

Bundle BCU Health Board 30 July 2026

- 1 09:30 - PRELIMINARY MATTERS
 - 1.1 09:30 - 26.133 Welcome, Introductions and Apologies for Absence
Dyfed Edwards, Chair
 - 1.2 09:33 - 26.134 Declarations of Interest relating to the Agenda
Dyfed Edwards, Chair
 - 1.3 09:35 - 26.135 Minutes of the Previous Meetings held on 28 May 2026 and 25 June 2026
Dyfed Edwards, Chair
 - 26.135.1 Minutes from Health Board Meeting 28.05.26 V0.3 (Public)
 - 26.135.2 Minutes from Health Board Meeting 25.06.26 V0.3 (Public)
 - 1.4 09:40 - 26.136 Matters Arising and Action Log
Dyfed Edwards, Chair
 - 26.136 Summary Action Log Health Board (Updated 23.07.26) Public
 - 1.5 09:45 - 26.137 Experience Item
Teresa Owen, Executive Director of Allied Health Professionals & Health Sciences
 - 26.137 Experience Item (iCAN)
 - 1.6 10:00 - 26.138 Chair's Report
Dyfed Edwards, Chair
 - 26.138 Chair's Report
 - 1.7 10:10 - 26.139 Chief Executive Report and Escalation Progress Report
Carol Shillabeer, Chief Executive
Chief Executive Report
Escalation Progress Report
 - 26.139 Chief Executive Report
 - 26.139a Health Board Escalation Update (003) - final
 - 1.8 10:20 - 26.140 Vice Chair's Report
Gareth Williams, Vice Chair
 - 26.140 Vice Chairs Report July 26 V1.0
- 2 10:25 - STRATEGIC ITEMS
 - 2.1 10:25 - 26.141 Tywyn Community Hospital - Case for Change
Paolo Tardivel, Interim Executive Director of Transformation & Strategic Planning
Link to Supporting Papers
 - 26.141 Tywyn Community Hospital - Case for Change
 - 2.2 10:40 - 26.142 Mental Health Strategic Report
Teresa Owen, Executive Director of Allied Health Professionals & Health Sciences
 - 26.142 Mental Health Report - Final - 27.07.26
 - 2.3 10:55 - BREAK
 - 2.4 11:05 - 26.143 All Ages Community Health Digital Solution – Outline Business Case
Carol Shillabeer, Chief Executive
 - 26.143 All Ages Community Health Digital Solution OBC V1.0

26.143.1 Appendix A - BCUHB Community OBC - Final 20260610 (4)

- 2.5 11:15 - 26.144 North Denbighshire GP Practice Sustainability Proposal
Tehmeena Ajmal, Chief Operating Officer
26.144 North Denbighshire GP Practice Sustainability Proposal
- 3 11:30 - INTEGRATED PERFORMANCE
- 3.1 11:30 - 26.145 Planned Care
Tehmeena Ajmal, Chief Operating Officer
26.145 Planned Care
- 3.2 11:45 - 26.146 Chair's Assurance Report - Quality, Safety and Experience Committee
Caroline Turner, Independent Member
26.146 AAA Report for QSE Committee 02.07.26 V1.1
- 3.3 11:50 - 26.147 Urgent and Emergency Care Progress Report
Tehmeena Ajmal, Chief Operating Officer
26.147 UEC revised report July 2026 - Final
- 3.4 12:05 - 26.148 Integrated Quality Report
Clara Day, Executive Medical Director
26.148 Integrated Quality Report - July 26
- 3.5 12:15 - 26.149 Chairs Assurance Report - Performance, Finance and Information Governance Committee
Gareth Williams, Vice Chair
26.149 AAA Report for PFIG Committee 23.06.26 V1.0
- 3.6 12:20 - 26.150 Integrated Quality and Performance Report
Russell Caldicott, Executive Director of Finance
26.150 IQPR Coversheet - HB
26.150.1 IQPR - HB
- 3.7 12:30 - 26.151 Finance Report
Russell Caldicott, Executive Director of Finance
26.151 Finance Report Coversheet - Month 3
26.151.1 BCU 2026-27 M03 Finance Report v2
- 3.8 12:40 - LUNCH
- 4 13:10 - GOVERNANCE, RISK AND ASSURANCE
- 4.1 13:10 - 26.152 Chairs Assurance Report: Audit Committee
Paul Lambert, Committee Chair
26.152 Audit Committee Assurance Report
- 4.2 13:15 - 26.153 Corporate Risk Register
Pam Wenger, Director of Corporate Governance
Link to Supporting Papers
26.153 Corporate Risk Register Report July 2026 V2
26.153.1 Appendix 3 Corporate Risk Register Report July 2026 (Public)
- 4.3 13:20 - 26.154 Response to UK Covid 19 Inquiry
Pam Wenger, Director of Corporate Governance

26.154 Response to UK Covid 19 Inquiry

- 4.4 13:30 - 26.155 Corporate Governance Report
Pam Wenger, Director of Corporate Governance
26.155 Corporate Governance Report V1.0
CG Appendix 5 - Protocol for Managing Questions from Members of the Public V0.1
- 4.5 13:35 - 26.156 Committee & Advisory Group Chair's Reports
Remuneration Committee, Dyfed Edwards
Planning, Population Health and Partnerships Committee, Clare Budden
People and Culture Committee, Dyfed Jones
Charitable Funds Committee, Dyfed Jones
Stakeholder Reference Group, Peter Lewis
Healthcare Professionals Forum, Emma Adamson
Executive Committee, Carol Shillabeer
26.156.1 AAA Report Remuneration Committee 14.7.26 v1.0
26.156.2 AAA Report for PPHP Committee 02.07.2026 V2.0
26.156.3 AAA Report for P&C Committee 11.06.26 V1.0
26.156.4 AAA Report for CFC Committee V1.0
26.156.5 AAA Report for SRG 01.06.26 V1.0
26.156.6 AAA Report for HPF 05.06.26 V1.1
26.156.7 Executive Committee Report (Public)
- 5 13:40 - CLOSING BUSINESS
- 5.1 13:40 - 26.157 Review of Meeting Effectiveness
Dyfed Edwards, Chair
- 5.2 13:42 - 26.158 Date of the Next Meeting - Thursday 24 September 2026
Dyfed Edwards, Chair
- 5.3 13:44 - 26.159 Resolution to Exclude the Press and Public
Dyfed Edwards, Chair

Betsi Cadwaladr University Health Board (BCUHB)

Unconfirmed Minutes of the Health Board Meeting

held in Public on 28 May 2026

at Venue Cymru, Llandudno

Board Members present	
Name	Title
Dyfed Edwards	Chair
Emma Adamson	Associate Member: Chair of Healthcare Professionals Forum
Tehmeena Ajmal	Chief Operating Officer
Clare Budden	Independent Member
Russell Caldicott	Executive Director of Finance
Clara Day	Executive Medical Director
Debbie Eyitayo	Executive Director of People and Organisational Development
Urtha Felda	Independent Member
Paul Lambert	Independent Member
Prof Mike Larvin	Independent Member
Peter Lewis	Associate Member: Chair of Stakeholder Reference Group
Dr Jane Moore	Executive Director of Public Health
Billy Nichols	Independent Member
Teresa Owen	Executive Director of Allied Health Professionals and Health Science
Fôn Roberts	Associate Member (Representative of Directors of Social Services)
Carol Shillabeer	Chief Executive
Caroline Turner	Independent Member
Rhian Watcyn Jones	Independent Member
Gareth Williams	Vice Chair
Angela Wood	Executive Director of Nursing and Midwifery
In Attendance	
Laura Jones	Corporate Governance Manager
Stuart Keen	Director of Environment and Estates
Emma Lea	Interim Assistant Director of Corporate Planning (part meeting)
Phylis Makurunje	Aspiring Board Member
Llinos Parry	Regional Manager, Maethu Cymru (part meeting)
Philippa Peake-Jones	Head of Corporate Governance
Geoff Ryall-Harvey	Llais Regional Director, North Wales
Helen Stevens-Jones	Director of Partnerships, Engagement and Communications
Pam Wenger	Director of Corporate Governance

PRELIMINARY MATTERS

26.81 Welcome, Introductions and Apologies for Absence

The Chair welcomed Board Members, members of the public and those viewing online to the meeting. Llinos Parry from Maethu Cymru was also welcomed to the meeting.

Apologies were received for Paolo Tardivel, Dyfed Jones, Chris Lothian-Field and Justine Parry.

26.82 Declarations of Interest Relating to the Agenda

Fôn Roberts declared an interest in Maethu Cymru due to the service received by Anglesey County Council.

26.83 Unconfirmed Minutes of the Health Board meeting held on 26 March 2026

It was resolved that the Board:

- **AGREED** that the minutes of the Health Board meeting held on 26 March 2026 were a true and accurate record subject to one amendment on page seven in relation to the Clinical Services Plan. It was requested that the sentence is amended to read 'the aim is to launch *the development* of the Plan' rather than 'launch the Plan'.

Reference was made to item 26.59 Chairs Assurance Report - Performance, Finance and Information Governance Committee of the minutes noting that an item on Planned Care had been received by the Committee at its last meeting held on 28 April 2026.

26.84 Matters Arising and Action Log

Members received the action log and noted progress against the actions.

In relation to the minutes from the Board held on 26 March 2026, the following were highlighted:

Item 26.54 Integrated Medium Term Plan Progress Report: Reference was made to the discussion around the savings achieved in relation to **Value and Sustainability** and the agreement to make this more visible going forward. It was suggested that this becomes an action that is tracked via the Performance, Finance and Information Governance Committee.

Item 26.67 Review of Meeting Effectiveness: It was queried whether any progress had been made towards agreeing a consent agenda for Board meetings. It was confirmed that this is being discussed further by the **Chairs Advisory Group** to ensure the Board can be satisfied that relevant reports have received the required scrutiny at Committee level and it was agreed to include this as an additional action.

Action:

- **26.84.1** Performance, Finance and Information Governance Committee to review how savings can be achieved in relation to Value and Sustainability to ensure this information becomes more visible.
- **26.84.2** The Chairs Advisory Group to further discuss the implementation of a consent agenda for relevant items reporting from Committees to Board.

It was resolved that the Board:

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

26.85 Experience Item

The Executive Director of People and Organisational Development and Director of Partnerships, Engagement and Communications introduced the experience item and a video presentation was shared with the Board:

- It was noted that the video features an Advanced Nurse Practitioner who has been a **Foster Carer** for the past ten years and highlights the challenges staff may face when taking on a fostering role.

- The story highlights the important role of the Health Board as one of the largest employers in North Wales to assist in increasing fostering capacity and supporting staff who wish to become a **Foster Carer**.

Llinos Parry, Regional Manager for Maethu Cymru highlighted the importance of the work:

- Llinos Parry thanked the Board for inviting an update from **Maethu Cymru** and considering the importance of this work.
- Organisations such as the Health Board play an important role in assisting staff to be able to support young people in care noting that an increase in foster carers is required to ensure young people feel safe and can stay close to schools and communities.
- The Health Board have the opportunity to demonstrate leadership as an anchor organisation to support foster carers noting that if the proposal is approved, a close working relationship can ensue to translate the proposal into action.
- Gaining endorsement from the Health Board will change the lives of local children and the Board were thanked for the work completed with **Foster Wales** to date.

It was resolved that the Board:

- **NOTED** the Experience item.

26.102 Proposal to becoming a Maethu Cymru / Foster Wales Partner and Foster Friendly Employer

This item was discussed following the Experience Item due to the relevance of the topic.

The Board received the report and the Executive Director of People and Organisational Development highlighted:

- The Health Board, as an anchor organisation, is well positioned to make a commitment to become a **Foster Wales Partner** and a **Foster Friendly Employer** to support the most vulnerable within our society.
- The report has been received by the People and Culture Committee who endorsed the proposal for Board approval.

In discussing the report, the Board:

- Welcomed the proposal and the need to be aware of the important elements involved including the experiences faced by children, the commitment required by foster families and the support needed for staff who wish to take on a fostering role.
- Queried whether this links in with adoption leave, it was confirmed that employment legislation has changed in relation to caring leave and there is a need to review all policies to ensure they fully support foster carers.
- Confirmed the need to encourage and offer opportunities to staff to become foster carers and provide support as this would increase the number of staff able to take on a fostering role, enrich the lives of children and young people and allow shared learning to take place across the organisation.
- Queried how this work could link up with other services across North Wales and remove any barriers as well as the need for the proposal to be fully costed to allow managers to be able to support requests. It was agreed that the work should develop through the Executive Committee and People and Culture Committee and report back to the Board in future.
- Highlighted the need to focus on issues concerning children and young people at the Board in a more comprehensive manner noting that the organisation have a corporate partnership

responsibility to ensure children have the best start in life and suggested this is developed further to ensure the Board have a focus in this area.

- Thanked Barry Graham-Jones, Advanced Nurse Practitioner for sharing his story and Llinos Parry for joining the meeting and requested that the positive message of commitment from the Board is shared with **Maethu Cymru**.
- Agreed to support the recommendations as a Health Board.

Action:

- **26.102.1** The work to develop the Health Board to become a Foster Wales Partner and Foster Friendly Employer to progress via the Executive Committee and People and Culture Committee and report back to the Board in future.
- **26.10.2.2** Further work to be completed to develop a focus on issues concerning children and young people at the Board in a more comprehensive manner.

It was resolved that the Board:

- **ENDORSED** the intention for Betsi Cadwaladr University Health Board to become a Maethu Cymru/Foster Wales Partner, aligning with Foster Care Fortnight.
- **NOTED** that becoming a Maethu Cymru/Foster Wales Partner reflects the Health Board's role as an Anchor Institution, supporting the wellbeing of children and young people and contributing to regional fostering capacity across North Wales.
- **NOTED** that BCUHB already has a strong foundation through its adoption of All-Wales People Services policies, which provide flexibility and support for employees with caring responsibilities, including foster carers.
- **SUPPORTED** further work in 2026/27, led by People and Organisational Development, to progress to achieving Foster Friendly Employer status, including review of relevant policies, supporting guidance, and organisational practice.
- **AGREED** that organisational progress will be presented to the People and Culture Committee for assurance.

26.86 Citizen Experience and Engagement Report

The Board received the report and the Director of Partnerships, Engagement and Communications highlighted:

- The report provides a strategic overview of citizen and community feedback focussing on the key themes emerging from areas including patient interaction, surveys and community discussions.
- The information highlights that further progress is required in areas such as patient experience and conditions relating to **Urgent and Emergency Care**, waiting times and delays across whole pathways, access to **Primary Care** and **Dentistry** as well as prevention and intervention.
- Alongside these issues, citizens continue to recognise outstanding staff kindness, compassionate care, positive feedback for services and messages of thanks for staff.
- The report demonstrates how the feedback received is providing opportunities for change and highlights action being taken and longer term plans being put in place.

In discussing the report, the Board:

- Noted that the information being captured provides a full picture of patient experiences highlighting frustration and concern in accessing services but recognising the satisfaction from staff providing care.

- Requested that each headline sets out where work is being progressed through other programmes including the expected timescales for delivery, to support oversight and identify any gaps. It was noted that this suggestion has also been raised at the Planning, Population Health and Partnerships Committee in relation to lines of sight across the Health Board, and that this would be reflected in the next iteration of the report and will continue to evolve.
- Highlighted the regional work that is taking place with **Local Authorities** to strengthen prevention and support people to live healthier. The work taking place with partners to increase preventative steps was acknowledged noting that this will take time to embed however progress is being made and momentum is increasing.
- Queried how the feedback received is contributing to improved performance. It was confirmed that feedback is being shared with individual teams at service level and work is taking place to identify issues, implement actions and monitor outcomes, work with the **Emergency Departments** is also taking place around patient experience.
- Confirmed that going forward this work needs to be embedded into routine service delivery to ensure change is progressed through existing practice and programmes of work. There is a need for a relentless focus on the areas where feedback highlights dissatisfaction and the Board will be required to drive forward the improvements being made.

It was resolved that the Board:

- **NOTED** the key themes from citizen feedback.
- **ASSURED** itself that citizen voice is shaping organisational objectives and decision-making, as well as operational improvements.

26.87 Chair's Report

The Board received the report and the Chair highlighted:

- The **May elections** to the **Senedd** resulted in the formation of a new government and the detail is included within the report.
- A meeting took place in Ysbyty Glan Clwyd yesterday with the **Cabinet Minister for Health and Care** which included a visit to the **Emergency Department** and meetings with the additional **Ministers** will take place in due course.
- There are now 24 Senedd Members across all political parties with North Wales and work will continue to engage positively to support the work taking place in the representative constituencies to address the concerns of residents and support the preventative work taking place.
- Celebrations events have taken place to commemorate 25 years since the recruitment of Filipino nurses within the Health Board. The contribution and commitment from the nurses was noted as exceptional, highlighting the international culture within our workforce.
- The **Shackleton Play** took place at Tŷ Llywelyn, Bryn y Neuadd supported by the **Arts in Health Team** which is a project to support residents and staff. This provides a reminder of the support that can be provided by services in relation to **Health and Wellbeing** and is an important area of work that delivers benefits for patients.

In discussing the report, the Board:

- Referred to the **NHS Wales Digital Conference** and queried how the organisation compares with other Health Boards and Nations in this area. It was noted that there is a need for greater clarity on how to move forward in this space. The new **Government** are ambitious in this field and recognise digital as a key enabler however Wales currently remains behind elsewhere in terms of digital progress. The contribution from others at the conference was helpful and will allow elements of learning to be shared. The progress

completed to date along with the digital ambition of the Health Board was recognised, emphasising the importance of maintaining momentum and driving forward change in this area.

It was resolved that the Board:

- **NOTED** the content of the report.

26.88 Chief Executive's Report

The Board received the report and the Chief Executive highlighted:

- The **NHS Wales Escalation and Accountability Arrangements** are now in place noting that the Health Board remains a level five organisation which is the highest level of escalation. Due to the levels of escalation, **Welsh Government** have introduced a Performance Framework which has been identified via the **Ministerial Advisory Group Report**.
- Due to the organisation being at level five escalation and in line with the new arrangements, monthly meetings will be taking place with representatives from **Welsh Government**. The first **Escalation Board** took place on 14 April 2026 with the next meeting scheduled for 29 May 2026. It was requested that Board Members receive communication following the meeting taking place tomorrow.
- Board Members are being sighted on the correspondence in relation to these meetings and the Informal Board meeting provided an opportunity to discuss this in further detail.
- The Director of Corporate Governance confirmed that the **Corporate Governance Report** now includes a summary of matters discussed within Informal Board meetings to provide transparency and assurance to the public around how the Health Board transacts its business.
- A **Culture Change Leaders Celebration Event** took place during April 2026 noting that there are now approximately **200 Leaders** across the organisation. The event provided an opportunity to recognise and celebrate this work, hear local examples of improvement, and reflect on how compassionate and inclusive leadership is being embedded in practice noting the need to continue to strengthen a consistent culture across the organisation.

In discussing the report, the Board:

- Referred to the socialisation of the **Foundations for the Future Programme** and the Delivery Plan being presented to the People and Culture Committee on 11 June 2026. It was agreed to extend the Committee invite to Board Members for this item.
- Acknowledged that the finalisation of the structures element will be shared with Board Members noting that the consultation period will provide another opportunity for staff to share their views for consideration.

Actions:

- **26.88.1** The Chief Executive to provide communication to Board Members following the Escalation Board taking place on 29 May 2026.
- **26.88.2** Extend the invite for the People and Culture Committee taking place on 11 June 2026 to Board Members for the Foundations for the Future item.

It was resolved that the Board:

- **NOTED** the content of the report.

26.89 Vice Chair's Report

The Board received the report and the Vice Chair highlighted:

- The **Seren Mother and Baby Unit** at the **Countess of Chester Hospital** which has been jointly funded by the Welsh NHS in order to provide beds for mothers and babies from North Wales. The Vice Chair visited the unit which provides an environment to support mothers suffering from acute mental ill-health and also noted that the service provides bilingual signage and materials.
- A **'Treat and Train' Optometry facility** has been established in **Holywell Hospital** to train optometrists working within the community to offer a range of additional services. Thanks were extended to those driving the work forward.

It was resolved that the Board:

- **NOTED** the content of the report.

STRATEGIC ITEMS

26.90 Community by Design

The Board received the report and the Chief Operating Officer highlighted:

- Initial conversations have been taking place at the Informal Executive Committee and Planning, Population Health and Partnerships Committee around the opportunities for delivery within the community space.
- **Community by Design** is a nationally initiated programme aligned to a long-standing **Welsh Government** policy direction towards integrated, preventative and community-based care and provides significant opportunities for health and care services.
- The underlying principles include designing services with communities and working in partnership to move beyond primary care and focus on a whole system approach where activity is based in the community by default and in an acute setting by exception.
- There will be a focus on a move towards a **well-being and prevention led system** to support citizens to take greater ownership of their health.
- This would be part of a national programme with regional differences across North Wales and would provide significant transformation opportunities for partners and providers.
- There will be a need for a cultural shift in the expectation of the provision on care and a need to invest in communication to enable care to be provided as close to home as possible and ensure citizens only attend acute services when necessary.
- The diagram included on page seven of the report highlighted how **Community by Design** aligns with **Planned Care** and **Urgent and Emergency Care** supported by the **Clinical Services Plan** noting this is not a separate programme of work.
- The Health Board are being asked to support the framing of the **Community by Design programme** as the core operating framework for community-based transformation and provide a commitment to adopt a different perspective to how services are provided in the future.

In discussing the report, the Board:

- Acknowledged the journey required in this area and suggested it would be useful to see the steps of where, how and when this work will develop querying how this will translate into progress over the next 12 months to ten years. It was confirmed that the team are cautious about developing a plan at this stage as further discussions are required with partners to ascertain what is currently taking place within communities which will allow a shared approach to be developed that is owned by all involved in this area of health.

- Recognised that the Health Board is an anchor organisation and suggested clarity is required on the role of the Board as members of the community.
- Noted that in order to drive changes in health outcomes there is a need to focus on proactive **prevention and early intervention** to reduce the escalation of risks becoming issues. This requires co-design with communities to help address **health inequalities** and support a broader, non-medical approach to health which aligns to the work relating to the **Inverse Care Law**.
- Confirmed that discussions are taking place around workforce including nurse recruitment placements and the **Community by Design programme** may provide an opportunity to reimagine the distribution of workforce across communities noting that the requirement for significant workforce planning to be sustained for the future. It was confirmed that the discovery work will facilitate a detailed review of resource requirements.
- Highlighted that this area of work is also being addressed within the **Ten Year Strategy** and the **Foundations for the Future programme** and noted that dedicated resource will be required to move this forward as well as strong relationships with partners. It was confirmed that dedicated senior and strategic staff will be aligned to deliver this programme of work.
- Referred to **Key Performance Indicators** noting that the Board and Planning, Population Health and Partnerships Committee are unsighted in this space and suggested further work is required around data and reporting arrangements. It was agreed that data sharing has been an issue and addressing this will help to develop **Health and Wellbeing services** for the population of North Wales.
- Queried whether work is taking place to analyse the barriers as to why this has not been facilitated in the past. It was confirmed that an initiative was previously put in place and that needs to be reviewed in further detail to ensure any learning is transferred to this programme.
- Recognised that the greatest influence and impact on health takes place within communities noting the work that is already taking place to develop Mental Health services and the Audiology and Cardiology vans that are present within communities. It was confirmed that the discovery work will be important to identify what specific services are available in which areas and what may need to be rolled out across the Health Board.
- Acknowledged that transformation in this area will take time to deliver. Clear learning is available from past experiences and there will be a need to agree principles that offer a consistent offer with flexibility in delivery and clear measures to highlight progress. Improving population health will take a generation and require long-term ambition therefore investment in people and skills will be essential.

It was resolved that the Board:

- **NOTED** the strengthened strategic intent, informed by system-wide engagement and evidence.
- **SUPPORTED** the framing of Community by Design as the core operating framework for community-based transformation.
- **ENDORSED** the focus on outcomes, co-design, prevention and system integration.
- **SUPPORTED** the proposed next steps, including clear prioritisation and early demonstration of impact.
- **AGREED** that the Planning, Population Health and Partnership Committee take a lead on the oversight and delivery in accordance with the Integrated Medium-Term Plan.

26.91 Penley Community Hospital – Case for Change

The Board received the report and the Chief Operating Officer highlighted:

- Discussions have taken place around the need to temporarily close **Penley Community Hospital** due to significant and ongoing concerns regarding workforce sustainability, patient safety and service viability.
- A comprehensive review has been undertaken which demonstrates that the inpatient bed-based model at **Penley Community Hospital** is no longer clinically safe, sustainable or aligned with population need.
- A wide range of engagement has been undertaken including two independently facilitated “Balanced Room” sessions and wider engagement with residents, staff, third sector partners, clinicians and local authority representatives.
- This engagement has informed the development of three viable future service options via an open process noting that the three proposed and clinically supported alternative options for further consideration are included in the report.
- There are a number of next steps which include developing consultation documentation, a **formal consultation period**, a post consultation analysis and decision making by the Board in December 2026 / early 2027.
- The **Llais Regional Director for North Wales** noted that the Case for Change process has been well received locally. Residents have requested that the resource allocated to Penley remains in the area and would like enhanced local **Primary Care services** that are multi functional. The support from **Llais** was acknowledged and welcomed by the Board.

In discussing the report, the Board:

- Referred to the area where **Penley Community Hospital** is based and encouraged all Board Members to visit the area and gain an understanding of the community setting including transport links.
- Queried whether sustainability has been part of the options assessment. It was confirmed that it has and an agreed set of criteria have been developed that can be sustained.
- Highlighted that working within the previously allocated resources may be difficult as this may have been incorrect and suggested the service is evaluated around population need, the requirements of the community and aligning the service to contribute to the **Community by Design** principles before reviewing the costing element.
- Noted that as this is an area of service change, it is a **matter reserved for the Board** therefore the resolution would need to be clear in terms of the decision of the Board and an additional recommendation was proposed.
- Acknowledged the level of detail included in the supporting papers which are critical to the consultation and the decision-making process of the Board; including the impact assessments and relevant supporting papers for transparency.
- Noted that the timeline as to when this will return to the Board for decision making, will potentially be in January 2027.
- Confirmed that the Strategic Planning and Service Change Group have been overseeing the progress of the Case for Change noting the need to ensure the Board are kept informed as the engagement consultation progresses as well as the need to progress at pace towards the end of the year.

Action:

- **26.91.1** The Director of Corporate Governance to advise on the inclusion of an additional recommendation as this is a matter reserved for the Board and confirm with the Interim

Executive Director Transformation and Strategic Planning when Penley Community Hospital will return to the Board for final decision making.

It was resolved that the Board:

- **APPROVED** the proposed options for the purposes of formal public consultation, noting that no preferred option or final decision is being sought at this stage;
- **APPROVED** to commence the public consultation and that the outcome of the consultation was planned for January 2027 in accordance with the timescales in the report.

INTEGRATED PERFORMANCE

26.92 Chair's Assurance Report - Quality, Safety and Experience Committee

The Board received the report and the Committee Chair highlighted:

- The **Patient Story** received by the Committee had been supplied by **Llais** and focused on people living with Bipolar symptoms highlighting the need to understand the impact of people living with specific conditions and ensuring appropriate services are provided. The video was made available via the link in the report and it was noted that a community screening would be taking place at the Community Cinema in Porthmadog on 15 July 2026.
- The importance of data has been raised by the Committee and reports being presented are starting to provide appropriate data more fully for consideration.
- The Committee continue to receive updates on the **Clinical Services Plan** and **Challenged Services** noting the level of oversight being provided.
- The importance of **Welsh Language services** has been discussed by the Committee along with the need to offer services to patients in their language of choice and it was confirmed that the People and Culture Committee have oversight of the monitoring of Welsh Language and Culture as part of the Committee remit.

It was resolved that the Board:

- **NOTED** the content of the report.

26.93 Integrated Quality Report

The Board received the report and the Executive Director of Nursing and Midwifery and Executive Medical Director highlighted:

- The change in legislation entitled **Listening to People: The NHS Complaints, Incident and Redress Process** has been successfully implemented across the Health Board. This has enabled more listening conversations to take place, and congratulations were extended to the teams in clinical areas who are facilitating these discussions and dealing with concerns without the need for formal process.
- Performance against **Nationally Reportable Incidents** is positive noting that this area is consistently reviewed and progress is being made in relation to clinical audits. There has been greater focus on areas that have seen increased incidents and this is being monitored.
- **Health Inspectorate Wales** inspection action plans remain in progress, with some overdue actions requiring continued monitoring. **Health Inspectorate Wales** inspections are taking place at the **Emergency Department** in Ysbyty Glan Clwyd and work continues to ensure action plans are fit for purpose.
- Progress continues to establish the **Quality Management System** and further work is taking place to embed this into strategic planning as business as usual going forward.

In discussing the report, the Board:

- Queried how the **Quality Management System** will be embedded and what are the resource issues. It was confirmed that the work taking place around planning will feed into this and help to embed the system. In terms of resource, some services are less mature from a leadership perspective and therefore require additional wrap around support which is being provided.
- Suggested the report includes more information on process rather than impact and action which raises some challenges around overdue actions and requested further assurance in this area. It was confirmed that deep dives are taking place into specific themes and this is being discussed at the Quality, Safety and Experience Committee and linking through to the Board via the Chair's Assurance Report. There is a need to balance the length of the report with the amount of data included. Processes are in place to complete the actions required and the teams are working to embed these actions.
- Confirmed that the **Health Inspectorate Wales** inspections taking place at the **Emergency Department** in Ysbyty Glan Clwyd are critical and following the inspection, a submission will be provided with a revised action plan for immediate assessment and this will be shared with Board Members and overseen by the Quality, Safety and Experience Committee. It was also confirmed that once the report is in the public domain, the Board will require assurance on the response provided and the improvements required as **Urgent and Emergency Care** is a priority area of concern for the Health Board.
- Referred to complaints around attitude and behaviour and it was confirmed that complaints of this nature are routinely addressed. Support is provided to the relevant teams and work is taking place in line with the **Culture Champions programme**.
- Highlighted the **Call4Concern** patient safety initiative in Wales which is the alternative to Martha's Rule in England. It was confirmed that this is being implemented in line with the Welsh Health Circular noting that the timescales in Wales are different to those in England.
- Noted that work is progressing around learning and embedding culture change stating that this needs to be fully integrated across the organisation. The **Foundations for the Future programme** will support this area of work and enable managers to have time together to reflect. This has also been discussed by the Audit Committee around how this area of work can be embedded into practice and will be reflected in the Annual Report.

Action:

- **26.93.1** The submission to Health Inspectorate Wales in response to the inspection at the Emergency Department at Ysbyty Glan Clwyd to be shared with Board Members once complete.

It was resolved that the Board:

- **RECEIVED ASSURANCE** from the report noting that all exceptions within the report are being monitored and have management plans to track completion.
- **NOTED** the action plans are tracked through core quality forums.

26.94 Urgent and Emergency Care Progress Report

The Board received the report and the Chief Operating Officer highlighted:

- The tone of the report reflects the level of concern that remains as a Health Board around **Urgent and Emergency Care** in terms of ambulance handover times, the number of people moving through the department and the length of time people are waiting.
- Work is taking place with the **Intervention and Support Team** around flow and congestion, and the findings will be reflected in the **90-day Operational Improvement Plans** being developed with support from the Improvement Advisor.



- Discussions are being held with Local Authorities to ensure everyone is working with the shared purpose of directing people to the correct service.
- Proactive conversations are taking place with the **Welsh Ambulance Service Trust** around how to manage patients within the communities to avoid bringing people in through the **Emergency Departments**.
- Some improvements are being made, in particular in the Wrexham Maelor Hospital and work is taking place around disciplines on site for the number of ambulances waiting outside.
- There are significant issues in Ysbyty Glan Clwyd and there is a need to understand why performance fluctuates on a daily basis and address these areas of concern.
- There is a need to utilise space and staffing, identify dedicated resource to drive forward improvements and ensure a focus on safety, experience and outcomes for patients noting that this area of work aligns to the **Community by Design programme**.
- There is also a need to recognise the challenging working conditions within **Emergency Departments** and to provide appropriate support to ensure staff can work effectively.

In discussing the report, the Board:

- Confirmed that the report has been received by the Quality, Safety and Experience Committee as this is a critical service area and queried how staff can manage the service on a daily basis whilst also trying to enable long term sustained improvements. It was confirmed that this is intertwined with clinical and operational delivery. Incremental changes are being made however patient safety is a main area of focus and there is a need to move forward with improvements that have a direct impact in this area.
- Referenced a workshop that has taken place with the Health Board and the Local Authorities where discussions took place around complex processes that were prolonging hospital stays while patients awaited care plans. It was suggested that a proportionate level of risk may be needed to enable discharges to take place before care plans are finalised. It was confirmed that there is a need to support practitioners to make decisions and manage risk. This is based around culture, and additional support is required.
- Noted the need to review the whole system approach, ensure senior decision makers are available at the front door and facilitate a Health Board wide process to start to address this issue.
- Queried what action will result from the **90-day Operational Improvement Plans**. It was confirmed that the plans will focus on delivery, including the internal and external redirection of patients where required. The importance of clearly setting out the actions, timescales and expected impact was emphasised.
- Referred to the **Emergency Department Business Case** and the need to progress permanent posts and invest in staff. It was confirmed that this is expected shortly and will enable staffing issues to be addressed noting that the financial challenges have been highlighted to the **Cabinet Minister for Health and Care**.
- Enquired whether the Quality, Safety and Experience Committee should have oversight of this work as **Urgent and Emergency Care** is also critical to other areas of work. It was confirmed that the Quality, Safety and Experience Committee have a role to monitor progress against improvements and focus on safety and the Performance, Finance and Information Governance Committee have a role to track the progress against the plan noting that both Committees are required to provide assurance back to the Board.
- Requested that the **Emergency Department Business Case** is completed. A report on the implementation of the **90 day Operational Improvement Plans** is received at the next Board meeting in July 2026 and the relevant Committees provide assurance on the discussions that have taken place in relation to **Urgent and Emergency Care**.

Action:

- **26.94.1** The report to the next Board meeting in July 2026 to confirm progress against the completion of the Emergency Department Business Case, the implementation of the 90 day Operational Improvement Plans and provide assurance on the discussions held by Quality, Safety and Experience Committee and the Performance, Finance and Information Governance Committee.

It was resolved that the Board:

- **NOTED** the current performance and risk position.
- **SUPPORTED** the requirement for accelerated system-wide action on flow and discharge.
- **ENDORSED** strengthened operational accountability at site and system level.
- **MAINTAINED FOCUS** on delivery of measurable improvement over the next 90 days.

26.95 Chairs Assurance Report - Performance, Finance and Information Governance Committee

The Board received the report and the Committee Chair highlighted:

- The Committee have requested that the Executive Committee escalate data on theatre productivity within performance reporting as there is no evidence of positive change and this data requires a more prominent role in reporting. It was confirmed that a senior leadership session has taken place to discuss productivity and the areas of focus required noting that additional support is required to make improvements in this area.

It was resolved that the Board:

- **NOTED** the content of the report.

26.96 Integrated Quality and Performance Report

The Board received the report and the Executive Director of Finance highlighted:

- The report style is currently being redeveloped, a draft is due to be shared at the next Performance, Finance and Information Governance Committee and will come back to the Board in due course noting that a copy of the draft will be shared with Board Member in advance for comment.
- In relation to Workforce and Organisational Development, assurance was provided that staff wellbeing continues to be an area of focus and a **Staff Wellbeing Organisational Position Report** will be presented to the next People and Culture Committee being held in June 2026.

In discussing the report, the Board:

- Queried the 7% rate of General Practitioners referring urgent suspected cancers. It was confirmed that this is a positive percentage as the pathway is designed to be around 5% or less. There is a need to balance urgent and routine capacity noting that Cancer pathways are different as patients move between categories on the pathway.
- Noted that the rate of cancellations has deteriorated and queried whether this needs to be addressed. It was confirmed that patients cancel for a number of reasons and interventions are in place. It was also noted that detailed work is taking place in a number of areas to identify elements of decline and resolve.

It was resolved that the Board:

- **NOTED** the content of the report.



26.97 Integrated Performance and Accountability Framework 2026-2029

The Board received the report and the Chief Executive highlighted:

- A number of conversations have taken place in relation to the Health Board's journey to become a high performing organisation with the relevant systems and processes in place and the **Integrated Performance and Accountability Framework 2026-2029** addresses a range of areas.
- The document was considered in draft at the last Board meeting in March 2026 and the comments shared have been taken into account noting that the document has been revised to demonstrate the balance more clearly.
- If the document is approved, the next step will be to undertake an initial assessment of services and directors in relation to areas including culture, finance, productivity, governance and risk and an assessment of delivery will be completed.

In discussing the report, the Board:

- Welcomed the changes made and stated the need for implementation and review in line with controls.
- Queried what analysis has been completed in relation to the barriers and how this is different to previous processes. It was confirmed that the Framework helps to identify why services are not performing and where there are issues. The aim is to reach a position where staff have high autonomy and accountability and the Framework supports teams to address and improve performance.
- Noted the need for this approach to support the Health Board's improvement journey allowing progress to be reviewed as we move forward.
- Confirmed that as work takes place on implementing the Framework, the Performance, Finance and Information Governance Committee will have oversight of the progress and will report to the Board.

It was resolved that the Board:

- **APPROVED** the Integrated Performance and Accountability Framework 2026-2029 for implementation.

26.98 Finance Report

The Board received the report and the Executive Director of Finance highlighted:

- The original deficit position of £17.3m for 2025/26 has been reforecast to a position of £17.4m. The External Auditors are currently completing their assessment and the findings will be reported back to the Audit Committee on 23 June 2026 and the Health Board on 25 June 2026 to endorse the accounts.
- The Health Board submitted a deficit plan totalling £43m for the 2026/27 financial year, in relation to month one there is an in-month deficit of £5.4m which is £1.8m adverse compared to the Month 1 profiled financial plan deficit of £3.6m.
- The adverse position reflects a £3.2m shortfall in savings delivery for the month, partially mitigated by the continued application of the enhanced grip and control measures and work is taking place to review the measures in place.
- There is a requirement to submit a financial recovery plan which will focus on elements of performance and align to **Welsh Government** controls and this will be shared with the Audit Committee and the Performance, Finance and Information Governance Committee.

In discussing the report, the Board:

- Noted the current position and the shortfall in savings delivery, it was confirmed that if a decision is made to profile to deliver savings, then some of those savings may become available later in the year and there will be a need to reprofile as we move forward. A clear view of projections for the whole of the financial year is essential.
- Highlighted that the financial situation is difficult across Wales and there will be difficult decisions to be made by the Board. There will be a need to utilise funding and resource more effectively and suggested further detail is provided to the Board due to the significance of the challenge.

Action:

- **26.98.1** Further detail on the financial position to be provided to the Board due to the significance of the challenge.

It was resolved that the Board:

- **RECEIVED ASSURANCE** from the content of the report.

26.99 Annual Delivery Plan 2025/26 - Quarter 4 Progress and Key Programmes Report

The Board received the report and the Interim Assistant Director of Corporate Planning highlighted:

- The item includes two reports which highlight progress against the **Annual Delivery Plan** and the **Key Programmes**. Appendix 2 was not included in the papers but will be made available as this summarises the undelivered deliverables.
- Overall, the year end position is mixed, the report demonstrates improved delivery and impact against enabling actions however performance has not reached the required level.
- There is variation in terms of delivery against planned activity and service improvement including some challenges relating constraints and the ambition of 2025/26 plan has been reflected in the 140 deliverable that have not been achieved.
- There has been progress in frontline services and delivery, **Womens Health** and **Adult Mental Health Services** who have seen a reduction in long waiters.
- **Planned Care** did not reach the targets set and there continue to be significant challenges with demand and capacity however improvements have been made in some areas and work is taking place to triangulate and balance services.
- In relation to the **Key Programmes**, the **Electronic Prescribing and Medicines Administration (EPMA) system**, the **Radiology Informatics System Project (RISP)** and the **Digital Maternity System** have all been implemented however the **Electronic Healthcare Record (EHR)** and **Laboratory Information Management System (LIMS)** have been impacted by National delays and technical issues.
- Work continues to develop the **Royal Alexandra Hospital** and **Waunfawr Health Centre** noting that the **Planned Care Hub at Llandudno** has suffered further delays due to work with suppliers.
- Significant progress is being made with the **Health and Wellbeing Hubs** and this work aligns to the **Community by Design** programme.
- Overall, strong progress has been made in areas where the organisation has control noting that the level of progress is more difficult where there are external factors and focus is required on pace and scale.

In discussing the report, the Board:

- Highlighted that the reports have been received by the Planning, Population Health and Partnerships Committee noting the need for awareness around ambition against the



capability to deliver suggesting that targets may need to be adjusted to ensure more positive progression is achieved that is embedded and sustained.

- Raised concerns around the risks associated with the procurement of the **Mental Health Electronic Healthcare Record**. The Chair confirmed that this was raised directly with the **Minister** yesterday, **Welsh Government** are aware of the timescale and implications and will make the final decision.
- Queried whether the original deliverables were correct. It was confirmed that the deliverables included a wide range of **Ministerial expectations** noting that the Health Board is at level five escalation and the current position is challenging.

It was resolved that the Board:

- **RECEIVED ASSURANCE** on the progress made during 2025/26 and noted the end of year position of delivery against the 2025/26 Annual Delivery Plan.
- **NOTED** the work to review the Change Control process will be undertaken in line with reporting against the Annual Delivery Plan.
- **NOTED** the update regarding progress during the first year, including some notable achievements, whilst also being appraised of some challenges which remain of concern and which had prevented Planning, Population Health and Partnerships Committee from receiving full assurance.
- **AGREED** to the integration of future reporting into the Annual Delivery Plan to ensure increased synergy and reduced duplication.

GOVERNANCE, RISK AND ASSURANCE

26.100 Chair's Assurance Report: Audit Committee

The Board received the report and the Chair of the Audit Committee highlighted:

- Audit recommendation closure remains inconsistent and there is a need for Executive Directors to follow up recommendations for completion. This issue has been escalated to the Chief Executive and will be addressed for assurance.

It was resolved that the Board:

- **NOTED** the content of the report.

26.101 NHS Wales Staff Survey 2025 Report

The Board received the report and the Executive Director of People and Organisational Development highlighted:

- The report details the findings of the **2025 Staff Survey** which went live between October and December 2025.
- The qualitative and quantitative data has been received however the **Digital Health and Care Wales report** has not yet been shared.
- The key findings highlight an overall response rate of 24.9% which is an improvement from previous years.
- The staff engagement completed is highlighted with the report and the Health Board achieved an above NHS Wales Health Board average score in the intrinsic psychological engagement (motivation) element of the Staff Engagement Index.
- The report highlights the positivity scores by theme noting that these have deteriorated in certain areas but confirmed that action plans are being put in place.
- Detailed next steps are highlighted within the report and progress will be reported via the People and Culture Committee.

In discussing the report, the Board:

- Queried reference to the Local People and Culture Committees, it was confirmed that the Integrated Health Communities have individual Committees similar to the People and Culture Committee where issues are discussed and addressed. An Executive People and Culture Delivery Group is being developed to strengthen governance in this area.
- Noted the increase in response rate and suggested the need to encourage staff to engage with the organisation. It was confirmed that the 24.9% response rate is an improvement and going forward, there is a need to ensure staff feel a difference is being made as a result of completing the **Staff Survey**.
- Noted the views on compassion and culture and queried the work required to promote **Speaking up Safely** more widely across the organisation. It was suggested that improving quality management and leadership will improve staff experience and enable people to **Speak up Safely** as required, this work will form part of the development of the **Performance Management Framework**.
- Stated that Board Members are the leadership of the organisation and requested that **values and behaviours** are reflected and cascaded within teams to take this element of work forward.

It was resolved that the Board:

- **NOTED AND DISCUSSED** the results of the NHS Wales Staff Survey 2025.
- **SUPPORTED** the planned next steps.

26.103 Commissioning Assurance Framework

The Board received the report and the Executive Director of Finance highlighted:

- The purpose of the **Commissioning Assurance Framework** is to provide direction when placing external contracts for NHS provision, strengthening oversight of Health Board contracts.
- The initial phase of implementation will focus on NHS to NHS healthcare and independent sector planned care arrangements. While processes are in place for oversight of the care sector, these will be further strengthened and aligned to the **Commissioning Assurance Framework** going forward.
- The Executive Committee will have oversight of the implementation, assessment rating and escalation of providers. A Commissioning and Contracting Group will be established to take forward the detailed work and the Executive Committee will report performance to the Performance, Finance and Information Governance Committee. Where there are specific quality matters, these will be reported to the Quality, Safety and Experience Committee.
- The commissioning skill and expertise of the organisation has been less mature than that expected from an Integrated Health Board therefore the **Commissioning Assurance Framework** will start to build the commissioning and contracting expertise of the organisation.

In discussing the report, the Board:

- Stated the need for clarity in relation to whether the focus is on contracts or becoming a commissioning organisation. It was confirmed that the immediate priority is to ensure current contracts are operating effectively, with strategic commissioning to be developed over time.
- Noted that work is taking place by the teams to support the oversight of contracts and provide quality oversight which will then provide a foundation to build on.

- Referred to **third sector** and the need to foster long term relationships as well as recognise organisational boundaries. Work is taking place to establish longer term agreements and an event is due to take place with the **third sector** which will help build on this approach.
- Highlighted the need for clear specification for clinical delivery which will allow clarity around contracting at a more strategic level.

It was resolved that the Board:

- **APPROVED** the Commissioning Assurance Framework.
- **ENDORSED** the proposed governance and reporting arrangements.
- **SUPPORTED** the phased implementation approach.
- **NOTED** that a detailed Implementation Plan will be developed for Executive Committee oversight.
- **AGREED** that a formal review will be undertaken 12 months post-implementation.

26.104 Board Assurance Framework

The Board received the report and the Director of Corporate Governance highlighted:

- The report has been considered by the Committees and provides a consolidated overview of the current position.
- Progress against the plan demonstrates a mixed level of deliverability and the feedback from Committees suggested the need to strengthen key implications to provide assurance.
- Work is underway to map all existing and outstanding actions to the four **Strategic Intent**s as part of the development of the refreshed 2026–2029 **Board Assurance Framework** aligned to the **Integrated Medium Term Plan**.

In discussing the report, the Board:

- Noted the low level of deliverability suggesting the Board need to lead in this area. It was confirmed that this has been discussed with colleagues around collectively owning the level of risk. Deep dives have been taking place at the Executive Committee and the next iteration of the **Board Assurance Framework** will provide a clearer outline of the level of risk.
- Confirmed that work is taking place to commission external support to work with the Board around a range of elements including risk and the **Board Assurance Framework** will develop further through the **Foundations for the Future programme**.

It was resolved that the Board:

- **NOTED** the feedback from Committees following their review of the Board Assurance Framework, recognising the progress made to date whilst also highlighting the need for greater clarity, depth and evidential support in articulating actions and progress;
- **ENDORSED** the strengthening of the Board Assurance Framework during 2026/27, with a clear focus on ensuring that actions are specific, measurable and linked to demonstrable outcomes that support robust assurance;
- **AGREED** that enhanced reporting arrangements are developed to provide clearer evidence of delivery, including improved articulation of how actions mitigate risk and strengthen assurance to the Board;
- **SUPPORTED** the role of the Audit Committee in providing strengthened oversight and scrutiny of the Board Assurance Framework, including regular review of the quality and effectiveness of actions and the evidence underpinning assurance; and
- **REQUESTED** that progress against these improvements is reported to the Board through the agreed committee structure, enabling ongoing oversight and assurance of delivery.

- **COMMENTED** on the four proposed principal risks that have been developed for inclusion in the newly refreshed Board Assurance Framework (BAF), aligned to the organisation's strategic priorities and key areas of risk exposure.

26.105 Corporate Governance Report

The Board received the report and the Director of Corporate Governance highlighted:

- The report includes a number of **Chair's actions** which have increased in number. A mechanism is now in place to track **Chair's actions** and build these into governance processes.
- The summary of business discussed in the private session now includes rationale for why items were discussed in private and this will be part of the process for Board and Committees going forward.
- The revised **NHS Wales Joint Commissioning Committee Governance Framework**, including Standing Orders and Standing Financial Instructions require approval by the Board.
- An informal Board session took place at the end of April 2026 and the key areas considered have been included in the report.
- An update on the **Covid enquiry** has also been included in the report. The learning is being mapped out and a report will be shared with the Board in July 2026.

It was resolved that the Board:

- **NOTED** the contents of the Corporate Governance Report and the progress made in strengthening governance arrangements.
- **RATIFIED** the Chair's Actions taken since the last meeting.
- **NOTED** the decisions taken in private session and the affixing of the Common Seal.
- **RATIFIED** the approvals of Approved Clinicians and Section 12(2) Doctors in line with national requirements.
- **NOTED** the assurance provided through the NHS Wales Shared Services Partnership Committee.
- **APPROVED** the updated NHS Wales Joint Commissioning Committee Governance Framework, including Standing Orders and Standing Financial Instructions (subject to final Joint Committee approval).
- **ENDORSED** the continued development of Board effectiveness, including implementation of the Board development programme and Board visits aligned to IMTP priorities.
- **SUPPORTED** the identified areas for improvement arising from the Board Self-Assessment, particularly strengthening executive leadership sustainability, sharpening strategic focus and streamlining Board reporting.
- **RECOGNISED** the need for continued focus on strengthening assurance, including clearer articulation of actions and demonstrable impact in key governance and risk frameworks.

26.106 Committees and Advisory Group Chair's Reports:

The Board received and accepted the Chair's Reports from the following Committees and Advisory Groups:

- Remuneration Committee, Dyfed Edwards
- Planning, Population Health and Partnerships Committee, Clare Budden
- People and Culture Committee, Dyfed Jones
- Mental Health Legislation Committee, Gareth Williams



- Local Partnership Forum, Carol Shillabeer
- Executive Committee, Carol Shillabeer

The Chair of the Mental Health Legislation Committee provided assurance to the Board regarding the improvements made in relation to the Mental Health Capacity Act and expressed thanks to the team for the work completed in this area.

It was resolved that the Board:

- **RECEIVED** and **NOTED** the reports.

ANNUAL / BI-ANNUAL REPORTING

26.107 Annual Assurance Report of the Nurse Staffing Level May 2026

The Board received the report and the Executive Director of Nursing and Midwifery highlighted:

- The report provides assurance on compliance with the **Nurse Staffing Levels (Wales) Act** which is due to be reported on a bi-annual basis. Assurance is also provided that assessments have been undertaken in line with the nurse staffing levels in all wards covered by Section 25B of the Act.
- Discussions have taken place in relation to the requested uplifts and agreement was reached in terms of the decisions made.
- The report has been shared with the Executive Committee and Quality, Safety and Experience Committee for scrutiny and the non Section 25B wards will be reviewed at the next Quality, Safety and Experience Committee.

It was resolved that the Board:

- **NOTED** the risks outlined in the report, including those related to unfunded nurse staffing establishments and sustained escalation capacity, and agree that these remain under active Board oversight through the corporate risk register.
- **TOOK ASSURANCE**, based on the accompanying Annual Assurance Report and associated appendices, that Betsi Cadwaladr University Health Board has met its statutory duty to calculate nurse staffing levels and take reasonable steps to maintain them in all Section 25B wards, while recognising the current constraints to full assurance.
- **SUPPORTED** the actions and recommendations contained within the annual assurance report, including those necessary to address identified staffing, operational, and financial risks.

26.108 Emergency Preparedness, Resilience and Response Annual Report

The Board received the report and the Executive Director of Public Health highlighted:

- The report has received detailed scrutiny at the Civil Contingencies Assurance Group, Executive Committee and Planning, Population Health and Partnerships Committee.
- There is a statutory requirement for the Health Board to sign off the annual report due to being classed as a Category 1 responder.
- There are plans in place to maintain business continuity as well as the ability to respond the civil contingency incidents.
- Extensive progress has been made by the **Emergency Preparedness, Resilience and Response Team** to ensure the foundation work has been completed and the Health Board are able to respond to a major incident.

It was resolved that the Board **SUPPORTED** the Emergency Preparedness, Resilience and Response Team to:

- Work with Integrated Health Communities to gain further evidence to ensure that business continuity plans and supporting arrangements are being continually reviewed, maintained and embedded to the requirements of the Civil Contingencies Act and aligned standard / guidance, and that lessons learnt from incidents and exercises are incorporated into these plans.
- Continue raising awareness around roles and responsibilities for Emergency Preparedness, Resilience and Response across the Health Board and with our partner agencies.
- To maintain coordination of the Health Board's representation at North Wales Local Resilience Forum subgroups.
- To ensure Strategic and Tactical on-call staff attend necessary training and participate in training and exercise events.

CLOSING BUSINESS

26.109 Review of Meeting Effectiveness

The Board reflected on the discussions held noting:

- The level of detail included in the reports can make it difficult to identify the issues being addressed and some reports do not make reference to financial implications.
- The suggestion to reorder Board agendas to ensure items for assurance are scheduled earlier on the agenda. It was confirmed that this will be discussed further with the Committee Chairs at the next Chair's Advisory Group.

26.110 Date of Next Meeting:

Thursday 25 June 2026 at 9.30am in Venue Cymru to sign off the Annual Report and Accounts.
Thursday 30 July 2026 at 9.30am in Venue Cymru for the full Board Meeting.

26.111 Resolution to Exclude the Press and Public

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

Betsi Cadwaladr University Health Board (BCUHB)
Unconfirmed Minutes of the Health Board Meeting
held on 25 June 2026 in Venue Cymru

Board Members present	
Name	Title
Dyfed Edwards	Chair
Clare Budden	Independent Member
Russell Caldicott	Executive Director of Finance
Clara Day	Executive Medical Director
Debbie Eyitayo	Executive Director of People and Organisational Development
Dyfed Jones	Independent Member
Paul Lambert	Independent Member
Dr Jane Moore	Executive Director of Public Health
Billy Nichols	Independent Member
Teresa Owen	Executive Director of Allied Health Professionals and Health Science
Carol Shillabeer	Chief Executive (remotely)
Paolo Tardivel	Interim Executive Director of Transformation and Strategic Planning
Caroline Turner	Independent Member
Rhian Watcyn Jones	Independent Member
Pam Wenger	Director of Corporate Governance
Gareth Williams	Vice Chair
In Attendance	
Laura Jones	Corporate Governance Manager
Stuart Keen	Director of Environment and Estates
Chris Lynes	Deputy Executive Director of Nursing
Justine Parry	Acting Director of Digital, Data and Technology
Philippa Peake-Jones	Head of Corporate Governance
Helen Stevens-Jones	Director of Partnerships, Engagement & Communications

26.124 Welcome, Introductions and Apologies for Absence

The Chair welcomed Board Members, members of the public and those viewing online to the meeting.

Apologies were received for Angela Wood, Tehmeena Ajmal, Mike Larvin, Urtha Felda and Emma Adamson.

The Chair highlighted that the Health Board has a statutory requirement to prepare a set of Annual Financial Statements and an Annual Report and this was the primary focus of this meeting. These documents require approval by the Board for submission to Audit Wales and Welsh Government. The agenda also includes an urgent item relating to the Emergency Department Business Case.

26.125 Declarations of Interest relating to the Agenda

No declarations of interest were raised.



ANNUAL REPORT AND ACCOUNTS

26.126 Audit Committee Assurance Report

The Board received the report and the Chair of the Audit Committee highlighted:

- The Annual Accounts and the Annual Report have been considered by the relevant Committees and the significant amount of work undertaken by Finance colleagues in preparing the accounts was acknowledged.
- The Health Board has not achieved its first financial duty to break even, starting the year with a break-even budget and ending with a deficit of £17.3m.
- There is now a requirement for the Health Board to reinforce its grip on financial recovery alongside strengthening risk management.
- Management responses to Internal Audits are not being received at the required level noting that further support is required in this area.

It was resolved that the Board:

- **NOTED** that the Audit Committee approved the Annual Report and Accounts for onward submission to the Board.

26.127 Audited Annual Accounts Submission 2025-2026

The Board received the report and the Executive Director of Finance highlighted:

- Thanks to colleagues for their contribution in completing the documentation for the accounts within the required timeframe, and also to Audit Wales colleagues for their support.
- The 2025-26 unaudited annual accounts were submitted to Welsh Government and Audit Wales on 1 May 2026 and have attained a £17.3m deficit position.
- There were no amendments to the reported outturn position which remains unchanged between the unaudited and final submission.
- If the Health Board agree to endorse the accounts, these will be submitted to Audit Wales and the Auditor General to sign off by 30 June 2026.
- Audit Wales have reported two uncorrected misstatements resulting from the way in which the Health Board's capital asset register software calculates and reports certain types of transactions, these issues are contained within a specific note of the accounts and do not impact on the overall net book value of fixed assets.
- The Health Board's annual accounts for 2025-26 will receive an unqualified true and fair opinion, this means that the Auditor General is satisfied they reflect the current position of the Health Board and the net operating costs for the year.
- The accounts will receive a qualified regulatory opinion as the Health Board did not achieve its first financial duty to break-even over the three-year period 2023-24 to 2025-26.

As part of the discussion, the Board:

Noted the decrease in spend in relation to Primary Care and General Medical Services recognising that resources are not adequately being transferred from Secondary Care into Primary Care referring to the Welsh Government target to increase spend in Primary Care by 0.5%. It was confirmed that the Board have set a strategic intention to invest in the development of Primary and Community Care services and allocation of resource across the Health Board is crucial to underpin this work. General Medical Services allocation has been agreed and there is a need to ensure clear visibility on the impact of the funding.

- Confirmed that in accordance with the recommendation of the Audit Committee, the Health Board is requested to adopt the 2025-26 audited annual financial statements.

It was resolved that the Board:

- **ADOPTED** the 2025-26 audited annual financial statements.

26.128 Annual Report 2025-2026

The Board received the report and the Director of Corporate Governance highlighted:

- Thanks to colleagues involved in preparing the report and acknowledged the support received from External and Internal Audit, demonstrating the positive working relationships taking place.
- The Audit Committee met on 23 June 2026 and had the opportunity to review the Annual Report and Accounts confirming that the documentation has been subject to the appropriate governance processes.
- The Annual Report provides the Board with a comprehensive view of the Health Board's position ending 31 March 2026.
- The financial accounts will be incorporated into the documentation prior to submission to the Auditor General for sign off and will form part of the NHS Wales Manual for Accounts as required.
- Progress has been made throughout the year with compliance against statutory duties addressed within the Annual Report.
- The Audit Committee have received regular reports relating to Standing Orders and Standing Financial Instructions.
- Additional Internal Audit reviews have been undertaken in areas of identified risk and concern, including procurement, reflecting a proactive approach to maintaining high standards of governance and regulatory changes.
- Risk management was recognised as a key element and this requires continued focus and will remain a priority for the Executive Committee and Audit Committee during the year.
- The Report presents an honest and fair position, demonstrating the progress made whilst also recognising the operational challenges that remain and require regular Board review.
- The Annual Quality Report will be presented to the Board in July to provide a focus in this area.
- Planned Care continues to be an area of high concern, there has been a focus on reducing patients waiting more than 156 weeks and 104 weeks with significant reductions in both cohorts noting over 30,000 people have had appointments during the year and capacity is being increased to work on eradicating this length of wait.
- During 2025/26 more than 55,000 patients were referred to the Health Board with suspected Cancer. Each month over 4500 people are tested and approximately 4000 patients are being given the positive news that Cancer was not detected. There is a challenge to meet the National target in this area and plans are being put in place to make improvements.
- Mental Health performance continues to meet access standards in relation to Adult Services noting that there have also been some improvements in Children's Service however performance against neurodevelopment assessments is low noting that this is a UK wide issue and Health Boards in Wales are working to address this area of concern.
- Urgent and Emergency Care continues to be an area requiring sustained focus and additional support will be discussed in further detail during the meeting.

- Improvements are being seen in relation to internal controls however significant work is required to become a high performing organisation underpinned by strong governance.

As part of the discussion, the Board:

- Noted that the Planning, Population Health and Partnerships Committee have received a copy of the People's Experience Report from the Emergency Department and welcomed the insight it provided into people's experiences of using healthcare services. It was highlighted that feedback was generally positive, with the exception of Emergency Department services where experience remained very poor. Members emphasised the importance of focusing improvement efforts in these areas of greatest concern.
- Referred to the number of people with suspected Cancer and the high number of people where Cancer was not detected and queried whether more accurate referrals are required. It was confirmed that the suspected Cancer pathways are designed to support early diagnosis or early exclusion of Cancer, with referrals being triaged to ensure patients are seen more rapidly through routine pathways where appropriate, supported by ongoing work with Primary Care and specialist nurses to determine whether escalation to the urgent suspected Cancer route is required.
- Highlighted that Mental Health Services, including services for young people, have improved over recent years, supported by positive feedback from Healthcare Inspectorate Wales. However, it was recognised that current metrics remain limited and community services continue to be under significant pressure. It was confirmed that Welsh Government are taking forward a new community-based approach supported by staff focused on improving timely access to care.
- Noted that Delayed Transfers of Care continue to adversely impact both patients and the Health Board, with increasing numbers of people remaining in hospital beds despite no longer requiring acute care. It was confirmed that there are positive examples of services being transferred back into the community, supported by changes to pooled budget regulations and further work is required in this area.
- Highlighted the section referring to data breaches noting that the correct figure is five and the narrative will be amended to align with the information in the table, noting that this has been discussed with Audit Wales.
- Expressed gratitude to colleagues for the significant work undertaken and noted that the report provided a detailed snapshot of the current position, as well as a useful tool to support planning and delivery over the coming year.

It was resolved that the Board:

- **APPROVED** the Annual Report 2025-26 in readiness for submission to Audit Wales and Welsh Government.
- **APPROVED** the Annual Financial Statements in readiness for submission to Audit Wales and Welsh Government.
- **APPROVED** the Letter of Representation for signing by the Chair and Chief Executive, on behalf of the Board.

INTERNAL AUDIT

26.129 Head of Internal Audit Opinion and Annual Report 2025-2026

The Board received the report and the Director of Corporate Governance highlighted:

- The Audit Committee received the Head of Internal Audit Opinion Report in full, and it is being presented to the Board for completeness and will also be included in the Annual Report.

As part of the discussion, the Board:

- Noted that progress is being made in areas where limited assurance has previously been identified, and this is recognised within the report however reference is made to Internal Audits completed by other NHS Wales bodies that provide a more negative position. It was confirmed that the audits completed highlight common themes across Wales and this is being reviewed in further detail.

It was resolved that the Board:

- **NOTED** the content of the report.
- **RECEIVED** the Head of Internal Audit Opinion for 2025/26.

EXTERNAL AUDIT

26.130 ISA 260 Audit of Financial Statements

The Board received the report and the Director of Corporate Governance highlighted:

- The report has been received in full by the Audit Committee and was presented to provide full visibility of the findings, with areas for improvement to be progressed through the Committee over the coming year.
- Assurance was also provided to the Audit Committee in relation to Senior appointments, recognising the progress made in this area over recent years.
- The Audit Wales materiality level, set out on page seven and based on the 2025-26 draft financial statements had been calculated at 1% of the Health Board's turnover, reflecting the scale of the organisation's £26.5m spend, with a reporting threshold of 5% equating to £1.3m. Any areas of concern above this threshold would have been identified within the report.
- The report will be incorporated into the Annual Report.

It was resolved that the Board:

- **NOTED** the content of the report.
- **RECEIVED** the ISA 260 noting that it had been considered at the Audit Committee.

URGENT AND EMERGENCY CARE

26.131 Emergency Department Business Case

The Board received the report and the Executive Medical Director highlighted:

- Thanks to all staff working across the Health Board's Emergency Departments for the commitment to working for the population of North Wales, recognising that whilst patients are experiencing prolonged waits, they continue to provide encouraging feedback on the care being received.
- Sustained staffing is required across Emergency Departments noting that patient attendances have only increased marginally however occupancy and the number of patients requiring nursing care at any one time has risen significantly due to prolonged waits.

- The Business Case proposes an increase in registered nurses and Health Care Support Workers to provide safe and appropriate care for patients waiting for extended periods within Emergency Departments.
- Non-consultant medical rotas require the appropriate number of staff to reflect attendance patterns and ensure compliance with Working Time Directive requirements.
- National guidance and recommendations have been applied across all areas, with staffing currently increased through temporary arrangements however, using substantive staff is recognised as the most effective way to support productive care and reduce rota gaps.
- The financial requirement is substantial as the proposed investment requires a total spend of £32.9m against the current recurrent budget of £24.8m noting that a proportion of this funding is already reflected within the Integrated Health Communities budgets.
- It was recognised that funding alone will not resolve these challenges and that this forms part of a broader programme of work within Emergency Departments and across the wider system, underpinned by the standards of care required.
- Further work will be undertaken following recommendations from the Ysbyty Glan Clwyd inspection and in line with Getting it Right First Time (GIRFT) standards, which also highlight wider system flow issues.
- The Board recognises the wider programmes of work underway, working in partnership with Local Authorities. 90-day plans are also being put in place which will need to be adapted as required and monitored through the Executive Committee.

As part of the discussion, the Board:

- Expressed thanks to all staff for their work in this area noting that this is a long standing issue and queried what improvements will be made from this important investment to improve experiences for patients and staff. It was confirmed that establishing a stable substantive workforce within Emergency Departments would support consistent delivery against standards, improve productivity and enable skilled staff to undertake key roles such as triage, thereby strengthening team-based working and improving care for patients and staff.
- Emphasised that while the Business Case focuses on Emergency Departments, the underlying challenges span the whole patient pathway. Patients remaining in hospital beds directly contributes to Emergency Department overcrowding and patient safety risks therefore immediate steps are required to improve safety within departments, alongside wider pathway changes, evidence-based staffing models, a review of the financial implications and a clear implementation plan, noting that the Executive Committee recognise this as a key priority.
- Welcomed the proposed investment noting that this is an important element of a broader programme of work, with further collaboration with Local Authorities required to improve system flow and support sustainable improvement. It was noted that that this has been a persistent area of challenge despite only a marginal increase in attendances, it was also recognised that this represents only one element of the wider action required to address the overall challenges within Emergency Departments.
- Queried why the Business Case set out the minimum staffing requirement rather than the optimum position which would provide greater flexibility, and why the investment had not been incorporated into the annual budget-setting process. It was confirmed that provision had been sought within the plan however, as the case has developed and additional requirements have been identified, the financial requirement has increased above the original requirement, resulting in a shortfall.

- Noted that greater sustainability could be achieved by replacing temporary staffing arrangements with substantive posts, both within Emergency Departments and across wider service areas. It was also recognised that the Health Board remains consistently below establishment while exceeding funded staffing levels, with some gaps linked to recruitment challenges. It was noted that specific focus will be required where reliance on high-cost temporary staffing continues highlighting that the Foundations for the Future Programme will help to address issues related to structures.
- Highlighted the importance of improving the quality of care however, concerns were raised around the use of corridor care. It was confirmed that this is part of a wider programme of work to ensure patients are cared for safely and appropriately in all areas.
- Confirmed that the identified savings requirement would need to be underwritten and would present a further challenge, noting that Welsh Government have asked all Health Boards to provide a clear trajectory by 30 June 2026 noting that this will be brought back to the Board for agreement. It was also noted that, while there has not been a significant increase in Emergency Department footfall, challenges remain with patient flow out of hospital therefore this investment is being progressed alongside wider flow improvement work, with the final requirement of up to £3.9m dependent on progress in that area.
- Stated that the Business Case demonstrates a more mature approach to assessing services against agreed standards as part of the Quality Management System, with the need to review substantive staffing to support delivery; however, the core challenge remains as the need to improve flow across the whole system.
- Requested that the Healthcare Inspectorate Wales Reports are shared more widely and it was agreed to share these with Board Members for information.
- Agreed that the Performance, Finance and Information Governance Committee have oversight of this work and will report to the Board on a regular basis noting that this work will now proceed in a comprehensive manner across the Health Board.

Action:

- **26.131** The Director of Corporate Governance to share the Healthcare Inspectorate Wales Reports with Board Members for information.

It was resolved that the Board:

- **NOTE** the sustained and material patient safety risk within Emergency Departments, as previously reported and reinforced through Escalation Board oversight and Healthcare Inspectorate Wales (HIW) findings.
- **APPROVE** recurrent investment of up to **£3.9m** to stabilise Emergency Department workforce capacity as a necessary response to this risk.
- **ACKNOWLEDGE** that this investment is not within current financial plans and will require organisational reprioritisation and an increase in the savings requirement.
- **AGREE** a phased implementation approach, underpinned by clear expectations on delivery, benefits realisation and performance improvement.
- **REQUIRE** the Executive to develop and deliver a clear **benefits realisation plan**, demonstrating how the investment will improve Emergency Department performance and reduce patient safety risk, with defined measures, trajectories and clear accountability.
- **AGREE** that oversight and assurance will be provided through the Performance, Finance and Information Governance Committee, with clear lines of accountability.
- **REQUIRE** regular reporting to the Board on delivery and impact, including patient safety, workforce stability, operational performance and financial consequences.

- **ENDORSE** this investment as a necessary and immediate intervention to reduce avoidable patient harm and support wider Urgent and Emergency Care (UEC) improvement, recognising that it addresses a critical enabler but does not, in isolation, resolve underlying system flow constraints.

CLOSING BUSINESS

26.132 Date of Next Meeting

Wednesday 29 July 2026 in Queen's Market, Rhyl for the Annual General Meeting
Thursday 30 July 2026 at 9.30am in Venue Cymru for the Board Meeting.

Health Board Action Log (Public)

Updated 23.07.26

Open Actions						
Action No.	Minute Ref.	Date	Agreed Action	Lead	Timescale	Status
REMAIN OPEN						
1	26.131.1	25.06.26	Emergency Department Business Case The Director of Corporate Governance to share the Healthcare Inspectorate Wales Reports with Board Members for information.	Pam Wenger	Sept 26	Remain Open 21.07.26 The Healthcare Inspectorate Wales Reports will be shared once they become available.
2	26.102.1	28.05.26	Proposal to becoming a Maethu Cymru / Foster Wales Partner and Foster Friendly Employer The work to develop the Health Board to become a Foster Wales Partner and Foster Friendly Employer to progress via the Executive Committee and People and Culture Committee and report back to the Board in future.	Debbie Eyitayo	Jan 27	Remain Open 22.06.26 This work will be progressed to report to the People and Culture Committee in December 2026 before reporting back to the Board.
3	26.102.2	28.05.26	Proposal to becoming a Maethu Cymru / Foster Wales Partner and Foster Friendly Employer Further work to be completed to develop a focus on issues concerning children and young people at the Board in a more comprehensive manner.	Helen Stevens-Jones	Jan 27	Remain Open 26.06.26 The Youth Board presented at the Board Development Session held on 25 June 2026, further work is taking place in this area and will aim to report back to the Board in January 2027.



4	26.93.1	28.05.26	Integrated Quality Report The submission to Health Inspectorate Wales in response to the inspection at the Emergency Department at Ysbyty Glan Clwyd to be shared with Board Members once complete.	Clara Day	Sept 26	Remain Open 21.07.26 This action links with action 26.131.1 and the Healthcare Inspectorate Wales Reports will be shared once they become available.
5	26.98.1	28.05.26	Finance Report Further detail on the financial position to be provided to the Board due to the significance of the challenge.	Russell Caldicott	Sept 26	Remain Open The Financial Savings Plan was discussed at the Board Development Session held on 25 June 2026 and further discussions are ongoing.
6	25.209.1	27.11.25	Healthy Travel Charter Progress against the Healthy Travel Charter to report back to the Board in May 2026.	Stuart Keen Jane Moore	~~July 26~~ Revised timescale Nov 26	Remain Open 10.07.26 Further work is required in relation to the Healthy Travel Charter and this will be discussed further by the PPHP Committee. 21.04.26 A brief progress update on the Healthy Travel Charter has been included in the Q4 Population Health Delivery Report being provided to the PPHP Committee in May 2026 and a further report will be submitted to the Committee in July 2026. This will be reported back to the Board in July via the Committee AAA Report.



						16.03.26 This information will be included in the Public Health Delivery Plan and reported to the PPHP Committee in May 2026. 19.01.26 The Healthy Travel Charter has been included on the forward workplan for both the PPHP Committee and the Health Board in May 2026.
7	25/129.1	31.07.25	Chair's Report People and Culture Committee to discuss opportunities to support young people into the workplace and report back to the Board.	Debbie Eyitayo Georgina Roberts	May 26 Revised timescale Nov 26	Remain Open 19.01.26 This area of work will align to the Foundations for the Future Programme and will therefore report to the People & Culture Committee later in the year, the timescale has been revised to reflect this. 18.11.25 This will be the focus for the staff story in April 2026 and will report back to the Board. 09.09.25 This is planned to be the focus for the staff story at a future People and Culture Committee and will be reported back to the Board via the AAA Report.
ACTIONS PROPOSED FOR CLOSURE						
1	26.84.1	28.05.26	Matters Arising and Action Log Performance, Finance and Information Governance Committee to review how savings can be achieved in relation to	Russell Caldicott	July 26	Action proposed for closure 21.07.26 This is an item on the next PFIG Committee agenda.



			Value and Sustainability to ensure this information becomes more visible.			
2	26.84.2	28.05.26	Matters Arising and Action Log The Chairs Advisory Group to further discuss the implementation of a consent agenda for relevant items reporting from Committees to Board.	Pam Wenger Philippa Peake-Jones	July 26	Action proposed for closure 22.06.26 This is being discussed by the Chairs Advisory Group with the aim of moving towards a consent agenda in September 2026.
3	26.88.1	28.05.26	Chief Executive's Report The Chief Executive to provide communication to Board Members following the Escalation Board taking place on 29 May 2026.	Carol Shillabeer	July 26	Action proposed for closure 22.06.26 The Director of Corporate Governance shared a copy of the letter received following the meeting with the Board.
4	26.88.2	28.05.26	Chief Executive's Report Extend the invite for the People and Culture Committee taking place on 11 June 2026 to Board Members for the Foundations for the Future item.	Pam Wenger Philippa Peake-Jones		Action proposed for closure 22.06.26 An update was provided at the Committee meeting held on 11 June 2026 and an additional People and Culture Committee has been scheduled to take place during August 2026 to focus on structures and the organisational change element of Foundation for the Future ahead of the consultation period.
5	26.91.1	28.05.26	Penley Community Hospital – Case for Change The Director of Corporate Governance to advise on the inclusion of an additional recommendation as this is a matter reserved for the Board and	Pam Wenger Paolo Tardivel	July 26	Action proposed for closure 22.06.26 An additional recommendation was included in the minutes from the May 2026 meeting to confirm that the Board approved to



			confirm with the Interim Executive Director Transformation and Strategic Planning when Penley Community Hospital will return to the Board for final decision making.			commence the public consultation and that the outcome of the consultation was planned for January 2027 in accordance with the timescales in the report.
6	26.94.1	28.05.26	Urgent and Emergency Care Progress Report The report to the next Board meeting in July 2026 to confirm progress against the completion of the Emergency Department Business Case, the implementation of the 90 day Operational Improvement Plans and provide assurance on the discussions held by Quality, Safety and Experience Committee and the Performance, Finance and Information Governance Committee.	Tehmeena Ajmal	July 26	Action proposed for closure 21.07.26 The Emergency Department Business Case was received at the Board meeting held in June 2026. The additional elements of the action have been reflected in the Urgent and Emergency Care Progress Report being considered by the Board in July 2026.
7	26.52.1	26.03.26	Cancer Report Quality, Safety and Experience Committee to receive Cancer Services as an agenda item at a future meeting to consider how this area of work can be taken forward following discussion at the March Board and report back to a future meeting of the Board.	Tehmeena Ajmal	July 26	Action proposed for closure 21.07.26 An update on Cancer Services was provided via the Planned Care item at the QSE Committee in July 26 and is being reported back to the Board via the QSE Committee AAA Report to the Board meeting in July 2026. 21.04.26 This has been included on the forward workplan for the QSE Committee suggesting this



item is included on the agenda for the July meeting.

Closed Actions (as agreed at meeting on 28.05.26)

Action No.	Minute Ref.	Date	Agreed Action	Lead	Timescale	Status
1	26.50.1	26.03.26	Chief Executive's Report Chief Executive to circulate the revised accountability, escalation arrangements from Welsh Government and include as an appendix to the next Board report.	Carol Shillabeer	May 26	21.04.26 The letter from Nick Wood to all NHS Chairs and Chief Executive Officers regarding Accountability Interface Arrangements was circulated to Board Members on 21.04.26 via email and has been included in the supporting papers for the May Board meeting.
2	26.58.1	26.03.26	Performance Management Framework The Performance Management Framework to be discussed in further detail by the Board and reported back to the Performance, Finance and Information Governance Committee to provide assurance on progress.	Russell Caldicott	May 26	14.05.26 This will be reported to the Board in May 2026 and performance will be reported to the Performance, Finance and Information Governance Committee as part of normal governance process.
3	26.20.1	29.01.26	Integrated Performance Report Future Integrated Performance Reports to refer to the gap in performance against the Special Measure Cancer target to highlight what is required to reach the target.	Russ Caldicott	May 26	14.05.26 The Integrated Performance and Quality Report now includes reference to performance for Special Measures requiring the Health Board to have seen 55% of patients within appropriate timeframes on four consecutive months,



						comparing this to current performance. 18.03.26 The Integrated Performance and Accountability Framework is going through the governance process and this action will be addressed in the reporting cycle once approved.
4	25.208.1	27.11.25	Director of Public Health Annual Report Progress against the recommendations included in the Director of Public Health Annual Report to be taken forward by the Executive Committee and reported back to the Planning, Population Health and Partnerships Committee.	Jane Moore	May 26	23.04.26 As part of the Q4 activity in 2025/26, there has been significant focus on embedding the ambitions described in the Director of Public Health Annual Report into key Health Board plans and ongoing progress will be reported to the PPHP Committee via the Population Health Delivery Report. 16.03.26 This information will be included in the Public Health Delivery Plan and reported to the PPHP Committee in May 2026. 19.01.26 The Executive Director of Public Health is taking this forward with the Executive Committee and this has been included on the forward workplan for the PPHP Committee in May 2026.



5	25.210.1	27.11.25	Culture and Leadership Programme – Discovery Phase Synthesis Report The Three Year Culture, Leadership & Engagement Improvement Plan to be further developed and progress to be monitored by the People and Culture Committee to provide assurance up to the Board.	Debbie Eyitayo George Roberts	May 26	09.04.26 The revised report was presented to the Committee in April 2026 and progress will be monitored by the Committee for assurance. 23.02.26 The report was presented to the People & Culture Committee in February 2026 and it was agreed that further work was required to review and reprioritise some of the actions and present this back to the Committee in April 2026 once further work has been completed on the actions. 06.01.26 The Three Year Culture, Leadership & Engagement Improvement Plan has been included on the agenda for the P&C Committee being held in February 2026 and will be reported back to the Board via the AAA Report.

Health Board

ICAN: STRAEON GO IAWN, EFFAITH GO IAWN ICAN: REAL STORIES, REAL IMPACT

Date of Meeting	30 th July 2026
Publication Status	Open/ Public
	Not Applicable
Report Author name and title	Katie Hender – Senior People’s Experience Manager
Lead Executive Team Member name and title	Angela Wood, Executive Director of Nursing and Midwifery

Report Purpose	For Noting

Executive Summary

A patient or carer story is presented to Board to bring the voice of the people we serve directly into the meeting.

The digital story will be played at the meeting. A short summary of the experience and actions undertaken in response to the story is included in the paper.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

Committee / Group / Individuals	Date	Outcome, Evidence and Data
N/A		

Acronyms / Glossary of Terms

[iCAN FINAL v1 CYM.mp4](#)

1. Overview of patient story

The story highlights the life-changing impact of iCAN's community-based mental health support. Through lived experience accounts, individuals describe how early intervention, peer support and accessible community services helped them overcome isolation, build confidence, improve wellbeing and find a renewed sense of purpose. The stories demonstrate the value of co-produced, third-sector delivered support as a key component of a whole-system approach to mental health care.

1.1 Key messages

- iCAN demonstrates the importance of a whole-system approach to mental health support, providing a range of community-based interventions that complement statutory services.
- The third sector is a critical partner in delivering accessible mental health and wellbeing support across North Wales.
- Early intervention and open-access support enable people to receive help before reaching crisis, improving outcomes and reducing pressure on wider services.
- Small, person-centred interventions can have a transformative impact on confidence, independence, social connection and overall wellbeing.
- Co-production with people with lived experience is fundamental to the design and delivery of effective services.
- Peer support helps people feel understood, valued and connected, contributing significantly to recovery and wellbeing.
- Community-based support enables people to build sustainable relationships, routines and opportunities for recovery.

2. Summary of learning and improvement

The stories demonstrate the significant value of providing accessible, community-based mental health support at the earliest possible opportunity. Individuals described improvements in confidence, social connection, independence and wellbeing through early engagement with iCAN services, highlighting the importance of prevention and early intervention approaches.

The experiences reinforce the importance of co-production and peer support in mental health services. Participants valued being supported by individuals who understood their experiences and reported feeling listened to, accepted and empowered. These approaches contribute to recovery-focused support and encourage sustained engagement.

The stories highlight the important role that third-sector partners play within the wider mental health system. Through local delivery, open access and strong community connections, iCAN supports people to remain well, develop resilience and access support before problems escalate. Continued partnership working is essential to sustaining these positive outcomes for individuals and communities across North Wales.

3. Recommendations

3.1 The Board is asked to **NOTE** this report.

ASESIAD / ASSESSMENT	
Cysylltiad â'r Bwriadau Strategol	3. Improve Access, Outcomes and Experience
Link to Strategic Intentions	If more than one applies, please list below: 4. Create a Modern, People Centred Healthcare System
Yr Egwyddorion Dylunio Design Principles	People First Consistency with Organisational Values
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	Not applicable.

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Equality Act 2010 Public Sector Equality Duty: Has BCUHB provided evidence of 'Due Regard' to compliance with the three parts of the Public Sector Equality Duty (General Duty): https://www.gov.wales/public-sector-equality-duty-html Public Sector Equality Duty [HTML] GOV.WALES	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	Not applicable
Equality Act 2010 - Socio-economic Duty <i>Has BCUHB provided evidence of 'Due Regard' to compliance of their Socio-economic Duty when making strategic decisions?</i>	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	Not applicable.
<i>Have you completed an Integrated Equality Impact Assessment WP8a?</i> WP8a Template	Canlyniad/Outcome: Do/Yes:	Naddo/No: : ☒
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale: Canlyniad/Outcome:	

	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Human Rights Act <i>Have Human Right based concerns been addressed within WP8a</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	Not applicable
Compliance to the Welsh Language requirements? <i>Have you undertaken an Impact Assessment</i>	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Naddo/No: ☒
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not applicable
Compliance to giving 'Due Regard' to the principles of the Armed Forces Covenant <i>Have the principles of the Armed Forces Covenant been addressed within WP8a</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not applicable
<u>Ansawdd</u> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i> <u>Quality</u> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Galluogwyr Ansawdd Enablers of Quality All Apply Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
<u>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant</u>	A Healthier Wales	

Wellbeing of Future Generations Act – Wellbeing Goals		
Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	If more than one applies, please list below:	
	No - Not Applicable	
	If more than one applies, please list:	
Asesiad o Effaith ar Ddiogelu Data <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?</i> Data Protection Impact Assessment <i>Have you undertaken a Data Protection Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	Not applicable
Asesiad o Effaith ar Atal Twyll <i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i> Counter Fraud Impact <i>Have you considered the counter fraud impacts</i>	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	Not applicable
Cyfreithiol Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw Da Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith ar Adnoddau <i>(Pobl / Ariannol)</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	

Health Board

CHAIR'S REPORT

Dyddiad y Cyfarfod Date of Meeting	30 July 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Dyfed Edwards Chair
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	

Pwrpas yr Adroddiad Report Purpose	For Noting

Crynodeb Gweithredol **Executive Summary**

This report provides information on key issues within the organisation and external work with Government and other partners

- Meetings with Elected Representatives
- Appointments
- Details of visits and meetings

Ymgysylltu (mewnol/allanol) yr ymgwymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp)

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

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

Report of Chair to Betsi Cadwaladr University Health Board

July, 2026

Some of the work I have undertaken since my report to the May Board is summarised below:

Board and Committees

The **Audit Committee** have had oversight of the Annual Report and Accounts working with Audit Wales colleagues to ensure that the work was delivered on time and of the required standard. Our Board meeting of June 25 endorsed the **Annual Report and Accounts** and we are grateful to all for the work undertaken and the positive working relationship with Audit Wales colleagues.

The **Performance, Finance and Information Governance Committee** (PFIG) has ensured scrutiny of the plans to improve **Planned Care** performance and eliminate 104 week waits. These plans have been presented to Welsh Government in order to access additional funding and will be key to ensuring the reduction of waiting lists. I am very grateful to the members of PFIG for arranging additional meetings and for their contribution to this work. I also wish to thank everyone who has supported the work with many working very long hours to ensure that our plan was submitted on time in what was a very challenging time frame.

Engaging with others

Mabon ap Gwynfor MS, Cabinet Minister for Health and Care, visited Ysbyty Glan Clwyd shortly after his appointment and met and discussed issues with staff at the Emergency Department. He also visited **Ysbyty Gwynedd** earlier this month together with officials with others visiting **Ysbyty Glan Clwyd** and the **North Wales Surgical Hub, Llandudno**. We received positive feedback from officials and are grateful to staff for facilitating the visits.

These visits preceded an **Escalation Board** meeting with the Cabinet Minister and officials at government offices in Llandudno Junction. The meeting focussed on the progress of the Health Board and the need to meet the performance targets that have been set by government. The meeting was attended by Executive Directors and myself and Chairs of Committees as members of the Board. There is further background information of this meeting to be found elsewhere in the papers for today's Board.

Briefing Sessions with MSs/MPs held earlier this month provided an opportunity to share information with some of the elected members of our region. These online sessions were particularly useful as introductions for newly elected members from all party groups. We will continue to arrange such sessions on a more regular basis

going forward. Similarly, an event in the Senedd in June arranged by the **Welsh NHS Confederation** brought Chief Executives and Chairs of NHS bodies together to meet newly elected Senedd Members in informal introductions. This again was useful and allowed for some brief discussions with some of the 24 Senedd Members of our region.

I continue to attend a number of events across the north of Wales, all of which give me an insight into the work of staff and partners. I am often inspired and reminded of the excellent work that takes place in our Health Board and communities on a regular basis. Such an occasion was the opportunity to be present at a viewing of **'This Too Will Pass: My Bipolar Life'**, at Y Ganolfan, Porthmadog earlier this month. The film captures the story of **Chris Eastwood** and was a result of BCUHB working closely with **Llais**. The discussion following the film highlighted our efforts to embrace coproduction and support patients and families in shaping services. The film can be viewed here <https://youtu.be/uliVWOgd-7o>

Members of the **Filipino Community** celebrated **Philippine Independence Day** on June 12 and I was glad to be present at the event at Rhyl Town Hall. As well as celebrating the special day, it was also an opportunity for me to thank the many members of the Filipino Community for their contribution to the work of the Health Board over the years.

It is always a privilege to be part of the **Graduation Ceremonies for Supported Interns** that are an annual event across the region. The internship programme supports young people in the workplace and can lead to permanent employment for many of the cohort. This project offers practical assistance for young people who require extra support but also promotes their independence. It is an excellent programme and benefits from positive support from partners.

Below is a summary of some of my meetings and visits up to July 22, 2026.

Date	Meeting / Visit
26 May	All Wales Chair Peer Group
26 May	Pam Wenger, Director of Corporate Governance
26 May	Caroline Turner Independent Member Appraisal
26 May	Independent Members Meeting
26 May	Independent Members, Chief Executive and Director of Corporate Governance
26 May	Jane Farrell, Improvement Advisor
27 May	Cabinet Minister visit to Ysbyty Glan Clwyd
27 May	Rhian Watcyn Jones Independent Member Appraisal
27 May	Board Development
28 May	Health Board Meeting

Date	Meeting / Visit
1 June	Stakeholder Reference Group
1 June	Weekly Performance Review
2 June	Andrew Morgan, Chair Aneurin Bevan University Health Board
2 June	BCUHB Welsh Language Team
2 June	Pam Wenger, Director of Corporate Governance
2 June	Chairs' Advisory Group
3 June	Gareth Williams Vice Chair
3 June	Paul Lambert Independent Member
3 June	School of Health Sciences Student Award Ceremony Bangor University
4 June	Billy Nichols Independent Member Appraisal
5 June	Graduation Ceremony for Supported Interns from Ysbyty Glan Clwyd at Coleg Llandrillo
8 June	Carol Shillabeer, Chief Executive
8 June	Pam Wenger, Director of Corporate Governance
8 June	Board Development discussion
8 June	Weekly Performance Review
10 June	Dyfed Jones Independent Member
10 June	Mabon Ap Gwynfor Cabinet Minister for Health and Social Care
11 June	People and Culture Committee
11 June	Agenda setting for July Board
11 June	Carol Shillabeer Chief Executive
12 June	Kalayaan 2026 - Philippine Independence Day Celebration, Rhyl
15 June	Mabon Ap Gwynfor Cabinet Minister for Health and Social Care, Cardiff
16 June	Janet Finch-Saunders MS, Cardiff
16 June	Senedd Event for NHS Leaders, Cardiff
17 June	Debbie Eyitayo Director of Workforce and Organisational Development
17 June	Pam Wenger Director of Corporate Governance
18 June	Jacqueline Totterdell, Chief Executive NHS Wales
19 June	Joint Bangor University -BCUHB Strategic Steering Group
22 June	Graduation Ceremony for Supported Interns, Coleg Menai
22 June	Pam Wenger Director of Corporate Governance
22 June	Paolo Tardivel Director of Innovation and Planning
22 June	Weekly Performance Review
23 June	Audit Committee
23 June	Nick Wood, Deputy Chief Executive NHS Wales
24 June	Presentation to Switchboard Staff at Ysbyty Gwynedd
24 June	Chairs Advisory Group

Date	Meeting / Visit
25 June	Annual Report and Accounts and Board Development, Venue Cymru
26 June	Tehmeena Ajmal, Chief Operating Officer
26 June	Escalation Board Briefing Session
6 July	Briefing Sessions with MPs and MSs of the region
6 July	Weekly Performance Review
7 July	Pam Wenger, Director of Corporate Governance
7 July	Planned Care Meeting
8 July	Welsh Government Health and Care Ministers and NHS Leaders
8 July	Escalation Board pre-meeting
8 July	Carol Shillabeer, Chief Executive
9 July	Ysbyty Gwynedd with Welsh Government Officials and Cabinet Minister
9 July	Escalation Board with Welsh Government, Llandudno Junction
13 July	Chris Couchman, Associate Director of Primary Care
13 July	Penygroes Project Team
14 July	Remuneration Committee
14 July	Gareth Williams, Vice Chair
14 July	Pam Wenger, Director of Corporate Governance
14 July	Finance Oversight Group
14 July	Escalation Debriefing session for Board
15 July	Screening of This Too Will Pass at Y Ganolfan Porthmadog
15 July	Filming for July Board
15 July	Dyfed Jones Independent Member Appraisal
15 July	Helen Stevens-Jones, Director of Partnerships, Engagement and Communication
16 July	Matthew Edwards and Toma Haslam, Audit Wales
16 July	Carol Shillabeer, Chief Executive
16 July	Councillor Craig Ab Iago
17 July	Performance Finance Information Governance Committee
20 July	Interview Panel for Deputy CEO role
20 July	Performance Weekly Review
21 July	Pam Wenger, Director of Corporate Governance
21 July	Interview Panel for Interim Executive Director of Nursing
22 July	Public Bodies Chair Group Meeting
22 July	Intervention Meeting with Welsh Government



Health Board

CHIEF EXECUTIVE REPORT

Dyddiad y Cyfarfod Date of Meeting	30 July 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Carol Shillabeer, Chief Executive Officer
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Carol Shillabeer, Chief Executive Officer
Pwrpas yr Adroddiad Report Purpose	For Noting

Crynodeb Gweithredol **Executive Summary**

This report provides an overview of key activity undertaken by the Chief Executive between 14 May and 15 July 2026. The reporting period has been characterised by continued engagement with Welsh Government and NHS Wales Performance and Improvement following the announcement of Ministerial Directed Intervention, alongside progress in delivering the Health Board's improvement, recovery and transformation priorities.

The report highlights leadership and organisational developments, strategic engagement with national stakeholders and elected representatives, and examples of service excellence and innovation across the Health Board. Members are asked to note the report.

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

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

Acronymau / Rhestr Termau Acronyms / Glossary of Terms	
BCUHB	Betsi Cadwaladr University Health Board
NHS	National Health Service
CEO	Chief Executive Officer

1.0 INTRODUCTION

This report has been developed to provide an overview of key activity, progress and issues by the Chief Executive. It covers the period 14 May to 15 July 2026.

2.0 INTERFACE WITH WELSH GOVERNMENT

2.1 Escalation Board Meetings

The Health Board remains subject to Welsh Government Level 5 intervention arrangements and continues to work closely with Welsh Government and NHS Wales Performance and Improvement to support recovery and organisational improvement. Since the Cabinet Minister for Health and Care announced Ministerial Directed Intervention in June 2026, work has continued to progress the agreed improvement priorities, including preparations for the Well-Led Review and delivery of the organisation's recovery trajectories. A separate report elsewhere on this agenda provides a more detailed update on intervention arrangements, recent Escalation Board discussions, the Minister's expectations and the actions being taken in response to support sustained improvement and progress towards de-escalation.

3.0 KEY UPDATES

3.1 Executive Team

Angela Wood, Executive Director of Nursing will be retiring shortly following 39 years in the NHS. This is a phenomenal achievement and the Board and I would like to extend sincere thanks to Angela for her service and dedication to the NHS in North Wales. She has been a powerful advocate for nursing and overseen a wide range of improvements to the way safe, quality care is delivered. We wish her all the very best wishes for a fulfilling and joyful retirement.

We will also shortly be saying goodbye and thank you to Tehmeena Ajmal, Chief Operating Officer. Tehmeena has played an important role in supporting our services and teams and shown a strong commitment to improving care for the communities the health board serves. Her energy, insight and collaborative approach have been greatly valued by colleagues across the organisation. On behalf of the Health Board, I would like to thank Tehmeena for her contribution and leadership, and to wish her every success for the future.

Finally, Russell Caldicott, Executive Director of Finance and Performance, has recently been appointed to the role of Chief Finance Officer at University Hospital of North Midlands and will leave the Health Board at the beginning of October 2026. Russell has been with the health board for the past three years, joining at a particularly challenging time. While we continue to face challenges, there has been significant progress in strengthening our financial governance and improving performance during that time. Russell has played a key role in driving that improvement, and we are grateful for his significant contribution to the organisation. On behalf of the Board, I would like to thank Russell for his leadership and commitment over the past three years and wish him every success in his new role.

Work continues to strengthen the Executive Team and recruitment arrangements are in hand for these posts. Interim arrangements are being implemented where necessary to maintain continuity of leadership and organisational oversight while recruitment processes are completed. These arrangements support delivery of the Health Board's improvement priorities, including Special Measures requirements, and the Foundations for the Future programme.

4.0 MEETINGS/VISITS

4.1 Leading the Year Ahead

In May I convened a session of senior leadership within the Health Board to reflect on delivery over the previous year and align leadership focus on the key priorities for 2026/27. The session's focus was on *Leading the Year Ahead* and reinforced the need for a collective approach to improvement, with an emphasis on sustainable delivery, value, productivity, quality, population health and timely access to care. The outputs have informed the Health Board's planning and delivery arrangements, with priorities translated into defined programmes, performance trajectories and enabling actions that will be monitored through existing governance and accountability arrangements throughout the year.

4.2 Cabinet Minister for Health and Care Visit

In early July, the Health Board was pleased to welcome the Cabinet Minister for Health and Care to Ysbyty Gwynedd for a visit focused on urgent and emergency care services and flow through the hospital. The visit provided an opportunity to discuss the challenges facing the Emergency Department while showcasing the improvements being delivered to enhance patient flow, strengthen senior clinical decision-making, improve ambulance handovers and reduce corridor care. The Cabinet Minister met frontline staff and heard directly about the work underway to improve the quality, safety and timeliness of care for patients across North Wales. The visit also included meeting the Home First Bureau Discharge Team, where colleagues demonstrated the arrangements in place to support timely discharge and help patients return home as soon as they are well enough. Finally, the Cabinet Minister met with clinical colleagues in the Minor Operations Suite, where significant

efficiencies have been achieved, enabling more patients to be seen and treated more quickly.

On the same day, Welsh Government officials visited the new North Wales Surgical Centre in Llandudno to see the build and to meet the programme and clinical leads. The centre continues to make progress towards opening with the current timetable driven by completion, testing and validation of the building and its systems. Strict infection prevention standards must be met before the centre can welcome patients, as is standard for any new healthcare building.

The Director General of Health and Care, Jacqueline Toterdell, also visited the Emergency Department of Ysbyty Glan Clwyd to see the improvements and future plans. This was following the Cabinet Minister for Health and Care's earlier visit on the 28th May where he walked through the emergency pathway. These visits are welcomed and an opportunity to present the plans in place.

4.3 Meeting Welsh NHS Leaders – Senedd drop in

On 16 June, the Chair and I attended the Welsh NHS Confederation's Senedd drop-in event. The event brought together NHS leaders and newly elected Members of the Senedd to provide an opportunity to discuss the priorities and challenges facing health services, and to establish relationships and future engagement with elected representatives. More than 30 Members of the Senedd attended, providing a valuable opportunity to strengthen connections and raise awareness of the Health Board's work and priorities.

4.4 Primary Care Summit

On 18th June, I joined other key colleagues from the health board in attending the Primary Care Summit convened by the Cabinet Minister for Health and Care. The summit brought together senior NHS leaders to consider how the ambitions set out through the Community by Design Transformation Programme could be translated into practical delivery, with a focus on prevention, early intervention and care closer to home. There was broad agreement on the strategic direction of travel, with discussion centred on accelerating implementation, establishing clear accountability and supporting a sustainable shift of services and resources towards community and primary care settings. Further work will now be taken forward through the Community by Design Transformation Programme, including the development of plans to support increased investment in primary care and community-based services over future years.

4.5 Graduate Summit

On the same date a Graduate Summit was also convened by the Cabinet Minister for Health and Care, which brought together NHS Wales organisations, Higher Education institutions and system partners to consider the employment position for

nursing, midwifery and paramedic graduates qualifying in summer 2026. Discussion focused on maximising employment opportunities for graduates, strengthening transition arrangements into the workforce and ensuring consistent support for those not immediately securing substantive posts. The summit also highlighted the need for longer-term improvements to workforce planning, education commissioning and workforce modelling to better align training places with future service demand. A coordinated all-Wales approach will now be taken forward through Welsh Government, Health Education and Improvement Wales and NHS organisations

4.6 MS and MP briefings

On 6th July, I joined the Chair in hosting an online briefing session for North Wales Members of the Senedd and Members of Parliament, including newly elected representatives. The session formed part of our ongoing commitment to open and transparent engagement with elected members and provided an opportunity to discuss the challenges facing the Health Board, progress made in key areas of performance improvement and our long-term plans for transforming health and care services across North Wales. Attendees received an update on improvements in planned care and diagnostics, ongoing work to address pressures within urgent and emergency care, and the steps being taken to strengthen and accelerate the organisation's improvement journey.

The session also provided an opportunity to discuss the Health Board's strategic direction, including the development of a sustainable health and care system through the Integrated Medium-Term Plan, Community by Design and the Clinical Services Plan, alongside an open question-and-answer session. Further engagement sessions are planned to support continued dialogue and strengthen relationships with Members representing communities across North Wales.

5.0 RECOGNITION

5.1 National Recognition for Intravenous Access Services

BCUHB's award-winning Intravenous Access Service received national recognition at the National Infusion and Vascular Access Society conference, where colleagues were invited to deliver a keynote presentation to specialists from across the UK and internationally. The service was showcased as an example of excellence in practice, with evidence demonstrating improvements in patient outcomes, reduced complications, improved patient flow and cost efficiencies. Interest has subsequently been received from a number of organisations keen to visit and learn from the service, and the team has been invited to contribute to future national best practice guidance.

5.2 National Recognition for Stroke Service Improvement

The Health Board's stroke services received recognition from NHS Wales for their implementation of Pre-Hospital Video Triage across North Wales. National feedback

highlighted the potential of the approach to support timely assessment and access to specialist interventions, including thrombolysis and thrombectomy, and recognised the commitment and leadership of colleagues driving this improvement work. While stroke outcomes remain an area of focus for the Health Board, this recognition reflects the ongoing efforts being made to strengthen stroke pathways and improve outcomes for patients across North Wales.

5.3 Emergency Preparedness, Resilience and Response (EPRR)

I am pleased to report that BCUHB's Emergency Preparedness, Resilience and Response Team has received significant external recognition for its work to strengthen organisational resilience and business continuity arrangements across the Health Board. The team has been shortlisted for the NHS Wales Team Culture Award 2026, recognising its collaborative approach to embedding resilience as a shared organisational responsibility through strong leadership, engagement, innovation and governance.

In addition, Katie Spruce, Deputy Head of Emergency Preparedness, Resilience and Response, has been shortlisted for the Business Continuity Institute (BCI) Europe Awards 2026 in the Continuity & Resilience Newcomer category. Her shortlisting reflects both her personal achievement and the growing reputation of the Health Board's resilience function, with the awards recognising excellence across organisations and professionals from throughout Europe.

These achievements demonstrate the progress being made in strengthening resilience across the organisation and provide valuable external validation of the high-quality work being delivered by the EPRR team. Together, they highlight BCUHB's commitment to developing a resilient organisation that is well-prepared to respond to emergencies, major incidents and service disruption while maintaining continuity of care for our population.

5.0 CONCLUSION

The report intends to give an overview of key activities undertaken by the Chief Executive as well as important matters to draw attention to which may or may not be subject of other more detailed reports. Feedback on the report is welcome.

6.0 RECOMMENDATIONS

Members of the Board are asked to

- **NOTE** the updates provided in this report

ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol Link to Strategic Priorities	1. I  ng al  ctive  iisati   Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Yr Egwyddorion Dylunio Design Principles	People First Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	The activity outlined in this report does not give rise to any new corporate risks. The areas of focus during the reporting period particularly leadership and governance, delivery of improvement priorities, performance recovery and strengthening accountability are aligned to existing risks within the Board Assurance Framework and continue to be managed through established governance and escalation arrangements. Engagement with Welsh Government and the Intervention Support Team provides additional scrutiny and assurance against these risks, with progress and issues reported through the Executive Team, relevant oversight meetings and Board committees in line with the NHS Wales Accountability Framework.

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Cydraddoldeb <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	<i>Not required</i>
Asesiad o'r Effaith Economaidd-gymdeithasol <i>A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?</i> Socio-Economic Impact Assessment	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	<i>Not required</i>

<i>Have you undertaken a Socio-Economic Impact Assessment</i>		
<u>Ansawdd</u> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i> <u>Quality</u> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Galluogwyr Ansawdd Enablers of Quality All Apply	Meysydd Ansawdd Domains of Quality All Apply
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
<u>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant</u> <u>Wellbeing of Future Generations Act – Wellbeing Goals</u>	Not Applicable	

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

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

Health Board**HEALTH BOARD ESCALATION PROGRESS REPORT**

Dyddiad y Cyfarfod Date of Meeting	30 July 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Pam Wenger, Director of Corporate Governance
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Pam Wenger, Director of Corporate Governance
Pwrpas yr Adroddiad Report Purpose	For Noting

Crynodeb Gweithredol
Executive Summary

This report provides the Board with an update on the Health Board's continued engagement with Welsh Government through the Escalation Board process since the previous Board meeting in May 2026. The Health Board remains in Level 5 escalation arrangements, and Welsh Government has confirmed Ministerial Directed Intervention arrangements, including the commissioning of an independent Well-Led Review to assess leadership, governance, organisational culture, capability and readiness to deliver sustainable improvement.

The report summarises the key matters considered at the Ministerial Escalation Board meeting held on 9 July 2026, which focused on leadership, governance, quality, operational performance, workforce, financial sustainability and organisational transformation. The meeting provided an opportunity for the Health Board to demonstrate progress, discuss areas requiring further improvement, and show how strengthened governance, assurance reporting and organisational oversight are supporting the wider improvement journey.

The Escalation Board process and the forthcoming Well-Led Review are closely aligned and together provide an important framework for support, challenge and independent assessment of progress. While positive progress has been

recognised, the Health Board will need to continue demonstrating pace, consistency and sustainability of improvement across the organisation to support future consideration of de-escalation.

The Board is asked to note the update, note the commencement of the Well-Led Review, and take assurance that the Escalation Board process continues to provide a structured mechanism for assessing progress against Welsh Government expectations and supporting the Health Board's ongoing improvement and future de-escalation journey.

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

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

N/A		

Acronymau / Rhestr Termiau
Acronyms / Glossary of Terms

BCUHB	Betsi Cadwaladr University Health Board

HEALTH BOARD LEVEL 5 ESCALATION PROGRESS REPORT

1. Y SEFYLLFA/SITUATION

The report summarises the key discussions and outcomes from the Ministerial Escalation Board meeting held on 9 July 2026, which considered leadership, governance, quality, operational performance, workforce, financial sustainability and organisational transformation. The meeting provided an opportunity to demonstrate progress, discuss ongoing challenges and consider the organisational capacity and capability required to support sustainable improvement.

The Escalation Board process and forthcoming Well-Led Review are closely aligned and together provide an important framework for support, challenge and independent assessment of the Health Board's improvement journey. While positive progress has been recognised, continued focus will be required to demonstrate the pace, consistency and sustainability of improvement necessary to support future de-escalation decisions.

The Board is asked to note the report, note the commencement of the Well-Led Review, and take assurance that the Escalation Board process continues to provide a structured mechanism for assessing progress against Welsh Government expectations and supporting the Health Board's journey towards sustainable improvement and future de-escalation.

2. Y CEFNDIR/BACKGROUND

The Health Board remains subject to Level 5 escalation arrangements. The Escalation Board is the principal mechanism through which Welsh Government monitors progress, provides support and challenge, and assesses whether the Health Board is delivering the leadership, governance and organisational improvements required to support sustainable recovery.

The scope of the escalation extends beyond operational performance and includes oversight of leadership effectiveness, governance arrangements, organisational culture, capability and capacity. These factors are central to Welsh Government's assessment of progress and will be key considerations in any future de-escalation decisions.

In the new Government's 100 day plan a review, in partnership with Audit Wales, the Escalation and Intervention Framework was indicated. A letter has now been received from Welsh Government officials seeking contribution from the NHS. A process is being established internally to enable Board colleagues to form a response.

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

3.1 Ministerial Directed Intervention and Well-Led Review

In June 2026, following the Cabinet Secretary for Health and Social Care's oral statement regarding the Health Board's escalation status and future support arrangements, Welsh Government confirmed Ministerial Directed Intervention arrangements, including the commissioning of an independent Well-Led Review. The review will assess the effectiveness of leadership, governance, organisational culture and capability, together with the Health Board's readiness to deliver sustainable improvement. The detail of the review has subsequently indicated that the quality elements will not be part of the Well-Led assessment, instead forming part of the ongoing support through NHS Performance and Improvement.

The review will provide an independent assessment of the organisational conditions required to support long-term improvement and will complement the Escalation Board process in informing future decisions regarding the Health Board's improvement and de-escalation journey.

3.2 Escalation Board Activity Since May 2026

Since the Board meeting in May 2026, the Health Board has continued to engage with Welsh Government through formal escalation arrangements, including regular discussions with NHS Performance and Improvement, progress review meetings and Escalation Board sessions held during May and June 2026, culminating in the Ministerial Escalation Board meeting on 9 July 2026. These meetings were supported by a wider programme of organisational briefings, preparatory discussions and site visits.

The ongoing engagement with NHS Performance and Improvement provided an opportunity to review progress against escalation priorities, discuss emerging risks and challenges, consider evidence of improvement and support preparation for the Ministerial Escalation Board. This engagement enabled Welsh Government to maintain oversight of progress whilst providing both challenge and support in relation to the Health Board's improvement journey.

The Ministerial Escalation Board, chaired by the Cabinet Minister, represented an important milestone within this wider programme of engagement. Discussions focused mainly on:

- leadership,
- governance and Board assurance arrangements,
- operational performance,
- workforce, and

- financial performance.

3.3 Key Themes Discussed

3.3.1 Leadership

A significant part of the Escalation Board focused on leadership and culture and the pace of progress over the last 3 years. The health board team set out in a slidepack the starting point at escalation in 2023; the progress made to reach the current position, the next stage plan and the intended results and assurance.

Leadership (Well Led)

Where we were (baseline 2023) - Audit Wales 'Board Effectiveness' points to dysfunction; significant breakdown Board relationships leading to Escalation; Accounts Issue (highly contentious) - Directly appointed Independent members (x4); no governance committees in place; no CEO; 50% Executive team - Significant organisational cultural issues	Where we are now (current) - Board Effectiveness confirmed by Audit Wales and significantly improved. Structured Assessments confirm continuous improvement. - Cultural Change Programme well-established – Board-led - Exec Team turnover, presents challenge - Strengthening wider organisational leadership crucial
Where we intend to get to next (plan) - Well-Led Review – monthly reporting, final report October. Establishing internal mechanism as more information becomes available. - Executive Recruitment: Exec Director Nursing; Chief Operating Officer; Exec Director of Finance - Implementation of Foundations for the Future 'People' workstream – leadership development/talent management - Cultural Change Programme Phase 2 implementation (Michael West continues to support), with over 200 Culture Change Leaders now in place - Board Development Programme agreed (12 months), to build on development already undertaken.	How we will know we get there (results/assurance) - Outcomes of Well-Led Review (People and Culture Committee/whole Board) - Substantive recruitment into Executive Team roles (Remuneration Committee oversight) - 'People' workstream (FtF) outcomes achieved (P & C Committee) - Cultural Dashboard results; Organisational Development Intervention approach for teams in need of additional support/intervention (P & C Committee) - Outcome tracking part of Board Development Programme (whole Board); Structured Assessment 2026 – Audit Wales (revised format)

3.3.2 Delivery/performance – planned care

This area is both high profile and of specific focus for the health board and Welsh Government. Significant progress has been made in relation to planned care and diagnostics. Cancer performance is being maintained; however this is below the de-escalation criteria (this is subject to further discussion as re-submitted data indicates improved performance). The health board over 104-week RTT performance is currently meeting de-escalation criteria. The eradication of over 104 week waits and over 8-week waits for diagnostics is now a requirement of all health boards. Plans have been submitted to reflect the action proposed to move to eradication of 104 week referral to treatment waits and over 8-week diagnostic waits.

