagement with Welsh Government for the draft Instructions to be enacted. **Workforce risks are actively managed.** Delays in approvals could impact clinician availability, but proactive steps (automated

	reminders and engagement strategies) are in place. Clinicians receive one reminder to attend a one day MHA refresher training course and three reminders to apply for re-approval. There is in place an automated reminder system for expiring approvals and proactive engagement with at-risk clinicians The Approval Team also communicate at-risk clinicians to their Clinical Directors.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	There are no budgetary implications. Resources for compliance oversight are managed by the Office of the Medical Director. Workforce risks are actively managed. Delays in approvals could impact clinician availability, but proactive steps (automated reminders and engagement strategies) are in place.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	The ratification of approvals by the Approving Board for all Health Boards is the final step in the process of granting approval or reapproval to the workforce in all of the Health Boards in Wales.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	This is an ongoing process.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	Lack of Section 12(2) Wales Directions is recorded on Datix Risk Register number ID: 4134.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** Implementation of recommendations of this report will be the final step in the ratification of approval process and will fully accord with all legislative and written process requirements.	
Rhestr o Atodiadau: ***List of Appendices:*** **<u>Appendix 1:</u> Update of Register of Approved Clinicians - Wales**. Mental Health Act 1983 as amended by the Mental Health Act 2007, Approved Clinician (Wales) Directions 2018. **<u>Appendix 2:</u> Update of Register of Section 12(2) Approved Doctors - Wales**. Mental Health Act 1983 as amended by the Mental Health Act 2007. All Wales Section 12(2) Process and Criteria Document.	

APPENDIX 1

Update of Register of Approved Clinicians in Wales	
	Approved Clinicians
Approvals and Re-approvals	22
Approvals suspended	1
Approvals re-instated or returned to work in Wales	0
Left Wales and Removed from Register)	0
Retired	0
No longer Registered	0
Transferred from AC register (to S12 Register)	0
Removed from S12 – Became AC approved	0
Approval Ended	3
Death in Service	0
Performance Metrics Reporting period: 3rd September 2025 – 5th November 2025	
Total number of AC applications received	17
Number awaiting completion of application by the applicant	5
Pending Approvals	4
Average processing time per completed application.	**Initial AC approval:** 8 days (includes fast track applications). **AC reapproval:** 9.33 days
Number of lapsed approvals due to missed deadlines by the applicant	0

APPENDIX 1

Mental Health Act 1983 (as amended by the Mental Health Act 2007)
Mental Health Act 1983 Approved Clinician (Wales) Directions 2018

Update of Register of Approved Clinicians - Wales

Ratification Period: 3rd September 2025 – 5th November 2025

Approvals and Re-approvals: 22

Surname	First Name	Workplace	Date Approval Expires
Chandrappa	Poornima	Aneurin Bevan University Health Board, 6 Gold Tops, Newport, NP20 4PF.	3rd August 2027
Luffingham	Mark	Cygnet Healthcare Ltd, Cygnet Alders Clinic, 155 Podsmead Road, Gloucester, GL1 5UA.	3rd September 2030
Vaidya	Shashikant	Seren Gobaith Independent Hospital, 64 Brighton Road, Rhyl, Denbighshire, LL18 3HL.	11th May 2027
Leonard	Richard	Hywel Dda University Health Board, Bro Cerwyn Day Hospital, Fishguard Road, Haverfordwest, Pembrokeshire, SA61 2PZ.	4th September 2030
Farquhar	Fiona	Betsi Cadwaladr University Health Board, Bryn y Neuadd Hospital, Aber Road, Llanfairfechan, Conwy, LL33 0HH.	7th September 2030
Porter	Stuart	Betsi Cadwaladr University Health Board, Hafod CMHT, Beechwood Road, Rhyl, Denbighshire, LL18 3EU.	10th September 2030