Delivery/Performance – Planned Care, Cancer & Diagnostics

Where we were (baseline 2023) - Significant outlier on performance; with increasing referral rates outstripping capacity (worsening position particularly regarding cancer which saw a doubling of referrals over 5 year period) - Limited Executive oversight – recovery plan of £80M unfunded - wholly reliant on outsourcing - No Chief Operating Officer; individual Integrated Health Community working - No Performance Committee	Where we are now (current) - Over 104 weeks waits: Cohort 49,600 (end July 2025), down to 2,340 (end June 2026). Meeting de-escalation standard of 97% of people waiting less than 104 weeks. Tracking above IMTP trajectory - Over 52 week waits: Cohort 155k (August 2025), down to 32K (end June 2026). Not yet meeting de-escalation standard of 98% of people waiting under 52 weeks for first outpatient - Cancer: Reaching 54% against mean of 60% across Wales. Issues: skin, urology, gastroenterology, breast. Not yet meeting de-escalation standard of 55% - Diagnostics: significantly improved. On track to meet IMTP trajectory. Risk for 2nd half of year – to be fully mitigated
Where we intend to get to next (plan) - 104 weeks – intend to get to zero. Plan submission 19th July; Board oversight. - Over 52 weeks – intend to meet de-escalation standard. - Cancer – plan to meet de-escalation standard and move beyond. New plan for skin final stages. - Diagnostics – plan to get to de-escalation standard. Risk mitigation underway - Critical underpinning: more pan-BCU working, moving toward single PTL to improve Treat in Turn rates; internal capacity maximisation and shift of pathway.	How we will know we get there (results/assurance) - Recovery Director bringing additional capacity and expertise; support needed to shift to single PTL for priority specialties - Overarching Planned care, cancer and diagnostics plan – key milestones being met, plus intended impact being delivered - Weekly oversight – Chair and Vice Chair; PFIG scrutiny; whole Board focus - Submission of 104 week plan and wider planned care plan to WG – ensure full alignment internally to performance reporting – reset trajectory tracking (results).

3.3.3 Delivery/Performance – Urgent and Emergency Care

The issue of urgent and emergency care is a major focus for the health board. The Board approved the Emergency Department Sustainable Workforce Business Case in June; the implementation of this is key in the forward plan for improvement. The Board will consider progress as a separate item of business on the agenda.

Delivery/Performance - UEC

Where we were (baseline 2023) - Significant longstanding challenges in relation to performance at Wrexham Maelor Hospital (4 hours/12 hours); Ysbyty Glan Clwyd (HIW escalation in 2022); less so in Ysbyty Gwynedd (award winning doctor training programmes), however significant issues relating to pathway of care delays.	Where we are now (current) - Largely tracking IMTP trajectories (although not meeting de-escalation standard) - Pan-BCU UEC plan in final stages (with input of external advisors and NHS P and I); underpinned by each IHC plan given differing patterns of challenge and opportunity - Single biggest area of concern for Board - approved workforce sustainability business case; Board UEC Oversight Group established - Ysbyty Glan Clwyd ED Improvement Plan (HIW) in place; assessment complete from other 2 DGHs - Handover 45 plans developed – YGC plan aligned to HIW response
Where we intend to get to next (plan) - Implementation staffing business case to improve demand capacity balance/resilience/safety - Reduction number Pathway 3 patients - New Integrated Discharge Hub (YG); New Urgent Treatment Centre (YGC); Estate/special modifications – WMH and YG - Handover 45 - implementation - Shared Purpose with Local Authorities as aim 50% reduction in bed days delayed by end March 2027 - YGC specific plan – culture, leadership, clinical safety - Improved patient and staff experience feedback	How we will know we get there (results/assurance) - Agreed UEC plan with tracking of actions in line with agreed milestones, underpinned by each IHC 90 day delivery cycles (PFIG and QSE Committee) - Patient experience feedback (QSE) - Focus on Handover 45, including delivery of reduction in community waits – improved performance information regarding WAST access - Reduction pathways of care delays (PFIG/QSE)

3.3.4 Quality

The health board team outlined to Welsh Government and the new Cabinet Minister in particular the baseline position at escalation under Level 5 back in 2023 and shared as assessment of the current position. The intended forward plan headline were also shared with a focus on maturing the QMS, implementing the mental health Electronic Health Record and simplifying and strengthening the internal quality governance approach.

Quality

Where we were (baseline 2023) - No Quality Committee in place - Highest number of Prevention of Future Death Notices from HM Coroner in Wales (more than other HB collectively) – key issues: investigation process, lack of Electronic Health Record, urgent and emergency care pathways. - Poor complaint management processes; no citizen experience reports at Board/Committee; lack patient experience feedback - No Quality Management System; immature approach to Clinical Audit; Service oversight	Where we are now (current) - Effective Quality Committee; Audit Wales Quality Governance Review influencing next stage of development - Citizen Experience reporting regularly at Board; good feedback rates from patient. Focus on ED patient experience (poorest rating of all services) – biggest safety and experience issue. - QMS in place, now next stage development – focusing on ‘fragile’ services aligned to Clinical services Plan and FftF. - Significant progress on investigations – lower number PFDs; - Mental Health Electronic Health Record secured
Where we intend to get to next (plan) - Implement recommendations from Quality Governance Review - Simplify and strengthen internal quality governance approach - Implement QMS for all ‘fragile’ services; focus on higher risks - Implement MH EHR; engage in national digital strategy to reinstate work on wider EHR (noting community EHR not supported in DPIP review) - Implement improvement plan for Urgent and Emergency care – particular focus on ED safety and experience	How we will know we get there (results/assurance) - Tracking implementation of Quality Governance Review actions (Quality, Safety and Experience Committee) - All ‘fragile service’ have QMS assessment and a Quality Improvement/Quality Control and Quality Assurance Plan (QSE Committee) - UEC Oversight Group (Board level) – assurance on implementation of improvement plan. Regular liaison with HIW - Significant incidents/investigations oversight and learning evidenced (QSE; HM Coroner – PFDs; PSOW)

3.3.5 Planning

The baseline position was shared including the work of Sally Attwood in relation to an external review. The current position demonstrates the significant progress made in this domain and Welsh Government has recognised this progress. The plan for further development was clearly set out as were the results and assurances expected.

Finance/Planning

Where we were (baseline 2023) - No Planning, Population Health and Partnerships Committee - No Special Measures Response Plan; No Annual Plan/IMTP – hence no plan tracking/implementation oversight - Planning approach very limited across organisation. External Review commissioned – Sally Attwood	Where we are now (current) - Integrated Planning Framework approved by Board Sept 2023, recently updated; Submitted 1st balanced IMTP (2025/26) although not approved - Planning, Population Health and Partnerships Committee well established; good oversight Annual Plan/IMTP formation and implementation - Planning Maturity Matrix – mainly Level 2. Immature operational service planning needing urgent work - Strategic Intent Statements (x4) – approved by Board Nov 2025, providing clear strategic vision and direction
Where we intend to get to next (plan) - Implement the improvement actions aligned to Planning Maturity Matrix (aligned to Foundations for the Future) and Integrated Planning Framework – particularly related to operational service planning - Next stage development Strategy and Clinical Services Plan, building on Board approved Strategic Intent Statements/Vision; ensuring QMS assessment of 'fragile' services forms key part; with Community by Design at its heart - Implement Annual Plan 2026/27	How we will know we get there (results/assurance) - Tracking implementation of improvement actions (PPHP Committee) - Clinical Services Plan developed and agreed implementation approach - now a Major Change Programme; tracking milestone delivery, testing leadership and engagement (PPHP Committee/whole Board) - Quarterly tracking of Annual Plan deliverables; including delivery confidence and escalation/recovery where needed (all HB Committees) – reported at Board

3.3.6 Finance

The Escalation Board meeting discussed the current financial position and the work to develop a recovery plan to meet breakeven. It is acknowledged that significant progress has been made in relation to financial governance, probity and performance. The current financial climate however is challenging and the Welsh government highlighted that the organisation at the time had the lowest level of savings against overall budget of any health board in Wales.

Finance/Planning

Where we were (baseline 2023) - £134M deficit plan with additional £50M savings plan not underwritten. - 'No opinion' on financial accounts by Audit Wales - Forensic investigation into financial irregularities (EY report) – including significant staff impacts, political scrutiny - No Audit Committee/Performance and Finance Committee - Limited effectiveness on internal financial controls (governance)	Where we are now (current) - Delivered financial governance improvement plan actions - Improved financial performance (2nd best HB) – each year. Set balanced plan, however missed by £17M 2025/26. - 'Clean bill of health' financial accounts for 3 years running - Value and Sustainability Approach established – delivering significant cost reductions - EY matter (including HR issues) now closed – Accountable Officer Report to Board 2025. - Challenged in-year financial environment – stage 1 – underwrite savings plan; stage 2 – stretch savings to achieve break-even position. Board discussions underway.
Where we intend to get to next (plan) - Financial savings – end Q1 at least 50% savings identified and classified as 'green'. End July, August and Sept key milestones for further stretch (including Board level decisions). - Strengthen further Value and Sustainability approach and pipeline, focusing on clinical variation linking to national workstream, and workforce (noting wider system working on right-sizing the workforce). Balance Grip and Control. - Alongside Clinical Service Plan development, enable the medium-long term financial approach	How we will know we get there (results/assurance) - Underpinned savings plan, delivering to profile (Performance, Finance and Information Governance Committee) - Significant pipeline opportunities (moving from red to amber to green), including for 2027/28 and beyond. (PFIG Committee) - Medium-long term financial approach embedded into Clinical Service Planning, particularly regarding Community by Design and resource allocation/allocative efficiency (tested by PPHP Committee)

3.3.7 Workforce

The focus of the discussion regarding workforce centred upon workforce plans that support service delivery. In recognising that the health board did not have a workforce planning function or framework at the time of escalation (2023) both are now in place, although at present the capacity for workforce planning remains limited and subject to development under Foundations for the Future. Structural change was also discussed and a separate briefing for the Director of Workforce at Welsh Government has taken place.

Workforce

Where we were (baseline 2023) - Significant gap in Professional leadership – no Executive Director of People and OD - No People and Culture Committee - Very high levels of external agency interim staff (at all levels) - No workforce planning function/no medical staffing function - No culture/OD development plans - High levels of vacancies; high levels of bank and agency - No Staff Experience reporting to Board - Limited strategic connection with Higher and Further Education	Where we are now (current) - People and Culture Committee well established; Exec Director. - Workforce Planning Framework/(small) function now in place - Strong Partnership Forum and JLNC - Significant reduction in external agency interims (targeted only) - Vacancies reduced; retention increased; investment in staffing levels (£12M in nursing; 300+ additional doctors last 5 years) - Culture Change Programme and OD approach; Staff Engagement and Experience Team/approach in place – however staff survey results mixed (higher participation a positive) - MOUs with Education institutes (new Medical School)
Where we intend to get to next (plan) - Workforce planning implementation aligned to ‘fragile services’ work to be completed - Value and Sustainability workforce workstream phase 1 implementation (largely transactional), and Phase 2 work-up (Right-sizing the workforce) - Culture Change Programme implementation of milestones - Foundations for the Future structural change programme – consultation and ‘Delivery Phase’ by end of year	How we will know we get there (results/assurance) - Alignment of clinical service plan, QMS, and workforce planning for ‘fragile’ services (P & C Committee with PPHP and QSE) - Fully worked up V and S Workforce Workstream, approved Phase 2 approach (P & C/PFIG committees) - Foundation for the Future Structures workstream delivered (P & C committee) - Culture Dashboard results, including OD interventions tracking (P & C Committee)

The Health Board presented evidence of progress across a number of these areas, including strengthened governance and oversight arrangements, enhanced quality governance, improvements in assurance reporting and greater organisational focus on learning, accountability and continuous improvement. Discussions also recognised the importance of sustaining momentum and demonstrating that improvements are being embedded across the organisation in a consistent and measurable manner.

This engagement provided an opportunity for Welsh Government, NHS Performance and Improvement, and Health Board leadership to reflect on progress to date, consider areas requiring further development, and discuss the organisational capability and conditions required to support sustainable improvement and future de-escalation

3.4 De-escalation Criteria

The Health Board remains subject to Level 5 escalation arrangements. Decisions regarding future de-escalation will not be determined by a single event or review but will be informed by Welsh Government's assessment of whether improvement has been demonstrated.

Through the Escalation Board process, Welsh Government considers a range of factors including leadership effectiveness, governance and accountability arrangements, organisational culture, quality and safety, operational performance, workforce sustainability, financial stewardship and the organisation's capability to deliver long-term improvement.

A key consideration is not only whether improvement has been achieved, but whether it can be evidenced as sustainable and embedded across the organisation. This includes demonstrating effective Board leadership, robust assurance arrangements, a culture of continuous improvement, and the organisational capacity and capability required to maintain progress over time.

Evidence to support future de-escalation considerations is therefore drawn from a range of sources, including the Escalation Board process, ongoing engagement with NHS Performance and Improvement, organisational performance and assurance information, external reviews and inspections, and the findings of the forthcoming Well-Led Review.

The Health Board position against the criteria is attached at Appendix 1 and the Presentation Pack from the meeting in July attached at Appendix 2. These appendices are included in the supporting papers.

3.5 Assurance

The Board can take assurance that:

- The Health Board continues to engage proactively and constructively with Welsh Government and NHS Performance and Improvement through the established escalation arrangements, including regular review meetings and the Escalation Board process.
- Since May 2026, a programme of engagement has taken place encompassing Escalation Board discussions, progress review meetings, organisational briefings, site visits and the Ministerial Escalation Board held on 9 July 2026, providing opportunities to review progress, identify areas requiring further improvement and discuss organisational priorities.
- The themes considered through the escalation process align closely with the scope of the forthcoming Well-Led Review, including leadership, governance, organisational culture, quality, operational performance, workforce sustainability and organisational capability.
- The Escalation Board process continues to provide Welsh Government with a structured mechanism through which to assess progress, provide support and challenge, and consider the Health Board's readiness to deliver sustainable improvement and progress towards future de-escalation.

- The forthcoming Well-Led Review will provide an independent assessment of the Health Board's leadership, governance and organisational effectiveness and will contribute to the evidence base informing future improvement and de-escalation considerations.

Whilst progress has been recognised across a number of areas, Welsh Government has been clear that future de-escalation considerations will require evidence that improvements are not only being delivered but are embedded and sustainable.

Continued focus will therefore be required to demonstrate effective leadership, strong governance and assurance arrangements, organisational capability, and sustained improvement in quality, operational performance and financial stewardship. The ongoing engagement with NHS Performance and Improvement, the Escalation Board process and the Well-Led Review will provide important mechanisms through which progress can continue to be assessed, challenged and evidenced.

ARGYMHELLION/RECOMMENDATIONS

The Board is asked to:

- **NOTE** the update on Health Board escalation arrangements and engagement with Welsh Government and NHS Performance and Improvement since May 2026, including Escalation Board activity and the Ministerial Escalation Board meeting held on 9 July 2026.
- **NOTE** the commencement of the Well-Led Review as part of the Ministerial Directed Intervention arrangements and its role in providing an independent assessment of the Health Board's leadership, governance and organisational effectiveness.
- **NOTE** the escalation and de-escalation criteria being considered through the Escalation Board process, including leadership, governance, organisational culture, quality, operational performance, workforce sustainability, financial stewardship and organisational capability.
- **TAKE ASSURANCE** that the Escalation Board process, together with ongoing engagement with Welsh Government and NHS Performance and Improvement, provides a structured framework through which progress towards sustainable improvement and future de-escalation can be assessed, evidenced and supported.
- **NOTE** the appendices, including the July 2026 Escalation Board agenda, presentation materials and related Welsh Government correspondence.

ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol Link to Strategic Priorities	4.Create a Modern, People Centred Healthcare System
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Yr Egwyddorion Dylunio Design Principles	Simplify, Standardise, and Adopt Best Practices Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	CRR-16 – Leadership/Special Measures

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Cydraddoldeb <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not required for this report
Asesiad o'r Effaith Economaidd-gymdeithasol <i>A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?</i> Socio-Economic Impact Assessment <i>Have you undertaken a Socio-Economic Impact Assessment</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not required for this report
<u>Answadd</u> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Answadd?</i> Quality	Galluogwyr Answadd Enablers of Quality Leadership	Meysydd Answadd Domains of Quality All Apply

Have you undertaken a Quality Impact Assessment Screening?	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
<u>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals</u>	Not Applicable	

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

Asesiad o Effaith ar Atal Twyll <i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i> Counter Fraud Impact Assessment <i>Have you considered the counter fraud impacts</i>	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not required for this report
Cyfreithiol Legal	Yes (Include further detail below)	
Enw Da Reputational	Yes (Include further detail below)	
Effaith ar Adnoddau <i>(Pobl / Ariannol)</i> Resource Impact <i>(People / Financial)</i>	Yes (Include further detail below)	

Health Board

VICE CHAIR'S REPORT

Dyddiad y Cyfarfod Date of Meeting	30 July 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Gareth S Williams, Vice-Chair Vice-Chair's Report, July 2026
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Gareth S Williams, Vice-Chair

Pwrpas yr Adroddiad Report Purpose	For Noting

Crynodeb Gweithredol Executive Summary
This report provides an overview of the programme of visits, range of duties and activities undertaken by the Vice Chair.

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

Acronymau / Rhestr Termiau Acronyms / Glossary of Terms	
PFIG	Performance, Finance and Information Governance Committee
MHLD	Mental Health and Learning Disability

INTRODUCTION

As last year, I attended the **NHS Confederation/Alliance Expo in Manchester** which was hugely valuable in terms of gaining insights into developments elsewhere on both primary and community care and mental health.

1. COMMUNITY BY DESIGN

There were unsurprisingly a number of sessions considering how to achieve the 'left shift' and, relatedly, how to address the issues of Delayed Transfers of Care (DTOC) from acute hospitals and to prevent avoidable admissions and readmissions to acute beds from UEC.

Amongst (for me) the most striking sessions was one from Hull and East Yorkshire where NHS organisations working together have radically reorganised care for clinically optimised patients to prioritise care at home by creating a NHS funded, free to patient service which provides 6 weeks of home-based care on discharge. In only two years this has

- Led to much lower levels of DTOCs (consistently less than 100 compared to over 200 in 2023);
- Allowed the closure of acute and community beds with staff redeployed from community hospitals to the care at home service;
- significantly reduced the number of former patients who require long-term packages of care or care home places funded by the local authority because patients are assessed after having adjusted to being back at home;
- improved UEC performance (average ambulance handover times down from 61 minutes to 19 minutes); and
- delivered significant net financial savings.

While we have experimented with similar approaches in each of our IHCs, as a Health Board we have not yet, in my view, put in place a consistent, embedded and permanent offer. As a result, some staff in acute settings remain cautious about discharging clinically optimised patients home: we really have a lot to learn from this sort of ambitious approach.

I also attended a session on *'Reimagining Frailty Care: Early insights from the National Frailty Improvement Collaborative'*. This NHS England programme is focused on improving 'Frailty Attuned Care' in seven health systems in England, focussing on practical implementation.

One of the presentations here was from Central Lancashire, where an analysis of UEC waits had shown that patients over 65 awaiting admission had waited on average more than 30 hours, leading to real harm to patients. Work under the collaborative programme had focused on three things: (i) understanding and meeting demand at the front door, based on the recognition that fewer than a third of frail elderly attending UECs had had prior contact with the frailty team. Some resources

from the discharge team were redeployed to the front door in order to identify patients for whom there were alternatives to admission (ii) Focussing on developing neighbourhood led discharge, based on close partnership working between the NHS and local authorities (and actively bringing these teams together to discuss individual case-studies) and (iii) developing neighbourhood frailty services.

2. MENTAL HEALTH

I attended a session on preparing for the implementation of the new Mental Health Act, particularly regarding autism and learning disability. One of the presentations was from the Black Country Healthcare Mental Health Trust which had invested in community teams which are on call to deal with crises 24 hours a day 7 days a week with the focus being on immediate support to patients and their families rather than assessment. They have also invested in a number of 'crash pads' as alternatives to inpatient wards, particularly for those with autism and a co-occurring mental health disorder. Taken together these measures have resulted in a decline in inpatient cases by 62%, fewer ED attendances and admissions at nights and over the weekends, and an end to the scramble by families for support on a Friday because of fear of a loved one having a crisis over the weekend.

In the same session Jenni Shaw a Clinical Psychologist also spoke about the Intensive Support Team Network which is an umbrella for a number of Trusts who since 2015 had been developing a model of preventative home-based support to keep people with Learning Disabilities (LDs) and in some cases autism out of hospital. This involved crisis teams able to respond within the same day to a patient in crisis in the home. Evaluation suggested this approach had played a key role in reducing attendances at EDs and admissions and in one case (Hertfordshire) the number of beds for LD patients had been reduced from 150 to just six.

Another session focused on work undertaken in Greater Manchester to reduce the use of Out of Area and placements with non-NHS providers which had succeeded in cutting down Out of Area and third-party Mental Health (MH) placements by 95% and reducing the net cost by more than £30 million. This had been achieved by creating up an Integrated Support Fund which supports Community Mental Health Teams (CMHTs) to provide personalised at-home support for patients and a crisis resolution service. The Fund was initially pump-primed by the Integrated Care Board (ICB) but has subsequently been funded through the savings achieved in only around two years.

These models are very much in line with current Welsh Government thinking on the way services need to be reconfigured.

I also took part in an excellent Exchange Session arranged by the quality improvement network funding seven pilot of Neighbourhood 24/7 Mental Health

Hubs. I was particularly impressed by a project in Whitehaven in Cumbria which has had the highest suicide rate in England, with a majority of those committing suicide not having been in touch with MH services. The hub delivers integrated same-day support – with a focus on non-medical support – to those in mental health crisis through PeaceHaven, a physical centre on a hub and spoke basis. The Hub brings together a range of third sector organisations, including peer support workers and homelessness advisers with support from the CMHT and social workers and has also access to a four-bedded facility where individuals can stay for a maximum of 72 hours with appropriate support. It is still very early in the project's life but the CMHT's crisis workload has fallen as have unplanned admissions to in-patient wards, while the proportion of 'bounced back' referrals from GPs to the CMHT has also fallen significantly.

In this session there was also discussion about the requirement for all acute trusts in England to put in place specific MH Emergency Departments, with considerable concern from practitioners with the fact that funding allocated for this was only for capital, not running costs.

I have continued to have regular meetings with Teresa Owen, Executive Director with responsibility for MHLD, Lou Bell, Assistant Director for Children and Adolescents Mental Health Service (CAMHS) Strategy and Vicky Jones, Head of Integrated Strategy, MHLD.

Along with the Chair and senior staff from MHLD I attended an excellent event in Porthmadog which centred on a showing of *'This Too Shall Pass'* a film about living with bi-polar disorder, made with the assistance of Llais and of the Health Board. This film is both informative and moving and can be found on YouTube.

I have also continued to attend the Wales NHS Confederation Vice-Chairs' Peer Group which had a very useful in-person meeting in June: unfortunately, I was not able to attend a very welcome joint meeting between Chairs and Vice-Chairs as it clashed with a meeting of the Performance, Finance and Information Governance (PFIG) Committee.

3. PREVENTION AND EARLY INTERVENTION

I also attended a couple of sessions relating to the shift from treatment of disease to prevention which is another of the pillars of the NHS England 10-year plan. A session on the development of community pharmacy confirmed what I have been told by our own teams that Wales is significantly ahead of England in the roll-out of enhanced services in community pharmacies, particularly prescribing by pharmacists, although there was an interesting example from Northwest London of using pharmacies to offer blood pressure screening targeted particularly at more deprived communities and at individuals who had no or little contact with their GP practices.

More generally, I have continued my regular programme of meetings and visits, with a particular focus over the last two months on primary and community care, which is now the focus of more intense interest from the Welsh Government.

4. PRIMARY AND COMMUNITY CARE

I also attended a couple of sessions relating to the shift from treatment of disease to prevention which is another of the pillars of the NHS England 10-year plan. A session on the development of community pharmacy confirmed what I have been told by our own teams that Wales is significantly ahead of England in the roll-out of enhanced services in community pharmacies, particularly prescribing by pharmacists, although there was an interesting example from Northwest London of using pharmacies to offer blood pressure screening targeted particularly at more deprived communities and at individuals who had no or little contact with their GP practices.

More generally, I have continued my regular programme of meetings and visits, with a particular focus over the last two months on primary and community care, which is now the focus of more intense interest from the Welsh Government.

5. OTHER BUSINESS

In my capacity as Chair of PFG, I have also been heavily involved with work on the twin challenges of Urgent and Emergency Care (UEC) and Planned Care long-waits. I am Chairing a UEC Recovery Oversight Group and attend weekly meetings with the Chair, Chief Executive and other Executive Directors to consider progress in terms of both UEC and Planned Care. I also visited the Emergency Department of Ysbyty Glan Clwyd with our Medical Director, Clara Day and Chair of Quality, Safety and Experience Committee Chair, Dr Caroline Turner and took part in the Escalation Meeting on 9 July with the new Cabinet Minister as well as accompanying senior Welsh Government and NHS Performance and Improvement officials in a visit to the new orthopaedic site in Llandudno.

ASESIAD / ASSESSMENT

Cysylltiad â'r Bwriadau Strategol Link to Strategic Intentions	4.Create a Modern, People Centred Healthcare System
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Yr Egwyddorion Dylunio Design Principles	People First Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	The activity outlined in this report does not give rise to any new corporate risks.

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS

Cydraddoldeb <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	<i>Not required</i>
Asesiad o'r Effaith Economaidd-gymdeithasol <i>A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?</i> Socio-Economic Impact Assessment <i>Have you undertaken a Socio-Economic Impact Assessment</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	<i>Not required</i>
<u>Answadd</u> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Answadd?</i> Quality	Galluogwyr Answadd Enablers of Quality All Apply	Meysydd Answadd Domains of Quality All Apply

<i>Have you undertaken a Quality Impact Assessment Screening?</i>	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
<u>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals</u>	Not Applicable	

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

Asesiad o Effaith ar Atal Twyll <i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i> Counter Fraud Impact Assessment <i>Have you considered the counter fraud impacts</i>	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Cyfreithiol Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw Da Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith ar Adnoddau <i>(Pobl / Ariannol)</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	

Health Board

TYWYN COMMUNITY HOSPITAL – CASE FOR CHANGE

Date of Meeting	30 July 2026
Publication Status	Open/ Public
	Not Applicable
Report Author(s) name and title	Victoria Peach – Director West Integrated Health Community (Interim) Glesni Jordan – Community Services Operations Manager, West IHC Sophie Stevens-Jones, Strategy Programme Manager
Lead Executive Team Member name and title	Paolo Tardivel, Interim Executive Director Transformation and Strategic Planning. Tehmeena Ajmal, Chief Operating Officer
Report Purpose	For Approval

Executive Summary

Purpose

This paper presents the Case for Change for services provided at Tywyn Community Hospital and seeks approval from the Board to progress identified options for formal public consultation.

The Clinical Case for Change

The temporary closure of Dyfi Ward in 2023 highlighted longstanding challenges associated with maintaining a safe, high-quality and sustainable inpatient service within Tywyn Community Hospital. The need to close Dyfi ward was due to patient safety issues driven by workforce constraints, including difficulties recruiting and retaining appropriately skilled nursing staff, resulting in concerns regarding the immediate and long-term resilience of the service. Since the temporary closure, resources have been used to deliver a range of alternative community services to the local population which are detailed throughout the case for change.

Healthcare delivery has changed significantly in recent years, with increasing emphasis on providing care closer to home, reducing avoidable hospital admissions and supporting people to remain independent within their own communities wherever clinically appropriate. At the same time, the population served by Tywyn Community Hospital is ageing, with increasing levels of frailty, multiple long-term conditions and complex health needs requiring coordinated multidisciplinary care. In addition, community services are increasingly required to respond to a broader and more diverse range of needs across the population. This includes providing appropriate support for younger people, individuals experiencing mental health challenges, and those requiring access to a wider range of preventative, rehabilitative, and ongoing care services. As a result, community provision must be flexible and responsive, ensuring that services are inclusive, holistic, and capable of addressing wider health needs.

The review, requested by the Health Board in May 2025, has identified a number of clinical challenges that need to be addressed:

- Workforce fragility affecting the sustainability and resilience of inpatient services.
- The need to ensure services are staffed by appropriately trained and experienced professionals at all times.
- Maintaining clinical quality and patient safety standards within a limited-service model.
- Increasing demand associated with an ageing population and growing levels of frailty and chronic disease.
- The need to deliver care in line with modern clinical practice and national policy direction.
- Ensuring patients receive the right care, in the right place, at the right time.
- Improving integration between primary care, community services, social care and hospital services.
- Making best use of available clinical resources to maximise patient benefit.
- The need to balance local service provision with the wider health and care system across Meirionnydd, Gwynedd and the West Integrated Health Community.

The review has therefore sought to identify clinically effective and sustainable potential models for delivering community healthcare services from Tywyn Community Hospital, ensuring that services remain safe, accessible and responsive to the needs of the local population both now and in the future.

The review is limited to the operating model of Dyfi Ward and directly associated community hospital services; broader issues (for example dentistry and specialist mental health) remain outside scope.

Legislative considerations

Service change consultation for NHS bodies in Wales is not governed by a single statute, but by a framework of primary legislation, statutory duties and Welsh Government guidance, as outlined on page 71 (Legislation, Guidance and Governance) of the paper. Within the Health Board's governance framework comprising Standing Orders, the Scheme of Reservation and Delegation of Powers, and wider governance arrangements—the responsibility for determining service change sits with the Board as a reserved matter. The review and pre-consultation engagement phase has been undertaken in line with this framework and will continue to do so throughout the formal consultation process.

Pre-consultation engagement

Following a decision by the Board in May 2025 to review the service and develop a sustainable solution for the future; since July 2025, the Health Board has undertaken a programme of pre-consultation engagement to understand the experiences of those within the local community as well supporting the development of potentially viable options for the future of the service responding to the need to deliver safe, sustainable and value-based care to the local community, whilst acknowledging the challenges already faced.

Key Group	Date	Outcome/Evidence
Balanced Room 1	Sept 2025	Long-list and medium list of option assessed against essential criteria.
Balanced Room 2	Oct 2025	Development of desirable criteria and shortlisted options.
Balanced Room 2 re-run	March 2026	A discrepancy in scoring was identified from the previous session so a second session was carried out to revisit the longlist of options resulting in group consensus to revisit the essential criteria on a number of proposed hybrid options.
Follow-up stakeholder session to Balanced Room invitees	June 2026	The options deemed most viable were presented to stakeholders for discussion and questioning before further thoughts were gathered on the consultation process and how best to reach and involve local residents.

A series of face-to-face community engagement events as well as canvassing at outpatient clinics and MIU, online surveys and monitoring of correspondence. Social media and digital awareness raising An online survey Reaching out to stakeholder groups for face-to-face conversations and support in awareness raising. 04.08.2025: Attendance at a listening event in partnership with Hywel Dda University Health Board. 20.08.2025: Attendance at the Meirionnydd County Show. 28.08.2025: Attendance at the South Meirionnydd Older People's Forum 12.09.2025: Attendance at the Social Drop-in, Aberdyfi. 15.09.2025: Attendance at Aberdyfi Community Council. Monitoring of correspondence with MPs and MS'. Attendance for feedback gathering within the Minor Injuries Unit Attendance for feedback gathering within Outpatient clinics held at Tywyn Community Hospital	Jul 2025 – February 2026	Themes including: desire for the reinstatement of the inpatient ward as well as the development of the “new” services, clarity of approach and decision-making process, desire for wide involvement, desire for local services that meet the needs of a broad range of the community – particularly younger people, children and young families, recognition of the difficulties faced by rural and older populations in accessing healthcare.	



05.11.2025: Tywyn staff briefing onsite 12.11.2025: Attendance at Tywyn Town Council meeting 17.11.2025: Attendance at Bryncreug Council meeting 17.11.2025: Attendance at Aberdyfi Community Council meeting 18.11.2025: Attendance at Llanegryn Council meeting 21.11.2025: Tywyn staff drop-in 21.11.2025: Attendance at Friday evening youth club, Tywyn Baptist Church (c.45 young people) 24.11.2025: Attendance at Arfon Access Group meeting 25.11.2025: Attendance at morning parent and toddler group, Tywyn Baptist Church, (c.10 parents/carers) 13.01.2026: Attendance at Llanfihangel y Pennant council meeting 16.01.2026: Attendance at Tywyn Community Hub coffee morning (c.100 attendees changed the drop-in session to a "town hall" style event) 16.01.2026: Attendance at the social drop-in, Aberdyfi (8 attendees) 02.02.2026: Tywyn staff briefing.			

A total of 537 survey responses were also received and feedback is included in the Pre-consultation Engagement Report – appendix 4.		
Internal clinical and operational assurance as well as clear corporate governance.	Ongoing	Any developing model will continue to be clinically assessed against the Safe, Timely, Effective, Efficient, Equitable and Person-centred (STEEEP) Quality Standards of services.

Pre-consultation engagement identifies strong public support for retaining and enhancing healthcare services within Tywyn and highlighted the importance of local access to care for a predominantly rural and ageing population. Stakeholders consistently emphasised the value of services being delivered as close to home as possible, particularly for older people, carers and those with limited access to transport.

Feedback from the engagement demonstrated a strong attachment to local inpatient provision and highlighted concerns regarding travel, accessibility, and the impact of service changes on patients, families and carers. The engagement identified support for exploring opportunities to expand a range of locally delivered community, outpatient, rehabilitation and preventative services.

The purpose of the proposed service change programme is therefore to identify a sustainable, high-quality model for Tywyn Community Hospital that responds to current and future population needs, makes best use of available resources, and reflects the breadth of views and priorities expressed by the local community and stakeholders. This will include ensuring that services are clinically safe, aligned with national and regional strategies, and integrated with wider community and primary care provision. The programme will also seek to improve patient outcomes and experience, reduce health inequalities (appendix 10), and ensure that the model is deliverable and resilient in the context of workforce capacity and financial constraints.

How engagement has shaped the review

Throughout the review, engagement has not been undertaken simply to inform stakeholders of emerging proposals. Feedback from residents, staff, elected representatives, community groups and participants in the Balanced Room sessions has directly influenced the development and reassessment of options.

A number of examples demonstrate how views and challenge from stakeholders have shaped the process:

- Concerns regarding the composition and representation of the Balanced Room process resulted in the stakeholder sessions being revisited and broadened to include additional participants and perspectives.
- Following the identification of a scoring discrepancy within the second Balanced Room session, the Health Board reconvened stakeholders and repeated elements of the appraisal process to ensure transparency, robustness and confidence in the outcomes.
- Requests from stakeholders to explore a wider range of potential future models, including hybrid approaches combining inpatient beds with enhanced community services, led to further technical appraisal work being undertaken before options were shortlisted.
- Strong community support for retaining local inpatient provision was reflected in Option A remaining under consideration, despite the ongoing workforce and sustainability challenges identified through the review.
- Feedback highlighting the value of services introduced following the temporary ward closure helped shape and strengthen the development of Option B, including the continued provision of the Treatment Room, Tuag Adref service, Wellbeing Hub, expanded Minor Injuries Unit and wider community-based care.
- Stakeholder feedback also informed planning for consultation, including advice on engagement methods, identifying groups requiring further involvement and ensuring consultation materials are accessible and reach a broad cross-section of the community. All of which will be taken into account during the consultation phase.

Collectively, these examples demonstrate that engagement has been an active part of the decision-making process. Stakeholder feedback has informed the development, refinement and testing of options and will continue to do so throughout the formal consultation period before any final decision is made.

Proposed options for consultation

Although the Health Board has undertaken detailed analysis of the options available, no decision has been made. This consultation is intended to test the evidence, assumptions, impact assessments and conclusions presented within this document. The Board remains open to consultation responses, additional evidence and reasonable alternative proposals, all of which will be carefully considered before any final decision is made.

Following a period of review, feedback, analysis and the balanced room process to develop options for delivering safe and effective healthcare, presented for further consideration are:

- **Option A: A return to the inpatient model.** This option proposes the re-opening of the inpatient ward, Dyfi Ward, under the caveat of being able to sustainably achieve safe staffing levels at all times.

The ward would provide inpatient care for those who do not need care within one of the larger, acute sites but who might need ongoing support, rehabilitation and inpatient reablement before going home or into a care home, as well as the previous "step-up" support for those needing 24/7 support but not full consultant-led hospital care. The ward would also provide an additional option for inpatient end-of-life care for those in the local community who choose a hospital setting as their place of death.

This model proposes reverting back to the original purpose for the ward of 10 beds, recognising the strength of feeling within the community and could support care closer to home and as an option to maintain flow from acute sites.

OR

- **Option B: An expansion of the current community services put in place following the temporary closure – providing enhanced care at home and hospital-based clinics, treatments and therapies.** This option proposes the permanent closure of inpatient beds at Tywyn Community Hospital, whilst maintaining and expanding the current community service model that has been developed since the temporary closure. It builds on the success of existing services and further develops Tywyn as a hub for community-based care through the continued delivery of:
 - Tuag Adref (Homeward Bound) - helping people recover at home and avoid hospital admissions.
 - Wellbeing Hub – offering health advice and community support.
 - Treatment Room – providing wound care and routine tests.
 - Minor Injuries Unit (MIU) with extended opening hours (08:00–20:00, seven days a week)
 - Locally delivered treatments, including a range of IV therapies
 - Increased multi-team working across primary and community care

Dyfi Ward, its equipment and facilities would be retained but repurposed as a Day Treatment Centre, providing a broader range of outpatient and ambulatory services, supporting staff development, succession planning and cross-cover support across primary and community services.

Patients requiring inpatient rehabilitation or medical care (average of 4 per month) would continue to be supported through Dolgellau Hospital, while local nursing and residential homes would continue to provide additional options for end-of-life and step-down care where appropriate.

The model aims to deliver care closer to home, reduce unnecessary hospital admissions, improve patient flow, and strengthen community and care home partnerships, whilst maintaining as local as possible access to bed-based care when required.

A number of potential models and hybrid options have been considered, discussed and appraised over the last year with the above being the recommended options within scope for the consultation.

During engagement, many people expressed support for a hybrid model that would combine the reopening of inpatient beds at Tywyn Community Hospital with the enhanced community services proposed within the emerging model of care. The Health Board carefully considered this option as part of the technical appraisal process.

While the hybrid model brings together elements that were individually valued by stakeholders, the technical appraisal concluded that it could not be recommended because it was not considered deliverable, sustainable or an effective use of available resources. The option failed four of the five essential criteria used to assess viability.

The principal reason is workforce sustainability. Reopening inpatient beds alongside expanding community services would require approximately 14 additional staff members, including registered nurses, at a time when healthcare services across the area continue to experience significant recruitment and retention challenges. The appraisal concluded that maintaining safe staffing levels for both services simultaneously would be difficult to achieve and sustain in the longer term.

The appraisal also identified significant financial implications. Delivering both models together would require significant additional recurring investment per year above the currently available resource. Given the Health Board's responsibility to make best use of public resources across all services, the panel concluded that this level of additional investment could not be sustained without a significant impact on services across the Gwynedd and West Integrated Health Community. The additional workforce required for a hybrid model would likely need to be drawn from existing community services, increasing pressure on services such as district nursing, community support teams and the Minor Injury Unit. Rather than strengthening local healthcare provision overall, there was a risk that resources would be spread too thinly across multiple services, reducing resilience and affecting the quality and continuity of care.

The appraisal further concluded that operating both an inpatient ward and expanded community services would create operational complexity and reduce

opportunities to focus resources where they can benefit the greatest number of people.

For these reasons, the technical appraisal concluded that a hybrid model could not be delivered safely and sustainably over time and therefore is not being progressed as an option upon which to consult.

The shortlisted options are intended to support public consultation, testing the assumptions, evidence, impact and conclusions reached to date and are not presented as a final outcome. The Health Board remains open to alternative suggestions and modifications arising through the consultation process.

Next steps

The purpose of this paper is not to seek a decision on any potential future model or service reconfiguration. Instead, the paper provides the Case for Change to support the Board in approving options for full public consultation.

Timeline

18 June 2026	Service Change Oversight Group
24 June 2026	Strategic Planning and Service Change Group
2 July 2026	Planning, Population Health and Partnerships Committee (Private)
30 July 2026	Options suggested for approval by the Board (Public)
August 2026	Consultation documentation development and finalisation. Including easy read, bilingual, BSL, consultation survey. Continuous engagement will continue in this period to capture experience information of summer residents of which there are a high proportion in the area.
TBC September/October to November/December 2026	Formal consultation period for 12 weeks.
December 2026	Post consultation analysis and reporting
January 2027	Period of conscientious consideration by the Board
March 2027	Decision making Board meeting (Public)

Recommendations:

APPROVE the proposed options being taken forward to formal public consultation noting that no final decision is being sought at this stage and that the consultation is intended to test the evidence, assumptions, impact assessments and conclusions presented within this document.

APPROVE to commence public consultation and that the outcome of the consultation is planned for March 2027 as described in the timeline outlined in the report.

Supporting documentation:

Appendix 1 - Services available to meet population Health Need
 Appendix 2 - Welsh Language Impact Assessment
 Appendix 3 – Outpatient Services at Tywyn Community Hospital
 Appendix 4 – Pre-consultation Engagement Report
 Appendix 5 – Balanced Room One Output Report
 Appendix 6 – Balanced Room Two Output Report
 Appendix 7 – Options Appraisal Sessions
 Appendix 8 – Technical Appraisal Report
 Appendix 9 – Quality Impact Assessment
 Appendix 10 – Integrated Equalities Impact Assessment and Socio-Economic Duty
 Appendix 11 – Tywyn Community Hospital Services Travel Impact Assessment
 Appendix 12 – References

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome, Evidence and Data
Final pre-consultation stakeholder session	4 June 2026	Further consideration of hybrid options. Appendix 7 – Options Appraisal Sessions
Service Change Oversight Group	18 June 2026	Request for clarity of options detail and approval to continue through next phase of governance.
Strategic Planning and Service Change Group	24 June 2026	Approval to continue through to next phase of governance.
Planning, Population Health and Partnerships Committee	2 July 2026	Approval to continue to Board.
Acronyms / Glossary of Terms		

Balanced Room sessions	The balanced room approach supports having a diverse range of perspectives represented when developing and appraising options.
Continuous Engagement	Ongoing involvement of identified stakeholders in the development of proposals or options.
Consultation	A specific, duty and legally bound period of gathering direct input on proposed options.
SPSCG	Strategic Planning and Service Change Group
DPOC	Delayed Pathways of Care
POCT	Point of Care Testing
D2RA	Discharge to Recover and Assess
AvLoS	Average Length of Stay

Tywyn Community Hospital
Case for Change
July 2026

V2

1. Executive summary

In April 2023, the 10-bed Dyfi ward at Tywyn Community Hospital (a community hospital) was temporarily closed due to patient and staff safety and quality of care concerns, predominantly due to challenges with the recruitment and retention of nurses and clinical staff. The ward offered step up/step-down sub-acute medical care for people who needed ongoing 24/7 medical support but didn't need full consultant-led hospital care.

The Dyfi ward remains closed since April 2023. Local patients who would have used these services are now admitted to other local hospitals, including Dolgellau & Barmouth Community Hospital where 4 extra beds were added to the unit.

In the interim, the space and resource have been used to deliver community services for the Tywyn community, including a treatment room, wellbeing hub and some outpatient services. The existing Minor Injuries Unit opening hours have also been extended.

Since 2023, significant efforts have been made to fill staff vacancies, increase the workforce and reduce the reliance on agency staff, as well as increasing the capability and capacity of the staff through training.

It is important that a full and proper process is undertaken to understand and determine the most appropriate future for the Dyfi ward. In accordance, following the temporary closure, a review has been conducted to evaluate the current and future challenges and opportunities, and to determine the possible options available for the space moving forward.

This review relates to the Health Board's strategic direction using the quadruple aims to:

- Improve the health of the population (prevention, early intervention, and self-management).
- Enhance the patient/user experience including quality, access, and reliability (enabled by digital and supported by engagement).
- Have a motivated and sustainable health and social care workforce.
- Deliver value-based health care with demonstratable rapid improvement and innovation (enabled by data with a focus on outcomes).

It is essential that any future services delivered from the ward are safe, sustainable and provide high-quality care for the population of Tywyn and the surrounding area. These requirements have been at the heart of the review.

The review has considered significant evidence including clinical feedback, population health data, service access and usage data, financial information, and feedback from the community.

Following the initial evidence collection, working with the community, key stakeholders, and senior clinical and specialist experts, a long-list of options was developed for the potential future of the ward. Hurdle and evaluation criteria was also agreed that was then applied to the long-list of options to agree a short list of options.

The shortlisted options are:

- **Option A: A return to the inpatient model.** This option proposes the re-opening of the inpatient ward, Dyfi Ward, under the caveat of being able to sustainably achieve safe staffing levels at all times.

The ward would provide inpatient care for those who do not need care within one of the larger, acute sites but who might need ongoing support, rehabilitation and inpatient reablement before going home or into a care home, as well as the previous "step-up" support for those needing 24/7 support but not full consultant-led hospital care. The ward would also provide an additional option for inpatient end-of-life care for those in the local community who choose a hospital setting as their place of death.

This model proposes reverting back to the original purpose for the ward of 10 beds, recognising the strength of feeling within the community and could support care closer to home and as an option to maintain flow from acute sites.

OR

- **Option B: An expansion of the current community services put in place following the temporary closure – providing enhanced care at home and hospital-based clinics, treatments and therapies.** This option proposes the continued closure of inpatient beds at Tywyn Community Hospital, whilst maintaining and expanding the current community service model that has been developed since the temporary closure. It builds on the success of existing services and further develops Tywyn as a hub for community-based care through the continued delivery of:
 - Tuag Adref (Homeward Bound) - helping people recover at home and avoid hospital admissions.
 - Wellbeing Hub – offering health advice and community support.
 - Treatment Room – providing wound care and routine tests.
 - Minor Injuries Unit (MIU) with extended opening hours (08:00–20:00, seven days a week)

- Locally delivered treatments, including a range of IV therapies
- Increased multi-team working across primary and community care

Dyfi Ward, its equipment and facilities would be retained but repurposed as a Day Treatment Centre, providing a broader range of outpatient and ambulatory services, supporting staff development, succession planning and cross-cover support across primary and community services.

Patients requiring inpatient rehabilitation or medical care (average of 4 per month) would continue to be supported through Dolgellau Hospital, while local nursing and residential homes would continue to provide additional options for end-of-life and step-down care where appropriate.

The model aims to deliver care closer to home, reduce unnecessary hospital admissions, improve patient flow, and strengthen community and care home partnerships, whilst maintaining as local as possible access to bed-based care when required.

A number of potential models and hybrid options have been considered, discussed and appraised over the last year with the above being the recommended options within scope for the consultation.

During engagement, many people expressed support for a hybrid model that would combine the reopening of inpatient beds at Tywyn Community Hospital with the enhanced community services proposed within the emerging model of care. The Health Board carefully considered this option as part of the technical appraisal process.

While the hybrid model brings together elements that were individually valued by stakeholders, the technical appraisal concluded that it could not be recommended because it was not considered deliverable, sustainable or an effective use of available resources. The option failed four of the five essential criteria used to assess viability.

The principal reason is workforce sustainability. Reopening inpatient beds alongside expanding community services would require approximately 14 additional staff members, including registered nurses, at a time when healthcare services across the area continue to experience significant recruitment and retention challenges. The appraisal concluded that maintaining safe staffing levels for both services simultaneously would be difficult to achieve and sustain in the longer term.

The appraisal also identified significant financial implications. Delivering both models together would require significant additional recurring investment per year above the currently available resource. Given the Health Board's responsibility to make best

use of public resources across all services, the panel concluded that this level of additional investment could not be sustained without a significant impact on services across the Gwynedd and West Integrated Health Community. The additional workforce required for a hybrid model would likely need to be drawn from existing community services, increasing pressure on services such as district nursing, community support teams and the Minor Injury Unit. Rather than strengthening local healthcare provision overall, there was a risk that resources would be spread too thinly across multiple services, reducing resilience and affecting the quality and continuity of care.

The appraisal further concluded that operating both an inpatient ward and expanded community services would create operational complexity and reduce opportunities to focus resources where they can benefit the greatest number of people.

For these reasons, the technical appraisal concluded that a hybrid model could not be delivered safely and sustainably over time and therefore is not being progressed as an option upon which to consult.

It is therefore proposed that the two outlined options are taken forward to public consultation and further clinical consideration before a decision is taken on the future of the services offered at the Dyfi ward.

Although the Health Board has undertaken detailed analysis of the options available, no decision has been made. This consultation is intended to test the evidence, assumptions, impact assessments and conclusions presented within this document. The Board remains open to consultation responses, additional evidence and reasonable alternative proposals, all of which will be carefully considered before any final decision is made.

This case for change outlines further detail on the context, key issues and rationale for change, drawing on work undertaken to date and emerging evidence to support consideration of future service models. It also sets out the process undertaken to develop the options, with information on the two shortlisted.

2. Why change is needed

2.1 The problem

The events leading to the temporary closure in April 2023 demonstrate that the Dyfi ward cannot reliably provide a safe and sustainable inpatient ward under the existing model without either prolonged workforce fragility or adversely impacting on other local services (e.g. the Minor Injuries Unit and District Nursing Team).

2.2 Issue 1: Workforce challenges impacting safety and quality

Inpatient services within Tywyn Community Hospital were delivered by a range of multi-disciplinary professionals including nursing, therapies and medical.

Workforce challenges including recruitment and retention were a significant barrier to delivering safe, quality care and led to the temporary closure of the Dyfi Ward Tywyn Community Hospital on 18th April 2023.

Prior to this, as a result of longstanding vacancies within the registered nursing team, high sickness rates, and challenges in recruiting and retaining staff, there was a heavy reliance on overtime, regular requests for the use of bank and agency staff, and the continuous redeployment of staff from other clinical areas such as the Minor Injuries Unit in order to keep the ward fully and safely staffed.

2.2.1 Nursing workforce model

The historic funded staffing model to deliver 10 inpatient beds on the ward is 1 x Registered Nurse per shift (day and night) and 2 x Health Care Support Workers per shift (day and night), with a ward manager or deputy to provide leadership and clinical governance for the ward.

At the time of the decision to temporarily close Dyfi ward, there were a number of vacancies within the nursing team including 4 Band 5 registered nurses, 1 Band 6 Deputy Ward Manager and 1 Band 7 Ward Manager.

Long term vacancies and sickness within the team meant staff were working excessive hours over and above their contracted hours as overtime, and often unable to take annual leave or cancelling annual leave to ensure safe levels of staffing on the ward. Agency staff were unreliable and often cancelled at short notice which presented significant risk to patient safety.

The Minor Injuries service was disrupted and the service was unable to remain open, as staff employed to work in the Minor Injuries Unit were constantly required to support provision of safe inpatient staffing. Recruitment has been undertaken to the MIU since the temporary closure of the ward. Staff have been able to maintain service delivery of the MIU and develop competencies to enhance the service offer.

Progress has been made in terms of recruitment in a geographical area where it is generally difficult to attract health professionals. 4 internationally educated nurses have been successfully recruited to posts at Tywyn Community Hospital. These staff are now currently working in Dolgellau and Tywyn Community Hospital to maintain all required competencies to practice independently.

Work continues to develop and strengthen the local workforce to support the longer-term sustainability of services. This includes supporting staff to access relevant education and training opportunities to expand their scope of practice and enhance service provision. For example, one of the internationally educated nurses is currently undertaking the Emergency Nurse Practitioner (ENP) qualification to enable autonomous practice within the Minor Injury Unit, and a Healthcare Support Worker is due to commence a Nursing degree in September 2026. These developments, alongside ongoing recruitment and competency development, demonstrate a commitment to building workforce capacity, supporting career progression, and ensuring the service is resilient and able to meet future demand.

There remains the risks associated with having only one Registered Nurse on duty overnight are significant. The Executive Nurse Director has recently advised that, to ensure safe and effective care, a Band 5 Registered Nurse should not routinely act as the sole registrant on site, and no registrant should work in isolation overnight. This requirement would have substantial implications for the staffing model, including both skill mix and overall numbers. As a result, any future model will need further review to confirm that it is safe, sustainable, and deliverable within existing resources.

2.2.1.1 Nurse Staffing Levels

The Health Board is duty bound to have safe levels of staffing to ensure patient safety, quality, and standards of care, in line with the Nurse Staffing Levels (Wales) Act (2016). The Act requires organisations across NHS Wales to calculate and monitor the number of nurses needed to care sensitively for patients (NHS Wales, 2024). The Act was constructed to enable a phased implementation, and in August 2017, Welsh Government announced that the Act would be implemented in Adult Acute Medical and Surgical Wards from April 2018 (NHS Wales, 2024). The phased implementation is yet to arrive at Community Hospitals by law. There is however a professional duty to ensure patient safety through adequate staffing levels and skill mix. A triangulated approach is used for this calculation utilising any of the sources of information described below to determine the required nurse staffing levels (NHS Wales, 2024). In this situation, the information triangulated is both qualitative and quantitative in nature. The triangulated approach should include:

- Professional judgement.
- The effect of temporary staff on the nurse staffing level.
- The effect of a nurse's considerations of a patient's cultural needs.
- The turnover of patients receiving care.
- The Conditions of a multi-professional team dynamic.

- Patient acuity.
- Quality indicators.

On reviewing the training needs for Dyfi Ward staff, it became apparent that there were shifts being covered without the availability of what is considered basic clinical skills e.g., venepuncture, cannulation, catheterisation, ECG. This resulted in delays to patients accessing the required care and treatment. Since closure of Dyfi ward, training has been made available to all staff and the clinical skill set of the team has increased. The majority of the staff have now completed outstanding competencies with the MIU service now having expanded its opening hours to 08:00-20:00, there will be further opportunities for staff to complete competencies and maintain their skills.

Staff who have not yet achieved the required competencies are continuing to be supported to ensure all staff are and remain proficient and competent to deliver the basic skills required to safely manage an inpatient ward.

2.2.1.2 Nursing Workforce Gaps

In the two years prior to the temporary closure of the inpatient ward at Tywyn a total of 6463.58 hours were unallocated due to vacancies and sickness within the Registered Nurse workforce, this equates to 517 unfilled 12.5-hour shifts. In order to maintain safe staffing on the Dyfi ward overtime, re-deployment, bank and agency were utilised.

The MIU service in Tywyn Community Hospital was temporarily closed and the registered nursing staff were re-deployed to Dyfi ward, which covered a total of 3322.58 hours of these vacant shifts. Staff were re-deployed from Dolgellau Hospital and the local District Nursing team where possible who delivered a further 151 hours of work.

Following re-deployment of staff their remained 3141 hours of work unallocated, which equates to 251 unfilled 12.5-hour shifts. Between the 18th April 2021 and 18th April 2023, a total of 2196.05 hours of overtime were worked by the local registered nursing team to maintain patient safety on the ward. Reliance on overtime at such a significant demand was not sustainable.

A further 73.5 hours were picked up by nursing bank staff and a further 644 hours were undertaken by agency nursing staff. The bank and agency staff were only picked up in the two months prior to the temporary closure of the inpatient ward. There were challenges securing agency staff to undertake shifts on Dyfi due to the rural location and agency staff would require accommodation, creating additional challenges, or they would cancel at short notice due the distance required to travel.

2.2.1.3 Nursing Workforce Sickness

In the two years prior to the temporary closure of Dyfi ward the sickness rate across the nursing workforce in Tywyn (Inpatient Ward and MIU) remained consistently high. The average sickness absence was 15.99% with the highest sickness rates between December 2021 and March 2021. Whilst the sickness rate had improved mid-August 2022 sickness rates were increasing in early 2023, at 20.89% and 16.01% in March and April 2023. The national target for sickness rate is 4.2% per month.

[OBJ]

2.2.1.4 Nursing Workforce Turnover rate

In the two years prior to the temporary closure of the inpatient ward the 12 Month Rolling Turnover rate across the nursing workforce on Dyfi Ward remained consistently high. The average turnover rate was 19.10% with the highest turnover rates between April 2022 and June 2022 which was 34.8%, 33.3% and 33.3% respectively. The turnover rate in the months prior to the temporary closure of the ward increased from 15.5% in January 2023 to 21.6% in April 2023 with further known upcoming vacancies at the time. In March 2023 the overall vacancy rate for NHS Wales is 4.5% and the vacancy rate for Tywyn has consistently been above this.

[OBJ]

2.2.2 Medical Workforce

Medical oversight to the inpatient ward at the Community Hospital during the specified GMS core hours was provided by the Dolgellau GP Surgery under the bed contract with out of hours medical input being provided via the GP Out of Hours service where required. A clinical lead was in place for the ward to provide medical leadership in terms of care provision, service development, clinical governance matters, as well as to provide mentorship, guidance, and support to staff working within the community hospital.

In the interim whilst the inpatient ward at Tywyn Community Hospital is closed, the Dolgellau GP Surgery continues to deliver medical input to patient care for those admitted to Dolgellau Hospital from Tywyn and the surrounding area.

2.2.3 Therapies Workforce

Prior to the temporary closure of Dyfi ward, Physiotherapists and Occupational Therapists worked across both Tywyn and Dolgellau inpatient wards. This requires travel between sites and reduces the time available for direct clinical care which can impact patient length of stay and outcomes. Since the temporary closure of Dyfi ward, therapy staff have been able to provide increased levels of therapy support to patients improving their rehabilitation and recovery, and reducing the time needed for patients to remain in hospital.

The average length of stay (AvLOS) for patients at Dolgellau Hospital was 35.05 in 2022/23 and has shown an overall improvement since staff have been consolidated at Dolgellau Hospital. By January 2026, AvLOS had reduced significantly to 21.5 days. Although there has been some increase to 31.2 days as of 31st May 2026, this remains an improvement compared to the 2022/23 position. It is also important to note that higher levels of DPOC are a contributing factor for this increase.

2.2.4 Pharmacy

Pharmacy staff are required to work across both Tywyn and Dolgellau sites with travel time impacting time spent on direct clinical care. Since the temporary closure of the inpatient wards this resource has been consolidated at Dolgellau Hospital leading to improved patient outcomes and experience.

2.2.5 Recruitment and Retention

At the time of the decision to temporarily close Dyfi ward, there were a number of vacancies within the nursing team including 4 Band 5 registered nurses, 1 Band 6 Deputy Ward Manager and 1 Band 7 Ward Manager post.

Adverts were placed via NHS jobs, with many attempts not successful in attracting any appropriately registered applicants. Further targeted recruitment drives through social media aimed at attracting health professionals to relocate from out of area were unsuccessful.

Large banners have been erected and flyers distributed around the Tywyn area to promote working in the area and for the Health Board. Local events and venues of high footfall were targeted, in particular during peak visitor season.

Opportunities to network with schools and universities have been maximised with attendance at the local school careers fair as well as forging links with Aberystwyth University and the new School of Nursing. Placements for student nurses are being offered to gain experience across our community services, both ward based and in community settings.

Continued progress has been made in terms of recruitment to the nursing team within Tywyn Community Hospital and the staffing situation has improved. A Ward Manager and 5 registered nurses have been appointed (4 x internationally educated nurses) and the service is now awaiting confirmation of completion of all required competencies to practice independently for these staff.

It is worth noting that despite being successful in recruiting to secure the minimum safe staffing level requirement for a 24/7 in patient ward, reopening Dyfi ward would undoubtedly impact on the Health Board's ability to maintain other clinical services and community provision in the long term. Namely Tuag Adref and Treatment would not be able to continue. This has the potential to impact on the attraction of the job roles as the opportunity to develop clinical skills would be limited.

Vacancies as well as day-to-day absences (such as short- and long-term sickness, maternity leave, annual leave) would need to be covered, which would potentially impact services such as District Nursing, and Minor Injuries (capacity reduced or the service closed) as a consequence of registered staff from these services needing to work on the ward to ensure the correct safe staffing levels.

2.3 Issue 2: Impact on wider services

Securing the minimum safe staffing levels required for a 24/7 inpatient ward to re-open Dyfi ward impacted on the Health Board's ability to maintain other local clinical services and community provision in the long term.

Vacancies as well as day-to-day absences (short and long-term sickness, maternity leave, annual leave etc.) would impact on services such as District Nursing, treatment room, Tuag Adref and the Minor Injuries Unit (MIU) as a consequence of trained staff from these services needing to provide cover on the ward to ensure the correct safe staffing levels.

2.3.1 Minor Injuries Unit

The most impacted service historically was the MIU which is located within Tywyn Community Hospital and is accessible to the population of Tywyn and surrounding area.

In March 2020, the MIU at the hospital was closed on a temporary basis as staff were consolidated on the inpatient ward to enable an increase in beds as part of the Covid 19 response. The MIU staff were required to support this model to enable provision of safe staffing levels.

As a direct impact of Covid 19, Tywyn Community Hospital had a depleted number of registered staff to maintain professional duty and delivery of safe care on the inpatient ward. This necessitated the prolonged closure of the MIU to enable staff to

be re-deployed to the ward. Due to challenges recruiting to vacant posts for the inpatient ward the MIU could not be re-opened.

In July 2023, following the temporary closure of the inpatient ward the MIU service was able to re-open 3 days a week, this has now increased to 08:00-20:00 5 days a week.

2.3 Issue 3: Quality of care

Quality is more than meeting service standards and includes system-wide, safe, effective, person-centred, timely, efficient, and equitable care. To help achieve this the Duty of Quality came into effect in April 2023 as part of the Health and Social Care (Quality and Engagement) (Wales) Act 2020. All NHS organisations have a legal responsibility to continually improve the quality of services they provide; to help improve and protect the health, care and wellbeing of the current and future population of Wales.

The required quality standards for delivering in-patient care includes, but not limited to, medication safety, infection prevention and de-conditioning.

2.3.1 Medication safety

In line with safe medication processes, BCUHB requires an independent second check and witnessed administration of controlled drugs, intravenous medicines, all insulin products, and wherever a medication calculation is required. Staff must complete a competency framework to be able to undertake this role, which would typically be undertaken by a registered nurse.

The historic ward budget is only established to provide 1 registered staff member per shift and therefore non-registered staff are required to complete second checking on shifts. The MM01 BCUHB Medicines Policy states that non-registered staff require a Level 3 qualification to enable them to undertake the role of the second checker.

Not all non-registered staff in Tywyn have this level of qualification and there may, on occasion, be no second checker available. This can cause a delay in the administration of medication to patients leading to increased length of stay, a potential increased risk of medication errors, potential increased medication-related incidents, non-compliance with local and national regulations (with potential legal consequences), and increased stress for staff. It may impact on the quality of patient care and staff retention.

2.3.1 Deconditioning

Patients in community hospitals are expected to be discharged within 21 to 35 days. Prolonged hospital stays can negatively impact health, leading to sleep deprivation, increased risk of falls, delirium, infections, and muscle loss, which reduces mobility and independence (known as deconditioning or PJ paralysis). Addressing long stays is vital to preventing harm, disability, and unexpected costs, especially for vulnerable patients.

NHS Improvement 2018, refers to patients who have long lengths of stay in hospital and compares their pre-illness/pre-admission baseline. It was noted that 35% of 70-year-old patients experienced functional decline during hospitalisation. For people over 90 years of age this figure rises to 65% and a discharge audit found that 39% of people's length of stay or delay could have been discharged through alternative pathways and services better suited to their assessment need.

From April 2022 to March 2023, Dyfi Ward's average length of stay (AvLOS) consistently exceeded 30 days. There were three instances where AvLOS surpassed 50 days (September 2022 to November 2022) reinforcing the risks of extended hospitalisation.

Between July 2021 and April 2023, at least 4 (40%) of inpatient beds have been occupied by patients with pathway of care delays, peaking at 7 (70%) or higher on nine occasions. On one occasion, all 10 beds (100%) were occupied by patients with pathway of care delays.

2.3.2 Infection prevention

Infection prevention in Welsh Community Hospitals is guided by rigorous quality standards to ensure patient safety and minimize healthcare associated infections (HCAIs). The Code of Practice for the Prevention and Control of Healthcare Associated Infections sets out essential infection prevention measures, emphasizing evidence-based protocols, staff training, and environmental cleanliness.

Public Health Wales enforces a zero-tolerance policy for preventable HCAIs, integrating national guidelines such as the National Standards for Cleaning in NHS Wales. Additionally, hospitals implement infection prevention improvement plans, focusing on staff education, compliance monitoring, and timely incident reporting. These measures collectively foster a culture of accountability and continuous improvement in infection control.

At Tywyn Hospital, should a registered nurse from Dyfi require short term absence (for example become unwell whilst on shift or not be able to attend a shift at short notice) the ward could be left with one, or no, registered nurse. This would limit the care provided to patients and create a reliance on other community services to support the ward. This creates a risk to patient safety, provides a poor experience (for example patients would not be able to receive prescribed controlled medications without two registrants being available), and staff well-being is compromised as the registered nurse on the ward would not be able to have a break. There would be disruption to other community services such as a reduction in the number of patients seen by community teams and probable closure of the minor injuries' unit. This significantly limits services provided to the community of Tywyn in an unpredictable manner.

There can be risks to delivering infection prevention standards due to workload demand and pressure on the team. Furthermore, patients can be at an increased risk of exposure during a prolonged hospital admission where there is a pathway of care delay.

2.4 Issue 4: Changing population health need

The BCUHB Public Health 'Health and Wellbeing Profile' for Tywyn sets out the requirements for a healthy and well population. Based on the determinants of health they include chronic condition management, healthy lifestyles and behaviours such as healthy weight, tobacco, alcohol consumption, nutrition, and physical activity. There are key services available for Tywyn residents to support chronic conditions. These are conditions identified as being higher in Tywyn and therefore are priorities to meet population needs.

In the Public Health 'Health and Wellbeing Profile' screening has been identified as a priority. A mobile diabetic retinopathy screening service is available for Tywyn residents and routine screening such as bowel and cervical screening is offered through the GP practice.

A range of services are provided on the Tywyn Hospital site and in the community, delivered by Health, Local Authority and Third Sector providers. These services deliver physical wellbeing, mental health, midwifery, social care and public services such as the library and leisure centre. Refer to Appendix 1 for a full list.

For more information on the population health profile of Tywyn and what it meant for this review, please see section 3.

Overall, the evidence indicates that the health needs of the Tywyn population are increasingly characterised by an ageing demographic, higher levels of long-term conditions and a growing need for preventative, community-based and integrated care. While a range of services is already available locally, there remain opportunities to better align service provision with current and future population needs, particularly through improved coordination, earlier intervention and support to help people remain independent at home. This reinforces the need to consider whether the existing model of care within Tywyn Community Hospital is best configured to improve health outcomes, reduce avoidable hospital admissions and ensure services remain sustainable for the future.

From a change perspective, the key elements centre on aligning services to population health needs and addressing the main determinants of health. The Tywyn community health profile highlights priority areas such as chronic condition management and lifestyle, which imply a need for coordinated prevention and early intervention. Change efforts should be focused on strengthening integrated pathways that link primary care, community services, and public health initiatives, ensuring that people at higher risk, in particular those with long-term conditions are identified and supported earlier within the community.

This case of change recognised the importance of improving access, uptake, and better coordinating services such as screening and community-based provision. The presence of mobile and routine screening services e.g. diabetic retinopathy, bowel, and cervical screening, suggests opportunities to increase coverage through outreach. In addition, the wide range of services across health, local authority, and third sector providers highlights the importance of service integration, shared working, and navigation for residents. From a change perspective, this means enhancing collaboration and ensuring that services are person-centred.

2.5 Issue 5: Financial challenges

2.5.1 Financial context

The National Health Service Finance (Wales) Act 2014 places two financial duties on Local Health Boards:

- a) **Revenue resource performance:** A duty to ensure that expenditure does not exceed the total funding allocated to it over a period of 3 financial years.
- b) **Integrated planning:** A duty to prepare a plan, in accordance with planning directions issued by the Welsh Ministers, to secure compliance with the Revenue resource performance while improving the health of the people for whom it is responsible, and for that plan to be submitted to and approved by the Welsh Ministers.

The NHS in Wales, along with the wider Public Sector, has experienced significant financial pressures over recent years, most notably after the COVID 19 pandemic response. Rising demands and service pressures have been compounded by the significant increases in the costs of staffing, agency, consumables and energy.

The Health Board has faced a significant underlying deficit position, which is an accumulation of drivers that include cost pressures and non-delivery of savings programmes. In previous financial years, many of these cost pressures have been mitigated through non-recurrent measures and non-recurrent funding from the Welsh Government.

The Health Boards Integrated Medium Term Plan 2026-29, sets out how it will improve the quality, efficiency, productivity and effectiveness of the services that it delivers. How it must modernise practice and learn from others, sharing innovation and best practice across the health board. It will ensure the value for money use of public resources, particularly in the current financially constrained times. The Health Board's plan will strengthen its relationship with local communities and partners.

The 2026/27 Annual Inflationary Allocation for growth limits the ability of the Health Board to meet inflationary pressures, with the regulatory bodies for NHS Wales promoting this to be a zero-investment budget. The attainment of the key financial duty to deliver a balanced financial plan for the year is therefore challenging, requiring careful prioritisation and a disciplined approach to planning to balance affordability with ensuring high quality services remain accessible and delivered in a timely fashion for the local population. Prioritisation and clarity on where resources are deployed for 2026/27 will therefore be needed, decisions aligned to population need in meeting the immediate need in addition to a long-term strategic focus, ensuring services are sustainable in meeting the needs of those requiring our services today and fit for the challenge of meeting the increasing demands of tomorrow.

The targeting of improvements through implementation of a Value & Sustainability approach that delivers productivity and efficiency gains through benchmarking and service reviews is a key strategic focus.

2.5.2 Tywyn financial challenges

The overall financial resource for Tywyn Hospital in 2026/27 is £1,426,727 and 26.72 WTE; 19.58 WTE of direct nursing and 7.14 WTE of support services.

Financial Year	Budget £000's

2019/20	725
2020/21	744
2021/22	772
2022/23	823
2023/24	881
2024/25	901
2025/26	951

Whilst there is physical capacity for 16 inpatient beds, it must be noted that the recurrent funding for Tywyn Hospital is for 10 inpatient beds, inflated for annual pay awards.

The following table summarises the funded WTE establishment against those staff directly in post, excluding the use of bank, agency and overtime to cover any rota gaps.

Financial Year	Funded WTE	In Post WTE	Vacancy WTE
2019/20	19.31	16.40	(2.91)
2020/21	19.31	18.66	(0.65)
2021/22	19.58	16.76	(2.82)
2022/23	19.58	19.64	(0.06)
2023/24	19.58	17.10	(2.48)
2024/25	19.58	19.24	(0.34)
2025/26	19.58	18.76	(0.82)

During the financial years leading up to the temporary closure of the 10 beds in April 2023, the Health Board regularly maintained staffing levels using bank, agency and overtime: £35,000 in 2019/20; £31,000 in 2020/21; £38,000 in 2021/22; £77,000 in 2022/23. As well as when possible transferring nursing staff from other areas to support the 10 inpatient beds on Dyfi ward.

Since the temporary closure, resources have been re-allocated to provide alternative service provision within the local community. Whilst the IHC has been set annual savings targets to deliver, no direct savings have been taken out of the Tywyn Hospital budgets. Additional hospital security costs of circa £2,500 per month have however, been incurred due to the need for enhanced surveillance.

There are no patient facing service contracts or repatriation matters for consideration.

There is no income generation for Tywyn Hospital (for instance private patient or holiday dialysis).

In line with the Health Boards Integrated Medium Term Plan 2026-29, any future consideration of the allocated resources requires careful planning and redesigning of services to ensure that they are optimised, represent value for money and maintain financial sustainability whilst keeping patient safety and service quality as a priority.

2.6 Summary of issues

There are significant challenges that caused the ward to be closed in April 2023, the foremost being the issues around safe and sustainable staffing and the impact that had on both safety on the ward, the quality of services able to be offered. This also impacted on the stability of other services in the hospital and caused some financial concerns. The review has also highlighted the changing population health needs of the population, that requires consideration when considering the options for the future of the ward.

Summary of Issues – Tywyn In-Patient Ward	
Population Health Need	Tywyn Community Hospital serves a population of approximately 7,485. A range of services are available within the Hospital and in the Community to deliver physical wellbeing, mental health support, midwifery, and social care. They are provided by local Health Boards, Local Authority and the Third Sector (see Appendix 1 for full list). Further work is required to target gaps in service provision and strengthen and enhance delivery of existing services. The evidence suggests that future services need to be better aligned to changing population health needs through greater emphasis on prevention, integrated community services, rehabilitation and support to help people remain independent at home.
Quality and Safety Standards (Services meet standards, minimise risk to patients and patients have a good experience)	Quality is more than meeting service standards. It's system-wide, safe, effective, person-centred, timely, efficient, equitable care that should occur in a learning culture. To help achieve this, the Duty of Quality came into effect in April 2023 as part of the Health and Social Care (Quality and Engagement) (Wales) Act 2020. The current Tywyn Community Hospital service model does not always meet national quality standards and is therefore unsustainable. In order to maintain patient and

	staff safety on the inpatient ward other services including the MIU in Tywyn Community Hospital have been closed for prolonged periods. Evidence also demonstrates prolonged lengths of stay and high levels of delayed pathways of care, increasing the risk of deconditioning and reducing patients' independence. The required quality standards for delivering inpatient care include medication safety, de-conditioning and infection prevention including: • Impact on delivery and compliance with safe medication processes. • Impact on de-conditioning of patients due to prolonged hospital admission • Impact on ability to maintain infection prevention standards at all times. The Quality Statement for Palliative and End of Life Care outlines Welsh Government's vision for ensuring individuals receive high-quality care tailored to their needs, whether at home or in healthcare settings. The Tywyn Steering Group established a Task and Finish Group to review the provision of end-of-life Care in Tywyn and the surrounding area. The existing model to deliver end of life care has supported patients to die where they choose in Tywyn, however there is scope to enhance the service offer to improve respite, overnight care and support services.
Workforce	The Health Board is duty bound to provide safe levels of staffing to ensure patient safety, quality, and standards of care in line with the Nurse Staffing Levels (Wales) Act. A phased implementation of this was rolled out within District General Hospitals. Phased implementation has not, as yet, been rolled out in Community Hospitals by law, however there is a professional duty to ensure patient safety through adequate staffing levels and skill mix. To ensure the delivery of sustainable, safe services moving forwards, a resilient workforce is required. At present there is a lack of resilience within the nursing

	workforce model due to recruitment and retention challenges. Therapies and pharmacy services were being delivered across sites (Dolgellau and Tywyn) prior to the temporary closure of Dyfi ward, thus limiting available resource to support rehabilitation and care on site and impacting on patient experience and outcomes.
Financial (Affordability/Cost Effectiveness)	Betsi Cadwaladr University Health Board has a statutory obligation to plan and manage services within the allocation income it receives. The Executive Nurse Director has highlighted the significant risk of having only one Band 5 Registered Nurse on site overnight. This would significantly impact on the staffing mix and numbers required and any future model would require further review to ensure it is safe, sustainable and can be managed within existing resource. Future provision should maximise value from available resources while ensuring services remain clinically safe, sustainable and aligned to population need.
Deliverability and Sustainability (Realistic and Achievable)	The sustainability of the current service model is a challenge due to issues with workforce resilience including recruitment and retention.
Efficiency and Effectiveness (Efficient use of resources/effective service delivery)	Data indicates that demand for inpatient beds for the population is an average of 3.7 patients. The data suggests that there would be up to 6 beds vacant on Dyfi Ward at one time.

The evidence demonstrates that while Tywyn Community Hospital provides an important local service, the historic inpatient model is no longer able to consistently deliver the right care, in the right place, at the right time within available workforce and financial resources. Future services therefore need to better align with changing population need, improve patient flow and outcomes, and provide a clinically safe and sustainable model for the future.

3. Tywyn population health needs

The BCUHB Public Health team have produced a Health and Wellbeing Profile for Tywyn, Gwynedd, which describes the population of the area in terms of: age profile; the health and wellbeing of the local population; the wider determinants of health, which are the wider influences on health such as deprivation, education and employment and quality of housing.

The profile uses data from a range of sources and at different geographical levels to describe the population of Tywyn. The geographical levels used are Gwynedd Unitary Authority (UA) and Super Output Areas.

Tywyn is located in Middle Super Output Area (MSOA) of Gwynedd 017, which comprises of four smaller Lower Super Output Areas (LSOAs), including LSOA Tywyn 1 and LSOA Tywyn 2.

Super Output Area geographies
Lower Super Output Areas LSOAs have a mean population of approximately 1,500; a minimum population of 1,000 and a maximum population of 3,000. There should be a minimum of 400 households and a maximum of 1,200 households in each LSOA.
Middle Super Output Areas MSOAs have a mean population of about 7,000, with a minimum population of 5,000 people and not exceeding 15,000 people. The minimum number of households in each MSOA is 2,000 and the maximum is 6,000.



Figure 1 MSOA Gwynedd 017 & LSOAs Middle Super Output Area (MSOA) Gwynedd 017, which is composed of four LSOAs: Llangelynin, Tywyn 1, Tywyn 2 and Aberdovey/Bryncrug/Llanfihangel.

Primary Care Cluster Areas

Primary Care Cluster Areas are a small group of GP practices, which work together to develop services in the community. Primary Care Clusters each serve a registered population of 30,000 to 50,000 patients.

Primary care data for the **South Meirionnydd Primary Care Cluster** is presented in this report as this is where Tywyn is situated.

Betsi Cadwaladr UHB Clusters and LSOA'S (2021 Census)

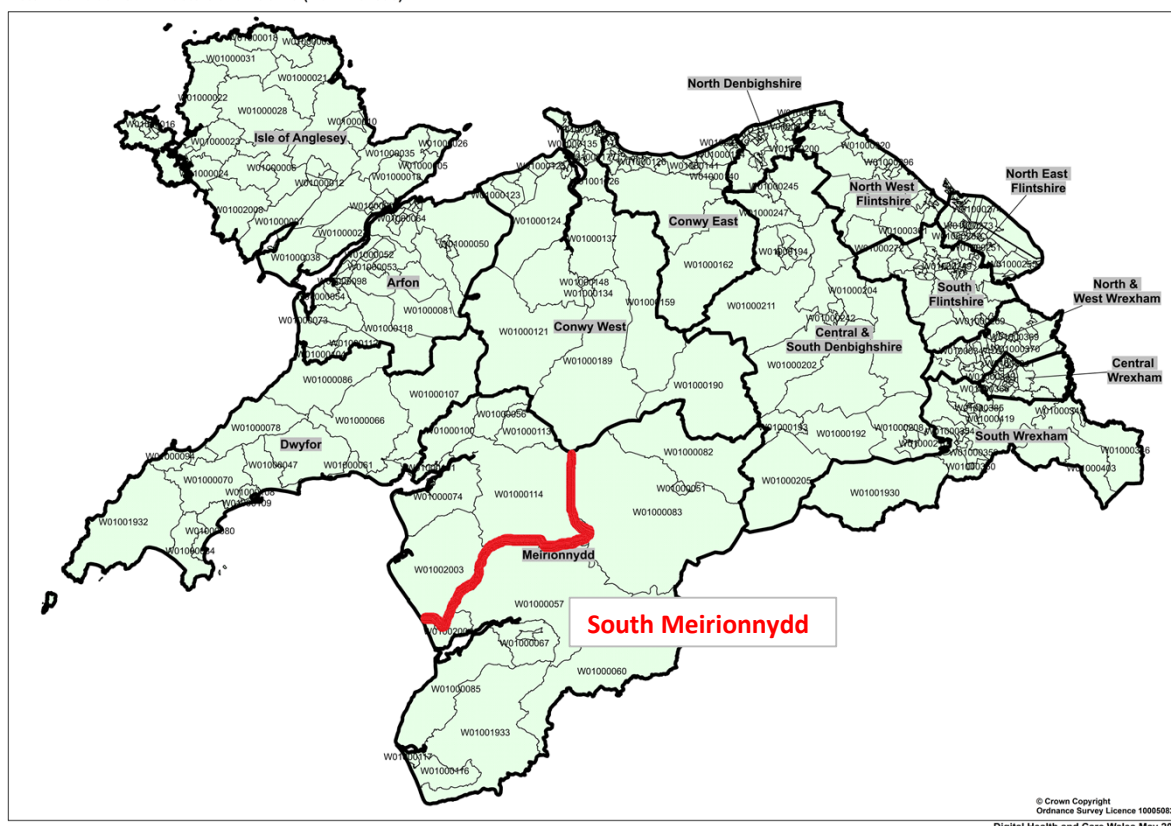


Figure 2: Betsi Cadwaladr UHB Clusters, 2023

Key messages from the Health and Well-being Profile are as follows:

3.1 Demographics and Wider Determinants

The wider determinants of health are social, economic and environmental factors that influence health, well-being and inequalities ([Public Health Wales](#)). Key determinants of health can be inter-related and include:

- Income and resources
- Good education and skills
- Fair work
- Quality, accessible, affordable housing
- Transport
- Built and natural environment

MSOA Gwynedd 017, in which Tywyn is located, has a population of just under 6,900. There are 1,275 residents aged 24 years and under in the Gwynedd MSA 017 which is just under

19% of the population; 36% are aged 65 years and over; and over 5% are aged 85 years and over. LSOAs Tywyn 1 and Tywyn 2 have a total population of circa 3,100. LSOA Tywyn 1 has the largest number of residents aged 65 years and over, with 41.2% of its population falling into this age group.

The population of Gwynedd UA is expected to grow by 3.8% by 2040 which is the largest increase in the North Wales region. Gwynedd is the only UA in North Wales predicted to experience an increase (2.1%) in residents aged 0 to 15 years; Gwynedd is expected to experience the smallest increase across the region, of older people aged 65 years and over (13.6%).

Gwynedd has three LSOAs in the most deprived 10% LSOAs in Wales. In MSOA Gwynedd 017, LSOA Llangelynin is the most deprived area and ranked as the 725th of 1909 most deprived in Wales. Tywyn 2 is ranked 747 of 1909 and Tywyn 1 is ranked 1,410 of 1909.

In the South Meirionnydd Primary Care Cluster, 37.8% of all households are occupied by one person and 19.8% of households are occupied by a single person aged 66 years and older. These figures are higher compared to averages for BCUHB and Wales. 19.7% of the population of the South Meirionnydd Primary Care Cluster report to be living with a limiting long-term illness.

In Gwynedd UA, 5.5% of babies are born with low birth weight which is amongst the lowest figure in the region and lower than the Welsh figure of 6.2%. There is a strong correlation between social deprivation and low birth weight.

26% of children 0 to 15 years in the South Meirionnydd Primary Care Cluster are in low-income families; the majority of which are in-work families. In the South Meirionnydd Primary Care Cluster, almost 19% of adults (aged 16 years and over) have no qualifications, 3.9% of households have no central heating and 2.0% of households are overcrowded.

3.2 Health, Wellbeing and Mental Health

Gwynedd UA has a higher proportion of those who smoke tobacco than in the rest of North Wales, at 14.9%. Gwynedd has the same proportion of adults who drink above the recommended guidelines of 14 units a week, at 17.2% as in the rest of Wales, higher than the BCUHB figure of 16.0%. In Gwynedd, 37.9% of adults report being of a healthy weight; 21.9% of adults report eating five portions of fruit or vegetables a day and 45.1% meet the recommended guidelines for physical activity. In the South Meirionnydd Primary Care Cluster, 16% of patients are registered by a GP as having obesity.

The mental health well-being score for Gwynedd is 47.9 which indicates worse mental health in the population than in other UA areas in North Wales, apart from Anglesey. 13.2% reported feeling lonely, one of the highest rates in UA areas in North Wales. 71.2% of adults feel a sense of community in Gwynedd UA and 25% regularly volunteer.

19.7% of the population of the South Meirionnydd Primary Care Cluster report to be living with a limiting long-term illness.

3.3 Children and Young People

The age profile of an area influences the type of services required to meet the needs of the local population. MSOA Gwynedd 017, in which Tywyn lies, has a population of around 830 residents aged 0 to 15 years, which is 12% of the total population of MSOA Gwynedd 017.

The percentage of four-year-olds up to date with routine vaccinations in MSOA Gwynedd 017 is 87.4%. 29% of children aged 4 to 5 years in Gwynedd UA are overweight or obese; this is statistically significantly higher compared to Wales as a whole (25.5%). In South Meirionnydd Primary Care Cluster, 31.6% of 4- to 5-year-olds are overweight or obese and 14.9% have obesity. These are amongst the highest cluster levels and higher compared to BCUHB and Wales.

3.4 Older People

Almost 36% of the resident population of Gwynedd MSOA 017, in which Tywyn lies, is aged 65 years and over and just over 5% aged 85 years and over.

The rate of persons registered by their GP as having osteoporosis in the South Meirionnydd Primary Care Cluster (320.0 per 100,000 population) is lower than BCUHB and statistically significantly lower compared to Wales. The rate of hip fractures per 100,000 amongst persons aged over 65 in Gwynedd is slightly higher than for BCUHB and Wales, but not statistically significantly higher. Registered dementia rates in the South Meirionnydd Primary Care Cluster for all persons (425.2 per 100,000 population) are lower than BCUHB and statistically significantly lower compared to Wales.

3.5 Welsh Language

In the South Meirionnydd Primary Care Cluster, 53% of residents aged 3 years and over speak Welsh. Welsh Language Impact Assessments can be viewed at Appendix 3.

3.6 Ethnicity

Data from the 2021 census shows that almost 96% of residents in the South Meirionnydd Primary Care Cluster are White-British. In Gwynedd, 3.8% of residents are Black, Asian and Minority Ethnic.

4. The existing services

4.1 Services prior to ward closure

A range of services are funded for delivery at Tywyn Community Hospital including inpatient care, minor injury care, primary care, and outpatient services as detailed below.

4.1.1 Inpatient Services

The function of inpatient services within Community Hospitals are as follows:

- **Discharge to Recover and Assess (D2RA) Pathway 2 – Rehabilitation** for patients who require further therapy that cannot be provided through delivery of services in the community, but whose needs do not require the facilities and specialist services from an Acute General Hospital.
- **Step Up Admission (D2RA) Pathway 2** – admission from home in appropriate cases for acute hospital admission avoidance (GP beds/Mon Enhanced Community Care in Anglesey). This would include conditions that can be safely managed in a community hospital such as urinary tract infection, chest infection.
- **Discharge to Recover and Assess (D2RA) Pathway 2** – People are supported in a short-term facility to enable recovery, rehabilitation, reablement, assessment, care planning or short-term intensive support in a 24-hour bed-based setting, before returning home.
- **Complex Support Pathway (D2RA) Pathway 3** - Those discharged will have such complex needs that they are likely to require 24-hour bedded care on an ongoing basis following an assessment of their long-term care needs outside of an acute hospital setting, but require further assessment.
- **End of Life Care** – The provision of end-of-life care where the community hospital is the preferred place of death, or where symptom control is complex and requires nursing input which would not be available at home.
- **Transitional Care** short term 'bridging' for those awaiting D2RA Pathway 1 (home with support) where it is not available immediately.

Dyfi Ward, the inpatient unit within Tywyn Community Hospital, is a 10 bedded inpatient ward dedicated to the provision of rehabilitation of patients from Tywyn and the surrounding area.

Medical oversight for these beds was provided by a local GP who had responsibility to deliver regular ward rounds on site and remote support as required.

The ward is supported by pharmacy and therapies staff. A number of these services are shared across Tywyn and Dolgellau hospitals including pharmacy, physiotherapy and occupational therapy, requiring staff to travel between sites reducing the clinical

time and presence available for patient care, leading to delayed discharge and delayed pathways of care.

As set out above, workforce challenges including recruitment and retention have been a barrier to delivering safe, quality care at Tywyn Community Hospital leading to the temporary closure of the Dyfi Ward on 18th April 2023.

The unit was regularly at capacity with challenges with delays of transfers of care or discharge and extended stays. The activity data below sets out the data for the year prior to the closure of the ward (March 2022 to April 2023) which is important context for any decision.

4.1.1.1 Inpatient Admissions

Between April 2022 and March 2023, a total of 92 patients were admitted to Dyfi ward, Tywyn Community Hospital.

90.2% of patients were transferred from another hospital (this includes transfers from BCUHB hospitals and out of area hospitals such as Bronglais). 6.5% of patients were admitted through the GP route and the remaining 3.2% were admitted as a method of 'Emergency – Other'.

Admission Source	Total Number (April 22-March 23)
Transfers	83 (90.2%)
Emergency	3 (3.2%)
GP	6 (6.5%)
Total	92

4.1.1.2 Admission source from BCUHB Hospitals (April 2022 – March 2023)

Of the 83 patients transferred to Tywyn from other hospitals, 16 were admitted from another BCUHB hospital and the remaining 67 were transferred from Bronglais Hospital. The table below outlines the specific BCUHB hospitals and wards from which these patients were prior to their admission to Tywyn.

Previous Hospital	Previous Ward	Transfers
Dolgellau & Barmouth Community Hospital	Cader Ward	3

Ysbyty Gwynedd	Ffrancon Ward	4
	Ogwen Ward	3
	Same Day Emergency Care Unit (SDEC)	6
	Tryfan Ward	
	Tegid Ward	
	Aran Ward	
	Enlli Ward	
	Conwy Ward	
Bronglais Hospital	Various Wards	67

4.1.1.3 Tywyn Midnight Occupancy

From April 2022 to March 2023, Dyfi ward consistently had a midnight occupancy of full capacity, often between 10 and 12 patients. This indicates that the ward was well utilised throughout the year. The reason for a high use was predominantly due to patients who were experiencing delay pathways of care and as such at risk of deconditioning.

OBJ

Since the temporary closure with the enhanced community provision, admission avoidance and alternative rehabilitation, historic ward occupancy is not directly comparable to the four beds commissioned via Dolgellau, e.g., historic occupancy reflected delayed discharges rather than demand for 24/7 inpatient care.

4.1.1.4 Admissions / Average Length of Stay and Bed Days

The data shows the Average Length of Stay (AVLoS) for patients admitted to the inpatient ward at Tywyn Community Hospital prior to the temporary closure on the 18th April 2023. It is expected that patients accessing inpatient services within Community Hospitals for rehabilitation would be discharged within 21-35 days.

Prior to March 2023, the AvLOS for inpatients in Dyfi Ward was consistently above 30 days.

There were 3 occasions where the AvLOS has been above 50 days (Sept 2022 to Nov 2022). Long length of stay for patients in hospital can have a harmful effect on long-term health and wellbeing (NHS Improvements 2018).

Date	Admissions	AVLOS	Bed Days
2022	70	43.0	2964
Apr	8	35.8	286
May	8	33.7	236
Jun	10	34.5	345
Jul	10	31.4	314
Aug	8	41.9	335
Sep	10	51.1	511
Oct	6	75.3	452
Nov	6	55.0	330
Dec	4	38.8	155
2023	22	29.5	649
Jan	5	41.8	209
Feb	9	34.7	312
Mar	8	16.0	128
Grand Total	92	39.7	3613

4.1.1.5 Pathway of Care Delays / Delayed Transfers of Care

A pathway of care delay (PoCD) is experienced by a patient who remains in hospital when they are ready to transfer to the next stage of care, but this is prevented by one or more reasons. PoCDs have a detrimental effect on the people who become delayed with significant implications for their independence.

Prior to the temporary closure of the inpatient ward at Tywyn Community Hospital there were a number of patients that were clinically optimised for discharge but were occupying inpatient beds due to delayed pathways of care. A number of these delays were caused by factors such as a lack of packages of care and patients awaiting a space in residential or community hospital beds. The optimal pathway for patients would be to go to the identified destination without delay.

Pathway of Care Delays (POCD) were known as Delayed Transfers of Care when Tywyn had in-patient beds. Between April 2022 and March 2023, Tywyn had 81 patients recorded as 'delayed transfers of care':

Date	Delays (number of patients)
Apr-22	6
May-22	11
Jun-22	6
Jul-22	7
Aug-22	12
Sep-22	8
Oct-22	3
Nov-22	6
Dec-22	3
Jan-23	5
Feb-23	8
Mar-23	6

With the top reasons for delayed pathways of care impacting on patient discharge from Dyfi Ward are described below:

Delay Codes	Delays (number of patients)
M25 - Discharge for specific date	15
Not Recorded	14
M6 - New Home Care Package	14
M1 - Residential bed required	9
M2 - Nursing home bed required	6
F10b - Discharge for specific date	4

M19 - Therapy Review – physio/OT/ Home Assessment/SALT	
M17 - Equipment - mattress, commodes, beds, hoist etc	
M7 - Restart Home Care Package	
M29 - Completion of nursing assessment / check list / DST	
F18b - General residential home bed	
M31 - Awaiting referral to HFB	
M9 - Peripheral Hospital	
M11 - Social Services Awaiting Allocation	
M16 - Capacity review	
F10a - Discharge planned for tomorrow	
NF - No longer fit	
M22 - Transport	
M11 - Allocation of Social worker	
F16 - Awaiting dom POC	19
Total	81

Of the 92 patients admitted to Tywyn Community Hospital between April 2022 and March 2023 81 (88%) of these patients were clinically optimised for discharge, had a delayed discharge and were in hospital without a clinical need for hospital care.

4.1.1.6 What does the inpatient data suggest?

The activity data demonstrates that Dyfi Ward was a well-used and valued service, operating at or near full capacity prior to its temporary closure. However, it also highlights significant challenges in the way inpatient beds were being utilised. The average length of stay was consistently higher than expected for a rehabilitation ward, with almost nine in ten patients experiencing a delayed discharge after they were clinically ready to leave hospital. This indicates that, for many patients, the ward was being used not only for rehabilitation but also as a place to remain while awaiting community support, care packages or longer-term care arrangements.

Extended hospital stays are associated with poorer patient outcomes, including an increased risk of deconditioning, loss of independence, hospital-acquired complications and reduced wellbeing, particularly for older people. The data therefore suggests that while the inpatient beds were in high demand, the model was not consistently enabling patients to receive care in the right place at the right time or supporting timely recovery and discharge.

Taken together, the evidence indicates that future services should seek to address the underlying causes of delayed pathways of care rather than simply increase inpatient capacity. This includes strengthening community-based support, improving rehabilitation and reablement pathways, enhancing discharge planning and working more closely with health, social care and third sector partners to enable people to return home safely wherever possible. The findings therefore support consideration of a future service model that responds to the wider needs of the local population, improves patient flow across the whole system and makes the most effective use of available workforce and resources.

4.1.2 Minor Injury Unit (MIU)

An MIU is located within Tywyn Community Hospital, accessible to the population of Tywyn and surrounding area. It was open 08.00 to 17.00, 5 days a week though there was seasonal variance, e.g., often closed during the winter to reopen in the summer based on demand.

Early in the COVID-19 pandemic, the MIU was temporarily closed so staff could be used to support the inpatient unit. A lack of resilience within the registered nursing workforce on Dyfi ward directly impacted on the ability to deliver the MIU service and the MIU remained closed until July 2023.

Prior to the closure, an average of 2100 patients were seen in the MIU per year. High activity is recorded yearly over the summer period associated with an influx in residents in the area.



Since the temporary closure of the Dyfi Ward, the MIU has been able to provide a more sustainable service due to improved workforce resilience (not needing to close in order to staff the inpatient ward).

4.1.3 Primary Care

Tywyn Health Centre is co-located on Tywyn Community Hospital site. It is a health board managed practice delivering primary care services to the population of Tywyn and the surrounding area.

There are currently 4 GPs at the practice supporting 5,356 registered patients. A further 17,000 temporary residents seek medical support during the year, with demand increasing particularly during the summer months.

The temporary residents may be seen by the multi-disciplinary team or navigated to other services such as the community pharmacy, treatment room or minor injury service.

There is some anecdotal suggestion that the practice has been impacted by the ward closure, with more patients being cared for at home who may require home GP visits.

While the Practice and Community Hospital function as separate services with distinct accountabilities and workforce arrangements, opportunities continue to be explored for service developments which derive the benefits of closer working together. This includes for instance the GPs supporting Point of Care testing and community staff providing nursing cover to the practice.

The wider temporary services have the potential to reduce pressure on the GP practice and increase multi-disciplinary team working.

4.1.4 District Nursing

The South Meirionnydd District Nursing Team operates across two sites, Tywyn and Bala, and currently manages a caseload of 230 patients.

Within this, the Tywyn District Nursing Team is responsible for 140 active patients, including 14 patients who attend the district nurse wound care clinic. The team currently has a 0.51 whole-time equivalent (WTE) Registered Nurse vacancy, arising from backfill requirements for a maternity leave secondment.

The team provide holistic nursing care to people residing within the community, this includes palliative and end of life care, wound care, complex care management and co-ordination, drug administration, continence care (bladder and bowel management), venepuncture, PICC line care and are working towards extending their skills to provide intravenous drug administration.

The Tywyn District Nursing team are based on site at Tywyn Community Hospital as part of the Community Resource team (CRT) providing high quality patient centered care in a variety of settings. The team in Tywyn provide cover from 8am until 8pm, 7 days per week with the out-of-hours District Nursing Team (based in Alltwen) available for district nursing care at night.

The District Nursing Service is one point of contact for people to access community home based general nursing services. They provide care through an appropriately

skilled and registered nursing workforce, which delivers an equitable and accessible range of services. They predominantly see patients who are deemed house bound, providing health promotion, support through ill health, promoting and maximising independence, recovery, and/or the terminal stages of life.

The District Nursing service leads and delivers care within patient's homes, residential and care home settings and clinics.

The provision of end-of-life care in Tywyn and the surrounding area is provided by the District Nursing Team supported by the CRT, which consists of the GP service, District Nursing, Specialist Palliative Care, Tuag Adref Team, Nursing and Residential Homes, Local Authority, Therapies, and Pharmacy.

Since the temporary closure of the inpatient ward, the District Nurses are no longer being redeployed to support staffing cover on the ward. There been a positive impact of having the Treatment Room in place as it has helped released District Nurse time and ability to focus on those patients who are housebound in the area.

4.1.5 Outpatient Services

A range of outpatient clinics are delivered within the Outpatient Department at Tywyn Community Hospital. These incorporate physical health, midwifery and mental health (refer to Appendix 2). These services are provided by a mixture of Betsi Cadwaladr University Health Board and visiting consultants from the neighbouring Hywel Dda University Health Board.

The radiology service delivers a weekly x-ray service within the Outpatient Department at Tywyn Community Hospital; this supports both outpatient services, inpatient services, and the MIU.

Outpatient services have not been impacted by the temporary closure but are important to acknowledge as part of the local service offer.

4.2 Interim service mitigation since April 2023

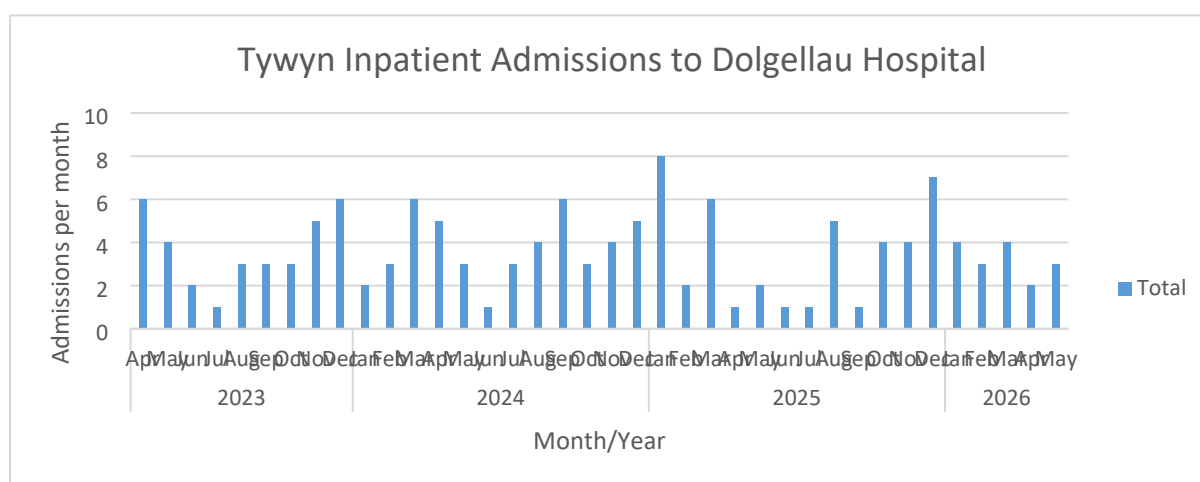
Following the decision to temporarily close Dyfi Ward, the Health Board explored other services that could be delivered to mitigate against the closure. This included exploring alternative models in rural areas where resilience, including recruitment, is a challenge.

The provision of alternative services in Tywyn and the surrounding area therefore includes providing health and care services directly in patient's homes, working closer with care homes in the area to provide services for their residents, and enabling and providing the health support for patients to spend their last few weeks and days with dignity in their own home.

Partnership working with key stakeholders including the Local Authority and third sector services has been key in delivering the service mitigations.

4.2.1 Inpatient Beds

An additional 4 inpatient beds were opened in Dolgellau & Barmouth Community Hospital to support patient demand from the Tywyn area. This increased Dolgellau from 14 to 18 beds. Some staff from Dyfi ward at Tywyn Community Hospital were re-deployed to support the additional beds.



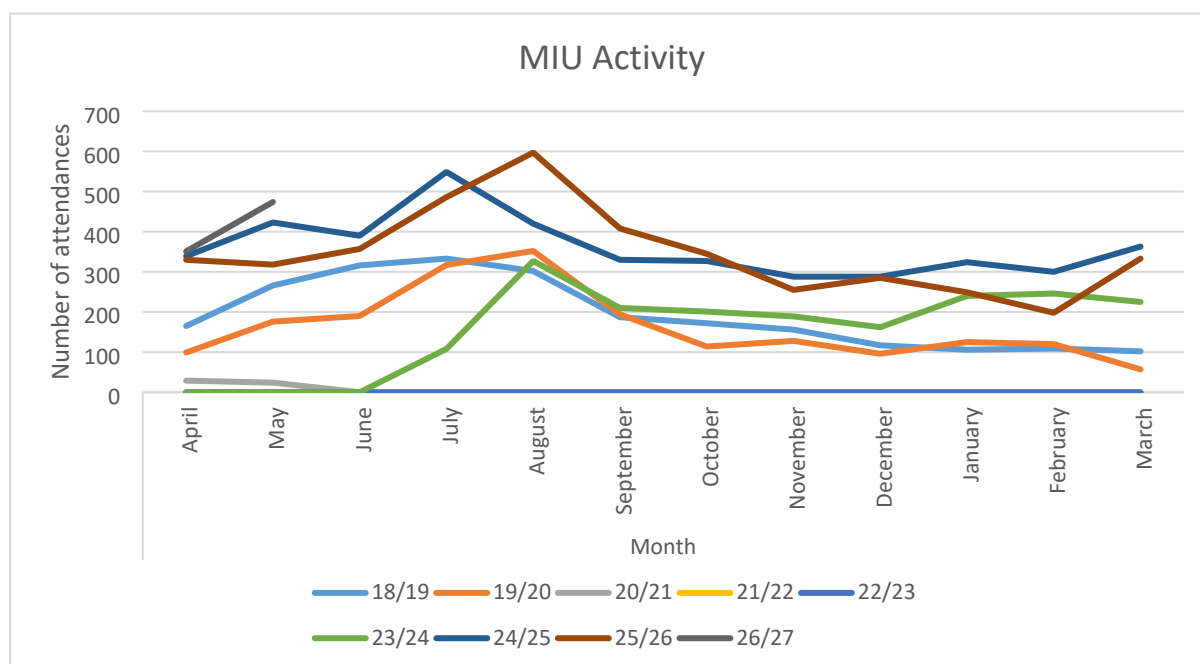
Following the temporary closure of Dyfi Ward at Tywyn in April 2023 a total of 136 patients from Tywyn postcodes have been admitted to Dolgellau Hospital up to the 31st May 2026. This is an average of 3.7 patients per month.

The temporary closure has reduced inappropriate admissions with enhanced support now available within the community. Prior to closure, there was high usage of the ward however, 9 out of 10 patients were impacted by delayed pathways of care with clinically optimised patients occupying beds and at risk of adverse effects.

4.2.2 Minor Injuries Unit (MIU)

The MIU re-opened in July 2023 and up until the 31st May 2026 there have been a total of 11,067 attendances with the highest demand being seen in August 2025 where 597 patients attended the unit.

These figures are an increase on the activity seen prior to the temporary closure of the Dyfi Ward. Without the pressures of staffing the ward, the MIU has been able to extend, offering out of hours care to the local community.



4.2.3 Treatment Room

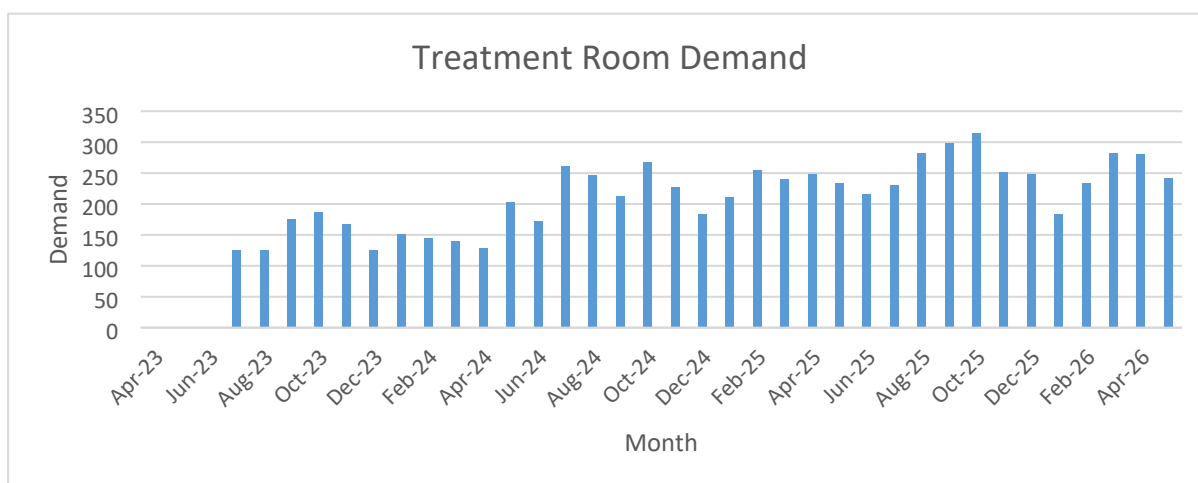
A new Tywyn Community Hospital Treatment Room opened in July 2023 providing additional community capacity for the local population. This service is delivered by members of the Tywyn nursing team that were re-deployed following the temporary closure of Dyfi ward.

This service currently offers wound care, blood tests, and catheter management, and has further developed to include IV therapy, and point of care testing (PoCT). The treatment room are currently undertaking PoCT and the GP will review results preventing unnecessary admission to hospital.

The treatment room continues to work closely with the GP practice and wider services to provide a collaborative approach to care delivery. There remains potential to further expand the range of services offered and to further develop staff skills and competencies, thereby enhancing workforce stability and supporting the service as an attractive and proactive place to work.

The establishment of the treatment room has reduced demand on primary care and released District Nursing capacity, allowing them to focus on complex patients within their own home.

The Treatment Room has received in excess of 7494 attendances since July 2023 (as at the 31st May 2026).

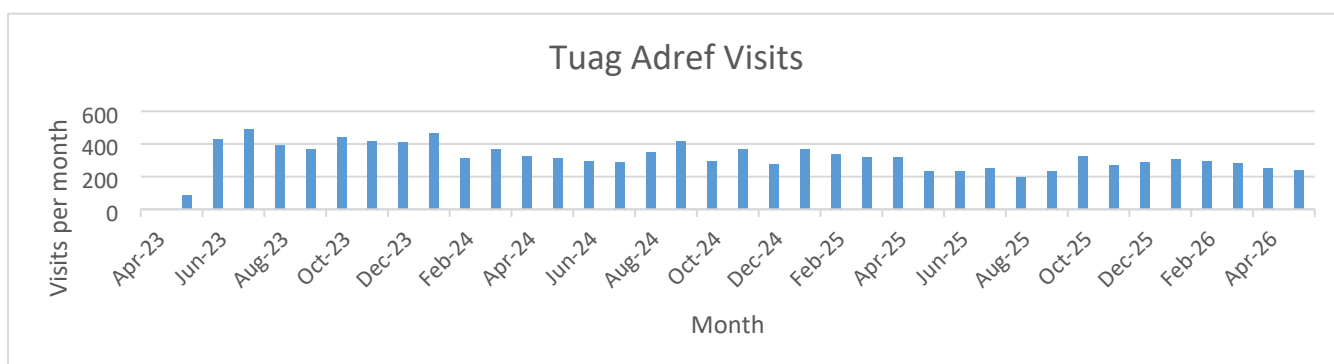


4.2.4 Tuag Adref

Additional community capacity has been created with the introduction of the Tuag Adref (Homeward Bound) service.

This service supports patients to remain at home, avoiding preventable hospital admissions and supports prompt discharge from hospital. Tuag Adref provides patients with low level support and rehabilitation at home following discharge.

Health Care Support Workers who had previously worked on the Dyfi ward were redeployed to the Tuag Adref service in May 2023.



Since the service commenced in May 2023 there have been 246 new referrals (as at the 31st May 2026). 103 (41.87%) of referrals for the Tuag Adref service were received from Community Services including District Nursing and GPs. This means that the Tuag Adref service has resulted in 103 patients remaining at home, avoiding the need for admission to hospital. 45 (18.29%) of patients were referred from Bronglais, 56 (22.76%) were referred from a BCUHB Hospital and the remaining 42 (17.07%) referred from social services.

On average, Tuag Adref has been supporting 12 patients on its caseload, delivering on average 321 visits per month. The average number of visits has decreased since the service was initially established in 2023. This reduction can be attributed to improved prescribing practices, which have helped minimise unnecessary visits, as well as the recent introduction of a care provider in Tywyn delivering social care support.

4.2.5 Wellbeing Hub

The staff at Tywyn Community Hospital established a new Wellbeing Hub on site in July 2023. The Hub offers health promotion and social support to the community, providing regular opportunities for engagement.

The programme includes a series of talks delivered by a range of stakeholders, aimed at supporting self-management, improving wellbeing, and promoting education. In addition, there are ongoing discussions with Maggie's Cancer Support to explore opportunities for virtual involvement, with the aim of expanding the service offer and enhancing support available through the group.

4.3 Training

Work is underway to ensure that all staff complete required training to become competent to deliver essential basic clinical skills e.g., venepuncture, cannulation, catheterisation, and ECG to deliver safe, compliant care and prevent adverse impact on patients or staff. The majority of staff have now completed those required competencies and continued support is in place to enable any outstanding competencies to be achieved as soon as possible.

4.4 Service gaps

A task and finish group was established to review existing services and identify health prevention and well-being service gaps in Tywyn.

The review highlighted the availability of a range of well-being services, mental health support and midwifery in Tywyn Community Hospital and in the local community ensuring that patients can access care close to home or at home. These services are provided by the Health Board, the Local Authority and third sector. A comprehensive list is included in Appendix 1.

However, the absence of a local dentist does stand out as a service gap, especially since dental care is essential for overall health and well-being. There is further scope and opportunity to enhance and strengthen the service offer of existing services to better serve the population needs.

5. Wider Tywyn service review

The Health Board has discussed local service priorities with the local community.

An initial Engagement Workshop held in April 2024 identified several services which participants identified as lacking or could be improved upon in the area. These included in-patient bed provision, end of life care, respite care and improved mental health support.

The workshop was attended by stakeholders including Cyngor Gwynedd, Tywyn Community Hospital Action Group, Local Town Councillors, Senedd Members, local nursing homes and Hywel Dda UHB.

Six key themes were identified from the output of the workshop which are being overseen as workstreams and focus areas through the establishment of a Tywyn Clinical Task and Finish Group:

Focus area	How it is being addressed
Recruitment and retention	Overarching consideration within the Care Closer to Home workstream
Care closer to home	The Care Closer to Home workstream looked at developing safe and sustainable pathways of care for the local population. This included exploring closer working with the care homes and exploring the possibility of a hybrid model of working utilised in other rural areas. Two further task and finish groups were established focusing on the delivery of; • End of Life Care • Admission Avoidance and Clinical Care Pathways These are described in more detail below.
Engagement	Updates provided regularly on the concentrated programme of pre-consultation engagement (full details of which provided in this document).
Population Health and Health Promotion	Overarching consideration in all discussions.
Digital solutions	Overarching consideration in all discussions.
Collaborative working	Overarching consideration in all discussions.

5.1 End of Life Care Workstream

The provision of end-of-life care in the Tywyn area is supported by the Community Resource Team (CRT) which consists of the GP service, District Nursing, Specialist Palliative Care, Tuag Adref, Nursing and Residential Homes, Local Authority, Therapies, and Pharmacy.

The Tywyn District Nursing Team has seen an increase in the number of patients requiring end of life and palliative care (Diagram 1). The task and finish group reported that end-of-life care is predominately provided according to patient choice, with the majority of patients supported to remain in their preferred place of care and death. During 2025, a total of 28 patients died in their preferred place of death, including 13 patients who died at home, 7 patients who died in residential care settings, and 8 patients who died in nursing homes.

There is a strong multi-disciplinary team working between all members of the Community Resource Team which is co-located on the Tywyn Community Hospital site and supports an integrated approach to patient care.

Analysis of 2025 end-of-life outcomes identified that 16 patients died in a hospital setting which is higher than in previous years, however, of these 14 patients died in an acute hospital setting following acute deterioration in their condition, while less than 5 patients died in Dolgellau Hospital as a matter of personal choice. Additionally, there were incidences of patients having died while visiting family or unexpectedly whilst travelling. Despite these cases, the majority of end-of-life care continued to be provided within community settings, reflecting the commitment of the Community Resource Team to delivering person-centred care close to home and reducing avoidable hospital admissions at the end of life.

Diagram 1 – Number of patients that have been on the district nursing and specialist palliative care caseload receiving palliative care

[OBJ]

Diagram 2 – End of Life Data for Tywyn and the surrounding area

[OBJ]

Gaps in service provision identified by the end-of-life task and finish group include:

- i. **No availability of overnight and respite care / no availability of Marie Curie Support**

Overnight care provision was reported as mostly unavailable and heavily dependent on family members. The specialist palliative care service employs a Healthcare Support Worker (0.8WTE) to provide support overnight for patients coming towards end of life. This is just one post that covers the whole of Gwynedd. The District Nursing Service and Specialist Palliative Care Service reported that there was no availability from Marie Curie Nursing Services for overnight care in this area. In the 12 months prior to the task and finish report the Marie Curie service has provided 14.7% planned care for patients throughout Gwynedd. Members reported that when they refer patients to the service it is not available in this area, and they have not had any cover for the past two years. The overnight District Nursing Team covers Dwyfor and Meirionnydd and responds to patients along with the GP Out of hours service providing symptom control and support as and when needed. Patients do not access care from inpatient hospice services as it is too far to travel to Wrexham and Llandudno. The Hospice service reported that there is nothing that they can provide in the Tywyn area.

ii. Limited access to home care

The availability of home care provision to support home care packages is not always readily available. It is envisaged however that the situation should improve as Social Services colleagues have been working on options to increase capacity in the Tywyn area. The Tuag Adref team is utilised mostly, and they have supported patients receiving end of life care since commencing delivery of a service in the Tywyn area. During the temporary closure of the inpatient ward in Tywyn Community Hospital, 9 of the Health Care Assistants are working in the community. This enabled the development of the Tuag Adref service for the Tywyn area. From 9th May 2023 to the end of March 2025, the Tuag Adref service has supported 30 patients in their own homes receiving end of life care.

iii. Limited rapid access to specialist palliative medication

The Specialist Palliative Care Nurse identified that it can at times be difficult to get rapid access to specialist palliative care medication from Ysbyty Gwynedd's pharmacy to Tywyn when more specialised medication is required. The Palliative Care Nurse and Consultant have investigated options to store a small supply of medicines in Tywyn to enable quicker access to medication, however this is not feasible at present. Any medication for specific patient use would need to be dispensed and labelled against a prescription, which must be done from a pharmacy. As such, having the medication in a

central area in Tywyn (e.g., the Minor Injury Unit) would not allow legal access to medication for patients. Many of the medications used in palliative care are controlled drugs with further legislation in their storage and supply.

There are nominated Community Pharmacy Urgent Medicines Hubs in Dolgellau and Criccieth which are contractually obliged to hold a minimum stock of end-of-life medications, including less frequently used medications such as phenobarbital. Some specialist medications are 'red' on the BCUHB formulary and therefore prescriptions usually come from secondary care. These medications are not routinely first line choice, so whilst a prescription being supplied from secondary care will be slower (next working day), a delay in treatment is unlikely as forward planning should have taken place.

iv. Transport Issues to visit relatives whilst in hospital

Transport has been reported as an issue when families are visiting patients in Bronglais and Dolgellau hospitals. Public transport has been reported as not readily available and there is no provision of a community car scheme in the area to support patient's families to visit their relative whilst in hospital. The Flexi bus scheme is available in some rural areas but does not cover as far as Tywyn. The Flexi bus scheme has been established through local councils in conjunction with Transport for Wales whereby members of the public ring and arrange a time to be picked up and dropped off.

5.1.1 Admission Avoidance and Clinical Care Pathways Workstream

The Admission Avoidance and Clinical Care Pathways task and finish group identified three key service areas that require enhancing for the population of Tywyn. These include:

i. Implementation of Point of Care Testing (PoCT) pathways.

At the time of the task and finish group the service model in Tywyn didn't offer Point of Care Testing, meaning that patients were required to travel a minimum of 30 miles to a District General Hospital to undergo the required diagnostic testing. This could be challenging in a rural area where transport is limited, and as such results in the need for increased WAST conveyances to a District General Hospital site.

Due to the lack of Point of Care Testing available in the area at the time, there were delays to the formulation of care plans for patients, resulting in delays in accessing the required treatment. This is a significant risk in Tywyn due to its rural nature, particularly in urgent health situations.

The lack of point of care testing available locally at the time limited the ability of the clinical teams to deliver care closer to home in appropriate cases. Access to point of

care testing would enable timely diagnosis and enable the clinical teams within Tywyn (e.g. GP, MIU or District Nursing) to liaise with other services for remote support to develop care plans and treat patients such as. Urgent Primary Care Centres or Specialist secondary or tertiary services. This could result in preventing a patient needing to attend a District General Hospital. There is scope to deliver point of care testing within the community setting via District Nursing or GPs when undertaking home visits.

Further to the task and finish group, the treatment room in partnership with the GP practice are currently delivering PoCT, at present they are undertaking tests and the GP will review preventing unnecessary admission to hospital. The service continues to be developed and in time the service aims to be able to deliver the required treatment resulting in admission avoidance for patients.

ii. Offer for same day urgent care (including MIU/Treatment Room/IV therapy etc).

The current provision of same day urgent care is delivered through the MIU and treatment room in Tywyn, however these services are currently only operational Monday – Friday 08:00-20:00, 5 days per week, meaning that the population of Tywyn is unable to access same day urgent care during the weekends, and bank holidays. This may result in increased attendances at the Emergency Departments on a District General Hospital site and an increase in the number of WAST conveyances to the site.

Due to the limited opening hours of the service 08:00-20:00 5 days per week, the MIU is unable to deliver QDS antibiotics and are only able to offer a limited number of appointments to patients. There is also a lack of clear referral pathways between services and uncertainty for patients in relation to which service to attend for care. This is impacting on both patient and staff experience.

iii. Multi-disciplinary collaboration to deliver services (focus on co-working between therapy and nursing services)

Whilst a collaborative working model has been fostered in Tywyn during the temporary closure of the ward to deliver integrated services and reduce silo working on site, it was identified by the Task and Finish Group that there is further room to collaborate and deliver multi-disciplinary services with nursing services and therapy services. This is aligned to the West IHC Frailty workstream and the Urgent and Emergency Care Major Change Programme Workstream 1 – Move to the ‘patients front door’: Keeping patients safe & well at home. Relevant stakeholders will work with the West Integrated Health Community Frailty Workstream to progress this element for Tywyn.

6. Engagement

There has been significant local public interest and scrutiny following the decision to temporarily close Dyfi ward and a wide range of engagement and stakeholder involvement has been undertaken.

6.1 Phased Engagement Approach

Since July 2025 there has been a focused engagement exercise with residents, staff and members of the Tywyn community and surrounding area.

A phased approach to engagement has been conducted to support the service review process as follows.

6.1.1 Phase one (July 2025 to October 2025)

This phase of communications and engagement focused on:

Listening to what matters to people — their priorities, concerns, ideas and experiences.

Recording the feedback

Raising awareness of the listening exercise, issues surrounding the temporary closure and opportunities to shape the future of local services.

This was done via the following activity:

- Social media and digital awareness raising
- An online survey
- Reaching out to stakeholder groups for face-to-face conversations and support in awareness raising.
- 04.08.2025: Attendance at a listening event in partnership with Hywel Dda University Health Board.
- 20.08.2025: Attendance at the Meirionnydd County Show.
- 28.08.2025: Attendance at the South Meirionnydd Older People's Forum
- 12.09.2025: Attendance at the Social Drop-in, Aberdyfi
- 15.09.2025: Attendance at Aberdyfi Community Council
- Monitoring of correspondence with MPs and MS'

Feedback was published as part of the Phase One Engagement Report.

6.1.2 Phase Two (November 2025 to April 2026)

Phase two of the communications and engagement activity focused on raising awareness of and inviting feedback on further developed thinking, explaining the work to develop options and actively seeking feedback from those who have been

involved throughout, those most affected (as outlined by the Integrated Equalities Impact Assessment), staff and the wider community, as well as being cognisant of the Health's Board duty under the Wellbeing of Future Generations Act.

The second phase placed more of a focus on face-to-face community engagement to have more detailed conversations with members of the local community and representative groups. This included:

- Continued digital awareness raising
- Online survey – paper copies were also available
- Reaching out to stakeholder groups, including local schools and colleges, for face-to-face conversations and support in awareness raising.
- Attendance for feedback gathering within the Minor Injuries Unit
- Attendance for feedback gathering within Outpatient clinics held at Tywyn Community Hospital
- 05.11.2025: Tywyn staff briefing onsite
- 12.11.2025: Attendance at Tywyn Town Council meeting
- 17.11.2025: Attendance at Bryncrug Council meeting
- 17.11.2025: Attendance at Aberdyfi Community Council meeting
- 18.11.2025: Attendance at Llanegryn Council meeting
- 21.11.2025: Tywyn staff drop-in
- 21.11.2025: Attendance at Friday evening youth club, Tywyn Baptist Church (c.45 young people)
- 24.11.2025: Attendance at Arfon Access Group meeting
- 25.11.2025: Attendance at morning parent and toddler group, Tywyn Baptist Church, (c.10 parents/carers)
- 13.01.2026: Attendance at Llanfihangel y Pennant council meeting
- 16.01.2026: Attendance at Tywyn Community Hub coffee morning (c.100 attendees changed the drop-in session to a “town hall” style event)
- 16.01.2026: Attendance at the social drop-in, Aberdyfi (8 attendees)
- 02.02.2026: Tywyn staff briefing.

A total of 537 survey responses were also received and feedback is included in the Pre-consultation Engagement Report – appendix 4.

It is important to note that as Tywyn is an area of high tourism impacting the population during holiday periods, continued engagement will take place throughout August 2026 to listen to the views and experiences of the area's summer residents. Whilst this will not form back of the consultation feedback it will support the information that goes to the Board as part of the later decision-making process.

6.2 Clinical, political and action group engagement

The establishment of the Tywyn Community Hospital Action Group has resulted in several requests to the Health Board for information around the decision-making process, and questioning the Health Board's efforts to recruit staff, culminating in several submissions to the Senedd's Petition Committee, *Petition P-06-1350 Re-open Dyfi Ward at Tywyn Community Hospital now*.

Regular meetings with local town and county councillors, local AM and MP have been held since the temporary closure of Dyfi ward at Tywyn Community Hospital. Updates on recruitment progress, feedback around patient experience, sharing information around service demand and service developments have been extremely useful and positive.

Various staff engagement workshops, drop-in sessions and training sessions have been held since the temporary ward closure, ensuring staff have the support to learn and develop as well as to listen to concerns and issues related to their redeployment. All staff have been given full protection of their terms and conditions including full reimbursement of any financial costs incurred due to their temporary redeployment.

The Health Board attended a public meeting arranged by the Hospital Action Group, on May 4th, 2023. The meeting was attended by the Chair, Chief Executive Officer, West Integrated Health Community Director, and the Chief Officer of Llais. During the meeting, assurances were provided that the Health Board were actively recruiting to vacant nursing posts, linking in with both Hywel Dda and Powys Health Board, Bangor and Aberystwyth Universities, local partners including Gwynedd Local Authority, third sector opportunities and private providers to maximise delivery of community services locally in the area.

Llais North Wales hosted a public forum on 28th November 2024 in Tywyn to assess the impact of the Dyfi Ward closure. Two sessions were held, allowing the community to voice concerns with BCUHB staff present to outline the steps taken to address healthcare needs following the closure. Further engagement is planned in collaboration with Llais, and work to develop a comprehensive engagement plan to ensure meaningful community involvement has been completed.

7. What the evidence suggests

Taken together, the evidence gathered throughout this review suggests that the previous inpatient model of care is not sustainable in its existing form. Analysis of population health needs, service activity, workforce availability, quality and safety, estate utilisation and financial sustainability indicates that maintaining the current approach would not provide the most effective or resilient model of care for the

Tywyn population over the longer term. While local access to services remains highly valued, the evidence suggests that future service provision must balance local need with the ability to deliver safe, high-quality care through a sustainable workforce and within available resources.

This conclusion is underpinned by a number of key drivers for change:

1. **Population health:** The current service model does not fully meet the changing health needs of the local population, with opportunities to strengthen prevention, community-based care and support for timely discharge.
2. **Quality and safety:** Services must consistently deliver safe, evidence-based and person-centred care in line with the Duty of Quality which came into effect in April 2023 as part of the Health and Social Care (Quality and Engagement) (Wales) Act (2020).
3. **Workforce:** Recruitment and retention challenges limit the ability to provide resilient inpatient services while also developing multidisciplinary community care.
4. **Financial sustainability:** Future services must represent value for money and be affordable within the Health Board's available resources.
5. **Deliverability:** The evidence indicates that providing a resilient 24/7 inpatient ward within existing workforce and financial constraints presents significant challenges.
6. **Efficiency:** Resources, including workforce, estate and funding, should be deployed to maximise patient outcomes and improve clinical pathways.

The findings from the work undertaken during this review conclude that there is a clear need for improvement to the way in which the existing service model is delivered in the Tywyn locality. This is consistent with the strategic direction of the Health Board to improve population health, enhance patient experience including quality, access, and reliability (focus and evidence base for greater gain), to have a motivated and sustainable workforce and to deliver value-based health care.

The scope of this work is limited to Dyfi ward and alternative care provision directly associated with the ward. Based on the outcome of the review it was recommended that work commenced to generate and review a range of options that improve health, provide safe services and deliver the best possible standards of care for the local population of Tywyn and surrounding area to ensure a sustainable future service model. Broader service gaps, such as access to dental care or specialist mental health services, are outside the remit of this review.

Partnership working between the NHS and its partner organisations, notably Local Authorities and the third sector partners will remain essential.

The Health Board needs to determine a sustainable long-term model that provides clarity for patients, staff and partner organisations and enables future proofing of the site and services.

8. Options development

The development of options for the future of services at Tywyn Community Hospital was undertaken through a structured, evidence-based and stakeholder-led process. Four independently facilitated stakeholder ("Balanced Room") sessions brought together representatives from health services, local government, patient groups, community organisations, elected members and local residents to identify, refine and appraise potential service models.

The process began with the development of a longlist of options which was progressively refined using agreed essential and desirable criteria, stakeholder feedback and technical appraisal. Following the identification of a scoring discrepancy, the appraisal process was revisited to ensure transparency and robustness, with options reassessed using updated service impact information and further technical analysis. Throughout the process, clinical advice, operational expertise and public engagement informed the development of proposals.

This iterative approach resulted in a shortlist of two options for public consultation, while making clear that no final decision has been made and that consultation feedback may lead to further refinement or reconsideration of the proposals.

Importantly, the process was responsive to stakeholder challenge, including revisiting previous appraisal exercises, undertaking additional technical assessment of hybrid models and retaining options for further consideration where there was strong public interest.

8.1 Stakeholder sessions – Development of options

During the period of engagement, the Health Board also conducted a series of "Balanced Room" stakeholder sessions to support the development of options for the future of services at Tywyn Community Hospital.

For each stakeholder session (Balanced Room), a cross-section of representative stakeholders was sought and invited to attend covering a range of groups including: Health partners (GP, cluster leads, third sector), Local Authority colleagues, Local Councillors and Members of the Senedd, Llais, Groups representing long-term conditions and specific access needs, the local Hospital Action Group, independent

members of the community and the Older People's Forum. Some stakeholders were identified later in the process and wherever possible were invited to take part.

Further sessions and reaching out will take place as part of the consultation process.

8.1.1 Stakeholder session 1 – 5 September 2025

The first Stakeholder Session (Balanced Room 1) was convened and independently moderated to develop a long list of options for consideration, which were then appraised using BCUHB's essential criteria to develop a medium list of options. Use of the essential criteria ensured that each option was operationally viable for further consideration.

A detailed output report on Balanced Room 1 has been embedded as an Appendices (Appendix 5 – Balanced Room 1 output report)

8.1.2 Stakeholder session 2 – 16 October 2025

The second Stakeholder Session (Balanced Room 2) was convened with broadly the same audience to develop a set of desirable criteria reflecting the views of wider stakeholders not just the health board. Weightings were applied to each criterion and then the medium list of options was appraised using the co-developed and agreed essential criteria to develop a shortlist.

A detailed output report on Balanced Room 2 has been embedded as an Appendices (Appendix 6 – Balanced Room 2 output report)

A discrepancy in the scoring at Balanced Room 2 was later identified and in the interests of transparency, it was agreed to reconvene the session whilst continuing with the ongoing engagement.

8.1.3 Stakeholder session 3 – 20 March 2026

The revisited stakeholder session was convened with broadly the same audience plus some newly identified members to reassess the original longlist of options. An all-room discussion took place, including looking at latest service impact information and it was agreed by the room that it would be sensible for a further Technical Appraisal against a number of options – original and suggested hybrid – take place before reconvening to agree which are proposed as the ones to take forward to the Board for consultation approval.

A detailed output report on the latest stakeholder sessions is embedded as an Appendices (Appendix 7 – Options Appraisal Sessions)

It is important to note that no public activity was able to take place during the pre-election period. During this time, the Technical Appraisal of the options took place (Appendix 8) before a further session was convened.

8.1.4 Stakeholder session 4 – 4 June 2026

The stakeholder session was re-convened as agreed with broadly the same audience to discuss the outputs from the Technical Appraisal, taking into account latest impact evidence. It was at this session that the two proposed options were presented and discussed as well as seeking further clarification on stakeholder interest in other options presented.

Views were also sought from the room about the consultation process in terms of stakeholder gaps, methods of communication and the clarification of any key points. This feedback will be used to inform the communications and engagement plan for consultation.

8.2 Options Development

A number of potential options were explored throughout the stakeholder sessions. The longlist being to:

- Use the ward as an end-of-life facility with the ward as hospice or charitable beds
- Develop the ward as a reablement facility
- Use the ward as a diagnostic facility
- Use Dyfi ward as a day treatment centre
- Develop Tywyn as a hub for community services (without beds) building on existing service provision (including end-of-life at home)
- Open beds on a 'need only' basis
- Ten bed ward, plus 'new services'
- Sixteen beds, fully funded with delivery of all 'new services' plus dementia care, mental health provision and past services (e.g. surgery/maternity)
- Reduced number of beds, plus 'new services', and increased community services
- Develop the ward as a dedicated dementia facility
- Maintain the current position of no beds plus 'new services'
- Reopen the ward as it was in 2023, without 'new services'.

Some were felt to be enablers and therefore discounted as individual options and some were felt to be similar and therefore combined. Following consideration of the desirable criteria as developed in the second stakeholder session and suggestions from the revisited session in March, the following list was given detailed consideration by the Technical Appraisers:

- **Option A:** Reopen the ward as it was in 2023, without 'new services.'
- **Option B/C/D (agreed combination):** Maintain the current position of no beds plus 'new services' / Use Dyfi ward as a day treatment centre / Provision

of beds for Tywyn by nursing and residential homes (including end of life beds) / Develop Tywyn as a hub for community services (without beds), building on existing service provision (including end of life at home)

- **Option E:** Use the ward as a re-ablement facility
- **Hybrid Option A+E:** Reopen the ward as it was + reablement services
- **Hybrid Option A+B:** Reopen the ward plus 'new services', using Dyfi Ward as a day treatment centre, develop Tywyn as hub and build on existing service provision
- **Hybrid Option B+E:** Maintain and develop all 'new services' plus use the ward as an inpatient re-ablement facility
- **Hybrid Option A+E:** Reopen the inpatient ward plus develop an inpatient re-ablement facility.

Detailed discussions took place during the Technical Appraisals as to the viability of each of the above options within the context of the essential criteria as well as public feeling, population health needs and scope of the current service review.

The service offer achieved under each of these options can be viewed as:

Option	Inpatient Beds (Tywyn) for rehab, step-down care and end of life care	Inpatient beds for rehab, step-down care and end of life care (Dolgellau / Care Homes)	MIU, 5-day service, reduced hours	Extended MIU (7 days, 8-8)	Treatment Room	Wellbeing Hub	Tug Aderf	Day Treatment (Dyfi Ward)	Reablement Facility
A	✓	✓ (Care homes)	✓	✗	✗	✗	✗	✗	✗



B/C/ D	✗	✓ (Care homes + Dolgell au)	✓	✓	✓	✓	✓	✓	✗
E	✓	✓ (Care homes + Dolgell au rehab beds retaine d)	✓	✗	✗	✗	✗	✗	✓
A + E	✓	✓ (Care homes)	✓	✗	✗	✗	✗	✗	✓
A + B	✓	✓ (Care homes)	✓	✗	✓	✓	✓	✓	✗
B + E	✗	✓ (Care homes + Dolgell au rehab beds retaine d)	✓	✓	✓	✓	✓	✓	✓

Based on the view of the technical appraisal, stakeholder sessions and feedback so far, the view is that the following options are taken forward for further consideration:

- Option A – reopen the ward.
- Option B (inclusive of C/D) – expand community service provision.

It must be clarified that within the technical appraisal, Option A failed on a number of the criteria but given it is the original service offer it was felt that it should remain with full transparency of the potential risk and loss of wider service offer.

During engagement, many people expressed support for a hybrid model that would combine the reopening of inpatient beds at Tywyn Community Hospital with the enhanced community services proposed within the emerging model of care. The Health Board carefully considered this option as part of the technical appraisal process.

While the hybrid model brings together elements that were individually valued by stakeholders, the technical appraisal concluded that it could not be recommended because it was not considered deliverable, sustainable or an effective use of available resources. The option failed four of the five essential criteria used to assess viability.

The principal reason is workforce sustainability. Reopening inpatient beds alongside expanding community services would require approximately 14 additional staff members, including registered nurses, at a time when healthcare services across the area continue to experience significant recruitment and retention challenges. The appraisal concluded that maintaining safe staffing levels for both services simultaneously would be difficult to achieve and sustain in the longer term.

The appraisal also identified significant financial implications. Delivering both models together would require significant additional recurring investment per year above the currently available resource. Given the Health Board's responsibility to make best use of public resources across all services, the panel concluded that this level of additional investment could not be sustained without a significant impact on services across the Gwynedd and West Integrated Health Community. The additional workforce required for a hybrid model would likely need to be drawn from existing community services, increasing pressure on services such as district nursing, community support teams and the Minor Injury Unit. Rather than strengthening local healthcare provision overall, there was a risk that resources would be spread too thinly across multiple services, reducing resilience and affecting the quality and continuity of care.

The appraisal further concluded that operating both an inpatient ward and expanded community services would create operational complexity and reduce opportunities to focus resources where they can benefit the greatest number of people.

For these reasons, the technical appraisal concluded that a hybrid model could not be delivered safely and sustainably over time and therefore is not being progressed as an option upon which to consult. However, the shortlisted options are intended to support public consultation, testing the assumptions, evidence, impact and conclusions reached to date and are not presented as a final outcome. The Health Board remains open to alternative suggestions and modifications arising through the consultation process.

8.3 Feedback from engagement

In addition to the development of shortlisted options, the feedback following the phased engagement process has also been collated and a number of themes have been highlighted.

- A strong desire for local inpatient care
- Appreciation of the wider community services
- Frustration with clarity and detail
- Distrust of the Health Board and attempts to recruit to the area
- A desire to understand how health budgets are set
- Access concerns for the rural, elderly community
- Desire for broader community benefit that promotes Tywyn as an attractive and thriving economy and place to live
- Desire to explore a variety of outpatient clinics and treatment options that benefit a wide range of the community and reducing the need to travel.

Concerns regarding travel, accessibility and the impact of service changes on older people, disabled people, carers and rural communities have been initially explored through the Integrated Equalities Impact Assessment and Travel Impact Assessment. These assessments identify a number of potential mitigation measures to explore, including transport support, travel cost reimbursement, flexible visiting arrangements, virtual visiting, home-based care and continued development of local services within Tywyn. These mitigations will continue to be refined throughout consultation and implementation planning.

Throughout the review, engagement has not been undertaken simply to inform stakeholders of emerging proposals. Feedback from residents, staff, elected representatives, community groups and participants in the Balanced Room sessions has directly influenced the process undertaken to develop the options.

A number of examples demonstrate how views and challenge from stakeholders have shaped the process:

- Concerns regarding the composition and representation of the Balanced Room process resulted in the stakeholder sessions being revisited and broadened to include additional participants and perspectives.

- Following the identification of a scoring discrepancy within the second Balanced Room session, the Health Board reconvened stakeholders and repeated elements of the appraisal process to ensure transparency, robustness and confidence in the outcomes.
- Requests from stakeholders to explore a wider range of potential future models, including hybrid approaches combining inpatient beds with enhanced community services, led to further technical appraisal work being undertaken before options were shortlisted.
- Strong community support for retaining local inpatient provision was reflected in Option A remaining under consideration, despite the significant workforce and sustainability challenges identified through the review.
- Feedback highlighting the value of services introduced following the temporary ward closure helped shape and strengthen the development of Option B, including the continued provision of the Treatment Room, Tuag Adref service, Wellbeing Hub, expanded Minor Injuries Unit and wider community-based care.
- Stakeholder feedback also informed planning for consultation, including advice on engagement methods, identifying groups requiring further involvement and ensuring consultation materials are accessible and reach a broad cross-section of the community.

Collectively, these examples demonstrate that engagement has been an active part of the decision-making process. Stakeholder feedback has informed the development, refinement and testing of options and will continue to do so throughout the formal consultation period before any final decision is made.

A detailed report on engagement activity has been embedded (Appendix 4 – Pre Consultation Engagement Report).

During the consultation phase, communications activity will build on the feedback, particularly around clarity of concerns, and will take place across multiple channels to raise awareness of proposals and ways in which to get involved.

Communications will also make it clear that no decision has been made and feedback received during consultation may result in refinement, combination, or reconsideration of the options presented.

8.4 Critical Challenge and Review

Throughout the period of engagement, critical challenge has been provided from a range of stakeholders.

8.4.1 Stakeholder Sessions (Balanced Room)

Technical Advisors were present throughout all Balanced Room sessions, who provided advice and where relevant guidance to the wider group of stakeholders. Representation from Nursing, Operational Management, Estates and Equalities were all available to provide support. Further medical leadership will be sought to support the consultation phase.

8.4.2 Clinical Task and Finish Group

A Clinical Task and Finish Group has been implemented. According to Welsh Government guidance, NHS service changes must be clinically led, evidence-based and patient-focused to achieve the best performance and value-based health outcomes. Changes should be supported by clinicians to ensure safety and sustainability, addressing issues like workforce shortages, service quality, or implementing new models.

The group has been implemented in order to:

1. Receive regular updates on the service review process, engagement activity and feedback.
2. Review and provide feedback on developing models based on clinical quality and safety.
3. Support multi-disciplinary pathway working across Tywyn services

The Clinical Task & Finish Group will continue to provide support, advice, challenge and guidance on the development of service models throughout the consultation process.

We will also seek independent clinical scrutiny and advice ahead of a final recommendation to the Board and a final decision on any future model being made.

8.4.3 Llais

In line with service change guidance ([How to make changes to health services: guidance for NHS organisations | GOV.WALES](#)) the Citizen Voice Body (LLAIS) has been included throughout the entire process, providing essential advice and critique on the engagement and service review. Representatives have been embedded in key forums such as the Balanced Room stakeholder sessions and active participants in the pre-consultation phase. Advice and critique from Llais has been key to ensure that consistency is applied and their recommendations regarding consultation have been followed.

9. Options for Consultation

The following options are presented to support meaningful public consultation. They are indicative models developed through engagement and stakeholder involvement and are intended to facilitate further discussion and feedback.

No final decisions have been taken on the future of the services delivered at Tywyn Community Hospital.

Before the Board can reach a final decision, a formal consultation will be held involving the community, patients and interested parties. The consultation will test the assumptions, evidence base, impact assessments and provisional conclusions set out in the Case for Change. This will support the Board to make an informed decision that takes into account community and patient feedback as well as clinical, operational and other evidence.

Two options for the future of services at Tywyn Community Hospital will be presented in the consultation for specific consideration. These options have been shortlisted following extensive engagement and options development work. They are currently considered the most evidence-based and deliverable future options for the hospital.

However, BCUHB remains open to any additional evidence and will review any reasonable alternative proposals to these options that may come through the consultation process. This means that following consultation, the Board may confirm one of the current options, modify either option, combine elements of options, consider a reasonable alternative, or decide that further work is required before any final decision is made.

Feedback and evidence from before and during the consultation, and any other sources including from continuous engagement activities, will be presented to the Board as part of this decision-making process. An explanation of how the feedback has been taken into account, and what difference it has made, will also be included.

9.1 Option Summary

Each of the options have been costed to demonstrate affordability from a revenue (ongoing) perspective. The models at this stage are proposed/indicative and will be refined as appropriate through consultation and in line with the Health Board's IMTP and statutory requirement to deliver long-term financial balance and sustainability.

OPTION	DRAFT COST OF INDICATIVE MODEL (£) AGAINST BUDGET (£1.427M) SUBJECT TO FINAL BUSINESS CASE DEVELOPMENT
A – REINSTATING THE INPATIENT WARD	£1.7m* *further work needed on implications of safe staffing levels for community services
B – EXPANSION OF COMMUNITY SERVICES	£1.6m
A + B – HYBRID MODEL (INCLUDED TO HIGHLIGHT THE SCALE OF INVESTMENT THAT WOULD BE REQUIRED)	£2.3m (to cover significant staffing increase required and highlighting the impact on wider service provision in the area)

Further detail of the proposed model of each option is provided within the ‘Options Detail’ section of the paper.

Both options show a marginal increase against the current overall Hospital budget which would have to be considered and taken into account with potential adjustments made if necessary, during final business case development in line with the Health Board’s statutory requirement to deliver finance balance and sustainability.

9.2 Options Detail

9.2.1 Option A – reinstating the inpatient ward

This option proposes the re-opening of the inpatient ward, Dyfi Ward, under the caveat of being able to sustainably achieve safe staffing levels at all times.

The ward would provide inpatient care for those who do not need care within one of the larger, acute sites but who might need ongoing support, rehabilitation and inpatient reablement before going home or into a care home, as well as providing an option for inpatient end-of-life care for those in the local community who choose a hospital setting as their place of death.

The ward would provide care for patients needing:

- Step-down care for patients transitioning from acute hospital to home or residential care.
- Sub-acute medical care: For patients recovering from illness who no longer need acute hospital treatment.
- Inpatient rehabilitation and reablement: Supporting individuals to regain independence after surgery, injury or illness.
- End-of-life care for patients nearing the end of life, close to family and community.

- Support for social care delays through providing temporary inpatient care for patients awaiting community support or placement.

This option would result in the closure of the 4 beds temporarily commissioned at Dolgellau Hospital.

Benefits:

- Local access to inpatient care:
Reopening Dyfi Ward brings rehabilitation and inpatient services closer to home for the population of Tywyn and surrounding communities.
- Care closer to home:
Enables delivery of care close to home, aligned with the principle of localised healthcare.
- Reduced travel burden, increased family involvement and minimised disruption to the community:
Reduces travel for carers and families, making visiting easier and more frequent.
- Increased opportunities for families to participate in rehabilitation planning and discharge preparation.
Patients would be within their community, reducing disruption to social support networks and daily life.
- Access to local inpatient end-of-life-care
Inpatient end-of-life care could be supported in the Dyfi Ward allowing for easier access for carers, family and loved ones.
- Supports local resilience and public confidence
Maintains a visible inpatient healthcare presence within Tywyn Community Hospital, which many residents regard as an important part of the local health and care system and may increase public assurance in local service provision.
- Additional system capacity
Provides additional bed capacity within the wider health and care system, which may support patient flow from acute hospitals during periods of increased demand.

Drawbacks:

- Closure of newly developed community services:
The Treatment Room, Wellbeing Hub, and Tuag Adref service could not continue, limiting local service provision for Tywyn residents
- Impact on other services:
Patient activity currently managed by the Treatment Room would be dispersed, increasing pressure on MIU, GP practices, and District Nursing.
- Increased pressure on patient flow

The reduction of community support could increase pressure on other hospital sites.

- **Reduced MIU availability:**
Minor Injuries Unit would revert to a reduced hour, 5-day service, reducing urgent care access on weekends/out of hours.
- **Lower service reach:**
Fewer people would be supported within the ward compared to a community-based model c.92 per year as opposed to over 7,000.
- **Risk of service disruption:**
Staffing challenges (e.g. vacancies, sickness) may lead to suspension or closure of MIU and other services to maintain safe ward staffing.
- **Reduced integration:**
Silo working may limit continuity and efficiency of care across services.
- **Sustainability concerns:**
The model lacks long-term resilience due to constraints in staff development and recruitment.
- **Low demand:**
Current activity data suggests that the number of patients requiring community hospital inpatient rehabilitation from the Tywyn catchment area is lower than historic ward occupancy levels and would require further assessment alongside future population need and service pathways.
- **Risk of inappropriate admissions:**
Potential for vacant beds or admissions not aligned with best care pathways.
- **Risk of patient deconditioning:**
Evidence suggests bed-based care may hinder recovery compared to care delivered in patients' own homes.

Workforce and financial implications:

Staffing Resource	WTE	Hours Per week
Registered Nurse Band 7	1.00	38
Registered Nurse Band 6	0.96	36
Registered Nurse Band 5	10.15	381
Nursing HCA / HCSW Band 2	8.53	320
MIU (9 to 5, Monday to Friday)	1.27	48
Estates, Facilities & Utilities	7.14	268
Total Staffing Resource	29.05	1,089

The indicative cost of this proposed model is £1.7m, compared to the current equivalent budget of £1.4m.

9.2.2 Option B – expansion of community services

This option proposes the permanent closure of inpatient beds at Tywyn Community Hospital, whilst maintaining and expanding the current community service model. It builds on the success of existing services and further develops Tywyn as a hub for community-based care through the continued delivery of:

- Tuag Adref (Homeward Bound)
- Wellbeing Hub
- Treatment Room
- Minor Injuries Unit (MIU) with extended opening hours (08:00–20:00, seven days a week)
- Locally delivered treatments, including a range of IV therapies
- Increase multi-team working across primary and community care

Dyfi Ward, its equipment and facilities would be retained but repurposed as a Day Treatment Centre, providing a broader range of outpatient and ambulatory services, supporting staff development, succession planning and cross-cover support across primary and community services.

Patients requiring inpatient rehabilitation or medical care (average of 4 per month) would continue to be supported through Dolgellau Hospital, while local nursing and residential homes would provide additional options for end-of-life and step-down care where appropriate.

The model aims to deliver more care closer to home, reduce unnecessary hospital admissions, improve patient flow, and strengthen community and care home partnerships, whilst maintaining as local as possible access to bed-based care when required.

Benefits

- Enhanced community care offer
Continuation and expansion of Tuag Adref, the Wellbeing Hub, and Treatment Room preserve and strengthen services that support people to remain independent and receive care closer to home.
- Improved access to urgent care
Extended MIU opening hours (08:00–20:00, seven days a week) improve local access to urgent care and may help reduce pressure on emergency

departments. This would also reduce travel for those needing urgent care out of hours or at a weekend.

- Reduced travel for a broader range of local treatments
Delivery of IV therapies, additional procedures and day treatments from Dyfi Ward reduces the need for travel and hospital transfers for many patients.
- Repurposing of Dyfi Ward for community benefit
Using Dyfi Ward as a Day Treatment Centre maximises use of the facility and supports a wider range of outpatient, ambulatory and preventative services for local people.
- Sustainable inpatient staffing model
Consolidating inpatient beds at Dolgellau Hospital focuses nursing resources and reduces reliance on maintaining fragile inpatient staffing arrangements across multiple sites.
- Improved workforce resilience and development
Cross-cover arrangements, training opportunities and succession planning across the MIU, Treatment Room and Day Treatment Centre support staff retention, recruitment and career development.
- Continued choice of end-of-life care
Continued support for end-of-life care at home through Tuag Adref, alongside access to nursing home beds for those who cannot or choose not to die at home.
- Improved patient flow and discharge pathways
Access to residential home step-down and reablement beds can support earlier discharge from hospital and provide recovery closer to home.

Drawbacks

- Increased travel for inpatient care
Patients requiring community hospital inpatient care would continue to be admitted to Dolgellau Hospital, increasing travel time for some patients, families and carers. This currently affects a relatively small number of patients.
- No inpatient beds at Tywyn
Some community members may remain concerned about the loss of local inpatient beds despite the expansion of community services and alternative.
- Reliance on external providers
The model would depend more heavily on the capacity, staffing and quality of independent nursing and residential care providers.
- Potential variation in care home provision
Achieving consistent availability and standards across commissioned care home placements may require ongoing partnership working and support.

Workforce and financial implications:

Staffing Resource	WTE	Hours Per Week
Clinical Leadership	1.00	38
MIU	2.72	102
Treatment Room & Wellbeing Hub	5.45	204
Tuag Adref	5.45	204
Dolgellau 4 beds	5.67	213
Estates, Facilities & Utilities	7.14	268
Total Staffing Resource	27.43	1,029

The indicative cost of this proposed model is £1.6m, compared to the current equivalent budget of £1.4m.

9.3 Quality Impact Assessment

A Quality Impact Assessment has been undertaken across the two options emerging from the options development process, which evaluates how the potential reintroduction of inpatient beds (Option A) compared with a community-based model (Option B) may affect the Safe, Timely, Effective, Efficient, Equitable and Person-centred (STEEEP) Quality Standards for the population served by Tywyn Community Hospital.

The integrated Quality Impact Assessment has been embedded as an appendix (Appendix 9 – Integrated Quality Impact Assessment).

9.3.1 Quality impact of implementing Option A – reinstating the inpatient ward

The overall level of risk to quality associated with reopening the inpatient ward is Medium to High.

This reflects concerns regarding sustainability, workforce safety, and the ability of the model to meet wider population health needs.

Main risks include:

- Inability to maintain safe staffing levels, particularly the requirement for a minimum of two registered nurses on duty 24/7, creating ongoing patient safety and service continuity risks.
- Increased risk of service instability or unplanned closures (including MIU or community services) due to workforce redeployment pressures.

- Limited-service reach (approx. 92 per year compared with over 7000) with inpatient beds serving a small cohort of patients relative to the broader population need, reducing overall effectiveness and equity of access.
- Loss of interim community-based services (e.g. Tuag Adref, Treatment Room, Wellbeing Hub), resulting in reduced prevention, early intervention and home-based care capacity.
- Reduced ability to meet modern models of care focused on prevention, independence, and care closer to home, potentially leading to avoidable admissions and poorer long-term outcomes.
- Financial and operational pressures that may impact long-term sustainability and divert resources away from more effective community services.
- Reputational risk associated with reverting to a model that remains instable.

Wider risk to other services in the area, e.g., increased pressure on primary care and the increased need for travel for the majority not the minority.

9.3.2 Quality impact of implementing Option B – the expansion of community services

The overall level of risk to quality associated with implementing a community-based model is Low to Medium.

This reflects that the model aligns closely with population need, workforce sustainability and best practice for delivering care closer to home. However, a number of risks have been identified which would require mitigation should the model be implemented:

Main risks include:

- Workforce capacity and recruitment challenges across community and multidisciplinary team services, including sustaining extended MIU provision and community nursing support.
- The need for clear communication with patients, staff and stakeholder as to what services are available, when and where (linking to public feedback that people feel unsure of what services can be accessed).
- The need to quality assure and understand capacity (currently available) within external partners (e.g., care homes and third sector).
- Infrastructure and operational readiness, including the need to ensure appropriate facilities, digital systems, and workforce competencies to support expanded community-based care models.
- Managing public and stakeholder perception regarding the absence of inpatient beds locally, particularly in relation to end-of-life care preferences and ensuring clear communication of options available.

9.3.3 Summary

Overall, the quality implications are that:

- The community-based model (Option B) presents a lower and more manageable level of quality risk, aligned with sustainable workforce models and improved population outcomes on a greater scale.
- The inpatient ward model (Option A) presents a higher level of inherent quality risk, primarily driven by workforce constraints, sustainability concerns and reduced system-wide effectiveness.

In conclusion, both options present distinct benefits and risks in relation to the STEEP quality domains. The community-based model (Option B) demonstrates strengths in terms of population reach, service flexibility and alignment with contemporary models of care, but carries implementation and system-dependency risks that would require ongoing management.

Conversely, the inpatient ward model (Option A) offers clear benefits in terms of maintaining local bed-based care and meeting certain community expectations, particularly around care closer to home. However, this option presents more significant challenges in relation to workforce sustainability, service resilience and long-term viability, which may impact the consistency and safety of service delivery if not successfully mitigated.

On balance, both options are associated with differing risk profiles. Any future decision would need to consider the relative weighting of these risks, the ability to mitigate them effectively and alignment with strategic priorities for sustainable, high-quality care delivery for the Tywyn population.

9.3.4 Mitigating actions to explore

The Integrated Equality Assessment and Travel Impact Assessment further explore potential impacts and identify that the groups most likely to experience adverse impacts of any service change in the area are older people, disabled people, unpaid carers, people experiencing socio-economic disadvantage and those living in rural communities. These impacts primarily relate to increased travel requirements, visiting arrangements, access to end-of-life care and potential social isolation. A range of mitigation measures would need to be explored to reduce these impacts, including:

- Continued access to patient transport services for eligible patients requiring transfer between hospital sites.

- Promotion and support for community transport schemes, including local voluntary transport services, to assist those without access to private vehicles.
- Access to the Healthcare Travel Costs Scheme for eligible patients and carers to reduce financial barriers associated with travel.
- Flexible visiting arrangements at Dolgellau Hospital, including for end-of-life patients, to support family involvement in care.
- Availability of virtual visiting through digital devices and hospital Wi-Fi to help maintain contact where travel is difficult.
- Availability of preventative services, reducing the need for hospital attendance and supporting people closer to home.
- Appointment scheduling and care planning arrangements designed to minimise travel burden, including aligning appointments with available transport options where possible.
- Continued provision of Welsh language services, reasonable adjustments and equality-informed service delivery to ensure accessibility for protected groups."

Potential mitigations will continue to be refined through the consultation process and, should any proposal be implemented, will form part of the implementation planning and ongoing monitoring arrangements.

11. Legislation, guidance and governance

Service change consultation for health bodies in Wales is not governed by a single piece of legislation. Instead, it must comply with a framework of primary legislation, duties, and Welsh Government guidance.

Section 183 of the National Health Service (Wales) Act 2006 requires Health Boards, with regard to services they provide or procure, to make arrangements to involve and consult current and prospective service users, or their representatives on:

- Planning to provide services for which they are responsible.
- Developing and considering proposals for changes in the way those services are provided.
- Making decisions that affect how those services operate.

In practice, this creates the legal expectation that the public must be involved in decisions about significant changes to services.

All change must be completed in line with Welsh Government guidance, "How to make changes to health services: guidance for NHS organisations" and pay due regard to representations made by Llais (the Citizen Voice Body established by the Welsh Government under section 15(4) of the Health and Social Services (Quality and Engagement) (Wales) Act 2020)

When undertaking service change, NHS organisations must also fulfil their statutory duties as described within the:

- Gunning Principles
- Public Sector Equality Duty under the Equality Act 2010
- The Socio- Economic Duty (The Equality Act 2010 (Commencement No. 26) (Wales) Order 2021) per Welsh Government guidance “More Equal Wales: The Socio-economic Duty” (2021)
- Welsh Language (Wales) Measure 2011
- Duty of Quality and Duty of Candour (Health and Social Care (Quality and Engagement) Act 2020)
- Governance and Protocol Adherence
- The NHS Finance (Wales) Act 2014
- The Social Services and Well-being (Wales) Act 2014
- The Well-being of Future Generations (Wales) Act 2015
- The British Sign Language (Wales) Bill 2026

The review and pre-consultation engagement phase has operated with all of the above in mind and will continue to do so throughout the consultation phase.

Programme governance has been established to support this review with work led locally by the Tywyn Clinical Task and Finish Group, Tywyn Steering Group and West IHC oversight before reporting to the Service Change Oversight Group. Progress, risk and issues are escalated via this group to the Strategic Planning and Service Change Group ahead of onward reporting to the Planning, Population Health and Partnerships Committee and ultimately, the Health Board. Strategic oversight is gained via the Senior Responsible Officer.

Established structures will continue throughout the consultation phase.

12. Recommendations

No final decision is being sought. It is recommended that the Board review and approve the following future service options to be included in the consultation as proposals for the future of Tywyn Community Hospital:

- 1. Option A: A return to the inpatient model.** This option proposes the re-opening of the inpatient ward, Dyfi Ward, under the caveat of being able to sustainably achieve safe staffing levels at all times.

The ward would provide inpatient care for those who do not need care within one of the larger, acute sites but who might need ongoing support, rehabilitation and inpatient reablement before going home or into a care

home, as well as providing an option for inpatient end-of-life care for those in the local community who choose a hospital setting as their place of death.

This model proposes reverting back to the original purpose for the ward, recognising the strength of feeling within the community and could support care closer to home and improving flow from acute sites.

2. Option B: An expansion of community services at home and hospital-based clinics, treatments and therapies. This option proposes the closure of inpatient beds at Tywyn Community Hospital, whilst maintaining and expanding the current community service model. It builds on the success of existing services and further develops Tywyn as a hub for community-based care through the continued delivery of:

- Tuag Adref (Homeward Bound)
- Wellbeing Hub
- Treatment Room
- Minor Injuries Unit (MIU) with extended opening hours (08:00–20:00, seven days a week)
- Locally delivered treatments, including a range of IV therapies
- Increase multi-team working across primary and community care

Dyfi Ward, its equipment and facilities would be retained but repurposed as a Day Treatment Centre, providing a broader range of outpatient and ambulatory services, supporting staff development, succession planning and cross-cover support across primary and community services.

Patients requiring inpatient rehabilitation or medical care (average of 4 per month) would continue to be supported through Dolgellau Hospital, while local nursing and residential homes would continue to provide additional options for end-of-life and step-down care where appropriate.

The model aims to deliver more care closer to home, reduce unnecessary hospital admissions, improve patient flow, and strengthen community and care home partnerships, whilst maintaining as local as possible access to bed-based care when required.

While both shortlisted options present potential opportunities and risks, the Health Board will need to consider how best to deliver clinical sustainability, workforce resilience and value for money, while remaining consistent with national policy direction to provide care closer to home and improve outcomes for patients.

As outlined within the paper, models will continue to be developed following feedback from stakeholders throughout the consultation. Alternative evidence-based suggestions will be welcomed throughout the consultation to be assessed for the Board to take into conscientious consideration before any final decision is made.

Following consultation, all responses will be independently analysed alongside any additional evidence received. The Board will consider whether the evidence presented in this document should be amended, whether the impact assessments require revision, and whether consultation responses support modification of the options before reaching any final decision.

The Health Board are therefore asked to:

APPROVE the proposed options being taken forward to formal public consultation noting that no final decision is being sought at this stage and that the consultation is intended to test the evidence, assumptions, impact assessments and conclusions presented within this document.

APPROVE to commence public consultation and that the outcome of the consultation is planned for March 2027 as described in the timeline outlined in the report.

Supporting Documentation:

- Appendix 1 - Services available to meet population Health Need
- Appendix 2 - Welsh Language Impact Assessment
- Appendix 3 – Outpatient Services at Tywyn Community Hospital
- Appendix 4 – Pre-consultation Engagement Report
- Appendix 5 – Balanced Room One Output Report
- Appendix 6 – Balanced Room Two Output Report
- Appendix 7 – Options Appraisal Sessions
- Appendix 8 – Technical Appraisal Report
- Appendix 9 – Quality Impact Assessment
- Appendix 10 – Integrated Equalities Impact Assessment and Socio-Economic Duty
- Appendix 11 – Tywyn Community Hospital Services Travel Impact Assessment discussion document
- Appendix 12 – References

ASESIAD / ASSESSMENT	
Cysylltiad â'r Bwriadau Strategol	All
Link to Strategic Intentions	If more than one applies, please list below: Focus on Health and Wellbeing Enhance the co-ordination of care for people Improve access, outcomes and experience Create a modern, people-centred healthcare system
Yr Egwyddorion Dylunio Design Principles	Choose an item. All
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	CRR25-05 Strategic Change – Impacting Care and Staff Delivery. There is a risk that patients may not benefit from planned improvements in care, access and outcomes if the Health Board does not effectively implement or develop its strategic change programmes. Link to BAF: BAF24-02

IMPACT ASSESSMENTS		
Equality <i>Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)</i>	Yes: ☒	No: ☐
	Outcome:	Appended to this paper
	If no, please include rationale:	
Socio-Economic Impact Assessment <i>Have you undertaken a Socio-Economic Impact Assessment</i>	Yes: ☒	No: ☐
	Outcome:	As above
	If no, please include rationale:	
Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Enablers of Quality All Apply	Domains of Quality All Apply
	If more than one applies, please list below:	If more than one applies, please list below:
	Appended to this paper.	
Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales	
	<i>If more than one applies, please list below:</i>	
Environmental /Sustainability Impact (5Rs)	Yes - Repurpose	
	If more than one applies, please list:	
Armed Forces Covenant Due Regard Duty Have you considered the Armed Forces Covenant Due Regard Duty?	Yes: ☒	No: ☐
	Outcome: The armed forces covenant due regard duty has been considered within Section 3 of the Equality Impact Assessment with the following outcome: ‘There is no evidence that the Tywyn service review work disproportionately	

	impacts on the Armed Forces community’.	
	If no, please include rationale:	
Data Protection Impact Assessment <i>Have you undertaken a Data Protection Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	A Data Protection Impact Assessment is not required for this paper as it does not propose any activity that involves the collection, use or processing of personal data. At this stage, the process does not introduce new systems or processes that would trigger data protection considerations.
Counter Fraud Impact Assessment <i>Have you considered the counter fraud impacts</i>	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	A Counter Fraud Impact Assessment is not required for this paper as it does not propose any operational changes or activities at this stage that could introduce fraud risks. The paper does not involve financial transactions, system changes or procedural amendments that would necessitate an assessment of fraud controls.
Legal	Yes (Include further detail below)	

	Service Change Section 183 of the National Health Service (Wales) Act 2006 requires Health Boards with regard to services they provide or procure, to make arrangements to involve and consult current and prospective service users, or their representatives on: • Planning to provide services for which they are responsible. • Developing and considering proposals for changes in the way those services are provided. • Making decisions that affect how those services operate. All change must be completed in line with Welsh Government guidance, “How to make changes to health services: guidance for NHS organisations” and be mindful of representations made by Llais (the Citizen Voice Body established by the Welsh Government under section 15(4) of the Health and Social Services (Quality and Engagement) (Wales) Act 2020) When undertaking service change, NHS organisations must also fulfil their statutory duties as described within the: • Gunning Principles • Public Sector Equality Duty under the Equality Act 2010 • Socio Economic Duty under the Equality Act 2010 • Welsh Language standards • Duty of Quality (Health and Social Care (Quality and Engagement) Act 2020 • Governance and Protocol Adherence • The NHS Finance (Wales) Act 2014 • The Social Services and Well-being (Wales) Act 2014 • The Well-being of Future Generations (Wales) Act 2015
Reputational	Yes (Include further detail below) Failure to fulfil the requirements for lawful public engagement and consultation.

Resource Impact <i>(People / Financial)</i>	Yes (Include further detail below) Costs associated with: • Specialist Advisory Support. • Specialist Co-ordination and Management Support. • Analysis of engagement feedback. • Design of materials. • Easy Read version of consultation document. • BSL version of consultation document. • Costs associated with holding engagement events e.g. venue, refreshments, travel, and specialist support; varies by location. • PO Box for survey returns. Following competitive tender, resource has been assigned to support formal public consultation in the form of the production of consultation materials, and specialist co-ordination and management support to undertake the necessary quality assurance and the independent analysis and reporting of results.

Health Board

MENTAL HEALTH STRATEGIC REPORT

Dyddiad y Cyfarfod Date of Meeting	30 July 2026
Statws Cyhoeddi Publication Status	Open/ Public
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Vicky Jones, Head of Integrated Strategy and Development, MHL D Carole Evanson, Director of Operations MHL D Pam Wenger, Director of Governance Phil Meakin, Associate Director of Governance Paolo Tardivel, Interim Executive Director of Transformation and Strategic Planning
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Carol Shillabeer, Chief Executive with Teresa Owen, Executive Director of Allied Health Professionals and Health Science
Pwrpas yr Adroddiad Report Purpose	For Approval
Crynodeb Gweithredol Executive Summary	
Purpose This report provides the Board with an overview of progress regarding the objective set by the Board in relation to the organisational approach to developing mental health approaches and services. The delivery mechanism is through the Mental Health Oversight and Delivery Group (MHODG) chaired by the Chief Executive and with Executive Team membership. It is important to stress that this is an organisational wide approach to developing modern mental health approaches rather than a purely Divisional one through the Mental Health and Learning Disabilities Division. The Board agreed the future scope of work when considering the previously reported Royal College of Psychiatry (RCP) review and Expert Advisory Group recommendations translating key priorities into a fully encompassing MHODG work plan.	

This report provides a focus on progress in relation to the development and delivery of the MHODG work; and specifically the draft Mental Health Outcomes framework informed by engagement with service users and their families. The report also identified areas where progress needs to accelerate and where risks to delivery exist, including the mitigations being drawn in to ensure achievement of priority actions. In addition, the report provides an update on significant developments within MHL D services, including implementation of the Electronic Health Record (EHR) programme and the sustained reduction in out-of-area placements. Particular emphasis is given to one of the key MHODG deliverables: the development of a draft Mental Health Outcomes Framework, informed by engagement with service users, carers and families, and included for Board consideration.

Summary

Overall, progress is positive, with clear delivery in strengthening governance, programme structure and system coordination through the MHODG to transition and subsume both Royal College Psychiatry review actions and Expert Advisory Group recommendations, whilst aligning with the organisations strategic priorities and IMTP/Annual Plan deliverables. Furthermore, the emerging direction of travel provided by the national Mental Health and Wellbeing Strategy, subsequent Quality statement and Strategic Programme for Mental Health led by NHS Performance and Improvement (NHSPI) team is considered as part of the work of the MH ODG.

Since January 2026, progress has been made at pace with the development of a MHODG workplan outlining 5 workstreams as follows:

1. Strategic Planning Outcomes & Service Model
2. Clinical Standards/QMS and Service Performance
3. Patient and Carer Engagement and Experience
4. Estates and Environment
5. Culture, Leadership and Organisational Development

There are a number of deliverables aligned to each of the 5 workstreams with Executive Director leadership to ensure a truly organisational approach to mental health.

Key priorities for the next 6 months will focus on finalising and commencing implementation of the Mental Health Outcomes Framework, strengthening performance and outcomes reporting at team level, progressing key Workforce and Estates priorities, and embedding the Open Access Model.

The Board is asked to:

Note the progress made through the Mental Health Oversight and Delivery Group (MHODG) since the previous update to the Board in January 2026. This includes the establishment of a single structured improvement programme across the five strategic workstreams.

Note the significant reduction in acute out-of-area placements, sustained compliance with Mental Health Measure performance standards, successful procurement outcome for the

MHLD EHR and progress made in strengthening workforce stability, service quality and patient experience.

Consider and endorse the draft Mental Health Outcomes Framework as the foundation for strengthening outcome-focused performance, quality and assurance reporting across MHLD services.

Take reasonable assurance that the governance, quality management and oversight arrangements established through the MHODG are supporting the delivery of sustainable improvement in Mental Health services and providing an appropriate framework for Board assurance.

List of Additional Information:

- Appendix 1 – RCP Actions transition to MHODG and progress update
- Appendix 2- EAG recommendations cross referenced to the MHODG workplan
- Appendix 3 – Scope of MHODG
- Appendix 4 – Draft Mental Outcomes Framework and accompanying Infographic.

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

Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	Dyddiad Date	Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data
Health Board Meeting	31 July 2025	Approved the Response to the (RCPsych) Invited Review Service Report and noted that updates against the report have been provided to the Quality, Safety and Experience Committee on a regular basis.
Quality Safety and Experience Committee	29 January 2026 Bi-Monthly from 15 August	Approved the MHODG proposal. Noted updates from the Chair of the Expert Advisory Group and the Executive Director of Allied Health Professionals and Health Science, and

Executive Committee	2025 to July 2026	received assurance on progress against the RCPsych Invited Services Review. MHODG AAA reports.
Evidence of Outcomes Group (reported into the Health Board Action Delivery Group)	May to July 2026	AAA reports and July update on progress.
Expert Advisory Group	Monthly meetings from October 2024 to January 2026	Peer reviewed and scrutinised progress against individual Improvement Actions from action owners and progress reported through the Regulatory Assurance Group and Health Board Action Delivery Group
	Introductory meetings and Work Programme from March 2025 to August 2025	Received information from Health Board teams against an agreed Work Programme. Feedback received that has informed reports to Quality Safety and Experience Committee and Health Board.
Acronymau / Rhestr Termau Acronyms / Glossary of Terms		
AAA	Alert, Assure, Advise	
AHP	Allied Health Professionals	
AMH	Adult Mental Health	
EAG	Expert Advisory Group	
CIVICA	The Health Board complaints and feedback management software	
CMHT	Community Mental Health Teams	
EHR	Electronic Health Record	
GDPR	General Data Protection Regulations	
HIW	Health Inspectorate Wales	
HSE NoC	Health and Safety Executive Notice of Contravention	
MDT	Multi-Disciplinary Team	
MHM	Mental Health Measure	
MHLD	Mental Health and Learning Disabilities	
MHODG	Mental Health Oversight and Delivery Group	
NICE	National Institute for Health and Care Excellence	
OPMH	Older Persons Mental Health	
PICU	Psychiatric Intensive Care Unit	

QSE	Quality Safety and Experience
RCP	Royal College of Psychiatrists
SLT	Senior Leadership Team (Mental Health and Learning Disabilities)

Mental Health Strategic Report

1. Y SEFYLLA/SITUATION

- 1.1 This report aims to provide the Board with assurance around progress made in the continued improvement of Mental Health services through the Mental Health Oversight and Delivery Group (MHODG), since the last Board report in January 29th 2026.
- 1.2 It aims to update on the work of the Mental Health Oversight and Development Group (MHODG), established to enable further sustained improvements to mental health services for the people of North Wales, working collaboratively across the Health Board and with partners. This work triangulates the previously reported Royal College of Psychiatry (RCP) review and Expert Advisory Group recommendations into a fully encompassing MHODG work plan.
- 1.3 The report also includes a focus on one of the MHODG work plan deliverables; the draft Mental Health Outcomes framework informed by engagement activity with service users and their families.

2. Y CEFNDIR/BACKGROUND

- 2.1 The January 2026 Mental Health Strategic report set out a strategic approach to embedding sustained, system-wide improvement in mental health services, moving to a more coordinated programme of delivery.
- 2.2 The 10 themes from the Royal College of Psychiatry (RCP) Invited Services Review are outlined below and these have influenced the priorities moving forward.

Royal College of Psychiatrists Invited Service Review Themes

Theme one: Patient and user centred care Theme two: Legislation and clinical guidelines Theme three: Governance Theme four: Staffing Theme five: Management structure Theme six: Clinical services organisation Theme seven: Training and development Theme eight: Leadership and staff engagement Theme nine: Resources Theme ten: Physical environment

- 2.3 In addition, the work of the Expert Advisory Group (EAG) has also directly informed the work programme for further development of mental health approaches across the health board. The EAG highlighted the need to embed and sustain improvements made through the RCP review, recognising that further progress was needed.
- 2.4 Listening to service users and their families and carers is key to ensuring the development and delivery of improvement priorities. During 2025, this was supported through the Expert Advisory Group (EAG) and is now supported through the ongoing

co-production of the draft Outcomes Framework. The summary of the EAG recommendations against the RCP key themes are highlighted in Appendix 2.

2.5 The RCP and EAG reports informed the priorities of the newly-established Health Board's Mental Health Oversight and Development Group (MHODG), chaired by the Chief Executive, created to provide effective oversight and drive delivery. The MHODG has brought together improvement activity into a single, structured programme with clear governance, and accountability. The scope of the Mental Health Oversight and Development Group is set out in Appendix 3.

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

3.1 The Health Board is committed to delivering high-quality, person-centred mental health approaches. In addition to the work of the RCP and EAG, recent national drivers include the Welsh Government Mental Health and Wellbeing Strategy 2025-35, the Welsh Government Quality statement and Strategic Programme for Mental Health all of which are informing the work of the Mental Health Oversight and Development Group.

3.2 Taking account of all the identified key improvement drivers, the MHODG has developed a clear workplan based on its scope and remit, with five workstreams and a number of key deliverables. Both the remaining actions relating to the Royal College of Psychiatrists Review and the key considerations made by the Expert Advisory Group have been assimilated into the work programme of the MHODG.

MHODG Workstreams

1	Strategic Planning Outcomes & Service Model
2	Clinical Standards/QMS and Service Performance
3	Patient and Carer Engagement and Experience
4	Estates and Environment
5	Culture, Leadership and Organisational Development

MHODG Workstream: 1. STRATEGIC PLANNING OUTCOMES & SERVICE MODEL

Leads - Interim Executive Director Transformation and Strategic Planning & MHLD Medical Director

Deliverables	Summary Position

a. Mental Health Outcomes Framework	A co-produced draft Outcomes Framework has been developed with over 1000 insights and contributions over a prolonged period. This provides confidence that a person-centred approach is increasingly being utilised to ensure that what matters most to people who use or are close to services provides the key focus. It is noted that wider measures of service provision are needed and this is aligned to the work under Workstream 2 in particular, although relevant to all workstreams. Further detail is provided below and as Appendix 4. The Board is asked to comment on the draft Outcomes Framework and to note the intention to test this Framework in use over the coming months, providing an opportunity for further revision.
b. Effective plan to deliver on the strategic programme for Mental Health	The Welsh Government in association with NHS Performance and Improvement have developed a Strategic Programme for Mental Health, providing policy direction to the NHS in Wales working with wider partners. There are a number of key priorities being driven through this mechanism including work on the configuration of mental health services in Wales. This work is at an early stage; however, it is going to be essential that any national work can dovetail with the needs of local communities in North Wales. The health boards Clinical Services Plan is under development and the focus on integrated and holistic care is going to be key.
c. Service Model and Commissioning Framework	The Quality Statement issued by the Welsh Government this year is referenced in more detail under workstream 2. Within it however is the need to ensure strong service planning. The key elements of the Statement include models and approaches that: Will ensure quality and safety through a whole-system approach that considers social determinants of health and coordinates services to provide equitable, integrated support for everyone. There will be meaningful engagement with people with lived experience and the third sector to co-produce learning, service improvement, and innovation. This will include: • Integration across services: primary care, community mental health, social care, housing, substance misuse, the voluntary sector. • Implementation of the cross sector open access model across the continuum of care, for example collaboration with justice, education, employment, physical health services.

	• Systems to manage transitions that are co-ordinated, planned, purposeful, person-centred and ensure continuity of care (e.g. between child/adolescent services to adult mental health). • Integrate social determinants of health (poverty, housing, social exclusion) as a core element of service planning. • A no wrong door approach – this means people can present at any point in the system and be guided to the right support without delay and without having to unnecessarily explain their needs multiple times. The development of new models within the Clinical Services Plan will need to meet these criteria. Importantly the health board has been identified as being an early site for Open Access Model. There will be a Board Briefing in due course as part of this work as it presents a significant opportunity to increase the same day access to mental health support.
d. Develop the required stages for the provision of Therapies in MHL settings.	The health boards Workforce Planning Framework has now been approved by the Executive Committee and considered by the People and Culture Committee. This provides the platform for assessing the workforce requirement for the future. It is clear from both internal work and the reports from Inspectorates (e.g. Healthcare Inspectorate Wales) that developing more interprofessional working is key. The MHODG has considered the initial steps of the work relating to Psychology and Allied Health Professions and will be following up on the workforce planning assessment as part of its work plan.
e. Service Model for Dementia	The Welsh Government has developed a draft Dementia Strategy for Wales and is currently considering the consultation responses. The draft strategy identifies seven priority areas for the next decade, reflecting a whole-system approach to dementia care • Early diagnosis and access to treatment through improved care pathways and competence frameworks. • Person-centred care that respects individual needs and preferences. • Support for unpaid carers, recognising their critical role in dementia care. • Integration of health and social care services to ensure consistency and quality. • Supportive environments, including housing, technology, and community settings that enable people with dementia to live well at home

	• Workforce development, ensuring staff have the skills and knowledge to provide high-quality dementia care. • Research, innovation, and evidence-based practice to inform ongoing improvements in care. The Strategy will help inform the regional work as well as health board focus, working as part of the Regional Partnership Board. The timeframe for this work is 2026/27.

Focus on Mental Health Outcomes Framework

The Mental Health Outcomes Framework is an identified key deliverable. This has been developed as a draft Mental Health Outcomes framework that reflects the strategy and objectives of the whole Health Board.

Work to date on a Mental Health Outcomes framework has largely been focused on the Royal College of Psychiatrists Invited Services Review, and it was agreed this needed to be broadened to be representative of the whole Mental health continuum, taking account of national and local drivers including the Welsh Government (WG) Mental Health and Wellbeing Strategy (2025-35), the subsequent Quality Statement and the strategic programme for mental health.

Of critical significance, is the population the Health Board serves and what is meaningful and important to them in relation to their care and that of a family member. Outcomes and measures therefore, need to demonstrate the high quality, safe care that is tangibly experienced by users of all mental health services.

The methodology for design of the Outcomes Framework has involved extensive consultation with service users/ carer representatives across North Wales in a series of 12 events over an 18-month period, reaching over 150 people. Key themes identified, from 1018 insights, that were important to service users and carers are summarised as follows:

- I want to feel heard, valued and empowered
- I want meaningful opportunities to share feedback, ideas and develop solutions together
- I want opportunities to be welcoming and accessible
- I want to see that my contributions are making an impact

People stated that they value the relationships they have with individual professionals, specific team or services they access. They felt things were working best when places and spaces were inclusive, accessible, community-based and person-centred. For people to feel valued, listened to and empowered there needs to be:

- **SAFE SPACES FOR OPEN DIALOGUE:** where people are provided with regular opportunities to share feedback, ideas and express themselves, and are provided with the safety and support to do so.

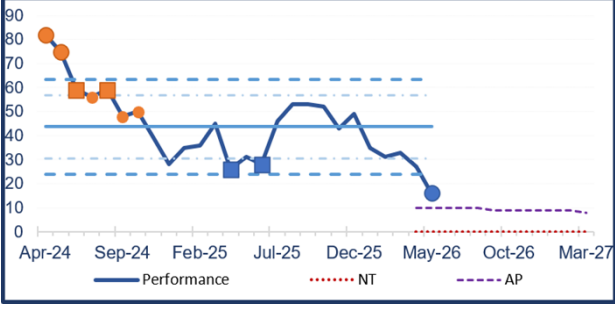
- **ACCESSIBILITY:** where services can be accessed swiftly without waits and feel inclusive and person centred.
- **STRONG RELATIONSHIPS:** with a strong sense of community between service users and service providers, and community-driven action enabling peer-to-peer relationships to foster.
- **TRUE CO-PRODUCTION:** where public service providers, third sector organisations, and service users come together as equals in service design, development and delivery.
- **PERSONALISED APPROACHES:** with accessibility and inclusivity the specific wants and needs of different people. Non stigmatised support that does not label.
- **COMPASSIONATE DELIVERY:** with warmth, kindness, sensitivity and trauma informed practices underpinning every interaction between service providers and service users. Where service users are not having to retell their story to different professionals' multiple times.

People shared that they are frustrated where waiting lists are long, access to services is hard, communication from service providers is poor, and when engagement opportunities are inaccessible and inconsistent. Based on the findings from the coproduction events and Civica experience data, plus consideration of alignment to the national drivers and direction of travel outlined above, the draft Outcomes Framework in Appendix 3, and as an infographic in Appendix 4, has been devised for review and consultation.

Next steps for the Outcomes Framework are to test and refine with service users and family/ carer representatives to ensure it is reflective of what was heard. It is critical to ensure that measures are accessible and measurable. As the first iteration of the work reaches a conclusion there will be a need for the development of different versions including easy-read.

MHODG Workstream: 2. CLINICAL STANDARDS/QUALITY MANAGEMENT SYSTEM AND SERVICE PERFORMANCE	
Leads - Executive Director of Allied Health Professionals and Health Science (supported by other Clinical Executives) & MHLD Directors	
Deliverables	Summary Position
a. Plan to continually improve standards of clinical practice aligning with Health Board Quality Management System (QMS)	The Quality Management System is moving into the next phase of development led by the Executive Medical Director and the Interim Director of Transformation and Strategic Planning. The strengthening of clinical governance arrangements is being underpinned by the Clinical Services Plan and the Health Board's Quality Management System (QMS). This ensures that improvement activity is systematically connected to clinical standards,

	including NICE guidance, Royal College standards, Healthcare Inspectorate Wales and Welsh Government quality requirements. This supports a more consistent approach to evidencing to the Board how service improvements translate into safer, more effective and person-centred care. The Division aims to embed the Quality Management System (QMS) principles into all improvement activity. This includes the standardisation of processes for monitoring compliance with clinical standards, triangulating data from audit, patient outcomes and experience, and ensuring that learning is systematically translated into practice. This provides a clear line of sight from frontline clinical care to Board-level assurance. There is a strong connection with the Outcome Framework measurement with team and service level data becoming increasingly visible as part of the overall approach. There have been a number of HIW inspections relating to mental health, and some in other services that connect to mental health. Overall, there is pattern of increasingly positive reports, with some key areas of focus including the condition of the estate/environment and the provision of effective staffing models that better meet the needs of service users. <u>The Quality Statement for Mental Health</u>
b. MH Service Performance against WG requirements at Team Level	The access standards relating to Mental Health as outlined in the Mental Health Measure are consistently being achieved, despite increasing demand at certain times of the year in particular. The service has increasingly needed to modify the way in which services can be provided to enable these standards to be met. The Integrated Performance Report provides the detailed performance. For 2026/27 there is a focus by Welsh Government on Out of Area placements. The health board undertook substantial work over the last 18 months in this area, with Out-of-area acute care placements significantly reduced demonstrating increased ability to provide care closer to home.

	 The graph displays three data series over time from April 2024 to March 2027. The 'Performance' series (solid blue line) begins at approximately 85, drops to 55 by September 2024, and then fluctuates between 30 and 50. The 'NT' series (red dotted line) remains at 0. The 'AP' series (purple dashed line) remains at approximately 10.
c. Implementation of EHR	The Board approved a business case for the development of a Mental Health Electronic Health Record in 2024/2025, and this gained the support of Welsh Government. The health board is working in partnership with Cwm Taf Morgannwg University Health Board. The procurement process has now been completed and work is underway on the implementation phase of the Programme. This represents a significant change to day-to-day business practices and a focus on enabling positive change is a key part of implementation. There is a separate Electronic Health Record Programme Board and the MHODG will align its work with that.

MHODG Workstream: 3. PATIENT AND CARER ENGAGEMENT AND EXPERIENCE	
Leads – Executive Director of Nursing and Midwifery & MHLD Director of Nursing	
Deliverables	Current Position <i>With Progress Jan to Jul 26 (in italics)</i>
a. Agreed strategy and implementation plan for patient and carer engagement	A detailed paper was considered at MHODG with regard progress to date on the coproduced strategy developments, alongside recovery college and peer workforce opportunities in line with the Strategic Programme for Mental Health. A Peer lead role has been extended to lead and support this important workstream. Further work is underway regarding the Recovery College and more detailed proposals will be considered as part of the work plan regarding Peer Mentorship.
b. Develop a proposal for a Patient Group/Council for inpatient facilities.	The proposal for a Patient Group/Council for inpatients services is being considered as part of the wider engagement and involvement work. This

	will help to advance the arrangements already in place.

MHODG Workstream: 4. ESTATES AND ENVIRONMENT Leads – Director of Estates and Environment & MHL D Director of Operations	
Deliverables	Summary Position
a. Agreed estates and physical environment plan	There is a well-established Group within the MHL D Division in association with Capital and Estates colleagues focusing on the improvements to the environment. The Capital prioritisation takes place through that group. Important to note is that the Estates strategic plan needs to be developed in tandem with the Clinical services Plan and service models for the future. There is key national work underway considering this.
b. Ligature reduction programme	There is a ligature reduction programme of work in place intended to improve the safety of the environment. Clinical practice however is also a key factor in reducing risks relating to ligature. Both elements working together improve patient/service user safety. In relation to the environment, the ligature estates work total circa £2.4M for 2026/27 and this builds on the multi-million pound investment implemented over the last 3 years.
c. Ablett Unit and Hergest Unit re-development	The national work on service configuration is underway and will consider the blueprint for service models/configuration across Wales. At this stage there is some uncertainty regarding the national approach on new large capital schemes and clarity is awaited from Welsh Government officials,
d. Develop a plan to improve comfort and dignity in the physical environment	This area is a key focus for the forthcoming MHODG, assessing and then building on the work that has been underway for some time. A focus on gardens and open spaces is key and likely to feature as part of the priorities moving forward.

MHODG Workstream: 5. CULTURE, LEADERSHIP AND ORGANISATIONAL DEVELOPMENT

Leads – Executive Director of Workforce and Organisational Development & MHLD Director of Operations

Deliverables

Summary Position

a. An effective MHLD leadership and OD model, reflecting the Health Board Approach

Detailed consideration was given to the work underway in this area at the last MHODG. The Wellness, Work and Us approach was discussed along with the Culture Change Programme and the proactive approach in the MHLD Division.

The Division has a clear view of the staff survey results and shared the work that is being taken forward as a result.

In relation to Foundations for the Future, the operating model structures specifically note that further work in the next phase will include a greater focus on mental health and learning disabilities services.

• BCUHB MH & LD data overview by theme



Positivity scores (%) by theme: 2025 NHS Staff Survey Betsi Cadwaladr University Health Board
*Green bars indicate scores above the NHS Wales Health Board average; pink bars indicate scores below the average.

Theme	Positivity score	Benchmark	Variance
We are stronger together	74.2%	68.7%	▲ 5.42 pp
We are compassionate and inclusive	72.8%	69.6%	▲ 3.20 pp
We recognise everyone's contribution	68.2%	61.2%	▲ 7.00 pp
We are continuously learning and improving	66.7%	63.1%	▲ 3.59 pp
We are all able to speak up	66.3%	65.6%	▲ 0.76 pp
We champion flexible working	65.2%	60.8%	▲ 4.36 pp
Staff engagement	58.2%	57.7%	▲ 0.48 pp
Patient safety	56.1%	59.7%	▼ -3.65 pp
We nurture healthy working environments	55.3%	56.5%	▼ -1.18 pp
Morale	55.3%	53.7%	▲ 1.59 pp

• This bar graph shows positivity score (%) by theme



b. A strategic plan for workforce with continued focus on recruitment and retention for inter-profession team working.

Aligned to workstream 1 and AHP and Psychology MDT.

Increased stability in inpatient medical staffing, reduction in vacancies and improved staff survey results.

Further reporting on this area will be made available once the workforce planning assessment is completed.

c. A plan for continuously developing compassionate and supportive culture in MHLD

Some good divisional progress noted with most recent survey results being above average in 8 out of 10 domains (as above). 29 Culture Change Leaders are within the MHLD division and examples of their work include:

- Delivering a Team Day to strengthen connection in complex conditions
- Creating a caring and connected team culture

	• Increasing awareness of BCU values to embed them more deeply into everything we do • Developing a clear, structured, and sustainable pathway for embedding the Culture Change Leader (CCL) programme • Creating a consistent compassionate and skilled workforce in Learning Disabilities Inpatient Services.

The Board is invited to consider the:

- **Progress of the Mental Health Oversight and Delivery Group (MHODG)-** including the robust governance and programme management approach, whilst taking assurance that recommendations arising from the Royal College of Psychiatrists Invited Service Review and the Expert Advisory Group review have been incorporated into a single, coordinated programme of improvement.
- **Delivery Against Strategic Priorities** focused on the key areas required to support improvement in quality, safety, patient experience and service sustainability aligned with the Welsh Government Mental Health and Wellbeing Strategy, Quality Statement and NHS Performance and Improvement priorities.
- **Mental Health Outcomes Framework** and its potential to strengthen outcome-focused performance, quality and assurance reporting.
- **Digital Transformation**-the significance of the successful procurement of the Mental Health and Learning Disabilities Electronic Health Record system and the anticipated benefits for patient care, clinical governance, information sharing and service integration.
- **Sustainability of Service Improvement** including current performance improvements and in particular the continued reduction in acute out-of-area placements
- **Quality Management and Assurance** that there is a clear line of sight between clinical standards, service delivery, patient outcomes and Board-level assurance.
- **Future Priorities** including implementation of the Outcomes Framework, EHR deployment, workforce development, estates improvements and the Open Access Service Model whilst considering the key risks/ barriers that could affect delivery of the programme and the adequacy of mitigation arrangements.

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

4.1 There is a risk that insufficient focus and leadership for effective models of care will mean people cannot access high quality mental health services. In addition, if the progress made to date is not sustained there is a risk to patient care, patient safety and the Health Board's ability to be legally compliant against regulatory assurance and/or Health Inspectorate Wales or Care Inspectorate Wales equivalent standards. Similarly, and as a result of the above, there is also a risk to the reputation of the Health Board with key stakeholders should this progress not be sustained and continued.

4.2 Work is ongoing to mitigate these risks through the delivery of the outlined work programme of the Mental Health Oversight and Development Group as outlined, chaired by the Health Board Chief Executive, with leadership from Executive Committee members.

BOARD ASSURANCE

5.1 The Board can take increasing assurance that the Health Board is establishing the organisational arrangements required to support the long-term strategic development of mental health services in North Wales. Whilst significant work remains, particularly in relation to performance improvement, service transformation and the delivery of sustainable outcomes, the Health Board has now established a clearer framework for oversight, accountability and improvement through the Mental Health Oversight and Development Group, strengthened executive oversight, and the development of a Mental Health Outcomes Framework.

5.2 Assurance is derived not solely from operational performance indicators, but from evidence that the Health Board is developing the strategic foundations required for sustained improvement. This includes the development of a whole-Health-Board mental health strategy and service model, alignment with the Health Board's wider strategic intentions, implementation of an outcomes-based approach, strengthened governance arrangements, and increasing integration of quality, safety, workforce, performance and financial considerations within a single improvement framework.

5.3 The Board should recognise that the principal assurance at this stage is that the organisation is establishing the conditions necessary for long-term improvement rather than demonstrating that all desired outcomes have yet been achieved. The maturation of the Mental Health Outcomes Framework, continued oversight through the three lines of defence, and regular reporting through Board committees will provide a more comprehensive basis for measuring whether strategic improvements are translating into demonstrable benefits for patients, staff and the wider population over time.

5.4 The Board can take reasonable assurance that the Health Board is strengthening the strategic development of mental health services through a developing Three Lines of Defence approach. First line assurance is provided through the delivery of the Mental Health Strategic Plan, Service Model and Outcomes Framework. Second line

assurance is provided through the Mental Health Oversight and Development Group, executive oversight and corporate monitoring of quality, performance, workforce, finance and risk. Third line assurance is provided through Board and Committee scrutiny, Internal Audit, regulatory review and external challenge. Collectively, these arrangements provide assurance that the strategic foundations, governance and oversight mechanisms are being established to support sustainable improvement in mental health services and outcomes across BCUHB.

6 ARGYMHELLION/RECOMMENDATIONS

The Board is asked to:

- **NOTE the progress** made through the Mental Health Oversight and Delivery Group (MHODG) since the previous update to the Board in January 2026. This includes the establishment of a single structured improvement programme across the five strategic workstreams.
- **NOTE** the significant reduction in acute out-of-area placements, sustained compliance with Mental Health Measure performance standards, successful procurement outcome for the MHL D EHR and progress made in strengthening workforce stability, service quality and patient experience.
- **CONSIDER and ENDORSE** the draft Mental Health Outcomes Framework as the foundation for strengthening outcome-focused performance, quality and assurance reporting across MHL D services.
- **TAKE REASONABLE ASSURANCE** that the governance, quality management and oversight arrangements established through the MHODG are supporting the delivery of sustainable improvement in Mental Health services and providing an appropriate framework for Board assurance.

ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol Link to Strategic Priorities	See below
	More than one applies, please list below: • Building an Effective Organisation • Developing strategy and long-lasting change • Creating compassionate culture, leadership and engagement • Improving quality, outcomes and experience • Establishing an effective environment for Learning
Yr Egwyddorion Dylunio Design Principles	• People First • Inclusive Design • Simplify, Standardise and Adopt Best Practices • Consistency with Organisational Values
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	BAF24-06 - Not Delivering the Required Improvements to Transform Care and Enhance Outcomes CRR25-04 – Modernising our Digital Infrastructure CRR25-08 – Non-Compliance with Regulatory and Legislative Requirements CRR 25-09 - Safe Environment
<u>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant</u> <u>Wellbeing of Future Generations Act – Wellbeing Goals</u>	A Healthier Wales

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Cydraddoldeb <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	This report is focussed on reporting on high level strategic improvement activity. Relevant parts of the workstreams, as they develop, will be impact assessed and therefore not applicable for this report.
Asesiad o'r Effaith Economaidd-gymdeithasol	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	

<i>A ydych chi wedi cynnal Asesiad o'r Effaith EconomaiddGymdeithasol?</i> Socio-Economic Impact Assessment <i>Have you undertaken a Socio-Economic Impact Assessment</i>	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	This report is focussed on reporting on high level strategic improvement activity. Relevant parts of the workstreams, as they develop, will be impact assessed and therefore not applicable for this report
Ansawdd <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Galluogwyr Ansawdd Enablers of Quality	Meysydd Ansawdd Domains of Quality All Apply
	This report is focussed on reporting on high level strategic improvement activity. Relevant parts of the workstreams, as they develop, will be impact assessed and therefore not applicable for this report	
Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	No - Not Applicable	
Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog <i>A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog:</i> Armed Forces Covenant Due Regard Duty <i>Have you considered the Armed Forces Covenant Due Regard Duty?</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	This report is focussed on reporting on high level strategic improvement activity.
Asesiad o Effaith ar Ddiogelu Data	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
<i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?</i> Data Protection Impact Assessment <i>Have you undertaken a Data Protection Impact Assessment Screening?</i>	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	This report is focussed on reporting on high level strategic improvement activity. Relevant parts of the workstreams, as they develop, will be impact assessed and therefore not applicable for this report.
Asesiad o Effaith ar Atal	Do/Yes: ☐	Naddo/No: ☒

Twyll <i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i> Counter Fraud Impact Assessment <i>Have you considered the counter fraud impacts</i>	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	This report is focussed on reporting on high level strategic improvement activity. Relevant parts of the workstreams, as they develop, will be impact assessed and therefore not applicable for this report.
Cyfreithiol Legal	Yes (Include further detail below)	
	The report highlights content that relates to legislation for the provision of Mental Health Services.	
Enw Da Reputational	Yes (Include further detail below)	
	This report highlights content that relate to the Health Board's progression of recommendations from the Royal College of Psychiatrists Invited Services Review and wider continuous improvement activity that if not progressed would have an adverse impact on patients and service users and the reputation of the Health Board.	
Effaith ar Adnoddau <i>(Pobl / Ariannol)</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	

Appendix 1 Progress with RCP Actions categorised as Red in Jan 26

Theme	Action	Progress since Jan 26 Mental Health Board report	RAG Status July 26
2	Complete consultation and approval of Physical health Strategy in preparedness for implementation	Consultation complete, and readiness for implementation phase. Transition to business as usual	AMBER
4	Recruit dedicated Consultant Psychiatrist for the Hergest Unit	Recruitment underway with posts on Trac. Long term locum cover secured with further support from the substantive East Consultant Psychiatrist. Imminent recruitment of substantive Speciality Doctor for Hergest. Provides a level of stability and consistency until successful substantive recruitment. Transition to business as usual with transfer to MHODG Workstream 5 outlined below.	AMBER
6	Desk top audit of Multidisciplinary (MDT) ward rounds	Assimilated into HSE NoC Action plan and transferred to MHODG Workstream 4 outlined below.	AMBER
9	Review the demand and capacity arrangements for therapeutic options available to all inpatient units to identify any gaps and agree next steps	Transferred to MHODG Workstream 5 outlined below.	AMBER
9	For any identified gaps in therapeutic provision across inpatients units develop a business case where relevant for therapeutic staffing by accessing WG Improvement Funds	Transferred to MHODG Workstream 5 outlined below.	AMBER
9	Ensure gaps in therapeutic services are regularly reviewed with a clear escalation procedure if further equipment/facilities are needed to ensure swift resolution	Transferred to MHODG Workstream 5 outlined below.	AMBER

Appendix 2: Expert Advisory Group (EAG) key considerations for further work as aligned with Royal College of Psychiatrists Review

Listening to service users, their families and carers is key to ensuring the development of improvement priorities. During 2025, this was supported through the Expert Advisory Group (EAG) and is now supported by the ongoing co-production of the draft Outcomes Framework. As part of this strengthened approach recommendations from RCP and the Expert Advisory Group were considered at the January 2026 Board and contain a number of considerations developed by the Chair of the EAG. The summary of the EAG recommendations against the RCP key themes are highlighted in figure 2 below, focussing on 7 of the original 10 themes:

EAG Recommendations Summary

Theme 1 – Patient and User Centred Care
Continue to develop and enhance service user & family centred experience, engagement, co-production and education. ☐ Continue the development of the Mental Health Strategic Public Patient Experience group ☐ Continue to further develop feedback themes and trends to demonstrate listening and learning including in the Outcomes Framework ☐ Continue to demonstrate the use of patient experience system CIVICA at scale Main streaming engagement and co-production opportunities in services including, Ablett re-development. ☐ Involve service users and families in the developing Mental Health Outcomes Framework. ☐ Ongoing development of the Recovery College ☐ Develop Peer Support Model in inpatient and community teams in MHLD
Theme 2 – Legislation and Clinical Guidelines

Team to Board leadership. Continuing to improve the reliability and quality of mental health care to demonstrate consistently meeting/ exceeding national and UK and local standards.

- ☐ Continue to reduce variation and improve quality and care standards
- ☐ Continue to demonstrate consistent models of care in service
- ☐ Demonstrate improvement in clinical standards developing real time measures including at team levels
- ☐ Embed QMS management system

Theme 3 - Governance

Effective governance and oversight at all levels MHLD Teams to Board

- ☐ Mortality review and reporting in line with national and UK standards
- ☐ Developing reliable data which is used consistently in all reports

Learning and improving safety and reducing harm

Theme 4 - Staffing

Board leadership to enhance and develop the Mental Health Multi-Disciplinary Team (MDT) workforce.

- ☐ Recruitment and retention in MHLD in all clinical professions, including Allied Health Professions and Psychologists
- ☐ Vacancy rates less than 5%, with reduced use of agency and temporary staff.
- ☐ Work with universities to aid recruitment collaboratively
- ☐ Revenue support for developing NICE evidence-based approach for MDT staff
- ☐ Progress Inpatient and CMHT staffing establishment reviews

Theme 8 – Leadership and Staff Engagement

Compassionate and effective high performing culture in all teams.

- ☐ Continue to drive staff survey response and feedback loop

- ☐ Embrace Cultural Change Leaders into Divisional activity
- ☐ Continued MHLD progress with compassionate leadership programme

Theme 9 and Theme 10 – Resources and Physical Environment

Health Board leading opportunities for revenue and capital investment supported by strong multiagency and system partnerships.

- ☐ Revenue and capital support to enable safe, comfortable, well equipped modern mental health estate
- ☐ Revenue and capital support to enable MHLD to become digitally enabled including implementing the Electronic Patient Record.

Appendix 3: Priorities in scope of the Mental Health Oversight and Development Group

Priorities in scope of the Mental Health Oversight and Development Group
• Effective Mental Health strategic plan and service model that has a whole Health Board consideration and alignment with national legislation and requirements. • A co-designed and created Outcomes Framework that reflects the strategy and objectives of the whole Health Board. • An effective approach for patient and carer involvement to inform service design, improvement and feedback on current service provision. • An effective estates and physical environment plan that also encompasses a focus on preventing and monitoring ligature risks and reflects key Health Board programmes. • A focussed plan to continually improve standards of clinical practice against national standards and aligning with the Health Board's Quality Management System approach. • An effective leadership and management model and approach that strengthens current arrangements and encourages succession planning. • A strategic plan for workforce that enables the provision of high-quality services in a future service model. • Development of the plan to continuously develop culture within Mental Health services, informed by the whole Health Board approach and provides targeted and specialist support. • Visibility of Mental Health services performance, including the development and reporting of service indicators and performance against Welsh Government requirements. • The continued focus on matters raised by legacy reviews to inform the continued improvement and strategy of Mental Health services, including implementation of recommendations. • Addressing matters of financial significance to Mental Health services by the identification of core issues and plans to address them. • Oversight of progress of key Health Board programmes that impact on Mental Health services, including the Mental Health Electronic Health Record and Ablett Unit development. • Ensuring the effective interplay of Mental Health services with other Health Board services, including Psychological Therapies and Childrens services.

Appendix 4: MHODG workstreams cross referenced with EAG chair recommendations

MHODG Workstreams	Deliverables	Reference to EAG Chair recommendations
1.Strategic Planning Outcomes & Service Model Leads - Interim Executive Director Transformation and Strategic Planning MHLD Medical Director	Mental Health Outcomes Framework Effective plan to deliver on the strategic programme for Mental Health Service Model and Commissioning Framework Develop the required stages for the provision of Therapies in MHLD settings. Service Model for Dementia	Theme 1 - Continue to develop and enhance service user & family centred experience, engagement, co-production and education Theme 9 & 10 - Health Board leading opportunities for revenue and capital investment supported by strong multiagency and system partnerships
2.Clinical Standards/QMS and Service Performance Leads - Executive Director of Allied Health Professionals and Health Science MHLD Directors	Plan to continually improve standards of clinical practice – aligning with Health Board Quality Management System (QMS) Implementation of EHR MH Service Performance against WG requirements at Team Level	Theme 2 - Team to Board leadership. Continuing to improve the reliability and quality of mental health care to demonstrate consistently meeting/ exceeding national and UK and local standards. Theme 3 - Effective governance and oversight at all levels Theme 9 &10 - Revenue and capital support to enable safe, comfortable, well equipped modern mental health estate
3.Patient and Carer Engagement and Experience Leads – Executive Director of Nursing and Midwifery MHLD Director of Nursing	Agreed strategy and implementation plan for patient and carer engagement Develop a proposal for a Patient Group/Council for in-patient facilities.	Theme 1 - Continue to develop and enhance service user & family centred experience, engagement, co-production and education

4.Estates and Environment Leads – Director of Estates and Environment MHLD Director of Operations	Agreed estates and physical environment plan Ligature reduction programme Ablett Unit and Hergest Unit re-development Develop a plan to improve comfort and dignity in the physical environment	Theme 9 &10 - Revenue and capital support to enable safe, comfortable, well equipped modern mental health estate
5.Culture, Leadership and Organisational Development Leads – Executive Director of Workforce and Organisational Development MHLD Director of Operations	An effective MHLD leadership and OD model, reflecting the Health Board Approach A strategic plan for workforce with continued focus on recruitment and retention for interprofession team working. A plan for continuously developing compassionate and supportive culture in MHLD	Theme 4 – Staffing Board leadership to enhance and develop the Mental Health MultiDisciplinary Team (MDT) workforce Theme 8 - Compassionate and effective high performing culture in all teams

Appendix 5: Draft BCUHB Person-Centred Mental Health Outcomes Framework

1. Core purpose/mission

To ensure every person in North Wales can access timely, compassionate, trauma-informed mental health support that improves their wellbeing, strengthens their rights, and enables them to live the life they value.

This framework is built around “**what matters**” principle and practice, **co-production**, and **whole-system working** across BCUHB, social care, housing, education and the third sector.

2. Principles (NHS Wales/BCUHB aligned)

6 principles are identified cognisant with the findings from the coproduction methodology applied:

2.1 Person-centred care

- Outcomes are defined by the person, not the service.
- Care and treatment plans (CTPs) are co-produced and reviewed regularly.
- Welsh language is actively offered (*Cymraeg Gwaith*).

2.2 Trauma-informed practice

- Safety, trust, empowerment and choice underpin every interaction.
- Staff are trained and supported to avoid re-traumatisation.

2.3 Early help and prevention

- Rapid access to support, including same-day or open-access models.
- Focus on preventing crisis, relapse and escalation.

2.4 Engagement and Co production

- Improvements are underpinned by listening and co production and co design

2.5 Rights-based and anti-discriminatory practice

- People understand their rights and can exercise voice and control.
- Active efforts to reduce inequalities (poverty, racism, disability, LGBTQ+ exclusion).

2.6 Integrated health and social care system

- BCUHB, local authorities and third sector work as one system.
- Ambition for shared assessments, shared plans, shared outcomes.

3. Proposed Outcomes Domains

Each domain uses “**I...**” **outcomes** (person-level) and **BCUHB responsibilities** “**We**” (service/system-level). Domains map directly to the **SSWB Act well-being outcomes** which is important from a systems perspective.

Five draft outcomes are identified alongside a number of proposed metrics:

3.1 Rights, Voice & Control (or Voice, Control and Participation)

Person outcome: “I am listened to, respected, and fully involved in decisions about my care and life.”	
BCUHB responsibilities, we will: • Provide accessible information and advocacy. • Ensure co-production in care planning and service design. • Uphold equality, Welsh language rights and reasonable adjustments.	Proposed Indicators: • % reporting feeling listened to • % reporting they were involved in decisions. • % offered advocacy. • Reduction in complaints relating to dignity, respect or communication. • Qualitative feedback statements.

3.2 Mental & Physical Health and Emotional Well-being

Person outcome: “I feel as well as I can, and I get help when I need it.”	
BCUHB responsibilities, we will: • Access to self-care information/ guidance • Timely access (including Mental Health Measure 28-day Part 1 and Part 2 targets). • Holistic care addressing physical health, substance use and social needs. • Trauma-informed crisis and urgent care pathways	Proposed Indicators: • Self-rated wellbeing improvement. (Requol- PROMS) • Waiting times to first contact (MHM Part 1a) and treatment (MHM Part 1b). • Reduced crisis presentations and compulsory admissions.

3.3 Safety & Protection from Harm

Person outcome: “I feel safe, and people act quickly if I am at risk.”

BCUHB responsibilities, we will: • High-quality safeguarding practice. • Timeliness of access to help and support • Compassionate response to self-harm and suicidality. • Reduction in restrictive practices.	Proposed Indicators: • % staff trained in safeguarding and trauma-informed care. • Waiting times to first contact (MHM Part 1a) and treatment (MHM Part 1b). • 111 Press 2 response times (WAST collaboration) • Use of restrictive interventions. • Timeliness of safeguarding responses.

3.4 Education, Work & Meaningful Activity

Person outcome: “I can work, learn or do things that matter to me.”	
BCUHB responsibilities, we will: • Include meaningful activity goals in care plans. • Commission community-based activities • Partner with employability, education and community organisations.	Proposed Indicators: • % with recovery goals linked to activity/work. • Employment/education outcomes for service users. • Recovery college/ ICAN indicators

3.5 Relationships & Connection

Person outcome: “I have supportive relationships and can stay connected to people who matter.”	
BCUHB responsibilities, we will: • Family-inclusive practice where the person wants it. • Support for carers (assessment, information, involvement).	Proposed Indicators: • Self-reported loneliness/isolation. • Number of out of Area placements • % carers offered assessment. • Carer wellbeing measures.

3.6 Social & Economic Well-being

Person outcome: “I have enough money, support and opportunities to live well.”

BCUHB responsibilities, we will: • Routine referral to welfare rights, debt advice and employment support (access to non-statutory community advocacy) • Address social determinants of mental health.	Proposed Indicators: • % offered welfare/housing advice. • Numbers accessing non statutory community advocacy • Financial wellbeing self-ratings. • Reduced poverty-related crisis presentations.

4. Levels of Measurement could be aggregated as follows:

Individual Level – “My Life”	Service Level – “Our Team”	System Level – “Our Health Board / System
• What-matters outcomes • Recovery measures (e.g., ReQol, WEMWBS, Recovery Star) • Narrative feedback	• PREMs & PROMs • Access, timeliness, continuity • Safety and restrictive practice data • Staff wellbeing and supervision quality	• Aggregated wellbeing outcomes • Crisis and urgent care trends • Suicide and self-harm data • Inequalities monitoring • Integration metrics (shared plans, joint assessments)

5. Governance, Implementation and Review

5.1 Shared Governance

- Joint boards
- Lived experience representation
- Annual public reporting (“You said, we did”)

5.2 Implementation Requirements

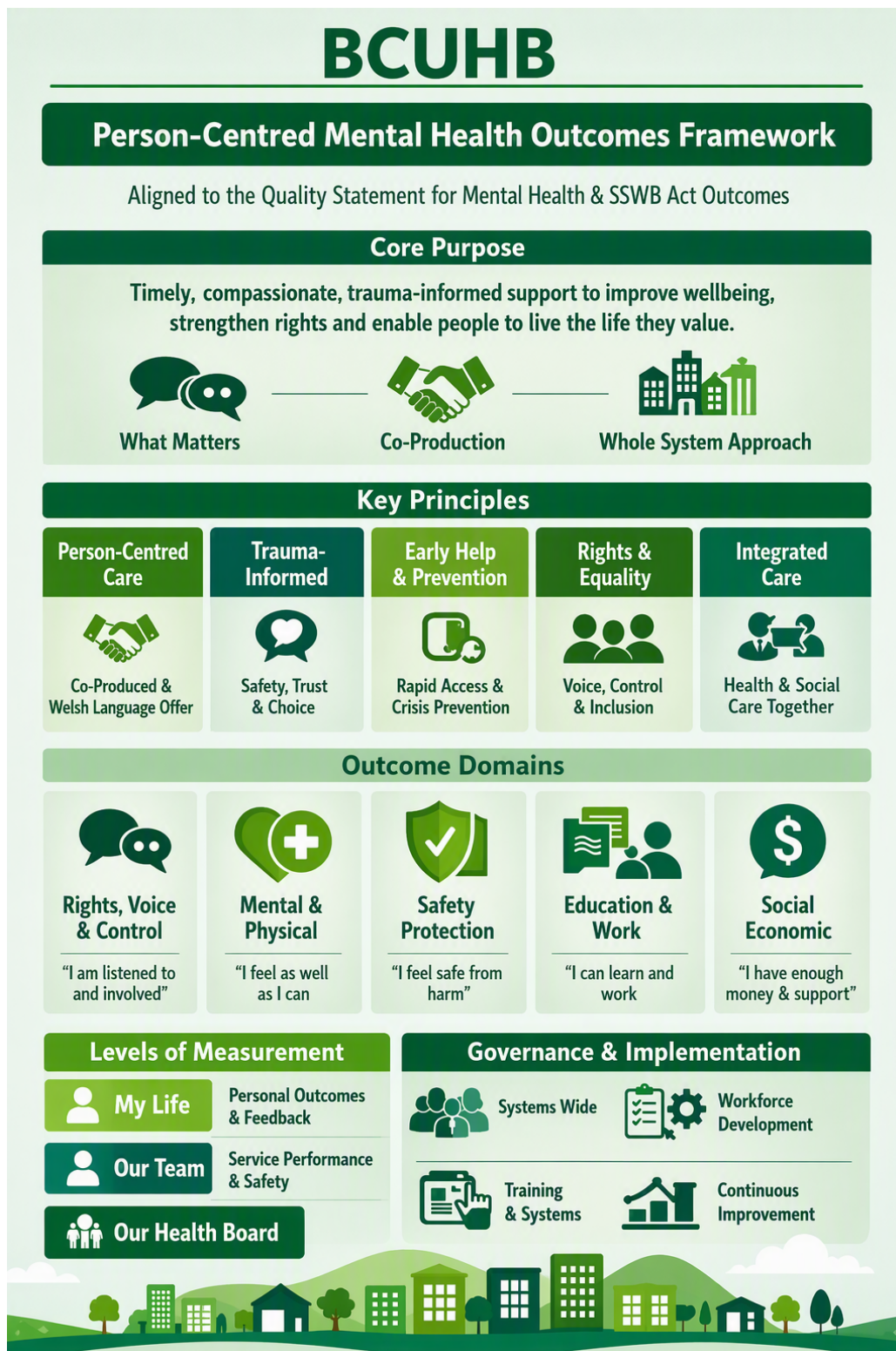
Implementation requirements include but are not limited to:

- Workforce training: trauma-informed, rights-based, anti-racist practice
- Digital systems that capture quantitative data and personal outcomes
- Underpinning Routine “what matters” practice
- Peer workforce development

5.3 Proposed Review Cycle to include:

- Quarterly service-level reviews
- Annual Health Board-level outcomes report
- Continuous quality improvement using PDSA cycles

Appendix 4: Draft Mental Health Outcomes Framework Infographic



Health Board

ALL AGES COMMUNITY HEALTH DIGITAL SOLUTION – OUTLINE BUSINESS CASE

Date of Meeting	30 July 2026
Publication Status	Open/ Public
	Not Applicable
Report Author(s) name and title	Alison Kemp, Associate Director, Primary Care & Community Services
Lead Executive Team Member name and title	Carol Shillabeer, Chief Executive Officer

Report Purpose	For Approval

Executive Summary

This Outline Business Case (OBC) sets out the strategic, clinical, and operational need for a comprehensive digital system to support community health services across all age groups within the Health Board. It aligns with the national Connecting Care Programme, which aims to digitise community health and care records and enable integrated, multi-agency working across Wales.

This Outline Business Case has been considered and supported by the Executive Committee on 18th June and Performance, Finance and Information Governance Committee (PFIG) on 23rd June 2026. The proposal is revenue neutral as set out in Table 16, subject to the Health Board securing implementation-phase funding support from the national Digital Priorities Investment Fund (DPIF). Approval is sought for the All-Age Community Health Digital Solution OBC to enable a formal procurement process to commence ahead of completion of the Full Business Case (FBC).

Community health services—including district nursing, children's services, and specialist community teams, deliver over 900,000 patient contacts annually across North Wales. These services rely heavily on paper-based records. These fragmented systems limit timely access to information, hinder coordinated care, and create significant clinical, safeguarding, and information governance risks.

National and local reviews have reinforced the need for improved information sharing to support safe, effective care delivery.

Earlier attempts to implement a national system Welsh Community Care Information System (WCCIS) were unsuccessful in meeting local needs. The replacement Connecting Care Programme now supports a “best of breed” approach, allowing Health Boards to procure systems tailored to their requirements while contributing to a national integrated care record.

The preferred option is the procurement and implementation of an All-Ages Community Health Digital System, complementing the recently approved Mental Health and Learning Disability Electronic Healthcare Records (EHR) system. This solution will:

- Replace multiple legacy systems and paper processes
- Enable real-time access to patient records across services
- Support integrated, multidisciplinary and multi-agency care
- Align with national specifications and interoperability standards

Funding in full for the implementation phase is expected through Welsh Government and Digital Health and Care Wales, subject to approval of a revised bid for implementation support. Our progress in securing this funding will be clarified at FBC stage.

The proposal strongly aligns with national and organisational priorities, including A Healthier Wales, the Social Services and Wellbeing (Wales) Act, Healthy Child Wales Programme, Community by Design and the Health Board’s digital and service strategies.

Key benefits include:

- Improved quality and safety of care through real-time, accessible patient information
- Enhanced patient experience via coordinated, joined-up services
- Workforce efficiencies by reducing administrative burden and duplication
- Support for service transformation, enabling more care to be delivered in community settings

Economic analysis indicates significant value, with total benefits estimated at £47.5m (£3.6m cash-releasing and £37.7m in productivity and efficiency, at OBC stage) against costs of £14.4m, resulting in a net cumulative economic benefit of approximately £33.1m over the course of the contract term.

At this OBC stage, a gross forecast recurrent revenue gap of £724k per annum from Year 4 is identified. Whilst these costs and assumptions will change as a preferred supplier is identified, and further work on business process redesign and

benefits realisation is finalised, the Project Board has identified and agreed actions to achieve recurrent revenue neutrality, as set out in OBC Table 16.

The Project Board will address in full any residual Full Business Case (FBC) revenue gap through realising productivity savings, including opportunities to manage an increased workload within existing resources as demand for community services grows, ensuring that the final FBC presented for Health Board approval demonstrates a deliverable recurrent revenue affordable proposition, and a positive return on investment.

Maintaining the current paper-based approach is considered unsustainable, with increasing risks as other parts of the system digitise. Failure to proceed may:

- Exacerbate patient safety and governance risks
- Impact workforce recruitment and retention
- Prevent access to national funding
- Leave the Health Board as an outlier in Wales, unable to fully contribute to the Integrated Care Record

Since PFIG approval on 23rd June, Welsh Government has advised Health Boards of the outcome of bids for Digital Priorities Investment Fund (DPIF) monies. Funding to support the procurement phase for the Community Health system has not been supported in the 2026/27 financial year. This impacts the economic assumptions made in Tables 2 and 12, and the financial assumptions made in Tables 3 and 15 of the OBC.

Despite the lack of confirmed DPIF funding for 2026/27, this project is still considered an organisational priority that mitigates key patient safety risks. We therefore, request approval for the OBC to enable progression to undertake a formal tender process and related FBC activity. The Project Board will mitigate this delay in funding by:

- Reallocate existing Health Board resources and protected staff time to continue and complete the FBC, at no additional cost to the Health Board.
- Continue to utilise the work already done for All Ages Mental Health where there is comparable overlap.
- Proceed with a Tender to confirm system availability and provide assurance on pricing and implementation costs, whilst managing risk through ensuring that any subsequent contract award is fully dependent upon an approved and affordable FBC.
- Where appropriate, work collaboratively with other Health Boards to progress joint tender process and FBC development, sharing risks and opportunities wherever possible.
- Re-submit a bid for DPIF funding for 2027/28 to support implementation costs.

- Delaying the progression of the Community Health FBC and implementation schedule to align with agreed funding timescales and opportunities for 2027/28.

The OBC concludes that there is a compelling case to proceed with procurement of a community digital system, supported by strong strategic alignment, clear risk mitigation, and significant anticipated benefits.

The Board is asked to:

- **APPROVE** the Outline Business Case (**Appendix A** - attached separately) in its current context, noting the need to secure Digital Priorities Investment Fund / Welsh Government funding to cover implementation costs and that a recurrently affordable Full Business Case will be presented for full approval before contract award and implementation.
- **APPROVE** the tender exercise to identify a preferred way forward for procurement, retaining the option for either a locally led or collaborative procurement with other Health Boards, noting that any subsequent contract award will be dependent upon a recurrently affordable Full Business Case.
- **SUPPORT** the use of existing Health Board resources to develop the Full Business Case, with the agreement that the Full Business Case presented for approval following formal procurement tender for the system will demonstrate and deliver recurrent affordability.

Ymgysylltu (mewnol/allanol) yr ymgwymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp)

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	Dyddiad Date	Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data
Electronic Health Record Programme Board	19.05.2025	Paper, proposing procurement of separate “best of breed” digital systems to support Mental Health and Community Health services was approved. DHCW in attendance and supportive.
Meeting with Carol Shillabeer	09.04.2026	Progress Summary on OBC presented. Secured CEO support to take finalised OBC through approval processes.