Surname	First Name	Workplace	Date Approval Expires
Smith	Jonathan	Cwm Taf Morgannwg University Health Board, Ysbyty Cwm Cynon, New Road, Mountain Ash, CF45 4BZ.	16th September 2030
Williams	Gemma	Aneurin Bevan University Health Board, Forglen House, St Mary's Street, Risca, Caerphilly, NP11 6GQ.	16th September 2030
Kele	Ildiko	Cwm Taf Morgannwg University Health Board, Dewi Sant Health Park, Pontypridd Taf Ely West CMHT, Albert Road, CF37 1LB.	22nd September 2030
Sakhuja	Divya	Aneurin Bevan University Health Board, Park Road Wellbeing Centre, Park Road, Pontypool,	23rd September 2030
Chakrabarti	Arpita	Cardiff and Vale University Health Board, University Hospital Llandough, Penlan Road, Llandough, Penarth, CF64 2XX.	2nd October 2030
Aslam	Ambreen	Cygnet Healthcare Ltd, St Teilo House, Goshen Street, Rhymney, NP22 5NF.	5th October 2030
Howe	Gareth	Aneurin Bevan University Health Board, Blaenau Gwent Community Learning Disability Team, The Bridge Centre, Foundry Bridge, Abertillery, NP13 1BQ.	6th October 2030
Argent	Sarah	Cwm Taf Morgannwg University Health Board, All Wales Forensic Adolescent Consultation & Treatment Services, Ty Llidiard, Princess of Wales Hospital, Coity Road, Bridgend, CF31 1RQ.	8th October 2030
Theologos	Georgios	Hywel Dda University Health Board, Gorwelion Resource Centre, Llanbadarn Road, Aberystwyth, Ceredigion, SY23 1HB.	9th October 2030
Hassan	Mohammad	Cwm Taf Morgannwg University Health Board, Rhondda CMHT Municipal Offices, Pentre, CF41 7BT.	10th April 2027
Khalid	Najeeb	Cwm Taf Morgannwg University Health Board, Mental Health Unit, The Royal Glamorgan Hospital, Ynysmaerdy, Llantrisant, RCT, CF72 8XR	12th October 2030
Oruganti	Radhika	Cardiff and Vale University Health Board, Liaison Psychiatry for Older People, 1st Floor, Monmouth House, University Hospital of Wales, Heath Park, Cardiff, CF14 0XW.	19th October 2030

Surname	First Name	Workplace	Date Approval Expires
Anjam	Muhammad	Aneurin Bevan University Health Board, Ysbyty Aneurin Bevin, Cwm Coch Mental Health Unit, Ebbw Vale, NP23 6GL.	22nd October 2030
Kale	Kishore	Cwm Taf Morgannwg University Health Board, Royal Glamorgan Hospital Ynysmaerdy, Pontyclun, CF72 8XR.	22nd October 2030
Leong	Kok Keong	Cwm Taf Morgannwg University Health Board, Royal Glamorgan Hospital, Llantrisant, CF72 8XR.	22nd October 2030
Kidman	Bonnie	Aneurin Bevan University Health Board, Forensic Psychiatry Service, St Cadoc's Hospital, Lodge Road, Caerleon, NP18 3XQ.	26th October 2030

Approvals Suspended: 1

Surname	First Name	Workplace	Date Approval Expires
Odume	Anthony	Formerly Powys Teaching University Health Board, Bro Hafren Community Mental Health Team, Back Lane, Newtown, SY16 2NG.	3rd May 2026

Approvals Reinstated or Returned to Work in Wales: 0

Surname	First Name	Workplace	Date Approval Expires

Left Wales and Removed from AC Register: 0

Surname	First Name	Workplace	Date Approval Expires

Retired: 0

Surname	First Name	Workplace	Date Approval Expired

No longer Registered: 0

Surname	First Name	Workplace	Date Approval Ended

Transferred from AC Register to S12 Register: 0

Surname	First Name	Workplace	Date Approval Expires

Approval Expired or Ended: 3

Surname	First Name	Workplace	Date Approval Expired
Jahan	Ali (Md)	Cygnet Healthcare Ltd, Cygnet Delfryn House Independent Hospital, Mold, Flintshire, CH7 6FQ.	2nd September 2025
Dhanushkodi	Rajasekar	Betsi Cadwaladr University Health Board, Denbighshire CAMHS Royal Alexandra Hospital, Marine Drive, Rhyl, LL18 3AS.	8th September 2025
Andrew	Martin	Cardiff and Vale University Health Board, Department of Traumatic Stress, Haydn Ellis Building, Maindy Road, Cardiff CF24 4HQ.	5th November 2025