Connecting Care Project Board	19.05.2026	Approval
Digital Programme Delivery Group	19.05.2026	Oversight
DDaT Senior Leadership Team	26.05.2026	For information
Operational Leadership Team	26.05.2026	OBC Approval to Exec Board
Executive Committee	03.06.2026	Outcome - Revision brief provided and requested for updated OBC to be brought back to Exec meeting scheduled 18.06.26 for further review
Executive Committee	18.06.2026	OBC Approval to PFIG
PFIG	23.06.2026	Endorsed for approval by Health Board

Acronyms / Rhestr Termiau	
Acronyms / Glossary of Terms	
Acronym / Term	Meaning
A&E	Accident and Emergency
ANP	Advanced Nursing Practitioner
API	Application Programming Interface
BAU	Business as Usual
BCUHB	Betsi Cadwaladr University Health Board
CCIO	Chief Clinical Information Officer
CNIO	Chief Nursing Information Officer
CSF	Critical Success Factor
CYPriS	Child Health System used in Wales
DCB0129 / DCB0160	Clinical Safety Standards for Health IT Systems
DDaT	Digital, Data and Technology
DHCW	Digital Health and Care Wales
DN	District Nursing
DPIA	Data Protection Impact Assessment
DPIF	Digital Priorities Investment Fund
DMS	Digital Maternity System
ECC	Enhanced Community Care
EHR	Electronic Health Record
eMPI	Electronic Master Patient Index
ePMA	Electronic Prescribing and Medicines Administration
EQIA	Equalities Impact Assessment
FBC	Full Business Case
FHIR	Fast Healthcare Interoperability Resources
GP	General Practitioner
HL7	Health Level Seven



HV	Health Visitor
ICR	Integrated Care Record
IHC	Integrated Health Community
ITT	Invitation to Tender
KPI	Key Performance Indicator
LPP	London Procurement Partnership
MDT	Multidisciplinary Team
MEAT	Most Economically Advantageous Tender
MDS	Minimum Data Set
MH / MHL	Mental Health / Mental Health & Learning Disabilities
NADEX	National Active Directory
NCV	Net Cumulative Value
NHS	National Health Service
NWSSP	NHS Wales Shared Services Partnership
OBC	Outline Business Case
OOH	Out-of-Hours
PACS	Picture Archiving and Communication System
PAS	Patient Administration System
PID	Project Initiation Document
PFIG	Performance, Finance and Information Governance Committee
PRINCE2	Project Management Methodology
PTR	Putting Things Right
RAID	Risks, Assumptions, Issues, Dependencies
RIS	Radiology Information System
RPI	Retail Price Index
SCPHN	Specialist Community Public Health Nursing
SLT	Senior Leadership Team
SNOMED CT	Systematized Nomenclature of Medicine – Clinical Terms
SRO	Senior Responsible Owner
SPOA	Single Point of Access
UAT	User Acceptance Testing
VAT	Value Added Tax
WCCIS	Welsh Community Care Information System
WCP	Welsh Clinical Portal
WDS	Welsh Demographic Service
WG	Welsh Government
WIS	Welsh Immunisation System
WNCR	Welsh Nursing Care Record
WPAS	Welsh Patient Administration System
WPRS	Welsh Patient Referral System
WRDS	Welsh Reference Data Service
WRRS	Welsh Results Reporting Service

All Ages Community Health Digital Solution – Outline Business Case

1. SITUATION

- 1.1 The Outline Business Case articulates the need for a Digital System to support the delivery of Community Health Services, across children, young people and adult services.
- 1.2 As part of the national Connecting Care Programme, Digital Healthcare Wales (DHCW) has submitted a business case to Welsh Government for funding to support the procurement and implementation of a Community Health Digital System in Health Boards across Wales. Welsh Government has awarded funding to BCU this financial year to support the All Ages Mental Health, Maternity and Optometry systems. WG has confirmed that there will be no DPIF funding for this project for the 2026/27 financial year. A bid for implementation cost support will be resubmitted for the 2027/28 and 2028/29 financial years.
- 1.3 Approval of this Outline Business Case at this stage will allow the progression of the tender in order to facilitate the completion of the FBC which will be submitted for approval before any contract can be awarded and progressed.
- 1.4 A recurrently affordable Full Business Case will then be developed to seek the Health Board's agreement and Welsh Government approval to enter into a contract with the preferred supplier to implement and operate a Digital Health System for Community Services.

1. BACKGROUND

- 1.1 The Welsh Government (WG) set out its intention to procure and implement an integrated, multi-agency, community IT system over a decade ago, to be delivered under the Welsh Community Care Information System (WCCIS) Programme
 - 1.1.1 A national evaluation of the WCCIS Programme concluded that a different approach was required. In 2023, the Connecting Care programme replaced the WCCIS Programme to digitise health and care records and enable the delivery of multi-disciplinary and multi-agency care in community settings.
 - 1.1.2 The Connecting Care programme supports the implementation of separate “best of breed” commercial systems in Local Authorities and Health Boards. Multi-agency information sharing will be achieved through the development of an overarching Integrated Care Record by DHCW.

- 1.1.3 The six North Wales Local Authorities have collaborated and are implementing the MOSAIC system to replace Care Director and PARIS systems.
- 1.1.4 Health Boards were asked if they would purchase combined Mental Health & Learning Disability (MHLD) and Community Systems, or to implement separate systems. BCUHB opted to procure separate systems.
- 1.1.5 Following approval of the Full Business Case by the Health Board in January 2026, an All Ages Mental Health & Learning Disability system, that also incorporates Neurodiverse patients and clients, is moving into the implementation phase.
- 1.1.6 An All-Ages Community system is now required to complete the Health Board elements of the Connecting Care Programme.
- 1.1.7 The Health Board's Electronic Health Record Programme Board endorsed this approach in its meeting in May 2025 and agreed the system's scope, which can be seen in the table below.

Community Nursing	
	• District Nursing • Complex Care Teams • Tissue Viability Nursing • Continence Nursing • Lymphoedema Nursing • Community Palliative Care Nursing* • Continuing Health Care* • Community Complex Conditions* (Aligned to cover all specialities) • Stroke Prevention Nurses
	(Community Midwives will be covered in the scope of Digital Maternity System (DMS))
Children's Community Services	
	• Health Visiting (including Specialist HV posts) • School Nursing • Community Children's Nursing • Community Specialist Nurses -Aligned to cover all specialities • Community Paediatrics* • Children's Palliative Care Medical* • Children's Continuing Care* • Children Looked After
	CAMHS Practitioner - Children Looked After, Neurodevelopment Services and Children's Learning Disabilities Services are all included in MH Scope
	* Required in addition to the service scope within the national Connecting Care OBC

-
- 1.1.8 These services deliver over 900,000 patient contacts each year across the Health Board. All operate using paper records, which are stored in multiple locations across North Wales. These separate records hamper timely multi-disciplinary and multi-agency working and introduce clinical, safeguarding and operational risks.
- 1.1.9 Support for a Community Digital System is in line with National and Health Board policy, both for digital provision and to support increased provision of clinical services and the care of more complex patients care in Community settings. This is a key enabler to deliver the Community By Design Programme.
- 1.1.10 Information Governance risks associated with the use and storage of paper records in the Health Board have been documented and escalated.
- 1.1.11 The need for timely access to records and the ability to share key information across teams and sectors have been highlighted in a number of investigations and reports, both nationally and locally.
- 1.1.12 Management teams have worked to address risks where possible. District Nursing teams have previously implemented and operationally manage an electronic scheduling system to support service delivery. This is not an electronic record. Child Health teams are supported to schedule and record some interventions with the Child Health System. Paper records are still required as the system is not accessible by wider teams and staff do not have mobile devices to access the system. A pilot has commenced using the EMIS Clinical Services system to support the work of Advanced Nurse Practitioners in the Central IHC following criticism by the Coroner of the lack of shared records for patients with complex needs in the community.

2. **SPECIFIC MATTERS FOR CONSIDERATION**

- 2.1 The procurement of a Community Digital system is in line with national and Health Board Service and Digital Strategies, including:
- A Healthier Wales
 - Social Services & Wellbeing (Wales) Act 2014
 - Healthy Child Wales Programme
 - Together for Children & Young People
 - Digital and Data Strategy for Health & Social Care
 - Connecting Care Programme
 - Community By Design National Programme
 - Establishment of Integrated Community Care Service
 - BCUHB IMTP 2026-2029
 - BCUHB Electronic Health Record Programme

- 2.2 Five options were considered, four of which were discounted as they were not achievable or did not deliver the identified Critical Success Factors. The option to procure a Community Health system was the favoured option, either through a BCUHB only procurement, or, as we did for the All-Ages MH&LD System, a joint procurement with another Health Board.
- 2.3 Market intelligence, gathered by DHCW as part of the national Connecting Care Programme, has demonstrated that commercial systems are available in the UK that meet the national core specification. Some of these systems are already on national frameworks.
- 2.4 The system implementation costs are planned to be met through resources secured through the national Connecting Care Business Case. Success is dependent on securing this external funding to cover the implementation phase between 2027/28 and 2028/29.
- 2.5 The development of the Health Board OBC has been undertaken in close partnership with DHCW, service stakeholders, the DDAT Team, and key leads in the All-Ages Mental Health System.
- 2.6 All resources allocated for the delivery of the WCCIS programme in BCUHB have been allocated to the delivery of the All-Ages Mental Health & Learning Disability system. Opportunities to share or utilise these resources to support the All-Ages Community elements of the overarching WCCIS programme have been explored and are reflected in the OBC. Further opportunities will continue to be explored at FBC stage.
- 2.7 Three systems; CIVICA Scheduling, CYPrIS Child Health System and Community Myrddin have been identified for replacement by the new All-Ages Community Health System, releasing these resources to contribute to the costs of the new system.

The OBC highlights an estimated gross revenue challenge to deliver the system in “business as usual,” of £724k per annum from Year 4. An agreed proposal for closing this gap is outlined in section 5 of the OBC. This will be fully resolved through procurement and FBC stage, with the final FBC being presented to the Health Board for approval on the basis of recurrent affordability and deliverability.



OBC Table 16: Proposal to achieve revenue neutrality

Cost / Benefit Item	10 years Total £000's
OBC Gross revenue gap	724
Tendered Licence costs in line with MHL EHR contract	(118)
VAT is reclaimable on licence fees (as per MHL EHR)	(51)
Risk & Bias removed at FBC	(58)
Residual operational revenue gap	497
Reduction in system support costs through further efficiencies in DDAT and Service provision.	(497)
Conversion of Efficiency & Productivity benefits into cash-releasing, including removal of vacancies and reduction in hours from across BCU Adult & Children Community service	
FBC REVENUE IMPACT	0

2.8 An assessment based on national benchmarks and local process mapping, has identified non-cash releasing productivity and efficiency benefits of £37m over the life of the contract of a Community System, as well as £3.6m of cash-releasing benefits.

2.9 The table, below, summarises the economic impact over the 10-year course of the contract and project.

Table 2: Breakdown Economic Assessment & Assumptions

Cost / Benefit Item	£000's
Supplier Costs	3,940
Health Board Revenue Costs	9,735
Risk & Bias	687
Total Costs	14,362
WG / DHCW Funding	(6,325)
Cash-releasing benefits	(3,579)
Non-cash-releasing benefits	(37,609)
Total Benefits	(47,513)
Net Cumulative Value	(33,151)

2.10 Should there be no subsequent funding support from DPIF, the economic assessment still demonstrates a significant net cumulative economic value.

2.11 The management case demonstrates that there is sufficient capability and competence in the Health Board to deliver the service change required to support the system implementation and benefits realisation.

3. KEY RISKS / MATTERS FOR ESCALATION

- 3.1 The status quo, of limited digital support for the scheduling of activity and our reliance on paper records for the delivery of clinical care in the community, is unsustainable. The clinical, safeguarding, information governance, and operational risks of not progressing to a digital system are significant. The relative risk increases as all other parts of the health and care system transition to digital platforms.
- 3.2 Failure to invest in a comprehensive digital system will increasingly impact on our ability to recruit and retain staff and to train students.
- 3.3 If the Health Board does not approve the Outline Business Case, there is a risk that we will not be able to access national resources to support implementation costs. Failure to implement a system may also result in BCUHB being the only Health Board that does not have a digital system in place for Community Services and the only Health Board in Wales that cannot contribute fully to the national Integrated Care Record.
- 3.4 The gross revenue gap highlighted at OBC stage will be refined during the development of the FBC. The Project Board will work to convert the level of identified productivity gains to cash-releasing as is necessary to ensure recurrent revenue affordability.
- 3.5 The implementation of the system also represents a significant opportunity to release capacity to support a shift of care from other settings to the community and meet the strategic intent of the Health Board.

4. RECOMMENDATIONS

- 4.1 The Board is asked to:
- **APPROVE** the Outline Business Case (**Appendix A** - attached separately) in its current context, noting the need to secure Digital Priorities Investment Fund / Welsh Government funding to cover implementation costs and that a recurrently affordable Full Business Case will be presented for full approval before contract award and implementation.
 - **APPROVE** the tender exercise to identify a preferred way forward for procurement, retaining the option for either a locally led or collaborative procurement with other Health Boards, noting that any subsequent contract award will be dependent upon a recurrently affordable Full Business Case.
 - **SUPPORT** the use of existing Health Board resources to develop the Full Business Case, with the agreement that the Full Business Case presented for

approval following formal procurement tender for the system will demonstrate and deliver recurrent affordability.

ASSESSMENT	
Link to Strategic Intentions	3. Improve Access, Outcomes and Experience
	The All-Ages Community Health Digital Solution directly supports BCUHB strategic priorities by: • Improving Quality and Safety of Care • Enabling real-time access to patient information, reducing clinical risk associated with fragmented and paper-based systems • Enhancing Patient Experience • Supporting more coordinated, joined-up care across community services • Supporting Workforce Sustainability • Reducing administrative burden, duplication, and inefficiencies associated with manual processes • Driving Digital Transformation • Contributing to the delivery of the Connecting Care Programme and wider digital ambitions
Design Principles	Digital First The proposed solution aligns with key design principles underpinning digital transformation within BCUHB: • Patient-Centred Care Systems designed to support seamless care across organisational and service boundaries • Interoperability Integration with national and local systems to enable information sharing across care settings • Standardisation Reduction in variation through consistent digital processes and workflows • Digital by Default

	Moving away from paper-based processes to improve efficiency, accuracy, and accessibility • Scalability and Future-Proofing Capability to expand and integrate with future services and technologies
Corporate Risks and Board Assurance Framework	The All-Ages Community Health Digital Solution directly contributes to the mitigation of a number of existing corporate risks captured within the Board Assurance Framework (BAF) and Corporate Risk Register (CRR). CR25-03 Population Need – additional control required) insufficient digital integration for community and neurodevelopmental services BAF 24-02 Not delivering strategic developments and digital transformation BAF 24-08 Not implementing evidence-based improvement and innovation At a service level: ID4905 (score 20): There is a risk that patient safety may be compromised due to the inability to access and maintain timely digital patient communication. This may be caused by a lack of integrated patient care records and has been subject to recent Regulation 28, Prevention of Future Death Reports, issued by HM Coroner, that a lack of digital patient records has contributed to patient death. This could lead to a continued pattern of lack of patient digital records being identified as a contributory factor in the review of serious incidents and at further Inquests.

**Wellbeing of Future
Generations Act – Wellbeing
Goals**

The proposal supports the Act's well-being goals as follows:

- **A Healthier Wales**
Improving health outcomes through better coordination and accessibility of care
- **A More Equal Wales**
Supporting equitable access to consistent, high-quality community services
- **A Prosperous Wales**
Driving efficiency and enabling better use of resources through digital transformation
- **A Resilient Wales**
Strengthening service resilience through modern, interoperable systems
- **A Wales of Cohesive Communities**
Supporting integrated, community-based care closer to home
- **A Globally Responsible Wales**
Reducing reliance on paper and supporting sustainable digital practices
- **A Wales of Vibrant Culture and Thriving Welsh Language**
Supporting bilingual service delivery through modern digital solutions where applicable

IMPACT ASSESSMENTS		
Equality <i>Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)</i>	Yes: ☒	No: ☐
	Outcome:	The assessment found an overall positive impact for protected groups, and that the programme will support the Health Board to improve both access and the patient experience through improved data collection and analysis, and to promote individualized, person-centred care. A number of minor potential negative impacts were identified, and these have been fully mitigated, with these mitigations documented in the assessment itself.
	If no, please include rationale:	
Socio-Economic Impact Assessment <i>Have you undertaken a Socio-Economic Impact Assessment</i>	Yes: ☒	No: ☐
	Outcome:	The assessment found an overall positive impact for protected groups, and that the programme will support the Health Board to improve both access and the patient experience through improved data collection and analysis, and to promote individualized, person-centred care. A number of minor potential negative impacts were identified, and these have been fully mitigated, with these mitigations documented in the assessment itself.
	If no, please include rationale:	
<u>Quality</u> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Enablers of Quality	Domains of Quality
	Too early to undertake at this stage.	Too early to undertake at this stage.

Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales	
Environmental /Sustainability Impact (5Rs)	No - Not Applicable	
Armed Forces Covenant Due Regard Duty Have you considered the Armed Forces Covenant Due Regard Duty?	Yes: ☒	No: ☐
	Outcome:	Community Health Service treat/support all patients including those that have been in the Armed service. The service considers the unique obligations of, and sacrifices made by, the Armed Forces. The system ultimately supports care and allows for the capture of information related to service and impact. The system would enable a patient's status as an Armed Forced veteran to be recorded, and care prioritised in line with the covenant.
	If no, please include rationale:	
Data Protection Impact Assessment <i>Have you undertaken a Data Protection Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome:	N/A
	If no, please include rationale:	Too early to undertake at this stage.
Counter Fraud Impact Assessment <i>Have you considered the counter fraud impacts</i>	Yes: ☐	No: ☒
	Outcome:	N/A
	If no, please include rationale:	Too early to undertake at this stage.
Legal	Yes (Include further detail below)	

	We will work with NWSSP to follow all relevant procurement legislation.
Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.
Resource Impact (People / Financial)	Yes (Include further detail below) The delivery of the programme will require a combination of national funding support and locally deployed resources to support procurement, implementation, and transition to business as usual. Workforce (People): A defined programme structure will be established, drawing on dedicated project, clinical, digital and operational roles. This will include: • Time-limited programme and implementation resources to support procurement, Full Business Case (FBC) development, system configuration, testing and deployment. Resources to support the procurement and FBC stage will be sourced internally. • Clinical and operational subject matter expertise to ensure safe design, pathway alignment and adoption • Digital, Data and Technology (DDaT) capacity to support integration, infrastructure, and ongoing system management Where possible, existing programme resources, including those aligned to the current Mental Health and Learning Disability digital programme and legacy system decommissioning, will be redeployed to reduce duplication and maximise value. Financial: The initial implementation costs are expected to be met through Welsh Government and Digital Health and Care Wales funding, subject to approval of the national business case. This will be clarified before FBC is submitted for Board approval.

	The OBC identifies an estimated ongoing revenue requirement associated with: • System licensing and supplier support costs • Ongoing DDaT and system administration capacity • Service-based digital support and optimization activity A forecast gross revenue gap of approximately £724k per annum from Year 4 has been identified. This will be refined through the FBC, including confirmation of supplier costs and operating model assumptions. Table 16 within the OBC demonstrates how this revenue gap will be fully addressed and resolved within the FBC., Affordability and Mitigation: The programme will actively pursue mitigation of the recurrent financial impact through: • Reinvestment of resources released through the decommissioning of legacy systems and reduction in paper-based processes • Opportunities to absorb increased service demand within existing workforce capacity through digital enablement • Realisation of productivity and efficiency benefits associated with reduced duplication, streamlined workflows, and improved information access



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University Health Board

All Ages Community Health

BCUHB Digital Solution

Outline Business Case

‘Finding a Community Health Digital Solution for people of all ages in North Wales,
transforming the way we provide care to save lives...’



Division / Area / Department	Primary Care & Community Services
Development or Scheme Title	All Ages Community Health
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Contents

Patient Story 1 – Fragmented Information and Unsafe Prescribing Risk	4
Patient Story 2 – Child Health, Lost Information and Clinical Risk	6
Patient Story 3 - Fragmented Systems and Poor Care Coordination Across Services	7
Patient Story 4 - Lack of Shared Records and Incomplete Clinical History in Complex Care	9
Staff Story 1 – Fragmented Records and Loss of Clinical Visibility.....	10
Staff Story 2 – Discharge, Duplication and Risk of Missed Care.....	11
Staff Story 3 – Community paediatrician - Fragmented Records and Time Lost Accessing Critical Information	12
Staff Story 4 - Lack of System Access and Delayed Clinical Decision-Making.....	13
1. Executive Summary.....	14
1.1 Introduction	14
1.2 Strategic Case	15
1.4 Commercial Case.....	17
1.5 Financial Case.....	18
1.6 Management Case	18
2. The Strategic Case	21
Part A: The Strategic Context.....	21
2.1 Organisational Overview	21
2.2 Current National Overview for Community Health, Mental Health and Social Care Systems – Connecting Care	21
2.3 Services Overview	22
2.3.1 In Scope	22
2.3.2 Out of Scope.....	23
2.4 Current Position, Business Strategy and Aims.....	23
2.4.1 Current Position	23
2.4.2 Business Strategy and Aims.....	24
2.5 Strategic Considerations.....	24
2.5.1 – National Strategies.....	25
2.5.2 - Local Strategies	26
Part B: The Case for Change.....	27
2.6 Project Aims	27
2.7 Investment Objectives.....	27
2.8 Business Needs – Current and Future	27
2.9 Strategic Case Conclusions	34
3. The Economic Case.....	36

3.1 Introduction	36
3.2 Long List Options.....	36
3.3 Critical Success Factors	37
3.4 Shortlisting	38
3.4.1 CSF Scoring Matrix	40
3.5 Detailed Shortlist Option Assessment	41
3.6 Economic Evaluation.....	42
3.7 Sensitivity Analysis.....	43
3.8 Preferred Option Statement.....	43
3.9 Economic Case Conclusions	43
4 The Commercial Case	45
4.1 Procurement Strategy.....	45
4.1.1 Procurement Options and Recommended Route	45
4.1.2 Procurement Timetable.....	46
4.1.3 Procurement Management	47
4.1.4 Evaluation Criteria	47
4.2 Framework Suppliers.....	48
4.3 Charging Mechanism	48
4.4 Contract Length.....	48
4.5 Outline Based Specification.....	48
4.6 Commercial Risks	49
4.7 Special Advisors	49
4.8 Stakeholders.....	49
4.9 Accountancy Treatment	50
4.10 Personnel Implications	50
4.11 Welsh Language Compliance (T9 Requirements)	50
4.12 Commercial Case Conclusions	51
5 The Financial Case	52
5.1 Revenue and Capital Costs	52
5.2 Financial Assumptions	52
5.3 Affordability and Source of Funding	53
5.3.1 Reducing the cost of investments	53
5.4 Financial Case Conclusions	54
6 The Management Case	56
6.1 Project Management and Governance	56
6.1.1 Project Management	56

6.1.2 Project Governance.....	56
6.2 Indicative Project Timelines	60
6.2.1 Change Management.....	60
6.2.2 Contract Management.....	61
6.3 Benefits Management	61
6.3.1 Benefits assumptions for Community Health	63
6.3.2 Quantifiable Benefits	66
6.3.3 Non-quantifiable Benefits	69
6.4 Risk management arrangements	72
6.5 Quality Assurance	73
6.6 Post-Project Evaluation	73
6.7 Equalities Impact Assessment and (EQIA) and Data Protection Impact Assessment (DPIA) ..	74
6.8 Current Risks/Issued with Mitigations.....	74
6.9 Assumptions, Constraints and Dependencies	75
6.10 The Management Case Conclusions.....	75
7. Conclusions and Recommendation	76
7.1 Conclusions	76
7.2 Recommendation.....	76
8 Declarations.....	78
9. Appendices	79

Patient Story 1 – Fragmented Information and Unsafe Prescribing Risk

A new patient to a care home was referred to the District Nursing (DN) team. The patient presented with significant skin integrity issues, including extensive blisters and wounds. The patient had already been reviewed by their GP and referred to dermatology. However, due to the absence of a shared electronic patient record, key clinical information was not readily accessible to all professionals involved in the patient's care.

The DN team were required to email clinical photographs separately to the Advanced Nurse Practitioners (ANP), as there was no shared system to view images. Historical photographs and clinical documentation held within GP records were not accessible to ANP or DN teams. This resulted in limited visibility of the progression of the patient's condition.

To gather essential background information, the clinician had to request a patient summary from the GP practice. While this contained core information, the referral letter to dermatology was not available to the ANP or DN Teams, nor was the plan Dermatology had recommended be followed. The DN team later were able to obtain an email from dermatology containing wound care guidance. However, this information was not centrally recorded or easily visible to all professionals, increasing the risk of inconsistent or delayed implementation of the treatment plan.

Further investigation via a separate hospital portal identified recent blood results, including antibody testing, but again required logging into a different system, adding to the time taken to build a complete clinical picture.

During assessment, the ANP identified a need to prescribe antibiotics. However, safe prescribing was delayed by the lack of immediate access to a complete allergy and medication history, requiring time-consuming checks across multiple systems. This increased both delay and potential risk.

Impact:

- Delayed clinical decision-making
- Increased risk of prescribing error
- Inconsistent implementation of treatment plans
- Significant time lost chasing information

Safety Risk:

Clinicians did not have access to a complete, real-time record at the point of care, increasing the risk of avoidable harm and delayed treatment.

Need for Change:

A shared digital record would provide immediate visibility of allergies, treatment plans and clinical history, enabling safe, timely decision-making and reducing risk of harm.

Patient Story 2 – Child Health, Lost Information and Clinical Risk

Sioned, a first-time mother in a rural area, relied on health visiting support following the birth of her daughter Lily. Key information about Lily's growth, feeding, and Sioned's mental health was recorded in handwritten health visitor notes and the Parent Held Record ("Red Book").

At 6 weeks, Sioned attended a GP appointment without the Red Book. As there was no shared access to health visitor records, the GP lacked critical information about Lily's slow weight gain and existing feeding plan. Sioned was unable to accurately recall details, creating a risk that care decisions were based on incomplete information.

A subsequent health visiting review identified ongoing poor weight gain and feeding difficulties. While liaison between services occurred, this relied on delayed communication rather than real-time information sharing, increasing the risk of late intervention.

When the Red Book was temporarily lost, key information—including immunisation status and prior assessments—was unavailable within clinical appointments at the GP practice over a three-month period. This created further risk around continuity of care and accurate clinical decision-making.

Although the book was eventually found, Sioned described feeling anxious that something important could have been lost permanently.

Following a house move when Lily was 6 months old, the time taken in transferring paper records meant the new health visiting team did not have immediate access to Lily's full history, increasing the potential for gaps in monitoring and risk identification.

Looking back, Sioned reflected:

"I believe that everyone supporting me tried their best to help—but systems in place made it harder. Electronic records would have made communication easier"

Impact:

- Incomplete clinical information available during GP appointments
- Delays in recognising ongoing weight and feeding concerns
- Reliance on parent recall to communicate clinical history
- Difficulty verifying immunisation status and previous interventions
- Increased anxiety for the parent due to risk of lost or missing information

Safety Risk:

Clinicians were making decisions without access to a complete, accurate record, increasing risk of:

- Missed or delayed identification of growth concerns
- Inconsistent feeding advice and care planning
- Safeguarding or health concerns not being visible across services
- Loss or delay of critical information during transfers between teams

Need for Change:

A shared digital child health record would provide real-time access to growth data, clinical notes, and care plans across GP and health visiting services, ensuring safe, consistent decision-making, improving continuity of care, and reducing reliance on paper records or parent recall.

Patient Story 3 - Fragmented Systems and Poor Care Coordination Across Services

Mrs J was admitted to hospital following a fall. While on the ward, she receives input from Occupational Therapy and Physiotherapy. On discharge, she also needs support from the District Nursing team for wound care.

A referral was sent electronically to the respective District Nursing generic email inbox and triaged by the Single Point of Access team. The referral was then entered onto the Digital scheduling system so that a visit could be arranged. During treatment, Mrs J's district nursing notes were kept as paper records in her home.

Mrs J needed a home visit from her GP. The clinical coordinator contacted the GP surgery to request the assessment. Clinical information such as blood tests, blood pressure, pulse, temperature, respiratory rate, oxygen saturations and level of consciousness had to be handed over verbally. The GP practice uses a different digital system, so this information was then entered separately into the GP record.

As Mrs J was struggling to manage at home and had care and support needs, the clinical coordinator completed a five-page SPOA referral for Social Services. As Mrs J was not previously known to the local authority, the information was entered onto a different digital system and sent onward to await allocation.

A separate paper referral was also completed for Tuag Adref, BCUHB's in-house community healthcare support worker service, so that support could be provided with activities of daily living such as washing, dressing, toileting and cooking. Tuag Adref then kept its own paper notes separately.

Mrs J needed some equipment to help her in her home. A paper referral was completed, scanned and sent for processing. There is no reliable audit trail within the current system. Mrs J experienced delays in obtaining her equipment as the staff member who raised the request was absent and the delay in the order was not picked up quickly.

The clinical coordinator also referred Mrs J to the medicines management team for a medication review because of her falls. The pharmacy accessed the GP digital system to carry out that review. Mrs J was then discussed at the daily Community Resource Team huddle, where key points were recorded on a separate spreadsheet. Further appointments continue to be managed through the DN Digital scheduling system. Once Mrs J was discharged from the District Nursing service, the paper notes were held in the DN Office and then sent for off-site storage after six months of no contact.

At present, the different professionals involved in the patient's care use different systems and different records. Therapies, district nursing, advanced nurse practitioners, GP, social care, palliative care, mental health and hospital services all hold information separately. Some information is digital some is paper-based, and some is recorded on local spreadsheets. This means there is no single shared view of the patient.

This creates a clear risk to safe and coordinated care. Important information may not be visible to the right professional at the right time. Staff may have to repeat data entry across multiple systems, rely on phone calls or handovers, and work around gaps in access to information. Patients may also need to repeat their story to different professionals because records are not shared effectively.

A shared digital record would support professionals involved in the patient's care to work from the same information. It would improve communication across teams, reduce duplication, support coordination of care, and make important clinical information more visible. It would also reduce the need for patients to repeat their story and help frontline staff spend less time chasing information that already exists elsewhere. Most importantly, it would help reduce the patient safety risks created by fragmented records and siloed working.

Impact:

- Delays in coordination of care across multiple teams and services
- Duplication of data entry across paper, digital systems, and spreadsheets
- Reliance on manual processes, phone calls, and email for information sharing
- Delays in equipment provision due to lack of tracking and audit
- Patients required to repeat their story to different professionals
- Significant clinical and administrative time spent managing fragmented information

Safety Risk:

Clinicians did not have access to a single, shared, real-time patient record, increasing risk of:

- Incomplete or inconsistent information being used for clinical decisions
- Missed or delayed interventions due to poor visibility of patient needs
- Communication failures across multidisciplinary teams
- Lack of audit trail for referrals and equipment requests
- Reduced ability to coordinate safe, timely care across services

Need for Change:

A shared digital record would enable all professionals to access and contribute to the same real-time patient information, improving coordination, reducing duplication, ensuring visibility of key clinical information, and supporting safer, more timely and joined-up care delivery.

Patient Story 4 - Lack of Shared Records and Incomplete Clinical History in Complex Care

A child with complex neuro-disability and epilepsy presented to ED following a prolonged seizure. Following the attendance, no information was made available to their community paediatrician, who became aware of the attendance when the child was next reviewed in clinic.

The child had a complex medication history. The disparate record keeping meant that there were significant difficulties in establishing timelines of previous prescriptions. This made it difficult for the child's Community Paediatrician to be certain what medication had previously been tried, to confirm the reasons why medication was changed, and, therefore, to make plans for managing the child's seizures going forward.

The same child was also reported to have had Genetic blood tests taken in 2024. The parent report that they had bloods taken themselves, however there are no results available in the notes. As genetic results don't appear on the Welsh Clinical Portal (WCP) and there is nothing in the notes, it was not possible to be sure whether all appropriate tests had been done. Obtaining this information required additional correspondence between clinicians and caused delays and prolonged uncertainty for the family, and also impacted on a timely, informed referral for tertiary neurology advice.

Impact:

- Lack of visibility of ED attendance for community clinicians
- Difficulty establishing accurate medication history and treatment timelines
- Delays in clinical decision-making for complex seizure management
- Additional time spent by clinicians chasing information across systems
- Delays in accessing investigation results and progressing specialist referrals
- Increased anxiety and uncertainty for the family

Safety Risk:

Clinicians did not have access to a complete, chronological patient record across care settings, increasing risk of:

- Inappropriate or duplicated prescribing due to incomplete medication history
- Missed or delayed diagnoses due to unavailable investigation results
- Duplication of tests and treatments
- Delayed escalation to specialist services
- Clinical decisions being made with incomplete or uncertain information

Need for Change:

A shared digital record would provide a single, longitudinal view of the patient's clinical history, including ED attendances, medications, and investigation results, enabling informed decision-making, reducing duplication, and supporting timely, coordinated care for complex patients across services.

Staff Story 1 – Fragmented Records and Loss of Clinical Visibility

When I first trained and worked in another NHS organisation, I experienced what a good digital system looks like. Every child and family had a single, structured electronic record. I could quickly see the full history—GP contacts, hospital attendances, care plans—and communicate easily with other professionals. I only needed to record information once, share it safely across records, and manage my workload efficiently, even when working in the community. It meant I could focus on families, not paperwork.

Moving into practice in North Wales, the contrast was stark. I found myself relying on paper records stored across multiple locations, with no single view of the child. To understand a child's needs, I often had to phone or email colleagues or even travel to collect notes. Information was duplicated, sometimes incomplete, and not always filed correctly.

"I know the information is out there somewhere—but it's not where I need it, when I need it."

This made it difficult to build a complete picture and slowed down decision-making. At times, I worried that important information might be missed, particularly when multiple professionals were involved or where there were safeguarding concerns. Manual documentation added further pressure—rewriting information, managing multiple records, and working around gaps in the system. It reduced the time I could spend with families and made it harder to provide the standard of care I know is possible.

"It's frustrating, and at times it makes you anxious—you feel like you don't have everything you need to make the safest decision."

This experience highlights how fragmented, paper-based systems create risk, delay care, and place unnecessary burden on staff. A shared digital record would transform this—giving immediate access to complete information, improving communication across services, reducing duplication, and enabling safer, more timely care for children and families.

Impact:

- Delays in building a complete picture of the child due to fragmented records
- Reliance on phone calls, emails, and travel to gather information
- Duplication of documentation and administrative workload
- Reduced time available for direct patient care
- Increased frustration and reduced confidence in delivering care

Safety Risk:

Clinicians did not have access to a complete, real-time patient record, increasing risk of:

- Missing or incomplete information impacting clinical decision-making
- Delays in identifying concerns, including safeguarding risks
- Inconsistent communication across multidisciplinary teams
- Reduced continuity and coordination of care
- Decisions being made without full visibility of patient history

Need for Change:

A shared digital record would provide immediate access to a single, complete and up-to-date patient record, enabling informed decision-making, improving communication across services, reducing duplication, and supporting safe, coordinated care delivery.

Staff Story 2 – Discharge, Duplication and Risk of Missed Care

David is an experienced District Nurse who relies on quick access to patient records to provide safe and timely care. Over time, archived paper notes have become increasingly difficult to manage and access. Storage boxes are damaged and collapsing, labels are unclear, and finding the right record can take far longer than it should. What used to be a simple task now causes delays, especially when urgent information is needed.

Across District Nursing bases, offices are filling up with archive boxes due to limited storage space. This is not just inconvenient, it's becoming unsafe. Staff are working around cluttered areas, lifting heavy boxes, and dealing with environments that increase the risk of trips and injuries, posing a health & safety risk for staff in bases.

The issue is now on the BCUHB risk register, but the day-to-day challenges remain. For David, it affects both patient care and staff wellbeing.

A digital community health record would mean information is safe, easy to access, and shared when needed. It would remove the risks linked to physical storage, reduce time spent searching for notes, and allow staff to focus on caring for patients instead of managing paper.

David wants a system that supports safe, efficient care where records are available when and where they are needed, without the burden of paper.

Impact:

- Repeated data entry and duplication
- Reliance on verbal handover
- Delayed or fragmented care coordination
- Patients repeating their story
- Equipment requests were also paper based with no clear audit trail, creating risk of delays not being identified.

Safety Risk:

Key information may not be available to the right professional at the right time, creating risk of:

- Missed or delayed care
- Incomplete care planning
- Failure to identify deterioration

Need for Change:

A shared digital record would provide a single, accurate view of the patient, improving coordination, reducing duplication and preventing gaps in care that create patient safety risk

Staff Story 3 – Community paediatrician - Fragmented Records and Time Lost Accessing Critical Information

Access to clinical information and the ability for my clinical information to be accessible to others is essential to provide safe and informed care for the children and young people in my care. The current systems simply don't support that.

One example is of a young person with complex additional needs that I reviewed in my clinic. There were significant on-going concerns that required a review of all previous investigations to determine

the most appropriate next steps. I requested their records which included their “special school file”, their “child health record” (which had to be requested from school nursing) and their pre-adoption records (two volumes which were in storage). This meant that information could not be immediately accessed and, once available, required several hours of consultant time to review all 4-5 volumes of notes filled. There were frequent duplications and documents filed out of order. With a digital system, information would be available in a timely fashion allowing efficient and safe decision making. It would also mean that information wouldn’t be scattered throughout services and storage risking essential information being missed. “

In my weekly practice access to and the handling of notes is very problematic. I had a clinic in Rhuddlan. After clinic I carried notes in my car to Rhyl for typing. I travelled from my office to the Community Children’s Centre in Llandudno to look at notes of siblings connected to a child I had seen in clinic. My plan was to do a thorough referral to Genetics with details of the siblings whom I have not met myself. When I looked through the notes there was a bundle of paper- continuation sheets and clinic letters loose in the front of the file. Information in the file is not filed in the correct order. I know that one sibling had blood investigations in the past but the information I was looking for (blood results particularly genetics) was not in the file. I suspect she has another file somewhere else! I will also collect my clinic notes and carry them to the office so that I can prepare for my next clinic. I feel like I spend quite a bit of time traveling to see notes/collect notes or drop off notes!”

Impact:

- Significant delays in accessing patient records held across multiple locations and services
- Extensive clinician time spent locating, transporting, and reviewing paper notes
- Difficulty identifying key clinical information due to disorganised and duplicated records
- Inefficient use of clinical time, including travel to retrieve and review notes
- Reduced time available for clinical decision-making and patient care

Safety Risk:

Clinicians did not have access to a complete, structured, and timely patient record, increasing risk of:

- Missing critical clinical information due to fragmented or misplaced records
- Delays in diagnosis and decision-making for complex cases
- Inaccurate or incomplete referrals due to unavailable information
- Increased likelihood of duplication of investigations
- Reduced ability to safely coordinate care across services

Need for Change:

A shared digital record would provide immediate, structured access to complete patient histories across services, reducing time spent locating information, improving accuracy, and enabling timely, informed clinical decision-making for complex patients.

Staff Story 4 - Lack of System Access and Delayed Clinical Decision-Making

During a recent case involving an elderly resident in an EMI care home, Advanced Nurse Practitioner Sally encountered significant delays in accessing essential clinical information due to the lack of direct EMIS access for ANPs. Without real-time visibility of the patient’s full medical history, current medications, allergies, and recent GP entries, Sally was dependent on practice administrative staff to manually send a patient summary before she could proceed safely. This created avoidable delays at a time when timely assessment was critical.

Sally was also unable to document her clinical findings directly into the GP record. Instead, she completed paper notes within the care home, which were uploaded several hours later. Further delays occurred while practices scanned these documents into the system. During this period, no record of Sally's visit was visible to the GP or to out-of-hours clinicians, who use the separate Adatastra system—another platform ANPs cannot access.

From the patient's perspective, this resulted in a fragmented and potentially unsafe experience. Clinicians involved in the resident's care, including Welsh ambulance were unable to see the most up-to-date information, increasing the risk of duplicated assessments, missed deterioration, and inconsistent decision-making. The coroner subsequently identified these IT barriers as a contributory factor in delayed communication and potential harm

Impact:

- Delays in clinical assessment due to lack of real-time access to GP records
- Reliance on administrative staff to provide patient summaries
- Inability to document directly into the clinical record, leading to paper-based workarounds
- Delayed visibility of clinical assessments to wider care teams
- Fragmented communication across GP, out-of-hours, and ambulance services

Safety Risk:

Clinicians did not have access to a complete, real-time shared record, increasing risk of:

- Delayed clinical decision-making in time-critical situations
- Prescribing errors due to lack of immediate access to medication and allergy history
- Missed deterioration due to lack of visibility of recent assessments
- Duplicated assessments and inconsistent decision-making across services
- Delayed communication contributing to potential harm (as identified by coroner)

Need for Change:

A shared digital record with direct access for ANPs would provide real-time visibility of patient history, medications, allergies, and clinical activity, enabling timely assessment, safe prescribing, and coordinated decision-making across GP, community, ambulance, and out-of-hours services.

1. Executive Summary

This Outline Business Case (OBC) sets out the case for Betsi Cadwaladr University Health Board (BCUHB) to progress a Community Health digital solution. The provision of this system will complete the local elements of the vision for community digital solutions committed to by the Health Board over a decade ago, as part of the Welsh Community Care Information System (WCCIS) Programme. While the proposed solution will integrate with national digital platforms and align with the Connecting Care programme, this remains a local business case. Ownership, delivery accountability, implementation decisions and benefit realisation sit with BCUHB, supported by national frameworks and funding where available.

1.1 Introduction

Community Health services within BCUHB currently operate across fragmented, predominantly paper-based systems, introducing significant clinical risk, inefficiencies, and barriers to integrated care delivery. These challenges directly impact patient safety, service quality, workforce sustainability, and regulatory compliance.

These challenges are evidenced throughout this OBC, including through patient and staff stories that demonstrate the real-world impact of disconnected records, manual processes, and delayed access to clinical information.

There is a corporate risk that has been identified which is pertinent to this OBC. ID4905 (score 20): *There is a risk that patient safety may be compromised due to the inability to access and maintain timely digital patient communication.*

This may be caused by a lack of integrated patient care records and has been subject to recent Regulation 28, Prevention of Future Death Reports, issued by HM Coroner, that a lack of digital patient records has contributed to patient death.

This could lead to a continued pattern of lack of patient digital records being identified as a contributory factor in the review of serious incidents and at further Inquests.

Approval of this business case and procurement of the community health system will go some way to mitigate this corporate risk

The OBC has been developed to fit the strategic direction of travel for Community Health digital transformation, confirm the high-level scope of services and requirements, and identify a preferred delivery approach to be taken forward to Full Business Case (FBC). At this stage, the OBC does not seek to confirm final or definitive supplier pricing or Health Board resources. Instead, it provides a structured qualitative assessment of credible delivery options using the latest available national and local cost assessments ~~risks~~, operational and financial achievability, and strategic fit.

This project will be delivered in full alignment with the All Ages MHL Digital Solution, ensuring a coherent and unified approach to digital transformation across Community, MH&LD and Children's services. As we progress to FBC and procurement, we will work closely with MH&LD colleagues, DDAT, DHCW and national architecture leads to assess interoperability options, agree shared priorities, and ensure that the Community Health solution complements rather than duplicates

existing or planned systems. This will include a clear cost–benefit assessment of integration approaches to ensure value for money and a simplified digital landscape for frontline teams.

Failure to proceed will result in continued patient safety risk, reduced service resilience, and inability to meet national digital and integrated care expectations.

1.2 Strategic Case

The Strategic Case demonstrates a clear and urgent need to modernise Community Health digital capability. Community services operate across complex, multi-agency pathways involving primary care, social care, mental health and wider partners. Despite the scale, complexity, and high-risk nature of these services (over 900,000 patient contacts annually), they remain largely paper-based, supported only by limited scheduling and activity systems that do not meet clinical or operational needs.

Paper-based workflows, inconsistent documentation, and limited access to shared records results in clinical risk and the potential for sub-optimal care. Failure to share appropriate information also introduces safeguarding risks, for both adult and children’s services. The lack of systems also reduces the organisation’s ability to meet national reporting requirements and to effectively use service data to inform service development and monitor and manage performance. These issues pose increasing risks as demand; service complexity and workforce pressures continue to grow.

Investment in a modern Community Health digital solution aligns strongly with national strategies, including A Healthier Wales, the Digital and Data Strategy for Health and Social Care, and the Welsh Government’s Connecting Care vision. It also enables the delivery of the Welsh Government’s vision of primary and community care led service offers, under the Community by Design Programme. At a local level, the programme supports BCUHB’s strategic goals to improve care quality, reduce variation, strengthen reporting, and deliver integrated, community-based services.

The project will be progressed in alignment with the All-Ages MH&LD Digital Solution, ensuring shared architectural principles, interoperability standards and co-ordinated prioritisation across both projects.

Across Wales Community and Mental Health services are progressing with the implementation of digital systems to support service delivery. Failure to progress this within BCUHB will leave the Health Board as an outlier, unable to contribute to the National Integrated Care Record and impact detrimentally on our work to implement the national Community by Design Programme.

The business case proposes implementing a modern, best-of-breed Community Health digital system that will replace paper-based records with real-time electronic health records (EHR) for community services. This will enable a single patient view across services and agencies and support multidisciplinary and multi-agency working. The work to implement the system will also result in business process redesign, standardising pathways and reducing unwarranted variation. The system will also enable integration with national systems and future shared care records.

The system will be used by 2,000 staff members, across adult and children's community services, including Community Paediatrics, Health Visiting, School Nursing, District Nursing, Palliative Care Nursing and Specialist Community Nursing services.

The programme is expected to deliver significant benefits including clinical safety improvements through real-time access to complete patient records; better care coordination via shared records and standardised workflows; efficiency gains by reducing duplication and administrative burden; improved compliance and reporting with structured, high-quality data; enhanced workforce experience and retention through the provision of modern digital tools and a reduction in safeguarding risks through timely and appropriate sharing of key information.

1.3 Economic Case

At this OBC stage of programme development, the purpose of the Economic Case is to set out the key options available and a high-level evaluation of each option.

The Health Board has 5 key Options for consideration at this stage:

Table 1: Summary of Options

	Option
Option 1	Do Nothing
Option 2	Include Community Health Records within the Health Board's core EHR OBC
Option 3	Test if Community Health Records can be included within the MHL D EHR Contract
Option 4a	Procure a Community Health Record individually through separate Invitation to Tender (ITT) and FBC
Option 4b	Procure a Community Health Record in partnership with another Health Board(s)
Option 5	Develop an internally built digital system specifically designed for BCUHB

At this current OBC stage the Health Board cannot formally evaluate actual supplier quotations, or the specific Health Board implementation and business as usual resource requirements based on the chosen system and supplier partner. It is therefore not possible at this stage to present a full Economic Appraisal comparison of all the possible options.

This OBC relies on Nationally estimated System Solution license costs, and resource funding availability as advised by DHCW in its National capacity. Following the DHCW site-visits with District Nursing and Health Visiting Teams, a range of benefits have been identified, and an assessment of the potential productivity and efficiency gains has been undertaken. The balance between productivity, efficiency and cash-releasing will be agreed during the FBC and through formal tender and discussions with the preferred system and supply partner. Other cash-releasing benefits (such as the decommissioning of existing systems) have been agreed with DDAT and Service Leads through the programme team and development of this OBC.

Detailed workshops have been held with DDAT, Adults and Children's Services to critically review and assess the level of Health Board resources required during the 3 key phases: procurement to FBC;

readiness and implementation; business as usual. These will be further refined and validated through the FBC and procurement stage, as the detailed system and supplier requirements and provisions are identified, assessed and evaluated. This will be done alongside the preferred system and supply partner and in the context of its integration and synergies with other Health Board EHRs.

The following table summarises the OBC-stage Economic assessment and assumptions (discounted net cumulative value) based on Procuring a Community Health Record system through formal tender (Options 4a and 4b), over a 10-year lifecycle. This will be refined and updated through the procurement and FBC stage.

Table 2: Breakdown Economic Assessment & Assumptions

Cost / Benefit Item	£000's
Supplier Costs	3,940
Health Board Revenue Costs	9,735
Risk & Bias	687
Total Costs	14,362
WG / DHCW Funding	(6,325)
Cash-releasing benefits	(3,579)
Non-cash-releasing benefits	(37,609)
Total Benefits	(47,513)
Net Cumulative Value (NCV)	(33,151)

Based on the information available at OBC stage, Options 4a and 4b are identified as *the preferable* approaches, with any financial benefits of the partnership procurement approach being realised through detailed commercial, financial and delivery analysis at Full Business Case stage.

1.4 Commercial Case

The Commercial Case confirms that BCUHB has viable and compliant procurement routes available to secure a Community Health digital solution. However, at this stage, the preferred commercial approach remains subject to further clarification and dependency resolution.

BCUHB is actively exploring the potential for a partnership procurement with Hywel Dda University Health Board (HDDUHB), recognising the possible benefits of collaboration. Progression on this route is dependent on HDDUHB confirming its appetite and ability to proceed jointly. In parallel, BCUHB retains the option to proceed with a locally led procurement should collaboration not be confirmed, ensuring that delivery is not unduly delayed. Final confirmation of the commercial route, procurement mechanism and contracting approach will be made and included within Full Business Case stage, informed by partner discussions, market engagement, affordability analysis and governance decisions.

1.5 Financial Case

The following table summarises the financial analysis at this OBC stage, to inform the management decision to move to Tender and FBC. This analysis is based upon intelligence from DHCW and Health Board services (DDAT, Adults, Children's services), and will be subject to full and critical review, challenge, and evaluation through the Tender and FBC process, as supplier pricing and implementation resources as well as business as usual resources are confirmed with the Preferred Supplier. This will result in a recurrently affordable FBC being presented for final approval.

Table 3 summarises the financial assessment and assumptions (ignoring inflation and RPI) based on procuring a Community Health Record system through formal tender, over a 10-year lifecycle.

Table 3: Breakdown Financial Assessment & Assumptions

Cost / Benefit Item	10-year total £000's
Supplier Costs	4,220
Health Board Revenue Costs	10,312
Risk & Bias	727
Total Costs	15,259
WG / DHCW Funding	(6,450)
Cash-releasing benefits	(3,892)
Total Benefits	(10,342)
Gross Revenue impact at OBC	4,917
Anticipated gains from Procurement Tender and conversion of efficiency and productivity into cash-releasing savings at FBC stage	(4,917)
Net Revenue impact at FBC	0

A detailed financial model, funding strategy and annual-affordability assessment will be developed at Full Business Case, following Tender evaluation and confirmation of actual resource requirements by the Supplier and the Health Board both within the Service and DDAT. This can only be done once a preferred supplier is identified, and the balance of work and resource inputs between the Supplier and the Health Board is confirmed.

1.6 Management Case

BCUHB has extensive experience delivering complex digital change programmes. The Management Case outlines the governance, leadership, user engagement, change management, and risk management arrangements necessary to implement a Community Health digital solution.

This includes:

- strong clinical leadership and SRO oversight.
- a dedicated programme team with multi-disciplinary representation (subject to funding approval at FBC stage).

- phased mobilisation and implementation planning aligned to national timelines.
- structured stakeholder engagement across adults' and children's community services.
- risk management, benefits management and quality assurance processes aligned with Health Board governance.

A detailed change management strategy will be co-designed with Community Health teams, recognising the scale of transformation required.

Project management DDAT will be underpinned by PRINCE2 principles and aligned to BCUHB's corporate approach.

A management structure comprising of a Project Board and Project Team would need to be identified with stated project roles and responsibilities ensuring governance arrangements align with Health Board standards for major digital programmes.

The project may choose to use Agile methodologies or within the constraints of PRINCE2 for specific work package activities in the project, like system build where an iterative and developmental process is required. This will be dependent on the implementation method of the supplier.

1.7 Overall Summary

Taken together, this OBC demonstrates a strong strategic, clinical and operational case for change. It provides a robust basis for progressing to Full Business Case (FBC) to finalise procurement arrangements and confirm recurrent affordability based on a tender and preferred system and supplier, and enable a safe, phased delivery of a modern Community Health digital solution.

1.8 Approval Route and Timescales

Indicative approval points are shown below. Dates will be confirmed following Executive endorsement and FBC planning.

Table 4: OBC Approval Route

Date	Approval
19/05/2026	Local BCU Connecting Care Project Board outside of meeting via voting functionality
26/05/2026	Operational Leadership Team
26/05/2026	DDaT Senior Leadership Team
03/06/2026	Executive Team
17/06/2026	Executive Team
23/06/2026	Performance, Finance & Information Governance Committee
30/07/2026	Health Board
September 2026	Welsh Government

End of Executive Summary

2. The Strategic Case

Part A: The Strategic Context

2.1 Organisational Overview

Betsi Cadwaladr University Health Board (BCUHB) is the largest health organisation in Wales, providing primary, community, mental health and acute services to more than 700,000 people across the six counties of North Wales. Services are delivered across three Integrated Health Communities (IHCs) and are supported by extensive regional partnerships with local authorities, GP practices, schools, third-sector organisations and specialist services.

BCUHB operates numerous community teams including District Nursing, Children's Community Services, Complex Care, Community Palliative Care, School Nursing, Health Visiting, and a range of specialist adult and children's services. These services rely on coordinated multi-agency delivery models and operate across multiple bases, clinics, community hospitals and partnership settings.

2.2 Current National Overview for Community Health, Mental Health and Social Care Systems – Connecting Care

The Welsh Community Care Information Solution (WCCIS) programme has been replaced by Connecting Care, a Welsh Government mandated programme introduced in 2023, to procure and implement best-of-breed systems for Community Health, Mental Health and Social Care. These systems will support service delivery and feed into to a shared care record, being developed by DHCW, to support the delivery of integrated, multi-agency care. Its objectives include:

- delivering improved shared care records.
- procuring market-leading digital solutions.
- improving data standards; and
- supporting integrated digital care across agencies.

In line with the national programme requirements, BCUHB has submitted the anticipated costs of implementation costs to DHCW. These have been incorporated into the national business case, submitted by DHCW to Welsh Government for the funding required to support the implementation costs in each Health Board. A decision is awaited.

Due to the significant risks relating to the lack of digital records within Mental Health & LD services, the Health Board took the decision to progress the case for mental health digitisation in advance of the national business case. The progression of the remaining Community Health elements remains dependent upon confirmation of WG support for implementation costs.

The figure below illustrates the ideal future state of best of breed systems linking to shared care record.

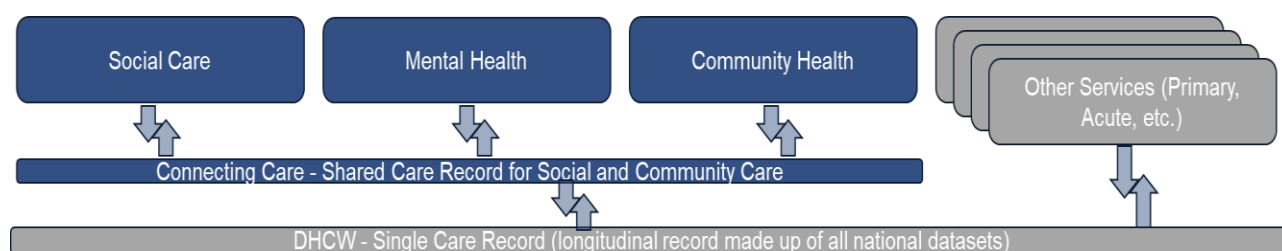


Fig 1. Best of Breed systems linking to Shared care record

2.3 Services Overview

2.3.1 In Scope

The scope for Community Health includes a wide range of adult and children's community teams covering clinical nursing, specialist conditions and public health functions. This scope was agreed by the BCUHC Electronic Health Record Programme Board in May 2025. These include:

Table 5: In Scope Services

Community Nursing
• District Nursing • Complex Care Teams • Tissue Viability Nursing • Continence Nursing • Lymphoedema Nursing • Community Palliative Care Nursing* • Continuing Health Care* • Community Complex Conditions* (Aligned to cover all specialities) • Stroke Prevention Nurses
(Note: Community Midwives will be covered in the scope of Digital Maternity System (DMS))
Children's Community Services
• Health Visiting (including Specialist HV posts) • School Nursing • Community Children's Nursing • Community Specialist Nurses -Aligned to cover all specialities • Community Paediatrics* • Children's Palliative Care Medical* • Children's Continuing Care* • Children Looked After
(Note: CAMHS Practitioner - Children Looked After, Neurodevelopment Services and Children's Learning Disabilities Services are all included in MH Scope)
* Required in addition to the service scope within the Connecting Care OBC

A planning assumption of 2,000 users has been used based on existing staff headcount. Final user volumes and licensing models (including concurrent and read-only access) will be defined through the formal procurement process.

2.3.2 Out of Scope

Community Midwifery, Children's mental health pathways, and Therapies are currently out of scope, as these services are within the scope of other designated systems, the Digital Maternity System, Mental Health All Ages System and Therapy Manager replacement respectively.

Table 6: Out of Scope Services

Out of Scope
○ CAMHS practitioners -Children Looked After (CAMHS Practitioners
○ Neurodevelopment Services
○ Children's Learning Disabilities
○ Community Midwives
○ Therapy Services

2.4 Current Position, Business Strategy and Aims

2.4.1 Current Position

The Community Health Services using the proposed digital system provide cradle to grave services across North Wales, collectively delivering over 900,000 patient contacts each year. They provide essential and often high-risk services, promoting health and wellbeing, supporting families and carers, caring for patients who are vulnerable, managing challenging safeguarding issues, working across agencies and sectors and supporting people at the end of their lives.

Despite this, these services remain predominantly paper-based, with core functions such as referral management, care planning, caseload management, assessments, clinical records and risk documentation all recorded manually. The systems available to them, the CIVICA scheduling system and CYPRIS, have been implemented to support the scheduling of their work and to record some activity, and do not support wider service delivery.

These services were within the scope of the national WCCIS Programme, which the Health Board committed to over a decade ago. However, after prolonged attempts to deliver the programme, local prototype testing demonstrated that the system was not fit for purpose and the nationally procured WCCIS product, CareDirector, did not meet the services' needs. The national WCCIS Programme ceased in 2023, moving to a different approach under the current Connecting Care Programme described above.

Data collection for mandated national reporting (e.g., Minimum Data Set, Enhanced Community Care indicators, Healthy Child Wales Programme metrics) is heavily reliant on manual spreadsheets, workarounds and systems not designed for clinical or operational reporting (e.g., Civica scheduling), resulting in inconsistent, incomplete and labour-intensive processes. Some WG data requirements, for example the number of referrals to District Nursing services, response times, and the length of stay in our Enhanced Community Care (virtual ward) services cannot be reported currently due to the absence of digital capture.

Across the three IHCs, service configuration, local partnerships and care models vary significantly. This variation leads to heterogeneous data requirements, inconsistent workflows and additional complexity when attempting to standardise practice digitally.

2.4.2 Business Strategy and Aims

BCUHB aims to deliver digitally enabled, integrated community care aligned with national and local priorities. The strategic aims include:

- improving quality, safety and timeliness of care.
- enabling multidisciplinary and multi-agency working.
- reducing unwarranted variation across geographic areas.
- strengthening national reporting and analytics.
- and preparing the organisation for participation in a future Integrated Care Record (ICR).

Digital transformation is therefore essential to achieve these aims and to support new care models reliant on shared, real-time information across organisational boundaries.

2.5 Strategic Considerations

The following diagrams summarise the current strategic landscape for Children & Young People and Adult Services:

Children & Young People

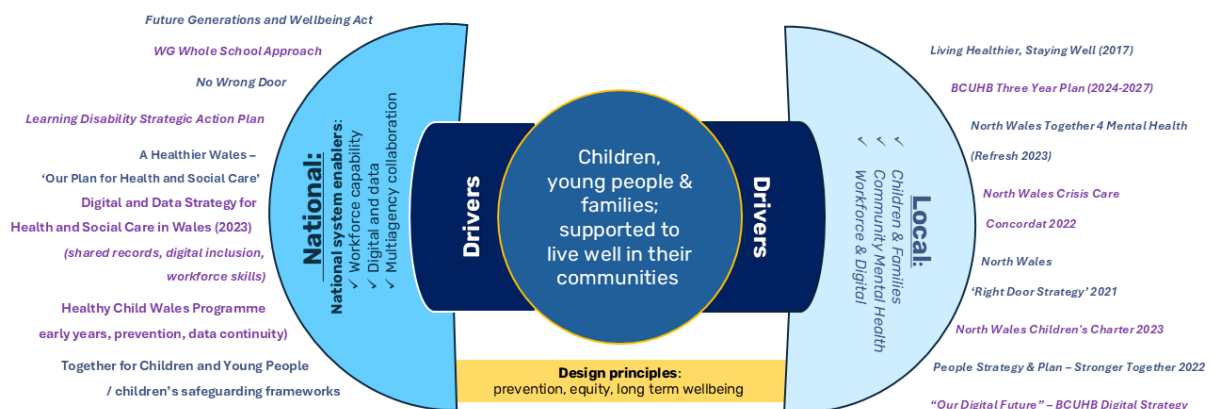


Fig 2: Current strategic landscape - Children's & Young People

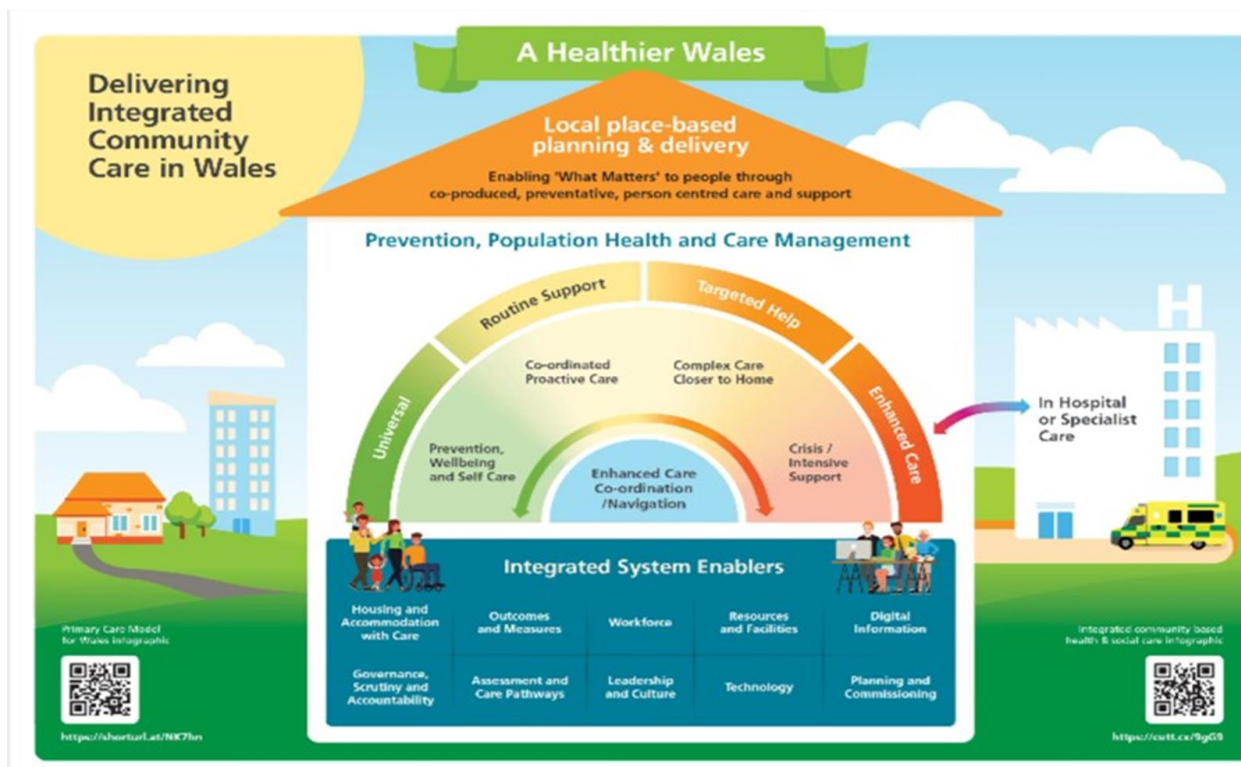


Figure 3: A Healthier Wales – Integrated Community Care

Multi—agency and multi-sector working



Figure 4: Multi-agency collaboration

There is a need within BCUHB to balance a wide range of clinical and operational requirements from services with long-established but ageing digital systems that are deeply embedded across multiple areas, to those under increasing pressure to digitise critical systems and processes for the first time.

This creates a complex service ecosystem with significant overlap across the Health Board's core areas, including mental health, community health, and social care. Integrated teams deliver blended services, and all services work closely with primary care.

2.5.1 – National Strategies

Community Health digital transformation directly supports multiple Welsh Government strategies and frameworks, including:

- **A Healthier Wales**, which identifies digital as a key enabler of integrated, person-centred care.
- the **Digital and Data Strategy for Health and Social Care**, emphasising modern digital platforms, improved data quality and enhanced information sharing.
- national ambitions for a Wales-wide **Integrated Care Record**, incorporating shared access across health and social care settings.
- National Clinical Framework (2021) ([National Clinical Framework 8.0 \(gov.wales\)](#)) – references integrated digital system to deliver safe, seamless Healthcare outcomes.
- **Community By Design Transformation Programme**, led by the Chief Medical Officer, delivering more care outside hospital, increasing complexity and timeliness across Prevention, management of long-term conditions and urgent and same day care

The Connecting Care programme is a central strategic driver for Community Health digital investment and provides the national strategy and support for procuring best-of-breed Community Health systems.

2.5.2 - Local Strategies

At Health Board level, Community Health digital transformation aligns with:

- the **BCUHB Three Year Plan**, which prioritises a Focus on Health & Wellbeing, Enhanced Coordination of Care, Improved Access to Services and a Modern, People Centred Healthcare System and emphasises the essential delivery of community-based care.
- the **‘Our Digital Future’**, emphasising the need to modernise digital infrastructure and improve digital maturity.
- local partnership strategies requiring improved data sharing and integrated working with local authorities, schools, and primary care.

The strategic direction is therefore clear: without digital transformation, BCUHB cannot fully deliver its local service improvement commitments or meet regional partnership expectations.

Part B: The Case for Change

2.6 Project Aims

The key aims of this project are to:

- implement a modern, fit-for-purpose digital solution to replace paper-based workflows.
- provide real-time access to patient information across Community Health teams and partner organisations.
- support integrated, multidisciplinary and multi-agency working.
- standardise pathways and reduce unwarranted variation across IHCs.
- strengthen patient safety and reduce operational risk.
- improve the experience of patients, carers and staff.
- have a Patient Administration System (PAS) and an Electronic Health Record (EHR) working efficiently across BCUHB; improve data quality, completeness and ability to meet national reporting.
- Reduce the Information Governance risks inherent in our existing systems.

Successful delivery of the programme will require a strong focus on change management and user adoption. A structured approach will be implemented, including stakeholder engagement, communication, training, and ongoing support. Digital maturity and workforce readiness will be assessed to ensure adoption is maximised and benefits are realised at the earliest opportunity.

2.7 Investment Objectives

Investment Objectives set out the outcomes we are trying to achieve by reflecting on our existing arrangements and business needs, these have been listed below:

1. Improve clinical quality and safety through timely access to accurate records.
2. Support consistent, evidence-based decision-making and standardised practice.
3. Enhance operational efficiency, productivity and accountability.
4. Enable personalised care, prevention and early intervention.
5. Deliver user-friendly, accessible digital tools.
6. Build a digitally enabled workforce.
7. Support effective interoperability across partners and systems.
8. Enable responsiveness to business change and service improvement.
9. Ensure compliance with cybersafe and sustainable technology standards.
10. Comprehensive functionality within the new system to enable the retirement of certain legacy systems, thereby releasing cash benefits to ensure recurrent system affordability.

2.8 Business Needs – Current and Future

Community Health urgently requires a digital solution that:

- provides a holistic, contemporaneous view of patients across pathways and agencies.
- enables national reporting requirements (MDS, ECC, children's datasets).
- supports a Patient Administration System (PAS) and an Electronic Health Record (EHR) working efficiently across Community and Secondary Care in BCUHB.

- reduces duplication and manual processes.
- supports improved service planning, benchmarking and quality assurance through reporting and Business Intelligence.
- improves staff experience, recruitment and retention by providing modern tools.
- prepares the Health Board for future digital integration across Wales.
- Enabling improved consistency and alignment of working practices across community-based services within BCUHB

To meet these needs, the Community Health Digital Solution must be developed in close collaboration with MH&LD and Children's colleagues, DDaT, DHCW and National Architecture teams. This will ensure that interoperability options and priorities are worked through collectively, that information can flow safely and efficiently across services, and that the chosen approach reduces duplication, supports shared workflows and contributes to a simplified digital landscape across BCUHB. Consideration of the cost, benefit and operational impact of different integration approaches will be essential to ensuring value for money and long-term sustainability.

2.10 Scope and Service Requirements

2.10.1 In Scope

The scope of the Community digital solution must cover all adult and children's Community Health services listed in Section 2.3, alongside:

- digital capture of live patient records.
- alignment with national Connecting Care functional requirements.
- integration with local and national systems
- standardisation of working practices across community-based working within BCUHB
- support for multi-agency working in community settings.
- Capability to capture Patient/Person or Parental Consents, especially for vaccinations.
- Digital infrastructure assessment to ensure current estate facilitates use of digital systems
- Inclusion of break glass functionality to ensure safe management of restricted information
- Provide comprehensive scheduling and caseload management capabilities, enabling community teams to plan, allocate, and co-ordinate visits and workload effectively. Support standard clinical documentation through configurable templates for assessments, care plans, risk tools, and other community-based clinical records.
- Must enable robust safeguarding workflows, including the capture, visibility and management of safeguarding concerns, alerts, and multi-agency information sharing requirements.

In addition to core functional requirements, the solution must also meet key non-functional requirements, including:

- usability and performance appropriate for mobile, community-based working, including offline capability where required.

- resilience, availability and disaster recovery arrangements consistent with clinical safety requirements.
- scalability to support future service growth and organisational change.
- Full support for clinical safety processes, including the creation and maintenance of a safety case and hazard log in line with DCB0129/0160 requirements.
- seamless interoperability by adopting national data standards such as FHIR-based API's, utilising accredited demographic services, and supporting secure, structured information exchange with local and national partner systems.

In addition to the above, the national Connecting Care Programme has set out the following scope of requirements to be included within solutions across Community Services:

- Single view of the patient.
- Effective and efficient clinical workflow.
- Fully integrated applications.
- Intelligent worklists/scheduling capability.
- Multi-Disciplinary Team solution(s).
- Clinical decision support.
- Full audit trails.
- Structured reporting capability.
- Business Intelligence Capacity in the agreement to support business change and growth.
- Product innovation and technical development incorporated over its lifetime of the contract.

The solution must also meet NHS Wales information governance, cyber-security and clinical safety requirements, including:

- Compliance with UK General Data Protection Regulation (UK GDPR) and NHS Wales Information Governance standards.
- Role - based access controls and appropriate information sharing arrangements to support multiagency working.
- Records management, data retention and audit functionality consistent with statutory and professional requirements.
- Compliance with relevant clinical safety standards (including DCB0129 / DCB0160 or Welsh equivalents).

The solution must also support bilingual (Welsh and English) use in line with Welsh Language Standards and meet accessibility requirements to ensure inclusive use across the workforce.

The solution must have interoperability with national solutions, including:

- (a) National Active Directory("NADEX").
- (b) Welsh Clinical Portal ("WCP").
- (c) Welsh Results and Reports Service ("WRRS").
- (d) Welsh Demographic Service ("WDS").

- (e) Welsh Reference Data Service (“WRDS”).
- (f) Electronic Master Patient Index (“eMPI”).
- (g) Welsh Patient Administration System (“WPAS”).
- (h) Welsh Immunisation System (“WIS”).
- (i) Welsh Nursing Care Record (“WNCR”).
- (j) Welsh Nursing Care Record Paeds (“WNCR”).
- (k) Welsh Patient Referral System (WPRS)
- (l) Mosaic (The Local Authority Social Care system across North Wales)
- (m) Electronic Prescribing Medicines Administration (ePMA) Primary Care Electronic Prescribing
- (n) Picture Archiving and Communication System (PACS)
- (o) Radiology Information System (RIS)
- (p) BadgerNet

The solution must have integration and interoperability with new Social Care solutions, including where appropriate:

- secure information sharing to support joint working across Health and Social Care.
- interoperability that enables shared access to relevant care information, subject to information governance requirements.
- alignment with emerging national standards and architectures for Social Care systems in Wales.
- flexibility to integrate with future Social Care digital solutions as they are procured or developed.

The new Community Health System must also be able to interoperate with existing national digital solutions, while adhering to established national standards and architectural principles. In addition, it must integrate effectively with systems that are currently hosted and managed by BCUHB.

Children’s Services operate the Child Health System, CYPrIS. This system is used to support the delivery of the Healthy Child Wales Programme and is the source for our reporting to Welsh Government. A team within Children & Young People’s Services manage the system. In line with BCUHB’s digital strategy of Digital first’ to consolidate the use of multiple legacy systems where possible and functionality would be expected to be replaced by the proposed community health system.

Given this, the recommended approach at this stage is to focus on enabling robust integration between the new Community System and both national and BCUHB-hosted/managed systems. The below illustrates the different clinical systems that would feed into or be replaced by the new Community Health System. This will need to be finalised as we move to Full Business Case.

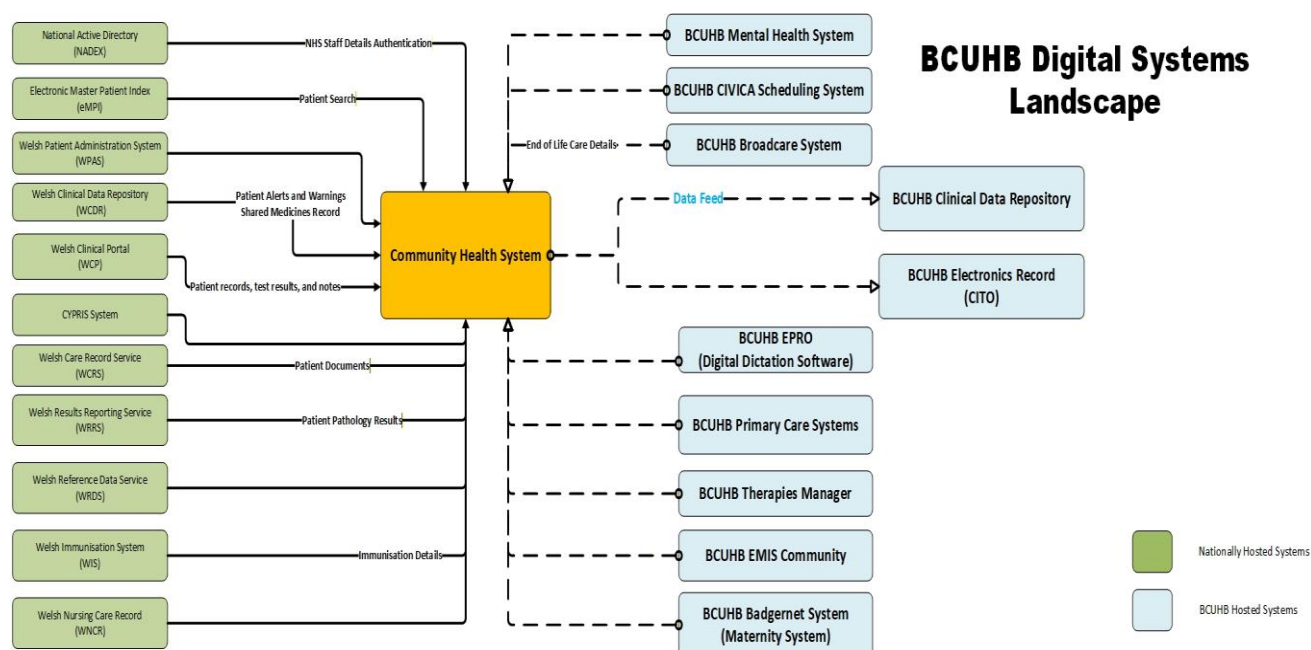


Figure 5: Community Health System data input

The National Requirements for a Community System have been developed and agreed by Health Boards across Wales, in collaboration with the national Connecting Care Programme, and have been formally agreed and accepted as a 'core set' of national requirements. All Health Boards have agreed to use these requirements as a consistent set of core requirements, with the acknowledgement that certain local amendments and nuances may need to be added.

These requirements cover all key aspects of a Community Health System, including technical specifications, data requirements, functional requirements, and non-functional requirements, ensuring a comprehensive framework to support the procurement and implementation of a digital community system.

The full set of National requirements for Community and Mental Health systems is included in the appendices below for reference. ([Appendix H](#))

Engagement has been undertaken with BCUHB children's and adult service leads to gather key insights to inform the development of the new Community System. This included identifying the services and staff groups who will use the system, along with associated headcount and the locations of staff bases. Current working practices were reviewed, including record-keeping processes, storage arrangements for paper notes (covering volume, location, and cost), and existing process mapping.

Discussions also explored current systems and processes, including whether these will be replaced by the proposed BCUHB Community Health System or require integration with the new solution, and the potential impacts of either approach. Key risks associated with current paper-based and fragmented working arrangements were identified, alongside anticipated benefits of moving to a digital system, such as improved efficiency, accessibility, and patient safety. Consideration has also been given to how the new system will enable effective collaboration and input from medical staff.

Further detail is provided in the appendices (Children and Adults requirements) - [Appendix D & E](#)

2.10.2 Out of Scope

Out-of-scope areas are also clearly defined (e.g., Community Midwifery, externally commissioned services), alongside:

Connecting Care objectives for Community Health that sit within and will be delivered through the national Connecting Care Programme ([Appendix K](#))

- HMP Berwyn (use their own system – ‘SystmOne’) Integration with System One (HMP Berwyn) is considered out of scope due to limited interaction and minimal operational dependency
- Archiving of legacy paper records
- Digitising of legacy paper records
- Externally commissioned services – NHS and Non-NHS Services
- Continuing Health Care (use their own specialist system – Broadcare)
- Twinkle specialist diabetes system for Children & Young People

2.11 Risks

Indicative Key risks include:

- lack of national funding to support implementation costs
- supplier capacity constraints.
- local resource risks.
- digitisation and management of live paper records.
- variation across IHCs that may impede standardisation.
- current lack of digital skills and training needs across teams.
- infrastructure gaps affecting mobile and community-based working
- Need for agreement to move from CYPriS and CIVICA to new Community Health System for reporting.

2.12 Main Benefits

Indicative high-level benefit categories include:

- improved quality and safety.
- improved regulatory compliance and reporting.
- increased efficiency, productivity and time to care.
- improved patient, carer and staff experience.
- reduced carbon footprint; Improved sharing of information between multi-disciplinary team members
- reduced preventable harm, litigation and serious incidents.
- Cash-releasing benefits that fully support the level of investment required

The table below provides a summary of how the key benefits associated with the Community Health digital solution directly mitigate identified organisational, clinical and operational risks. This includes

alignment to the corporate risk relating to patient safety associated with fragmented records and lack of timely access to information.

Table 7: Digital System Benefits mitigating risks

Risk Area	Key Risks Identified	Relevant Benefits	How the Benefit Mitigates Risk
Patient Safety & Clinical Risk	- Incomplete or inaccessible patient records - Delays in diagnosis, treatment and prescribing - Risk of clinical error	- Real-time access to complete patient records - Clinical decision support (alerts, allergies, history) - Reduction in clinical incidents and errors	Ensures clinicians have accurate, up-to-date information at the point of care, improving decision-making, reducing delays in treatment, and minimising the risk of patient harm.
Fragmented Care & Poor Coordination	- Disconnected systems across services - Inconsistent care planning - Communication failures between MDTs	- Integrated shared care record - Improved MDT communication - Standardised documentation and workflows	Enables all professionals to access and contribute to a single, shared record, improving coordination, reducing duplication, and ensuring continuity of care across services.
Operational Inefficiency & Workforce Pressure	- Time spent searching for information - Duplication of data entry - Reduced clinical time and workforce strain	- Time savings through reduced administrative burden - Mobile working capabilities - Automated workflows and data capture	Reduces administrative burden and duplication, releasing clinical time, improving productivity, and mitigating workforce capacity risks. Facilitates the delivery of cash-releasing savings to ensure recurrent affordability.
Governance, Reporting & Compliance Risk	- Inability to meet national reporting requirements - Poor data quality and auditability - Risk of regulatory non-compliance	- Improved data quality and standardisation - Enhanced reporting and analytics - Full audit trails and traceability	Provides structured, reliable data and reporting capability, improving regulatory compliance, audit readiness, and organisational oversight.
Patient, Carer & Staff Experience Risk	- Poor patient and family experience - Staff dissatisfaction and retention challenges - Risks associated with paper-based records	- Improved patient and carer experience - Enhanced staff usability and digital tools - Reduction in paper processes	Improves communication, reduces repetition for patients, and enables safer, more efficient working practices, improving both patient and staff experience.
Organisational & Financial Risk	- Increased risk of serious incidents and litigation - Inefficient use of resources - Rising operational costs	- Reduction in preventable harm and litigation - Efficiency and productivity gains - Reduction in paper, storage, and travel costs	Reduces avoidable incidents and associated costs while improving resource utilisation and supporting long-term financial sustainability. Delivers cash-releasing savings to ensure recurrent system affordability

Collectively, these benefits address the root causes of current organisational risk, including fragmented systems, reliance on paper records, and limited access to timely and accurate patient information. By enabling a single, integrated digital record and improving efficiency, governance,

and user experience, the proposed solution will significantly reduce clinical, operational, and compliance risks.

The high-level benefit and risk categories outlined at this OBC stage will be subject to further development and refinement at the Full Business Case (FBC) stage, ensuring they comprehensively reflect the project's objectives and requirements.

2.13 Digital and IT

The following technical standards and requirements are mandated in the national technical authority of requirements schedule which, where applicable, will see the Community Health digital system able to integrate with both National and Local system. This must align with national technical standards, including:

- HL7 FHIR,
- SNOMED CT UK,
- national APIs and interoperability standards, ([Appendix C](#))
- national data standards,
- Cloud first architecture aligned with the All-Wales Infrastructure Programme.
- Principles of Open Standards and Open Architecture,

Further work is needed to understand and define what is required for prescribing. Any inclusion of prescribing requirements will need to adhere to the DSCN (Data Standard Change Notice) 2022/76 medicines and interoperability standards. Data migration requirements will become clearer once the functionality of the procured system is clarified and will ultimately be decided by project board. The assumption that all data needed for clinically and operationally safe continuity of care at Go-Live will be migrated. A detailed Data Migration Approach and plan will be developed. Identified infrastructure gaps include WIFI coverage and device readiness, both of which are being addressed through wider Digital, Data and Technology (DDaT) programmes.

A comprehensive integration scope will be defined at Full Business Case stage; however, provision for integration costs has been included within this OBC.

2.9 Strategic Case Conclusions

The Strategic Case demonstrates:

- clear alignment with national and local strategies.
- longstanding and significant operational, clinical and safeguarding risks caused by paper-based Community Health services.
- insufficient ability to meet national reporting requirements.
- strong drivers for modern, integrated digital workflows.

- and the need for investment to deliver safe, standardised and efficient community-based care.

Without this transformation, Community Health Services will continue to face increased risk, inefficiency and variation. The strategic justification for a digital solution is therefore compelling and urgent.

3. The Economic Case

3.1 Introduction

At Outline Business Case (OBC) stage, the purpose of the Economic Case is to support identification of the option that is most likely to offer value for money and to prepare the scheme for procurement. This is achieved through a qualitative comparison of options based on expected costs, benefits and risks, recognising that validated cost data, quantified benefits and formal economic modelling will be developed through formal procurement tender at Full Business Case (FBC) stage.

The Economic Case assesses the available options for delivering a sustainable digital solution for Community Health Services and determines which approach offers the greatest value for money. The appraisal uses the Investment Objectives set out in the Strategic Case and Critical Success Factors (CSFs) below comparing each option in terms of benefits, risks, affordability and achievability.

Given that the Health Board cannot formally evaluate actual supplier quotations, Health Board implementation and business as usual resource requirements, it is not possible at this stage to present a full Economic Appraisal as would be expected in a typical Outline Business Case. However, the economic appraisal does focus on options based on nationally and locally identified costs and benefits, and the rationale for progressing to the next stage (FBC) at which point a full economic and financial appraisal will be developed once formally tendered commercial and delivery information is available.

3.2 Long List Options

The following table shows the list of options that have been considered at this stage.

Table 8: Options Appraisal – Long List options

	Options
Option 1	Do Nothing
Option 2	Include Community Health Records within the Health Board's core EHR OBC
Option 3	Test if Community Health Records can be included within the MHL EHR Contract
Option 4a	Procure a Community Health Record individually through separate Invitation to Tender (ITT) and FBC
Option 4b	Procure a Community Health Record in partnership with another Health Board(s)
Option 5	Develop an internally built digital system specifically designed for BCUHB

During initial filtering:

- **Option 1 – Do Nothing**
Eliminated/discounted as Community Health Services cannot continue without a clear digital roadmap. Maintaining the current position presents significant clinical, operational, and governance risks and is contrary to national policy for the implementation of best of breed Digital Community Systems, feeding into an Integrated Care Record.
- **Option 2 – Include within Community Health Records within the HB's Core EHR OBC**
The Health Board's EHR Programme Board considered the desired scope of the Proposed Core EHR. Following an option appraisal, it concluded that All Ages Community Health and Mental Health were outside the scope of the core EHR. Even if this scope were to change, the core EHR

programme is not currently able to prioritise or deliver a Community Health Record solution within the timeframe needed to address existing risks. In addition, progression of the Core EHR programme is currently paused pending the development of a Welsh Government national roadmap. As a result, the future scope, sequencing and delivery timelines for Community Health Record functionality remain uncertain.

- **Option 3 – Test Inclusion of Community Health Records within the MHL D EHR Contract**

Eliminated/discounted as the MHL D procurement did not specify these services and an increase in circa 2,000 users is in excess of any increases outlined in the procurement process. Amending a formally tendered contract could risk non-compliance with procurement regulations.

- **Option 5 - Develop an Internally Built, Bespoke Digital System for BCUHB**

Eliminated/discounted as this approach is not achievable within the organisation's available technical capacity, funding envelope, or required timescales. A bespoke build would also introduce long-term sustainability and maintenance challenges.

The following Options are considered the most preferable and viable for moving to FBC stage:

- **Option 4a** – Procure a Community Health Record individually through separate Tender
- **Option 4b** – Procure a Community Health Record in partnership with another Health Board(s)

The options appraisal demonstrates that Options 4a and 4b provide the strongest alignment to the programme's critical success factors, offering a balance between strategic fit, deliverability, and user benefit. Lower-cost options fail to adequately address the identified risks, while more complex options introduce unnecessary delivery risk at this stage. The preferred option therefore represents the most viable and proportionate investment.

3.3 Critical Success Factors

Key Critical Success Factors (CSFs) have been identified as the attributes essential for successful delivery of the project, against which the initial assessment of the options for the delivery of the project will be appraised.

Assessment against the Critical Success Factors at OBC stage is indicative and based on existing programme knowledge, stakeholder input and professional judgement. At this stage, CSF scoring is not supported by supplier evidence or confirmed cost data and is intended to support relative comparison of options only. Final scoring will be confirmed at Full Business Case and procurement stages.

Table 9: Critical Success Factors for Community Health Digital System

	Critical Success Factor	Description
CSF 1	Strategic fit and business needs	How well the option meets the strategic context, programme scope and objectives, related business needs and service requirements

CSF 2	Potential value for money	How well the option optimises economic value (social, economic, and environmental), in terms of the potential costs, benefits and risks
CSF 3	Supplier capacity and capability	How well suppliers can meet the requirements and timescales of the Health Board
CSF 4	Potential affordability	How well the option can be financed from available funds and aligns with resourcing constraints
CSF 5	Potential achievability	How well the option is likely to be delivered given an organisation's ability to respond to the changes required and matches the level of available skills required for successful delivery, this also includes technical complexity
CSF 6	User Experience	Meets key usability and design principles and has a positive impact on user experience
CSF 7	Adoption	How effectively Community Health Services adapt and standardise practices and deliver the organisational and cultural change needed to adopt the core capabilities of new systems, without reliance on bespoke solutions or workarounds.

The Critical Success Factors 1-5 are the standard Green Book Factors; additional Critical Success Factors 6 and 7 have been added, the reasons for their addition are:

- **CSF 6** – User Experience – to ensure that the end user experience is considered as part of the procurement process.
- **CSF 7** – Adoption – to ensure the Services' ability to adapt and cultural change is considered.

3.4 Shortlisting

A high-level review of the shortlisting assessment is as follows:

Table 10: Options Appraisal – Short List options

	Option	Assessment	Justification	RAG
Option 1	Do Nothing	Eliminated / Discounted - but will be used for comparison	Does not meet the strategic or business needs of the organisation.	Red
Option 2	Include Community Health Records within the Health Board's core EHR OBC	Eliminated / Discounted – Inclusion within the core EHR programme is unlikely to align	The core EHR programme is operating to a longer-term strategic timeline, meaning Community Health Records could not be prioritised or delivered within the timeframe required to address operational needs. As a result, this route would lead to significant delays and does	Red

		with the required delivery timeframe.	not provide a viable option for timely implementation.	
Option 3	Test if Community Health Records can be included within the MHL EHR Contract	Feasibility uncertain – potential contractual and legal limitations.	The existing MHL EHR contract was submitted through a formal procurement process with defined service scope. Adding new services at this stage may breach procurement regulations and could expose the organisation to legal and commercial risk. Further exploration would be required, but the likelihood of this being permitted appears low.	Red
Option 4a	Procure a Community Health Record individually through separate Invitation to Tender (ITT) and FBC)	Preferred	Meets all Investment Objectives and Critical Success factors. Enables increased confidence in fast-paced incremental delivery to reduce current clinical risk, with clear scope, accountability and local governance. Lower dependency on external programmes and simpler to govern and fund. Short-term architectural fragmentation is considered acceptable given the time-bound need for risk mitigation and does not prevent future alignment or convergence with Core EHR or national solutions. In contrast to collaborative procurement approaches, this option avoids dependency on partner Health Board priorities and governance timelines.	Green
Option 4b	Procure a Community Health Record in partnership with another Health Board(s)	Preferred commercial approach - providing there is no detrimental impact on the timing and delivery of a solution for BCUHB from working in collaboration	Meets Investment Objectives and Critical Success Factors; however, delivery risk is higher due to dependency on partner Health Board priorities, timelines, governance and decision-making. Differences in service maturity and urgency may lead to misalignment of requirements, with BCUHB seeking fast-paced clinical risk reduction while partners may be focused on optimisation or longer-term transformation. Joint governance and procurement processes could increase coordination overheads and extend timescales, potentially delaying benefits realisation. Cost savings are uncertain and may relate more to	Green

			shared procurement effort than material reduction in solution cost. Overall risk may be redistributed rather than reduced when compared to an individually procured approach.	
Option 5	Develop an internally built digital system specifically designed for BCUHB	Eliminated / Discounted – Not feasible within current organisational capability.	Developing a bespoke system inhouse would require substantial technical expertise, long-term funding, and extended development and testing periods. This approach is unlikely to be deliverable within the required timescales and would create sustainability, maintenance, and governance challenges. Therefore, it does not represent a practical or cost-effective solution.	Red

Options 4a and 4b are considered the most preferable on the following basis:

- stronger alignment with community-specific workflows.
- a more mature supplier market for Community Health solutions.
- potential access to national funding.
- reduced procurement complexity.
- more realistic implementation timescales.

3.4.1 CSF Scoring Matrix

The table below is the shortlist appraisal utilising the options framework and critical success factors as listed within this OBC. The scoring matrix was developed collaboratively by the programme board, drawing on methodology consistent with the All-Age Mental Health assessment and formally agreed through programme governance processes.

Table 11: Critical Success Factors – Scoring Matrix

Opt.	Shortlist Options	Strategic fit and business needs	Potential value for money	Supplier capacity and capability	Potential affordability	Potential achievability	User Experience	Adoption	Shortlist?
1	Do Nothing			N/A	N/A				No
2	Include Community Health Records within the Health Board's core EHR OBC								No
3	Test if Community Health Records can be included within the MHL EHR Contract								Partial
4a	Procure a Community Health Record individually through separate Invitation to Tender (ITT) and FBC								Yes

4b	Procure a Community Health Record in partnership with another Health Board(s)								Yes
5	Internally develop a system specifically for BCUHB								No

KEY	
No	Yes
Partial	N/A

3.5 Detailed Shortlist Option Assessment

Options **4a** and **4b** share a common baseline of advantages and challenges, including a constrained supplier market for community health systems and the requirement to integrate with national platforms and standards. The key differentiator between the options is not whether a Community Health Record can be delivered, but the trade-off between delivery pace and local control versus the potential benefits of scale and shared investment.

Option 4a: Procure a Community Health Record individually through a BCUHB specific Tender

Advantages:

- Greater ability to prioritise fast-paced delivery to address BCUHB-specific clinical and operational risks.
- Clear scope, accountability and single-organisation governance, enabling faster decision-making and issue resolution.
- Higher certainty over delivery sequencing and timescales.
- Reduced dependency on external organisations, programmes or approval processes.

Disadvantages:

- Limited supplier market, with BCUHB bearing delivery and commercial risk independently.
- No opportunity for cost-sharing or economies of scale.
- Potentially higher unit costs compare to collaborative procurement approaches.
- Short-term architectural fragmentation, requiring future convergence planning.

Option 4b: Procure a Community Health Record individually through a joint BCUHB / another Health Board(s) Tender

Advantages

- Potential for economies of scale and shared investment, although the level of cost saving is uncertain.
- Opportunity to align approaches across organisations where requirements and maturity are compatible.
- Risk may be shared across partner organisations rather than held by a single Health Board.

Disadvantages

- The same constrained supplier market applies, with added procurement and coordination complexity.
- Delivery pace may be affected by differing priorities, urgency, service maturity and decision-making timelines between partners.
- Increased governance overhead through joint decision-making structures.
- Greater uncertainty around delivery sequencing, approvals and timescales.
- Risk may be redistributed rather than reduced, with dependencies on partner commitment and capacity.

Summary

Option 4a offers higher delivery certainty, clearer accountability and faster progression to mitigate current risks, at the expense of scale and shared investment. Option 4b offers the potential for shared cost and alignment benefits but introduces greater dependency, complexity and uncertainty, particularly in relation to pace and governance.

3.6 Economic Evaluation

At this stage, it has not been possible to calculate benefit–cost ratios, net present social value or apply quantified optimism bias adjustments to individual options, due to the absence of confirmed supplier pricing, implementation costs and validated benefit baselines. These elements will be developed as part of the Full Business Case once market engagement and procurement activity has been completed.

In addition to the above:

- National procurement has not yet defined supplier pricing. DHCW have estimated supplier costs within the national OBC which have informed the local OBC.
- Local BCUHB architecture, integration and implementation resource requirements are unknown / not yet identified.
- No specific Community Health cost model exists.

The OBC therefore presents financial considerations based on BCUHB and DHCW expertise and intelligence at this stage of the process:

- **Option 4a** presents a potentially quicker procurement and implementation, thereby reducing the indirect cost of delays.
- **Option 4b** potentially provides a better commercial solution through economies of scale of a National or Collaboration Tender, however this may have a detrimental impact on the timescales for BCUHB implementation.

A detailed financial model (costs, benefits and recurrent affordability) will be presented for final approval at FBC, once the “national Connecting Care/BCUHB” OBC is approved, and suppliers’ costs are confirmed through a formal Tender exercise.

3.7 Sensitivity Analysis

At this OBC stage 5% risk and optimism bias adjustments have been applied. This will be removed once costs are known at Full Business Case stage, following a formal tender and evaluation.

3.8 Preferred Option Statement

Following the long-list and short-list appraisal, and assessment against the Investment Objectives and Critical Success Factors, the preferred way forward is:

Option 4 – Procurement of a Community Health Digital Solution, through either:

- **Option 4a:** a BCUHB-led procurement via a standalone Invitation to Tender (ITT); or
- **Option 4b:** a joint procurement in partnership with another Health Board(s).

Both Option 4a and Option 4b meet all Investment Objectives and Critical Success Factors and represent viable, market-ready routes to securing a modern Community Health Digital Solution.

The primary distinction between the two sub-options relates to the balance between **local control and pace of delivery** (Option 4a) versus the **potential benefits of shared investment and scale** (Option 4b).

Option 4a provides greater certainty over delivery sequencing and timescales, clearer local accountability, and reduced dependency on external decision-making, enabling BCUHB to prioritise rapid risk reduction. Option 4b offers the potential for shared procurement effort and economies of scale; however, these benefits are contingent on alignment of priorities, governance and timelines, and on collaboration not introducing delays to delivery for BCUHB.

Options 1, 2 and 5 were discounted as they do not meet the required timeframe, strategic need, operational urgency or deliverability criteria. Option 3 is not preferred due to significant legal and procurement constraints that limit feasibility.

On this basis, **Option 4 is the recommended way forward**, with the choice between Option 4a and Option 4b to be confirmed during development of the Full Business Case (FBC) and through national procurement alignment discussions. This approach enables BCUHB to progress at pace while retaining the flexibility to leverage collaborative or national opportunities where these do not introduce unacceptable delay or additional delivery risk.

3.9 Economic Case Conclusions

Based on DHCW cost benchmarking and early market insight and initial Health Board resource and affordability considerations, the Economic Case indicates that **Options 4a and 4b** represent the most credible and deliverable routes for progression at this stage, subject to confirmation through detailed financial and affordability analysis at Full Business Case, following formal tender, evaluation and identification of the preferred system and supplier partner.

Options 4a and 4b are considered economically viable, and provide the strongest alignment to critical success factors, balancing deliverability, strategic fit, and user outcomes. Option 1 and 2 fail to address the identified risks and are therefore discounted.

Option 4a is expected to involve higher locally borne costs but offers greater certainty over spend control and delivery timescales. Option 4b presents potential for shared costs and economies of scale; however, the scale of any such savings and economies is uncertain and may be offset by increased coordination, timescale and dependency risks.

The following table summarises the estimated discounted Economic assessment and assumptions based on Procuring a Community Health Record system through formal tender (Options 4a and 4b), over a 10-year lifecycle. This will be further refined through the procurement and FBC stage.

Table 12: Breakdown Economic assessment and assumptions

Cost / Benefit Item	£000's
Supplier Costs	3,940
Health Board Revenue Costs	9,735
Risk & Bias	687
Total Costs	14,362
WG / DHCW Funding	(6,325)
Cash-releasing benefits	(3,579)
Non-cash-releasing benefits	(37,609)
Total Benefits	(47,513)
Net Cumulative Value	(33,151)

4 The Commercial Case

4.1 Procurement Strategy

The Commercial Case sets out the commercial approaches available to BCUHB to procure a Community Health Digital Solution that meets local service requirements, while remaining aligned to national standards and programmes.

At OBC stage, this section does not commit the Health Board to a single procurement route. Instead, it establishes a commercial strategy that enables BCUHB to progress procurement at pace, either independently or collaboratively, subject to further engagement, affordability confirmation and governance decisions at Full Business Case (FBC) stage.

Procurement will be led locally by BCUHB, supported by NHS Wales Shared Services Partnership (NWSSP), with national alignment retained where this does not introduce unacceptable delay or dependency.

The approach will be developed in line with partner digital solution projects to ensure coherence and avoid the creation of parallel or duplicative systems. As part of the procurement process, interoperability options and priorities will be explored collaboratively with local and national teams. This will ensure that the selected solution can operate effectively within the wider digital ecosystem and that commercial decisions reflect the cost, benefit and sustainability considerations associated with different integration approaches.

4.1.1 Procurement Options and Recommended Route

Several procurement routes were reviewed to determine the most appropriate method for securing a Community Health digital solution. Options considered include:

- Welsh Open Procedure
- Open Market Procedure
- London Procurement Partnership (LPP) Clinical Digital Solutions Framework – Further Competition
- LPP Framework – Direct Award

Following initial review of pace, compliance, supplier maturity and market constraints, **framework-based competition is currently considered the most proportionate procurement mechanism**, subject to confirmation at Full Business Case stage.

Suitable NHS-compliant frameworks **may include** the London Procurement Partnership (LPP) Clinical Digital Solutions Framework or other available national or public-sector frameworks in place at the time of procurement. This framework provides:

- access to a pre-qualified supplier pool within a limited, specialised market.
- a structured and compliant competitive process.
- ability to refine call-off terms and conditions to suit local requirements.
- increased assurance of technical and functional fit.
- reduced procurement timescales compared to running a full open tender.

The recommended route also aligns with national findings indicating that the LPP framework is an appropriate mechanism for procuring clinical digital systems for community-based care.

Framework-based procurement routes are favoured at this stage because they:

- provide access to a pre-qualified supplier market in a constrained and specialist domain.
- reduce procurement timescales compared to open procedures.
- lower legal and commercial risk through established and compliant terms.
- enable competitive tension through further competition while allowing local specification refinement.

Alternative routes, such as fully open market procurement, were not preferred at this stage due to longer timelines, increased resourcing requirements and misalignment with the urgency of clinical risk reduction.

The LPP Clinical Digital Solutions Framework is the preferred route due to its compliance, speed to market, and proven supplier capability within NHS environments.

4.1.2 Procurement Timetable

The following table outlines the provisional procurement process and approval path which would commence on OBC approval. Timescales are dependent on OBC and FBC approvals.

Table 13: Procurement process and approval path

No.	Action
Pre-procurement	
1.	Approval of OBC and authorisation to progress to procurement phase
2.	Signed Framework Access Agreement
3.	Pre-market Engagement
4.	Procurement Document Preparation
5.	Approval of Procurement documentation (Project Board)
Procurement and Recommendation	
6.	Welsh Government Approval to Commence
7.	Invitation to Tender – Request for Proposal (RFP)
8.	Tender bid submission deadline
9.	Evaluation of tenders
10.	Contract Award recommendation report
Full Business Case Approvals	
11.	Full Business Case Completion
12.	DDaT SLT

13.	Project Board Approval
14.	Executive Team
15.	Performance, Finance, and Information Governance Committee (PFIG) Approval
16.	Health Board
17.	Welsh Government
18.	Award/Regret Letters standstill
19.	Contract Award
20.	Completion of the operational schedules with supplier
21.	Contract Execution/Start

4.1.3 Procurement Management

The procurement will be managed by NWSSP, supported by the SRO and Programme Manager from Digital, Data and Technology. Clinical, operational, technical and commercial stakeholders will contribute to the evaluation process to ensure that the chosen supplier meets the full breadth of Community Health requirements.

4.1.4 Evaluation Criteria

The framework uses the most economically advantageous tender (MEAT), using Technical/Quality and Commercial as the evaluation criteria, these must be used but the Health Board, under the framework can decide on the weightings and can include sub-criteria if they are clearly stated to all suppliers upfront in the further competition tender documents.

The following evaluation criteria and weightings will be used:

Table 14: Procurement evaluation criteria

Criteria	Comprising	Weighting
Technical/Quality	Sub Criteria - - Clinical (40%) - Technical (30%) - Social Value (10%) - Service Management (10%) - Risk Transfer (10%) Sub Criteria <i>Technical/Quality (100%) = 70% Overall</i>	70%
Commercial	Best and Final Offer	30%
Total		100%

With the necessity to incorporate Social Value and the importance of the right system to enable the transformation required the Health Board have prioritised Technical/Quality over cost on a 70/30 basis.

4.2 Framework Suppliers

The LPP CDS Framework includes a Supplier Matrix covering around twenty suppliers qualified to deliver Electronic Health and Care Record solutions. All suppliers on the framework who meet the relevant lot criteria will be invited to participate in the Expression of Interest stage. This ensures fairness, transparency and equal treatment, while allowing BCUHB to identify suppliers capable of meeting the specific functional needs of Community Health Services.

4.3 Charging Mechanism

Charging mechanisms will be determined through the call-off contract and supporting schedules. These will outline the pricing model for licences, implementation services, support, hosting, and additional optional modules. Details will be finalised during the FBC following supplier evaluation.

4.4 Contract Length

The preferred contract term is:

- 5 years initial period, with
- two extension options of 2 years each, giving a maximum contract length of 9 years.

This provides an appropriate balance between investment stability, supplier accountability, and future flexibility to align with national digital direction.

4.5 Outline Based Specification

The functional and non-functional specification will be informed by:

- National Community Health requirements.
- local service needs.
- technical standards and policies.
- and interoperability requirements across Community Health, Primary Care, Acute Care, Mental Health and Social Care services.

Key areas include:

- single patient view across community pathways.
- digital case management and clinical documentation.
- risk assessment and care planning.
- mobile and agile working.
- standardised workflows.
- reporting and analytics.
- integration with national systems via HL7 FHIR, SNOMED CT, and APIs.
- robust cybersecurity and cloud hosting requirements.

Requirements will be validated with end-users and technical specialists as part of the procurement and implementation process.

4.6 Commercial Risks

Key commercial risks include:

- limited supplier market capacity.
- risk of insufficient supplier responses to further competition.
- potential delays in procurement or contract award.
- risk that supplier proposals may not fully meet Community Health requirements.
- dependency on other Health Board timelines, particularly where alignment with joint or partnership procurements is required.
- affordability pressures.
- Risk of misalignment with the All-Ages Digital Solution mitigated through joint engagement on interoperability requirements and shared architectural standards.

These risks will be actively managed through robust pre-market engagement, clear specification development, strong evaluation processes and ongoing dialogue with both suppliers and Health Boards.

4.7 Special Advisors

External specialist advice may be required in areas such as:

- procurement support.
- clinical safety assurance.
- technical architecture and integration.
- data migration.
- change management.
- DDaT Specialist teams

4.8 Stakeholders

Extensive engagement across Community Health Services will underpin all phases of the programme. Engagement will include clinicians, operational staff, administrative teams, service managers, data and information specialists, and partners in primary care and local authorities where relevant.

These stakeholder groups have been identified below:

- Nursing Teams
- Medical Teams
- Clinical Directors
- Patients / Service Users
- Therapy Services
- Pharmacy Team
- Prescribed Medication & Counselling Support Services

- Service Management Teams
- Administration Teams
- Planning & Performance Team
- Finance Team
- Procurement Team
- Digital, Data & Technology Teams
- Transformation & Improvement Team
- Change Management Team
- Corporate Communication Team
 - Primary care
 - Local authority / social care
 - Secondary care
 - Welsh language services

Further stakeholders will be identified and engaged as required throughout the programme lifecycle.”

4.9 Accountancy Treatment

The financial treatment of system costs will follow NHS accounting principles and be confirmed at FBC stage, including the appropriate treatment of VAT, capital assets, revenue expenditure and depreciation policies.

4.10 Personnel Implications

No TUPE implications are anticipated at this stage. Additional programme resources may be required during procurement and implementation, with roles defined within the Management Case.

4.11 Welsh Language Compliance (T9 Requirements)

BCUHB must comply with the Welsh Language (Wales) Measure 2011 and the organisation’s Welsh Language Standards.

For Community Health Services, bilingual capability is essential to ensure fair access, clear communication and safe clinical decision making. This OBC adopts the same approach used in the Mental Health OBC, aligning with the requirements previously reviewed by the Welsh Language Team.

The Connecting Care programme must meet the full Welsh Language requirements set out in the T9 Requirements Table, which is included in **Appendix F**. These requirements cover areas such as storing language preference, displaying bilingual content, supporting Unicode, providing bilingual error messages, managing dual language interfaces, and ensuring bilingual search, URLs, metadata, documents and automated communications.

These requirements will be built into the procurement process, with suppliers being evaluated using the established evidence and scoring criteria provided in the Welsh Language requirements dataset, including

the technical scoring scale (0–10), and evidence categories (A–F). Welsh Language officers will take part in evaluating supplier responses and demonstrations.

The contract will require full compliance with the T9 requirements.

Any supplier offering only partial bilingual capability will need to provide a clear, time bound development plan, as defined in evidence category F. Bilingual functionality will form part of contract monitoring and go-live assurance.

A risk has been recorded relating to the possibility that a supplier may not be able to deliver full bilingual functionality at implementation. This will be mitigated through mandatory requirements, scoring controls and contractual obligations.

4.12 Commercial Case Conclusions

The Commercial Case confirms that BCUHB has viable and compliant commercial routes available to procure a Community Health Digital Solution, either through a locally led procurement or through collaboration with other Health Boards, subject to further confirmation.

Framework-based procurement mechanisms offer an efficient route to market within a constrained supplier landscape and support delivery at pace, while maintaining compliance with NHS Wales procurement requirements.

Final confirmation of the preferred commercial route, framework selection and contracting approach will be made and included within the Full Business Case stage, informed by further engagement, affordability analysis, and alignment considerations, ensuring that delivery is not delayed by unresolved dependencies.

The recommended procurement route through the LPP CDS Framework (Further Competition) provides a compliant, efficient and strategically aligned mechanism to secure a modern digital solution for Community Health Services. This approach ensures access to suitable suppliers, supports value for money, reduces procurement risk and enables BCUHB to progress digital transformation at pace while maintaining alignment with national digital direction.

5 The Financial Case

5.1 Revenue and Capital Costs

The Financial Case outlines the expected financial implications of implementing a Community Health digital solution. At this OBC stage, detailed cost modelling is not yet available as the national DHCW procurement route, supplier pricing, and implementation scope are still under development. The costs presented at this stage reflect the latest national intelligence, insight and advice from DHCW alongside the Health Board assessed level of resources required to implement and then operationally manage such a system.

Revenue costs for a Community Health digital system will include

- system licensing and subscription fees.
- implementation support, including configuration, testing and training
- technical integration, interoperability work and data migration.
- programme staffing and change management.
- device, infrastructure or connectivity upgrades where required.
- ongoing support, maintenance and management once operational.

Capital expenditure may be required for elements such as hardware refresh, infrastructure upgrades, or one-off implementation components. Whilst additional hardware does not fall within the scope of this project, the technological estate is already being updated in alignment with wider change and transformation initiatives. Any Capital requirement will be managed through the Discretionary Allocation.

5.2 Financial Assumptions

Several working assumptions underpin this OBC Financial Case:

- Implementation and system costs will span multiple years across the procurement, implementation and stabilisation phases.
- The contract length is expected to be 5 years plus 2x 2-year extension options, as such the revenue assessment has been undertaken over the full 10-year period.
- Costs exclude VAT and depreciation, unless otherwise confirmed through supplier and finance review.
- A 5% level of risk and optimism bias is included at this OBC stage
- Programme staffing costs will include project management, clinical leadership, digital specialists, data migration support and change management.
- Technical specialist costs will include digital specialists, data migration from legacy systems.
- Integration with centrally provided national systems will not incur additional charges.
- Hardware and device refresh cycles may be required during the contract term, through the existing Discretionary Allocation process.
- Three current Community Digital Systems will be replaced by the new system.