Death in Service: 0

Surname	First Name	Workplace	Date Approval Expired

APPENDIX 2

Update of Register of Section 12(2) Approved Doctors - Wales	
	Section 12(2) Approved Doctors
Approvals and Re-approvals	9
Approvals suspended	0
Approvals re-instated/ returned to work in Wales	1
Removed (Left Wales)	0
Retired	0
Registered without a licence to practise and retired	0
Transferred from AC register (to S12 Register)	1
Became AC approved	0
Approval Ended or Expired	1
Death in Service	0
Performance Metrics - Reporting period: 3rd September 2025 – 5th November 2025:	
Total number of Section 12(2) doctor applications received	13
Pending approvals	5
Number awaiting completion of application by the applicant	2
Average processing time per application	Section 12(2) initial approval: 25.5 days Section 12(2) reapproval: 16 days
Number of lapsed approvals due to missed deadlines by the applicant.	0

APPENDIX 2

Mental Health Act 1983 (as amended by the Mental Health Act 2007)
Mental Health Act 1983 – All Wales Section 12(2) Process and Criteria Document

Update of Register of Section 12(2) Doctors - Wales

Ratification Period: 3rd September 2025 – 5th November 2025

S12 Approvals and Re-approvals: 9

Surname	First Name	Workplace	Date Approval Expires
Sharma	Bulbul	Swansea Bay University Health Board, Ty Einon Centre, Princess Street, Gorseinon, Swansea, SA4 4US.	23rd September 2030
Faisal	Mohammad	Swansea Bay University Health Board, Ty Garngoch Hospital, Hospital Road, Gorseinon, Swansea, SA4 4LH.	25th September 2030
Lydon	Mary	Independent Practitioner c/o Home Address	13th October 2030
Viswanath	Madappa	Hywel Dda University Health Board, Bryngofal Ward, Prince Phillip Hospital, Bryngwyn Mawr, Dafen, Llanelli, SA14 8QF.	13th October 2030
Metwali	Ramy	Cardiff and Vale University Health Board, St David's Hospital, Cowbridge Road East, Cardiff, CF119XB.	13th October 2030
Deshwal	Shivani	Betsi Cadwaladr University Health Board, Cefni Hospital, Bridge Street, Llangefni, Ynys Mon, LL77 7PP.	27th October 2030
Nnagha	Onyedika	Betsi Cadwaladr University Health Board, Pwll Glas Resource Team, Pwll Glas Road, Mold, Flintshire, CH7 1RA.	27th October 2030

Surname	First Name	Workplace	Date Approval Expires
Andrew	Martin	Cardiff and Vale University Health Board, Cardiff Traumatic Stress Service, Haydn Ellis Building, Maindy Rd, Cathays, Cardiff, CF24 4HQ.	29th October 2030
Gajdhar	Wamiqur	Betsi Cadwaladr University Health Board, Community Mental Health Team, Pwll Glas Resource Centre, Pwll Glas Road, Mold, Flintshire, CH7 1RA.	29th October 2030

S12 suspended: 0

Surname	First Name	Workplace	Date Approval Expires

S12 Approval Reinstated/Transferred/Returned to Wales: 1

Surname	First Name	Workplace	Date Approval Expires
Pandarangi	Disha	Cwm Taf Morgannwg University Health Board, Ward 14, Princess of Wales Hospital, Coity Road, Bridgend, CF31 1RQ.	6th July 2030

Removed (Left Wales): 0

Surname	First Name	Workplace	Date Approval Expires

Retired: 0

Surname	First Name	Workplace	Date Approval Expired

Registered Without a Licence and Retired: 0

Surname	First Name	Workplace	Date Approval Expired

AC Approval Ended and Became S12(2) Approved Only: 1

Surname	First Name	Workplace	Date Approval Expires
Owen	Angela	Independent Practitioner, c/o Home Address	13th December 2025

S12 Approval Ended or Expired: 1

Surname	First Name	Workplace	Date Approval Expired
Davey	Charlotte	Cardiff and Vale University Health Board, CAMHS, St David's Hospital, Cowbridge Road East, Canton, Cardiff, CF11 9XB.	29th September 2025

Death in Service: 0

Surname	First Name	Workplace	Date Approval Ended