These assumptions will be refined during procurement and the Full Business Case process.

5.3 Affordability and Source of Funding

Based upon National intelligence and insight from DHCW and the Health Board initial assessment of resource requirements, the following table summarises the OBC stage analysis of costs of procuring, implementing and maintaining such a system:

Table 15: OBC procurement, implementation & maintenance cost

Cost / Benefit Item	Readiness £000's	Implement & Go-live £000's	Business as Usual per year £000's	10 years Total £000's
Supplier Costs	0	1,266	422	4,220
BCU Costs	396	4,805	730	10,312
Risk & Bias	20	304	58	727
TOTAL COSTS	415	6,375	1,210	15,259
WG / DHCW Funding	(575)	(5,875)	0	(6,450)
Cash-releasing benefits	0	(486)	(486)	(3,892)
TOTAL FUNDING SOURCE	(575)	(6,361)	(486)	(10,342)
GROSS OBC REVENUE IMPACT	(160)	14	724	4,917

Current financial indications are that the Readiness and Implementation Phases can be funded in full of within the WG / DHCW revenue allocation.

The current assumptions of cost, cash releasing benefit and operating costs result in a Business-as-Usual Revenue Gap of £724k p.a. Whilst these costs and assumptions will change as we identify a preferred supplier and undertake further work on business process redesign and benefits realisation, the Project Board has identified interim steps to achieve revenue neutrality. These are:

- Reduce the cost of investments
- Increase the cash-releasing savings

5.3.1 Reducing the cost of investments

The OBC supplier cost is based on intelligence and advice from DHCW in advance of undertaking a formal tender. The unit cost per licence provided by DHCW is materially higher than the licence cost achieved for the Mental Health EHR as a result of formally tendering. Should the formal tender for Connecting Care result in the same system, or a similar licence fee rate, the affordability gap would reduce by £0.120m per annum.

Commercial discussions within the approved Mental Health Business Case will seek to reduce OBC costs through potentially reclaiming the VAT on the contract, as well as any potential to capitalise costs and reduce Health Board costs based on supplier deliverables. Should these VAT arrangements prove successful, this would further reduce the Connecting Care affordability gap by £0.05m per annum.

Should the formal tender result in the same supplier and system, all opportunities for sharing business as usual resources across Connecting Care and Mental Health EHR will be fully explored with a key focus on further reducing the OBC affordability gap.

At OBC, a 5% contingency and optimum bias has been included as standard. This will be removed at FBC once tender prices are confirmed, thereby reducing the affordability gap by £0.06m per annum.

5.3.2 Increasing the level of cash releasing savings

All in-scope services commit to collectively converting productivity and efficiency benefits to cash-releasing benefit in order to bridge any residual affordability gap after the level of investment has been reduced to the minimum acceptable and deliverable level.

Subject to residual affordability challenge after the commercial tender and reduction of Health Board investments, removing 8 wte established posts across all in-scope services would be sufficient to release the outstanding revenue gap.

Intelligence from DHCW following their site-visits with the District Nursing and Health Visiting Teams, has been used to calculate anticipated productivity and efficiency benefits. These can be seen in section 6.3.1 and are at a level that indicate that this level of additional cash releasing benefit is realistic. Current workforce analysis indicates that this can be delivered through existing vacancies and natural staff turnover.

It is anticipated that over the implementation period, there will also be opportunities to use new investment in community services to offset operational system costs, delivering increased activity through productivity gains generated by the system's implementation and adoption of business process redesign.

Table 16: Proposal to achieve revenue neutrality

Cost / Benefit Item	10 years Total £000's
OBC Gross revenue gap	724
Tendered Licence costs in line with MHL EHR contract	(118)
VAT is reclaimable on licence fees (as per MHL EHR)	(51)
Risk & Bias removed at FBC	(58)
Residual operational revenue gap	497
Reduction in system support costs through further efficiencies in DDAT and Service provision. Conversion of Efficiency & Productivity benefits into cash-releasing, including removal of vacancies and reduction in hours from across BCU Adult & Children Community service	(497)
FBC REVENUE IMPACT	0

5.4 Financial Case Conclusions

The Financial Case recognises the scale and complexity of moving Community Health Services from paper-based and manual processes to a modern digital environment. The overall level of investment required over a 10-year contract period is significant given the breadth of service transformation and the multi-agency nature of community-based care. This is consistent with evidence from the Mental Health EHR as well as other EHR business cases across NHS Wales and NHS England.

To achieve recurrent cost neutrality all in-scope community services commit to collectively converting productivity and efficiency benefits and natural staffing changes to cash-releasing savings.

The Full Business Case will provide:

- a full recurrent annual affordability risk-based proposal
- a financial model based on fixed supplier responses to a formal Procurement.
- a refined cost profile across implementation and business as usual periods, based on the preferred system and supplier partner.
- confirmation of national and local funding contributions.

The high-level assessment at this OBC stage confirms that investment in a Community Health digital solution will result in long-term value through improved quality, safety, efficiency and data reliability, provided it is supported by a clear funding strategy and sustained financial commitment from the in-scope services.

6 The Management Case

6.1 Project Management and Governance

The Community Health digital solution will be delivered through a structured programme management approach, ensuring clear accountability, strong clinical leadership, and robust oversight throughout procurement, implementation and benefits realisation.

6.1.1 Project Management

Project management arrangements are aligned with BCUHB's corporate approach, which is underpinned by PRINCE2 principles.

PRINCE2 methodology has a prescribed structure of governance and reporting mechanisms which can be tailored to the magnitude, scope, and complexity of individual projects to enable successful and efficient project delivery.

The project may choose to use Agile methodologies or within the constraints of PRINCE2 for specific work package activities in the project, like system build where an iterative and developmental process is required. This will be dependent on the implementation method of the supplier.

The Project Manager will use these principles to ensure that the project is properly led, planned, resourced, monitored and controlled for its entire lifecycle. It is recommended that the project secures a project assurance role, as set out in the roles and responsibility section of this document. A management structure comprising of a Project Board and Project Team would need to be identified with stated project roles and responsibilities.

The project will be supported by a Programme Team from BCUHB and DHCW including a Programme Manager, Project Manager(s), Business Analysts, Change Leads, Clinical Safety Officers and technical integration specialists where required (subject to funding requests as part of the national OBC). Progress will be reported through established Health Board governance structures and digital assurance routes.

6.1.2 Project Governance

Project governance is critical as to monitor and control the delivery, implementation and closure of the project, the indicative governance structure is provided below and will be finalised during the project start up and documented in the Project Initiation Document (PID) and Project Board Terms of Reference.

Governance arrangements will align with Health Board standards for major digital programmes.

A Programme Board will provide strategic direction, decision-making, and assurance. It will be chaired by the Senior Responsible Owner (SRO) and will include clinical leaders, Community Services managers, digital specialists, information governance, finance and procurement representatives. Sub-groups will support specific areas such as clinical safety, technical design, change management and benefits realisation.

Representatives from the Community Health project will also have representation at appropriate boards for EHR and MH EHR.

The indicative project governance diagram in Figure 6 below will link into the DHCW - National Connecting Care Governance and Programmes Structure (**Appendix: A**), the Regional Connecting Care Steering Group to ensure national and regional alignment.

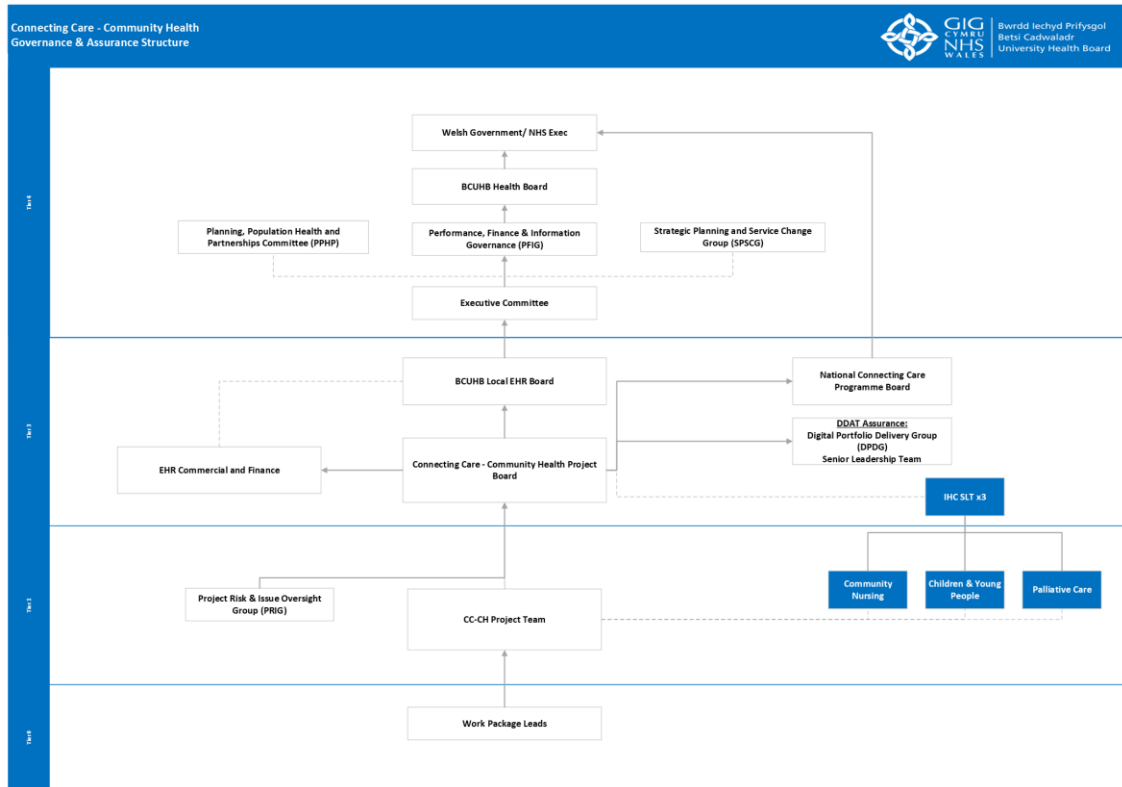


Figure 6: Community Health Local Governance Map

Figure 7 below describes the governance for All Ages MHL D EHR programme. We intend to replicate this structure during the implementation of the All-Ages Community Health system, when the full scope of the programme is known.

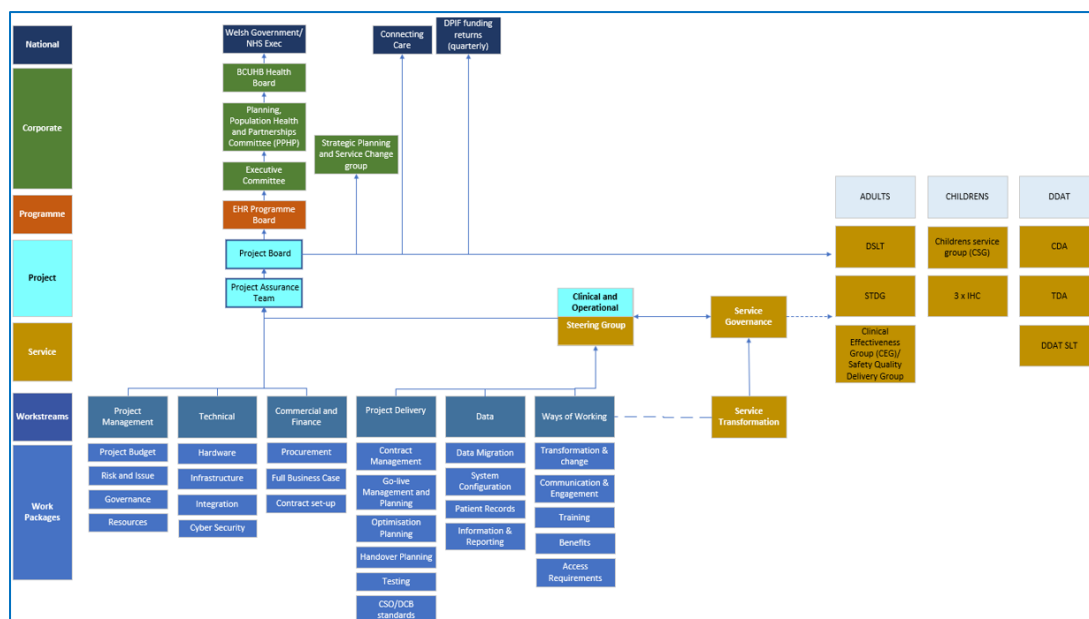


Figure 7: All Ages MHL D EHR Governance Map

Roles and Responsibilities

Roles & responsibilities are indicative at OBC level and will be further informed at Full Business Case stage as this develops.

Table 17: Project Roles and Responsibilities

Job Title	Role in Project	Responsibilities
SRO (Senior Responsible Owner)	Accountable executive lead / Programme Sponsor	Accountable for delivery of programme objectives and outcomes; provides strategic direction; secures funding/resources; chairs/oversees governance; approves key decisions and stage gates; ensures risks/issues are managed and escalated appropriately; acts as senior point of contact with Executive Team/Welsh Government as required. Also responsible for Benefits Realisation.
Programme Manager	Programme lead / Delivery manager	Leads end-to-end delivery of the programme; develops and maintains programme plan, RAID log and governance reporting; coordinates workstreams (clinical, technical, change, data, training); manages dependencies and interfaces with national/regional programmes; specifically local EHR and Mental Health programmes and National Connecting Care programme, ensures agreed standards (e.g., clinical safety, IG) are embedded; prepares materials for boards and decision points.
Chief Nursing Information Officer (CNIO)	Nursing Digital & Clinical Lead	Provides nursing leadership for digital initiatives; ensures nursing workflows and patient care processes are reflected in system design; supports adoption and engagement across nursing teams; contributes to clinical safety, quality, and data standards; acts as liaison between nursing workforce and digital/IT teams.
Chief Clinical Information Officer (CCIO)	Senior Clinical Digital Lead	Provides overarching clinical leadership for digital strategy; ensures alignment with clinical priorities and safety standards; leads clinician engagement and adoption; supports service transformation and pathway redesign; oversees clinical risk, governance, and assurance;

		acts as interface between clinical services, executives, and digital teams.
Business Change Manager	Change management lead	Provides change management support, guidance and assurance across the project. Supports the development of the change management strategy and plan; advises on stakeholder engagement, communications, readiness and adoption; helps identify people, process and role impacts; supports the training approach with operational leads; provides assurance around go-live preparation; and helps capture feedback, adoption risks and lessons learned to support continuous improvement.
Project Manager	Day-to-day project delivery lead	Manages day-to-day delivery against scope, time, cost and quality; maintains detailed plans, actions, issues and risks; coordinates suppliers and internal teams; manages project controls (change control, milestones, reporting); supports procurement/tender activity where required; organises workshops, testing, cutover and go-live activities; ensures documentation and governance artefacts are produced.
Benefits Management Service Lead	Benefits realisation lead	Develops and maintains benefits framework and benefits realisation plan; defines baselines, KPIs, measures and data sources; agrees benefit owners and tracking cadence; supports identification of cash-releasing and non-cash benefits; monitors delivery and reports benefits progress to governance; coordinates post-implementation reviews and ensures benefits are sustained in BAU.
Senior Business Analyst	Requirements & process lead	Leads requirements capture and documentation; maps current and future state workflows; supports options appraisal and specification development; manages requirements traceability; supports configuration decisions with clinical/operational leads; develops user stories/use cases; supports testing (UAT scenarios) and ensures solution meets agreed needs.
Senior Finance Manager	Finance lead / Business case support	Leads financial modelling for OBC/FBC; supports affordability assessment and funding strategy; validates cost assumptions (capex/opex, VAT, depreciation) and cost profiles; advises on procurement/commercial financial evaluation; supports benefits quantification and cash-releasing savings methodology; ensures alignment with finance governance and reporting.
Clinical Lead	Clinical sponsor / clinical design authority	Provides clinical leadership and ensures solution supports safe, effective care; represents clinical users and agrees clinical requirements; leads/oversees clinical workflow design and standardisation; supports clinical engagement, training and adoption; contributes to procurement evaluation (clinical demonstrations); champions clinical safety and quality improvement throughout implementation.
Digital Clinical Safety Lead	Clinical safety lead (DCB0129/0160)	Leads clinical safety management for the programme; maintains Clinical Safety Case/Plan and hazard log; ensures compliance with relevant standards (e.g., DCB0129/0160) and local governance; advises on safety-related requirements, configuration and workflows; supports incident/near-miss learning during testing and go-live; signs off safety documentation and provides assurance to governance.

6.2 Indicative Project Timelines

The timelines for procurement, implementation and go live will be dependent on BCUHB EHR Programme Board decisions, supplier availability and community service readiness. Indicative phases include:

- procurement preparation and pre-market engagement.
- formal procurement and supplier evaluation.
- contract award and mobilisation.
- system configuration, integration and testing.
- data migration and assurance.
- staff training and change management.
- go live plan aligned to service readiness.
- benefits tracking, realisation and long-term optimisation.

Table 18: Indicative Project Timeline

Phase	Indicative Timing
OBC Approval	July 2026
Procurement Phase	July – September 2026 (indicative)
FBC Development	September 2026 – March 2027
Approvals (FBC)	April – July 2027
Implementation	September / October 2027
Transition to BAU	From April 2029

Further detail will be developed as part of Full Business Case planning.

6.2.1 Change Management

Community Health digital transformation will require significant changes to working practices, information flows, roles, behaviours and local processes across adult and children's community services. The change approach will therefore focus on preparing services to adopt new ways of working, not simply supporting technical implementation.

Change management will be delivered in line with the BCUHB DDaT Change Management Framework and will be developed further through the Full Business Case and PID. The approach will include stakeholder analysis, change impact assessment, current-to-future state mapping, service readiness assessment, change network development, communications, role-based training, digital skills support, go-live readiness and post-implementation adoption support.

A dedicated change management function will work with DDAT Project Managers, clinical, operational, administrative, digital training, communications, IG and supplier colleagues to understand the impact of the change across services. This will include identifying affected staff groups, assessing digital maturity and readiness, mapping changes to workflows, and supporting teams to prepare for standardised processes where these sit within the project scope.

Local ownership will be supported through a representative change network or champion model across Community Health services and geographic areas. This network will provide two-way feedback, support local engagement, identify risks early, and help teams prepare for implementation and stabilisation. Training and adoption support will be role-based and aligned to future workflows. This will include formal training, digital skills support, super-user or champion support, floorwalking where appropriate, issue feedback routes, refresher learning and clear handover into BAU.

Adoption will be monitored through agreed change and readiness measures, including training completion, service readiness, user confidence, uptake of agreed workflows, reduction in paper or workaround processes, issue themes, and evidence linked to benefits realisation. This will help the project understand whether the new system and ways of working are being embedded safely and consistently.

Dependencies such as device availability, connectivity, infrastructure, data quality, supplier implementation approach, integration with wider digital programmes, and service capacity will need to be actively managed through project governance. Further detail will be developed at FBC stage once the preferred option, supplier approach, implementation model and resourcing assumptions are confirmed.

The level of change activity required will be refined during FBC planning once the preferred solution, implementation model, supplier responsibilities and service deployment approach are confirmed.

Most of the change effort will focus on people and processes rather than technology alone. Whilst hardware does not fall under the project scope, this will need to be taken into consideration to ensure alignment to the wider change/transformation initiatives in updating our technological estate.

6.2.2 Contract Management

Following contract award, structured contract management processes will ensure supplier performance, service quality, delivery of milestones and compliance with service level agreements. Operational schedules will set out roles, responsibilities and performance frameworks. Contract management will transition from Programme Team oversight to business-as-usual digital operations once stabilisation is achieved.

6.3 Benefits Management

Benefits realisation will be managed in accordance with the DDaT Benefits Management Framework, which provides a structured approach to defining, governing and managing benefits throughout delivery and post-implementation.

The project will apply the benefits management cycle, ensuring benefits are identified and refined, assessed for value and affordability, and planned with clear ownership, measures and accountability, before being monitored through to realisation.

Benefits will be aligned with national reporting requirements where applicable and will be evidenced through baseline data, implementation metrics and post-implementation evaluation.

Benefits will be documented and managed using agreed DDaT templates, including the Benefits Register, with roles and responsibilities defined in line with the framework. Progress will be reviewed through established project and programme governance, including oversight by the Programme Board.

The table below provides a summary of how the key benefits associated with the Community Health digital solution directly mitigate identified organisational, clinical and operational risks. This includes alignment to the corporate risk relating to patient safety associated with fragmented records and lack of timely access to information.

Table 19: Benefits of Community Health digital solution risk mitigation

Risk Area	Key Risks Identified	Relevant Benefits	How the Benefit Mitigates Risk
Patient Safety & Clinical Risk	- Incomplete or inaccessible patient records - Delays in diagnosis, treatment and prescribing - Risk of clinical error	- Real-time access to complete patient records - Clinical decision support (alerts, allergies, history) - Reduction in clinical incidents and errors	Ensures clinicians have accurate, up-to-date information at the point of care, improving decision-making, reducing delays in treatment, and minimising the risk of patient harm.
Fragmented Care & Poor Coordination	- Disconnected systems across services - Inconsistent care planning - Communication failures between MDTs	- Integrated shared care record - Improved MDT communication - Standardised documentation and workflows	Enables all professionals to access and contribute to a single, shared record, improving coordination, reducing duplication, and ensuring continuity of care across services.
Operational Inefficiency & Workforce Pressure	- Time spent searching for information - Duplication of data entry - Reduced clinical time and workforce strain	- Time savings through reduced administrative burden - Mobile working capabilities - Automated workflows and data capture	Reduces administrative burden and duplication, releasing clinical time, improving productivity, and mitigating workforce capacity risks.
Governance, Reporting & Compliance Risk	- Inability to meet national reporting requirements - Poor data quality and auditability - Risk of regulatory non-compliance	- Improved data quality and standardisation - Enhanced reporting and analytics - Full audit trails and traceability	Provides structured, reliable data and reporting capability, improving regulatory compliance, audit readiness, and organisational oversight.
Patient, Carer & Staff Experience Risk	- Poor patient and family experience - Staff dissatisfaction and retention challenges - Risks associated with paper-based records	- Improved patient and carer experience - Enhanced staff usability and digital tools - Reduction in paper processes	Improves communication, reduces repetition for patients, and enables safer, more efficient working practices, improving both patient and staff experience.
Organisational & Financial Risk	- Increased risk of serious incidents and litigation	- Reduction in preventable harm and litigation	Reduces avoidable incidents and associated costs while improving

	- Inefficient use of resources - Rising operational costs	- Efficiency and productivity gains - Reduction in paper, storage, and travel costs	resource utilisation and supporting long-term financial sustainability.

Collectively, these benefits address the root causes of current organisational risk, including fragmented systems, reliance on paper records, and limited access to timely and accurate patient information. By enabling a single, integrated digital record and improving efficiency, governance, and user experience, the proposed solution will significantly reduce clinical, operational, and compliance risks.

6.3.1 Benefits assumptions for Community Health

(Figures from Connecting Care National Benefits Model)

The following benefit benchmarks are drawn from the *Connecting Care National Business Case* and describe expected areas of efficiency and time savings associated with implementing a digital Community Health EHR. These benchmarks are evidence-based and have been developed at a national level to provide a consistent and standardised basis for estimating benefits.

These benchmarks reflect typical changes in working practices, including reduced duplication of documentation, improved access to patient information, and more streamlined clinical and administrative processes.

Within this Outline Business Case, these benchmarks have been used as a reference point to inform the identification and high-level estimation of potential benefits.

Table 20: Benchmarking for Benefits

Right information available at the right time - Moving from paper to IT system			
Who	Saving	Applied to	Description
All Nursing staff	8 minutes	Per working day	The assumption is that there will be a reduction in duplication completing paperwork and updating the system for all nursing staff engaged in handover activities. Previous case history is now digital so staff member can review online and do not have to look at paper and/or create new paper records.
Right information available at the right time - Moving to a mobile application			
Who	Saving	Applied to	Description
All Nursing staff	20 minutes	Working day	An average of 8.1 miles per person, per day (travel back to base) can be saved with the introduction of a

			mobile app supporting access to case load data for front-line staff working in the community, releasing an additional 20 minutes of clinical time to care.
Reduction in travel by removing 'back to base' requirement when using mobile application			
Who	Saving	Applied to	Description
All Nursing staff	8.1 miles	Per working day	An average of 8.1 miles per person, per day (travel back to base) can be saved with the introduction of a mobile app supporting access to case load data for front-line staff working in the community.
Standardised documentation resulting from the availability of national forms in digital solutions			
Who	Saving	Applied to	Description
Community nurses	9.5 minutes	Per referral	The national form 'Confidential Community Nursing Service Patient Record' which District Nurses complete for every new referral will save nursing time of 9 minutes and 30 seconds per form.
Improved processing of electronic forms and referrals reducing amount of paper and storage in use			
Who	Saving	Applied to	Description
Community nurses	44%	Total costs for printing, postage, storage	It is expected that there will be a significant reduction in paper, printing and postage costs, and associated record storage, because of staff using a digital system.
Improved insight and decision-making from better quality information			
Who	Saving	Applied to	Description
Band 7 - Community auditor	25.5 minutes	Per community audit	A time saving of 25.5 minutes for each Band 7 undertaking a clinical audit of patients records by using patient dashboard.

6.3.2 Quantifiable Benefits

This section outlines the key quantifiable benefits of implementing a Community Health EHR. At this stage, the benefits provide an early indication of the potential value, based on national benchmarks and initial local insight through the DHCW site-visits with operational teams. These will be refined and strengthened as part of the FBC.

Table 21: High Level Benefits for OBC

High Level Benefits for OBC					
Ref.	Benefits	Benefit Category	Benefits noted by	Measures	Benefit Savings
Ben1	Improved quality and safety of care (staff having the right information at the right time, standardising ways of working, legible records, automated data collection, resource allocation, alerts, warnings, tracking)	Qualitative – non-financial	Children and Adult Services	<u>Possible Measures</u> Reduction in clinical incidents / patient safety incidents, medication errors, duplicate tests or procedures. Time taken to retrieve patient information Reduction in duplicate patient records Patient-reported experience measures (PREMs)	Approx 100 minutes saved per day per WTE staff member. (Handover, referral, admin, etc.) <i>(Figures from National Benefits Model following DHCW site-visits with BCUHB operational front-line teams)</i>
Ben2	Improved regulatory compliance, performance and reporting	Qualitative – non-financial	Children Services	<u>Possible Measures</u> % compliance with national clinical standards or regulatory requirements. Improvement in service response times or waiting times. Reduction in time taken to produce statutory reports.	Approx 60 minutes saved per day per Band 5 staff member. (Auditing patient information) <i>(Figures from National Benefits Model, following DHCW site-visits with BCUHB operational front-line teams)</i>

Ben3	Improved efficiency, increasing time to care - less time assessing and more time intervening (Includes travel, standardisation)	Quantifiable – Non-cash Releasing and Cash Releasing	Children and Adult Services	Possible Measures- <u>Non-cash Releasing</u> Time saved inputting new referrals into a system that has integration to demographics service (patient data not need to be entered from scratch). Time saved in processing and completing patient related documentations. Time saved in accessing updated digital care treatment plans for each client by using a mobile application. Time saved identified when using national forms which are completed as part of the nursing assessment for every patient. Specifically, "CPA recovery assessment" and "Initial Assessment" <u>Cash Releasing</u> Travel time saved with the introduction of a mobile app to access case load data for front-line staff working in the community.	Approx 20 Minutes saved per day in travel. (Figures from National Benefits Model, <i>following DHCW site-visits with BCUHB operational front-line teams</i>)
Ben4	Improved patient, carer, and family experience	Qualitative – non-financial	Children and Adult Services	<u>Possible Measures</u> % of patients reporting they received clear and timely information about their care. Patient-reported experience measures (PREMs)	To be defined

Ben5	Improved staff experience and retention	Qualitative – non-financial	Children Services	Possible Measures- Staff satisfaction and engagement survey results Reduction in time spent on manual data entry or paperwork % of staff reporting more time for direct patient care Increase in tasks completed per day or appointments handled Reduction in unplanned vacancies Reduction in staff risk to accidents when accessing paper records in storage containers Time saved in duplication of national reporting documents outside standardised nursing assessment forms & documentation	To be defined
Ben6	Reducing our Carbon Footprint by reducing paper use, storage and travel (Net Zero Target)	Quantifiable – Cash Releasing Benefit	Generic to All	Possible Measures- A reduction in paper, printing and postage costs, and associated record storage as a result of using a digital system. % of patient records fully digital. Reduction in miles/km travelled for administrative tasks or meetings and Reduction in CO₂ emissions from travel	Approx £ 47,881 (Accounted for Community Nursing Only) (Figures from National Benefits Model)
Ben7	Reduction in Hospital admissions and usage	Quantifiable – Cost Avoidance and Quantifiable – Societal Benefit	Generic to All	Possible Measures- Increase in Bed Day saved (Preventing admissions) - Cash saving % reduction in unexpected deaths, observed vs expected mortality Reduction in hospital-acquired infections, falls etc	To be defined

				Reduction in readmissions within 30 days	
Ben8	Reduction in litigation / Improved management of litigation cases	Quantifiable – Cost Avoidance	Generic to All	Possible Measures- Number of litigation cases opened per year Total cost of settlements or legal fees Number of serious incidents reported	To be defined
Ben9	Reduction / Improved management in 'Listening to People' Procedures, investigations	Quantifiable – Cost Avoidance	Generic to All	Possible Measures - Number of new Putting Things Right (PTR) or Listening to People cases per month/year % reduction in repeat PTR cases for similar issues	To be defined
Ben10	Service Optimisation and development opportunities	Quantifiable – Cost Avoidance and Cash Releasing Benefit	Generic to All	Possible Measures- Reduction in the digital system or process in place to record and store information. Reduction in payment to the external suppliers to update or manage different systems	To be defined

Benefits mapping has been progressed using the national benefits model, with a benefits tracking roadmap developed through a structured benefits register. This will support ongoing monitoring, realisation, and governance of identified benefits throughout the programme lifecycle. Benefits Register is added in **Appendix G**.

6.3.3 Non-quantifiable Benefits

The following table summarises the key non-quantifiable benefits associated with the Programme. These reflect expected improvements to health service delivery that are not currently fully achieved through existing systems and highlight the wider value of the EHR beyond measurable financial or efficiency benefits.

Table 22: Non-quantifiable benefits

Theme	Type	Description
Improved care, citizen experience and	Consistent and standardised service	There is an opportunity to use standardised documentation resulting from the availability of

increased trust in the service from users	throughout the patient journey	national forms on a digital solution. This provides the opportunity for staff to accurately record patient/citizen information in a consistent and standardised manner and to improve communication following handovers. Helps eliminate unwarranted service variation by approaching care in a more consistent and standardised manner. Opportunity for citizen records to be better understood and organised and therefore easier to navigate leading to improved quality of care.
	Improved access to patient records by clinical staff	Improved access to patient records and the ability to see assessments etc created by other services, will create an improved experience for the patients as they won't be asked to repeat the same information.
	Reduction in referral to treat times	Easier caseload management and the ability to link electronically booked appointments to reminder services can reduce waiting lists. Also increased compliance to meet Healthy Child Wales Measure, reducing community waiting lists.
	Reduction in DNA appointments / missed contacts	Through integration, the system will deliver text message reminders, reducing the number of DNA appointments / missed contacts.
	Reduction in wasted visits	Notifications sent from other national systems will inform teams of when their patients have been admitted elsewhere and are unavailable for appointments.
	Better management of cases	Improved record keeping and communication leading to a lower risk of adverse events and errors, particularly those involving the management of higher-risk cases e.g. safeguarding.
	Accessibility of information for complaints	By information being more easily accessible for investigations and complaints it will potentially reduce the amount of time for investigations and citizen/family, waiting for a response
	Increase in the number of patients who have a current care and treatment plan	A digital solution will provide clinical staff with reminders when care and treatment plans and other documents (e.g. completed assessments, safeguarding referrals) are due for review which will help staff to plan review meetings and ensure care and treatment plans are up to date.
	Enhanced data security	Digital citizen data is better protected than manual

		records (provided it is supported by appropriate data and security protocols). Electronic information has a reduced risk of records being lost.
	Clinical governance	Digital tools such as dashboards help to identify citizen safety issues through alerts and ensure timely and appropriate action can be taken, where required, to ensure high quality care.
Added security and audit trail	Easier to track changes in a more secure environment	Added security of an electronic record with auditable access logs reduces the risk of data breaches.
Workforce planning and staff safety	Improved workforce planning of resources	Digital solution will provide information through dashboards for effective caseload management. Mobile also shows where staff are, based on their last status change so the closest, most relevant worker can attend any urgent visits that may come in during the day.
	Improved staff experience	Improve staff experience and make it easier for them to deliver the high value work they are trained to do and enable them to provide a better and more responsive service to the people they are supporting. This will support staff retention and employment objectives.
	Improved staff safety in the community	Digital solution will display patient risks in the banner, making staff aware. A lone worker app function can also be installed on a mobile device to track staff.
	Carbon footprint	Mobile can help to minimise unnecessary travel by enabling staff to complete work whilst they are out in the community without the need to return to an office base to update their records. A reduction in paper, printing and postage costs, and associated record storage as a result of using a digital system.
Monitoring and reporting	Tracking outcomes	The system will store care outcome data so there will be an improved ability to track outcomes leading to an improved citizen experience.
	Improved information available for reporting and benchmarking	As some standard reports will be generated by the system, staff will spend less time gathering information manually.
	Improved information available for the operational management of teams	As a result of Connecting Care dashboards, teams have improved information available to support the day to day running of wards and teams. The diary function supports improved staff safety as managers can view staff location. For Phase 3 staff will be able to check in

		and out of appointments which will give improved visibility

6.4 Risk management arrangements

The benefits outlined above form a core component of the programme's risk mitigation strategy and will be actively monitored through the Benefits Realisation Plan to ensure that anticipated risk reduction is achieved and sustained over time.

A comprehensive risk management approach will be applied throughout procurement and implementation. Risks will be systematically identified, recorded, regularly reviewed, and escalated through established project governance arrangements. Where appropriate, risks will be escalated to the corporate risk register, as directed by the Senior Responsible Owner (SRO), to ensure appropriate organisational oversight and management.

We anticipate the key risk themes will include:

- clinical safety and service continuity.
- procurement and supplier capacity.
- data migration and integration.
- workforce readiness and digital skills.
- infrastructure and device availability.
- change saturation across services.

Risks will be actively identified, assessed, and managed through the project's Risk Governance Framework, with categorisation covering the following areas to ensure comprehensive oversight and mitigation:

- Benefits
- Communication
- Compliance
- Financial
- ICT
- Operational
- People
- Performance
- Plan/Progress
- Process
- Project Dependency
- Resources
- Scope

- Strategic
- Technical

Mitigation plans will be embedded within programme planning and regularly tested.

All risks are scored using the Health Boards matrix:

Table 23: Risk Scoring Matrix

Likelihood →					
Consequence ↓	1 - Rare	2 - Unlikely	3 - Possible	4 - Likely	5 – Almost Certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Score Matrix		
	1 to 3	Low risk
	4 to 6	Moderate risk
	8 to 12	High risk
	15 to 25	Extreme risk

6.5 Quality Assurance

A formal Quality Management approach will be created, specifying the Quality assurance processes which will be delivered through formal programme reporting, gateway checks, digital assurance processes, clinical safety reviews, technical validation, and compliance with national standards. Independent assurance may be sought for key milestones such as procurement, migration and go live readiness.

Assurance will be sought from the Digital Clinical Safety Officer to ensure the system is fit for purpose and poses no risk to patient safety as part of the UAT sign off process prior to any implementation.

6.6 Post-Project Evaluation

Post-implementation reviews will assess whether the project has delivered the intended benefits, met clinical and operational objectives, and achieved value for money. Evaluations will include staff and user feedback, data quality metrics, reporting completeness, workflow improvements and service outcomes. Lessons learned will be documented to inform future digital transformation programmes.

The following post-project evaluations will be undertaken and shared nationally with DHCW and other Health Boards:

1. Project Closure
2. Post Project Evaluation Strategy (PPES)
 - a. Project Implementation Review (PIR)
 - b. Project Evaluation Review (PER)

Currently, the PRINCE2 best practice framework is used for Post-Project Evaluation, however this approach will be reviewed to incorporate guidance within the Magenta Book.

A lesson learnt review will also take place and will be available to other HBs and DHCW.

6.7 Equalities Impact Assessment and (EQIA) and Data Protection Impact Assessment (DPIA)

An Equalities Impact Assessment (EQIA) and Data Protection Impact Assessment (DPIA) will be undertaken to ensure the digital solution is compliant with equality legislation, accessible to all users, and meets data protection and information governance standards. These assessments will be updated throughout the programme lifecycle.

6.8 Current Risks/Issues with Mitigations

The risks identified below articulate risks to the success of the project. It is expected that mitigation will be required in the following areas and are related to the identified risks and issues against their probability of happening.

Table 24: Current Risks/Issues with Mitigations

Risk/Issue	Plan
Insufficient national funding	Health Board to assess financial position and if funding can be prioritised
Insufficient Health Board funding	Reduce the scope of the project with the focus on the higher risk, interdependent services
Any cost-saving benefits not being realised	Monitor the benefits plan, significant savings have not been identified as focus is on more time to care
Service change leads not being able to be released from duties due to staffing levels	Backfill has been added into the Financial Case or backfill is not possible due to recruitment and current staffing levels so the low intensity services will be used to support the high intensity services i.e. reduction in routine activity. Re-aligning the priorities of service managers.
Delays in recruitment and not able to recruit to the capacity and capabilities required to deliver the projects	Covered within 5% Optimism Bias
Additional deployment costs	Dependant on amount covered within 5% Optimism Bias for revenue but if Capital, the

	Health Board Capital budget would be required to be prioritised
Additional staffing on costs i.e., national salary increases	Covered within 5% Optimism Bias or provided by the Welsh Government through DHCW / DPIF

6.9 Assumptions, Constraints and Dependencies

Key assumptions include availability of national procurement outputs, supplier participation, and sustained funding. Constraints may include workforce capacity, infrastructure readiness and digital literacy. Dependencies span local digital programmes, national Connecting Care timelines and integration with existing systems.

Assumptions

- Continued Welsh Government support for digital transformation.
- Availability of suitable suppliers via approved frameworks
- Workforce engagement with digital transformation

Constraints

- Workforce capacity to support implementation
- Existing legacy systems and technical limitations
- Financial pressures within the organisation

Dependencies

- Alignment with Connecting Care programme timelines.
- Integration with national systems and platforms
- Availability of digital infrastructure and technical resources

6.10 The Management Case Conclusions

The Management Case sets out the governance arrangements, delivery approach and capability requirements needed to successfully procure and implement a Community Health digital solution.

At Outline Business Case stage, this section demonstrates that BCUHB has considered the scale, complexity and critical success factors associated with delivery, including (but not limited to) clinical leadership, engagement, assurance, and structured approaches to benefits, risk and change management, which directly support the Critical Success Factors set out in Section 3.3.

While the proposed arrangements provide a credible and proportionate framework at this stage, further development, confirmation and resourcing will be required at Full Business Case (FBC) to provide the level of assurance and confidence needed to proceed to delivery. This will include confirming programme capacity, final governance structures, detailed delivery plans and assurance mechanisms.

Subject to this further development, the Management Case establishes a sound foundation for progressing to FBC and for planning a safe, phased and sustainable transition to a modern digital Community Health system.

7. Conclusions and Recommendation

7.1 Conclusions

This Outline Business Case sets out a clear and evidence-based justification for investment in a modern digital solution for Community Health Services within Betsi Cadwaladr University Health Board.

Across all five cases, the OBC demonstrates that the current reliance on paper-based records and fragmented systems presents growing risks to patient safety, service quality, workforce sustainability and regulatory compliance. These risks are no longer theoretical; they are evident in day-to-day clinical practice and are illustrated through patient and staff experiences included within this document.

The Strategic Case confirms that digital transformation of Community Health is essential to delivering integrated, person-centred care and meeting both national and local strategic commitments. Without investment, Community Health Services will continue to face inefficiency, service variation and avoidable clinical and safeguarding risks.

The Economic Case identifies procurement of a dedicated Community Health digital solution as the most credible and deliverable way forward at this stage. While a detailed post-tender cost-benefit analysis is not yet possible, qualitative appraisal demonstrates that progressing to Full Business Case is necessary to confirm affordability, delivery approach and value for money.

The Commercial Case confirms that compliant procurement routes are available to BCUHB and that progression to market is achievable.

The Financial Case recognises that costs remain estimated at this stage, subject to formal tender and commercial discussions with the preferred system supplier. The OBC demonstrates that the Services are committed to ensuring recurrent financial affordability through the delivery of cash-releasing savings, including the need to maximise the conversion of efficiency and productivity benefits into cash-releasing benefit, whilst also maintaining safe and effective community services.

The Management Case provides assurance that proportionate governance, leadership and delivery arrangements can be put in place to manage the complexity of the programme, subject to further development and resourcing at Full Business Case stage.

Overall, the OBC provides a coherent and balanced case for progression to FBC and supports an informed decision to move to the next stage of development.

7.2 Recommendation

This Outline Business Case presents a clear and compelling case for investment in a Community Health Digital Solution. The preferred option offers a deliverable, strategically aligned, and affordable approach to addressing current service challenges and enabling future transformation.

It is recommended that Betsi Cadwaladr University Health Board:

Approve progression to Full Business Case for the procurement and implementation of a Community Health digital solution, based on:

- a locally led procurement approach, either through
 - **Option 4a:** a BCUHB-led standalone procurement, or
 - **Option 4b:** a joint procurement with one or more Health Boards,
- with the preferred route to be confirmed at Full Business Case stage following further commercial, financial and governance analysis.
- the final FBC presented for Board Approval will demonstrate and evidence recurrent affordability.

In line with the national programme requirements, BCUHB has submitted the anticipated costs of implementation costs to DHCW. These have been incorporated into the national business case, submitted by DHCW to Welsh Government for the funding required to support the implementation costs in each Health Board. A decision is awaited.

- confirm the strategic direction for Community Health digital transformation.
- progress a procurement exercise including detailed commercial planning and market engagement.
- refine scope, costs, benefits and affordability.
- and develop a Full Business Case that enables timely risk reduction while retaining alignment with national digital standards and opportunities.

8 Declarations

☐	The above information has been reviewed to ensure it is accurate and represents a true and fair view of the service to be provided, the benefits and the costs
☐	Where third parties have provided information, this is in writing/e-mail format, and they have confirmed it is correct to the best of their knowledge
☐	Where the OBC has an impact on another Area / Division / Department the impact has been agreed with that Area / Division / Department in writing and the relevant Managers have signed below to confirm

Title	Name	Signature	Date

9. Appendices

Appendix Ref	Name	Link
A	Governance Map	Link
B	Risk Register	Link
C	BCUHB Non-Functional Integration Requirements	Link
D	Children's Services Requirements	Link
E	Adult Services Requirements	Link
F	Welsh Language Compliance	Link
G	Detailed Benefits Register	Link
H	National Requirements	Link
I	Technical Process Map	Link
J	Stakeholder Register for OBC	Link
K	Connecting Care OBC – SMART Goal Definition	Link
L	Community Health Financial Model	Link



Health Board

NORTH DENBIGHSHIRE CLUSTER GP PRACTICE SUSTAINABILITY PROPOSAL

Dyddiad y Cyfarfod Date of Meeting	30 July 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Alison Kemp - Associate Director, Primary Care & Community Services Central IHC Robyn Watson -Primary Care Programme Manager Central IHC
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Tehmeena Ajmal - Chief Operating Officer
Pwrpas yr Adroddiad Report Purpose	For Noting

Crynodeb Gweithredol **Executive Summary**

Healthy Prestatyn Iach (HPI) was established in 2016 following the resignation of three independent GP practices to support a registered patient population of approximately 23,000. Since that time, the list size has reduced by more than 20% to around 17,600 patients; however, the practice boundary and operating model have never been reviewed.

Following discussions with the North Denbighshire GP collaborative and cluster, individual practices and the HPI management team, a proposal has been developed to revise the HPI practice boundary. This would result in approximately 5,000 patients transferring to neighbouring practices, supporting the long-term sustainability of general practice services across the North Denbighshire Cluster. Independent practices within the cluster have indicated support for the proposal and have identified opportunities, by increasing their list size, to support workforce development, partnership succession planning and practice sustainability.

An eight-week engagement period commenced on the 4th of June, running to 31st July 2026. All affected households have received information by letter on the proposal and opportunities to provide feedback. Although the engagement period

remains open until the end of July and a final engagement report has not yet been completed, there are themes that have been identified. These include continuity of care, support for patients with complex healthcare needs, concerns regarding travel and public transport links, capacity within receiving practices, arrangements for palliative care patients and those awaiting diagnosis. These themes are being reviewed and will inform the development of the proposal and additional mitigation where required.

Initial analysis indicates that most affected patients would transfer to a practice that is either closer, or as close, to their home address as HPI sites. A small number of patients may experience increased travel times, particularly where public transport is relied upon, and this is being considered through the programme risk register and EqIA and may inform some modification to the initial boundary proposals.

All patients would be allocated to alternative Practices, with no need to take action to re-register. No patient would be left without a GP Practice. Patients will only be allocated to GP Practices who have expressed a desire to increase their list size. These Practices will be asked to submit plans for how they will accommodate increased numbers of patients, to ensure they are prepared to meet their needs and the needs of their existing patients in the Practice.

If approved by the Primary Care Panel, the proposal would require a review of HPI's operating model to ensure services and workforce arrangements are aligned to the revised patient population. Any workforce implications arising from this review would be managed through the Health Board's Organisational Change Policy (OCP).

The Health Board is asked to note the proposals and engagement process and approve the process for the agreement of the final proposals.



Ymgysylltu (mewnol/allanol) yr ymgwymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp)

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	Dyddiad Date	Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data
North Denbighshire General Practice Collaborative	Ongoing from 2024	All six practices in the Cluster are supportive of the proposal. Practices have expressed appetite to grow their own list size to support long term sustainability and partnership succession planning
Llais	2025 onwards	Discussions with Llais regarding the proposals and approach to engagement. Discussions have continued and Llais officers have supported the current engagement process. Chief Officer attended engagement event in Trelawnyd on 9 th July 2026.
Paper to Operational Leadership Team	28/10/25	Supported rationale and need to engage on proposals. Requested that engagement take place in late Spring.
Conwy & Denbighshire Wellbeing Network	04/06/26	Briefed approx. 40 attendees from local statutory and third sector organisations on the proposals and engagement plans and invited feedback
Email to elected officials and senior officers in DCC and FCC.	10/06/26	Informed elected officials (MS, MPs, Leader of DCC and FCC Councils) and senior officers of the proposals, and shared a copy of the letter being sent to affected patients and details of the engagement process.
Email to affected GP Practices outside North Denbighshire Cluster	10/06/26	Email to six GP Practices outside the North Denbighshire Practice whose boundaries overlap HPI's current boundary, informing them of the proposals and seeking feedback.



Ageing Well in Denbighshire Forum	16/06/26	Attended meeting to brief attendees (statutory and third sector organisations), and to support dissemination of information
Letter outlining proposals	04/06/26-31/07/26	Letters sent to 2,535 households identified as falling outside of the proposed boundary, detailing the proposed changes, the potential impact, and details on how to feedback questions, concerns and views.
Feedback received via Microsoft forms	04/06/26-31/07/26	107 responses have been received to date. The most common feedback themes are around continuity of care, with patients noting their relationships with the team at HPI; concerns about those with complex care needs changing practices; access and transport to alternative practices; capacity of receiving practices; future of Rhuddlan Surgery.
Feedback received via email	04/06/26-31/07/26	37 emails have been received to date. The main issue raised (n=14) related to patients requesting additional information such as the proposed boundary map or asking if their postcode would be affected. 11 patients noted that they wished to remain with HPI and therefore objected to the proposal. Other themes included continuity of care, access and transport, and concerns around the impact of moving to a different practice.
Feedback received via telephone		32 calls have been received to date. The largest category of calls related to patients requesting additional information (n=8). Five patients noted that they wished to remain with HPI and therefore objected to the proposal. Other themes included access and transport, complex health needs, and continuity of care.
Patient engagement event at Rhyl Library	23/06/26	Led by BCU team, representatives from Clarence Medical Centre and Lakeside GP Practices. Around 10 members of the public and a town councillor attended to discuss the



		proposal and provide feedback. Patients were supportive of sustainable GP services but sought reassurance around continuity of care, communication and access to local services.
Attendance at Workforce Planning Forum	26/06/26	Briefed Trade Union and Workforce team on the boundary change proposals and possible impact on staffing configuration in HPI, which would be managed in line with the Health Board's Organisation Change Policy (OCP). EqIA requested prior to an OCP commencing.
Patient engagement event at Rhuddlan surgery (HPI branch)	26/06/26	Led by BCU team, Senior GP Partner and Practice Manager from Madryn House Surgery attended. About 22 members of the public attended, including patients, the mayor of Rhuddlan, County and Town councillors. Attendees asked about maintaining access to the Rhuddlan branch site and continuity of care.
Meeting with Becky Gittins, MP	02/07/26	Meeting to provide background to the proposals, discuss issues raised by constituents and discuss engagement activity.
Patient engagement event at Trelogan Community Centre	02/07/26	Led by BCU team, Senior GP Partner, Practice Manager and Deputy Practice Manager from Park House Surgery attended. Around 30 members of the public attended, including patients, town councillors and local MP. Residents expressed significant concern about transport (limited public transport to Prestatyn or Holywell), continuity of care and maintaining relationships with trusted healthcare professionals. Attendees welcomed the opportunity to ask questions directly and appreciated the reassurance that feedback would help shape the final proposals. Patients were also reassured that all affected patients would be allocated to a new GP Practice.
Patient engagement event at Trelawnyd Memorial Hall	09/07/26	Led by BCU team, with approximately 20 members of the public attending, including patients and town councillors. Those present asked about the impact of the proposals on

		continuity of care if they were transferred to a different GP practice. There were also questions about what services would continue to be available at HPI if the proposals were approved.
Text message to 200 parents of children aged under 7 years registered with HPI	10/07/26	Text message sent with a link for responses due to low response rate from this group to previous methods. 14 responses received to date.
Patient engagement event at Gwespyr Community Centre	23/07/26	The event has not taken place at the time this paper was submitted. All feedback received will be incorporated into the final engagement report.
Health Board's AGM in Rhyl	29/07/26	The AGM has not taken place at the time this paper was submitted. All feedback received will be incorporated into the final engagement report.

Acronymau / Rhestr Termau

Acronyms / Glossary of Terms

HPI	Healthy Prestatyn Iach / Healthy Rhuddlan Iach
North Denbighshire Cluster	Designated geographical area covering the north of the county of Denbighshire, with established arrangements for collaborative working across health, social care and third sector organisations, including independent primary care contractors.
Practice Boundary / Area	Designated area, marked on a map, which forms part of each General Medical Services contract. Patients living within a practice area are entitled to register with the GP Practice (unless they have been excluded following a formal process).
EqIA	Equality Impact Assessment
OCP	Organisational Change Policy
GP	General Practitioner
NWSSP	NHS Wales Shared Services Partnership
GPOOH	GP Out of Hours Service

NORTH DENBIGHSHIRE CLUSTER GP SUSTAINABILITY PROPOSAL

1. Y SEFYLLFA SITUATION

- 1.1 The North Denbighshire Cluster includes six GP Practices. Discussions have been held in the GP Collaborative meetings to consider options to improve Practice sustainability. A number of the Practices in the Cluster have identified a need to grow their patient lists and to secure branch premises, to improve their long-term sustainability and ensure comprehensive provision for the population.
- 1.2 One of the Practices in the Cluster, Healthy Prestatyn Iach (HPI) is a Health Board Managed Practice. It is the fourth largest GP Practice in North Wales and operates across five sites, with a list size of just over 17,500 patients. The practice boundary, formed by the merger of three former practices, currently covers the whole of the North Denbighshire Cluster and extends into the north east area of Flintshire. Consolidating HPI's services over a smaller area, from fewer sites, could improve its operational efficiency whilst supporting neighbouring practices who need to grow their lists to support their own sustainability.
- 1.3 It is therefore proposed that HPI reduce its boundary and allocate patients living outside its new boundary to neighbouring practices, enhancing the sustainability of all Practices in the Cluster and securing long-term service provision for the population. Just under 5,000 patients would be affected by the current proposals.
- 1.4 Due to the scale of the proposed boundary change, the Health Board is engaging with patients and stakeholders. The purpose of this paper is to update Board members on the proposal, the progress of the engagement and the process the Health Board will follow to make a decision on the boundary change proposals.

2 Y CEFNDIR BACKGROUND

- 2.1 HPI was established in 2016 following the resignation of three local independent GP practices. It had a patient list of 23,000 patients and was the largest practice in North Wales. However, its patient list has fallen consistently since 2016, and has now reduced by 23%, to 17,600 patients. Despite this significant change in list size, the practice's operating model and boundary have not been reviewed.

-
- 2.2 Over the past 18 months, discussions have taken place with the North Denbighshire GP collaborative, individual practices and with the HPI management team around the long-term sustainability of GP services within the cluster. These discussions confirmed support by all practices within the Cluster for HPI's proposal to reduce its patient list by adjusting its boundary and subsequent movement of patients to support their own practice sustainability.
- 2.3 Practices have stated that this action would support workforce and service development within their practices , benefitting the whole practice population.
- 2.4 Two GP Practices in the Cluster, Madryn House and Park House, have increased their Practice boundaries, to support a growth in their list size.
- 2.5 Following discussion within the Central Integrated Health Community (IHC) Management Team and with primary care colleagues in the East IHC, proposals to reduce HPI's list size were developed. These proposals were supported by the Central IHC's Senior Leadership Team and were subsequently agreed at the Operational Leadership Team meeting, chaired by the Health Board's Chief Operating Officer.
- 2.6 Agreement to change GP Practice boundaries is sought through a submission to the Health Board's Primary Care Panel. The Panel acts on behalf of the Board, to consider and make decisions on applications from GMS Contractors to amend service provision in accordance with the relevant Contractual regulations.
- 2.7 In line with the Health Board's obligations, the documentation submitted to the Panel must demonstrate that appropriate stakeholder engagement has been undertaken on any proposed changes.
- 2.8 The engagement approach has been determined in discussion with Llais and has been informed by the 'Welsh Government How to Make Changes to NHS Services' guidance. The proposals have been assessed as a Moderate Service Change. In line with the guidance, an eight-week engagement period started on the 4th June and will conclude on 31st July 2026.
- 2.9 Engagement activity is summarised in the table at the beginning of this paper. It has included written communication, in person engagement sessions with patients and meetings with elected representatives. A report of engagement activity will be produced at the conclusion of the engagement period. The feedback received will influence the formulation of final proposals, including possible changes to the proposed boundary and additional mitigation regarding any concerns expressed by patients and stakeholders.
-

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

- 3.1 Engagement activities will continue until 31st July 2026 and a final engagement report will be compiled. Themes identified through the patient and stakeholder feedback to date include continuity of care, support for patients with complex needs, travel and transport, capacity within receiving practices, access to services within the town of Rhuddlan, arrangements for palliative care patients and those on 62-day cancer pathways.
- 3.2 Initial review of the affected patients demonstrated that the vast majority of patients would transfer to a practice that is as close, or closer, to their home address than HPI premises. Exceptions, explored further through our engagement sessions, are patients residing in and around Llanasa, Trelawnyd, Trelogan and Bodelwyddan (n=340).
- 3.3 The primary care team is working with Cluster Practices to identify additional options to mitigate the issues outlined in 3.1 and 3.2 and these will be reflected in the final proposals submitted for the Primary Care Panel's consideration. This will include a commitment to the continued operation of the Rhuddlan surgery premises as a branch surgery; no transfer of patients who are receiving end of life care, or are on 62-day cancer pathways; clinical handover of complex patients between GPs and, in exceptional circumstances, patients remaining with HPI; and suitable arrangements for current HPI patients living in the areas highlighted in 3.2 above.
- 3.4 Advice has been sought from the NHS Wales Shared Services Partnership (NWSSP) on our approach to the allocation of patients, ensuring that all contractual and procurement requirements are followed. Receiving practices will be required to confirm the number of patients they can accommodate and any additional workforce they will be recruiting to support the additional demand. A structured and phased patient dispersal approach will be used to ensure patients continue to have access to primary care services throughout the process. Patients will only be allocated to Practices that wish to grow and have robust plans in place. Patient dispersals would not commence until January 2027 and would take place over a number of weeks.
- 3.5 The process for the proposal's consideration is as follows:
- 30th July 2026: Health Board Public Board
 - 18th August 2026: Primary Care Panel will consider the final boundary change proposal
 - 26th August 2026: Strategic Planning, Sustainability and Capital Group (SPSCG), chaired by Chief Executive Officer, for ratification

3.6 The Panel will be asked to approve a boundary change to come into effect from 1st January 2027. This implementation date recognises the programme of work required prior to patient transfer, including governance approvals, contractual and procurement considerations, patient allocation processes, and communication with patients. After the Panel's decision, new patients wishing to register with HPI who live outside a revised boundary will continue to be eligible to register with HPI until 31st December 2026 but will be informed of the changes which would come into effect from 1st January 2027, where they would be allocated to a new Practice.

3.7 Work has commenced with the team in HPI to review and revise the Practice's staffing model. This is being supported by professional leads and trade union colleagues. The size of the Practice will be determined by the Panel's decision and this will inform the model and subsequent consultation with the staff on any changes.

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

4.1 The boundary change proposals and any subsequent changes agreed by the Health Board are being coordinated through a formal project, led by the Associate Director for Primary Care & Community Services and supported by a full time Project Manager. Formal project documentation, including a risk and issues log, has been developed and there will be close management of risks within the project. The Project reports to the Central IHC and will also submit highlight reports to the Primary Care Board and Strategic Planning, Sustainability and Capital Group.

4.2 The key risks can be categorised under four headings; North Denbighshire Cluster GP Practice sustainability, Patient Dispersal and Transition, Access & Transportation and HPI Service and Workforce model.

4.3 North Denbighshire Cluster GP Practice sustainability

4.3.1 Practices within the Cluster have indicated that increasing their own list sizes would support their own long-term sustainability. Smaller incremental patient growth is unlikely to provide practices with the same opportunity to increase their staffing as they will need to build the lists and reach thresholds of patient numbers before investing. This will not enable service development or support long term sustainability.

4.3.2 If HPI's boundary does not change, it will result in HPI continuing to operate across a boundary that was established to support approximately 23,000 patients. Their list size, which has already reduced by more than 20% since 2016 is likely to continue to fall (has every year since formation).

Neighbouring practices will have to continue to pick up patients without the opportunity to plan and increase their provision in line with the changing demand. The incremental fall will also create challenges for HPI in its review of its service model and opportunities to develop a more sustainable service and model.

4.4 Patient dispersal and transition

- 4.4.1 The proposed patient dispersal approach has identified risks relating to continuity of care, patient experience and access to services. Through engagement, patients have expressed concerns regarding transferring to a new GP practice, maintaining established relationships with the team at HPI, disruption to ongoing treatment and potential impact on vulnerable patients, carers and those with complex needs and on those receiving end of life care when the changes were implemented.
- 4.4.2 Early discussions have been held with NWSSP who will support the dispersal process. The dispersal will be undertaken in partnership with NWSSP and the Practices involved in a structured and phased approach to support a safe transition for patients. Patient allocation, exemption and complex patient handover processes will be developed as part of the plan and will be supported by ongoing communication with patients and stakeholders. Patients receiving end of life care will not be transferred to a new practice.
- 4.4.3 There will be a focus on maintaining continuity of care for vulnerable patients, those with complex needs and patients awaiting a diagnosis. This will aim to minimise disruption to patients and ensure receiving practices have appropriate capacity to safely welcome and care for patients who have been allocated to a new practice.
- 4.4.4 Quality indicators will be closely monitored before, during and following the changes to ensure standards are maintained. These indicators will include timely access to services, onward referrals to secondary care services, ED attendances, GPOOH attendances, and the management of chronic conditions in primary care. This monitoring will inform ongoing management of contracts with the Practices and any remedial support or action required.

4.5 Access and transportation

- 4.5.1 A small number of patients (n=207) may experience longer travel times to a different practice, particularly those living in Llanasa, Trelawnyd and Trelogan. The impact would be most for those who rely on public transport, have limited access to a car, have disabilities, or who are required to attend the practice regularly.

4.5.2 Options are being explored to support the mitigation of this risk for patients living in these areas. These include discussions with neighbouring practices regarding boundary arrangements and consideration of whether affected patients could register with a Prestatyn Practice.

4.6 HPI workforce and service model

4.6.1 HPI's workforce model was developed in 2016 when the practice had approximately 23,000 patients. Since that time, the list size has reduced to approximately 17,600 patients, however, the staffing structure has not been formally reviewed. There is a risk therefore that the current model is not suitable to the size of the practice

4.6.2 In recognition of its already falling list size, and further potential changes, HPI has already held recruitment to some non-clinical roles and advertised some roles on a fixed term basis. Subject to the outcome of the boundary proposal, a full review of the service model and staffing will be undertaken. Any workforce implications identified will be assessed through a separate Equality Impact Assessment and managed in accordance with the Health Board's Organisational Change Policy, ensuring staff are appropriately engaged, consulted and supported throughout the process.

5 **ARGYMHELLION RECOMMENDATIONS**

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

- Note the proposals to improve GP Sustainability in the North Denbighshire Cluster
- Note the progress of the engagement process and actions bring considered following feedback
- Note the timescale and process for the boundary change proposals



ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol Link to Strategic Priorities	     4. Improving quality, outcomes and experience
Yr Egwyddorion Dylunio Design Principles	Simplify, Standardise, and Adopt Best Practices
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	Approximately 90% of patient contacts take place in Primary Care. Stable primary care provision is essential to enable timely access to care for our population. These proposals seek to improve the sustainability of GP Services within the Cluster, ensuring provision in the long term.

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Cydraddoldeb <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)</i>	Do/Yes: ☒	Naddo/No: ☐
	Canlyniad/Outcome:	Full EqIA required and populated with data, themes from engagement and mitigation
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	n/a
Asesiad o'r Effaith Economaidd-gymdeithasol <i>A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?</i> Socio-Economic Impact Assessment <i>Have you undertaken a Socio-Economic Impact Assessment</i>	Do/Yes: ☒	Naddo/No: ☐
	Canlyniad/Outcome:	EqIA screening highlighted a need for a SEIA and this is complete
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	n/a
<u>Answadd</u> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Answadd?</i> Quality	Galluogwyr Answadd Enablers of Quality All Apply	Meysydd Answadd Domains of Quality All Apply

Have you undertaken a Quality Impact Assessment Screening?		
	In progress	
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals	A Resilient Wales	

Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog: Armed Forces Covenant Due Regard Duty Have you considered the Armed Forces Covenant Due Regard Duty?	Do/Yes: ☒	Naddo/No: ☐
	Canlyniad/Outcome:	For inclusion in the EqIA, at this stage no specific impact has been identified as a result of this proposal.
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Asesiad o Effaith ar Ddiogelu Data A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data? Data Protection Impact Assessment Have you undertaken a Data Protection Impact Assessment Screening?	Do/Yes: ☒	Naddo/No: ☒
	Canlyniad/Outcome:	DPIA completed and sent for review
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Asesiad o Effaith ar Atal Twyll A ydych chi wedi ystyried yr effeithiau ar atal twyll?	Do/Yes: ☒	Naddo/No: ☐
	Canlyniad/Outcome:	No risks identified at this stage

Counter Fraud Impact Assessment <i>Have you considered the counter fraud impacts</i>	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Cyfreithiol Legal	Yes (Include further detail below)	
	Any relevant procurement and contractual legislation will be followed in the dispersal of patients to new Practices.	
	GDPR and Information Governance requirements will be met, in partnership with Digital Health & Care Wales and all participating practices. All relevant employment law will be followed in the planning and implementation of any workforce changes.	
Enw Da Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith ar Adnoddau (Pobl / Ariannol) Resource Impact (People / Financial)	Yes (Include further detail below)	
	People: A review of staffing levels in HPI is required due to the fall in patient numbers which has taken place over recent years. Agreement to a change in the boundary as proposed, would result in a further reduction of around 5,000 patients in the number of registered patients in HPI, impacting further on the revisions needed in the staffing model. This will be managed in line with the Health Board's Organisational Change Policy. Engagement with staff is taking place and the Workforce Planning Forum have been briefed. Financial: There will be some transitional costs associated with the changes, for example in communicating with patients and supporting safe transfers of care. We propose to manage this within existing budgets. GP Practices receiving transferred patients will be reimbursed through the GMS budget and funding arrangements.	

Health Board

PLANNED CARE MAJOR CHANGE PROGRAMME

Dyddiad y Cyfarfod Date of Meeting	30 July 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Danielle Edwards, Programme Director – Planned Care Michael Kaiser, Recovery Director Planned Care
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Tehmeena Ajmal, Chief Operating Officer (SRO)
Pwrpas yr Adroddiad Report Purpose	For Assurance

Crynodeb Gweithredol Executive Summary

The Planned Care Major Change Programme continues to provide the strategic framework for planned care transformation across BCUHB, delivering against IMTP commitments while supporting immediate recovery and longer-term sustainability objectives. Following closure of the 2025/26 programme, lessons learned were incorporated into the 2026/27 prioritisation process, resulting in 15 approved projects and initiatives, with 1 additional project pilot approved to start in the July meeting, and a further 8 opportunities identified for future development. A broader Planned Care Recovery Plan is now being developed, with the longer-term ambition of consolidating recovery, fragile services, transformation, and improvement activity into a single specialty-based delivery framework.

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

Alongside the major change programme, the Health Board is developing a single recovery plan to ensure delivery of IMTP trajectories and consistent and sustained overall improvement in activity, productivity and efficiency. Speciality level reviews have been completed with clinicians and operational leads from across the Health Board to identify issues, opportunities and priorities. The plan will operate at a speciality level, that is utilising capacity across the Health Board rather than site by site. This will enable the Health Board to equalise waits across the region and make best use of available capacity, ensuring the Health Board operates as a single regional organisation.

In addition, the Cabinet Minister for Health recently announced a new funding programme to ensure in-year delivery of planned care trajectories across Wales, whilst developing sustainable solutions going forwards. Health Boards are required to submit detailed proposals, which will be reviewed by a central expert panel. The first stage focused specifically on eliminating 104 waits; the second stage will include diagnostics, productivity and longer-term solutions for sustainability.

Key achievements during Q1 include:

- Deployment of the 'tranche' version of the Patient Validation Chatbot; now live within Gynaecology and scheduled for wider rollout to long-waiting patients from >26 weeks across Stages 1 and 4.
- Expansion of national WPRS WAP e-Referrals, with 10 specialties now live across BCUHB.
- Delivery of 228 Community Health Pathways (CHP), exceeding the Q1 target and supporting more consistent referral management, with work to embed threshold management from CHP within the clinical triaging model.
- Increased Teledermoscopy capacity, maintaining a 66% discharge rate and reducing unnecessary outpatient appointments.
- Development of the One Waiting List programme model for approval in August Programme Board and drafting of, and engagement on, a standardised booking Service Level Agreement.
- Submission of the Surgical Hub Accreditation application, with Llandudno selected for national cohort two review.
- Completion of all national specialty self-assessments (CIN reviews), providing a foundation for future service optimisation and GIRFT implementation.
- Successful relaunch and expansion of See on Symptom (SOS) and Patient Initiated Follow-Up (PIFU) pathways, alongside commencement of follow-up waiting list reduction.

Areas of risk requiring continued focus during Q2 include:

- Recruitment delays affecting the expansion of validation capacity.
- Consultant job-planning constraints impacting dermatology transformation and clinical validation activity.
- Workforce and leadership capacity within the booking workstream.
- Funding decisions required to support implementation of the standardised Health Screening Questionnaire and Pre-Operative Assessment model.

- Alignment of programme governance with the emerging Planned Care Recovery Plan and wider organisational changes.
- Confirmation of future Senior Responsible Officer (SRO) arrangements following the planned transition from the current Chief Operating Officer.
- Ensuring sufficient capacity to deliver in year recovery alongside sustainable improvement

The principal risks remain workforce capacity, inconsistent adoption of improvement initiatives across services, limited operational leadership dedicated to planned care, and the ability to embed transformational changes alongside significant recovery pressures. Despite these challenges, the programme continues to demonstrate measurable progress against its transformation objectives and remains a critical enabler of improving access, outcomes, and patient experience across North Wales.

Overall Assessment: The programme is delivering tangible benefits across pathway validation, referral optimisation, booking, and follow-up management, but more specialised work is required in the space of theatre optimisation. While several initiatives are forecast as at risk for Q2, mitigating actions are in place and the programme remains well positioned to support recovery ambitions and the development of a single integrated Planned Care delivery plan.

Ymgysylltu (mewnol/allanol) yr ymgwymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp)

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	Dyddiad Date	Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data
Cancer Network Manager	09/07/2026	Contribution to the update for Workstream 2/6(i)
Lead for diagnostic capacity and demand improvement.	09/07/2026	Contribution to the update for Workstream 2/6(ii)
Recovery Director	10/07/2026	Contribution to sections 2.3 and 4.1

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

CIN self-assessments	National specialty self-assessments against best practice (including GIRFT) to reduce unwarranted variation, maximise capacity, improve outcomes and safety, and ensure equitable access to standardised, evidence-based pathways through robust governance
Clerical Validation	Skilled technical and administrative validation of the pathway to ensure accuracy and appropriate listing
Clinical Validation	Validation of the patient's clinical suitability



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Betsi Cadwaladr
University Health Board

Community Health Pathways (CHPs)	Digital tool designed to support healthcare professionals (HCPs) in primary care settings by facilitating adherence to standardised, evidence based, and locally adapted clinical pathways
Direct Booking	The patient is sent an appointment with information on how to contact to change, or is contacted by phone to arrange the appointment
DSCN	Data standards notice. Provided by Digital Health and Care Wales on direction of Welsh Government
e-POAC	Digital system management of the pre-operative assessment process
GIRFT	Get it Right First Time - a national NHS England programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change
Health Screening Questionnaire (HSQ)	Nationally endorsed, standardised tool supporting safe, equitable, and proactive elective pathway management in Wales
High-volume low-complexity listings	Standardised, routine elective surgeries (e.g., cataract extractions, simple joint replacements, or hernia repairs) performed efficiently in ring-fenced surgical hubs
IHCs	Integrated Health Communities
IMTP	Integrated Medium Term Plan
One Waiting List	All patients are waiting to be seen within a speciality 'in turn' across the whole health board (rather than a list per main hospital site)
Partial Booking	The patient is sent a letter asking then to contact to arrange an appointment, with reminder letters.
Patient Validation Chat-bot (EBO)	A system whereby the patient is contacted via a text message and invited to join in a virtual conversation to ask if they still want, or need their appointment, capturing the reason for the response and signposting to waiting well and mental health resources
Perioperative Care of Older People (POPS)	Improves surgical outcomes for older adults by integrating comprehensive geriatric assessments and multidisciplinary care into the surgical pathway
Q	Quarter e.g. Q1 is Quarter 1 of the financial year
RTT Guidelines	Sets out clearly and succinctly the rules and definitions for referral to treatment consultant-led waiting times to ensure that each patient's waiting time clock starts and stops fairly and consistently
SCEG	Strategic Clinical Effectiveness Group



See on Symptom (SOS) and Patient Initiated Follow-up (PIFU)	See on Symptom (SOS) and Patient-Initiated Follow-Up (PIFU) enable patients to access specialist follow-up when symptoms arise or when they feel review is needed, reducing unnecessary routine appointments while maintaining timely clinical support
Surgical Hub Accreditation	Nationally-led pan-Wales review of surgical hubs against a common criteria to support effective theatre optimisation
Teledermoscopy	Remote dermatology technique that uses dermoscopic imaging to assess skin lesions and support early detection of skin cancers
USC	Urgent suspected cancer
WPAS	Welsh Patient Administration System
WPRS WAP Full e-Referrals	National system that manages the referrals from primary care into secondary care for electronic triage, with the ability to provide e-advice and guidance back to the referrer

PLANNED CARE MAJOR CHANGE PROGRAMME

1. Y SEFYLLFA SITUATION

- 1.1 To report seeks to provide the Board with a clear, candid, and evidence-based assessment of progress against the Planned Care Major Change Programme, including delivery against milestones, impact on performance, and the current risk and assurance position. A summary section on planned care performance is provided and should be read in conjunction with the Integrated Performance Report also provided on the Board agenda.

2 Y CEFNDIR BACKGROUND

- 2.1 As a Major Change Programme, the Planned Care Programme Board has formal reporting arrangements to the Executive Committee via 6-weekly AAA reports, which provide strategic oversight and assurance, and serves as the primary forum for escalation and accountability. In addition, the Programme submits regular progress updates through the corporate reporting portal. The Portfolio Office provides consolidated monthly reporting to the Executive Committee, supplemented by programme-specific deep dives on a rotational basis or where heightened scrutiny, assurance, or decision-making is required.
- 2.2 The 2025/26 Planned Care Programme was closed following a detailed review presented to the Informal Executive Meeting on 18 March 2026. The review concluded that, across 27 projects supported by a programme resource of 7 WTE, 3 projects had been completed, 10 were on track, 10 were off track, 3 were on hold, and 1 was classified as a longer-term deliverable.

In order to learn and continuously improve an assessment of the factors that both supported and constrained progress was undertaken. A number of factors contributing to delivery delays were identified, including:

- the limited capacity in planned care operational leadership and management given the highly volume of work associated with day to day management of planned care – this constrains the delivery of programme elements into business-as-usual arrangements;
- competing Integrated Health Community (IHC) recovery priorities including across Urgent and Emergency Care, Primary and Community and Financial recovery;
- redeployment of programme resources to support operational activities;
- financial prioritisation and more limited nationally allocated resourcing constraining progression from design to implementation; and
- digital capacity limitations, particularly in relation to digital integration work.

Lessons learned from the previous programme cycle were considered during the 2026/27 Programme Board prioritisation process, alongside financial constraints, and the requirement to align delivery with Integrated Medium-Term Plan (IMTP) commitments. As a result, 15 projects and initiatives were initially approved for formal programme management, with 1 additional project pilot approved to start mid-way through Quarter 2, and a further 8 opportunities identified for scoping, business case development, and prioritisation. Engagement with Primary Care has been strengthened with regular meetings with nominated stakeholders, increased membership on the Programme Board and presentations to Local Medical Committee.

- 2.3 The health board has commissioned a Recovery Directory to support the delivery of Planned Care recovery. The longer-term ambition is to consolidate all planned care improvement and recovery activity into a single delivery plan. This approach is currently being scoped, with governance arrangements under development. In the interim, the Programme will continue to operate through its existing structure while the recovery plan is established, with the intention of transitioning to a single integrated plan.
- 2.4 Speciality level reviews have been completed with clinicians and operational leads from across the Health Board to identify issues, opportunities and priorities. The plan will operate increasingly at a speciality level, that is utilising capacity across the Health Board rather than site by site. This will enable the Health Board to equalise waits across the region and make best use of available capacity, ensuring the Health Board operates as a single regional organisation.
- 2.5 Therefore, a review of all specialities, services and modalities has been undertaken across the region to understand what is required to ensure no patients are waiting >104-weeks for planned care or >8-weeks for diagnostics. Services that are pivotal include Dermatology, ENT, Gastroenterology, General Surgery, Gynaecology, Ophthalmology, Oral Surgery, Pain, Trauma & Orthopaedics, Urology and Cardiac Physiology.
- 2.6 In addition, the Cabinet Minister for Health recently announced a new funding programme to ensure in-year delivery of planned care trajectories across Wales, whilst developing sustainable solutions going forwards. Health Boards have been directed to submit detailed proposals, which will be reviewed by a central expert panel. The first stage focuses specifically on eliminating 104 waits and over 8-week diagnostic waits; the second stage will include actions that support longer-term sustainability. It is important to note that the Welsh Government funding is non-recurrent for 2026/27.
- 2.7 The plan acknowledges areas where significant improvement has already been delivered, with the progress and current performance position outlined

below. Actions to address further challenges and fully meet the 104-week wait requirement in planned care and 8-week position in diagnostics have been identified with specialities across the Health Board. These include improved productivity and efficiency (particularly in Stage 1 – Referral Management and Outpatients), targeted insourcing & outsourcing (particularly at stage 4 – Operations/Procedures), increased validation, improved booking processes, use of modular theatre units and existing theatres at weekends with insourced teams, strengthened pathway management and tracking and additional capacity to ensure that all patients have undertaken pre-operative assessment in a timely manner. This includes maintaining diagnostic insourcing where required.

3 **ATERION PENODOL I'W HYSTYRIED SPECIFIC MATTERS FOR CONSIDERATION**

3.1 **Current Planned Care Performance – Summary** (note – performance slides are also provided in the Integrated Performance Report)

3.1.1 Diagnostics

There is both significant and sustained improvement in the timely provision of diagnostics, with performance ahead of the IMTP trajectory. Special Measures/Level 5 de-escalation is 75% and whilst this was planned in to be met at the end of Quarter 3, Welsh Government require the health board to meet this by the end of Quarter 2 (September 2026).

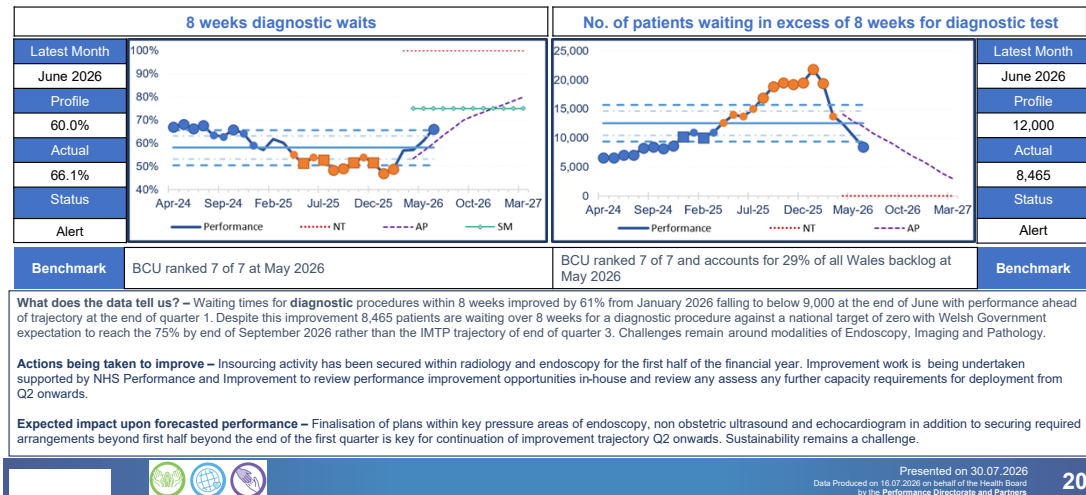
Management information at the end of June confirms the improved BCU position as 66%; benchmark performance against all other health boards indicates BCU is now 4th out of 7 Health Boards, with only 2 health boards delivering over 90% against the WG requirement for 100%. In terms of numbers of diagnostic episodes (one patient may have more than one diagnostic episode), BCU has a total diagnostics waiting list of circa 25,000 and an over 8-week wait total of circa 8,400.

The new Planned Care funding announced by Welsh Government requires all health boards to achieve zero over 8-week waits for diagnostics as soon as possible. This funding, should the health board proposals be approved by WG, will enable further progression toward the achievement of 100% of diagnostic waits being under 8-weeks through the provision of additional capacity as well as some efficiency and productivity improvements.



Planned Care: 8-weeks Diagnostic Waits

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



3.1.2 Over 104 week waits for Referral To Treatment (RTT)

Management information indicates that the health board maintained the significant improvement that occurred to end of March 2026 in relation to over 2 -year waits for completion of referral to treatment. The end of March position was 2139, with the end of June position being 2167. This was against an IMTP planned trajectory of 1597 at end of Quarter 1 (June), hence approximately 570 adverse to plan.

In comparison on other Health Boards, BCU and only 1 other has been able to maintain the end of March waiting times position at the end of Quarter 1; all other health boards performance deteriorating. This is a key achievement and demonstrates an improved approach to operational planning and service delivery, whereas in every previous year quarter 1 performance has deteriorated significantly.

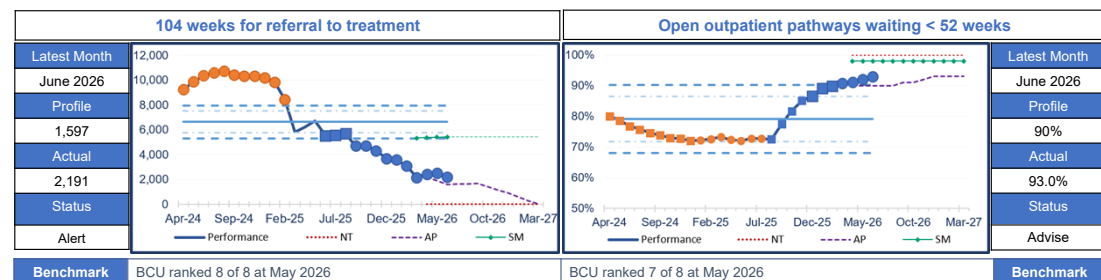
Quarter 2 IMTP trajectory plan is for no more than 1668 patients waiting over 104 weeks. There is currently risk to this position, particularly relating to August holiday absences and the reduction in uptake of Waiting List Initiatives and other internal additionality. Intensive work is underway to mitigate this impact.

Whilst the focus on 104 week waits is particularly high profile, the issue of over 52 week first outpatient is important. Considerable work was undertaken last year to successfully reduce the numbers of patients waiting for a first outpatient (which went from 31,000 patient to under 5,000 in approx. 10

months). This number is now creeping up and a balance of focus will be needed to ensure this does not further deteriorate. Key elements of the Planned Care Major Change programme are focused on the 'front end' of the patient pathway including referral advice and guidance.

Planned Care : Referral to Treatment Metrics

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



Benchmark BCU ranked 8 of 8 at May 2026

BCU ranked 7 of 8 at May 2026

Benchmark

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

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

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

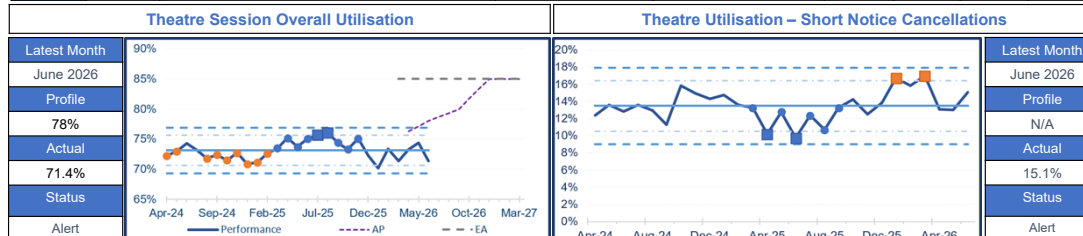
3.1.3 Elective Optimisation – Theatres

A particular challenge for the health board is the efficient and productive use of existing resources in relation to pre-peri and post operative care pathways. The issue of under-utilisation of theatre capacity (available sessions, 'fallow' theatre sessions and slots, and late starts and early finishes) and patient cancellations for various reasons means that not as many people are having their treatment as there could have been.

Given the shape of the waiting list is now weighted toward Stage 4 (operation/procedure) it is essential that efficiency and productivity improve. As part of the Plan Towards Sustainability that the WG has directed, the health board will be concentrating improvement actions and possible external expertise in this area.

Planned Care : Productivity / Utilisation

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



What does the data tell us? – Performance against the overall utilisation metric has fluctuated between 70% and 76% over the last thirteen months. Whilst this remains within normal variation the position was over 6% adrift of the end of quarter 1 target and with the trajectory requiring improvement to 85% by end of March 2027, current performance does not suggest stepped change to reach required level. Cases per session (CPS) needs to be monitored alongside overall utilisation. Latest twelve months data indicates that performance varies from 2.0 to 2.3 cases per session. At local level, the performance has been below 70% in West IHC (Oct-25, Mar-26) and East IHC (Jan-26) during the last twelve calendar months. Short notice cancellation data is at 15% as at end of June, the rate is c. 5% higher than same period last year.

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

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

Area	CPS
West	2.0
Central	2.0
East	2.3
BCU	2.1

23

3.2 Planned Care Major Change Programme

3.2.1 Workstream 1 - Validation

IMTP 3B.1	Consistent clerical and clinical validation will be in place incorporating national guidance and a suite of initiatives included expanding the reach of the EBO virtual chat-bot for patient validation		
Workstream Status		Q1 Status	Q2 Projected Status
		Not met	At risk
In Q4 2025/26, Welsh Government funding supported an overtime Clerical Validation programme that validated 31,815 pathways across the core team and IHCs, delivering: 7,978 pathway closures (25%) for patients waiting >36 weeks, including 2,823 (9%) waiting >104 weeks. - A 49% reduction in Stage 3 pathways and 51% reduction in duplicate pathways. On the basis of the Q4 evidence, approval was received in May to strengthen the Core Validation Team, with additional permanent capacity benchmarked against other Health Boards. Staff expected to be in post by the end of Q2. Targeted training has been delivered to Gastroenterology and Diagnostics services to improve pathway management and reduce future validation demand. A version of the Patient Validation chatbot was developed and deployed in Q1, and is now live in Gynaecology, with rollout in Q2 to all Stage 1 patients waiting			

>78 weeks, supporting delivery of Q2 recovery targets and reducing reliance on manual validation capacity.

The programme has developed **Clinical Validation pathways** for a range of conditions, drawing on input from local and national clinical leads. The next step is to better understand how clinical validation can be delivered in line with the imminent adoption of the Job Planning Policy.

Project/Initiative		Q1 Milestone
1a	Expanding the reach to patients across specialities with the EBO Virtual 'Chat-Bot' patient validation (Rolling Programme)	Achieved
1b	Strengthening Clinical and Clerical pathway validation, including training within IHC pathway administrators	Not met

Further Opportunity:

- (i) Expand the success of the West **Perioperative Care of Older People (POPS)** pilot following the cessation of the national funding, which ended on 31 March 2026. Evaluation shows that POPS is delivering clear clinical, operational, and patient-centred benefits, including improved optimisation, more accurate waiting-list validation, strengthened shared decision-making, and avoidance of unnecessary or high-risk surgery.
- (ii) Further explore the use of **OWLS** (Outpatient Waiting List) within BCU to support GP validation of Stage 1 pathways

* in the absence of any national DSCN this is based on validated within 12 months

3.2.2 Workstream 2 – Referral Pathway Refinement

IMTP 3B.2	A range of initiatives to support a reduction in referrals to outpatients in high-volume specialties, adopting best practice in waiting list management including the continuing roll-out of the community health pathways, to ensure better prioritisation of available capacity for the longest waiting patients with a particular focus on unwarranted variation and associated referral threshold management	
Workstream Status		Q1 Status
		Q2 Projected Status
		Achieved
		At risk
Delivery of the national WPRS WAP Full e-Referrals programme remains on track, with Gynaecology and Vascular successfully going live in Q1. A total of 10 specialties are now live (<i>Urology, Dermatology, Breast, Vascular, ENT, Max Fax, Gastro, CMATS, Respiratory Medicine and Gynaecology</i>), and preparation is underway for the Q2 rollout of Trauma & Orthopaedics and General Surgery. 228 Community Health Pathways (CHPs) are now live, exceeding the Q1 target of 210, with work underway to assess the associated benefits and value realised.		



Enhanced work has commenced to embed CHP clinical thresholds within secondary care triage through the WPRS WAP Full project. This will enable more consistent use of Advice & Guidance and support the return of referrals to Primary Care that do not meet agreed thresholds, contributing to recovery of the IMTP P07 Q2 target, currently rated at risk.

Health Boards have been notified that the national funding for the CHP platform will cease from February 2027. Work has commenced to prepare an options appraisal for review.

Project/Initiative		Q1 Milestone
2a	Expanding the use of national WPRS WAP Full e-referral system pan BCU (Rolling Programme)	Achieved
2b	Establish referral pathways for use within Primary Care via CHP platform, prioritising pathways in line with planned care priorities (Rolling Programme)	Achieved

Further Opportunity:

- (i) A **GP with Extended Role (GPwER) model** has been identified as a potential future option for referral triage and demand management. However, it is not yet sufficiently defined or resourced to be prioritised and should not detract from delivering more immediate, lower-complexity interventions.

IMTP 3B.11	Increase compliance with national optimal pathways with particular focus on increasing straight to test rates	
Workstream Status	Q1 Status	Q2 Projected Status
	Achieved	At risk
<i>It is important to note, that the Programme only features aspects of longer-term pathway change that requires support; there is a short-term cancer plan focusing on recovery.</i> Work to improve compliance with the gynaecology post-menopausal bleeding pathway began in Q2. Delivery depends on either diagnostic ultrasound capacity and outpatient alignment (radiology-led model) or workforce training, equipment, governance, and mobilisation requirements (clinician-led model). Q1 met the milestone, increasing Teledermoscopy capacity to 84 out of a possible 144 sessions and maintaining a 66% discharge rate from image review, reducing unnecessary appointments. Q2 delivery risks are being worked through in order to mitigate. The national 'breast pain only' pathway has been locally adapted and clinically ratified by the Breast Clinical Advisory Group. Delays in securing Welsh Government funding through the National Cancer Recovery Programme have been mitigated by Chief Executive Officer approval to progress with recruitment using with local funding, which will be recovered when the national funding is released. Appointment is anticipated in August, requiring an amendment to the quarterly trajectories.		

Project/Initiative		Q1 Milestone
2c	Increase compliance with national optimal pathways, with a particular focus on increasing straight to test rates: Gynae - Post Menopausal Bleeding Pathway	Formally commences Q2
2d	Increase compliance with optimal pathways for Dermatology USC through Teledermoscopy	Achieved
2e	Increase compliance with national optimal pathways, with a particular focus on increasing straight to test rates: Introduce a 'breast pain only' pathway to ensure women receive the most appropriate care in a timely manner	Achieved

IMTP 3B.1 6	With the support of the NHS Wales Performance and Improvement (NHS Wales P&I) develop diagnostics plans which are safe, sustainable, and fit for the future. This includes the full implementation of digital technology as a key service enabler to address workforce shortages		
Workstream Status		Q1 Status	Q2 Projected Status
		N/A	N/A
<i>It is important to note, that the Programme only features aspects of longer-term pathway change that requires support; while opportunities has been identified and initial discussions with the operational and clinical leads held, this has been superseded by the collaborative work between NHS Executive P&I and the Diagnostic Service.</i>			
A Diagnostic Strategic Plan has been agreed, with development of an activity plan for implementation on track for early Q2. The Programme will work with the lead to identify the longer-term transformational change opportunities to align with existing projects, or scope the requirements to step-up as new activity.			
In addition, work has progressed in reviewing the appropriate application of the RTT Guidelines to diagnostic patients who did not attend (DNAs) and could not attend (CNA) pathways within the stage 2 waiting lists. The Core Validation Team is supporting this to retrospectively apply corrections to pathways, supporting a true reflection of the waiting list demand.			
Project/Initiative			Q1 Milestone
2f	Better management of referral pathways into Diagnostics, with an emphasis on appropriate diagnostics in line with best practice		
2g	Deliver improved diagnostic pathways by ensuring timely and appropriate referral, reducing unnecessary investigations, supporting timely clinical decision-making. and optimising diagnostic capacity.		

3.2.3 Workstream 3 - Booking

IMTP 3B.3	Reduce variation in outpatient waiting times and improve communication with patients on the waiting lists by adopting best



practice including modernisation and standardisation of centralised booking services		
Workstream Status	Q1 Status	Q2 Projected Status
	Achieved	At risk with mitigation
A multidisciplinary task and finish group is on track to present the technical and administrative model for a One Waiting List approach to the August Planned Care Programme Board, underpinning the development of pan-BCU clinical services to enable more equitable access across North Wales. Engagement has commenced with workforce to scope the impact and opportunity for aligning this work with the future model for booking services. In Q2, work is progressing on a quality accreditation standard to enable greater administrative workforce flexibility. An experienced IHC operational lead has been assigned to drive this work. Delivery risk relates to capacity within the Booking leadership team; this is being supported currently through the programme for the scoping and commitment from workforce to provide support. The Planned Care Programme Board approved a pilot return to 'partial booking' on 30th June 2026. This follows evidence of worsening attendance rates since 'direct booking' was introduced in 2022. The pilot will assess impacts on patient engagement, clinic utilisation, unused capacity, and RTT performance before wider implementation is considered. A Booking Service Level Agreement (SLA) has been developed to clarify roles, responsibilities and performance expectations between booking teams and operational services.		
Project/Initiative		Q1 Milestone
3a	Model & implement the move to a one pan-BCU Waiting List approach, supporting the location of care pathway management in the WPAS	Achieved
3b	Develop the model for a 'quality standard accredited' administration workforce to flexibly support fluctuating areas of demand	Formally commences Q2
3c	Pilot the return to partial booking to assess the impact on deteriorating DNA/CNA across services	Formally commences Q2 - agreement from PCPB on the 30/06/2026 to commence with a pilot in one service
<i>Further Opportunity:</i> (i) National development of the NHS Wales App to expand planned care functionality beyond Stage 1 acknowledgements and appointments remains on hold pending direction from the new government. Since go-live on 31 October 2025, NHS Wales App registrations have increased to 178,841 (+10,445 in the last month). In June, 15,627 waiting list notifications and 18,217 appointment notifications were issued, both up on May.		



3.2.4 Workstream 4 – Pre-operative and Operative Effectiveness

IMTP 3B.4	Adopt best practice in theatre management through standardising pre-operative assessment process, and driving theatre productivity across North Wales. Undertake the national Surgical Hub Accreditation to support improved efficiencies and High-Volume Low Complexity listings		
Workstream Status		Q1 Status	Q2 Projected Status
		Achieved	On Track
Q1 milestone to submit the Surgical Hub Accreditation application was achieved, and the Health Board has been informed that the Llandudno Hub will undergo national accreditation in cohort 2 (date to be confirmed). Focus in Q2 will be on maintaining engagement with NHS Executive and responding to any follow-up queries or feedback as required. In parallel, the team is undertaking preparatory work to support future accreditation requirements, including gathering information, evidence and supporting documentation based on current understanding of the requirements being requested of Health Boards in Cohort 1. All CIN self-assessments have been completed and submitted. Review meetings with NHS P&I and clinical leads are ongoing, with the final specialty review scheduled for the week commencing 20th July. Delivery of the Q2 milestone remains dependent on the outcome of the Planned Care Recovery Plan review and refresh. Findings from the self-assessment specialty reviews will inform priority actions, although the approach to incorporating these into service and transformation plans may need to align with any revised recovery plan priorities. There will also be the opportunity to improve consistent uptake of GIRFT principles, in particular for high-volume low-complexity listings.			
Project/Initiative			Q1 Milestone
4a	Undertake the national Surgical Hub Accreditation supporting day-to-day efficiencies and High-Volume, Low Complexity (HVLC) listings		Achieved
4b	Complete CIN Optimisation Self-Assessments to inform the opportunities for improvement, in particular HVLC		Achieved
Further Opportunity:			
(i) Early health screening is key to improving RTT performance, reducing cancellations, and ensuring patients are fit for surgery. The Programme has developed and successfully evaluated a standardised Health Screening Questionnaire (HSQ) and Pre-Operative Assessment (POA) model , enabling earlier risk identification, identifies patients suitable for high-volume low-complexity lists, improves patient stratification, fewer unnecessary POA appointments, better data quality, and overall, more productive theatre lists. Full implementation is currently constrained by workforce capacity, and the programme is awaiting the outcome of funding decisions before implementation can proceed.			



- (ii) Welsh Government is exploring a pan-Wales tender for an **e-POAC** solution to digitise and standardise the pre-operative assessment process. To date, the process has not move to a procurement stage and there is no timescale for this system being made locally available.
- (iii) Introduce **optimisation** at the earliest point in the patient's pathway, supported by a baseline and maturing of the Health Board's optimisation offer for all modifiable condition
- (iv) Establishing a procedure specific **consent** and electronic consent model.

3.2.5 Workstream 5 – Follow-ups

IMTP 3B.5	Modernise Outpatient Services management of follow-up care through ensuring consistent and best practice application of See on Symptom (SOS) and Patient Initiated Follow-Up (PIFU) across all specialties and undertaking pathway validation and data quality cleanse of the follow-up waiting lists in line with the National Clinical Implementation Networks (CIN) Network pathways and discharge protocols	
Workstream Status		Q1 Status
		Achieved
		Q2 Projected Status
		On Track
National CIN Self-Management Protocols have been adopted and shared across services to support discharge and follow-up pathways. They have underpinned the expansion of See on Symptom (SOS) and Patient Initiated Follow-up (PIFU), with Q1 implementation in Dermatology Squamous Cell Carcinoma and Breast Cancer pathways. Work is underway in Dermatology and Trauma & Orthopaedics and remains on track for Q2. To address the follow-up backlog, a pilot to validate and apply CIN protocols to patients waiting over 100% beyond their target date has commenced. Validation has commenced in Gynaecology, with 25% of the initial cohort of 805 patients appropriately closed within the first two weeks of activity (work ongoing).		
Project/Initiative		Q1 Milestone
5a	Re-launch of See on Symptom (SOS) and Patient Initiated Follow-up (PIFU) (Looking Forward) including Cancer Pathways (Rolling Programme)	Achieved
5b	Undertake pathway validation and data quality cleanse of the follow-up waiting list in line with the national Clinical Information Network (CIN) pathways and discharge protocols	Achieved

3.2.6 Workstream 6 – (a) Cancer and (b) Diagnostics (Service Planning)

(a) see 2c, 2d, 2e

(b) While initial opportunity has been identified - this is currently on hold pending further consideration and alignment with the 90-day service plans and Fragile Services plans. There will be further consideration of Clinical Service Planning approaches as part of the Plan Toward Sustainability work.

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

4.1 Primary Risks

The Programme holds and manages a risk register. For the Board level however the primary risks to delivery to draw members attention to are reflective of the challenges assessed at the end of 2025/26, including:

1. **Operational capacity to deliver the significant changes whilst also undertaking a pressurised day to day operational service delivery requirement.**
Mitigation: A revised approach is being worked up that will bring the Major Change Programme elements and the day to day operational delivery more closely together. Careful prioritisation is required not to overload and hence fail to deliver the requirements; and in addition, supplementary resource may be available through the WG planned care funding for 2026/27.
2. **Welsh Government funding is non-recurrent for 2026/27.** Whilst the significant additional funding is welcomed, it is in-year funding only and will require significant efforts to deploy it most effectively, and to ensure exit strategies exist should funding not follow on into 2027/28.
Mitigation: A clear assessment for deploying resources will be undertaken and a robust tracker implemented. Projects that risk ongoing financial commitments will be flagged and exit strategies agreed ahead of implementation.
3. **Some elements of delivery are predicated on developments outside the Health Boards main control.** One clear example of this is the electronic POAC system that is crucial to streamline processes and enable a more efficient service, supporting improved theatre utilisation. The decision to procure the new system sits outside of the health board and an agreed approach at an All-Wales level is yet to be secured.
Mitigation: Health Board leads will continue to stress the essential nature of these types of developments, assessing and seeking to manage the impact of non-delivery.

5 **ARGYMHELLION RECOMMENDATIONS**

5.1 Gofynnir i'r Pwyllgor/Cyfarfod/Grŵp:

The Board is asked:

- to DISCUSS and NOTE the current position for Quarter 1 planned care performance delivery and the Planned Care Change Programme delivery, including further opportunity.

ASESIAD / ASSESSMENT

Cysylltiad â'r Bwriadau Strategol	3. Improve Access, Outcomes and Experience
Link to Strategic Intentions	If more than one applies, please list below:
Yr Egwyddorion Dylunio Design Principles	Simplify, Standardise, and Adopt Best Practices Aligns to all design principles
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS

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

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

<u>Deddf Llesiant</u> <u>Cenedlaethau'r Dyfodol -</u> <u>Nodau Llesiant</u> <u>Wellbeing of Future</u> <u>Generations Act –</u> <u>Wellbeing Goals</u>	A Healthier Wales	
Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Asesiad o Effaith ar Ddiogelu Data <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?</i> Data Protection Impact Assessment <i>Have you undertaken a Data Protection Impact Assessment Screening?</i>	Do/Yes: ☒	Naddo/No: ☐
	Canlyniad/Outcome:	All projects undertake a DPIA where applicable
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Asesiad o Effaith ar Atal Twyll <i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i> Counter Fraud Impact <i>Have you considered the counter fraud impacts</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Cyfreithiol Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw Da Reputational	Yes (Include further detail below) Impact on timely access to care	
Effaith ar Adnoddau <i>(Pobl / Ariannol)</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	

Health Board Key Issues Report			
Board Date		30/07/2026	
Date of Committee		02/07/2026	Report of: Quality Safety and Experience Committee
Quoracy met:		Yes	
1	Agenda	The Quality, Safety and Experience (QSE) Committee continues to meet bi-monthly. The Committee considered an agenda which is attached: QSE Committee - BCUHB	
2a	Alert	The QSE Committee wish to Alert members of the Board that: 1. Regarding the new NHS Concerns, Complaints and Redress Arrangements. Listening to People has now been implemented, the Health Board worked closely with NHS P&I on the transition, some documents and training were delayed but the HB was prepared for the implementation and transition from putting things right . Llais noted that communication with their organisation was not as effective. Members of the Committee will visit the People's Enquiry and Resolution Service (PEARS) during the Autumn. 2. There is an understandable and significant pressure to improve ambulance handover delays to a level of zero 45 min breaches by the autumn. This will reduce community risk for patients awaiting an ambulance. This must however be balanced by ensuring that this doesn't result in increased risk in overcrowded departments. A local Quality Impact Assessment will be performed alongside continued work to reduce occupancy within the Emergency Departments. 3. The Committee noted the importance of ensuring appropriate implementation of the recent Supreme Court judgement on Deprivation of Liberty Safeguards (DoLS), including staff training, communication with patients and families, and ongoing monitoring of any implications for safeguarding arrangements. 4. HHIW has designated YGC ED as a Service Requiring Significant Improvement, with BCUHB required to act on several immediate actions. A plan is in place to deliver against these actions, with Health Board wide learning being developed. The full report is not due until late summer.	
2b	Assurance	The QSE Committee wish to Assure members of the Board that:	

		1. The Committee received assurance that patient experience feedback remains overwhelmingly positive once patients access services, demonstrating the continued commitment of staff to delivering compassionate, person-centred care, even during periods of significant operational pressure. This patient experience is lower in Emergency Departments than for other services but with the majority of patients describing their experience of care as positive. 2. The Committee noted positive examples of holistic care and support, including the contribution of chaplaincy services, Welsh language provision and personalised care approaches which can have a significant impact on patient and family experience. 3. The Committee received assurance that work is underway to simplify governance arrangements across the organisation, focusing on effective and streamlined assurance processes that support operational delivery. 4. Cancer treatment performance in national audits is strong, particularly in relation to outcomes survival and adherence to clinical guidance. Focussed improvements programmes to specific diagnostic and treatment pathways are noted. 5. There was good assurance from the Improving Quality, Outputs and Experience Maternity and Neonatal report, noting maternal and neonatal outcomes. This report will be reviewed in QSE every 4 months. Learning is being collated from Welsh and English reports, including English National Maternity and Neonatal Investigation and review and the Ockenden review in maternity services at Nottingham University Hospitals NHS Trust. 6. The Committee received the Mental Health and Learning Disabilities Advocacy Annual Report and was assured that advocacy services continue to support the rights, voice and involvement of service users in decisions relating to their care and treatment.
2c	Advise	The QSE Committee wish to Advise members of the Board that: 1. That future safety reporting should continue to provide appropriate context alongside incident and never event data, including evidence of learning, trends and improvement actions, whilst maintaining a balanced view that reflects strengths as well as areas requiring improvement. 2. Emphasised the importance of maintaining a positive safety culture that supports open reporting, learning and continuous improvement across services.

		3. The Urgent and Emergency Care Programme update was received, noting that for further iterations enhanced detail will be required for the Committee to be assured as the emerging picture evolves. 4. Received an update on Research, Development and Innovation, noting that there would be an external review relating to provision of national standards. This will include some aspects relating to the Centre for Mental Health and Society as raised by Internal Audit. 5. Received the Quality Governance Report from Audit Wales and agreed that an update will be received in six months' time.
2d	Review of Risks	The Committee reviewed the Risks within its remit and noted that deep dives were on-going to ensure that there is a clear understanding between Risks and Issues.
2e	Sharing of learning	Learning from the patient story highlighted the significant impact of compassionate, person-centred care, the value of Welsh language provision, and the contribution of Chaplaincy services in supporting patients and families during difficult circumstances.
3	Actions to be considered	Nothing to refer.

Health Board

URGENT AND EMERGENCY CARE PERFORMANCE

Dyddiad y Cyfarfod Date of Meeting	30 July 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Tehmeena Ajmal, Chief Operating Officer Supplemented by Carol Shillabeer, CEO
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Tehmeena Ajmal, Chief Operating Officer
Pwrpas yr Adroddiad Report Purpose	For Assurance

Crynodeb Gweithredol Executive Summary

Urgent and Emergency Care remains one of the Health Board's most significant risks. While there is evidence of improvement in some operational measures, particularly at the front door of Emergency Departments, there has not yet been sufficient improvement in the key outcome measures that matter most to patients: ambulance handover delays, prolonged Emergency Department stays and discharge delays. The system continues to operate under sustained pressure, driven principally by poor patient flow and delays in discharge.

The position is challenging but not irrecoverable. Recent weekly performance data demonstrates that some sites are delivering improvement against their trajectories; however, performance remains materially below the level required to meet Welsh Government expectations by September 2026.

The Intervention and Support Team has completed the diagnostic and a new Recovery Director of UEC will commence early August. The final Improvement Plan will be agreed following review by the Recovery Director; however active work is being implemented to make improvement already with Integrated Health Communities having 90-day operational improvement plans in place.

The work of the Intervention and Support Team, drawing on wider learning from elsewhere that have delivered Improvements in urgent and emergency care is

provided to assist the Board in confirming 'what good looks like', and hence the focus on the health board actions. The Board has established an Urgent and Emergency care Oversight Group to specifically focus on the improvements in ED as well as across the wider system. The Group is chaired by the Vice Chair and Chair of the Performance, Finance and Information Governance Committee.

Key Message for the Board

There is now credible evidence of improvement in triage times, clinical assessment times and some site-level reductions in 12-hour waits and ambulance handover delays. However, these improvements have not yet translated into the scale of system-wide recovery required.

The Board's primary focus should remain on:

1. Delivering the September expectation of no more than 970 ambulance handovers over 1 hour (de-escalation criteria) and then progressing to zero ambulance handovers over 45 minutes.
2. Reducing 12-hour waits to below 10% at every site Emergency Department and across the health board as a whole (de-escalation criteria). The national target is zero.
3. Accelerating discharge and reducing pathway of care delays, which remain the fundamental barrier to sustainable improvement.

In summary: front-door performance is improving, but flow through and out of hospital remains the critical weakness. Without a step-change in discharge and length-of-stay performance, improvements in ambulance handovers and ED waits are unlikely to be sustained.

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

Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	Dyddiad Date	Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data
Executive Committee	15/07/2026	Further drafting required to ensure focusses on the improvements aligned to the performance trajectories

Acronymau / Rhestr Termiau Acronyms / Glossary of Terms

UEC	Urgent & Emergency Care
WG	Welsh Government
IMTP	Integrated Medium-Term Plan

ED	Emergency Department
POCD	Pathways of Care Delays
GIRFT	Getting it Right First Time
SPOA	Single Point of Access
SDEC	Same Day Emergency Care
HALO	Hospital Ambulance Liaison Officer
WAST	Welsh Ambulance Services (NHS) Trust
D2RA	Discharge to Assess then Recover
MDT	Multi-Disciplinary team
MCP	Major Change Programme
OPEL	Operational Pressures Escalation Levels
IHC	Integrated Health Community

URGENT AND EMERGENCY CARE PERFORMANCE REPORT

1. Y SEFYLLFA SITUATION

- 1.1 The UEC system has been under **sustained and significant pressure** for some years with performance across key indicators **well below the level required** to assure patient safety and meet improvement requirements. The Board has specifically focused on this area following a deep-dive in September 2025 and has given specific attention to this area at every Board meeting since.
- 1.2 The Welsh Government has set an expectation of achieving de-escalation criteria in 2 of the urgent and emergency care measures **by the end of September**. This is outlined in the correspondence from the Cabinet Minister to the Chair and Chief Executive following the Escalation Board held on 9th July 2026. This includes:
1. No more than 970 ambulance handovers of more than one hour.
 2. No more than 10% of patents waiting over 12 hours at each Emergency department and overall, as a health board.

The Board had agreed clear expectations aligned to special measures de-escalation, within the Integrated Medium-Term Plan/Annual Plan (below). There is now a requirement to bring forward the timing of the improvement of the first 2 measures by the end of quarter 2 rather than quarter 4:

- Reduce the proportion of ambulance handovers over 45 minutes to 22% by end of quarter 4. National standard is zero. This is now **'achieve no more than 970 ambulance handovers over one hour by the end of September 2026 (Q2)'**.
- Reduce the number of people waiting over 12-hour waits in ED to 10% by end of Q4. National standard is zero. This is now to **'achieve no more than 10% of patients waiting over 10% in each Emergency Department and across the Health Board as a whole by end of September (Q2).'**
- Improve the time for patients' arrival at ED to an **assessment by a senior clinician to 90 minutes by end of Q4**, against a national standard of 60 minutes.
- Deliver sustained improvement through **90-day operational Improvement Plan cycles**

The fuller outline of the trajectories against special measures de-escalation criteria and the Planning Framework is set out below:

ID	Performance Expectations	Ref	Level 5 De-escalation criteria	Planning / Performance Framework	Baseline	Q1	Q2	Q3	Q4
P01	Reduce ambulance handover waits over 45 mins *	DE-01 SM-17 MAG-09 IPT-02	970 ¹	Zero	2,466 (58%)	2,318 (55%)	1,923 (45%)	1,282 (30%)	950 (22%)
P02	Ambulance handovers in 15 mins *	EA-08 MAG-09	N/A	90%	471 (12%)	670 (17%)	819 (21%)	1,117 (28%)	1,788 (46%)
P03	Reduce 12 hour wait in major and minor emergency care setting *	DE-02 SM-19	< 10%	Zero	3,826 (42%)	3,189 (35%)	2,743 (30%)	2,297 (25%)	1,850 (10%)
P04	Reduce median time to assessment by senior clinical decision maker in ED *	SM-18	<60 mins	<60 mins	180	160	140	140	90
P05	Reduce delayed pathways of care - number of people who are delayed in hospital *	DE-10 SM-20 IPT-05	273	12m reduction	316	260 (-18%)	221 (-30%)	158 (-50%)	158 (-50%)
P06	Reduce delayed pathways of care - total days delayed for these patients *	DE-10 IPT-03	N/A	12m reduction	14,180	11,628 (-18%)	9,926 (-30%)	7,090 (-50%)	7,090 (-50%)

Notes: ¹ 17% improvement in 1 hour ambulance handover, * This area will be supported by the Welsh Government and NHS Performance and Improvement Intervention Team.

2.0 Y CEFNDIR BACKGROUND

The Board has been focusing on urgent and emergency care at each meeting and through its Committees intensely since a deep dive in September 2025.

Additional, external expertise has been utilised to support the identification of opportunity for improvement and to learn from other NHS bodies who have already made improvements.

The Intervention and Support Team, drawing in other external experts, has worked closely with clinical and operational teams in each of the areas and also drawn the health board and 6 local authorities together. The main intervention and support work is now concluded, with very clear opportunities for improvement set out.

A Recovery Director of Urgent and Emergency Care has now been appointed and starts in early August. Although there is a draft UEC Plan developed, it is considered beneficial to enable the new Recovery Director to review and refine the Plan in the first 2 weeks of taking up post before finalising this. This coincides with the timing of the Healthcare Inspectorate Wales draft report following its inspection of Ysbyty Glan Clwyd Emergency Department. There are 'Handover 45' and '90-day operational improvement plans' in place and all of these will be aligned into a single plan for the organisation to utilise.

3.0 MATERION PENODOL I'W HYSTYRIED SPECIFIC MATTERS FOR CONSIDERATION

This section focuses on the specific high-level actions and related performance that are targeted to improving the key indicators, and in doing so will improve patient

safety and the experience of both staff and patients in the Emergency Department. At Committee level (Performance, Finance and Information Governance and Quality Safety and Experience Committees) more detail of each Integrated Health Community key performance issues (including safety and experience) and the key high impact areas of action required at the local level will be presented.

3.1 Ambulance Handovers

Performance remains substantially below required levels and continues to represent a significant patient safety and operational risk.

Much of the reporting is against the 45 minute handover standard where the Welsh government have set a zero position for all health boards. Against this, the June report showed that only 38% of ambulance patients were handed over within 45 minutes, against an internal trajectory of 45% and a national expectation of 100%. However, more recent weekly data demonstrates improvement although there is variation across sites:

- Wrexham Maelor: 71% handed over within 45 minutes.
- Ysbyty Gwynedd: 53%.
- Ysbyty Glan Clwyd: 43%.

There are signs of improvement compared with earlier points in the year, particularly in Wrexham Maelor and Ysbyty Gwynedd, but progress remains insufficient to give full confidence that the progress will be sustained and shared across the health board.

In relation to Level 5/Special Measures de-escalation requirement of 970 ambulance handovers within **one hour**, performance is improving. At the end of March the position was in excess of 2,000 patients, at end of June this was circa 1755, and the July performance is currently tracking to circa 1400. This is a demonstrable improvement which if spread and sustained will enable the de-escalation criteria to be achieved. There is medium confidence at this stage, progress dependent on learning across the health board, particularly from the significant progress being made in Wrexham Maelor, and this being sustained.

Improving Ambulance Handovers: Actions

- **Handover 45:** The Chief Operating Officer is working with counterparts in other Health Board and the Welsh Ambulance Services Trust to prepare for the full implementation of the 45-minute standard, i.e. all patients will be handed over to hospitals as a standard to enable greater ambulance availability for new calls. This practice has been implemented in England. There is risk regarding this next step of implementation in terms of

overcrowding further already congested EDs, and therefore a careful risk assessment will be undertaken.

- **Care in Undesignated Areas Standard Operating Procedure:** This has been revised and the updated version implemented during June. The tracking of care areas that are undesignated will be undertaken and reported. The aim is to reduce the risks associated with caring for people in overcrowded Emergency Departments, improving safety and experience.
- **Site-specific 90-day recovery plans,** particularly focused on decongesting the ED to enable ambulance handovers to take place.

Assessment for Board

Trend: Improving but materially off target.

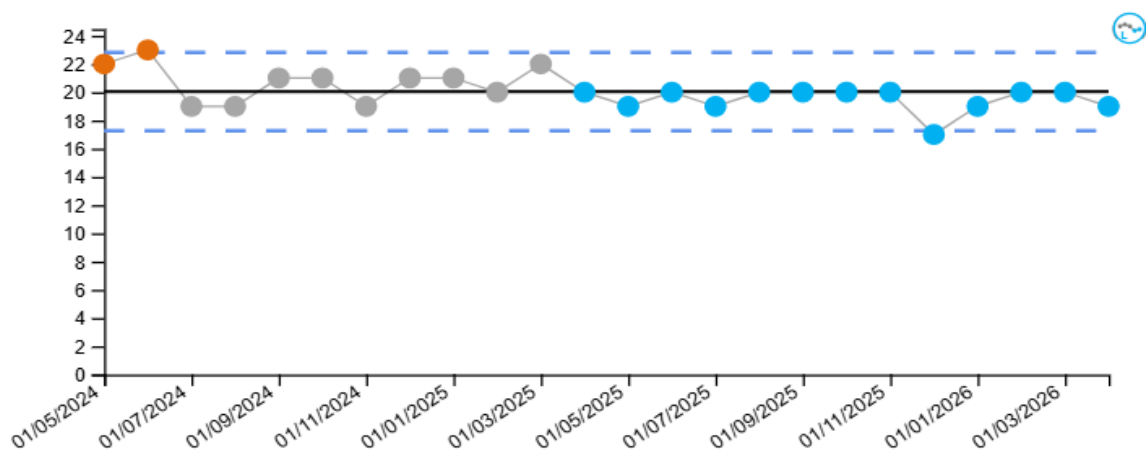
Risk: High.

September requirement: no more than 970 ambulance handovers of more than one hour. (Note - much of the data reporting by WG is now against the 45 minute handover requirement).

3.2 Time to Triage

Performance remains significantly stronger than many other UEC measures. The health board has added this indicator in as an essential component of patient safety in terms of those people who self-present at the ED. The standard is 15 minutes and mean performance across the health board is currently 19 minutes, which is a small improvement (December 2025 achieved 17 minutes).

Median Arrival To Triage - Monthly



Current median triage times are:

- Ysbyty Gwynedd: 13 minutes.
- Wrexham Maelor: 20 minutes.
- Ysbyty Glan Clwyd: 19 minutes.

There have been improvements seen over the last year and these have largely been sustained, despite recent plateauing. It is becoming common practice to double up on triage at times of high demand in the ED department.

Improving Time to Triage: Actions

- **Matching capacity with peak demand:** There is a review of hour of day triage times to enable increased/redeployed staffing capacity to deal with peak demand (usually between 3 – 8pm each day). In some part only, this links to the ED business case development, approval and implementation to ensure sustainable improvement is made. Evidence of improvement will be through monitoring hour of demand with available triage capacity, resulting in reducing triage times.
- There is potential for **alternatives to ED** for some patients, and increasingly these alternatives will need utilisation and expansion. Where Urgent Treatment Centres are not in place, consideration to potential benefit will be undertaken during June, particularly for Ysbyty Glan Clwyd.
- **Validation of the data** relating to time to triage will be considered to ensure that accurate records are being maintained and is a precise assessment of current performance.

Assessment for Board

Trend: Sustained improvement.

Risk: Low relative to other UEC measures.

Challenge: Maintaining gains while improving flow and reducing overcrowding.

3.3 Time to assessment by ED clinician

This is the area showing the clearest evidence of improvement. Quarter 1 trajectory looks to be on track at this stage, although the internal 'target' set is a considerable way off the national standard expected and should be subject to further internal challenge. Current performance sits at 127 minutes (mean) for June. There is minimal variation in median minutes across the three sites: Wrexham and YG are both 126 minutes, and YGC is 129 minutes (June data).

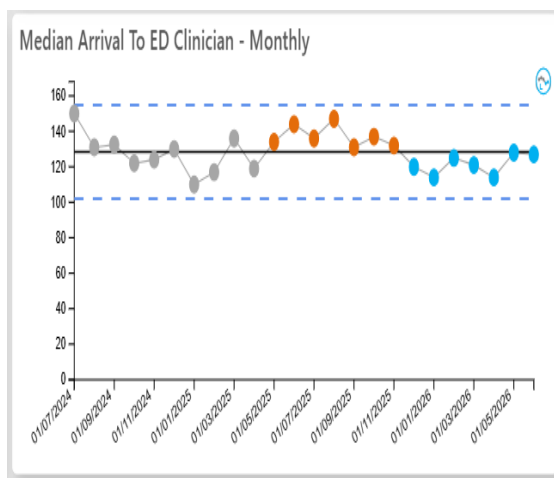
This indicator is affected by doctor staffing levels, and the matching of doctor availability to peak demand patterns. A further factor is the availability of clinical rooms for assessment within crowded EDs. This indicator is a key factor relating to patients staying over 12 hours in the ED.

Current performance (week ending 14/07/26):

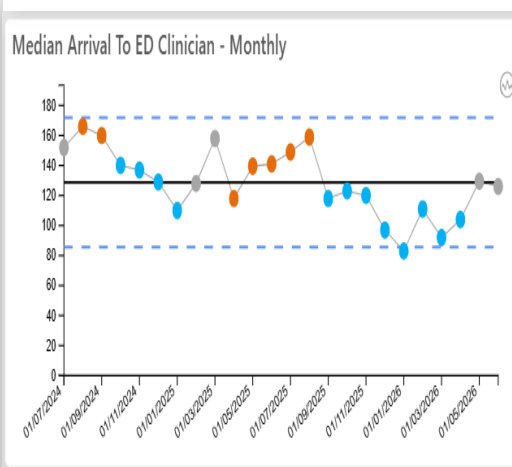
- Ysbyty Gwynedd: 125 minutes.
- Wrexham Maelor: 136 minutes.
- Ysbyty Glan Clwyd: 154 minutes.

Although performance remains around twice the national standard, it is one of the few metrics where a sustained positive trajectory is evident.

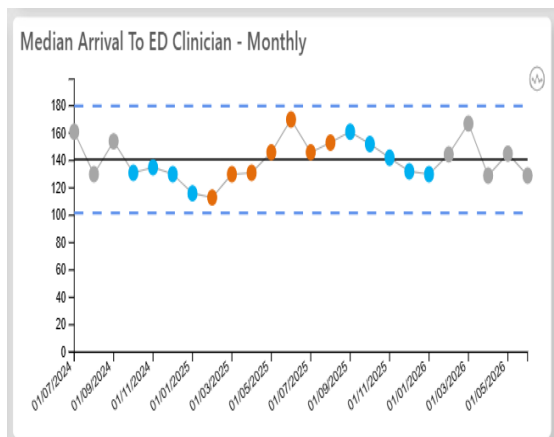
BCU



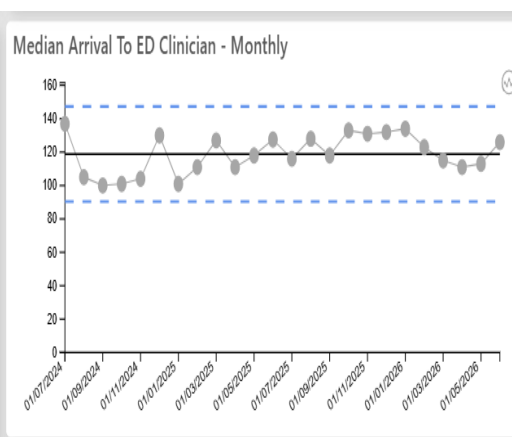
Ysbyty Gwynedd



Ysbyty Glan Clwyd



Ysbyty Wrexham Maelor



Improving Time to Assessment by ED Clinician: Actions

- Implementation of the ED Business Case, including recruitment to medical and nursing posts.

- Better alignment of staffing with peak demand periods.
- Expansion of assessment capacity and clinical room availability.

Board Assessment

Trend: Improving overall.

Risk: Moderate.

Key issue: Sustainability and reducing variation between sites.

3.4 12 hour+ stays in the Emergency Department

This remains the most visible indicator of system congestion. General performance at the start of the year indicated that approximately one in four patients (23–24%) waits longer than 12 hours in an Emergency Department. Most of these patients are waiting for an inpatient bed rather than treatment (circa 60% awaiting a bed, with circa 40% on a non-admitted pathway).

It is important to note that there are 2 measures relating to 12 hours within the de-escalation criteria. The first is each ED should not have any more than 10% of patients waiting more than 12 hours in the department; the second is as a health board there should not be any more than 10% of patients waiting more than 12 hours. The second measure includes Minor Injury Units, the former does not. Taking the second, health board wide measure, the organisation was at 21% in January and has improved slowly each month to achieving 17% of patients waiting over 12 hours in May. The trajectory for July has potential to improve to 15%. It is possible, if that improvement continues, to achieve the 10% requirement by the end of September 2026. This however requires further, focused action for both non-admitted and admitted pathways.

Improving 12 hour+ waits: Actions

- Rollout of the revised Forward Waiting Standard Operating Procedure.
- Earlier movement of admitted patients from ED to wards.
- Additional staffing supporting overcrowded areas.
- Strengthened specialty response standards.
- Weekly performance monitoring through site recovery plans.
- A crucial development in Ysbyty Glan Clwyd is the development of an Urgent Treatment Centre. This will become operational during August and into early September and should make a significant impact on overcrowding in the department; the streaming of patients to the most appropriate pathway and a reduction in over 12 hour waits (non-admitted in particular). The impact will be closely monitored.



Board Assessment

Trend: Early signs of improvement

Risk: High due to continuing safety concerns.

September requirement: $\leq 10\%$ at every site and across the health board.

3.5 Pathway of Care Delays

This remains the single most important issue facing the Health Board. Delayed discharge continues to be the fundamental driver of:

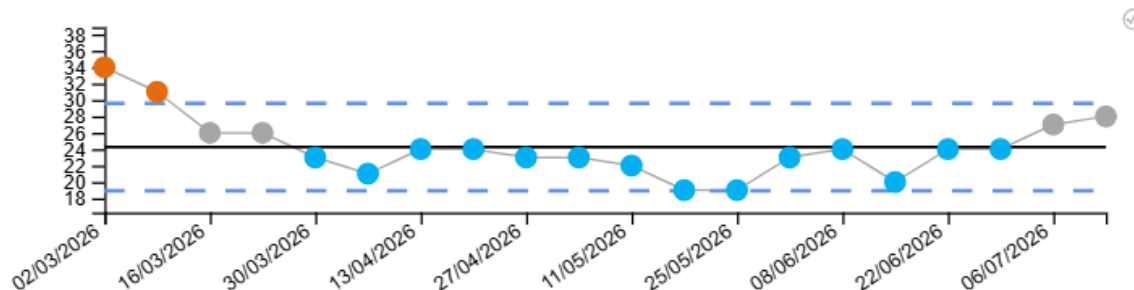
- 12-hour ED waits.
- Ambulance handover delays.
- Corridor care.
- Poor patient experience.
- Reduced ambulance availability.

While there has been some improvement since April in acute hospital delayed pathways, overall delays remain high and improvement has not been sustained at system level. Community hospital delays remain particularly challenging.

A significant focus is on long length of stay. It is encouraging that work at Ysbyty Glan Clwyd has enabled more patients to leave hospital within 21 days, and work in this area is underway at the other sites, as well as a focus on community hospitals

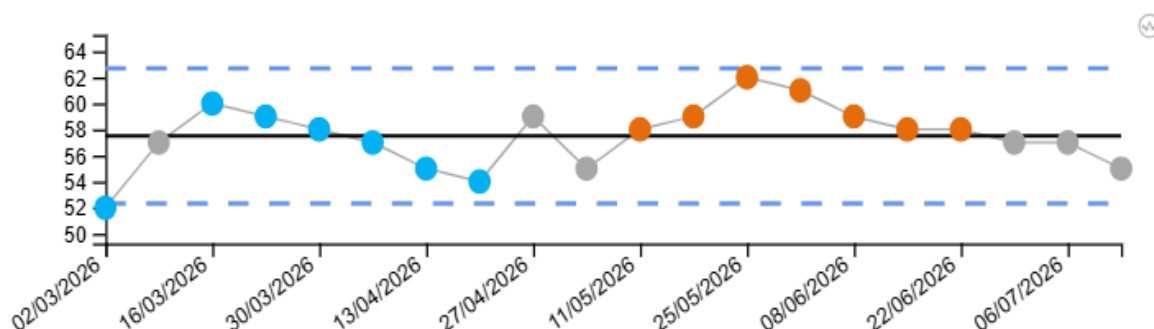
Ysbyty Gwynedd

Total Patients LOS ≥ 21 - Weekly (Last 20 Weeks)



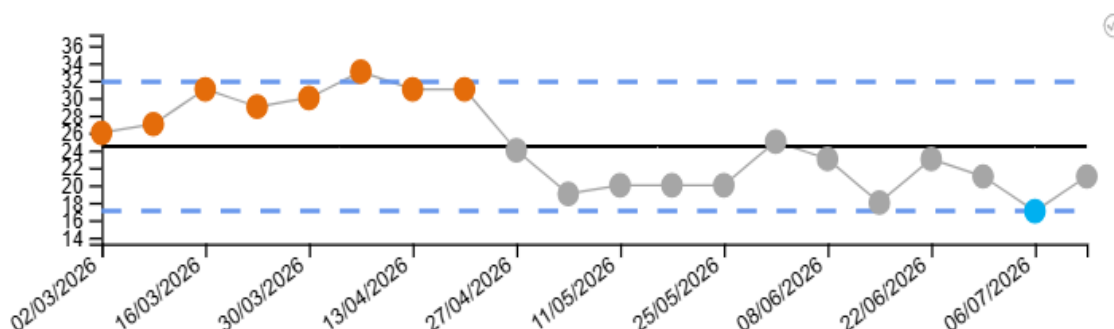
Ysbyty Wrecsam Maelor

Total Patients LOS >= 21- Weekly (Last 20 Weeks)



Ysbyty Glan Clwyd

Total Patients LOS >= 21- Weekly (Last 20 Weeks)



Improving Flow and Discharge: Actions

- Weekly director-led discharge reviews, supporting the unlocking of issues and delays.
- New Pathway Of Care Delay dashboards.
- Shared Purpose programme with Local Authorities – this is essential to enable a fully joined up approach to supporting people to get back to their usual place of residence as quickly as possible.
- Expansion of Home First and Discharge to Recover pathways. It is essential to maximise the use of Community Resource Teams and this stream of work will becoming increasingly evident over the next few months.
- Increased use of virtual wards and Hospital at Home.
- Importantly the implementation of Integrated Discharge Hubs in both Ysbyty Wrecsam Maelor and Ysbyty Gwynedd in early September are key. Both hospitals have high levels of patient delays directly impacting flow through the hospital. The impact of these will be closely monitored.



- A particular focus, drawn through the work of the Intervention and Support Team is the number of patients placed on Pathway 3 (Complex). Decisions about pathway allocation have been made in line with Welsh government guidance at the start of the hospital stay. This however means patients are usually at their most unwell and have not yet had an opportunity for treatment and recovery. The mindset associated with pathway 3 is by the already set. Changes in the approach are being introduced and a reduction in the numbers of people requiring complex care is expected. This will be tracked in detail over the coming weeks and months.

Board Assessment

Trend: Limited improvement.

Risk: Critical.

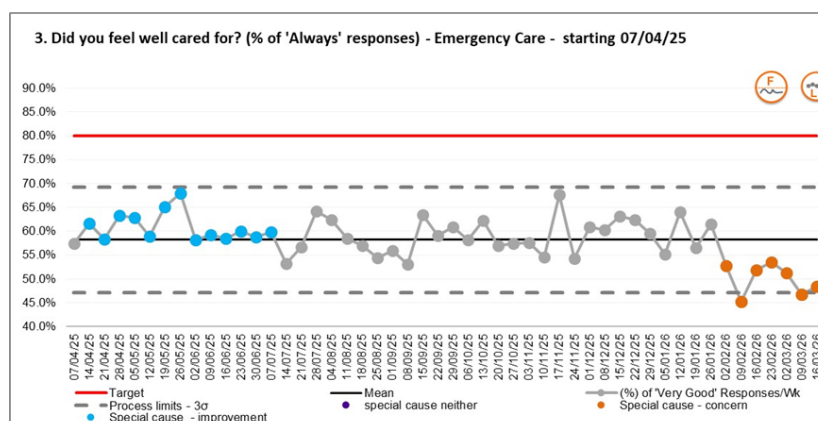
Conclusion: This remains the principal constraint on system recovery.

Patient Experience

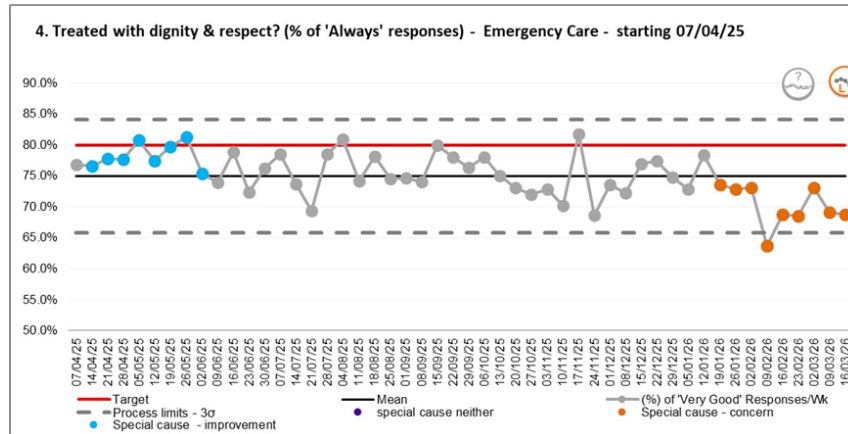
Patient experience information was presented in detail at the Board in May. It will again feature in detail during the September meeting, as this should start to reflect some of the improvements being made over the summer period. Positively, the health board continues to secure the highest level of feedback of any health board through a concerted effort and systematic approach to seeking that feedback and making it as easy as possible for patients/carers to feedback. It is clear that the current position is unacceptable and positive change must be implemented urgently, improving both the experience and confidence in the emergency care system.

Individual Integrated Health Communities (IHC) will have their patient experience feedback reviewed as part of the Integrated Performance Framework process and accountability mechanisms.

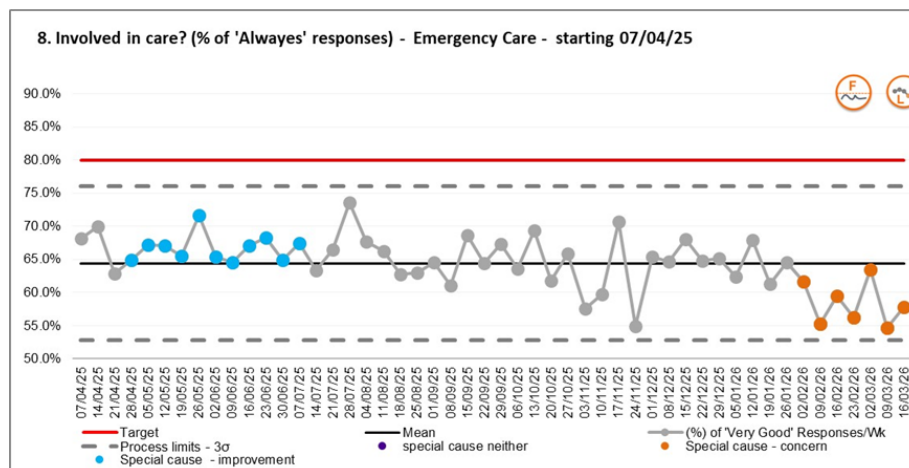
Did you feel well cared for



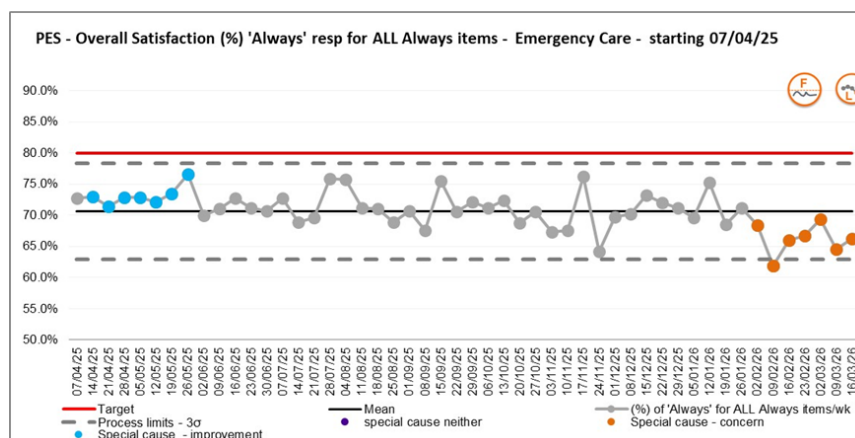
Were you treated with dignity & respect?



Were you involved as much as you wanted to be in your care?



Overall Satisfaction (%) of 'Always' responses



Quality

The quality of care is directly impacted by timely access. The whole of the Improvement Plan is geared to improving the quality and experience of the urgent and emergency care system – both for patients and for staff.

Significant focus is being placed at Ysbyty Glan Clwyd using the Healthcare Inspectorate Wales review as a core learning in that hospital/system and across the health board.

The September report to the Board on Urgent and Emergency Care will cover more detailed information on quality, given the publication of the HIW report and an analysis of trends from incidents. Further information will also be provided relating to the safety of people in the community awaiting an ambulance response and the ambulance response times across the region. It is expected that there would be direct improvement as a result of improving ambulance handovers.

The Executive Led – Integrated Concerns meeting focuses on ED/UEC matters each fortnight and the ED Learning Forum is established.

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

The risks are well articulated throughout the report and are found in detail in the Corporate Risk Register. Importantly, the Boards attention is drawn to our effectiveness at learning from elsewhere. The summary below indicates that those organisations with higher performing urgent and emergency care systems have the following characteristics and deploy these consistently. These have been shared in particular through the work of the Intervention and Support Team.

What We Are Learning from Elsewhere

The emerging evidence from NHS systems that have delivered sustained UEC improvement is remarkably consistent. The strongest performers have not focused primarily on Emergency Departments themselves; they have focused on **flow through the whole hospital and discharge from hospital**.

1. Flow, Not ED Capacity, Is the Primary Constraint

A consistent finding from high-performing systems is that overcrowding in Emergency Departments is primarily caused by exit block rather than front-door demand. This is consistent with the findings of the Health Board's own diagnostics and current performance data. Whilst improvements are being seen in triage and clinical assessment times, gains are being lost because patients continue to wait for inpatient beds and discharge delays remain high.

Implication for BCUHB

- Continue to prioritise discharge and length-of-stay reduction as the principal recovery strategy.
- Maintain executive focus on patients with extended length of stay.
- Ensure all hospitals operate a single standardised approach to flow and discharge management.

2. High Performing Systems Move Patients Earlier

Several systems that have achieved significant reductions in ambulance handover delays and long ED waits have adopted an approach whereby admitted patients are moved from ED into inpatient areas much earlier, sharing risk across the whole hospital rather than concentrating it within the Emergency Department.

The introduction of the revised **Forward Waiting SOP** aligns with this principle and early operational intelligence from Wrexham suggests this approach is contributing to improved ambulance handover performance.

Implication for BCUHB

- Consistent implementation of the Forward Waiting SOP across all sites.
- Increased ownership by inpatient specialties for flow from ED.
- Reduced tolerance of boarding patients within ED.

3. Daily Senior Clinical Leadership Matters

High-performing organisations typically have visible consultant and director leadership of patient flow, often through daily review of delayed patients, stranded patients and discharge barriers.

The Health Board has already strengthened its approach through:

- Weekly CEO-led oversight.
- Director-led discharge reviews.
- System-wide delayed discharge reviews.
- IHC-level accountability arrangements.

Implication for BCUHB

The focus should now shift from oversight of actions to oversight of outcomes:

- Patients delayed over 21 days.
- Daily discharge rates.
- Long lengths of stay.
- Delayed pathways of care.

4. Hospital at Home and Virtual Wards Create Capacity

Systems demonstrating sustained improvement have increased alternatives to admission through:

- Hospital at Home.
- Virtual Wards.
- Frailty pathways.
- Same Day Emergency Care (SDEC).

The Health Board is already developing these approaches and implementing Home First and D2RA principles, but current utilisation remains variable.

Implication for BCUHB

- Accelerate implementation and uptake.
- Focus on measurable reductions in admissions and length of stay.
- Identify variation between sites and scale best practice quickly.

5. Strong Site Leadership Produces Better Results

The most recent weekly performance data demonstrates variation between sites:

- Wrexham Maelor currently shows the strongest performance in both handovers and 12-hour waits.
- Ysbyty Gwynedd and Ysbyty Glan Clwyd continue to experience greater challenges.

This suggests there are opportunities to rapidly spread learning and operational practice within BCUHB itself rather than looking solely outside the organisation.

5.0 ARGYMHELLION RECOMMENDATIONS

The Board is asked to:

- **NOTE** the current performance
- **SUPPORT** the requirement for accelerated system-wide action on flow and discharge
- **ENDORSE** strengthened operational accountability at site and system level
- **MAINTAIN FOCUS** on delivery of measurable improvement over the next 90 days

ASESIAD / ASSESSMENT

Cysylltiad â'r Bwriadau Strategol Link to Strategic Intentions	3. Improve Access, Outcomes and Experience
Yr Egwyddorion Dylunio Design Principles	Simplify, Standardise, and Adopt Best Practices
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	Corporate Risk – Access to Care

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS

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

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

<u>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals</u>	Choose an item.	
Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below: Choose an item. Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Asesiad o Effaith ar Ddiogelu Data <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?</i> Data Protection Impact Assessment <i>Have you undertaken a Data Protection Impact Assessment Screening?</i>	Do/Yes: ☐	Naddo/No: ☐
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Asesiad o Effaith ar Atal Twyll <i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i> Counter Fraud Impact <i>Have you considered the counter fraud impacts</i>	Do/Yes: ☐	Naddo/No: ☐
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Cyfreithiol Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw Da Reputational	Yes (Include further detail below) The issue of urgent and emergency care presents a significant reputational threat	
Effaith ar Adnoddau (Pobl / Ariannol) Resource Impact (People / Financial)	Yes (Include further detail below) The ED Business Case will require funding. Funding has been set aside for this to a degree; until the Business Case is fully reviewed it cannot be confirmed if this will be fully funded.	

Health Board

INTEGRATED QUALITY REPORT

Dyddiad y Cyfarfod Date of Meeting	30 July 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	• Patient Safety: Chris Lynes, Deputy Director of Nursing (Patient Safety) and Tracey Radcliffe, Head of Patient Safety • Safeguarding and Public Protection: Michelle Denwood, Director of Safeguarding and Public Protection • IPC: Deputy Director of Nursing Infection Prevention and Decontamination • Patient and Carer Experience: Chris Lynes, Deputy Director of Nursing (Patient Experience) and Leon Marsh, Head of Patient Experience • Clinical Effectiveness: Joanne Shillingford, Head of Clinical Effectiveness • Quality Assurance: Jo Kendrick, Head of Quality, Erika Dennis, Quality Lead Manager, Sarah Musgrave Quality Learning Business Manager • Healthcare Law: Matthew Joyes, Deputy Director for Legal Services and Debbie Kumwenda, Healthcare Law Lead Manager
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	• Angela Wood, Executive Director of Nursing and Midwifery (Lead Executive) • Dr Clara Day, Executive Medical Director • Teresa Owen, Executive Director of AHPs and Healthcare Science • Dr Jane Moore, Executive Director of Public Health
Pwrpas yr Adroddiad Report Purpose	For Noting

Crynodeb Gweithredol Executive Summary

This report provides the Board with assurance, underpinned by analysis, on significant quality issues alongside longer-term data and information on the improvements underway.

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

Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	Dyddiad Date	Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data
Quality, Safety & Experience Committee	2-7-26	Report discussed and noted.

Acronymau / Rhestr Termiau Acronyms / Glossary of Terms

NRIs	Nationally Reportable Incidents
IO	Investigating Officer
PST	Patient Safety Team
IHCs	Integrated Health Communities
DoLs	Deprivation of Liberty Safeguards
ECHR	European Convention on Human Rights
HCAI	Healthcare Associated Infection
AWTTC	All Wales Therapeutics and Toxicology Centre
WHC	Welsh Health Circular
IPC	Infection Prevention and Control
FMT	Faecal Microbiota Transplant
PIR	Post Infection Review
HLD	High Level Disinfection
ATP	Adenosine Triphosphate
PSOW	Public Services Ombudsman Wales
PEARS	People's Enquiry and Resolution Service
PES	People's Experience Service
NICE	National Institute for Health and Care Excellence
CET	Clinical Effectiveness Team
AMaT	Audit Management and Tracking
SCEG	Strategic Clinical Effectiveness Group
BAT	Baseline Assessment Tool
SSNAP	Sentinel Stroke National Audit Programme
CHKS	Healthcare intelligence and quality improvement service
RAMI	Risk Adjusted Mortality index



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

HIW	Healthcare Inspectorate Wales
CIW	Care Inspectorate Wales
CAF	Commissioning Assurance Framework
PET (scan)	Positron Emission Tomography Scan
PFD	Prevention of Future Deaths
LFERs	Learning from Events Reports
WRP	Welsh Risk Pool



Trugaredd
Compassion



Agored
Openness



Parch
Respect

INTEGRATED QUALITY REPORT

1. Y SEFYLLFA / SITUATION

- 1.1 For the NHS in Wales, quality is defined as continuously, reliably, and sustainably meeting the needs of the population that we serve.
- 1.2 In achieving this, under the statutory Duty of Quality, Welsh Ministers and NHS bodies will need to ensure that health services are **safe, timely, effective, efficient, equitable, and person-centred**. Underpinning these domains are six enablers, which are **leadership, workforce, culture, information, learning and research** and **whole-systems approach**.
- 1.3 These domains and enablers form the **Health and Care Quality Standards** for Wales introduced in April 2023 through statutory guidance.

2. Y CEFNDIR / BACKGROUND

- 2.1 BCUHB remains committed to delivering high-quality services across all areas of care. To provide assurance and drive continuous improvement, the BCUHB routinely monitors a range of quality metrics. These measures enable informed decision-making, support organisational learning, and underpin growth and development.
- 2.2 This report summarises BCUHB's current position regarding quality performance and identifies key actions required to strengthen outcomes and achieve sustained improvement.

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

- 3.1 **Never Events:** One Never Events was reported this period; eleven recorded in the last 12 months. Full investigations are underway with system learning review planned.
- 3.2 **Increase in National Reportable Incidents (NRI)** this period (8 vs 20). Median completion time remains best in Wales (75 days), proportion open >90 days has decreased. Ongoing focus on investigation timeliness and quality.
- 3.3 **Patient Safety Incidents:**
Incident backlog remains high (5084 open; 59.3% overdue). Reduction target not achieved; refreshed recovery trajectories being agreed with IHCs and Divisions. Enhanced PST training and early-stage investigation improvements planned.

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

- 4.1 **HIW overdue actions and rising assurance requests** signal continued regulatory pressure, particularly in emergency departments.
- 4.2 **Attorney General for Northern Ireland [2026] UKSC 16**

This UK Supreme Court judgment handed down on the 2nd June 2026 is likely to have significant and important implications for health and social care practice.

- 4.3 **Wrexham Maelor Hospital has been identified as a ‘borderline outlier’** for case mix adjusted mortality within the Sentinel Stroke National Audit, which benchmarks standardised mortality rate and other key performance indicators in centres across the UK.
- 4.4 **HIW Inspection – Emergency Department, YGC (5th to 7th May 2026)**
Immediate Actions received from HIW with initial improvement plan agreed.

5. ARGYMHELLION / RECOMMENDATIONS

- 5.1 The Board is asked to:
- **NOTE** the contents of the Integrated Quality Report and the progress being made across the quality domains.
 - **TAKE ASSURANCE** from the improvements described within the report whilst recognising a number of areas requiring enhanced oversight and sustained management action;
 - **ENDORSE** the continued focus on reducing regulatory and patient safety risks, including delivery of HIW improvement plans, completion of overdue actions, and strengthening organisational learning arrangements; and
 - **AGREE** that the Quality, Safety and Experience Committee maintain oversight of the key exception areas identified within this report and provide escalation to the Board where improvement trajectories are not achieved.

ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol Link to Strategic Priorities	3. Improve Access, Outcomes and Experience
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below: 4. Improving quality, outcomes and experience
Yr Egwyddorion Dylunio Design Principles	Simplify, Standardise, and Adopt Best Practices Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	BAF-SP18 and CRR-24-04 – Quality, Innovation and Improvement Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)

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

<i>Have you completed an Integrated Equality Impact Assessment WP8a?</i> WP8a Template	Canlyniad/Outcome: Do/Yes: Os naddo, dylech gynnwys y rheswm: If no, please include rationale: Canlyniad/Outcome:	Naddo/No: ☒ This report is purely administrative in nature and submitted for information only.
Human Rights Act <i>Have Human Right based concerns been addressed within WP8a</i>	Do/Yes: ☐ Canlyniad/Outcome:	Naddo/No: ☒ This report is purely administrative in nature and submitted for information only.
Compliance to the Welsh Language requirements? <i>Have you undertaken an Impact Assessment</i>	Os naddo, dylech gynnwys y rheswm: If no, please include rationale: Os naddo, dylech gynnwys y rheswm: If no, please include rationale: Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Naddo/No: ☒ This report is purely administrative in nature and submitted for information only.
Compliance to giving 'Due Regard' to the principles of the Armed Forces Covenant <i>Have the principles of the Armed Forces Covenant been addressed within WP8a</i>	Do/Yes: ☐ Canlyniad/Outcome: Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Naddo/No: ☒ n/a This report is purely administrative in nature and submitted for information only.
<u>Ansawdd</u> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i> <u>Quality</u> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Do/Yes: ☐ Canlyniad/Outcome: Galluogwyr Ansawdd Enablers of Quality All Apply Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:	Naddo/No: ☒ n/a

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

Patient Safety

1. Patient Safety Incidents

1.1 Incidents

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

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

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

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

1.5 Nationally Reportable Incidents

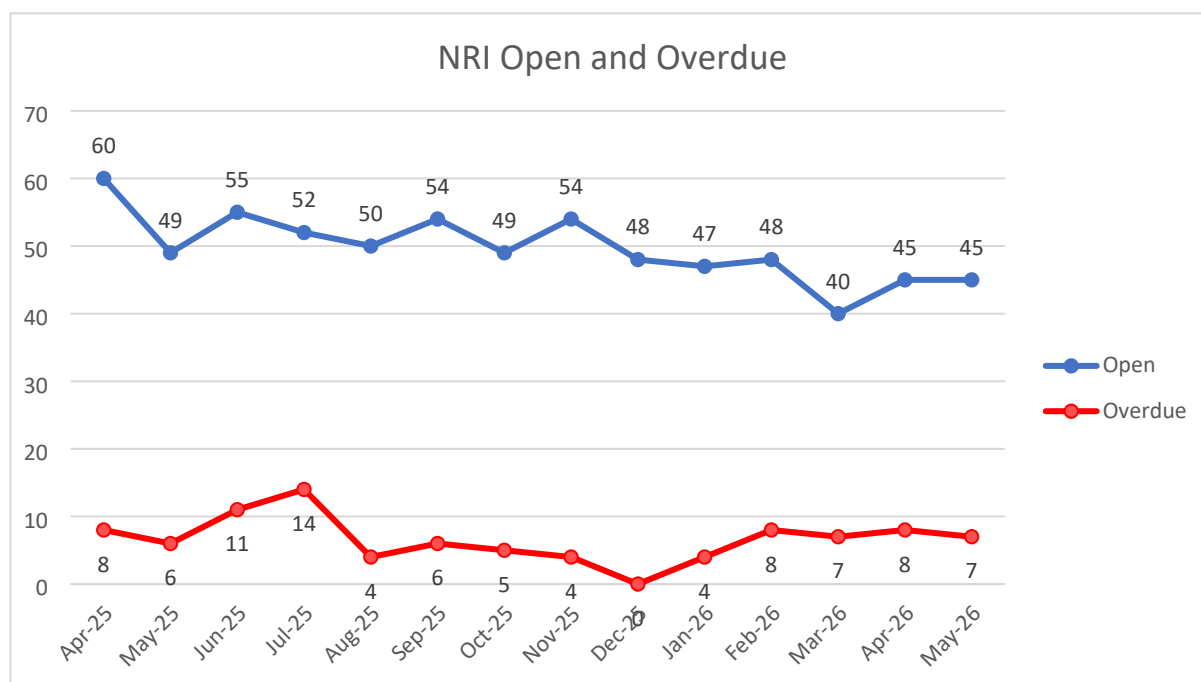
From 01st April 2026 to 31st May 2026, there were 11 Nationally Reportable Incidents (NRIs) submitted (by incident date) compared with 30 for the previous reporting period (N.B these numbers may change due to retrospective reporting of avoidable patient pressure ulcers and patient falls that have occurred in this time period.) These can be categorised as follows: -



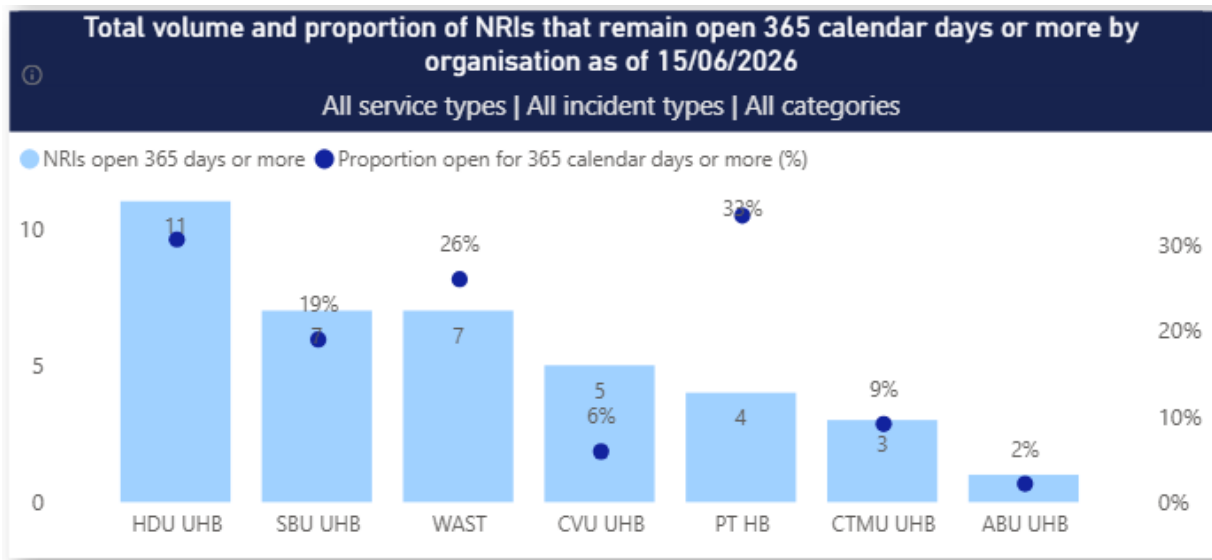
BCU UHB top 10 NRI categories occurring by volume (incident dates between Apr-26 and May-26) as of 15/06/2026

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

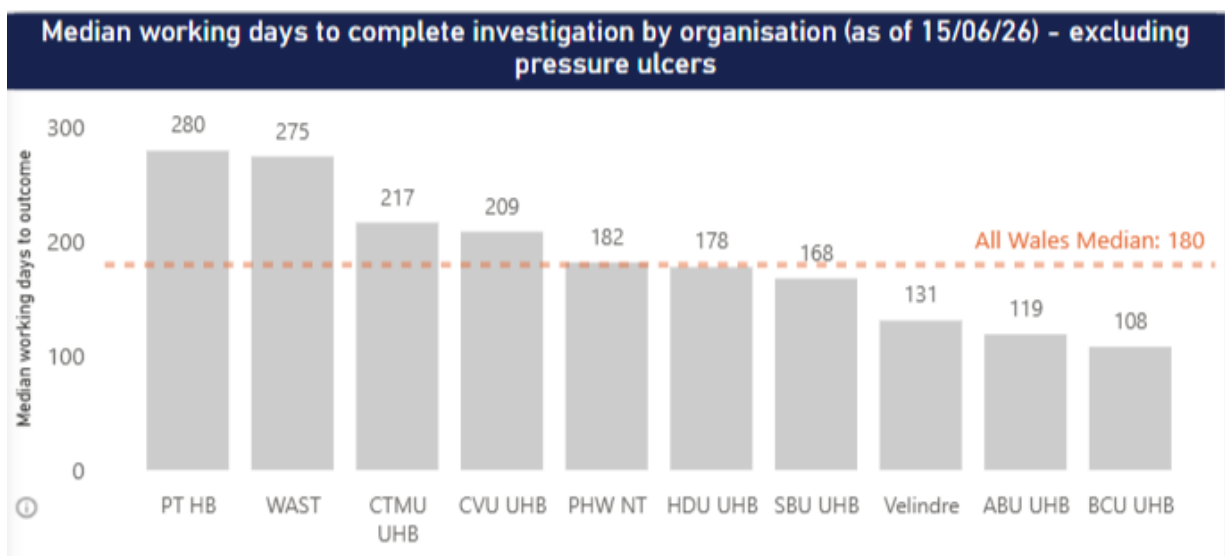
The total number of NRI investigations that were open as at the end of May 2026 was 45 with 7 overdue closures.



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



The median working days to completion is the lowest in Wales at 108 compared to the All-Wales median of 180 days.



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

1.8 Never Events

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

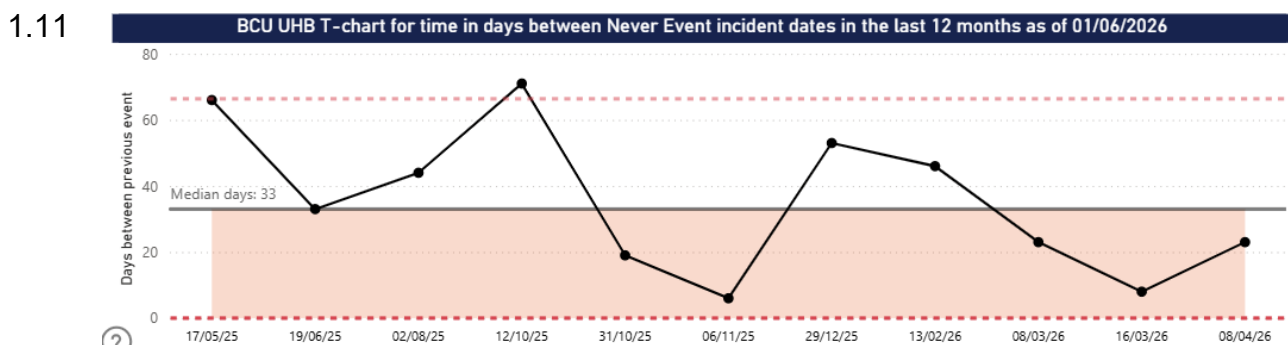
There were no Never Events reported in May 2026.



1.9 Please note Beacon does not contain May 2026 data

BCU UHB Never Events occurring (by incident date, May-25 to Apr-26) as of 01/06/2026														
Year	2025							2026						
Never Event	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr		
Administration of medication by the wrong route	1	0	0	0	0	0	0	0	0	0	0	0	0	
Retained foreign object post procedure	0	0	0	1	0	0	1	0	0	0	0	0	1	
Wrong implant/prosthesis	0	0	0	0	0	1	0	0	0	1	0	0	0	
Wrong site surgery	0	1	0	0	0	1	0	1	0	0	2	0	0	
Total Never Events	1	1	0	1	0	2	1	1	0	1	2	1		

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



1.12 The above mentioned Never Events are currently going through the full investigation process.

Further detail and initial learning can be found in the confidential quality report.

2. Patient Safety Alerts

- 2.1 The Patient Safety Team have circulated 3 pharmacy recalls, 5 pharmacy notifications, 2 field safety notices and 3 internal alerts. No new national alerts received.
- 2.2 **PSA019 Delayed administration of RasbriCase:** Approval for the revised process has been granted at the centralised Cancer Services Governance meeting. The documentation is currently with Pharmacy for final comments and is expected to be approved and distributed following the next meeting.
- 2.3 **PSA020 – Incorrect Recording of Penicillin vs Penicillamine Allergy:** Deadline for compliance is 30/11/2026. Implementation of ePMA has now completed. System warnings and reporting options being explored. Meeting 15th May 2026, initial progress done by ePMA team and report established for identification of patients in BCUHB that have penicillamine allergy. Need to link in with GP practices and review other data systems where this information is held.

2.4 **PSA021 – Risk Associated with Adult Breathing Circuits Lacking a Patent**

Exhalation Route: Deadline for compliance is 28/08/2026.

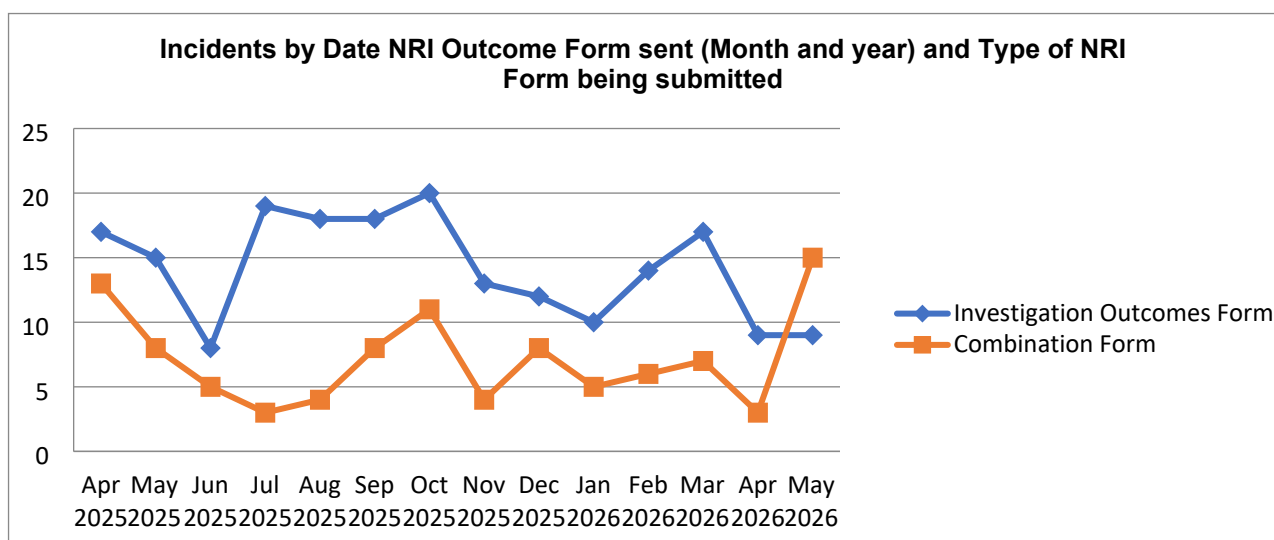
A formal Task and Finish Group has now been established with an agreed draft Terms of Reference and defined scope across all IHCs and relevant services. Clinical Lead and Chair confirmed. Membership has been identified across East, West and Central, with corporate support from Patient Safety. IHC/service areas are producing a point-in-time position statement to establish a baseline of current practice, equipment, training, and risks. The next task and finish group is to convene on 1st July 2026.

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

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

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

3.1 BCUHB submitted a total of 37 closure forms for reportable incidents during the reporting period April to May 2026, of which 23 were combination forms (e.g., falls and pressure sores) submitted at the conclusion of investigations.



3.2 A total of 14 National Reportable Incidents were closed during this period and are presented as a summary in the confidential paper, outlining the incident, key learning and post investigation harm level.

3.3 The key themes identified from the closed NRIs during this period include

- Failure to recognise or respond to deterioration in a timely manner
- Gaps in clinical assessment, monitoring, and escalation

- Documentation and communication issues across teams
- Non-adherence to established clinical pathways and protocols
- Patient identification and verification failures
- System and pathway tracking weaknesses

3.4 Actions have been identified and implemented across services to address these learning points, including reinforcement of protocols, improved documentation standards, targeted training, and strengthening of governance oversight.

Safeguarding and Public Protection

4. Deprivation of Liberty Safeguards (DoLS)

4.1 Attorney General for Northern Ireland [2026] UKSC 16

This UK Supreme Court judgment handed down on the 2nd June 2026 is likely to have significant and important implications for health and social care practice.

4.2 Background

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

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

4.4 Outcome

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

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

4.6 Position

The judgement is complex and requires detailed legal analysis. We will continue to operate in accordance with current statutory requirements, case law, and existing procedures. While implications of the Supreme Court judgement are being considered, immediate changes to local practice will be implemented as agreed with BCUHB Legal

and Risk services, existing statutory duties remain in force and UK and Welsh Government guidance has not yet been issued.

4.7 Next Steps

The Board is advised that the Supreme Court judgment on deprivation of liberty represents a significant change in the legal framework. While immediate legal advice has been obtained and current statutory arrangements remain in place, the full impact is not yet known. The Board can take limited assurance that appropriate interim controls are operating, with governance, risk management and oversight arrangements being strengthened pending further national guidance.

Infection Prevention Control

5. Strategic Improvement Goals (2025-2027)

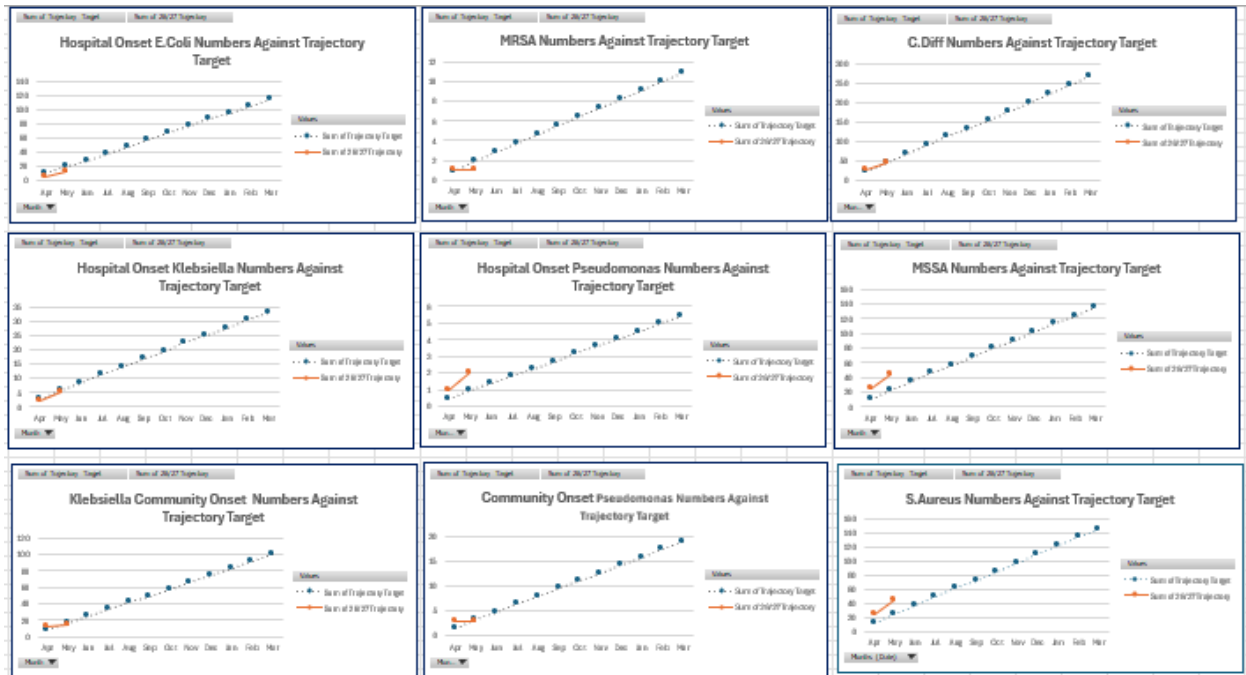
- 5.1 Performance against the HCAI improvement goals is mixed, with 4 organisms currently below trajectory, 3 exceeding their target trajectories and 2 on trajectory.

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

- 5.2 Additional expectations:

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

5.3



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

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

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

6. Outbreak Management

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

Impact:

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

7. Key Improvement Initiatives

- 7.1 To address identified performance gaps and sustain progress, a comprehensive programme of work is underway across BCUHB. This programme combines targeted quality improvement activity, strengthened assurance processes, and a focus on cultural and behavioural change.
- 7.2
- **IPC Quality Statement Gap Analysis**
A comprehensive gap analysis against the IPC Quality Statement (published February 2026) has been completed. The findings are informing BCUHB IPC Programme of Work for 2026–2028.
- 7.3
- **National *C. difficile* Collaborative**
BCUHB continues to actively participate in the national *C. difficile* collaborative, delivering three Quality Improvement Projects with a strong Infection Prevention and Control (IPC) focus. These initiatives are underpinned by behavioural science principles to drive sustainable improvements in practice and compliance. This work is closely aligned with antimicrobial stewardship to reduce modifiable risk factors associated with infection.
- 7.4
- **Faecal Microbiota Transplant (FMT) Service**
A nurse-led FMT service is established and operational, providing an effective treatment pathway for recurrent *C. difficile* infection. Plans are progressing to scale this service across all sites to improve equitable access and patient outcomes.
- 7.5
- ***C. difficile* Cohort Capacity and Estates Development**
A temporary *C. difficile* cohort unit has been established at Wrexham Maelor Hospital to support effective isolation and management of cases. In parallel, project plans are being developed to secure a permanent cohorting solution through Targeted Estates Funding. This forms part of a wider estates strategy to improve IPC compliance, including increased single room capacity, improved patient flow, and enhanced environmental standards.
- 7.6
- ***Pseudomonas* Surveillance and Epidemiological Review**
Following an earlier increase in *Pseudomonas* cases, it has been recognised that a significant proportion are not healthcare-associated and are therefore largely unavoidable. However, the Post-Infection Review (PIR) process has been strengthened to improve epidemiological understanding, identify any emerging trends or risk factors, and ensure that appropriate preventative and control measures are implemented where possible.
- 7.7
- **Enhanced Surveillance and Data-Driven Decision Making**
Work is progressing to strengthen surveillance systems to support earlier

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

- 7.8
- **Workforce Development, Leadership and Culture**
Workforce development remains a key priority, with a focus on embedding behavioural science approaches to improve IPC compliance and organisational culture. This includes strengthening IPC leadership at ward and divisional level, supporting link practitioners and champions, and improving training compliance and competency assessment across the workforce.
- 7.9
- **Audit, Compliance and Triangulated Assurance**
The IPC audit programme continues to be strengthened, with expanded focus on key areas such as hand hygiene, environmental cleanliness, and isolation practices. A triangulated approach to assurance has been adopted, bringing together audit findings, surveillance data, incident reporting, and feedback to provide a more comprehensive and robust assessment of IPC performance.
- 7.10
- **High-Level Disinfection (HLD) Standardisation**
High-Level Disinfection technology has been standardised across BCUHB. Final stages of staff training are nearing completion to ensure full operational implementation and consistent practice.
- 7.11
- **Environmental Cleanliness and ATP Monitoring**
Adenosine Triphosphate (ATP) monitoring technology is now in use across BCUHB, providing quantitative assurance of cleaning standards and enabling targeted improvement where required.
- 7.12
- **Patient and Public Engagement**
Work is underway to strengthen patient and public involvement in IPC, including the development of educational materials and initiatives to promote good infection prevention behaviours among patients and visitors.
- 7.13
- **Outbreak Preparedness and Organisational Resilience**
The Health Board continues to strengthen its outbreak preparedness arrangements through updated policies, clear escalation processes, and ongoing organisational learning. This includes planning for seasonal pressures such as influenza and norovirus.
- 7.14
- **Innovation and Sustainable Practice**
Opportunities to adopt innovative technologies and more sustainable IPC practices are being actively explored, supporting both quality improvement and environmental objectives.

Patient and Carer Experience

8. Complaints

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

8.2 The new Listening to People: The NHS Wales Complaints, incidents and redress framework was successfully launched on the 1st April, 2026, and all key milestones of the Implementation plan were achieved on time

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

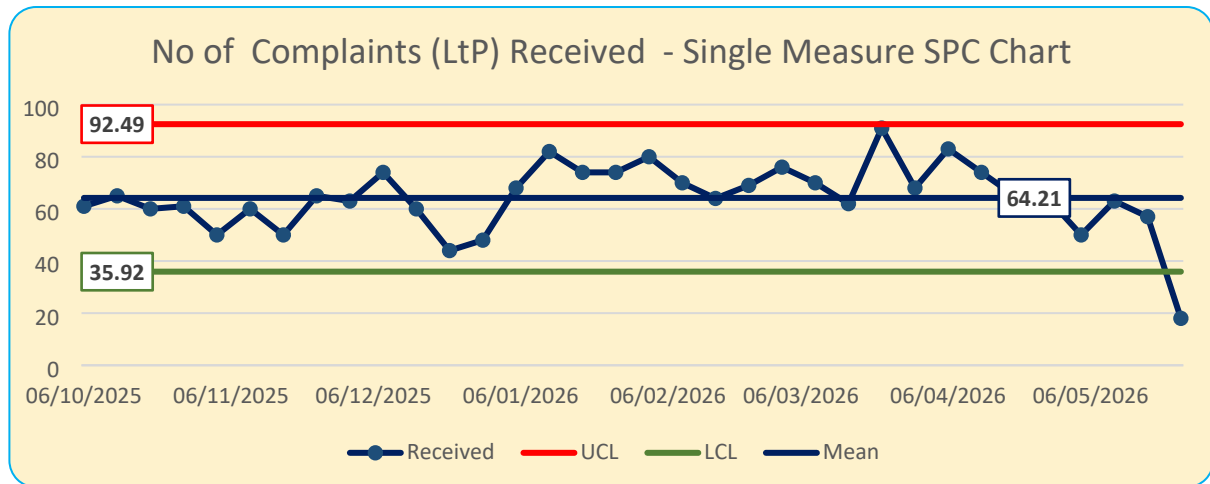
Metric	Status	Trend
Total Open Complaints	286	Decrease from 311
Number Overdue	83	Increase from 69
Overall Compliance (Target 75%)	70.89%	Decrease from 77.81%

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

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

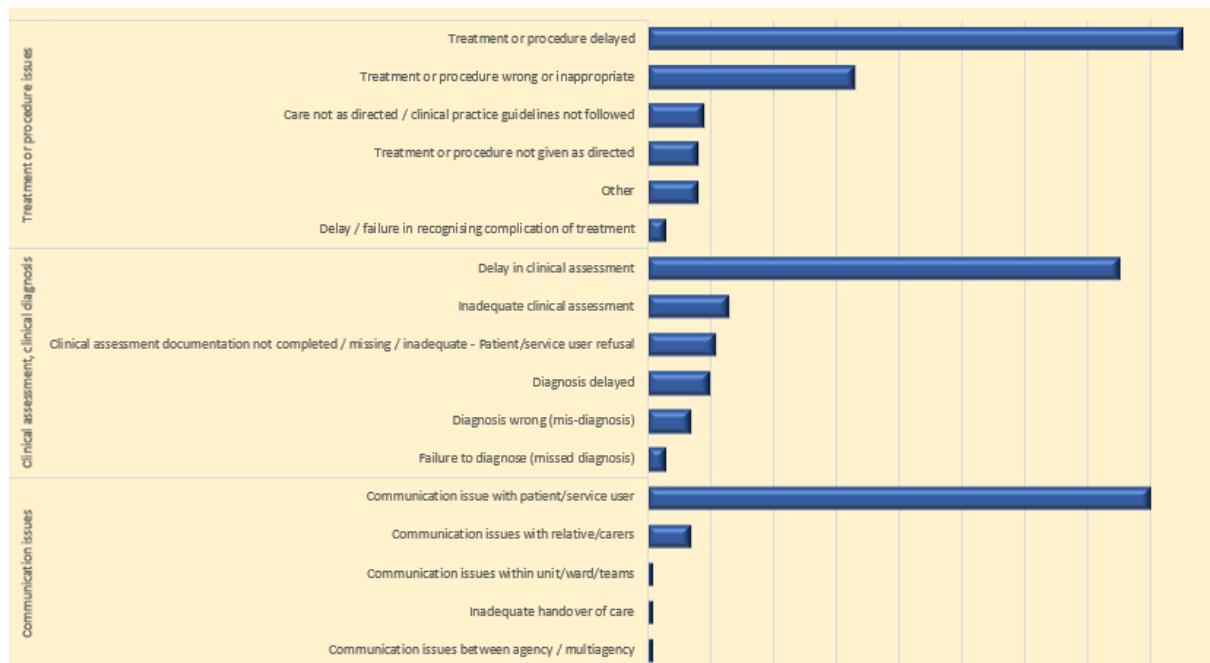
8.5 Between 1st April 2026 and 31st May 2026, BCUHB received 450 complaints, a reduction from 553 complaints in the previous quarter, and closed 515 complaints a positive variance of 65.

Complaints Received SPC chart



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

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



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

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

8.7 Benchmarking nationally BCUHB continues to perform well:

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

Real-Time Performance: BCUHB has consistently performed better than the Welsh national average for closing complaints within 30 days of receipt since September 2024 and continues to do.

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

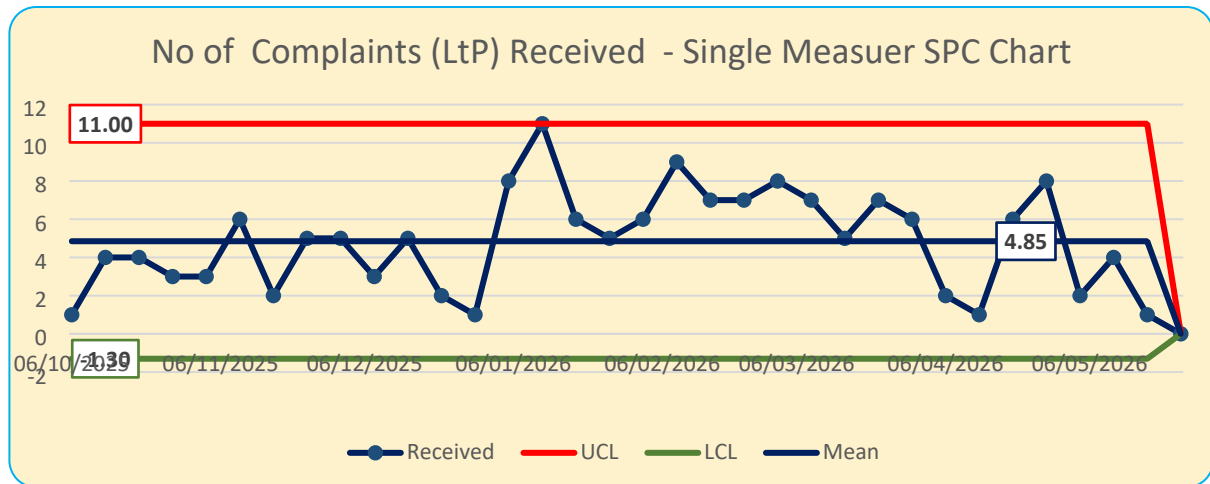
8.8 **Re-opened Complaints:** There is no data available nationally to benchmark re-opened complaints.

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

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

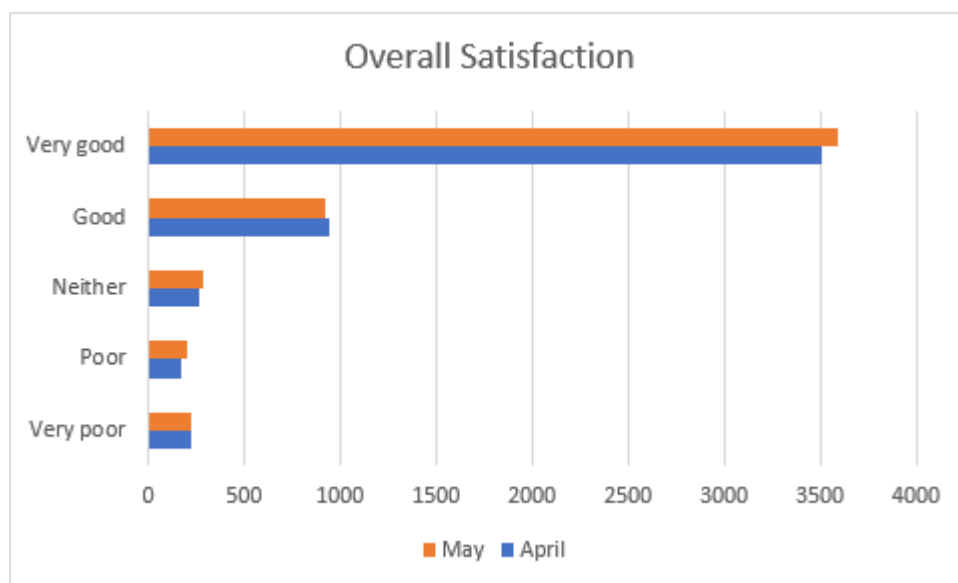
8.10 The purpose of a re-opened complaint is to not only improve patient experience, it is not unusual to be asked additional questions once a response has been provided, or simply the complainant requires some further clarity. This person-centred approach, reduces PSOW referrals and intervention, reducing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

8.11 Re-opened complaints SPC Chart



9 Patient Feedback

- 9.1 The People's Enquiry and Resolution Service (PEARS) supported the resolution of 939 enquiries between 1st April 2026 and 31st May 2026.
- 9.2 The top 3 enquiry themes included appointments, access to services, and test and investigation results. During this period, the service also received 100 written compliments praising general care and respect and 9 suggestions for improvement.
- 9.3 Findings from the All-Wales People's Experience Survey remain highly positive. Based on 10,617 responses, 86.97% of patients rated their overall experience as 'Good (18.09%)' or 'Very Good (68.88%)'. Satisfaction levels were high with people reporting they were 'Always' treated with dignity and respect (87.05%) and being able to communicate in a preferred language (90.80%) which exceeded the national benchmark of 85% satisfaction.



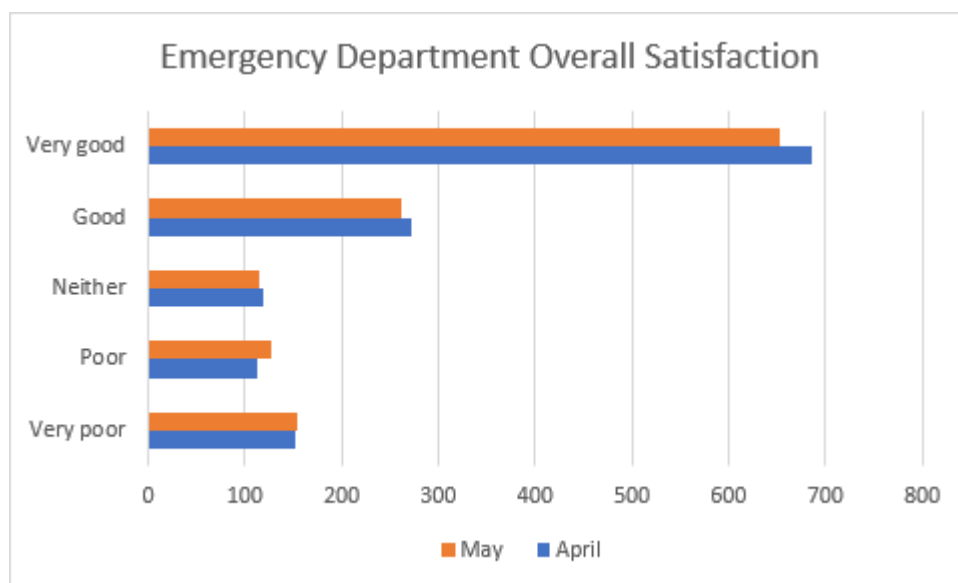
9.4 The following table displays key feedback metrics for the reporting period:

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

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

9.6 Emergency Department Feedback

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



9.7 Key Emergency Department feedback data:

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

9.8 Advocacy and Support

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

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

10. Other Patient Experience Updates

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

10.2 Key feedback themes:

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

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

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

Clinical Effectiveness

11. Clinical Audit

- 11.1 During April and May (Quarter 1), there was one Tier 1 national clinical audit published, which is scheduled for reporting during July 2026.
- 11.2 **One National Audit report has been published in Quarter 1, all included BCU identifiable data.** The table below outlines the benchmarking information:

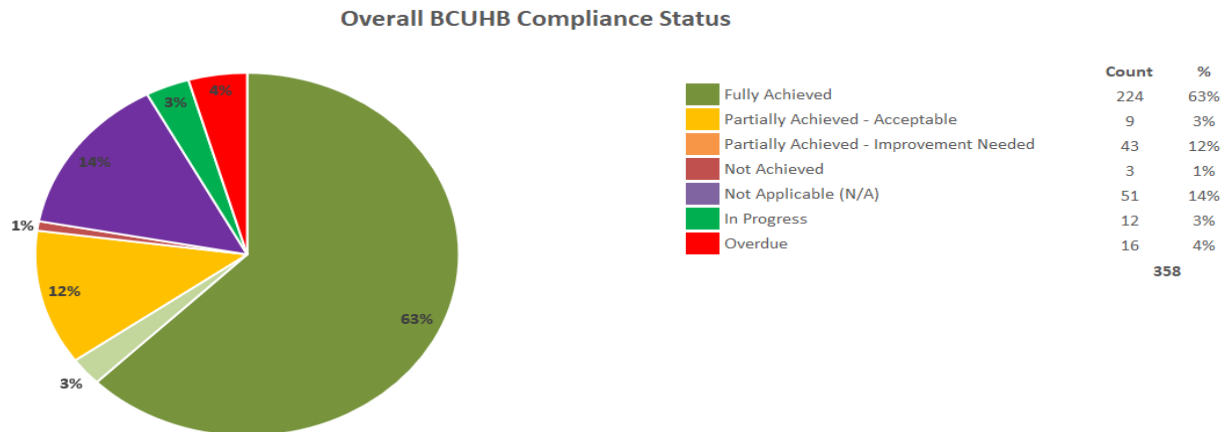
Tier 1 Project reference	Title	Performance against	
		National Benchmark	Last BCU report
NCAORP/ 2025-26-33	National Respiratory Audit Programme (NRAP): Primary Care Wales Audit: Clinical Audit report 2026 (2023-2025 audit period)	G	G

Key	Comparison with National Benchmark:	Comparison with Last BCUHB Report:
R	Where BCUHB reported performance is at or above the benchmark in fewer than 50% of KPIs	Where the previously reported BCUHB performance has deteriorated in more than 50% of Key performance indicators (KPIs) according to the latest National audit report
A	Where BCUHB reported performance is at or above the benchmark in 50% to 74% of KPIs.	Where the previously reported BCUHB performance has been maintained or improved in 50% to 74% of KPIs in the latest reporting period.
G	Where BCUHB reported performance is at or above the benchmark in 75% or more of KPIs.	Where BCUHB has maintained or improved in 75% or more of KPIs since the previous reporting period

12. NICE Guidelines

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

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

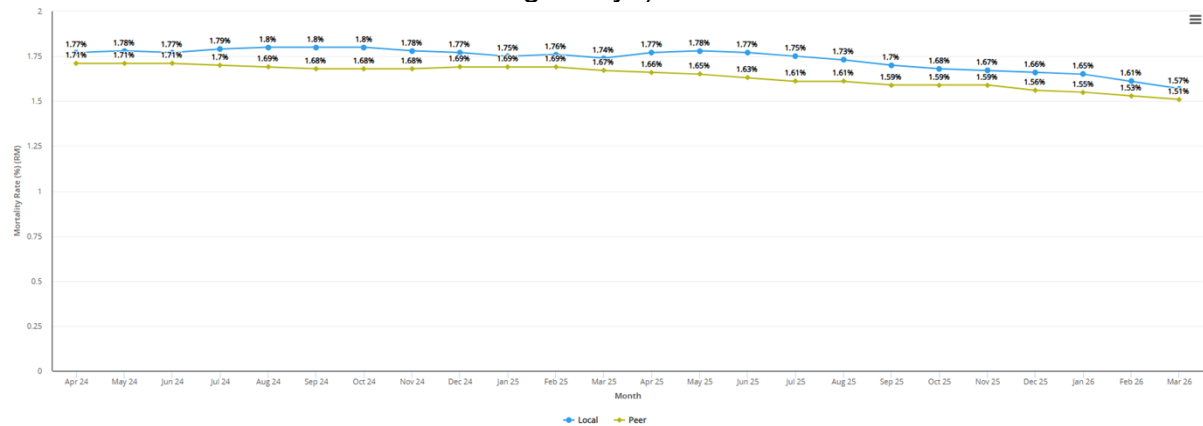


- 12.3 Instances of '**Not Achieved**' compliance (where the service **has not met the standards** that the National Institute for Health and Care Excellence (NICE) recommendations) are now being escalated monthly to Strategic Clinical Effectiveness Group (SCEG) to provide targeted support and drive improvements in compliance, which is starting to take effect. The responsible service must put together an action plan or Baseline Assessment Tool (BAT) to show how they are planning to meet the national standard in the near future and the timescale for this to be achieved. In a recent Internal Audit for NICE, it has been identified that this area needs to be improved further within services and targeted training is being put in place to achieve.
- 12.4 This internal audit had also highlighted that some clinical leads were able to bypass the full compliance review process by overriding their responses within AMaT. In response, AMaT is working on removing this functionality, and the Clinical Effectiveness NICE team will contact the clinical leads who have used the override to ensure the required compliance reviews are completed in full. A standardised message has also been prepared by the Clinical Effectiveness (CE) team and circulated across the Health Board to ensure that this is used correctly and only by the CE team if required until the problem is rectified. The Internal Audit review resulted in a Limited Assurance opinion, reflecting demonstrable progress in NICE compliance, alongside the need to enhance assurance through strengthened governance, oversight and reporting processes.

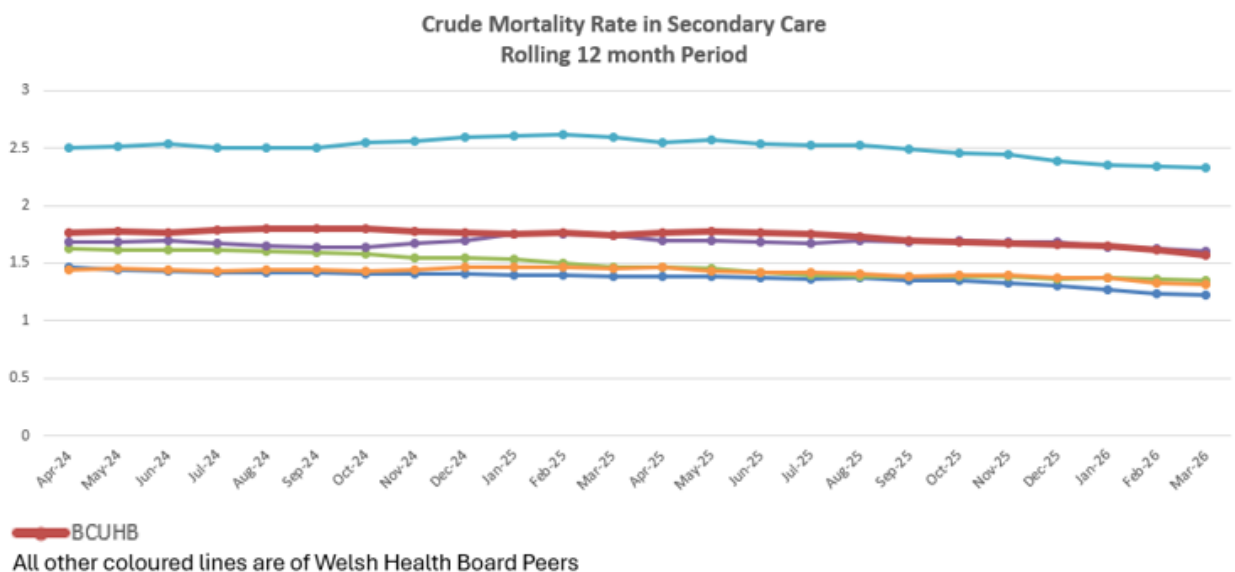


13. Mortality

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



13.2 Peer breakdown:

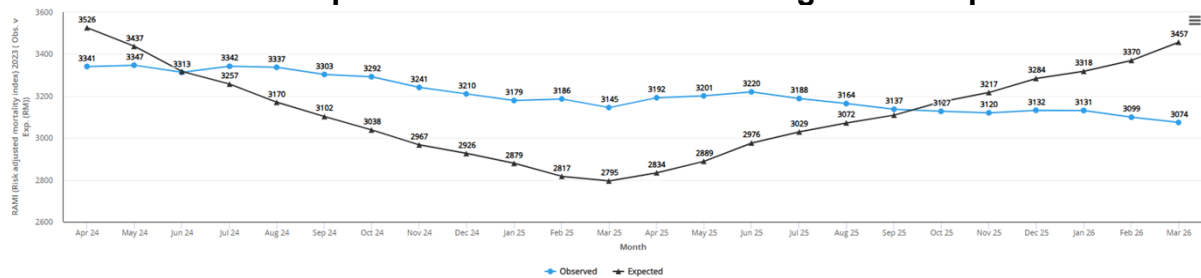


- 13.3 Crude mortality rate in BCUHB is consistently above the national average, although the gap has reduced in recent months. Crude mortality rates for other Welsh Health Boards are included in the graph above for comparison.
- 13.4 Crude mortality is not risk adjusted, and it can be affected by many factors. Population demographics including age, socioeconomic status, population health and rate of chronic disease will affect the crude mortality rate.
- 13.5 Crude mortality in secondary care will also be affected by the number of individuals dying outside the acute hospital setting. Capacity in community hospitals, care homes and hospices alongside availability of social care packages will affect length of stay and increase mortality in secondary care where a lack of downstream capacity prevents

discharge. This will lead to variation between IHCs in BCUHB and needs to be considered when making external comparison with other Welsh Health Boards.

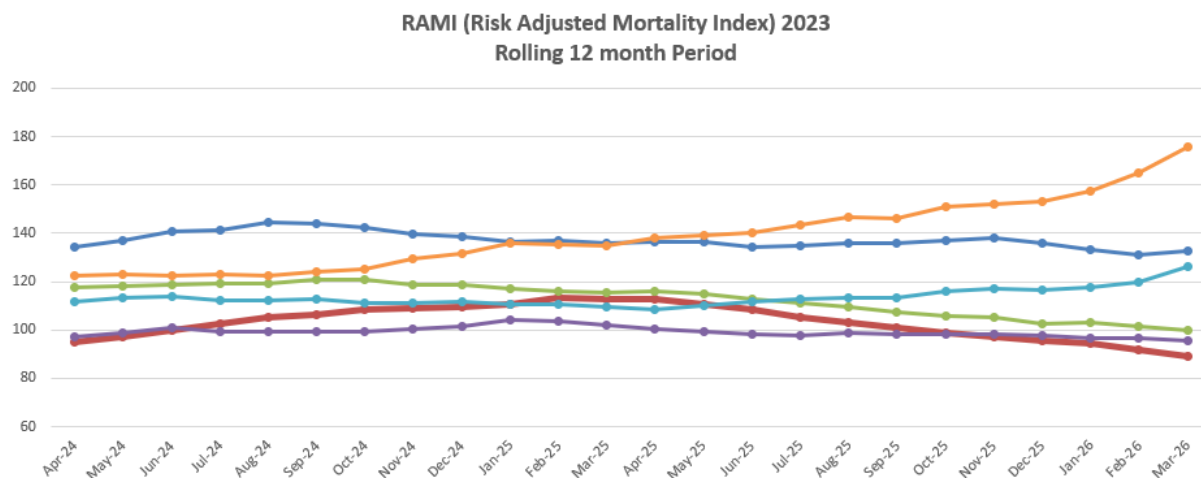
- 13.6 We continue to monitor risk adjusted mortality metrics. There has been a downward trend in Risk Adjusted Mortality Index (RAMI) in BCUHB since May 2025 associated with improved coding completion as previously discussed.

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



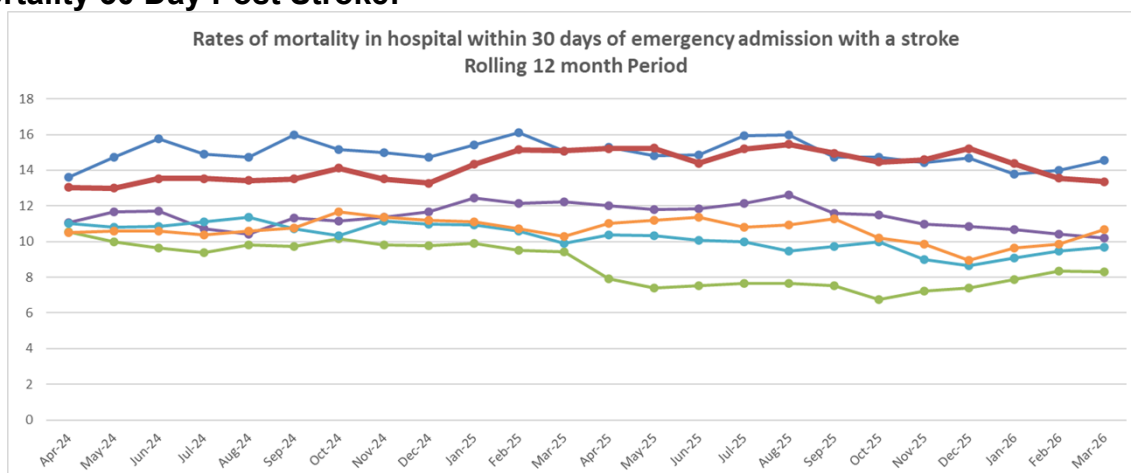
RAMI = Number of deaths observed / Number of deaths expected.

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



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

13.9 Mortality 30 Day Post Stroke:



— BCUHB

All other coloured lines are of Welsh Health Board peers

- 13.10 Wrexham Maelor Hospital has been identified as a 'borderline outlier' for case mix adjusted mortality within the Sentinel Stroke National Audit, which benchmarks standardised mortality rate and other key performance indicators in centres across the UK. While no formal response from BCUHB is required, there is a need for a detailed review of this cohort. Methodology will be agreed following preliminary discussion with the SSNAP Audit Team. CHKS data also shows increased mortality within 30 days of admission with stroke. Advice from a provider who has performed a similar review will be taken.
- 13.11 Triangulation of mortality data with other key performance indicators will be essential and is reflected in the terms of reference for the newly formed BCUHB Stroke Clinical Governance Group which will be initially chaired by the Associate Medical Director for Mortality.
- 13.12 **Morbidity and Mortality (M&M) Form, Learning and Process:**
Clinical Governance and/or dedicated Mortality and Morbidity (M&M) meetings provide an effective forum for reflection, discussion and learning to inform service development and individual practice. This practice aligns with existing requirements for clinicians to reflect on concerns and other significant events within their annual appraisal. At present these are not consistently in place across BCUHB nor is a consistent and agreed methodology followed. A BCUHB wide approach is being introduced. This includes a Mortality and Morbidity Form which provides a structure for review and discussion including the development of accountable action plan. It ensures that an overall judgement is made about the quality of care provided to the patient. These forms will be collected by site Mortality Leads to ensure review is taking place and to allow shared learning.
- 13.13 **MCCD Completion Rate Update:**
MES dashboard data shows that BCUHB is performing well in comparison with other Health Boards: mean time to MCCD completion is currently 7.19 days.

13.14 Learning

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

13.15 Secondary Care

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

Primary Care

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

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

Quality Assurance

14. Health Inspectorate Wales

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

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

14.3 Inspection – Ysbyty Gwynedd Emergency Department (14–16 Apr 2025)

- Status:** Complete
- Recommendations:** 28
- Actions:** 66 total; 66 completed (100%)
- Outstanding:** None
- Closure Date:** Complete
- Governance:** Continuous monitoring via Local HIW Review Meeting, Regulatory Assurance Group (RAG), and Executive Quality Delivery Group (EQDG).

14.4 Inspection – Pantomime Ward, Ysbyty Maelor (14th to 16th October 2025)

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

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

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

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

The service has submitted their improvement plan to HIW and the final report has now been received.

14.7 **HIW Inspection – Emergency Department, YGC (5th to 7th May 2026)**

Immediate Actions outlined from HIW and escalated to Service Requiring Significant Improvement.

Concerns raised requiring Immediate Action include:

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

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

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

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

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

14.9 Concerns / Requests for Assurance (3)

- **Nant Y Glyn Community Mental Health Team (April 2026)**

Assurance request from HIW following concerns received via a voicemail from the mother of an individual raising concerns about her mental health wellbeing and her safety. It also highlighted communication issues with the service. There is no indication within the clinical notes, or reception emails, that calls have been received, where the CMHT have not responded. The clinical notes capture that there were two records of contact via reception and on both occasions a Practitioner made contact

14.10 • **Wrexham Community Mental Health Team (April 2026)**

Assurance request from HIW highlighted concerns regarding a patient's dissatisfaction with the way their psychiatric assessment was managed. The email also mentions the patient's decision to discontinue their prescribed medication. There was an indication that the patient is a high risk to his personal safety and wellbeing. The service provided a further update to HIW a month after the initial concern, to provide further assurance regarding the patient's care.

14.11 • **Neonatal Department Ysbyty Glan Clwyd, IHC Central (April 2026)**

Assurance request from HIW in relation to concerns received by Healthcare Inspectorate Wales in relation to the Neonatal Unit at Glan Clwyd hospital. The concerns received relate to safety, care standards and the working environment of the Unit. A full review was undertaken by the service, and the Health Board will continue to monitor delivery of actions through established governance processes to ensure sustained improvement and organisational learning.

15. Care Inspectorate Wales

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

16. Public Services Ombudsman for Wales

- 16.1 BCUHB has maintained sustained compliance with Ombudsman requirements, with overall compliance against recommendations at 92%. Engagement with the Ombudsman's office has strengthened, supporting timely resolution and improved assurance.
- 16.2 BCUHB currently has 50 open Ombudsman cases.

Notification of New Full Investigations	2
Awaiting Draft Report	18
Draft Report Received	1

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

16.3 Public Interest Reports

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

16.4 • Final Public Interest Report 202301141

The Ombudsman's investigation considered the following:

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

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

All compliance evidence has now been shared with the Ombudsman. Compliance has been met and the case was closed on 25 June 2026.

16.5 • Final Public Interest Report 202404388

The Ombudsman's investigation has considered the following:

The care and treatment the patient received, following his prostate cancer diagnosis, between September 2023 and July 2024. In particular, the significance of the delays in him receiving a PET scan and oestrogen, and whether this impacted the spread of his cancer.

The Final report was issued on 4 March 2026.

Evidence relating to all actions due by April 2026 have been shared with the Ombudsman.

An apology letter has been issued. The Ombudsman's report has been shared with those clinicians involved in the patient's care so the findings can be considered and discussed. The report has also been shared with the complaint handling staff of the need for in-depth and robust investigations.

All remaining actions due by September 2026 are progressing in line with agreed timescales. These include a review of the Health Boards local prostate cancer pathway, and an audit is currently underway to demonstrate evidence about the impact of any changes made. The case is also being reviewed in line with its legal requirements under the Duty of Candour to determine how the cancer pathway journey took more than 180 days.

The Health Board has already completed an audit of those patients that have required a PET scan in the last 2 years, the results of which will be shared with the Ombudsman's office. The Joint Commissioning Committee (JCC) target for PET scans is 10 days and the Health Boards current waiting times (early July 2026) is within the JCC target.

16.6 Final Public Interest Report 202501841

The Ombudsman's investigation has considered the following:

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

This was published on 17 June 2026.

Evidence relating to all actions due by July 2026 have been shared with the Ombudsman.

An apology letter has been issued together with financial redress payment of £2,000 to reflect the injustices caused. The Ombudsman's report has been shared for learning with all medical and pharmacy staff to remind them of their responsibilities in accordance with the NICE controlled drugs guidance and the Health Board's medicines Policy. The report has also been shared with the Consultant for the purpose of reflection as part of continued professional development and also shared with the Health Boards investigation team to review the conduct of its investigation in line with the Duty of Candour and identify learning points. All evidence has been shared with the Ombudsman.

All remaining actions due by December 2026 are progressing in line with agreed timescales. These include a review of process and practice within the medical and pharmacy teams to address all the failings identified. An audit is also underway of randomly selected discharges from the Acute Medical Unit (AMU), from the past 6 months to determine whether the prescriptions provided on discharge were subject to appropriate internal and external checks.

17. Duty of Candour

- 17.1 Betsi Cadwaladr University Health Board (BCUHB) is committed to upholding the statutory Duty of Candour and ensuring compliance with all associated legislative and regulatory requirements. The organisation continues to promote a culture of openness, transparency, and honesty in all aspects of care delivery, placing patients, families, and carers at the centre of its approach.
- 17.2 The Health Board provides assurance that systems and processes are in place to support the identification, reporting, and appropriate management of notifiable patient safety incidents. Duty of Candour is embedded within incident reporting, investigation, and concerns processes, ensuring that individuals affected by harm are informed in a timely, compassionate, and structured manner.
- 17.3 BCUHB recognises the importance of continuous improvement and learning. A dedicated Task and Finish Group is currently in place to review the organisation's compliance with Duty of Candour requirements. This group is actively assessing current practices, identifying any gaps in compliance, and overseeing the implementation of necessary improvements. This work ensures that Duty of Candour remains a strategic and operational priority across the Health Board.
- 17.4 Learning from incidents and concerns is a key component of this approach. The Health Board is committed to using insights from investigations and reviews to strengthen patient safety, improve service delivery, and reinforce a culture where staff feel supported to be open and honest.
- 17.5 Through these ongoing efforts, BCUHB aims to ensure that Duty of Candour is consistently applied, that patients and families are treated with dignity and respect, and that organisational learning drives meaningful and sustained improvement.
- 17.6 The task and finish group are currently reviewing the way Duty of Candour data is captured to be able to provide informative data for reporting. This is being undertaken with National forums to ensure it is aligned with other Health Boards across Wales.

18. Organisational Learning

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

HealthCare Law

19. Coroner and Inquests

19.1 Prevention of Future Deaths (PFD) Reports

During the reporting period, there were no new PFD or responses to PFDs.

19.2 Response to other Coroner Concerns

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

20. Liability Claims

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

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

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

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



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Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Health Board Key Issues Report			
Board Date		30/07/2026	
Date of Committee		23/06/2026	Report of: Performance, Finance and Information Governance
Quoracy met:		Yes	
1	Agenda	The Performance Finance and Information Governance Committee (PFIGC) continues to meet bi-monthly. The Committee considered an agenda which is attached: PFIG Committee - BCUHB	
2a	Alert	The PFIG Committee wish to Alert members of the Board that: - Planned Care recovery remains off trajectory, with particular concern regarding 104-week waits: there is limited confidence in deliverability. - Urgent and Emergency Care performance remains fragile, with ongoing challenges in patient flow, delayed discharges and inconsistent delivery of improvement across sites. - Achieving a balanced budget remains challenging, with a material gap in deliverable savings and increasing deficit pressures: identified savings to date are largely from the value and sustainability work.	
2b	Assurance	The PFIG Committee wish to Assure members of the Board that: - A revised Planned Care recovery approach is being developed, including strengthened leadership, a speciality-led model and improved alignment between operational and financial planning. - Some early signs of improvement are emerging, including reductions in the longest waits and improved operational grip in some services, supported by strengthened recovery governance. - A Value and Sustainability framework is in place, with a defined pipeline of opportunities and a focus on productivity, efficiency and outcomes. The Committee will have a development session specifically relating to this. - A revised approach to business case governance is being implemented, strengthening prioritisation, aligning proposals to planning and available funding envelopes, and enabling greater local ownership of resource decisions to reduce unnecessary reliance on formal business cases. This needs to be accompanied by a	

		streamlining of the ECR process and a review of the centralised decision making on certain types of expenditure even when these are within devolved budgets.
2c	Advise	The PFIG Committee wish to Advise members of the Board that: • The organisation must accelerate delivery of systemic improvements, particularly around productivity (e.g. theatres, diagnostics and workforce utilisation). • Stronger clinical engagement and ownership are critical to achieving sustainable improvement and delivering value-based changes: again, greater flexibility in applying centralised controls and in handling business cases where these are needed will be important in securing buy-in. • The new version of the Integrated Performance Report was received for the first time, the Committee were pleased with the new format although significant concerns remain about many aspects of performance.
2d	Review of Risks	The risks that the Committee has oversight of were reviewed with the Committee noting that deep dives were ongoing.
2e	Sharing of learning	There were no specific learning items to draw to the Board's attention on this occasion.
3	Actions to be considered by P&C Committee	People and Culture Committee to review the work underway to simplify the Establishment Control Record process.



Health Board

INTEGRATED QUALITY AND PERFORMANCE REPORT (IQPR)

Dyddiad y Cyfarfod Date of Meeting	30 July 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Draft Status - Final Version will be Published
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Ed Williams Dirprwy Cyfarwyddwr Perfformiad Deputy Director for Performance
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Russell Caldicott Cyfarwyddwr Gweithredol Cyllid Executive Director of Finance
Pwrpas yr Adroddiad Report Purpose	For noting

Crynodeb Gweithredol **Executive Summary**

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

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

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

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

INTEGRATED QUALITY AND PERFORMANCE REPORT

1.0 Y SEFYLLFA / SITUATION

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

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

2.0 Y CEFNDIR / BACKGROUND

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

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

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

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

3.1 Performance and access

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

more than three years at the end of the quarter. This demonstrates the fragility of progress achieved to date and the need for sustained delivery of recovery actions.

To support further improvement, 90-day operational recovery plans have been developed for 2026/27.

Cancer performance remains the worst in Wales at 54% and significantly below the required standard. The challenges are notable in skin, breast, urology, colorectal, and head and neck services, reflecting ongoing capacity, pathway and demand pressures.

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

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

After a period of sustained improvement during 2025, performance against the percentage of people accessing **adult psychological therapy** within 26 weeks of referral has continued to deteriorate through 2026 to 50% against an 80% target.

Access for children requiring **neurodevelopment** assessments remains poor at 12.7% for BCUHB and 23.3% for all- Wales with no health board achieving the 80% target rate.

Urgent and emergency care services across the health board continue to operate under ongoing pressure, and present risks to patient safety and experience, quality of care, staff wellbeing and organisational reputation. In June, ambulance conveyances were static (3,340), with 39% of handovers achieved within the 45-minute target, well below the requirement of 100%. Emergency department 12-hour performance has deteriorated by 1% over the past three months, 24% of patients continue to wait over 12 hours in ED's and MIU's. Time to triage is above target (median 21 minutes against the 15-minute target), while median time to clinician stands at 127 minutes (67 minutes over the national target). The number of patients with delayed pathways of care and number of delayed days has increased with West IHC accounting for 50.4% (6,592) of all delayed bed days across BCU. Improvement work has been supported by a dedicated intervention team. Following an inspection of the Emergency Department at Ysbyty Glan Clwyd in June 2026, Healthcare Inspectorate Wales (HIW) identified a number of areas requiring immediate assurance and designated the service as an area of significant concern. A detailed recovery plan has been developed to respond to the concerns raised

3.2 **Quality, safety and patient experience**

Four new never events were reported during quarter 1, bringing the rolling 12-month total to 13. There has been an increase in nationally reportable incidents at 45 while the proportion of cases remaining open for more than 90 days remains consistent. Whilst the median investigation completion time remains the best in Wales at 108 days, (all Wales median is 180) the continued occurrence of never events and increasing number of incidents highlights the need to strengthen organisational learning and ensure that lessons identified are consistently embedded into practice.

The patient safety incident backlog remains significant and is increasing, with 5,084 incidents open, 59.4% of which are overdue. This continues to present a challenge for the organisation, with refreshed recovery trajectories being agreed with Integrated Health Communities and divisions. Progress continues against national Patient Safety Alerts.

The UK-wide Profemur hip recall affects 821 patients across BCUHB. A dedicated management plan is in place, supported by executive oversight.

The 'Listening to People: The NHS Wales Complaints, Incidents and Redress Framework' was launched on 1 April 2026, all implementation plan milestones were completed on time. The average closure rate is 21 days (target is 30), complaint closure performance has reduced to 70.9% compared to 77.8% in the previous month. Open complaints have risen from 311 to 335, with overdue cases increasing from 49 to 69. Delays in treatment and /or assessment and lack of communication with patients remain the top 3 issues of concerns raised.

3.3 **Finance and sustainability**

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

At the end of June 2026, the year-to-date deficit stood at £17.1 million, which is £6.4 million behind plan. This variance is largely attributable to under-delivery of savings. Whilst financial controls continue to provide some mitigation, delivery of planned savings remains a significant organisational risk and further improvement is required.

The health board is targeting £46 million of savings, with an additional stretch target of £17 million, bringing the total ambition to £63 million (2.4% of turnover). Achievement of this level of savings would support access to additional central funding and strengthen the organisation's route to financial sustainability. As at June 2026, savings schemes with a forecast deliverable value of £24.1 million have been progressed, but only £10.1 million of these are budget reducing, highlighting the need for significant further work to identify and deliver recurrent budget releasing savings and restore a sustainable financial trajectory.

Failure to achieve the statutory financial duty places at risk access to approximately £82 million of Welsh Government funding. This would significantly increase the financial challenge facing the organisation and constrain its ability to maintain services, invest in workforce and infrastructure, and support delivery of operational recovery plans.

3.4 **People and places**

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

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

4.0 **ASSESSMENT**

Whilst improvement has been achieved in a number of areas over the past year, the Health Board continues to face significant challenges in delivering sustained recovery. Performance against national standards remains below expectation in several key services, most notably urgent and emergency care, cancer and planned care. Alongside these operational challenges, the health board faces substantial financial risk, with delivery of the statutory financial duty critical to maintaining access to Welsh Government support funding and supporting future service sustainability. Taken together, these factors mean the organisation remains some distance from achieving the level of performance and sustainability required for de-escalation from Special Measures. Recovery plans are in place, but delivery at pace will be critical during the remainder of 2026/27.

5.0 **ARGYMHELLION / RECOMMENDATIONS**

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

Acronymau / Rhestr Termau

Acronyms / Glossary of Terms

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

ASESIAD / ASSESSMENT	
Cysylltiad â'r Bwriadau Strategol	3. Improve Access, Outcomes and Experience
Link to Strategic Intentions	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Yr Egwyddorion Dylunio Design Principles	Equity and Accessibility Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	CRR 25-01 Timely Access to Safe and Effective Care CRR 25-06 Value Delivery and Financial Sustainability CRR 25-08 Non-Compliance with Regulatory and Legislative Requirements

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

<u>Quality</u> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
<u>Deddf Llesiant</u> <u>Cenedlaethau'r Dyfodol -</u> <u>Nodau Llesiant</u> <u>Wellbeing of Future</u> <u>Generations Act – Wellbeing</u> <u>Goals</u>	A Healthier Wales	

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



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

Thursday, 30 July 2026



**Trugaredd
Compassion**



**Agored
Openness**



**Parch
Respect**

Health Board

Integrated Quality and Performance Report

Data Produced on 16.07.2026 on behalf of the Health Board
by the Performance Directorate and partners

Title	Page	Title	Page
Cover	1	Section 1: Access and Operational Performance	10
Table of Contents	2	Section 2: Quality, Safety and Experience	30
Introduction	3	Section 3: People and Places	37
What is the data telling us	4	Section 4: Finance and Sustainability	40
Executive Summary:		Section 5: Population Health	44
• Performance and access	5	Appendix	47
• Quality, safety, and patient experience	6	Interpreting Statistical Process Control (SPC) Charts	48
• People and places	7	Interpreting the Scorecards	50
• Finance and sustainability	8	Abbreviations	51
• Population health and prevention	9	Further Information	52

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

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

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

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

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

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

What is our data telling us?

Performance and access

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

Quality, safety and patient experience

Four new never events were reported during quarter one of 2026/27 (1 in April and 3 in June). There has been an Increase in national reportable incidents this period (20 vs 14). Median completion time remains the best in Wales (108 days), though the proportion open over 90 days has increased. Patient safety incident backlog remains high and has increased (5,084 open with 59.4%% overdue). Progress noted against national patient safety alerts (PSA); some compliance timelines extended. There is a UK wide profemur hip recall affecting 821 patients in BCUHB with management plan and executive sponsorship in place. Legislative transition to *Listening to People* successfully implemented. Whilst the average closure rate is 21 days (target is 30), complaint closure performance has reduced to 70.9% compared to 77.8%, as pressures have increased. Open complaints have risen from 311 to 335, with overdue cases increasing from 49 to 69. Delays in treatment and /or assessment and lack of communication with patients remain the top 3 issues of concerns raised.

Finance and sustainability

As at the end of Month 3 (June 2026) the health board is reporting an in-month deficit of £6.2m, which is £2.6m adverse compared to the Month 3 profiled financial plan deficit of £3.6m. Focus is required at pace on accelerating the transition of identified savings schemes to green-rated and budget releasing delivery status. The 2026/27 £43.0m financial plan deficit does not attain the key duty of the health board to achieve a balanced position, and therefore the £82m conditionally recurrent allocation being at risk. Focus is required on accelerating the transition of identified savings schemes to green-rated and budget releasing delivery status.

People and places

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

Executive Summary: Performance and access

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

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

Cancer performance remains disappointing, with an overall deterioration from over 60% at the end of March 2025 to 54% at the end of May 2026 against a standard target of 75%. Recovery focus is on skin, colorectal, urology and breast.

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

Adult Mental Health performance is compliant across the health board in several areas; the May performance highlights that compliance with Part 1a is above the 80% target at 84.35% and Part 1b at 85.52%. However, there is significant variation across the three sites and within some pathways. Part 2 Valid Care and Treatment Plan compliance is below the 90% target at 86.79%.

Psychological therapy waits under 26 weeks are significantly below the 80% target at May 2026 with a rate of 50.00% across the Health Board.

Children and adolescent mental health performance remain compliant with the 80% standard at the end of May with Part 1a – Assessment performance at 93.3% and Part 1b – interventions at 82.8%. Part 2 performance also remains compliant with 90% standard at 92.7% in May.

Neurodevelopment assessments are below expectation with those waiting less than 26 weeks to start an ADHD or ASD assessment at 12.7% at May 2026, no health board is currently achieving target of 80% with April 2026 all-Wales performance at 23.3%

Executive Summary: Quality, safety and patient experience

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

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

Patient Safety – Never Events – A total of 12 Never Events have been recorded for the period July 2025 – June 2026. Following a period of 59 days safe care between April and June 2026, three Never Events were reported between 13 and 17 June 2026. The most frequent theme was wrong site procedures, along with incidents involving retained items and implant or prosthesis errors. Continued focus on learning, assurance and preventative actions has been highlighted as a mechanism to mitigate against the non-reoccurrence of incidents and improve patient safety outcomes

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

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

Executive Summary: Finance and sustainability

Financial Plan

- The 2026/27 £43.0m financial plan deficit does not attain the key duty of the health board to achieve a balanced position, and therefore the £82m conditionally recurrent allocation being at risk. Focus is required on accelerating the transition of identified savings schemes to green-rated and budget releasing delivery status.

Financial Position

- As at the end of Month 3 (June 2026) the health board is reporting an in-month deficit of £6.2m, which is £2.6m adverse compared to the Month 3 profiled financial plan deficit of £3.6m.
- The Year-to-date position is reporting a deficit of £17.1m, £6.4m adverse to the planned year to date £10.8m deficit. The adverse variance to plan indicating a run rate exceeding plan by approximately £2m per month, the adverse position driven by a shortfall in savings delivery.
- The below table summarises the monthly actual and forecast variance for 2026/27

	2026/27 Monthly Variance													
	Actual			Forecast									Year to Date Position	Full Year Forecast Outturn Position
	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Total Monthly Surplus/ (Deficit)	(5.4)	(5.6)	(6.2)	(4.5)	(4.0)	(3.0)	(2.5)	(2.5)	(2.5)	(2.5)	(2.2)	(2.2)	(17.1)	(43.0)

Savings and mitigations

- As at the end of June (Month 3), the health board has identified £24.1m Green saving schemes, an increase of £10.8m from previous month.
- In-month savings delivery is £5.4m and year-to-date savings delivery is £8.1m, of which £2.1m is budget releasing, resulting in a £9.4m impact on the position.
- Focus is required on accelerating the transition of identified savings schemes to green-rated and budget releasing delivery status.
- Welsh Government require the health board to deliver the key duty and submit a balanced plan, which would require enhanced savings delivery stretch target of £63m (an additional £17m on the £46m contained within the plan) that would result in £26m of Welsh Risk Pool costs being mitigated through the National team and the health board being able to submit a balanced plan for 2026/27 and attain the key statutory duty of break-even.

Capital programme

The approved Capital Resource Limit (CRL) for 2026-27 is £58.577m. The current full-year forecast outturn is £58.550m, reflecting the variance of £0.027m for the End of Year Digital Funding.

Executive Summary: People and places

Vacancy Rate

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

Workforce Planning and Efficiency Programme

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

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

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

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

Turnover

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

Sickness Absence

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

Agency Workforce Usage

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

Performance Appraisal and Development Review (PADR)

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

Mandatory Training Compliance

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

Executive Summary: Population health and prevention

Public Health plays a fundamental role in delivering the Health Board's strategic ambition to shift care towards prevention, reduce health inequalities and improve long-term population outcomes. Whilst much of this work sits outside traditional operational performance management, it underpins delivery of the Annual Delivery Plan, NHS Wales Performance Framework, Ministerial priorities and the emerging 10-year strategy.

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

Areas of Positive Performance

- Smoking cessation services continue to demonstrate strong performance in supporting quit attempts and successful quits, although further improvement is required in CO-validated quit rates.
- Substance misuse treatment completion remains high.
- The majority of vaccination and immunisations programmes continue to perform well, with particular progress on staff flu vaccination and Covid vaccination in the community. However, HPV and RSV 75+ uptake are areas of focus, together with reducing unwarranted variation and addressing inequalities remain key priorities.
- Building on the work established through the Well North Wales programme, the Regional Partnership Board (RPB) and Health Board have worked collaboratively with partners to co-produce a Regional Anchor Charter.
- Public Health continues to support delivery of strategic prevention programmes aligned to the Health Board's priorities, including health protection, population health management and reducing health inequalities.

Areas Requiring Focus

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

Next Steps

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

Section 1

Performance and access



Scorecard : Performance and access – (1 of 3)

REF	Measure Description	Target Suite			Wales Benchmark	Actual Performance				Status
		NT	SM	AP		Apr-26	May-26	Jun-26	6 Month Activity	
LMU01	Total number of ambulance conveyances to acute emergency departments	-	-	-	N/A	3237	3580	3340		Advise
3AP02	Percentage of ambulance handovers within 15 minutes	80%	-	-	6th of 6 (at Apr 26)	10.6%	11.6%	10.0%		Escalate
3AP01	Number of ambulance patient handovers over 45 minutes	0	-	-	N/A	1960	2143	2059		Escalate
LMU02	Number of ambulance patient handovers over 1 hour	-	1710	-	6th of 6 (at Apr 26)	1697	1820	1755		Escalate
LMU03	Number of ambulance patient handovers over 4 hour	-	-	-	N/A	569	582	527		Advise
LMU04	Median emergency ambulance response time to purple: arrest category calls	6-8 Mins	-	-	N/A	07:46	07:36	RIA		Advise
LMU05	Median emergency ambulance response time to red: emergency category calls	6-8 Mins	-	-	N/A	09:21	09:12	RIA		Advise
LMU06	Total number of attendances to Minor Injury Units (MIUs)	-	-	-	N/A	5443	5992	RIA		Alert
LMU07	Total number of attendances to acute emergency departments	-	-	-	N/A	15070	15724	15771		Alert
LMU08	Median time from arrival at an emergency department to triage by a clinician	-	60	-	4th of 6 (at Mar 26)	19.00	19.00	21.00		Alert
3AP04	Median time from arrival at an emergency department to assessment by a clinical decision maker	-	-	-	5th of 6 (at Mar 26)	114.0	128.0	127.0		Alert
NPF25	Percentage of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge	95%	-	-	7th of 7 (at Mar 26)	61.0%	60.3%	59.9%		Alert
3AP03	Number of patients who spend 12 hours or more in all hospital major and minor emergency care facilities from arrival until admission, transfer or discharge	0	2210	-	7th of 7 (at Mar 26)	3405	3645	3793		Escalate
LMU09	Total number of patients who spent over 24 hours in the ED	-	-	-	N/A	1708	1783	1864		Escalate
LMU10	Total number of patients who spent over 48 hours in the ED	-	-	-	N/A	464	463	466		Escalate
LMU11	Number of patients who did not wait to be seen at the ED	-	-	-	N/A	1408	1725	1745		Escalate
LMU12	Consistently realise 33% of discharges by midday.	-	-	-	N/A	17.1%	16.7%	17.2%		Alert
LMU13	Total number of unplanned returns to ED within 48 hours with the same complaint	-	-	-	N/A	1297	1356	1393		Escalate

Scorecard : Performance and access (2 of 3)

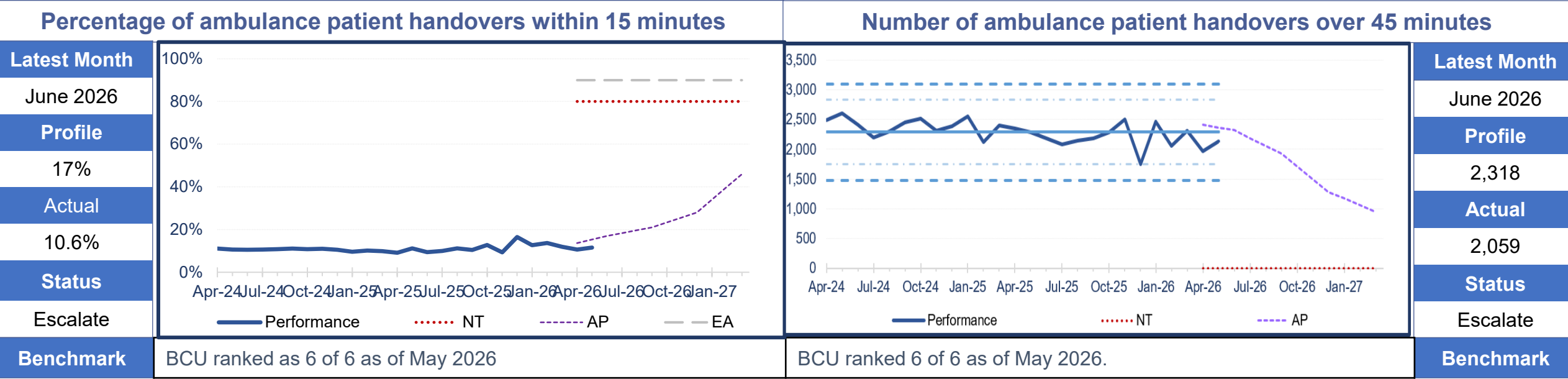
REF	Measure Description	Target Suite			Wales Benchmark	Actual Performance				Status
		NT	SM	AP		Apr-26	May-26	Jun-26	6 Month Activity	
3AP05	Number of Pathways of Care Delayed discharges (total patients)	-	0	-	8th of 8 (at Apr 26)	293	308	317		Alert
3AP06	Number of bed days lost to delayed pathways of care (total)	-	-	-	N/A	13874	12784	13085		Escalate
LMS01	Stroke: percentage patients received CT scan within 20 minutes of clock start	-	-	-	N/A	30.9%	21.4%	RIA		Escalate
LMS02	Stroke: percentage of eligible patients thrombolysed	-	-	-	N/A	100.0%	100.0%	RIA		Assure
LMS05	Stroke: Thrombolysis Patients with Door-To-Needle <=45 mins	-	-	-	N/A	6.3%	7.7%	RIA		Escalate
LMS06	Stroke: percentage direct admission to ASU within 4 hours	-	-	-	N/A	29.1%	37.5%	RIA		Escalate
3BP03	Number of patients waiting more than 26 weeks for a new outpatient appointment (Welsh Patients Only)	0	-	-	N/A	16583	16971	17378		Alert
3BP02	Number of patients waiting over 52 weeks for a new outpatient appointment	-	-	-	7th of 7 (at Mar 26)	5922	5385	4963		Advise
3BP01	Number of patients waiting more than 104 weeks for referral to treatment	0	-	-	7th of 7 (at Mar 26)	2436	2528	2191		Alert
3BP14	Percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)	75%	55%	-	6th of 6 (at Mar 26)	52.6%	53.9%	RIA		Escalate
3BP15	Number of patients on an active suspected cancer pathway after day 62	-	-	-	N/A	192	211	RIA		Escalate
3BP16	Number of pathways waiting more than 8 weeks for a specified diagnostic (all ages)	0	-	-	7th of 7 (at Mar 26)	12386	10461	8465		Alert
NPF28	Percentage of R1 patient pathways, which have a target date allocated, waiting within their clinical target date or within 25% beyond their clinical target date for an outpatient	95%	-	-	N/A	40.3%	38.9%	38.4%		Alert
3BP04	Number of patients waiting for a follow up outpatient appointment who are delayed by over 100%	96,059	137002	-	7th of 7 (at Mar 26)	131031	137003	139713		Alert
3EP01	Percentage of Local Primary Mental Health Support Service (LPMHSS) assessments undertaken within (up to and including) 28 days of the date of receipt of referral (for those	80%	-	-	5th of 7 (at Mar 26)	92.9%	93.3%	RIA		Assure
3EP02	Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS (for those aged under 18 years)	80%	-	-	5th of 7 (at Mar 26)	78.1%	82.8%	RIA		Alert
3DP01	Percentage of Local Primary Mental Health Support Service (LPMHSS) assessments undertaken within (up to and including) 28 days of the date of receipt of referral (for those	80%	-	-	5th of 7 (at Mar 26)	84.4%	89.9%	RIA		Assure
3DP02	Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS (for those aged 18 years and over)	80%	-	-	5th of 7 (at Mar 26)	85.5%	85.7%	RIA		Assure

Scorecard : Performance and access (3 of 3)

REF	Measure Description	Target Suite			Wales Benchmark	Actual Performance				Status
		NT	SM	AP		Apr-26	May-26	Jun-26	6 Month Activity	
LMM01	Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan (for those age 18 years and over)	-	-	-	5th of 7 (at Mar 26)	86.5%	86.6%	RIA		Alert
NPF19	Percentage of patients waiting less than 26 weeks to start a psychological therapy in specialist Adult Mental Health	80%	-	-	3rd of 7 (at Mar 26)	50.6%	50.0%	51.2%		Alert
3DP06	Material reduction in the number of adult mental health out of area placements	-	-	-	N/A	27	16	RIA		Alert
NPF18	Percentage of children and young people waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment	80%	-	-	7th of 7 (at Mar 26)	12.2%	12.7%	RIA		Alert
3BP05	Number of patients (all ages) waiting more than 14 weeks for a specified therapy (excluding audiology)	0	-	-	6th of 7 (at Mar 26)	1423	1632	1676		Advise
NPF30	Number of adults waiting more than 14 weeks for all audiology pathways (to include new and existing pathways for hearing aids, tinnitus and balance)	0	-	-	N/A	20	31	46		Advise
NPF31	Number of children waiting more than 6 weeks for all audiology pathways (to include new assessment and intervention pathways)	0	-	-	N/A	678	695	741		Alert
3BP11	Percentage of lists with a start time 15 minutes or more past the scheduled start time	-	-	-	N/A	41.4%	40.2%	41.1%		Alert
3BP12	Percentage of theatre procedures finished more than 60 minutes early	-	-	-	N/A	23.2%	22.4%	26.1%		Alert
LMP01	Number of cases per theatre session	-	-	-	N/A	2.1	2.1	2.1		Alert
LMP02	Percentage of scheduled operations cancelled either on the day or the day before the scheduled operation	-	-	-	N/A	12.9%	12.7%	15.1%		Alert
LMP03	Percentage Treat in Turn Rate (Stage 4)	-	-	-	N/A	20.0%	25.0%	23.0%		Alert

UEC: Ambulance Handover

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



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

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

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

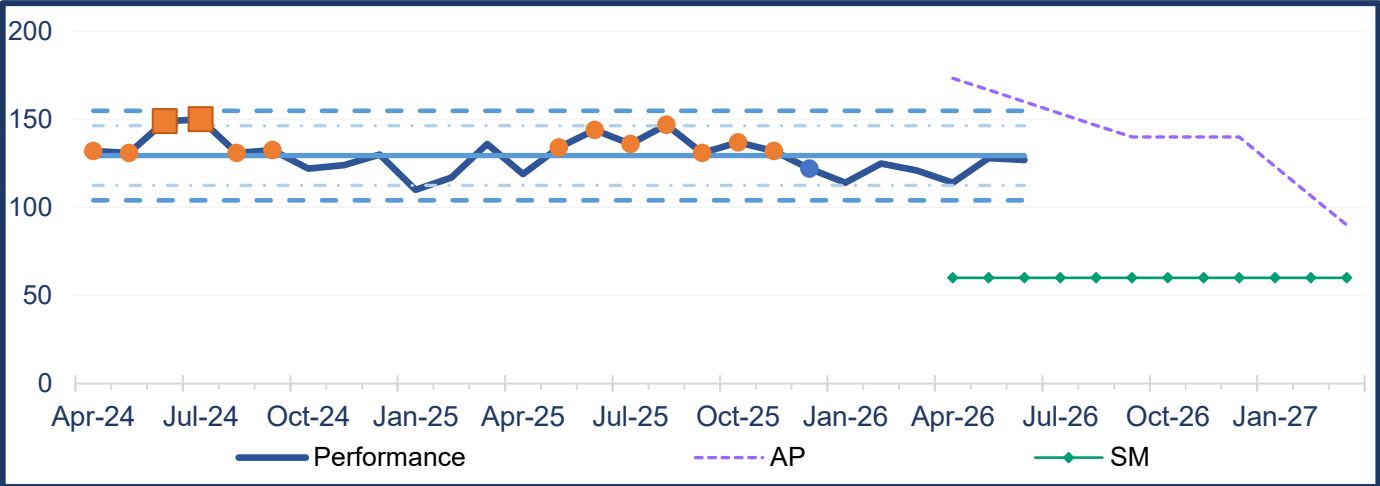
UEC: Median time to assessment by clinical decision maker in less than 60 minutes

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

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

Latest Month
June 2026
Profile
160
Actual
127
Status
Advise
Benchmark

BCU ranked 5 of 6.



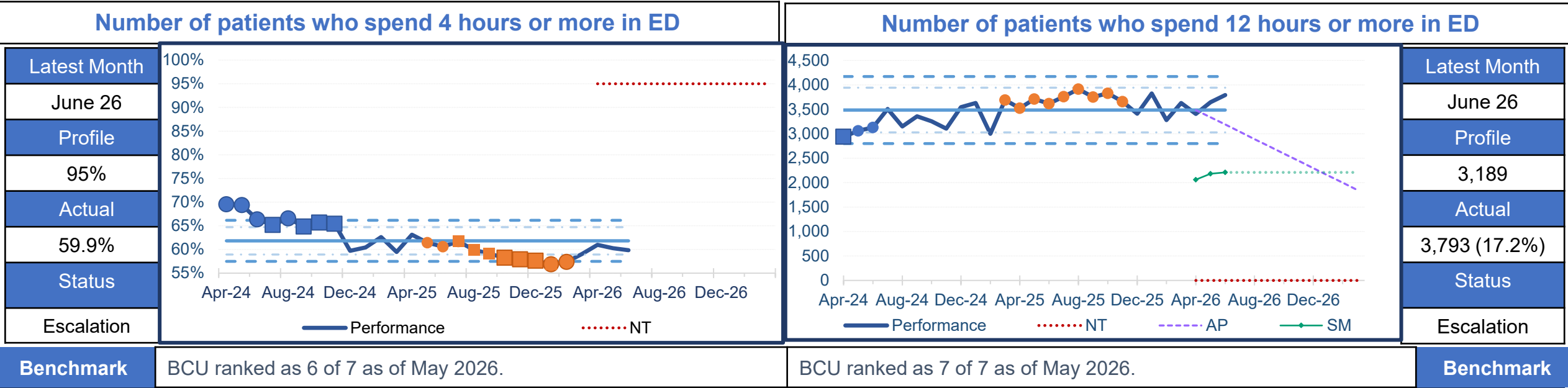
What does the data tell us? Performance improved between February and April 2026, with the median time to assessment reducing by 11 minutes. Performance then deteriorated in May, reaching 128 minutes, with a further one-minute improvement noted in June. . Performance remains ahead of the health board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

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

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

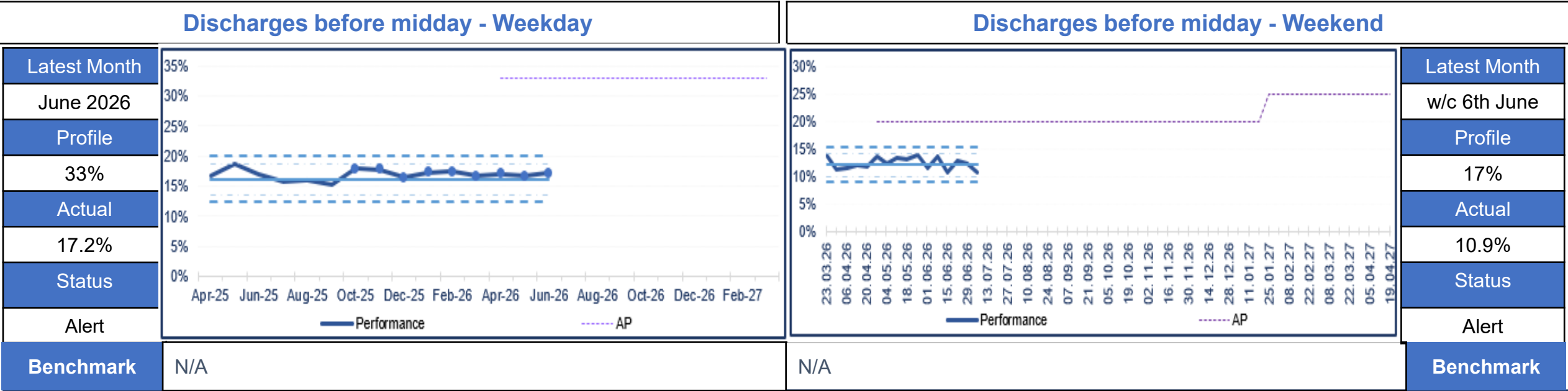
UEC: Number of patients who spend 4 hours and 12 hours or more in all hospital major and minor emergency care facilities from arrival until admission, transfer, or discharge

Metric Overview	ID	Metric	SM De-escalation	Planning / Performance Framework	Q1	Q2	Q3	Q4
	Local	Number of patients who spend 4 hours or more in ED and MIU	N/A	95%	95%	95%	95%	95%
	3AP03	Number of patients who spend 12 hours or more in ED and MIU	<10%	Zero	3,189 (35%)	2,743 (30%)	2,297 (25%)	1,850 (20%)



UEC: Discharges before midday

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



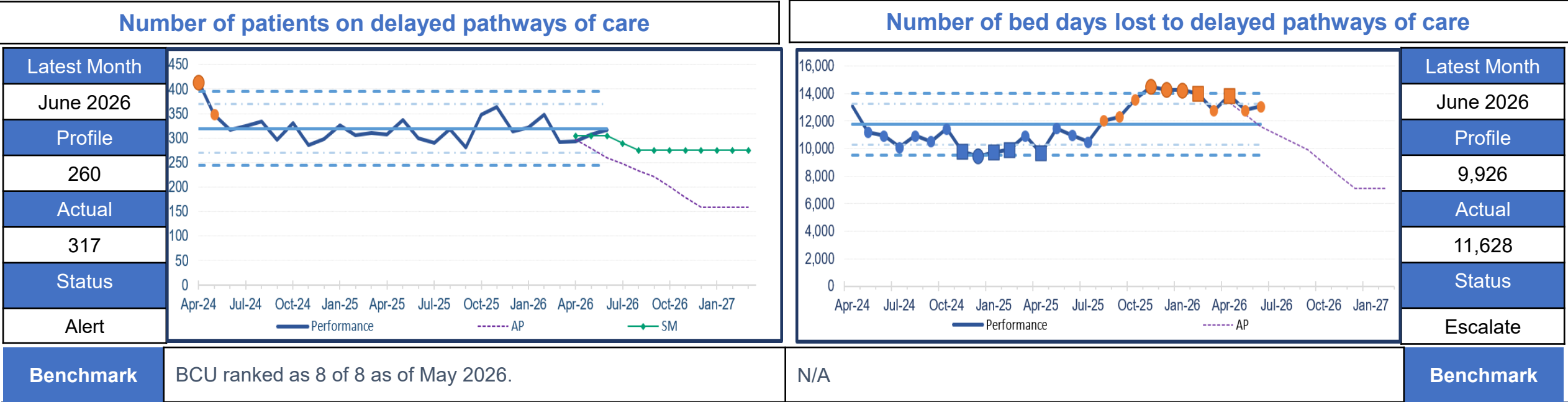
What does the data tell us? – Both metrics remain below the agreed trajectory. However, weekday performance has shown slight improvement, improving by 0.5% in June. Weekend discharges have deteriorated by 1.3% in June reflecting ongoing operational pressure, a widening gap against plan, and a continued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

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

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

UEC: Pathway of Care Delays (PoCD)

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



Planned Care: Suspected Cancer Pathway Metric

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

Suspected cancer pathway 62 days wait

Latest Month	80%
May 2026	75%
Profile	65%
55.7%	60%
Actual	55%
53.9%	50%
Status	45%
Escalate	40%

— Performance NT - - - - AP —◆— SM

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

Latest Month	4,000
June 2026	3,500
Profile	3,000
1,286	2,500
Actual	2,000
2,123	1,500
Status	1,000
Escalate	500

— Performance - - - - AP

Benchmark

BCU ranked 6 of 6 at May 2026

Benchmark

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

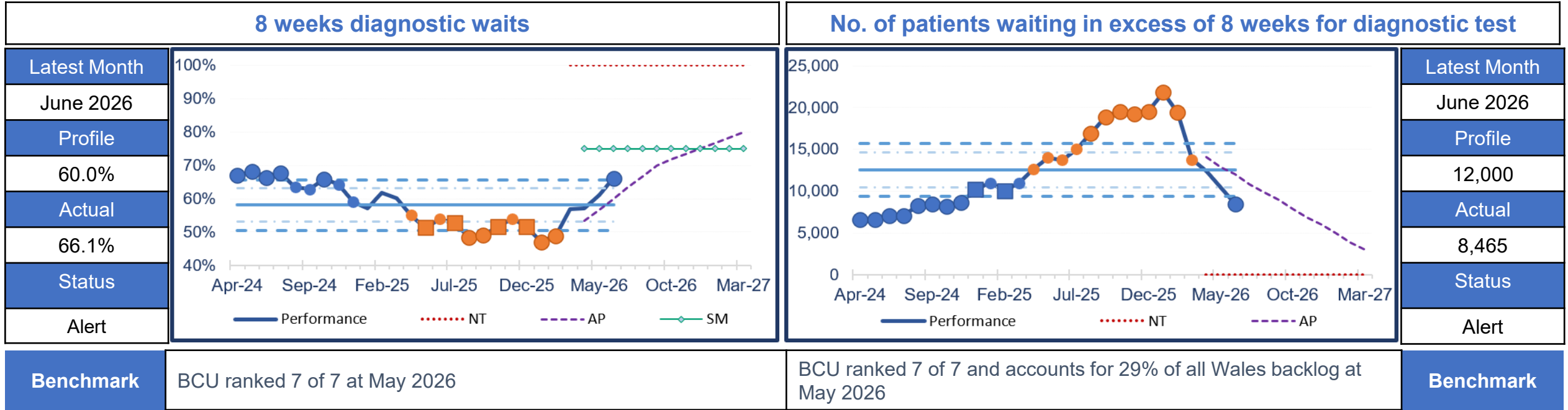
What does the data tell us? - Cancer performance has shown no improvement since January 2025. The number of patients waiting over 62 days on a suspected cancer pathway has increased over the last 4 months. Both metrics are considerably adverse to the agreed trajectory and management data indicates that end of June position for suspected cancer pathway 62 day wait will remain similar to May performance. There is Welsh Government expectation that the health board attains performance of 55% by the end of Quarter 2. Between January and May 2026, 20,558 patients were told that they did not have cancer.

Actions being taken to improve – Focus is on four key areas of skin (appoint additional posts to prioritise teledermoscopy and cancer first appointment and insourced capacity continuation) , colorectal (requirement for increased endoscopy capacity), urology (increase cases per session to delivery additional prostate biopsy capacity) and breast (reducing surgical waiting times).

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

Planned Care: 8-weeks Diagnostic Waits

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

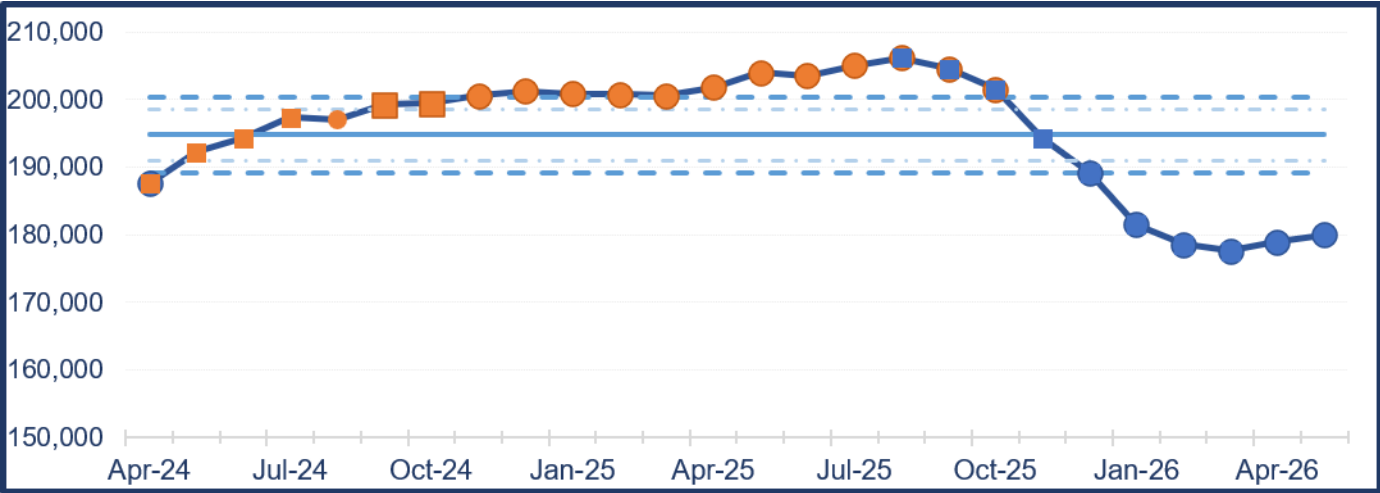


Planned Care : Referral to Treatment Metrics

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

Total RTT Pathways

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



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

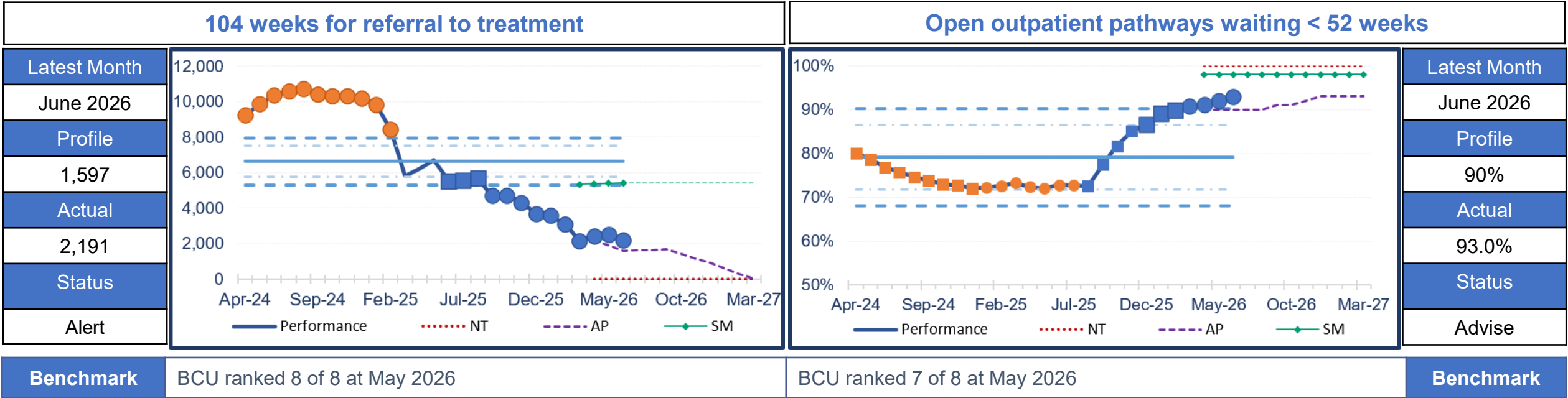
What does the data tell us? - over the last 12 month the overall waiting list has fallen by 11% from over 201k in April 2025 to under 179k in April 2026. This reduction is linked to the increased volume of activity undertaken between August 2025 and February 2026 where additional new outpatient appointments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

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

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

Planned Care : Referral to Treatment Metrics

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



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

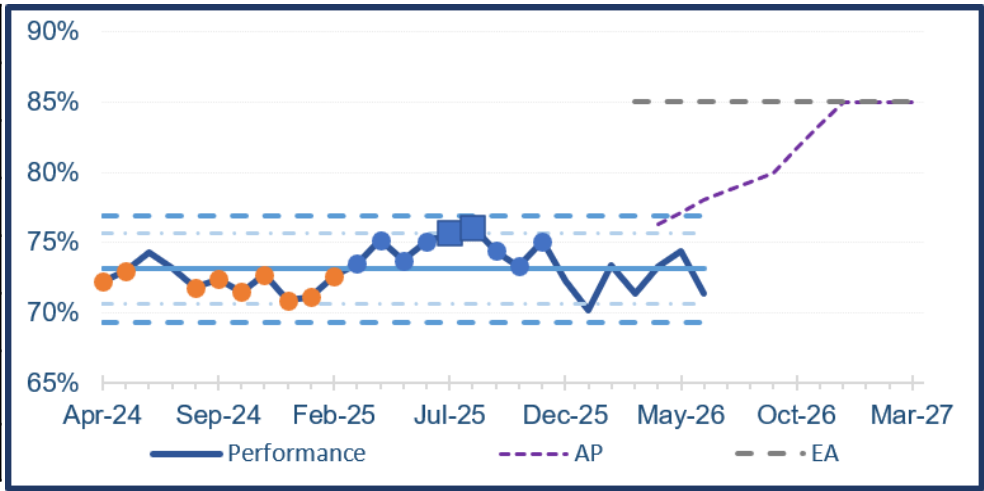
Actions being taken to improve – Work is taking place to finalise the single integrated recovery plan for planned care led by the recently appointed Recovery Director working to the Chief Operating Officer with continuation of focused support by the national intervention support team. This work which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

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

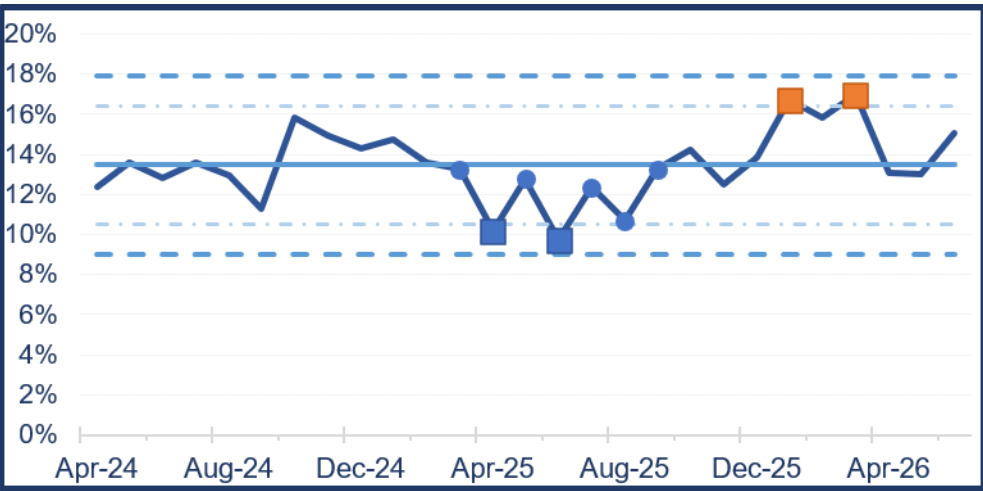
Metric Overview	ID	Metric	SM De-escalation	Planning / Performance Framework	Q1	Q2	Q3	Q4
	3BP13	Theatre session overall utilisation is reported as a key KPI to underpin the GIRFT standard	N/A	85%	78%	80%	85%	85%
	LMP02	Theatre Short Notice Cancellations	N/A	N/A	N/A	N/A	N/A	N/A

Theatre Session Overall Utilisation

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



Theatre Utilisation – Short Notice Cancellations



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

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

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

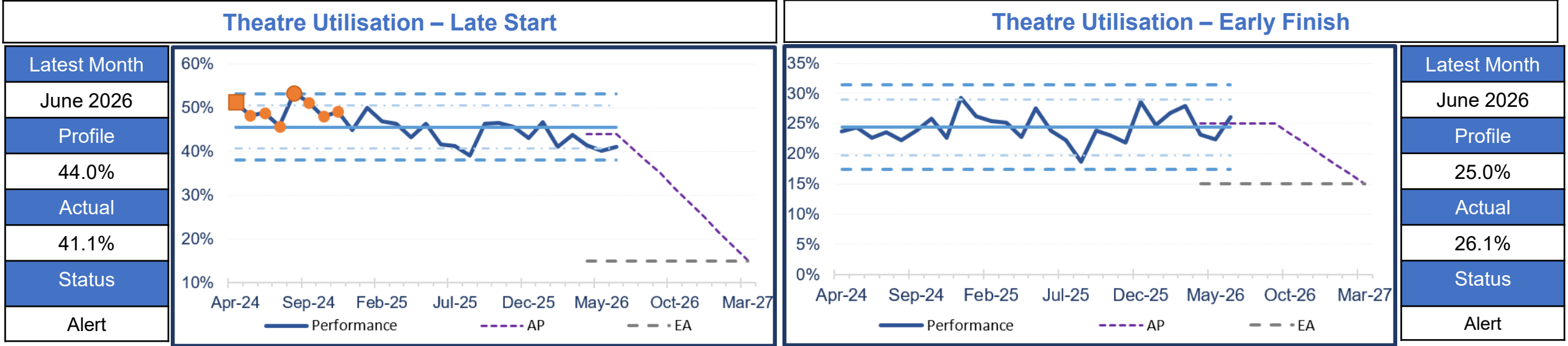
Expected impact upon forecasted performance – Based on current trend, overall theatre utilisation performance is not expected to deliver the step up required during the next quarter. Further detail on local and pan BCU actions to deliver sustained improvements will be required as part of ongoing improvement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

Area	CPS
West	2.0
Central	2.0
East	2.3
BCU	2.1



Planned Care : Productivity / Utilisation

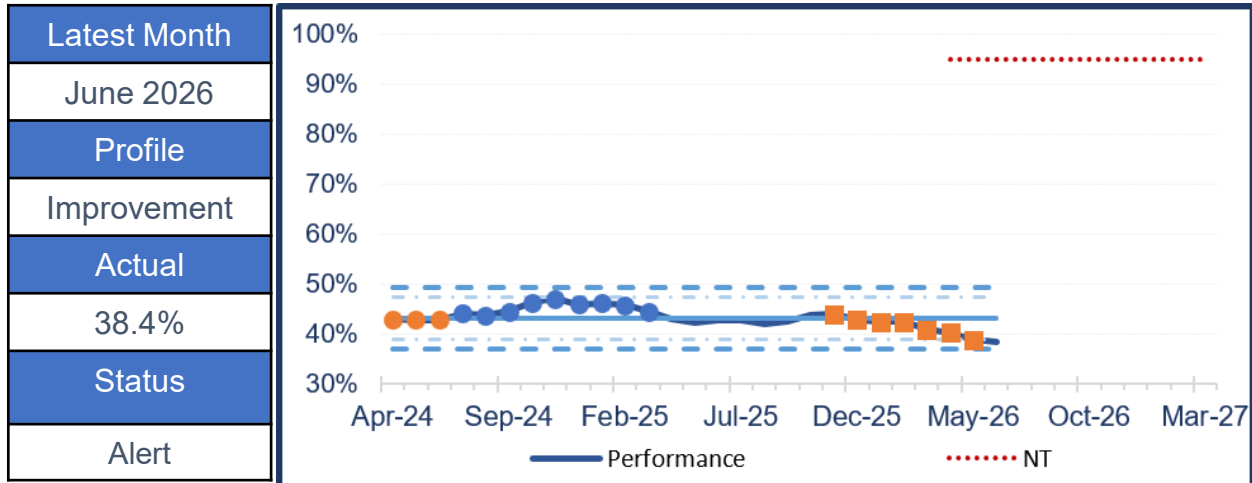
Metric Overview	ID	Metric	SM De-escalation	Planning / Performance Framework	Q1	Q2	Q3	Q4
	3BP11	Theatre session utilisation is improved to achieve GIRFT standard late starts (>15 mins)	N/A	<15%	44%	35%	25%	15%
	3BP11	Theatre session utilisation is improved to achieve GIRFT standard of early finishes (>60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



Planned Care : Outpatient Activity

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

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



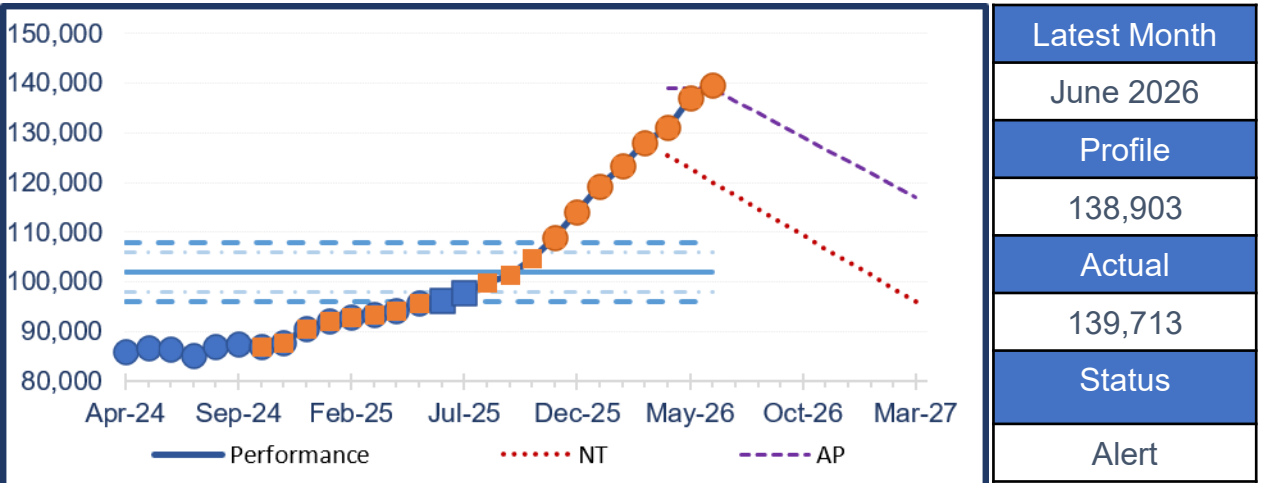
Benchmark BCU ranked 8 of 8 at May 2026

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

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

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

Follow Up Delayed by over 100%



Benchmark BCU ranked 7 of 7 at May 2026

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

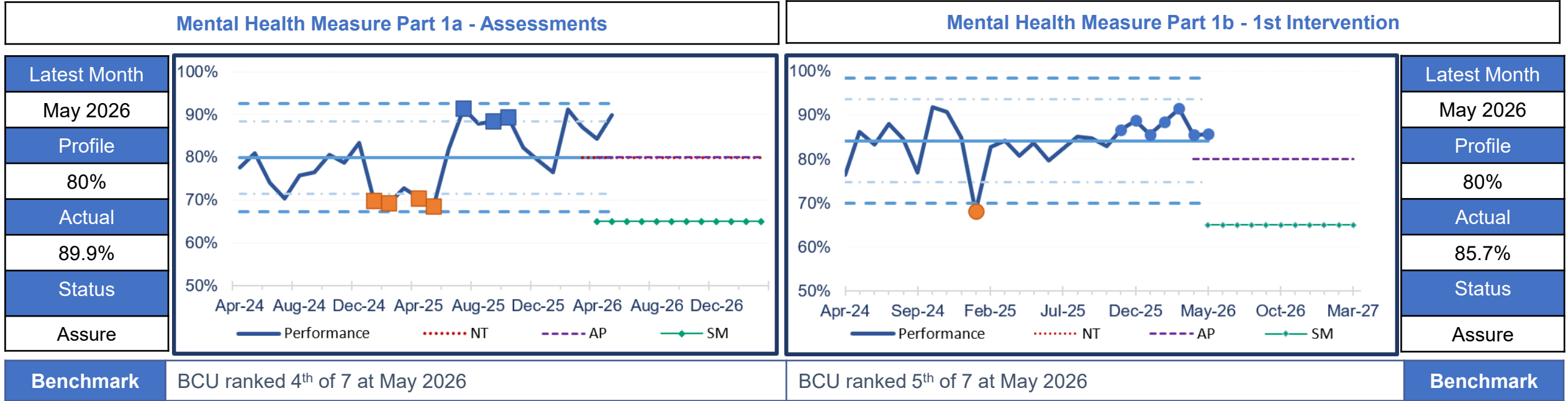
Actions being taken to improve – National Self-Management Protocols have been adopted and shared across services to support discharge and follow-up pathways. They have underpinned the expansion of See on Symptom (SOS) and Patient Initiated Follow-up (PIFU), with Q1 implementation in Dermatology and Breast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

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



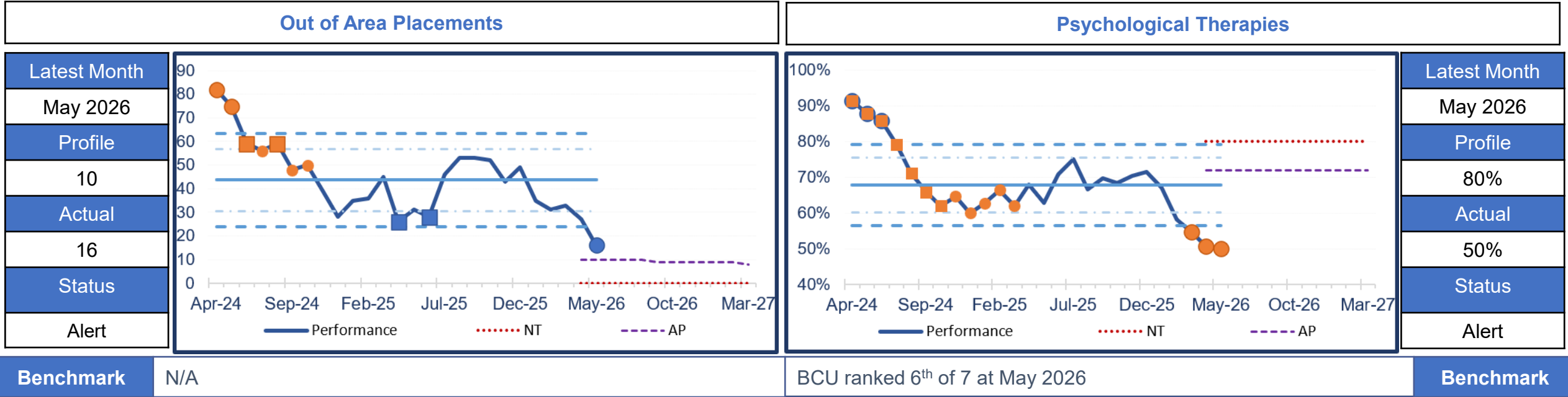
Adult Mental Health Measures

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



Adult Mental Health Measures

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

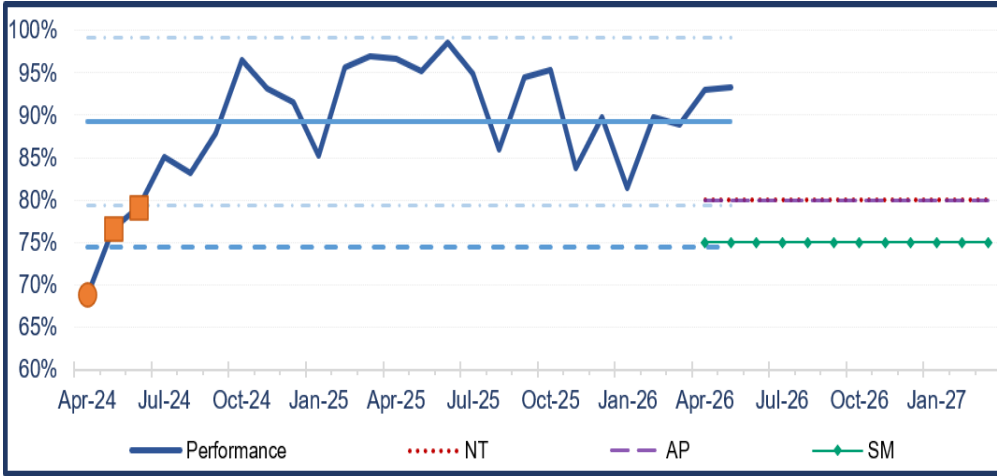
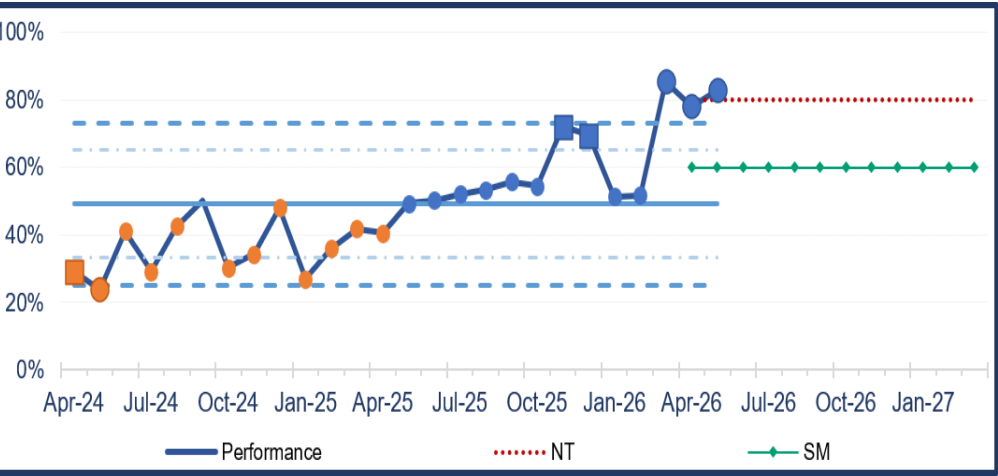


What does the data tell us? Psychological Therapy access remains significantly below target. In May 2026, 50.00% of patients were waiting less than 26 weeks to start psychological therapy in specialist Adult Mental Health against the 80% target, with 86 patients waiting in total. In relation to out-of-area placements, May showed improvement compared with April. There were 16 placements and 118 placement days in May, compared with 27 placements and 359 placement days in April. Reported out-of-area placement expenditure reduced from £339k in April, to £185k in May.

Actions being taken to improve: For Psychological Therapies, recovery activity continues through recruitment and retention initiatives, embedding psychological therapists within Community Mental Health Teams and ongoing operational oversight of waiting lists. The service is also working to address estates constraints, including the availability of suitable clinical space. For out-of-area placements, recovery actions include local and national daily focus through new reporting structures, strengthened discharge planning, ongoing review of delayed patients, collaborative working with partner organisations and continued focus on reducing reliance on out-of-area placements through improved patient flow.

Expected impact upon forecasted performance For Psychological therapies, improvement relies upon the resolution of capacity, workforce and estates constraints. For out-of-area placements, continued improvement is expected. However, progress remains dependent on reducing delayed pathways of care across the wider system.

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

Measure – Part 1A (Assessments) – people aged under 18 years		Mental Health Measure – Part 1B (Interventions) – people aged under 18 years	
Latest Month		Latest Month	
May 2026		May 2026	
Profile		Profile	
80%		80%	
Actual		Actual	
93.3%		82.8%	
Status		Status	
Assure	Advise		
Benchmark	BCU ranked 5 of 7 at May 2026	Benchmark	BCU ranked 6 of 7 at May 2026

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

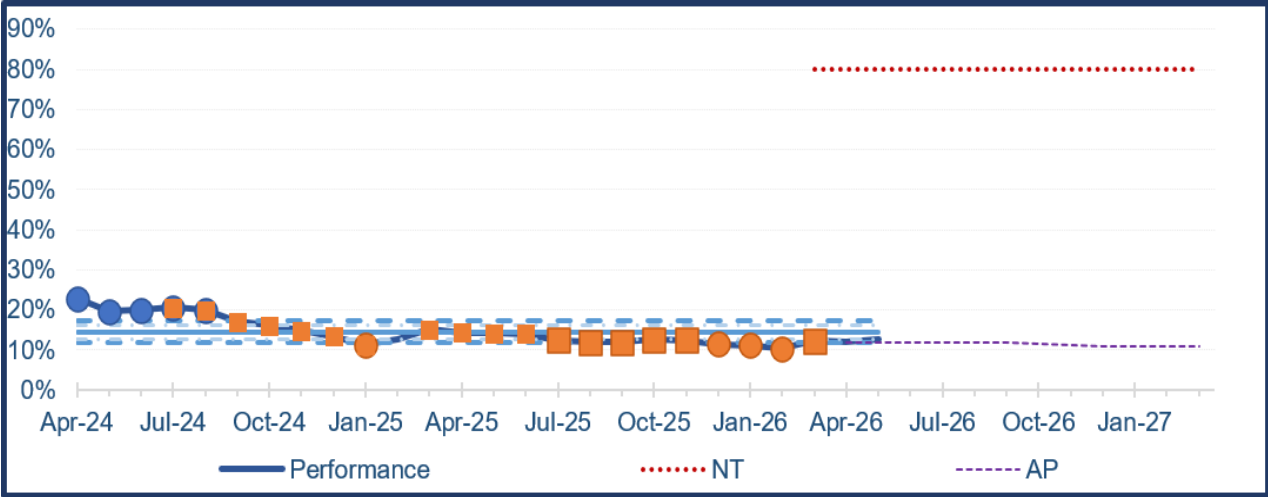
Actions being taken to improve – Weekly monitoring in place to ensure pathways remain appropriate. Agency staffing secured during quarter 1 to support activity delivery with discussion regarding provision beyond this point ongoing as part of delivery planning. Reporting alignment taking place for getting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

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

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

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

Latest Month
May 2026
Profile
12%
Actual
12.7%
Status
Alert



Waiting List Profile			
Month	<26 weeks	26+	ND Total
Dec-25	900	6,929	7,829
Jan-26	883	6,982	7,865
Feb-26	756	6,560	7,316
Mar-26	851	6,069	6,920
Apr-26	856	6,162	7,018
May-26	895	6,151	7,046

Benchmark	BCU ranked 6 of 7 at May 2026.

What does the data tell us? – Performance is considerably below national expectation with those waiting less than 26 weeks to start an ADHD or ASD assessment at 12.7%. No health board is currently achieving target of 80% with latest all-Wales performance at May 2026 at 23.3%

Actions being taken to improve – Ongoing work has taken place to review pathway and process with the monthly demand and capacity gap reduced from 250 in 2024/25 to 90 in current financial year. Additional commissioning is taking place during 2026/27 with initial focus on extreme waits above four years, with aim to clear all four year wait patients by mid August. The remaining contract up to the end of December 2026 will support reducing patient in excess of three years, however available funding will not be sufficient to mitigate all of the three year wait cohort. Ongoing support is being provided by NHS Performance and Improvement colleagues

Expected impact upon forecasted performance – Whilst additionality continues to support reduction in extreme wait patients, given the size of the waiting list and that over 6,000 patients are waiting in excess of 26 weeks, the focus that is currently on three year wait this is not expected to have a significant impact on the 26 week percentage during this financial year.

Section 2

Quality, safety and patient experience



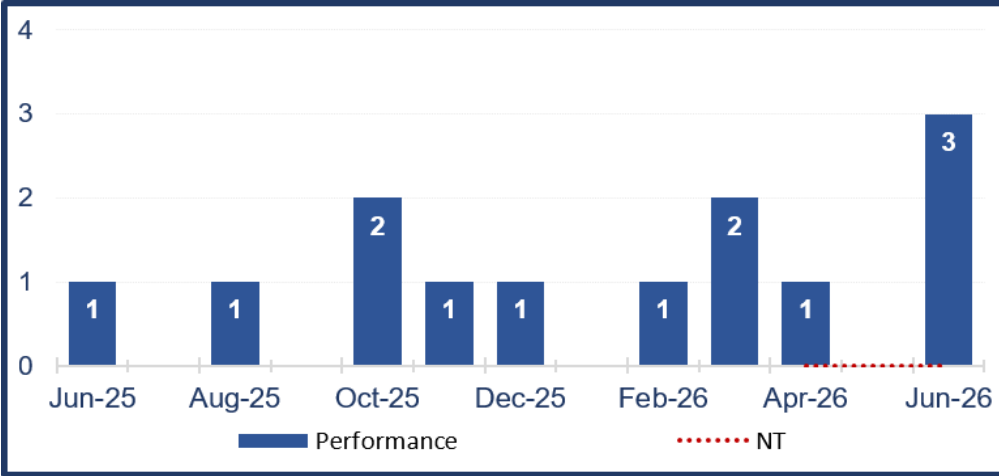
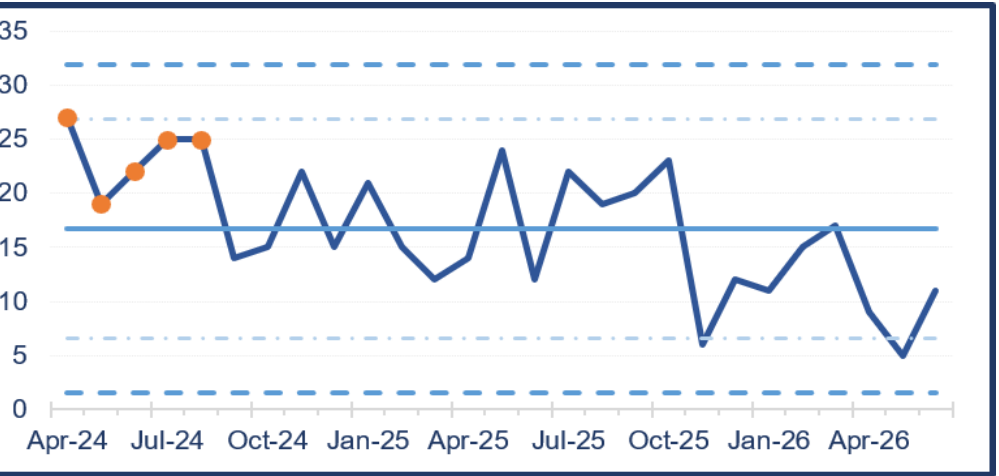
Scorecard: Quality, safety and patient experience

REF	Measure Description	Target Suite			Wales Benchmark	Actual Performance				Status
		NT	SM	AP		Apr-26	May-26	Jun-26	6 Month Activity	
NPF40	Nationally reportable incidents open over 12 months	0	-	-	N/A	0	0	0		Advise
4HP02	12 month rolling average crude mortality rate	-	-	-	N/A	1.5	1.5	RIA		Assure
NPF41	Cumulative number of hospital onset Klebsiella spp BSI cases	7	-	-	N/A	2	5	9		Assure
NPF42	Cumulative number of hospital onset Pseudomonas aeruginosa BSI cases	0	-	-	N/A	1	2	3		Alert
NPF43	Cumulative number of hospital onset E.coli BSI cases	26	0	-	N/A	6	14	21		Alert
NPF44	Cumulative number of MSSA BSI cases	32	-	-	N/A	24	46	63		Assure
NPF45	The cumulative rate of laboratory confirmed C.difficile cases per 100,000 of the population	-	-	-	5th of 6 (at Mar 26)	47.1	37.8	42.0		Assure
LMQ01	Number of new reported falls	-	-	-	N/A	337	386	354		Advise
LMQ02	Number of reported falls with actual harm (moderate and above, post review)	-	-	-	N/A	32	23	18		Advise
NPF50	Overall HB patient experience score (out of 10)	9	-	-	N/A	8.6	8.6	8.6		Advise
LMQ03	Number of avoidable hospital acquired pressure ulcers (HAPU) (post review)	-	-	-	N/A	50	57	60		Advise
LMQ04	Number of National reportable incidents (NRIs)	-	-	-	N/A	9	5	11		Alert
LMQ05	The number of complaints open	-	-	-	N/A	375	331	333		Alert

REF	Measure Description	Target Suite			Wales Benchmark	Actual Performance				Status
		NT	SM	AP		Q2 25/26	Q3 25/26	Q1 26/27	Notes	
3HP02	Gabapentin and pregabalin (DDD's per 1,000 patients)	10%↓ YoY	-	-	N/A	1676.5	1592.4	RIA		Advise

Never Events

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

Number of new never events			New National Reportable Incidents (NRI) by incident date (snapshot in time and data likely to fluctuate)		
Latest Month					
June 2026					
Profile					
0					
Actual					
3					
Status	Alert		Advise		
Benchmark	BCU ranked joint 1st of 11 at May 2026		N/A		Benchmark

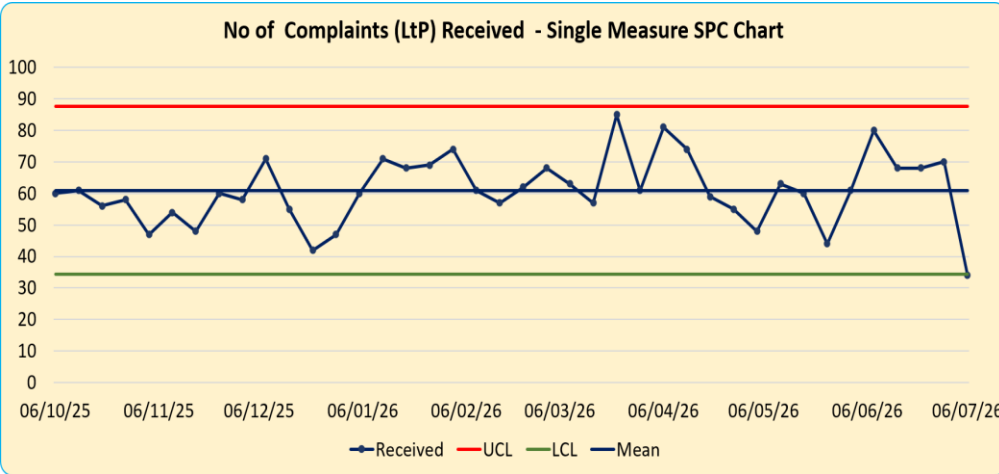
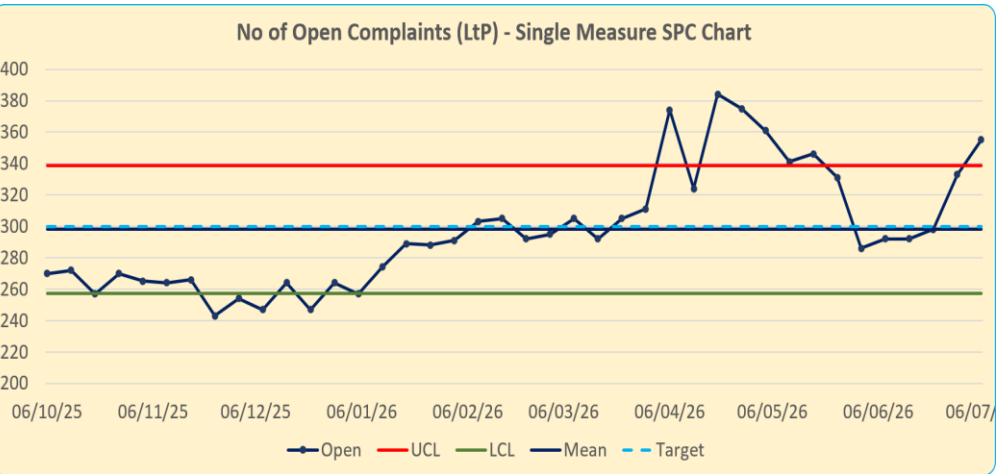
What does the data tell us? – A total of 12 never events have been recorded in the period July 2025 – June 2026. Following a period of 59 days safe care between April and June 2026, four never events were reported between 13 and 17 June 2026, including one severe harm event and one subsequently downgraded from a never event following investigation. The most frequent theme was wrong site procedures, along with incidents involving retained items and implant or prosthesis errors.

Actions being taken to improve – Detailed analysis and scrutiny of themes and trends presenting in relation to Never Events has been undertaken, with further analysis ongoing as investigations are pending. Common themes highlighted so far include: procedural verification; human factors; checklist reliability and imaging integrity. Local Safety Standards for Invasive Procedures (LocSSIPs) oversight group has been established to ensure that there is strengthening of compliance with LocSSIPs, along with the WHO Surgical Safety Checklist.

Expected impact upon forecasted performance – The embedding of learning is a key element of this ongoing work in order to provide assurance and reduce the risk of recurrence.

Complaints

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

Number of complaints received (weekly)					Number of open complaints (weekly)				
Latest Position	No of Complaints (LtP) Received - Single Measure SPC Chart 				Latest Position				
w/c 6 th July					w/c 6 th July				
Profile					Profile				
N/A					N/A				
Actual					Actual				
34					355				
Status	No of Open Complaints (LtP) - Single Measure SPC Chart 				Status				
Alert					Advise				
Benchmark	N/A				Benchmark				

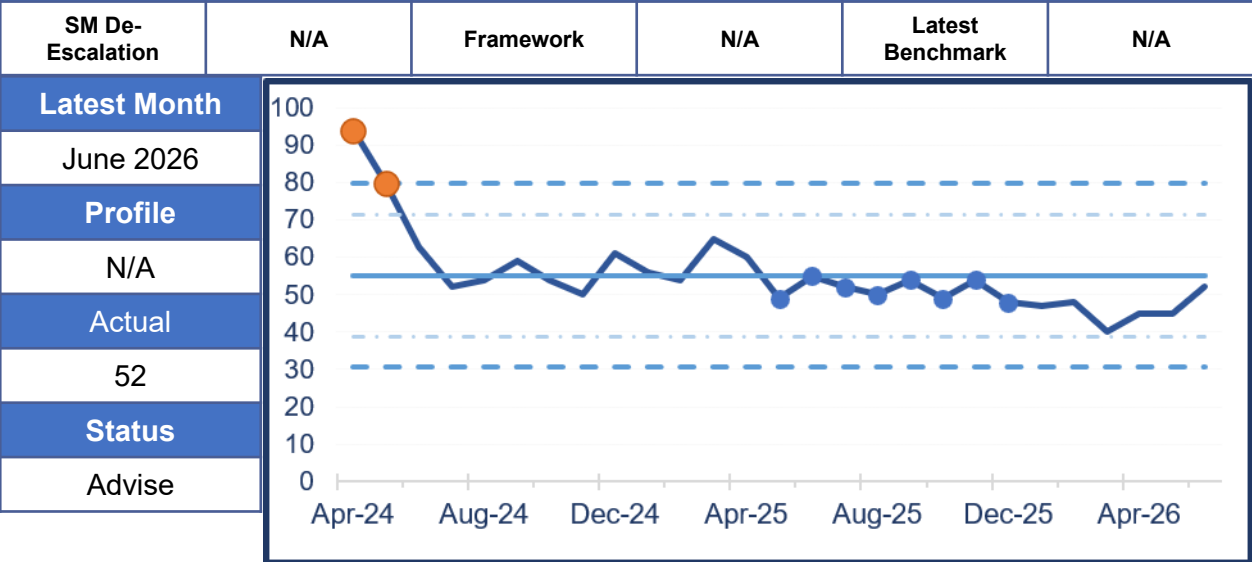
What does the data tell us? –34 complaints were received during the week of 29th June, 2026 to 6th July 2026, which was below the median average of 65 complaints per week received between 6th October 2025 and 28th June, 2026. Although the number of complaints being received by the health board is showing a slight rising trend in quarter 4 of 2025/26 and Quarter 1 of 2026/27, above the 65 median. One specific driver cannot be attributed to this rise; however, a number of significant events took place during this period, notably a significant rise in patient contacts (Insourcing) and the introduction of the new Listening to People: The NHS Complaints, incidents and redress Framework and associated press coverage (Special causation events). The number of complaints however, that remain open has seen a sustained increasing trend with 243 open complaints at the end of November 2025 rising to 355 on the week commencing 6th July 2026, an increase of 46%. This is attributed to demand and capacity issues within IHC/Divisions and corporate services to respond to concerns, but also new systems and processes that continue to be embedded as part of the new LTP process from the 1st April 2026

Actions being taken to improve – LTP Process refinement, recruitment into corporate services complaints, work programme for the Patient Experience Service with targeted intervention, development of complaint management system to increase efficiency

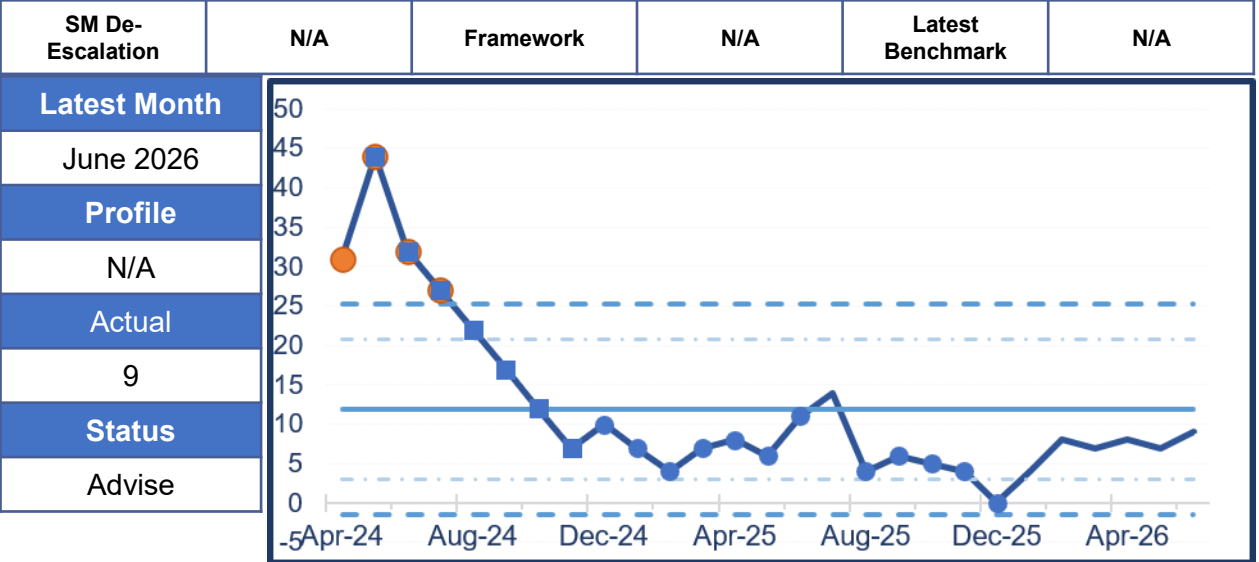
Expected impact upon forecasted performance – Reduction in the overall total number of complaints

Quality: Patient Experience and Regulation 28 notices

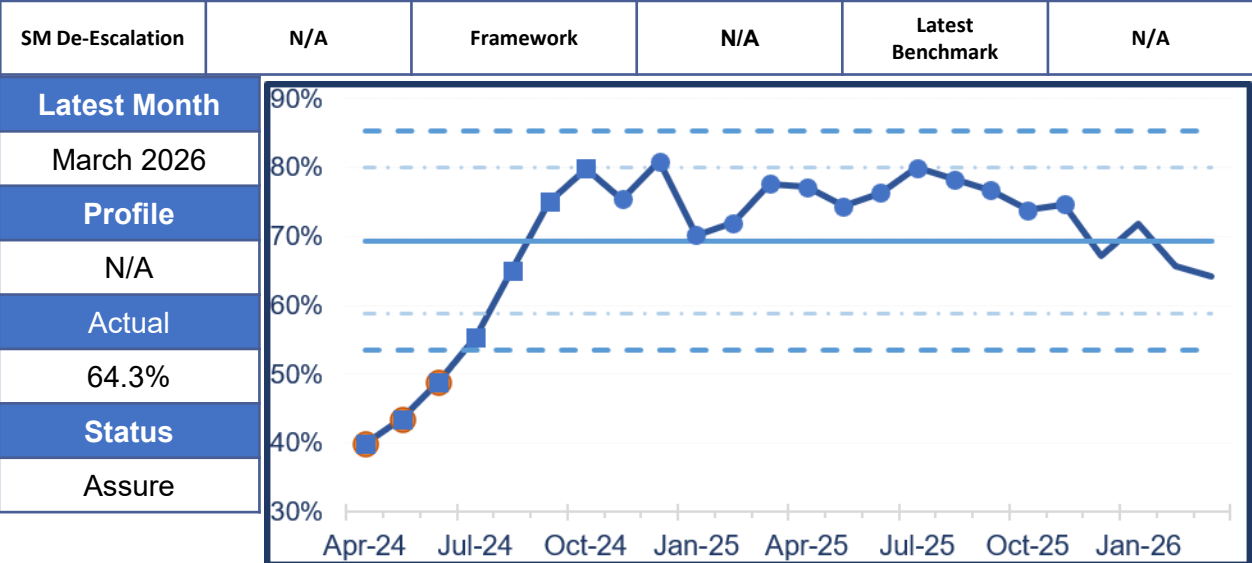
All open NRIs



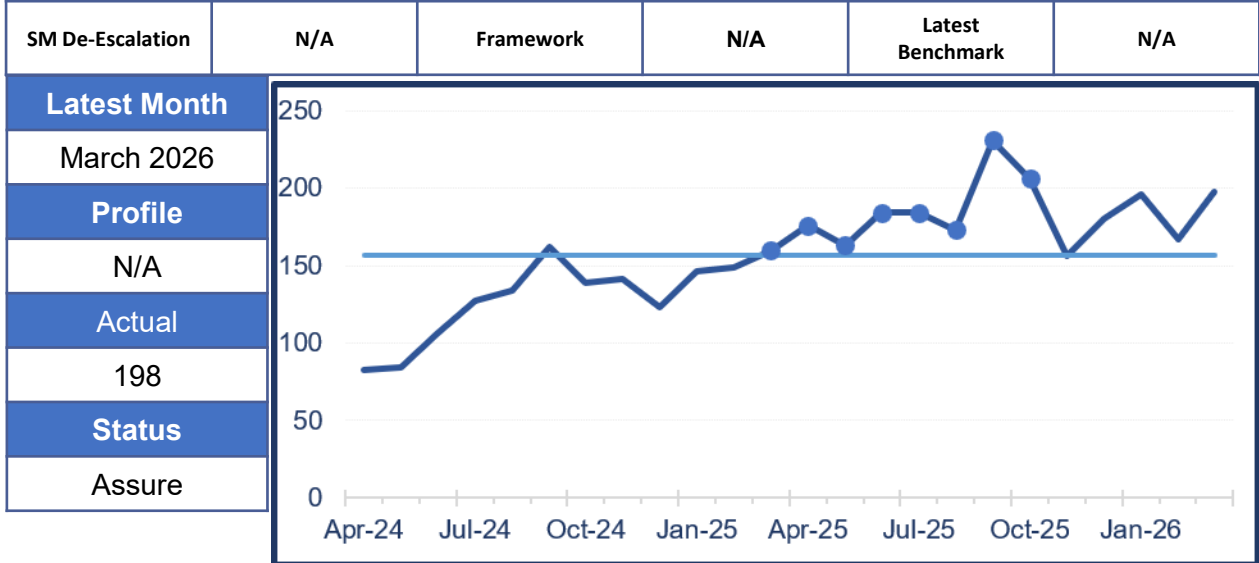
All overdue NRIs



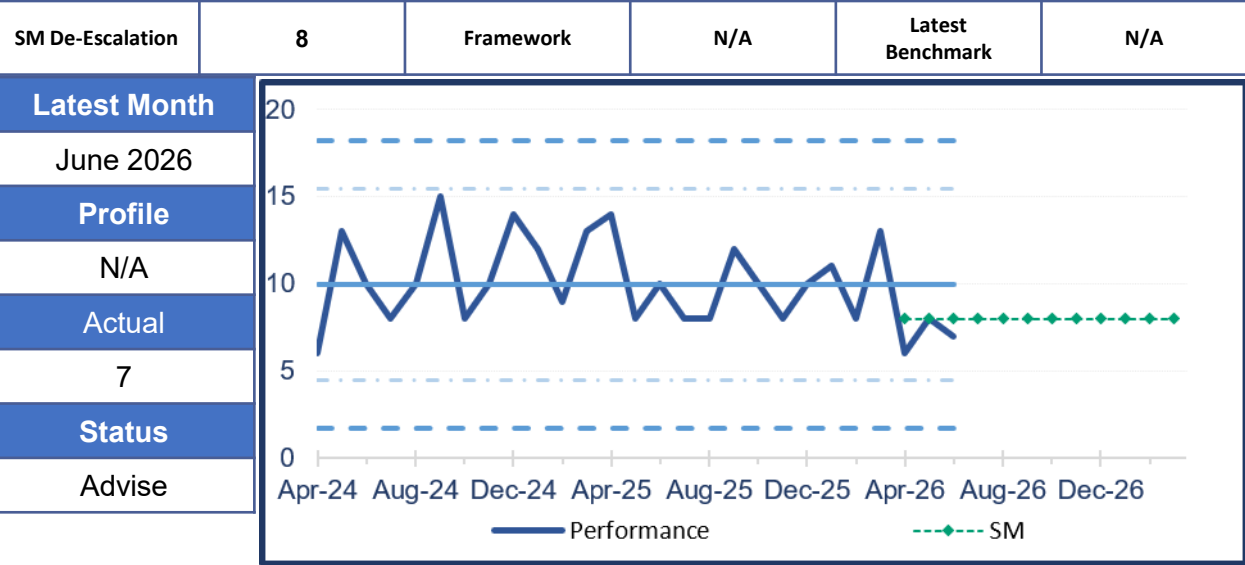
Percentage of complaints closed within 30 days of date received



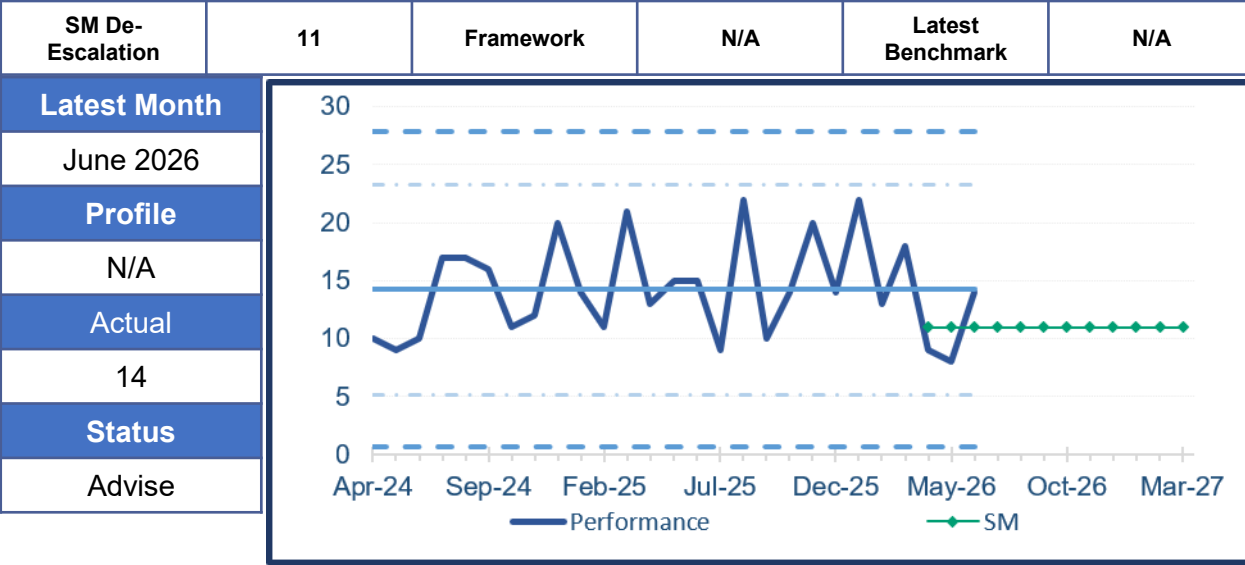
Number of complaints closed within 30 days of date received



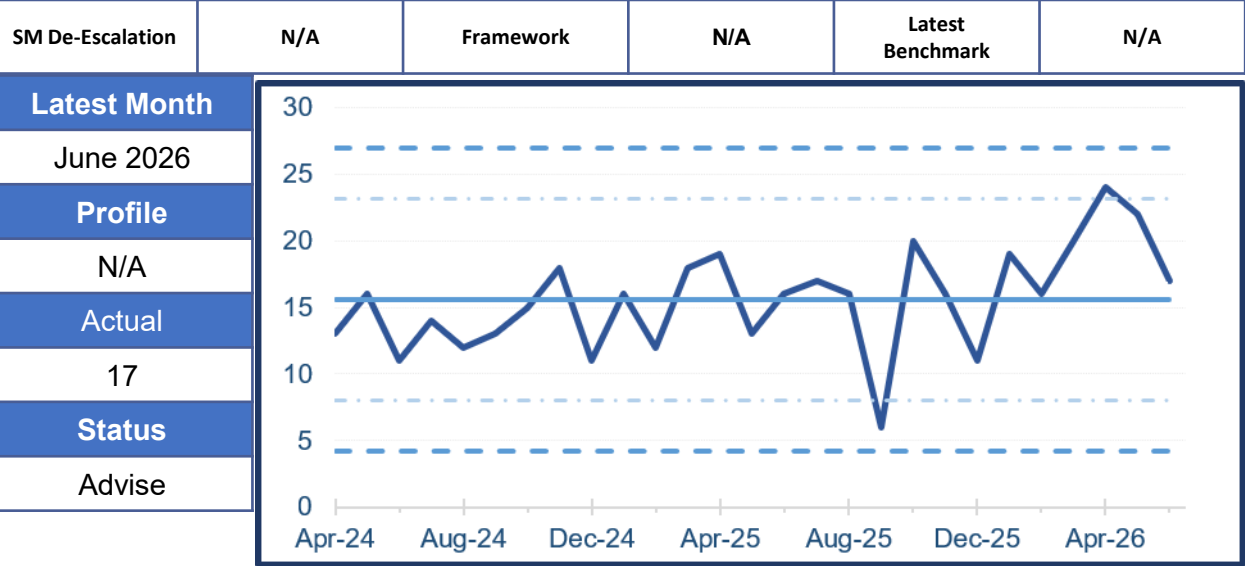
Number of hospital onset E-coli BSI cases



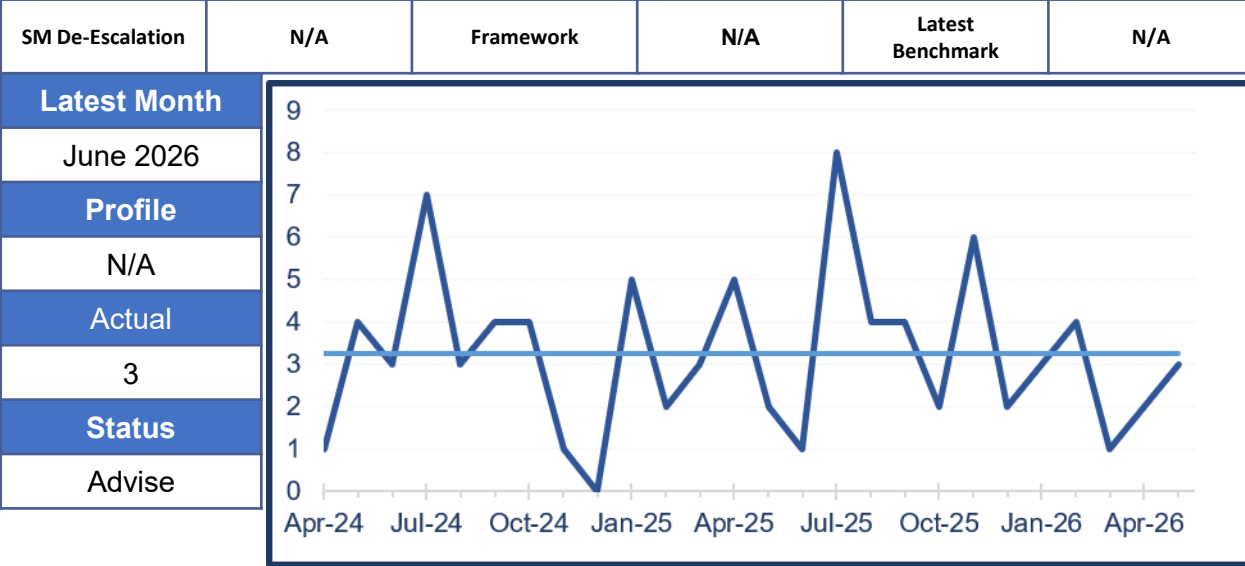
Number of hospital onset C-Diff cases



Number of MSSA BSI cases

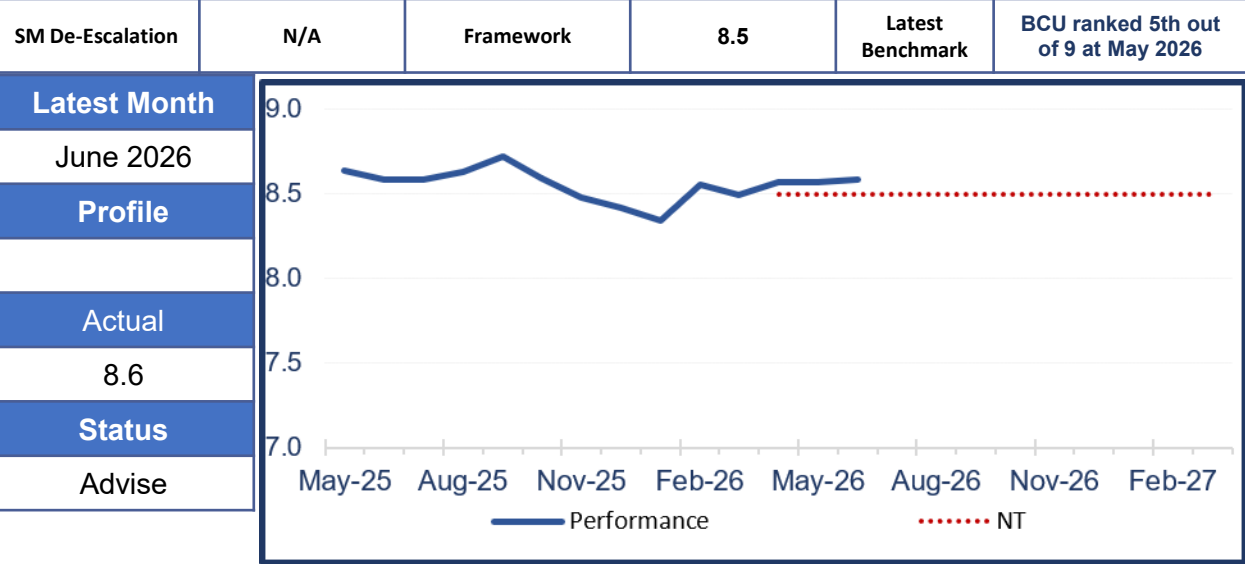


Number of hospital onset Klebsiella spp BSI cases

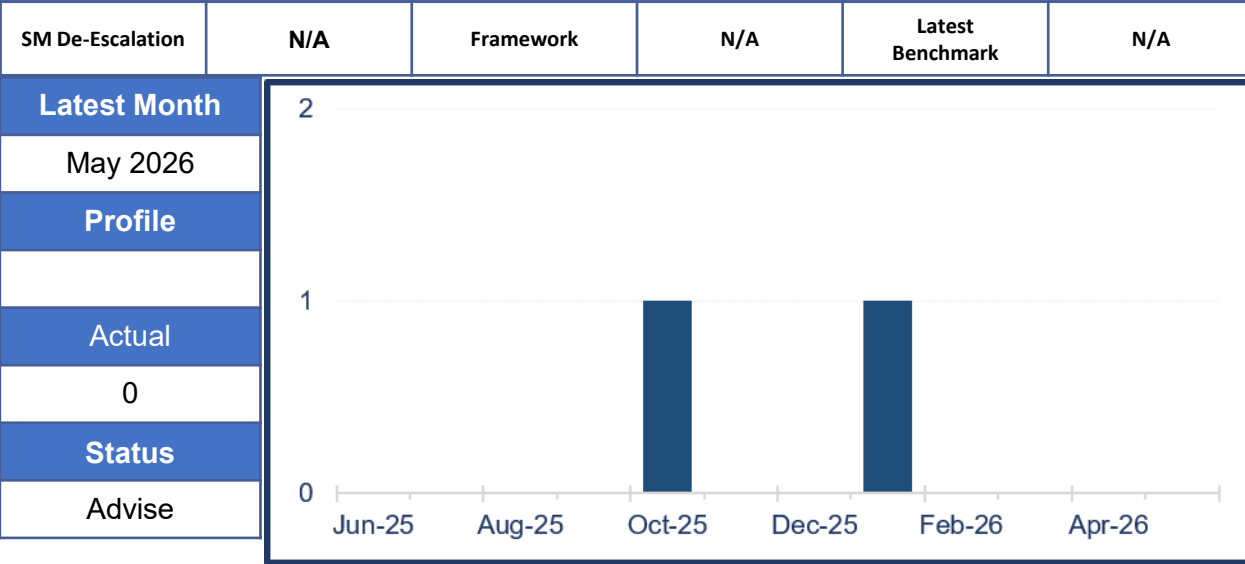


Quality: Patient Experience and Regulation 28 notices

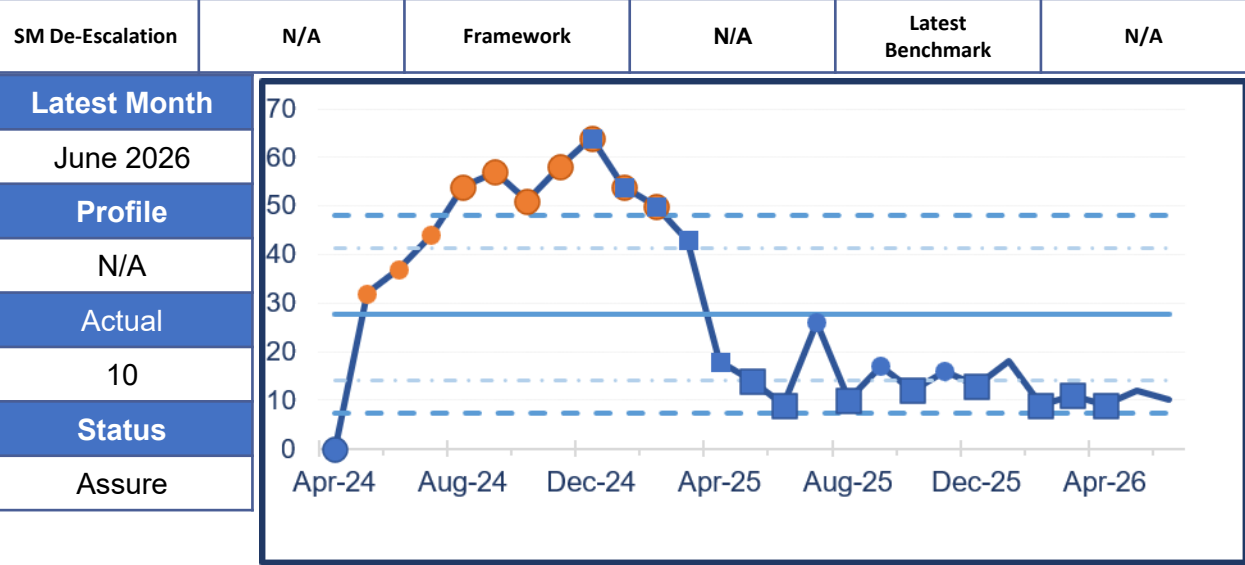
Overall health board patient experience score



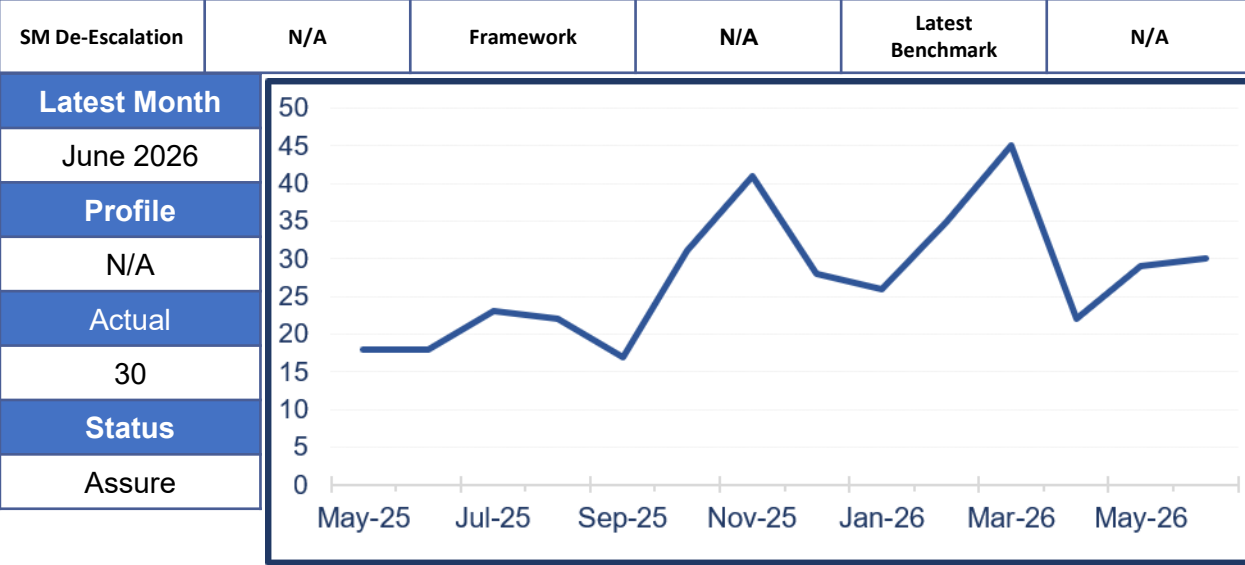
Regulation 28 notices (Prevention of Future Deaths reports)



Number of overdue Learning from Event Reports (LFERs)



Number of new Ombudsman contacts



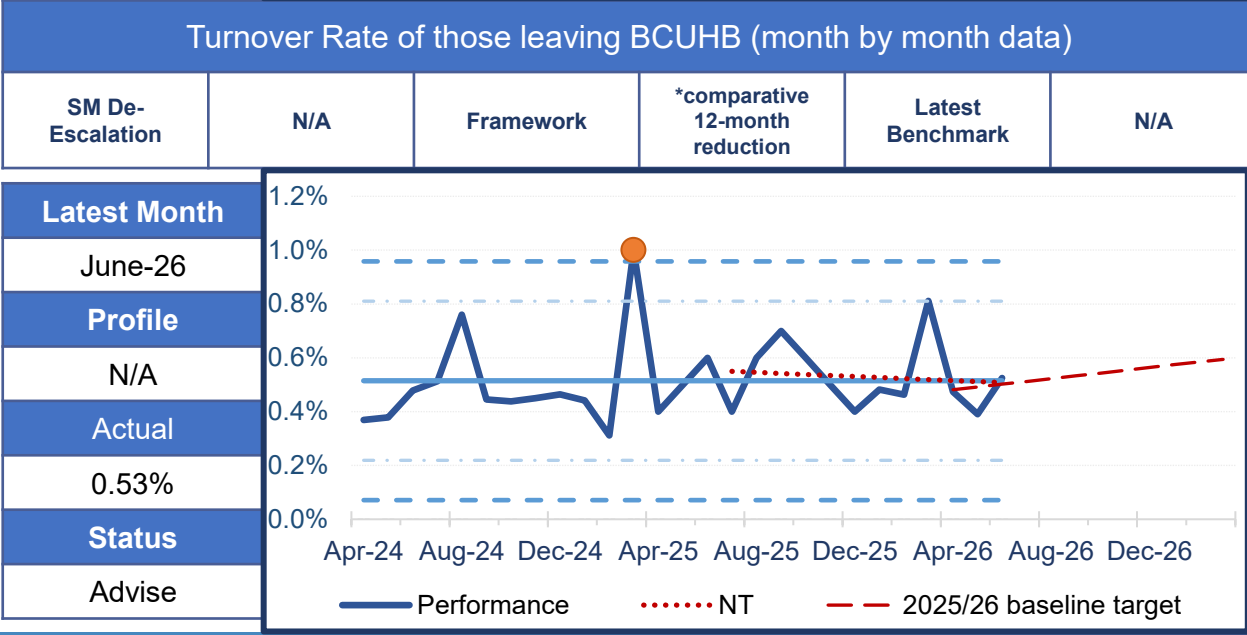
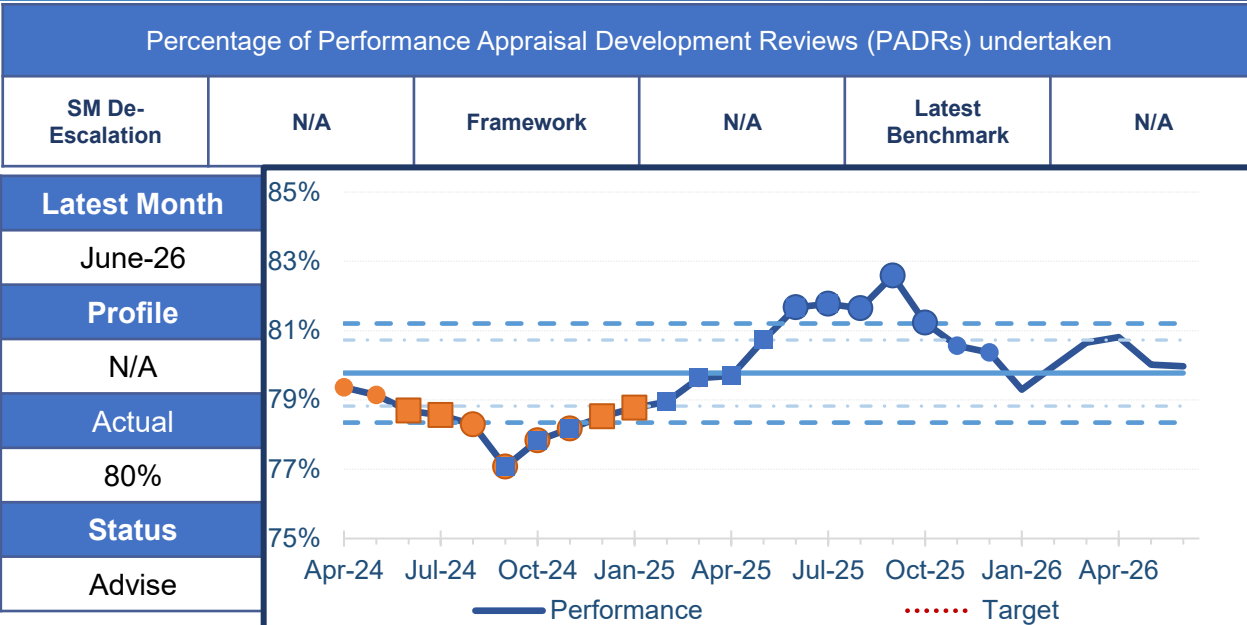
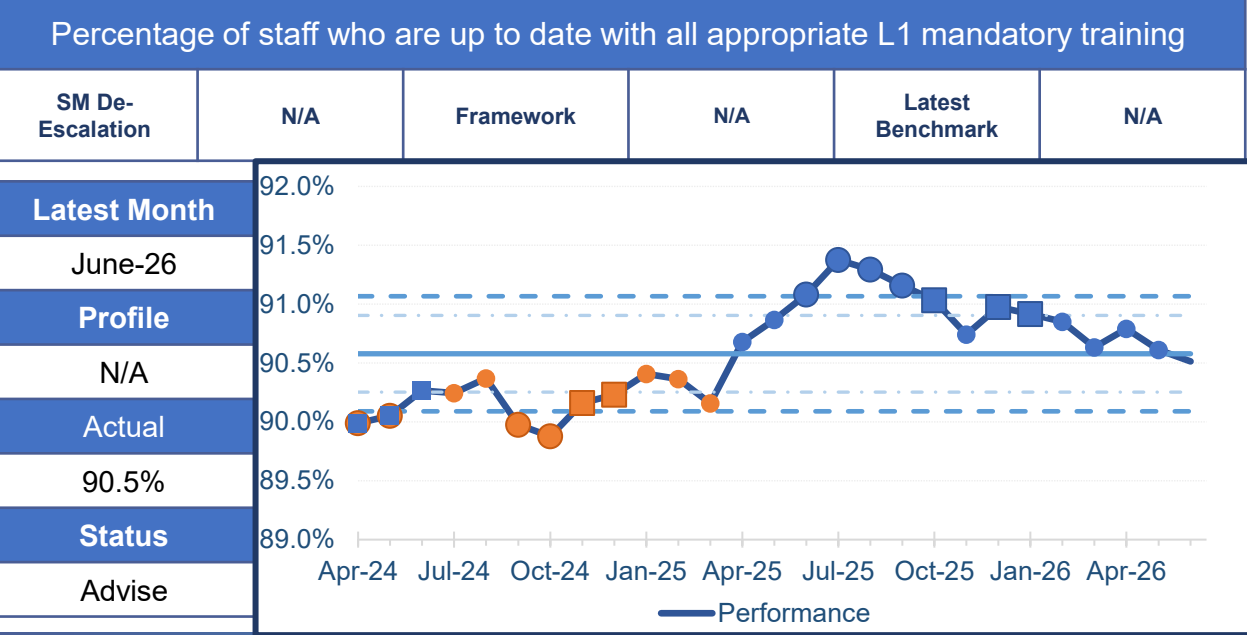
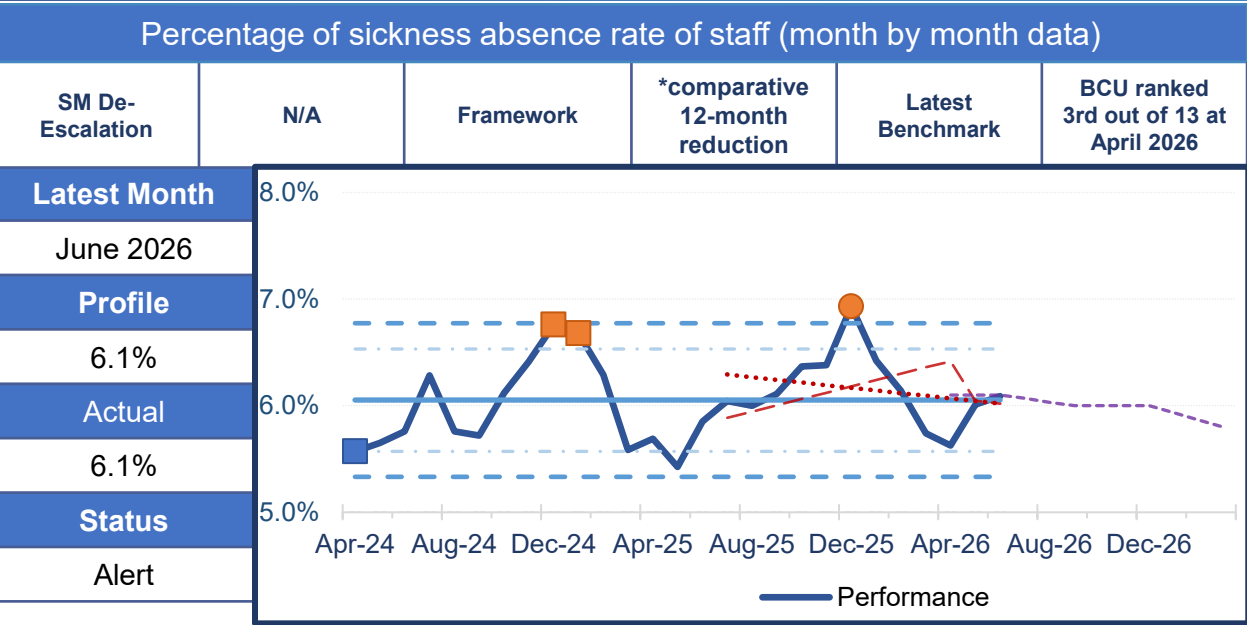
Section 3

People and places



Scorecard: People and places

REF	Measure Description	Target Suite			Wales Benchmark	Actual Performance				Status
		NT	SM	AP		Apr-26	May-26	Jun-26	6 Month Activity	
NPF36	Percentage of sickness absence rate of staff (month by month)	YoY↓	-	-	7th of 13 (at Feb 26)	5.63%	6.01%	6.09%		Advise
LMW05	Percentage of headcount by organisation who have had a Personal Appraisal and Development Review (PADR) in the previous 12months (excluding medical appraisal,	-	-	-	6th of 13 (at Jan 26)	80.8%	80.0%	80.0%		Assure
LMW06	Percentage compliance for all completed level 1 competencies of the Core Skills and Training Framework by organisation	-	-	-	N/A	90.8%	90.6%	90.5%		Assure
LMW07 (NPF37*)	Turnover rate for nurse and midwifery registered staff leaving BCUHB (monthly, not 12 month rolling figure)	-	-	-	N/A	0.47%	0.39%	0.53%		Assure



Section 4

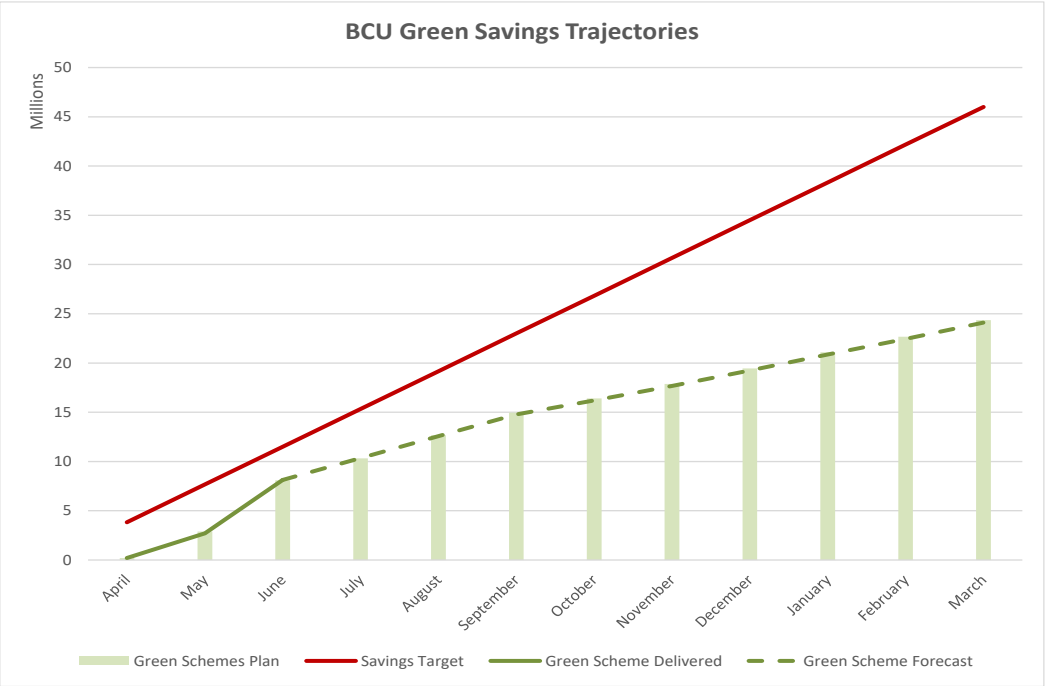
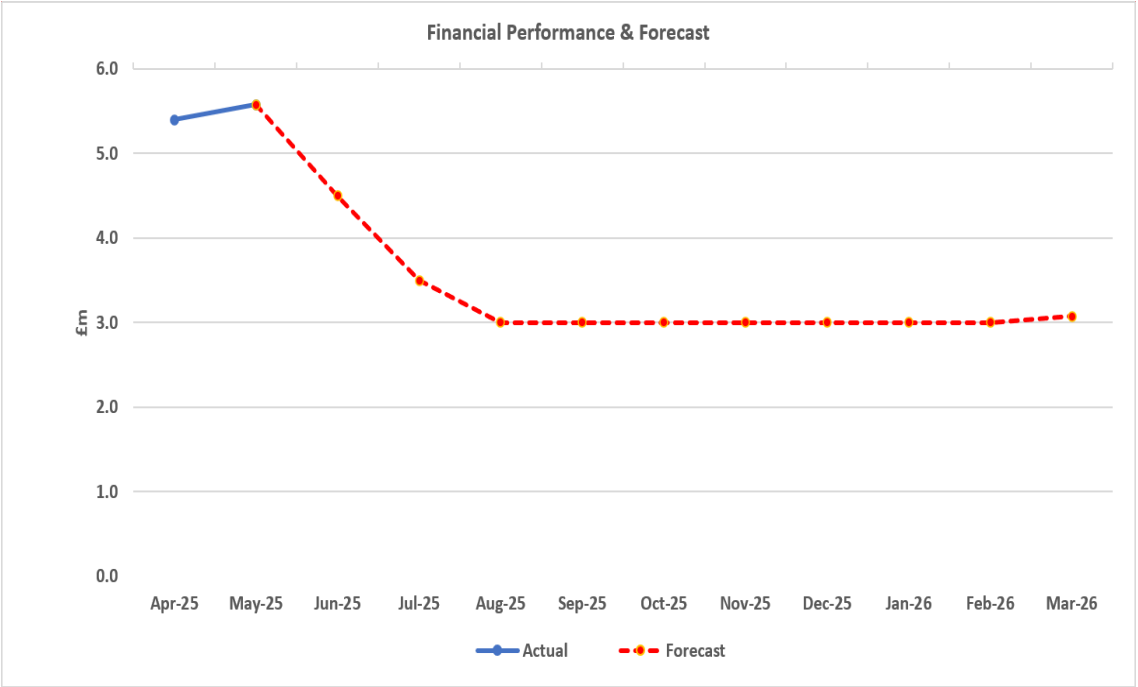
Finance and sustainability



Scorecard: Finance and sustainability

REF	Measure Description	Target Suite			Wales Benchmark	Actual Performance				Status
		NT	SM	AP		Apr-26	May-26	Jun-26	6 Month Activity	
NPF38	Agency spend (30% reduction in 2026-27 from 2025-26 outturn)	30%↓	-	-	13th of 13 (at May 26)	19%	22%	20%		TBC
LMF01	Revenue position - expenditure over profile deficit position per month (£m)	43	-	-	N/A	1.8	2.0	2.6		TBC
LMF02	Value and sustainability forecast (up to pipeline) (£m)	46	-	-	N/A	34.4	45.2	43.6		TBC
4GP01	Green deliverable schemes (cash releasing savings forecast) (£m)	46	-	-	N/A	0.2	13.3	24.1		TBC
LMF03	Budget releasing savings (£m)	46	-	-	N/A	2.6	4.6	10.1		TBC
LMF04	Capital spend (£m)	58.6	-	-	N/A	-	1.7	2.8		TBC
LMF05	PSPP: Non-NHS invoices paid within 30 days by number	95%	-	-	N/A	N/A	N/A	92.6%	Quarterly metric	Alert
LMF06	PSPP: Non-NHS invoices paid within 30 days by value	95%	-	-	N/A	N/A	N/A	96.9%	Quarterly metric	Assure
LMF07	PSPP: NHS invoices paid within 30 days by number	95%	-	-	N/A	N/A	N/A	89.0%	Quarterly metric	Alert
LMF08	PSPP: NHS invoices paid within 30 days by value	95%	-	-	N/A	N/A	N/A	98.0%	Quarterly metric	Assure

Scorecard: Finance and sustainability



Scorecard: Finance and sustainability

	Actual			Forecast									2026/27 Cumulative against Plan			
	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	Budget	Actual	Variance	Variance
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	%
Revenue Resource Limit	(197.0)	(197.3)	(200.1)	(198.2)	(195.4)	(198.1)	(197.5)	(196.7)	(198.6)	(197.4)	(195.7)	(197.0)	(594.5)	(594.5)	0.0	0.0%
Miscellaneous Income	(14.7)	(15.4)	(15.3)	(15.0)	(14.9)	(15.0)	(15.0)	(15.0)	(15.1)	(15.0)	(15.0)	(15.8)	(43.2)	(45.4)	(2.2)	5.1%
Health Board Pay Expenditure	101.6	102.4	104.9	102.0	102.0	102.4	101.9	101.9	102.0	102.4	102.2	102.0	306.4	308.9	2.5	0.8%
Non-Pay Expenditure	115.5	115.9	116.7	115.8	112.3	113.8	113.1	112.4	114.1	112.5	110.7	113.1	331.3	348.1	16.8	5.1%
Total Deficit / (Surplus)	5.4	5.6	6.2	4.5	4.0	3.0	2.5	2.5	2.5	2.5	2.2	2.2	0.0	17.1	17.1	
Planned Deficit	3.6	3.6	3.6	3.6	3.6	3.6	3.6	3.6	3.6	3.6	3.6	3.6	10.8	0.0	10.8	100.00%
Total Deficit / (Surplus) above Plan	1.8	2.0	2.6	0.9	0.4	(0.6)	(1.1)	(0.7)	(1.1)	(1.1)	(1.4)	(1.4)	10.8	17.1	6.4	

Section 5

Population health and prevention



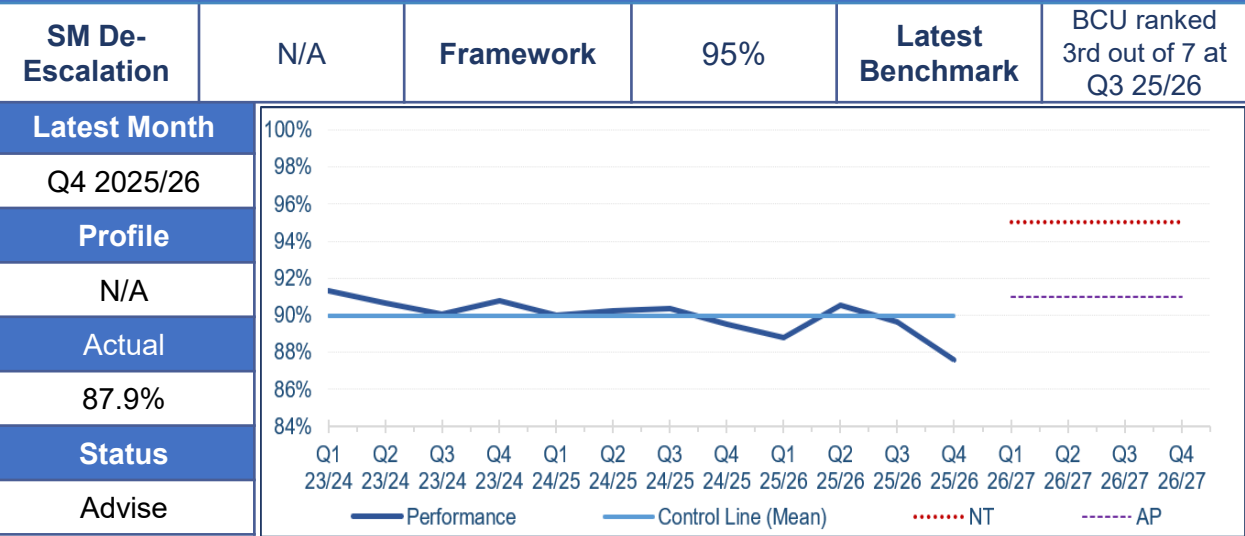
Scorecard: Population health and prevention

REF	Measure Description	Target Suite			Wales Benchmark	Actual Performance				Status
		NT	SM	AP		Q2 25/26	Q3 25/26	Q1 26/27	Notes	
1AP01	Percentage of adult smokers who make a quit attempt via smoking cessation services	Q1: 1.5%	-	-	2nd of 7 (at Dec 25)	6.0%	8.1%	RIA	Annual Target	Assure
1AP02	Percentage of adult smokers who made a quit attempt via smoking cessation services who are CO-validated as quit at 4 weeks	40%	-	-	4th of 7 (at Dec 25)	78.5%	93.6%	RIA		Advise
1DP01	Percentage of children who are up to date with the scheduled vaccinations by age 5 ('4 in 1' preschool booster, the Hib/MenC booster and the second MMR dose)	95%	-	-	3rd of 7 (at Dec 25)	89.7%	87.6%	RIA		Advise
1DP02	Percentage of children receiving the Human Papillomavirus (HPV) vaccination by the age of 15	90%	-	-	7th of 7 (at Dec 25)	70.3%	70.8%	RIA	School year based programme	Advise
LMPH01	Percentage of teenagers receiving the MenACWY vaccination by the end of year 11	-	-	-	N/A	73.1%	74.5%	RIA		TBC
LMPH02	Number of patients who started a L2 WM intervention	-	-	-	N/A	422	519	434		TBC

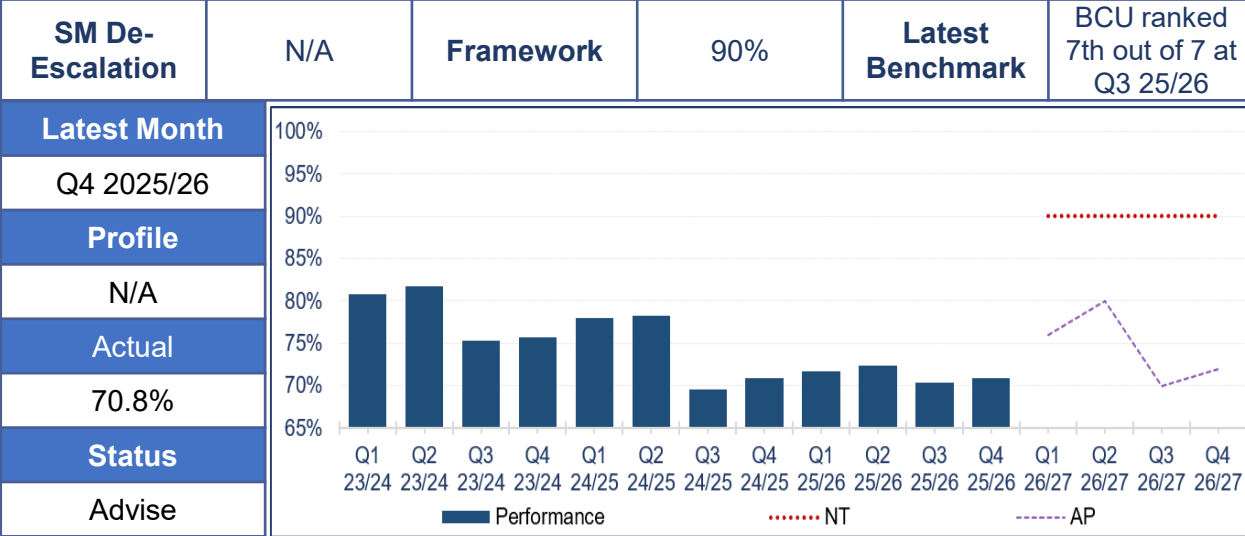
REF	Measure Description	Target Suite			Wales Benchmark	Actual Performance				Status
		NT	SM	AP		Apr-26	May-26	Jun-26	6 Month Activity	
1BP02	Percentage of patients offered an index colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioner assessment appointment	90%	-	-	4th of 7 (at Feb 26)	8.6%	RIA	RIA		Alert
3DP05	Percentage of people who have been referred to health board services who have completed treatment for substance misuse (drugs or alcohol)	80%	-	-	1st of 7 (at Dec 25)	97.6%	97.1%	RIA		Assure
LMPH03	Percentage of patients (*adults) with diabetes who received all eight NICE recommended care processes	-	-	-	7th of 7 (at Mar 26)	43.7%	43.2%	43.0%		Advise
1AP07	Percentage of patients (*adults) with diabetes who have had foot surveillance recorded within last 15 months	80%	-	-	N/A	67.1%	66.1%	65.3%		Advise
1AP08	Percentage of patients (*adults) with diabetes who have had their urine albumin recorded within last 15 months	80%	-	-	N/A	65.0%	64.6%	64.4%		Advise
LMPH04	Babies exclusively breast fed at birth	-	-	-	N/A	#REF!	RIA	RIA		TBC
LMPH05	Percentage of babies who are exclusively breastfed at 10 days old	-	-	-	N/A	39.8%	33.0%	RIA		TBC
2AP01	Increase in % of adult populations accessing NHS Dental care over a 24 month period	-	-	-	N/A	181706	179750	179432		TBC
2AP02	Increase in % of child populations accessing NHS Dental care over a 12 month period	-	-	-	N/A	56025	55525	55351		TBC
3HP01	Percentage of community pharmacies providing Pharmacist Independent Prescribing service (PIPS)	63%	-	-	N/A	43.4%	42.7%	47.6%		TBC

Population health and prevention

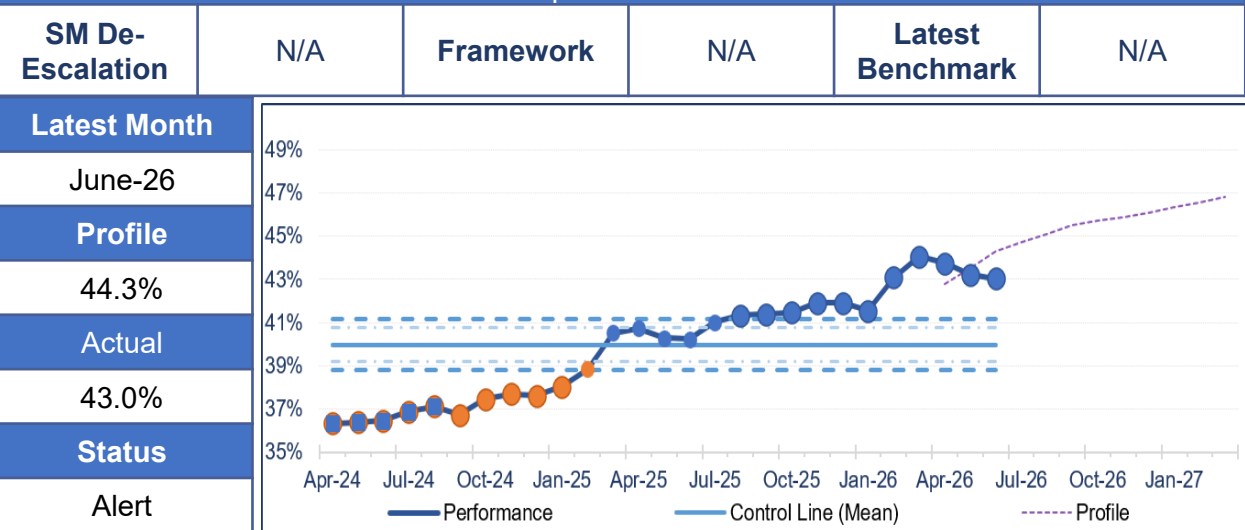
Percentage of children who are up to date with the scheduled vaccinations by age 5



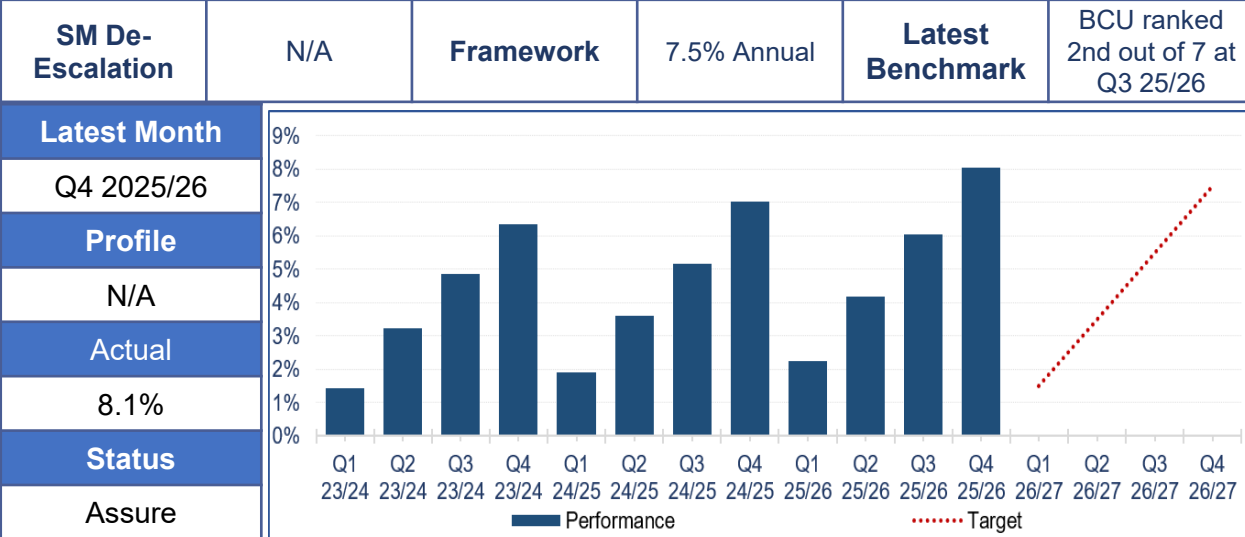
Percentage of children receiving the HPV vaccination by the age of 15



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



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



Appendices

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

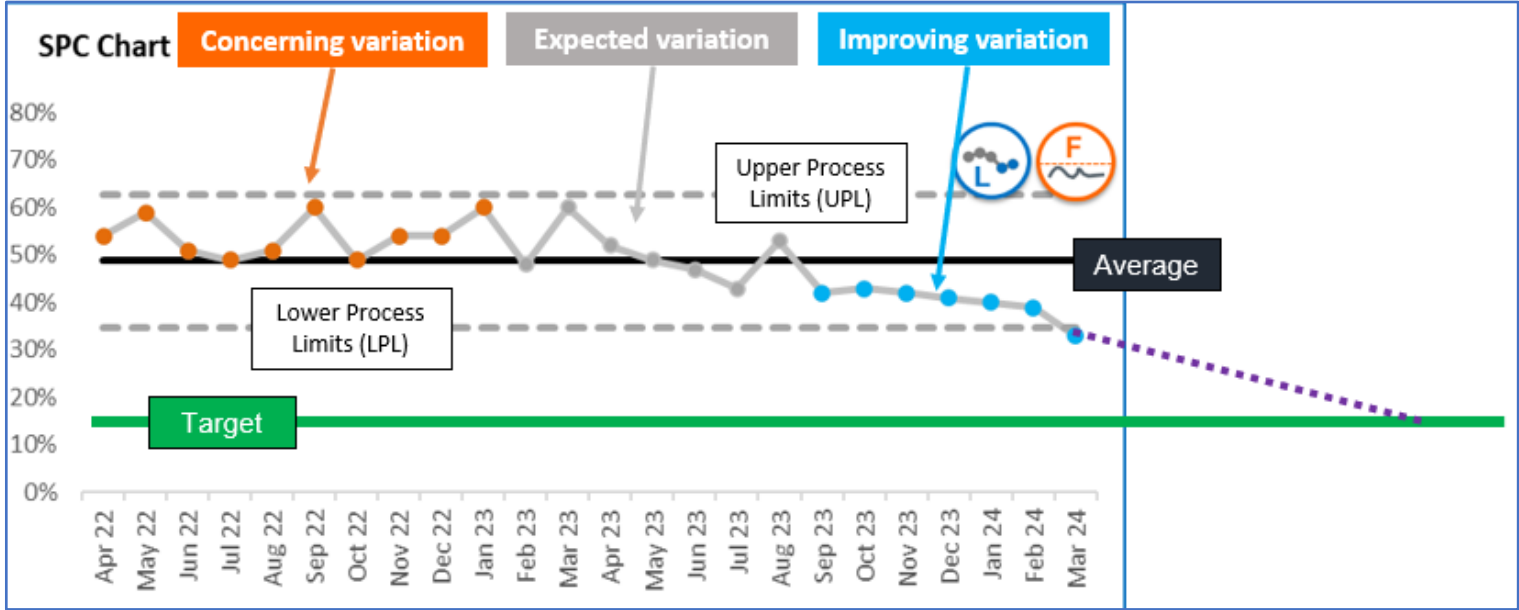


Interpreting Statistical Process Control (SPC) Charts

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

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

- Orange** – there is a concerning pattern of data which needs to be investigated and improvement actions implemented
- Blue** – there is a pattern of improvement which should be learnt from
- Grey** – the pattern of variation is to be expected. The key question to be asked is whether the level of variation is acceptable



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

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

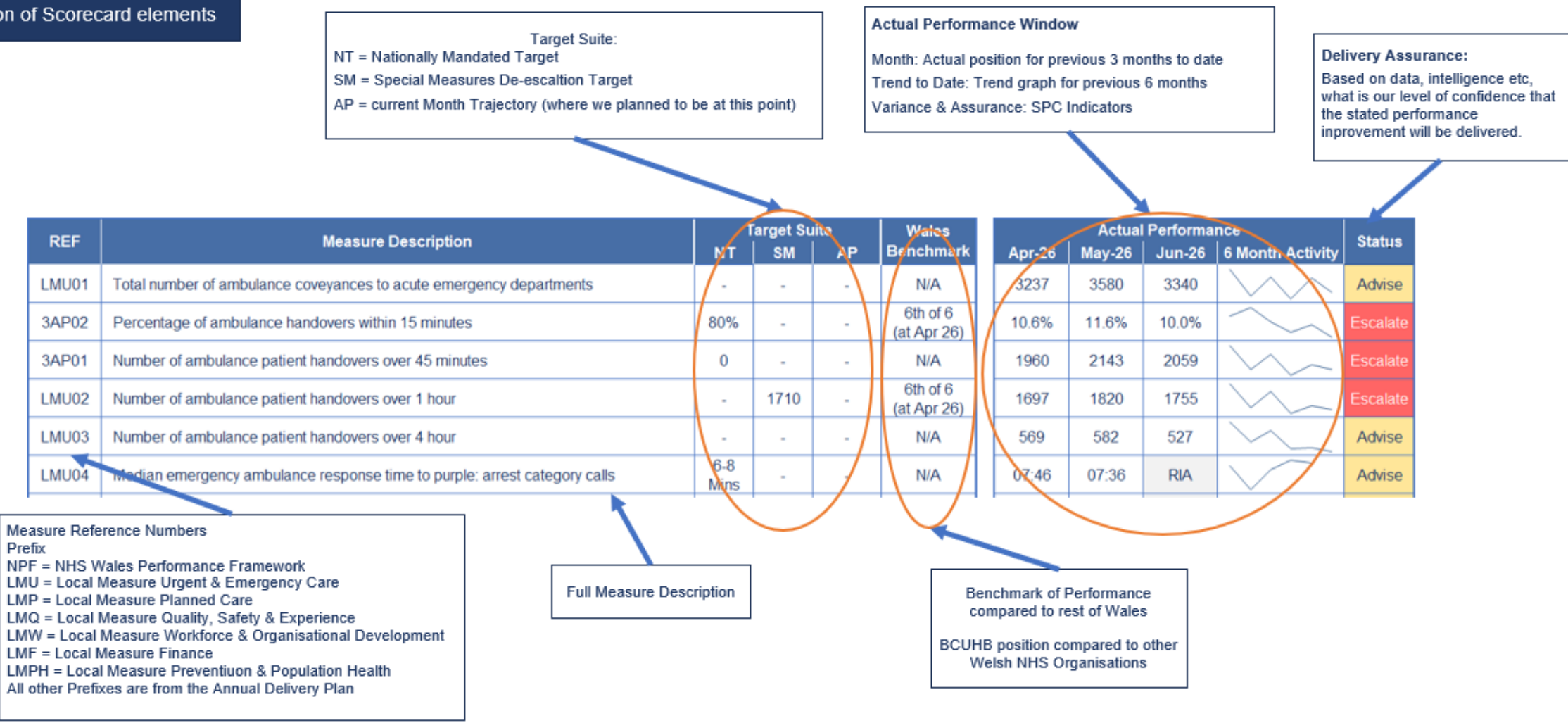
SPC charts therefore describe not only the type of variation in data, but also provide an indication of the likelihood of achieving target.

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

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

How to interpret the Integrated Performance Scorecard

Diagram and description of Scorecard elements



Abbreviations

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

Abbreviation	Definition
3As	alert, advise or assure
A&E	Accident and Emergency
ADHD	Attention Deficit Hyperactivity Disorder
AHP	Allied Health Professional
ASD	Autistic Spectrum Disorder
ASU	Assessment and Support Unit
BCUHB	Betsi Cadwaladr University Health Board
BSI	Bloodstream Infection
C&YP	Children and Young People
CD	Controlled Delivery
CO	Carbon Monoxide
CRL	Capital Resource Limit
D2RA	Discharge to Assess and Recover
DOSA	Day of Surgery Admission
ED	Emergency Department
FTE	Full Time Equivalent
HPV	Human Papilloma Virus
IHC	Integrated Health Community
IMTP	Integrated Medium Term Plan
L1	Level 1
LFER	Learning from Event Reports
LocSSIP	Local Safety Standards for Invasive Procedures
LPMHSS	Local Primary Mental Health Support Service
LTP	Listening to People
MDT	Multi-disciplinary Team
MDU	Medical Decision Unit

Abbreviation	Definition
MenACWY	Meningococcal A, C, W, and Y
MHLD	Mental Health and Learning Disabilities
MIU	Minor Injuries Unit
N/A	Not Applicable
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NMQS	Nursing and Midwifery Quality Standards
NRI	National Reportable Incident
PADR	Performance Appraisal and Development Review
PIPS	Pharmacist Independent Prescribing Service
PoCD	Pathways of Care Delays
PSA	Patient Safety Alerts
PSPP	Public Sector Payment Policy
Q	Quarter
QMS	Quality Management System
RSV	Respiratory Syncytial Virus
RTT	Referral to Treatment
SDEC	Same Day Emergency Care
SPC	Statistical Process Control
TBC	To Be Confirmed
UEC	Unscheduled and Emergency Care
V&S	Value and Sustainability
WM	Weight Management
WTE	Whole Time Equivalent
YoY	Year on Year

Presented on 30.07.2026

Data Produced on 16.07.2026 on behalf of the Health Board
by the Performance Directorate and Partners



Integrated Quality and Performance Report Betsi Cadwaladr University Health Board



Information on our performance can be found online at:

Our website www.bcu.wales.nhs.uk

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

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



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Health Board

2026-27 BCU FINANCE REPORT – MONTH 3 (JUNE)

Date of Meeting	30 July 2026
Publication Status	Open/ Public
	Not Applicable
Report Author name and title	Michelle Jones, Head of Financial Reporting Daniel Eyre, Head of Capital Development
Lead Executive Team Member name and title	Russell Caldicott, Executive Director of Finance.

Report Purpose	For Noting

Executive Summary

This report provides a briefing on the on the financial position of the Health Board as at the end of Month 3 (June 2026) and includes an update on delivery of the approved Capital Programme and Savings delivery against target.

Finance Report

The Year-to-date position is reporting a deficit of £17.1m, £6.4m adverse to the planned year to date £10.8m deficit. The adverse variance to plan indicating a run rate exceeding plan by approximately £2m per month, the adverse position driven by a shortfall in savings delivery. The in-month (June 2026) position an in-month deficit of £6.2m.

Targeted savings delivery for quarter 1 totals £11.4m (3/12ths of the annual target of £46m) with savings delivered to date totalling £8.1m. However, of these savings £2.1m is budget releasing which results in a £9.4m shortfall in budget extractable savings verses the year-to-date target.

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

	2026/27 Monthly Variance													
	Actual			Forecast										
	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Year to Date Position	Full Year Forecast Outturn Position
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Total Monthly Surplus/ (Deficit)	(5.4)	(5.6)	(6.2)	(4.5)	(4.0)	(3.0)	(2.5)	(2.5)	(2.5)	(2.5)	(2.2)	(2.2)	(17.1)	(43.0)

2026/27 forecast position is to deliver the planned deficit of £43m, which is in line with the financial plan for the year. The forecast position assumes that Welsh Government will fund all pay awards and associated pay uplifts in 2026/27 in full, along with receipt of all anticipated income.

Focus will remain on containing cost overruns and recovering the in-month deficit. Grip and Control additional actions implemented during 2025-26 will continue in 2026-27, including:

- **Procurement and Non-Pay Expenditure Controls** where this doesn't impact direct clinical care, with enhanced approvals for requisitions
- **Pay** – Oversight and controls placed upon external recruitment
- **Temporary Workforce** – Clinical Executive leadership oversight

Risks

The identification of savings to deliver the plan for 2026/27 and then stretch ask to attain the key financial duty is now key. This will include our being required to contain and offset earlier cost overruns, the risk of attainment of the 2026/27 financial plan assessed as circa £108.0m (with the potential income loss in year of £82m for the conditionally recurrent funds).

Cash

Closing cash balance for June was £5.4m, including £2.3m cash held for revenue expenditure and £3.1m for capital projects. The Health Board is currently forecasting a closing cash balance for 2026-27 of (£35.1m) made up of (£40.5m) revenue cash and £5.5m capital cash.

Savings

The Health Board's financial plan requires a savings target of £46.0m to be delivered in 2026/27 with savings identification, reporting and monitoring developed through the Value and Sustainability thematic model. The savings target is set at 2.4% based on recurrent budgets that exclude ringfenced budgets. The Value and Sustainability approach is focused on delivering improvements within the core domains of Clinical Value, Workforce, Continuing Healthcare, Medicines Management and Non-Pay & Procurement. The £46.0 target is profiled on an equal twelfth's basis.

As at the end of June (Month 3), the Health Board has identified £24.1m Green saving schemes, an increase of £10.8m from previous month. Of these savings £13.5m have been identified as recurring, with a full year effect of £19.9m and £10.6m are non-recurring savings. As at Month 3, £20.8m is reported as cash releasing, £2.4m accountancy gains and £0.9m income generation and cost avoidance schemes.

In-month savings delivery is £5.4m and year-to-date savings delivery is £8.1m, of which £2.1m is budget releasing, resulting in a £9.4m impact on the position.

Full year plan value of Red Schemes and pipeline totals £19.5m. It is vitally important that the identified opportunities are converted to green schemes at pace, so as not to result in adverse performance in the early part of 2026/27, and avoid the necessity of additional recovery actions in future months.

Focus is required on accelerating the transition of identified savings schemes to green-rated and budget releasing delivery status. To support this, the Chief Executive Officer has scheduled escalated scrutiny meetings with individual IHC Directors and Value & Sustainability Leads between the 15th and 21st of July to eliminate barriers to progress of existing schemes and identify alternative schemes to, as a minimum, underpin the savings target for Month 4 reporting.

The Health Board is also required to deliver the key duty by Welsh Government and submit a balanced plan, which would require delivery of a savings stretch target of £63m (additional £17m on the £46m contained within the plan). The delivery of plan would result in £26m of Welsh Risk Pool costs being mitigated through the National team and the Health Board being able to submit a balanced plan for 2026/27 and attain the key statutory duty of break-even.

Capital Programme

The approved Capital Resource Limit (CRL) for 2026-27 is £58.577m. The current full-year forecast outturn is £58.550m, reflecting the variance of £0.027m for the End of Year Digital Funding.

As previously agreed with Welsh Government the prior year expenditure of £1.377m for Royal Alexander Hospital – Phase 1 is to be re-provided to discretionary from the All-Wales allocation.

Donated Income of £0.800m has been reported in Month 3. Further donated income in relation to the Ysbyty Gwynedd Helipad will be reported from Month 4 onwards to align with the Project Progress Report.

The Health Board is currently reviewing the overall estates strategy.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome, Evidence and Data
N/A		

Acronyms / Glossary of Terms	
IMTP	Integrated Medium Term Plan
CRL	Capital Resource Limit

BCU 2026-27 M3 Finance Report

Please see Appendix A - BCU 2026/27 M03 Finance Report – June 2026

ASSESSMENT	
Link to Strategic Intentions	4.Create a Modern, People Centred Healthcare System
	If more than one applies, please list below: This paper aligns to the strategic goal of attaining financial balance and supports a number of organisational priorities.
Design Principles	Wise Spending
Corporate Risks and Board Assurance Framework	Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR) Appendix A BAF risks BAF SP14 – Estates & Capital <i>(There is a risk of failing to deliver and provide a safe and compliant built environment, equipment and digital landscape due to limitations in capital funding, adversely impacting on the Health Board's ability to implement safe and sustainable services through an appropriate refresh programme, could result in avoidable harm to patients, staff, public, reputational damage and litigation.)</i> BAF24-03 – Value Delivery & Financial Sustainability <i>(There is a risk that the Health Board will be unable to secure current non-recurrent (one-off) allocations in future financial years, as these allocations are conditional on meeting agreed financial plans. Failure to secure this resource will require services to operate within a significantly reduced financial envelope. The objective is to achieve long-term financial sustainability or maximise value from its spending).</i>

	Link to Corporate Risk Register: CRR24-06 Suitability and Safety of Sites CRR26/27-Fin-01 Delivery of the 2026/27 Financial Plan and Financial Sustainability
<u>Wellbeing of Future Generations Act – Wellbeing Goals</u>	A Resilient Wales
	If more than one applies, please list below:

IMPACT ASSESSMENTS		
Equality <i>Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)</i>	Yes: ☐	No: ☒
	Outcome:	Not applicable
	If no, please include rationale:	
Socio-Economic Impact Assessment <i>Have you undertaken a Socio-Economic Impact Assessment</i>	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	The health board continues to assess the requirement for carrying out Equality Impact Assessments and Social-Economic impact assessments on a capital project by project basis.
<u>Quality</u> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Enablers of Quality Data to Knowledge	Domains of Quality Effective
	If more than one applies, please list below:	If more than one applies, please list below:
<u>Wellbeing of Future Generations Act – Wellbeing Goals</u>	A Resilient Wales	

Environmental /Sustainability Impact (5Rs)	If more than one applies, please list below:	
	No - Not Applicable	
	If more than one applies, please list:	

Armed Forces Covenant Due Regard Duty Have you considered the Armed Forces Covenant Due Regard Duty?	Yes: ☐	No: ☒
	Outcome:	No - Not Applicable
	If no, please include rationale:	
Data Protection Impact Assessment <i>Have you undertaken a Data Protection Impact Assessment Screening?</i>	Yes: ☒	No: ☐
	Outcome:	No personal data included in the report.
	If no, please include rationale:	
Counter Fraud Impact Assessment <i>Have you considered the counter fraud impacts</i>	Yes: ☒	No: ☐
	Outcome:	
	If no, please include rationale:	
Legal	There are no specific legal implications related to the activity outlined in this report.	
Reputational	Yes (Include further detail below)	
	Implications of deterioration of forecast to reputation.	
Resource Impact (People / Financial)	Yes (Include further detail below)	
	The Health Board is in receipt of £82m of conditionally recurrent funding from Welsh Government that requires attainment of the 2025/26 plan (a) delivery of financial balance £40m and (b) de-escalation from Special Measures £42m for these funds to be received recurrently (available for future financial years). If the plan is not improved upon and delivered the funding of £82m will be at risk of clawback from Welsh Government and this places risk on the sustainability of existing service models. Delivery of the key financial duty is also a requirement for the Health Board to receive funding in support of the increased costs associated with the Welsh Risk Pool of £26m. In summary, £108m in cost mitigation or income is at risk if the Health Board is unable to deliver the key statutory duty to break-even.	



**Trugaredd
Compassion**



**Agored
Openness**



**Parch
Respect**

Finance Report – Health Board June - Month 3 2026/27

Russell Caldicott
Executive Director of Finance

Executive Summary		
Situation	To provide assurance on financial performance and delivery against Health Board financial plans and objectives; and give early warning on potential performance issues. To make recommendations for action to continuously improve the financial position of the organisation, focusing on specific issues where financial performance is showing deterioration or there are areas of concern.	
Statutory Financial Duties	Revenue	- In-month deficit of £6.2m for June, a £2.6m adverse variance compared to the £3.6m in-month profiled financial plan deficit. - Year to date deficit of £17.1m and £6.4m adverse compared to the year to date financial plan deficit of £10.8m. - Full year forecast outturn for 2026/27 remains in line with the £43m planned deficit as per the 2026/27 financial plan.
	Cash	Closing cash balance as at 30th June 2026 was £5.4m, including £2.4m for revenue and £3.1m for capital projects. The Health Board is currently forecasting a closing cash balance for 2026-27 of (£35.1m) made up of (£40.5m) revenue and £5.5m capital cash.
	Savings	- The financial plan has set a savings target of £46.0m to be delivered in 2026/27 profiled equally across the financial year. - Full year forecast value of deliverable (Green) schemes total £24.1m, resulting in £21.9m still to be identified. - Targeted savings delivery for quarter 1 totals £11.4m (3/12ths of the annual target of £46m) with savings delivered to date totalling £8.1m. Of these savings, £2.1m is budget releasing, therefore resulting in a £9.4m shortfall in budget extractable savings compared to year to date target. - Red schemes and pipeline opportunities totals £19.5m, with work progressing to convert to deliverable schemes.
	Capital	Approved Capital Resource Limit (CRL) for 2026/27 is £58.6m. Year to date expenditure is £2.8m.
	PSPP	96.9% of Non-NHS invoices paid within 30 days by value and 92.6% by number, both against a Target of 95% 98.0% of NHS invoices paid within 30 days by value and 89% by number, both against a Target of 95%
Key Risks & Matters for Escalation	➤ It is of note that the 2026/27 £43.0m financial plan deficit does not attain the key duty of the Health Board to achieve a balanced position, and therefore the £82m conditionally recurrent allocation being at risk. ➤ Focus is required on accelerating the transition of identified savings schemes to green-rated and budget releasing delivery status. To support this, escalated scrutiny meetings with individual IHC Directors and Value & Sustainability Leads will take place between the 15th and 21st of July to eliminate barriers to progress of existing schemes and identify alternative schemes to, as a minimum, underpin the savings target for Month 4 reporting. ➤ Achieving the full £46.0m target as budget releasing is a key risk for the Health Board. ➤ The Health Board is seeking to deliver a stretch savings target of £63m (an additional £17m above the £46m contained within the plan) that would result in £26m of Welsh Risk Pool costs being mitigated through the National team and the Health Board being able to submit a balanced plan for 2026/27 and attain the key statutory duty of break-even.	

Key Performance Indicators

Month 3 Position

In Month: £206.3m against plan of £203.7m
£2.6m adverse position

YTD: £611.6m against plan of £605.2m
£6.4m adverse position

Forecast

Projection held at planned deficit
but this is subject to risk.

£43.0m deficit

Month 3 Divisional Variance

West IHC	£2.8m adverse
Central IHC	£4.1m adverse
East IHC	£5.4m adverse
Womens	£0.9m adverse
MH & LD	£1.3m adverse
Commissioning Contracts	£4.3m adverse
ICD Primary Care	£0.9m favourable
ICD Regional Services	£4.2m adverse
Support Functions	£1.2m adverse
Other Budgets	£16.9m favourable



Savings

In Month: £5.4m against target of £3.8m

£1.6m favourable



Full Year Savings Delivery

£24.1m forecast against target of £46.0m

£21.9m adverse

(Red and pipeline totalling £19.5m are being developed)



Year to Date Income

£45.4m against budget of £43.2m

£2.2m favourable



Year to Date Pay

£308.9m against budget of £306.4m

£2.5m adverse



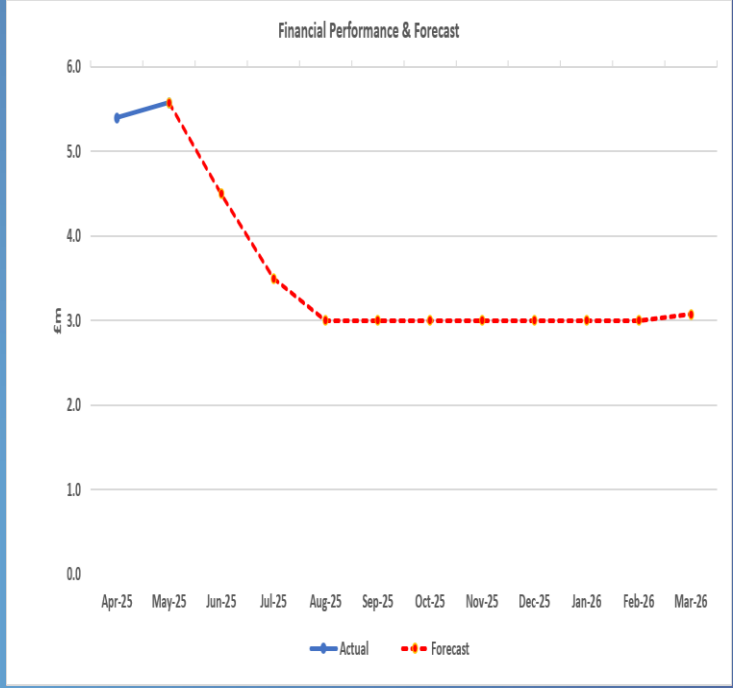
Year to Date Non-Pay

£348.1m against budget of £331.3m

£16.8m Adverse

Revenue Position

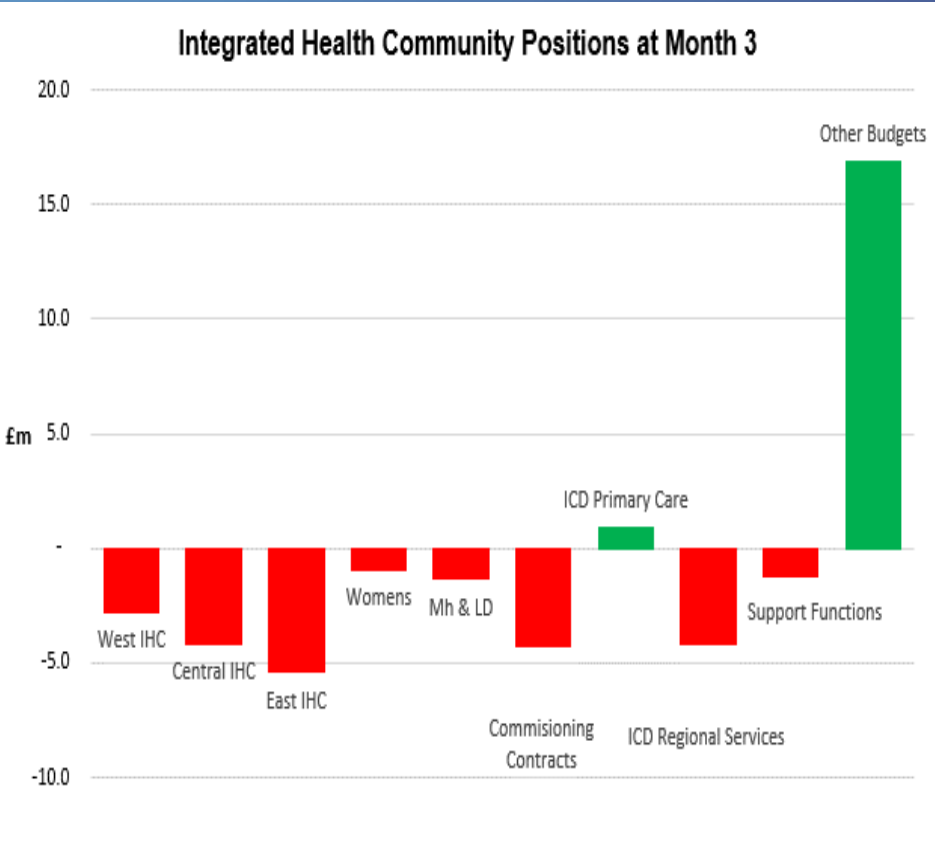
	Actual			Forecast									2026/27 Cumulative against Plan			
	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	Budget	Actual	Variance	Variance
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	%
Revenue Resource Limit	(197.0)	(197.3)	(200.1)	(198.2)	(195.4)	(198.1)	(197.5)	(196.7)	(198.6)	(197.4)	(195.7)	(197.0)	(594.5)	(594.5)	0.0	0.0%
Miscellaneous Income	(14.7)	(15.4)	(15.3)	(15.0)	(14.9)	(15.0)	(15.0)	(15.0)	(15.1)	(15.0)	(15.0)	(15.8)	(43.2)	(45.4)	(2.2)	5.1%
Health Board Pay Expenditure	101.6	102.4	104.9	102.0	102.0	102.4	101.9	101.9	102.0	102.4	102.2	102.0	306.4	308.9	2.5	0.8%
Non-Pay Expenditure	115.5	115.9	116.7	115.8	112.3	113.8	113.1	112.4	114.1	112.5	110.7	113.1	331.3	348.1	16.8	5.1%
Total Deficit / (Surplus)	5.4	5.6	6.2	4.5	4.0	3.0	2.5	2.5	2.5	2.5	2.2	2.2	0.0	17.1	17.1	
Planned Deficit	3.6	3.6	3.6	3.6	3.6	3.6	3.6	3.6	3.6	3.6	3.6	3.6	10.8	0.0	10.8	100.00%
Total Deficit / (Surplus) above Plan	1.8	2.0	2.6	0.9	0.4	(0.6)	(1.1)	(0.7)	(1.1)	(1.1)	(1.4)	(1.4)	10.8	17.1	6.4	



- The Health Board’s in-month position is reporting a deficit of £6.2m and is £2.6m adverse to the Month 3 profiled financial plan deficit of £3.6m.
- Year-to-date position is reporting a deficit of £17.1m, £6.4m adverse to the planned year to date £10.8m deficit. The cumulative shortfall on savings delivery is £3.4m. Targeted savings delivery for quarter 1 totals £11.4m (3/12ths of the annual target of £46m) with savings delivered to date totalling £8.1m. Of these savings, £2.1m is budget releasing, and therefore resulting in a £9.4m shortfall in budget extractable savings compared to year to date target.
- 2026/27 forecast position is to deliver the planned deficit of £43m, which is in line with the financial plan for the year.
- Focus should remain on containing cost overruns and recovering the in-month deficit. Enhanced Grip and Control actions implemented during 2025-26 will continue in 2026-27 as necessary, including:
 - **Non-Pay Expenditure Controls** – Additional controls will be widened to all non-pay categories which do not directly impact clinical care or are covered by reasonable adjustments” under H&S legislation. Controls are also extended to include Travel Bureau requests and orders which are processed directly to Stores.
 - **Procurement** – Review all pending requisitions in Oracle, cancelling any that are not critically urgent.
 - **Pay** – With immediate effect, a freeze on all non-clinical external recruitment and further oversight for any clinical posts prior to recruitment.
 - **Temporary Workforce** – Additional oversight and scrutiny for use of temporary workforce through the relevant Clinical Executive leadership.

Divisional Positions

	In Month				Cumulative				Forecast Year End Variance against the Planned Deficit
	Budget	Actual	Variance to Plan	Variance e to Plan	Budget	Actual	Variance to Plan	Variance e to Plan	
	£m	£m	£m	%	£m	£m	£m	%	
WG RESOURCE ALLOCATION	(200.1)	(200.1)	0.0	0%	(594.5)	(594.5)	0.0	0%	0.0
WEST INTEGRATED HEALTH COMMUNITY									
Management	0.1	0.1	0.0		0.4	0.3	0.0		0.1
West Area	18.7	19.0	(0.2)		55.3	55.9	(0.6)		(4.0)
Ysbyty Gwynedd	13.1	13.7	(0.6)		38.0	40.0	(2.0)		(8.4)
Facilities	1.2	1.3	(0.1)		3.7	3.9	(0.2)		(0.4)
Total West	33.2	34.1	(0.9)	-3%	97.4	100.1	(2.8)	-3%	(12.8)
CENTRAL INTEGRATED HEALTH COMMUNITY									
Management	0.2	0.2	(0.0)		0.4	0.5	(0.0)		(0.1)
Central Area	24.3	24.8	(0.6)		71.6	73.2	(1.7)		(10.7)
Ysbyty Glan Clwyd	15.8	16.1	(0.3)		46.1	48.5	(2.4)		(13.4)
Facilities	1.5	1.5	(0.0)		4.6	4.6	(0.1)		(0.3)
Total Central	41.7	42.7	(0.9)	-2%	122.7	126.8	(4.1)	-3%	(24.5)
EAST INTEGRATED HEALTH COMMUNITY									
Management	0.1	0.1	0.0		0.3	0.3	0.0		0.1
East Area	27.3	28.3	(1.0)		80.6	83.2	(2.6)		(12.3)
Ysbyty Wrexham Maelor	13.5	14.6	(1.1)		39.7	42.4	(2.7)		(12.0)
Facilities	1.4	1.4	(0.0)		4.2	4.3	(0.1)		(0.5)
Total East	42.3	44.4	(2.1)	-5%	124.8	130.2	(5.4)	-4%	(24.7)
Total Midwifery and Women's Services	4.6	4.8	(0.3)	-6%	13.3	14.2	(0.9)	-7%	(3.3)
Total Mental Health and LDS	16.6	17.3	(0.6)	-4%	50.4	51.7	(1.3)	-3%	(8.1)
Total Commissioning Contracts	26.9	28.3	(1.4)	-5%	80.4	84.7	(4.3)	-5%	(14.6)
INTEGRATED CLINICAL DELIVERY PRIMARY CARE									
Covid Programmes	0.0	0.0	0.0		0.0	0.0	0.0		0.0
Dental North Wales	3.1	2.9	0.2		9.4	8.7	0.7		1.0
Community Dental Services	0.7	0.6	0.0		1.9	1.8	0.1		0.3
Other Primary Care	0.2	(0.0)	0.2		0.4	0.3	0.1		(0.1)
Total Integrated Clinical Delivery Primary care	3.9	3.5	0.4	11%	11.7	10.8	0.9	8%	1.2
INTEGRATED CLINICAL DELIVERY REGIONAL SERVICES									
Provider Income	(1.9)	(1.8)	(0.1)		(5.8)	(6.6)	0.8		2.6
Diagnostic and Specialist Clinical Support	7.3	8.4	(1.1)		21.6	25.2	(3.6)		(12.8)
Cancer Services	6.4	7.0	(0.6)		19.0	20.4	(1.4)		(6.6)
Total Integrated Clinical Delivery	11.8	13.6	(1.9)	-16%	34.9	39.0	(4.2)	-12%	(16.9)
Total Service Support Functions	14.8	15.2	(0.4)	-2%	45.0	46.2	(1.2)	-3%	(6.0)
Total Other Budgets	7.9	2.5	5.4	68%	24.7	7.9	16.9	68%	109.7
Total Health Board Position	3.6	6.2	(2.6)		10.8	17.1	(6.4)		(0.0)



- In-Month Position is reporting a deficit of £6.2m, which is £2.6m higher than the profiled Financial Plan deficit of £3.6m.
- The forecast position is to deliver a deficit of £43.0m, which is in line with the financial plan for the year.
- Further detail on Pay and Non-Pay spend is reported in Slide 6 and 11.

Expenditure – Pay & Non-Pay

Pay Costs	2026-27												Cumulative			Full Year Forecast
	Actual			Forecast									YTD Budget	YTD Actual	YTD Variance	
	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	£m	£m	£m	£m
Administrative & Clerical	14.0	13.9	13.9	14.7	14.7	14.8	14.7	14.7	14.7	14.8	14.8	14.7	48.4	41.8	6.5	188.3
Medical & Dental	23.3	23.5	25.5	22.7	22.8	22.8	22.7	22.7	22.7	22.8	22.8	22.7	66.8	72.3	(5.5)	290.6
Nursing & Midwifery Registered	31.2	31.5	31.9	31.5	31.5	31.6	31.5	31.5	31.5	31.7	31.6	31.5	93.1	94.6	(1.5)	402.7
Additional Clinical Services	15.3	15.6	15.6	15.6	15.6	15.7	15.6	15.6	15.6	15.7	15.6	15.6	44.5	46.5	(2.0)	199.3
Add Prof Scientific & Technical	4.4	4.4	4.4	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	13.8	13.1	0.7	50.9
Allied Health Professionals	6.8	6.8	6.9	6.8	6.8	6.8	6.8	6.8	6.8	6.8	6.8	6.8	19.8	20.5	(0.8)	86.4
Healthcare Scientists	1.9	1.9	1.9	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	5.7	5.7	0.0	21.6
Estates & Ancillary	4.6	4.7	4.7	4.9	4.9	4.9	4.9	4.9	4.9	4.9	4.9	4.9	14.1	14.0	0.1	62.2
Students	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.3	0.0	1.2
Health Board Total	101.6	102.4	104.9	102.0	102.0	102.4	101.9	101.9	102.0	102.4	102.2	102.0	306.4	308.9	(2.5)	1303.3
Other Services (Incl. Primary Care)	3.2	3.2	3.3	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	8.5	9.6	1.1	38.4
Total Pay	104.7	105.6	108.2	105.2	105.3	105.6	105.1	105.1	105.2	105.6	105.4	105.2	314.8	318.5	(3.6)	1341.7

Non-Pay Costs as per Monitoring Return Table	2026-27												Cumulative			Full Year Forecast
	Actual			Forecast									YTD Budget	YTD Actual	YTD Variance	
	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	£m	£m	£m	£m
Primary Care Contractor	22.3	22.2	22.0	22.4	22.4	22.5	22.5	22.6	22.7	22.7	22.7	22.7	68.4	66.6	1.8	269.8
Primary Care - Drugs & Appliances	11.1	10.6	11.8	12.0	10.6	11.7	11.4	10.9	12.0	10.9	10.3	11.2	34.2	33.5	0.7	134.4
Provider Services - Non Pay	20.1	19.6	20.1	17.9	17.7	18.0	17.9	18.1	18.1	17.9	17.9	18.0	39.8	59.8	(19.9)	221.3
Secondary Care - Drugs	9.2	9.1	9.3	9.5	9.0	9.4	9.3	9.1	9.5	9.0	8.8	9.2	29.7	27.6	2.1	110.3
Healthcare Services Provided by Other NHS Bodies	33.4	33.9	33.7	33.8	33.6	33.6	33.6	33.6	33.6	33.6	33.6	33.8	99.6	101.0	(1.4)	404.0
Continuing Care and Funded Nursing Care	11.9	12.4	12.6	13.3	12.4	12.1	12.4	12.1	12.4	12.4	11.5	12.4	36.3	37.0	(0.7)	148.1
Other Private & Voluntary Sector	3.5	3.5	2.8	2.6	2.4	2.2	1.7	1.7	1.7	1.7	1.7	1.7	11.2	9.8	1.4	27.0
Joint Financing and Other	0.5	0.4	0.4	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.8	1.3	(0.5)	4.3
Losses, Special Payments and Irrecoverable Debts	0.3	0.3	0.6	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.8	1.2	(0.5)	4.7
Non-pay costs	112.3	112.1	113.2	112.3	108.8	110.2	109.6	108.9	110.6	109.0	107.2	109.6	320.8	337.6	(16.8)	1323.8
AME/DEL Depreciation	3.2	3.9	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5	10.5	10.5	0.0	42.1
Total non-pay	115.5	115.9	116.7	115.8	112.3	113.8	113.1	112.4	114.1	112.5	110.7	113.1	331.3	348.1	(16.8)	1365.9

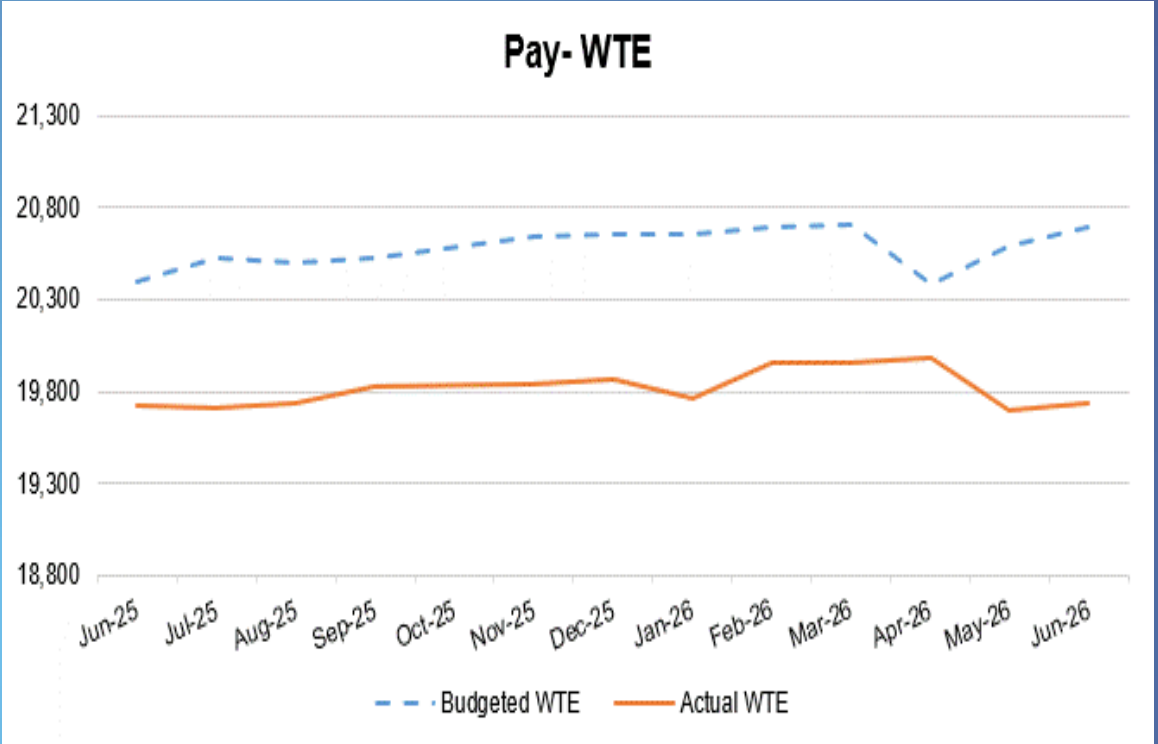
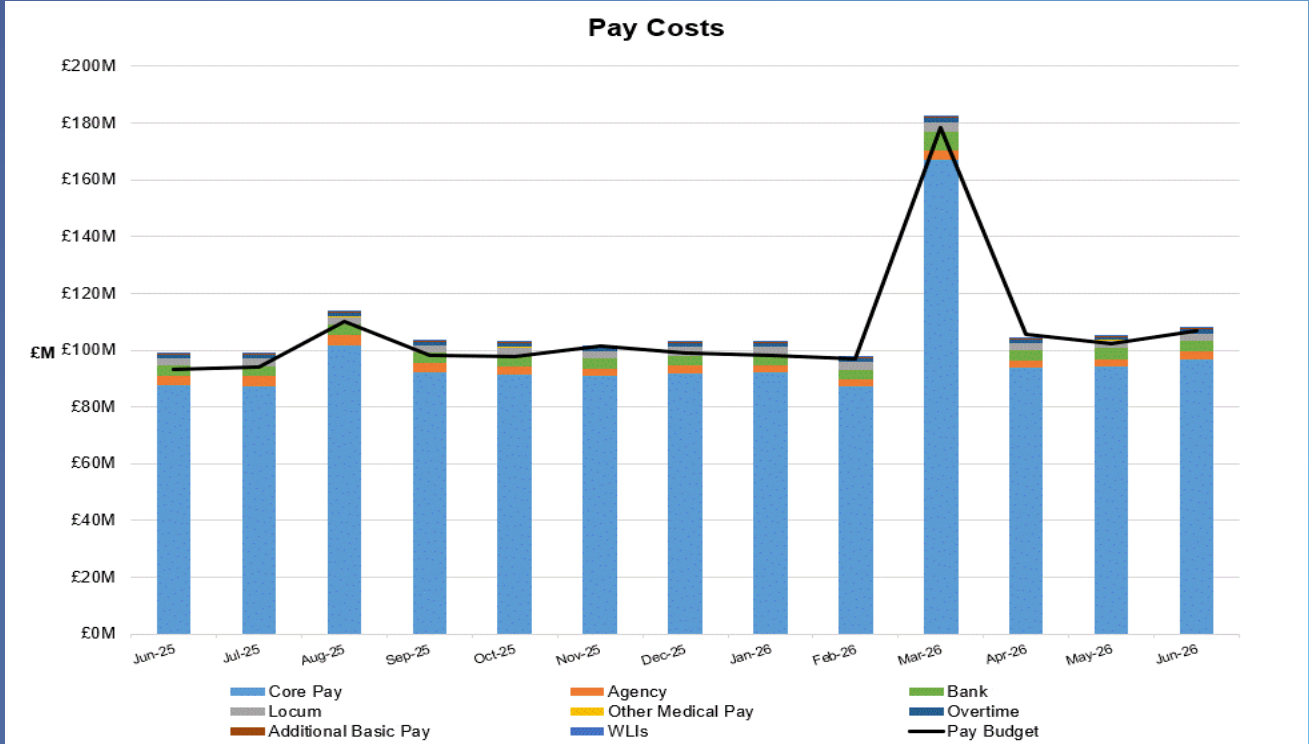
Health Board Pay:

- Month 3 Provider Services Pay increased by £2.5m (2.4%) from previous month total pay, of which £2.1m is the year to date impact of the Medical & Dental Pay Award..
- Variable Pay totals £11.4m for June, an increase of £0.1m from previous month driven by increases of £0.1m in Agency, £0.1m in Overtime and £0.1m in WLI offset by a £0.2m reduction in Bank and £0.1m reduction in Locum spend.
- Other detail on Variable Pay is reported in Slide 7 and Agency in Slide 9.

Non-Pay Expenditure (excluding Depreciation):

- Total Non-Pay expenditure (excluding AME/DEL Depreciation) increased by £1.1m from previous month.
- Further detail on Non-Pay expenditure movements is reported in Slide 11.

Expenditure – Pay



Variable Pay	Actual						
	2025-26			2026-27			Total
	M10	M11	M12	M01	M02	M03	
	£m	£m	£m	£m	£m	£m	£m
Agency	2.6	2.3	3.1	3.3	2.5	2.6	8.5
Overtime	1.3	1.4	1.6	1.1	1.2	1.3	3.6
Locum	2.7	2.5	3.3	2.6	2.8	2.7	8.1
WLI	0.5	0.4	0.4	0.4	0.4	0.5	1.3
Bank	3.8	3.7	6.5	3.2	4.0	3.8	11.1
Other Non Core	0.1	0.1	0.5	0.1	0.1	0.0	0.2
Additional Hours	0.4	0.4	0.4	0.4	0.4	0.4	1.3
Total	11.2	10.8	15.8	11.2	11.3	11.4	34.0

- June budgeted WTE increased by 95 WTE from May. See Slide 8 for further detail.
- Variable Pay totals £11.4m for June, an increase of £0.1m from previous month driven by increases of £0.1m Agency, £0.1m Overtime and £0.1m WLI, offset by reductions in Bank and Locum spend.

Pay - WTE

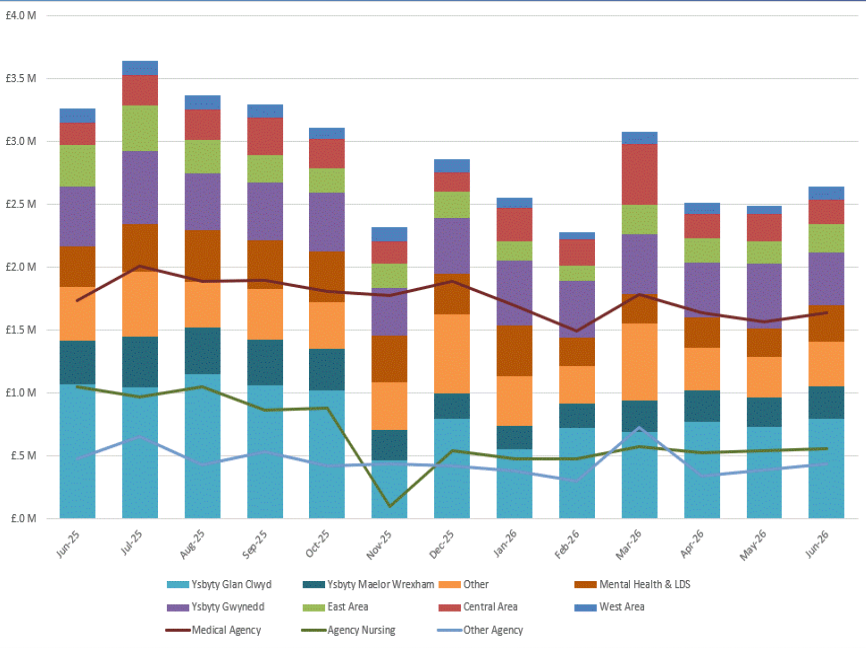
	2025/26						2026/27			
	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	June-26	Movement M3 V M2
Budgeted WTE	20,575	20,637	20,649	20,656	20,693	20,705	20,384	20,593	20,688	95
Actual WTE	19,907	19,844	19,869	19,767	19,952	19,951	19,978	19,691	19,740	49

- Budgeted WTE increased by 95 WTE in June from previous month, with the below table providing further detail on Budgeted WTE movements.
- Actual worked in June is 19,740, an increase of 49 WTE from May.

	2025/26						2026/27				
	WTE Budget						WTE Budget				
	M07 Oct	M08 Nov	M09 Dec	M10 Jan	M11 Feb	M12 Mar	M01 Apr	M02 May	M03 Jun	In Month Movement	Explanation of in-month movements (>5WTE)
West IHC - Management	8	8	8	8	8	8	8	8	8	0	28.52 WTE ED Business Case Nursing (RNs and HCSW) funding draw-down as per approved Business Case
West IHC - West Area	1,575	1,572	1,572	1,572	1,573	1,573	1,567	1,585	1,589	4	
West IHC - Ysbyty Gwynedd	1,839	1,838	1,840	1,841	1,846	1,855	1,836	1,885	1,913	28	
West IHC - Facilities	382	382	382	382	382	382	382	382	382	0	
Centre IHC - Management	8	8	8	8	14	14	15	15	17	2	
Centre IHC - Central Area	2,312	2,310	2,309	2,303	2,307	2,307	2,263	2,296	2,296	-1	
Centre IHC - Ysbyty Glan Clwyd	2,241	2,243	2,245	2,245	2,248	2,250	2,243	2,256	2,258	2	
Centre IHC - Facilities	422	422	421	421	419	419	420	420	420	0	
East IHC - Management	10	10	10	10	10	10	10	10	10	0	
East IHC - East Area	2,476	2,483	2,485	2,481	2,485	2,484	2,470	2,479	2,508	29	
East IHC - Ysbyty Wrexham Maelor	1,906	1,954	1,962	1,970	1,971	1,972	1,908	1,963	1,962	-1	Income Target and Pay Budget set for Flying Start and HEIW
East IHC - Facilities	365	365	365	365	365	366	365	365	365	0	
Midwifery & Womens Services	694	695	696	696	696	695	684	687	693	6	
Mental Health & LDS	2,319	2,327	2,327	2,326	2,327	2,331	2,299	2,324	2,347	23	
COVID Programmes	0	0	0	0	0	0	0	0	0	0	
Dental GDS	14	14	14	14	14	14	14	14	15	0	
Dental CDS	168	168	167	165	165	165	166	166	166	0	
Other Primary Care	15	15	15	15	15	15	15	15	15	0	
Diagnostics & SCS	1,024	1,028	1,028	1,029	1,031	1,030	1,023	1,023	1,024	1	
Cancer Services	423	423	423	424	423	423	423	425	425	0	
Corporate	2,251	2,249	2,249	2,255	2,269	2,265	2,147	2,146	2,151	5	20.70 WTE Crisis Care Model SIF, 1.00 WTE Band 6 funded by JCC & 1.00 WTE WG funded Wellbeing Practitioners.
Med ED/R&D	123	124	125	125	125	127	126	126	123	-3	
Health Board Total	20,575	20,637	20,650	20,656	20,693	20,705	20,384	20,593	20,688	95	N/A

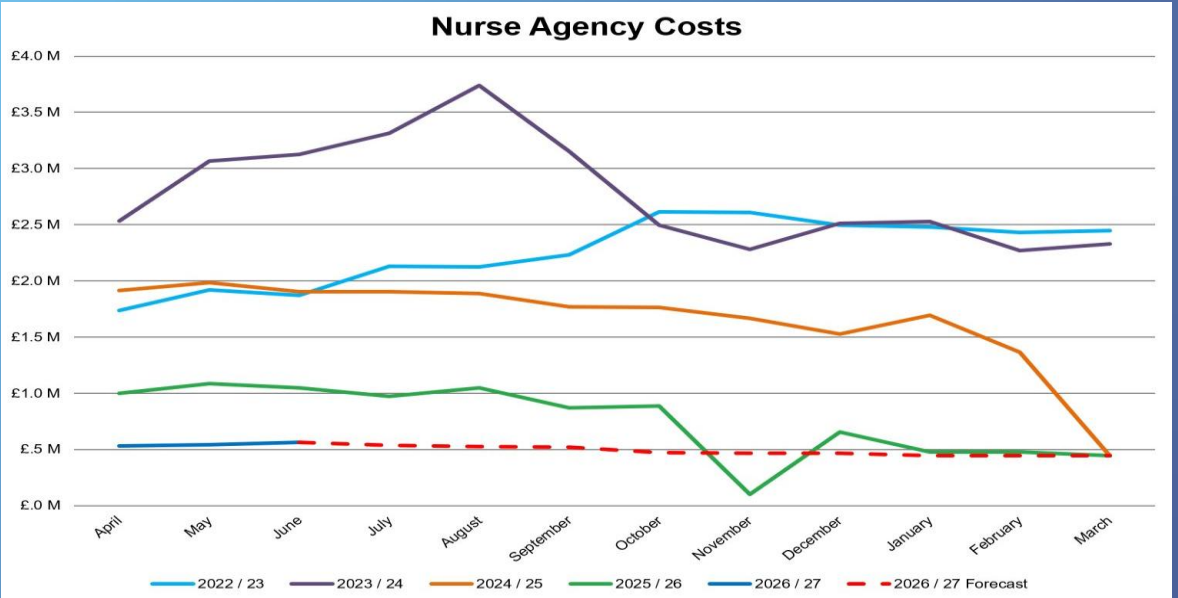
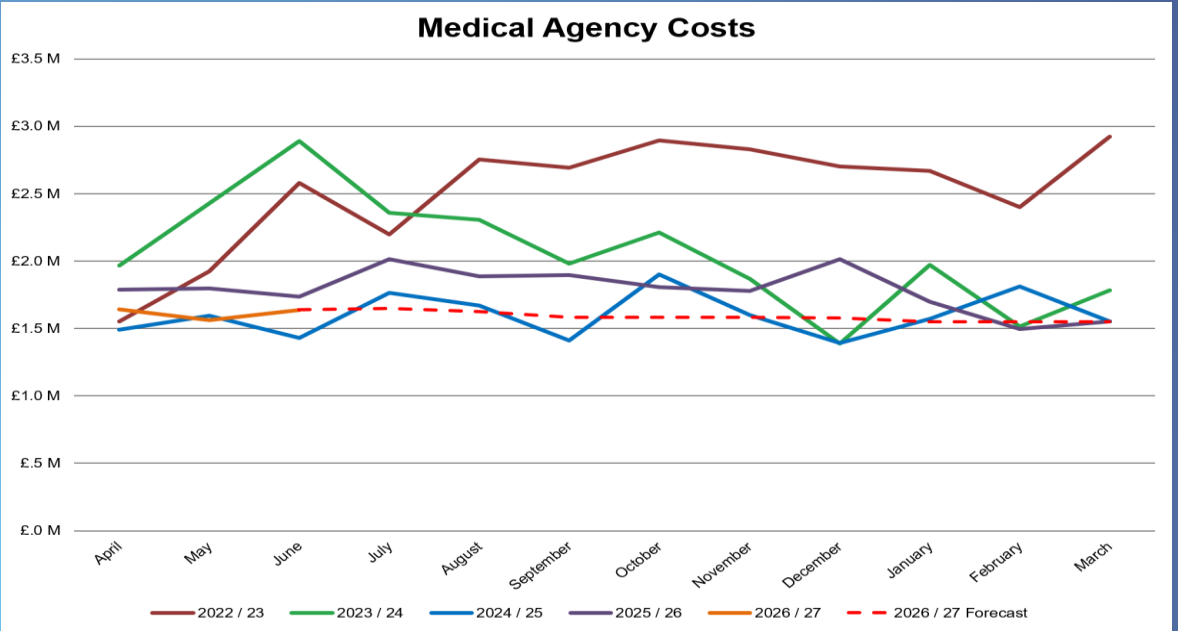
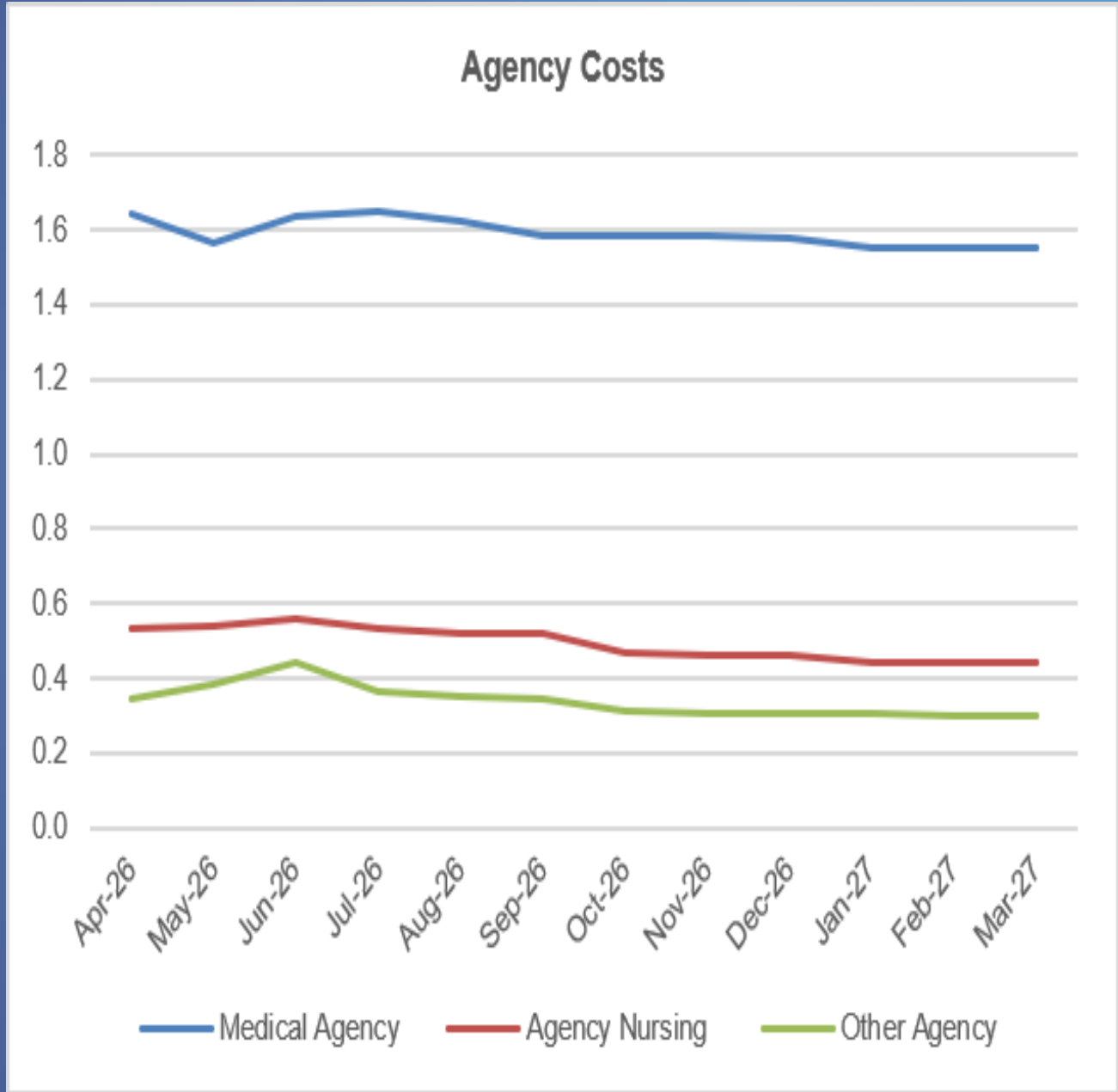
Pay Costs – Agency

	2026-27 Agency Spend £m												YTD Expenditure £m	Forecast £m
	Actual			Forecast										
	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27		
West Area	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	1.1
Central Area	0.2	0.2	0.2	0.2	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.6	1.7
East Area	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.6	2.3
Ysbyty Gwynedd	0.4	0.5	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	1.4	4.8
Ysbyty Glan Clwyd	0.8	0.7	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	2.3	9.4
Ysbyty Maelor Wrexham	0.3	0.2	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.7	3.1
Mental Health & LDS	0.2	0.2	0.3	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.8	2.9
Womens	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.4	1.4
Other incl pan BCU Cancer Servcies and Corporate	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.6	2.4
Total Agency	2.5	2.5	2.6	2.5	2.5	2.5	2.4	2.4	2.3	2.3	2.3	2.3	7.7	29.1



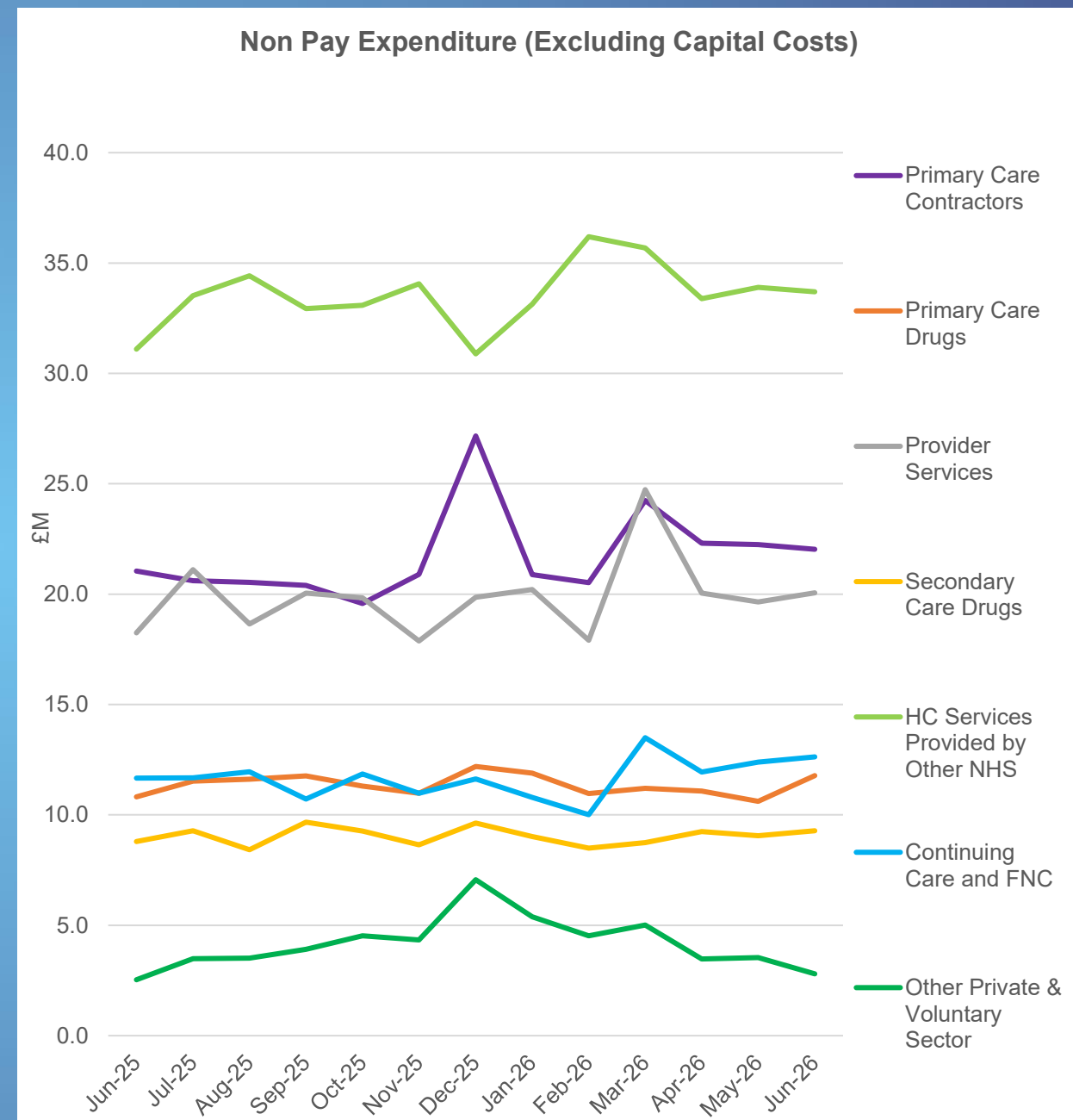
- Agency expenditure for June (Month 3) is £2.6m (2.4% of total pay). Monthly average spend in 2025/26 was £3.1m.
- 2026/27 Full year Agency forecast outturn is £29.1m (2.3% of total pay), a £7.5m reduction compared to the £36.6m 2025/26 full year actual agency spend and a 20% reduction compared to the 30% enabling target.
- Month 3 Medical Agency expenditure is £1.6m, in line with May. Monthly average medical agency expenditure for 2025/26 was £1.8m. Medical Agency spend is predominantly within Ysbyty Glan Clwyd (£0.5m), Ysbyty Gwynedd (£0.3m), Ysbyty Wrexham Maelor (£0.2m), Women's (£0.1m) and Mental Health (£0.2m), covering medical vacancies and sickness.
- Registered Nurse agency costs totalled £0.6m for the month, an increase of £0.1m from previous month, being predominantly within Ysbyty Glan Clwyd (£0.2m), Ysbyty Maelor Wrexham (£0.1m), and Gwynedd (£0.1m).
- Other agency costs totalled £0.4m in June, mainly consisting of Allied Health Professionals Agency costs.
- Work continues to support delivery of the Cabinet Secretary enabling target of 30% reduction in agency spend. Focused actions are being undertaken to reduce agency utilisation, particularly within the medical workforce and focus remaining on strengthening existing bank capacity where appropriate across all staff groups.

Pay Costs – Agency



Expenditure - Non-Pay

- Primary Care Contractor:** June in-month expenditure decreased by £0.2m (1.0%) from May spend, being mainly due to an accountancy gain reported in-month.
- Primary Care Drugs:** Expenditure is £1.2m (9.9%) higher than May spend of which £0.4m is an under accrual relating to previous months following receipt of April data due to both price and volume of items prescribed.
- Provider Services Non-Pay:** Expenditure is £0.4m (2.0%) higher than May spend, with the increase being reported in Clinical Services & Supplies non pay expenditure being partly driven by increased orthopaedic activity implants expenditure. June expenditure is £3.6m higher than forecast for the month due to planned mitigations yet to be finalised reprofiled into future months.
- Secondary Care Drugs:** Expenditure increased by £0.2m (2.4%) from previous month, with the in-month increase predominantly reported in Cancer Services. June patient activity in Cancer Services was 5,508, an increase of 14.9% above the 25/26 monthly average of 4,795.
- Healthcare Services provided by Other NHS Bodies:** Expenditure is £0.2m (0.6%) less than previous month and is £0.1m higher than forecast for the month. Accountancy gains of £0.5m have been reported in Month 3, however this is offset by additional costs of 2 new CAMHS Out of Area placements and an increase in JCC English contracts for Merseyside & West Lancashire, Christie and Manchester.
- Continuing Health Care (CHC) and Funded Nursing Care (FNC):** Expenditure increased by £0.2m (2.0%) from previous month and is £0.1m higher than forecast for the month due to an increase in both MHLT and adult care packages in Area Teams.
- Other Private & Voluntary Sector:** In-month expenditure decreased by £0.7m (26.5%) from previous month and is £0.3m less than forecast for the month due to an adjustment in relation to an over provision included within previous month and an in-month reduction in private rehabilitation costs following discharge of patients.



Allocations

	£m
Total Allocations Received	2,348.9
Total Allocations Anticipated	20.3
Total Welsh Government Income	2,369.2

- The Health Board is funded in the main from the Welsh Government allocation via the Revenue Resource Limit (RRL). Total Revenue Resource Limit (RRL) for the year is 2,369.2m.
- Confirmed allocations to date are £2,348.9m.
- Further anticipated allocations in year total £20.3m as detailed in the table.



Description	£m
Allocations Received	2,348.9
Total Allocations Received	2,348.9

Description	£m
Allocations anticipated	
Donated Asset Depreciation	1.5
Removal of IFRS-16 Leases (Revenue)	-4.8
WRP Forecast Contribution	-34.0
IM&T Refresh Programme	2.6
Prevention and Early Years fund allocation 2026/27	1.2
A4C Payaward funding	33.7
All Ages Mental Health Digital Solution 26/27	2.4
ESR charges 2026-27 "Future Workforce Solution - WG Support"	2.3
ESMCP Resources / CRS / MDVS / ARRP	0.7
GMS Disp Doctors / PADMS & List Size funding	1.2
26/27 Payaward funding for M&D	8.4
Neurodivergence Improvement Programme	2.0
MH Advocacy funding	0.5
Other	2.5
Total Allocations Anticipated	20.3

Risks

- The below are risks to the Health Board’s financial position for 2026/27. Where it is clear of specific costs for risks and opportunities, these are incorporated into the forecast position.

	Risks – Pressures not assumed in Forecast Outturn		
1	Risk of conditionally recurrent funding removed	£82.0m	Medium
2	Risk that Prescribing costs may rise by up to 4% when growth of certain items is included	£2.0m	Medium
3	Risk of final actual Band 2/3 costs being higher than the provision	TBC	Medium
4	Resident Doctors New contract impact	TBC	Medium
5	Impact of new contracts for Dental, GMS and Community Pharmacy	TBC	Medium
	Risks – Benefits assumed in the Forecast Outturn		
1	Non-Delivery of Planned Mitigations yet to be finalised	£20.0m	Low
2	Dental Ring Fenced Allocation Underspend potential clawback	£4.0m	Medium
	Total Risks	£108.0m	

Balance Sheet & Cash

- Closing cash balance as at 30th June 2026 was £5.433m, which included £2.339m cash held for revenue expenditure and £3.094m for capital projects.
- The Health Board is currently forecasting a closing cash balance for 2026-27 of (£35.061m) made up of (£40.517m) revenue cash and £5.456m capital cash.
- The forecast closing cash balance assumes working balance support of £3.997m for capital payments relating to Right of Use Assets and £8.658m for movements in revenue balances.

	Opening Balance Beginning of Apr-26 £'m	Closing Balance End of Jun-26 £'m	Forecast Closing Balance End of Mar-27 £'m
Non-Current Assets			
Property, plant and equipment	812.0	804.4	829.3
Intangible assets	1.2	1.1	1.2
Trade and other receivables	185.3	185.1	185.3
Non-Current Assets sub total	998.5	990.6	1015.7
Current Assets			
Inventories	21.7	22.0	21.7
Trade and other receivables	140.7	132.7	135.7
Other financial assets	0.0	0.0	0.0
Cash and cash equivalents	8.0	5.4	-35.1
Non-current assets classified as held for sale	0.0	0.0	0.0
Current Assets sub total	170.4	160.1	122.4
TOTAL ASSETS	1168.9	1150.7	1138.1
Current Liabilities			
Trade and other payables	245.2	228.9	232.6
Borrowings (Trust Only)	0.0	0.0	0.0
Other financial liabilities	0.0	0.0	0.0
Provisions	49.6	50.9	44.6
Current Liabilities sub total	294.8	279.8	277.2
NET ASSETS LESS CURRENT LIABILITIES	874.1	871.0	860.9
Non-Current Liabilities			
Trade and other payables	21.2	21.2	21.2
Borrowings (Trust Only)	0.0	0.0	0.0
Other financial liabilities	0.0	0.0	0.0
Provisions	185.8	185.8	185.8
Non-Current Liabilities sub total	207.0	207.0	207.0
TOTAL ASSETS EMPLOYED	667.1	664.0	653.9
FINANCED BY:			
Taxpayers' Equity			
General Fund	412.6	409.5	399.5
Revaluation Reserve	254.5	254.5	254.5
PDC (Trust only)	0.0	0.0	0.0
Retained earnings (Trust Only)	0.0	0.0	0.0
Other reserve	0.0	0.0	0.0
TOTAL FINANCED BY	667.1	664.0	653.9

Capital

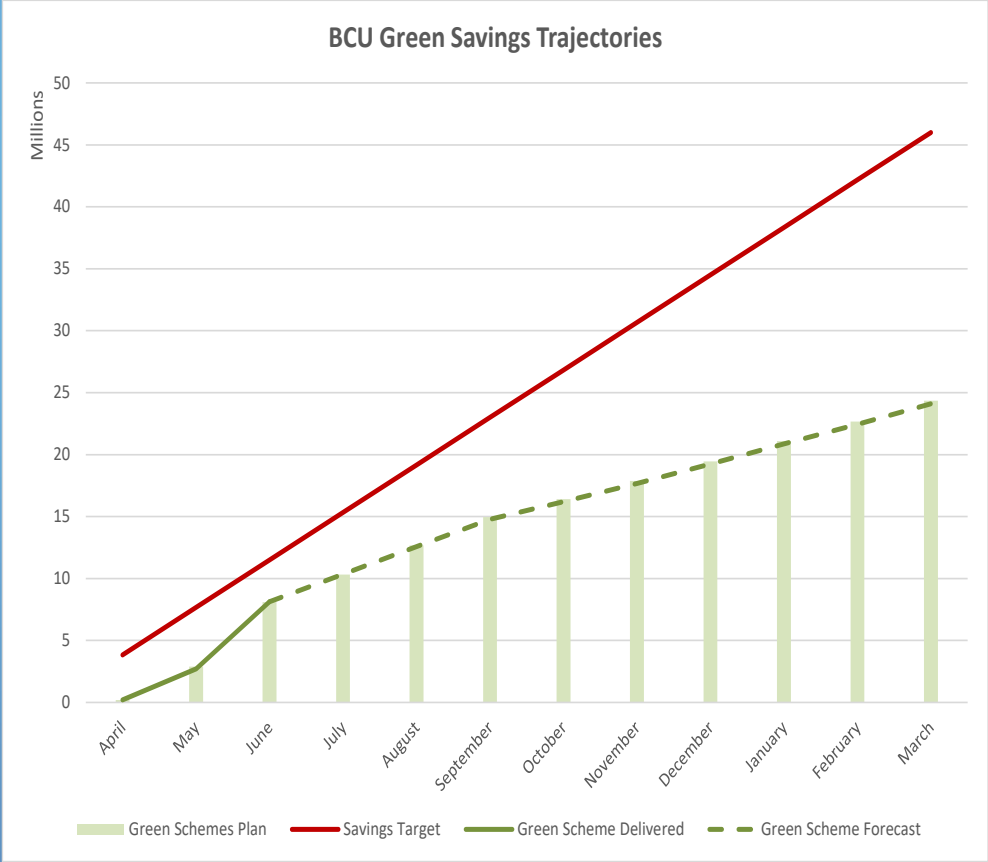
BUDGET 2025/26					
Capital Resource Limit 2026/27	£m	Brief Overview / Update			
WG Discretionary Capital	14.1	The purpose of this dashboard is to brief the committee on the delivery of the approved capital programme to enable appropriate monitoring and scrutiny. The report provides an update, by exception, on the status and progress of the major capital projects and the agreed capital programmes. The report also provides a summary on the progress of expenditure against the capital resources allocated to the Heath Board by the Welsh Government through the Capital Resource Limit (CRL).			
All Wales Scheme	44.5				
CRL	58.6				
CAPITAL PROGRAMME 2026/27	Initial Programme (£m)	Year to Date (£m)	Forecast Outturn (£m)	Current Over/Under Commitment (£m)	Comments
Divisions	4.5	0.8	5.9	1.4	Programmed planned works progressing supported by tenders/purchase orders.
Operational Estates	1.6	0.1	1.6	0.0	Programmed planned works progressing supported by tenders/purchase orders.
Medical Devices	5.0	0.4	5.0	0.0	Programmed planned works progressing supported by tenders/purchase orders.
Informatics	2.5	0.0	2.5	0.0	Programmed planned works progressing supported by tenders/purchase orders.
Mental Health	0.0	0.0	0.0	0.0	Programmed planned works progressing supported by tenders/purchase orders.
All wales funding brokerage to be re-provided from discretionary	0.6	0.0	0.6	0.0	Brokerage managed within the programme.
WG Discretionary Capital	14.1	1.4	15.5	1.4	Over Commitment
MAJOR CAPITAL SCHEMES (with in year spend)	Programme (£m)	Year to Date (£m)	Forecast Outturn (£m)	Current Over/Under Commitment (£m)	Comments
Royal Alexander Hospital - Phase 1	20.1	0.0	18.7	(1.4)	The principle contractor is MTX. The demolition contractor has been appointed. Works on site is due to start in July 2027.
Replacement Diagnostic and Treatment Equipment	1.6	0.5	1.6	0.0	The first Linac has been installed with the second Linac due for installation in quarter 2.
Electrical Infrastructure upgrade - Ysbyty Glan Clwyd	4.5	0.3	4.5	0.0	Construction has progressed well to both substations and they are on programme.
TEF - Fire	2.4	0.0	2.4	0.0	The TEF funding is across a number of projects and being delivered on over a 2 year programme.
TEF - Infrastructure	5.0	-0.1	5.0	0.0	The TEF funding is across a number of project sand being delivered on over a 2 year programme.
TEF - Decarbonisation	2.5	0.0	2.5	0.0	The TEF funding is across a number of projects and being delivered on over a 2 year programme.
TEF - Mental Health	2.1	0.0	2.1	0.0	The TEF funding is across a number of projects and being delivered on over a 2 year programme.
TEF - Infection Prevention Control	0.6	0.0	0.6	0.0	The TEF funding is across a number of projects and being delivered on over a 2 year programme.
TEF - Decontamination	0.8	0.0	0.8	0.0	The TEF funding is across a number of projects and being delivered on over a 2 year programme.
Redevelopment the Hospital Helipad at Ysbyty Gwynedd	1.0	0.3	1.0	0.0	The contractor has started on site and is on programme to complete quarter 3 of this financial year.
Diagnostic Equipment 2026-27	2.5	0.0	2.5	0.0	Design is complete and have commenced procurement preparations.
End of Year Digital Funding 2025-26	0.4	0.4	0.4	(0.0)	Complete.
Mental Health Quality and Safety Schemes 2026-27	0.7	0.0	0.7	0.0	In detailed design stage, all works to be complete by March 2027.
North Wales Medical School Fees	0.4	0.0	0.4	0.0	Works to prepare business case is ongoing. We are targeting business case submission to be quarter 4.
All Wales Capital	44.5	1.5	43.1	-1.4	
Total	58.6	2.8	58.6	0.0	

- Approved Capital Resource Limit (CRL) for 2026/27 is £58.6m.
- The forecast outturn and subsequent variance relating to Royal Alexandra Hospital – Phase 1 and Electrical Infra structure upgrade – Ysbyty Glan Clwyd, reflects a revised CRL agreed with Welsh Government. Once a revised CRL has been received the above variances will clear and the Health Board will forecast spending the CRL in full.

Savings Performance against Target

- The Health Board’s financial plan has set a target of £46.0m to be delivered in 2026/27, profiled on an equal twelfth's basis with savings identification, reporting and monitoring developed through a Value and Sustainability thematic model.
- Full year value of Green Schemes total £24.1m, of which £13.5m is recurring, with a full year effect of £19.9m. £20.8m is cash releasing, £2.4m are accountancy gains and £0.9m is income generation and cost avoidance schemes. Of the full year value only £10.1m of these savings have been identified as budget releasing.
- Targeted savings delivery for quarter 1 totals £11.4m (3/12ths of the annual target of £46m) with savings delivered to date totalling £8.1m. However, of these savings £2.1m is budget releasing which results in a £9.4m shortfall in budget extractable savings verse that targeted year to date. In-month delivery is £5.4m, against the £3.8m target.
- Red schemes and pipeline opportunities total £19.5m, work is progressing to convert into green schemes.

			Budget Releasing Savings						
Services	Total Saving YTD £m	Total Saving Forecast £m	Recurring Target £m	Forecast - Delivery £m	Forecast - Variance (+ve = adverse) £m	FYE Savings forecast £m	YTD - Target £m	YTD - Delivered £m	YTD - Variance (+ve = adverse) £m
West Integrated Health Community	0.7	3.5	7.1	2.3	4.7	2.8	1.8	0.3	1.4
Central Integrated Health Community	1.6	4.7	9.6	0.4	9.2	0.4	2.4	0.1	2.3
East Integrated Health Community	1.4	4.2	9.1	1.7	7.4	0.5	2.3	0.6	1.7
MHLD	0.9	4.3	4.3	4.3	0.0	4.9	1.1	0.9	0.2
Commissioning Contracts	0.0	0.0	1.1	0.0	1.1	0.0	0.3	0.0	0.3
Womens Services	0.0	0.1	7.0	0.1	7.0	0.0	1.8	0.0	1.7
Diagnostic and Specialist Clinical Support	0.3	0.4	1.9	0.1	1.8	0.1	0.5	0.0	0.5
Cancer Services	0.4	1.0	1.8	0.7	1.1	1.5	0.5	0.1	0.4
Dental Services	0.0	0.0	0.2	0.0	0.1	0.0	0.0	0.0	0.0
Service Support Functions & Other Budgets	0.2	0.4	3.9	0.4	3.5	0.2	1.0	0.2	0.8
Grip and Control Savings	2.7	5.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Saving Total	8.1	24.1	46.0	10.1	35.9	10.3	11.5	2.1	9.4
Non Budget Releasing Savings				11.7	-11.7	9.6		3.6	-3.6
Accountancy Gains			0.0	2.4	-2.4	0.0	0.0	2.4	-2.4
Total	8.1	24.1	46.0	24.1	21.9	19.9	11.5	8.1	3.4



Health Board

AUDIT COMMITTEE ASSURANCE REPORT

Dyddiad y Cyfarfod Date of Meeting	30 July 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Chair	Paul Lambert
Executive Lead	Russell Caldicott, Executive Director of Finance
Report Author name and title	Philippa Peak-Jones, Head of Corporate Governance

Agenda Item	AC26.66 Financial Annual Accounts 2025/26	
Level of Assurance (Third Line)		The Committee provides moderate assurance to the Board. Whilst there are areas of strong financial control and improvement, delivery against statutory financial duties has not been achieved, and there remain ongoing structural financial pressures and risks to sustainability
Summary of Key Messages	- Accounts were submitted on time - The first financial duty to break even had not been achieved. - The net deficit was reported as £17.3m, contributing to a 3-year cumulative deficit of £49.2m. - The total gross expenditure was approximately £2.6bn (net operating costs ~ £2.46bn). - Capital underspend of £65k was within tolerance limits. - There had been strong payment performance of 96.9% of invoices paid within 30 days. - Agency spend had reduced significantly (approx. £72.7m → £36.6m). - Medical agency costs had increased - Expenditure increases had mainly been driven by substantive staff costs and clinical supplies and services	



	• There had been limited shift toward community care despite policy ambition. • Significant costs had been incurred in Primary care (notably GMS and prescribing) and also commissioned services (notably Joint Commissioning Committee and Continuing Health Care/Funded Nursing Care)
Escalation of Risk and issues	• Financial Pressure Risk: Ongoing concern regarding the disproportionate growth in acute expenditure relative to primary care, with additional uncertainty around increasing non-Welsh provider spend (cost versus activity drivers not fully understood). • System Partnership Risk: Pooled budget arrangements are limited in scope (primarily community equipment) and offer minimal practical risk-sharing, reducing the system's ability to mitigate financial and demand pressures collaboratively. • Demand and Capacity Risk: Insufficiently developed long-term demand modelling, particularly in relation to Continuing Healthcare and the ageing population, presents a risk to future financial sustainability and service planning. • Procurement and Governance Risk: Weaknesses in forward procurement planning and supply chain management increase the likelihood of reactive decision-making, including reliance on Chair's Actions, potentially undermining governance controls and compliance expectations.
Recommendation to Board	The Committee approved the Annual Report and Accounts for onward submission to the Board.

Agenda Item	AC26.67 Annual Report 2025/26	
Level of Assurance (Third Line)		Overall assurance is assessed as Limited, reflecting strengthening governance arrangements but continued delivery challenges, sustained risks above appetite, and the need for further improvement in control effectiveness and implementation.
Summary of Key Messages	• Governance and Board Effectiveness: Governance arrangements are assessed as sound and continuing to strengthen, supported by Audit Wales and Internal Audit. Further improvements are expected through the Board development programme.	



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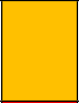
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	• Progress and Maturity: Positive progress has been made in strengthening governance frameworks, risk management, and Board transparency and effectiveness. • Risk Profile and Delivery Gap: Despite improved frameworks, impact is not yet translating into reduced risk exposure, with 10 of 11 corporate risks remaining above appetite and limited movement in risk scores. • Operational and Financial Performance: Significant challenges remain across key performance areas (urgent and emergency care, planned care, cancer, diagnostics), alongside ongoing concerns regarding financial sustainability and the absence of a balanced plan. • Assurance and Control Environment: Internal Audit continues to report a number of limited assurance opinions, with recurring challenges in the timely closure of recommendations. • Compliance and Responsiveness: Persistent issues in procurement compliance and delays in reporting and organisational responsiveness are noted, with actions being progressed through the Chief Executive and Executive Team.
Escalation of Risk and issues	• Performance & Delivery: Ongoing challenges across UEC, planned care, cancer and diagnostics. • Corporate Risk: Majority of risks remain above appetite with limited reduction. • Assurance & Controls: Multiple limited assurance findings and delays in closing audit actions. • Procurement Compliance: Continued breaches of SFIs and weaknesses in planning and contract management. • Governance Effectiveness: Strengthening frameworks not yet consistently delivering measurable impact.
Recommendation to Board	The Committee approved the Annual Report and Accounts for onward submission to the Board.



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Green – Substantial / Adequate Assurance		Aligned to “on target” and routine monitoring where milestones are being achieved without significant outliers
Amber – Moderate / Partial Assurance		Reflects “risk to delivery”, where targets may not be fully met but there is an agreed improvement trajectory and aligns with “limited assurance” where more significant management attention is required
Red – Limited / No Assurance		Aligned to “not on target”, persistent failure and escalation requiring detailed action plans

Health Board

CORPORATE RISK REGISTER

Dyddiad y Cyfarfod Date of Meeting	30 July 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Jody Evans, Assistant Head of Risk Management
	Anthony Hughes, Risk Assurance Manager
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Pam Wenger, Director of Corporate Governance
Pwrpas yr Adroddiad Report Purpose	For Assurance

Crynodeb Gweithredol Executive Summary

All Corporate Risks have now been reviewed and reported using a consistent framework, supported by Executive-led deep dives and oversight through the Risk Scrutiny Group and Executive Committee. This has strengthened the quality of risk reporting, executive challenge and the identification of assurance gaps.

Despite these improvements, limited movement has been seen in residual risk scores, with nine of the eleven Corporate Risks remaining above the Health Board's agreed risk appetite. This indicates that while governance arrangements and oversight continue to mature, further work is required to demonstrate the effectiveness of mitigating actions and deliver measurable reductions in risk exposure.

During the reporting period, focused reviews have been undertaken across a number of priority Corporate Risks, challenging the adequacy of controls, assurance arrangements and risk reduction plans. Particular attention has been given to those risks that remain significantly above appetite.

Corporate Risk CRR25-08, Non-Compliance with Regulatory and Legislative Requirements, has been reviewed and its score reduced from 16 to 12 following

improvements in regulatory oversight, accountability and relationship management arrangements. The risk now falls within the Health Board's agreed risk appetite.

The Board can take assurance that risk governance, Executive oversight and risk management processes continue to strengthen. However, only moderate assurance can currently be taken regarding the effectiveness of controls in reducing overall risk exposure, given the number of Corporate Risks that remain above appetite. Future reporting will place greater emphasis on risk trajectory, delivery of mitigating actions and evidence of risk reduction to support more outcome-focused scrutiny.

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

Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	Dyddiad Date	Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data
Executive Committee	15/07/2026	Full Corporate Risk Register Review
Executive Committee	17/06/2026	Full Corporate Risk Register Review
• People and Culture Committee • Performance • Finance and Information Governance Committee • Quality Safety and Experience Committee • Planning, Population Health and Partnership Committee	June and July Cycle	Relevant Risks to Committee reported. Note: The CRR was not presented to Audit Committee in June 2026. The next update will be submitted to Audit Committee in August 2026.
Informal Executive Committee	27/05/2026	Deep Dives: • CRR25-02 Future Demand & Sustainable Workforce • CRR25-07 Leadership and Operating Model
Executive Committee	20/05/2026	Full Corporate Risk Register Review
Risk Scrutiny Group	12/05/2026	Following review by the Risk Scrutiny Group (RSG) on the 12th May 2026, minor further amendments to the template were agreed, alongside the need to present action details in a more succinct and consistent

		manner in future iterations of the cycle. All risks have since been transferred onto the updated template.
Informal Executive Committee	15/04/2026	Deep Dives: • CRR25-11 Cyber & ICT Failure • CRR25-04 Modernising Infrastructure
Informal Executive Committee	01/04/2026	Deep Dives: • CRR25-06 Value Delivery & Financial Sustainability • CRR25-01 Timely Patient Access to Safe and Effective Care • CRR25-03 Population Needs
Informal Executive Committee	18/03/2026	Deep Dive: • CRR25-08 Non-Compliance with Regulatory and Legislative Requirements
Acronymau / Rhestr Termau Acronyms / Glossary of Terms		
CRR	Corporate Risk Register	
RSG	Risk Scrutiny Group	
BAF	Board Assurance Framework	

CORPORATE RISK REGISTER.

1. Y SEFYLLFA SITUATION

The purpose of this report is to present the updated revised corporate risk register for scrutiny and provide any recommendations to the Executive Committee for approval following approval of the revised Corporate Risk Register Report template.

2. Y CEFNDIR BACKGROUND

The Corporate Risk Register comprises eleven strategic risks (Appendix 1). Significant work has been undertaken to strengthen the quality, consistency and assurance provided through the Corporate Risk Register, including the development and implementation of a revised reporting template that more clearly articulates risk exposure, controls, assurance gaps and mitigating actions.

All Corporate Risks have now been transitioned to the revised format. This work has been supported by targeted Informal Executive Committee deep dives, enabling enhanced Executive scrutiny and challenge of key strategic risks. Ongoing refinement continues through Executive review, oversight by the Risk Scrutiny Group and consideration through relevant governance forums, with a continued focus on strengthening assurance, improving the alignment between risks and mitigating actions, and supporting measurable reductions in risk exposure.

There are 2 Corporate Risks which have been removed from this public report and will be presented to the Private Board Meeting; *CRR25-04 Modernising Infrastructure and CRR25-11 Cyber & ICT Failure*).

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

All eleven Corporate Risks have been comprehensively reviewed and reformatted into the newly agreed template (see Appendix 1), ensuring consistent and robust articulation of risk positioning. This work explicitly aligns identified gaps and required additional controls, with clearly defined actions to address those gaps, strengthening the link between risk evaluation and risk mitigation. The updates were completed in line with the approval of the revised template, providing improved clarity, assurance, and oversight of the corporate risk profile.

- **CRR25-01 – ‘Timely patient access to safe and effective care’**

Following the Quality, Safety and Experience Committee meeting on the 2nd July 2026 and the Deep dive undertaken on the 1st April 2026; work remains ongoing to split CRR25-01 ‘Timely patient access to safe and effective care’ into individual risks to focus on individual services.

- **CRR25-02 & CRR25-07 – Workforce Corporate Risks**

Targeted Executive-level deep-dive sessions have recently been undertaken for both risks, highlighting opportunities to strengthen assurance and further refine risk narratives, controls and associated action plans. Discussions continue with the Executive Director of People Services & Organisational Development to ensure both risks accurately reflect the current position and planned mitigations. A full refresh will be completed and reported through the next Corporate Risk Register reporting cycle.

- **CRR25-08 – Non-Compliance with Regulatory and Legislative Requirements**

CRR25-08 – Non-Compliance with Regulatory and Legislative Requirements was reviewed by the Governance and Regulatory Group on 7 July 2026. The Group noted positive progress in establishing enhanced oversight of regulatory and statutory bodies, including the development of a Regulatory Relationship Management Matrix and the ongoing mapping of regulatory responsibilities, reporting arrangements and accountabilities across the Health Board. Consequently, the risk score has reduced from 16 to 12. The revised score is now within the Health Board's agreed risk appetite, demonstrating the effectiveness of the mitigating actions implemented and the resulting reduction in risk exposure.

4. **Overdue/Delayed Actions**

Two actions are due to commence relating to risk CRR25-02 ‘Future Demand & Sustainable Workforce’ with both actions due to commence following the completion of an additional action, in relation to Demand and Capacity forecasting.

5. **Governance Oversight, Scrutiny and Assurance**

The Corporate Risk Register continues to be subject to review through a range of governance forums, including the Risk Scrutiny Group, Executive Committee, Informal Executive Committee Deep Dive sessions and relevant Board Committees. This review process has provided increased scrutiny of risk narratives, risk scoring, controls, assurance arrangements and mitigating actions.

Review by the Risk Scrutiny Group identified opportunities to improve the consistency and quality of risk reporting, strengthen the alignment between

assurance gaps and mitigating actions, and enhance the articulation of controls and outcomes. These observations informed the refined Corporate Risk Register template now adopted across all eleven Corporate Risks.

Targeted Informal Executive Committee Deep Dive sessions have provided enhanced Executive challenge across the prioritised Corporate Risks, including Timely Patient Access, Value Delivery and Financial Sustainability, Population Needs, Modernising Infrastructure, Cyber and ICT Failure, Regulatory Compliance, Health and Safety and Safe Environment. These reviews have challenged the robustness of controls, the adequacy of assurance arrangements, the clarity of risk ownership and the measurability of planned outcomes. Outputs from these sessions are informing further refinement of risk narratives and action plans.

Relevant Board Committees have continued to scrutinise risks aligned to their remit and have sought additional assurance where risks remain outside appetite or where planned mitigations have yet to demonstrate sufficient impact. This has been particularly evident in the ongoing review of CRR25-01 (Timely Patient Access to Safe and Effective Care), where further refinement and segmentation of the risk remains required to strengthen oversight and assurance.

Collectively, these governance reviews provide assurance that appropriate mechanisms are in place to identify, monitor, challenge and escalate strategic risks. However, the review process has also highlighted that nine of the eleven Corporate Risks remain above the Health Board's agreed risk appetite and that, whilst governance maturity and oversight continue to improve, further work is required to strengthen controls, close assurance gaps and demonstrate measurable reductions in risk exposure. Executive-led review and challenge will therefore continue throughout 2026/27 to support further maturation of the Corporate Risk Register and improvement in risk management effectiveness.

Given the limited movement in residual risk scores across the majority of Corporate Risks, the principal assurance obtained through recent governance reviews relates to the strengthening of governance arrangements, Executive oversight and risk management processes; however, assurance regarding the effectiveness of current mitigating actions in reducing risk exposure remains moderate and requires continued Executive focus.

6. Risks above Health Board 25/26 appetite

Of the total 11 Corporate Risks, **nine** corporate risks above tolerance are for the oversight of the Committees and Board. Two risks CRR25-05 – 'Strategic Change – Impacting Care and Staff Delivery' and CRR25-08 'Non-

Compliance with Regulatory and Legislative Requirements' remains within tolerance with a current risk score of 12.

Risk Ref	Risks	Lead Exec Director	Current Risk Score	Risk Tolerance Range in Appetite Score
CRR25-01	Timely Patient Access to Safe and Effective Care	Chief Operating Officer	20	Quality <15
CRR25-02	Future Demand & Sustainable Workforce	Executive Director of Workforce	16	Quality <15
CRR25-03	Population Needs	Executive Director of Public Health	16	Quality <15
CRR25-04	Modernising Infrastructure	Chief Digital Information Officer	20	Quality <15
CRR25-06	Value Delivery and Financial Sustainability	Executive Director of Finance	20	Financial <15
CRR25-07	Leadership and Operating Model	Executive Director of Workforce	16	Quality <15
CRR25-09	Safe Environment	Director of Environment and Estates	20	Regulatory <15
CRR25-10	Health and Safety	Director of Environment and Estates	16	Regulatory <15
CRR25-11	Cyber & ICT Failure	Chief Digital Information Officer	20	Quality <15

Review of Risk Appetite 2026/27

The Health Board's Risk Appetite Framework will be reviewed during 2026/27 to ensure it remains appropriate in the context of the organisation's strategic priorities and current risk profile. Given that nine of the eleven Corporate Risks currently exceed the agreed risk appetite, the review will provide an opportunity to reaffirm the Board's appetite for risk and ensure that risk tolerances continue to support effective scrutiny, escalation and decision-making. Any proposed changes will be presented through the relevant governance arrangements for approval.

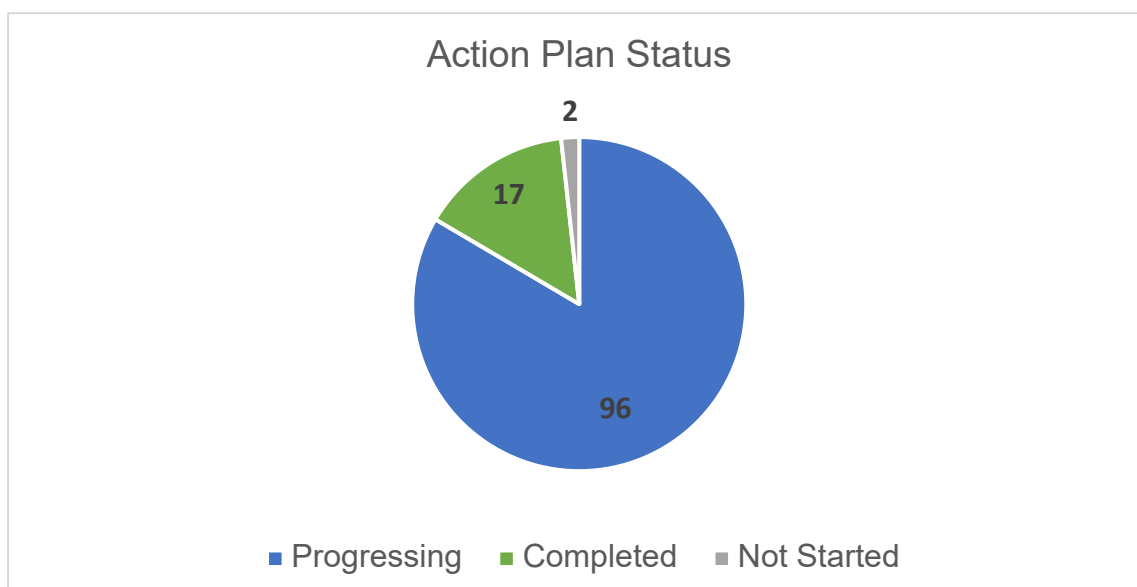
Executive Committee is therefore asked to require each Executive Lead responsible for a Corporate Risk that remains above appetite to:

- confirm whether the current risk score remains appropriate;
- provide a clear trajectory for achieving movement towards the agreed risk appetite;
- identify any barriers preventing risk reduction and any additional support or intervention required; and
- review whether current controls and actions remain sufficient to address the principal sources of risk.

Future Corporate Risk Register reports will include an assessment of risk movement and delivery against planned risk reduction trajectories, enabling Executive Committee to focus scrutiny on areas where risks continue to remain static or above appetite

7. Action Plan status of Corporate Risks

Of the 11 Corporate Risks, 115 actions have been developed to mitigate the risks 17 actions have been completed, 96 actions are progressing and on track, 2 actions not started and due to commence.



8. ARGYMHELLION RECOMMENDATIONS

The Board is asked to:

- **NOTE** the current Corporate Risk Register and assurance position.
- **NOTE** that nine Corporate Risks remain above the Health Board's agreed risk appetite.
- **ENDORSE** the continued Executive review and scrutiny of Corporate Risks.
- **REQUIRE** Executive Leads to establish clear risk reduction trajectories for all risks that remain above appetite.
- **SUPPORT** the continued development of outcome-focused risk reporting and assurance arrangements.

ASESIAD / ASSESSMENT	
Cysylltiad â'r Bwriadau Strategol	3. Improve Access, Outcomes and Experience
Link to Strategic Intentions	If more than one applies, please list below:
Yr Egwyddorion Dylunio Design Principles	People First
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	Corporate Risk Register and Board Assurance Framework - Betsi Cadwaladr University Health Board

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

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

	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Asesiad o Effaith ar Ddiogelu Data <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?</i> Data Protection Impact Assessment <i>Have you undertaken a Data Protection Impact Assessment Screening?</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Administrative Report
Asesiad o Effaith ar Atal Twyll <i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i> Counter Fraud Impact <i>Have you considered the counter fraud impacts</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Administrative Report
Cyfreithiol Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw Da Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith ar Adnoddau <i>(Pobl / Ariannol)</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	
	This report does not directly create additional resource requirements; however, it describes corporate risks which may have significant workforce, financial and estate implications if not effectively mitigated.	

Appendix 1 – Corporate Risk Register Dashboard 2026

Lead	Ref	Risk Title	Current Score (Impact x Likelihood)	Risk Target Score	Appetite Main Risk Type Appetite Level	Lead Board Committee	Action Progression			Risk Management Commentary
							Total	Completed	Delayed or Overdue	
COO	CRR25-01	Timely Patient Access to Safe and Effective Care	5x4 20	12	Quality (<15) Above Tolerance	Quality, Safety and Experience Committee	11	4	0	Four actions now completed Action plan to be reviewed
EDoW	CRR25-02	Future Demand & Sustainable Workforce	4x4 16	8	Quality (<15) Above Tolerance	People & Culture Committee	11	0	2	Action plans to be reviewed to include metric based for tracking outcome and impacts. Full review of the risk to be undertaken by the Executive Lead to update the risk Deep Dive undertaken in May 2026
EDoPH	CRR25-03	Population Needs	4x4 16	12	Quality (<15) Above Tolerance Above Tolerance	Planning, Population Health & Partnership Committee	19	6	0	19 actions with 13 progressing, risk updated to reflect the current 2026–27 position and the strategic direction set out in the Integrated Medium Term Plan (IMTP)
EDoTSP	CRR25-05	Strategic Change – Impacting Care and Staff Delivery	4x3 12	8	Quality (<15) In Tolerance	Planning, Population Health & Partnership Committee	6	3	0	Additional actions to be identified to reduce the risk to achieve the target risk score

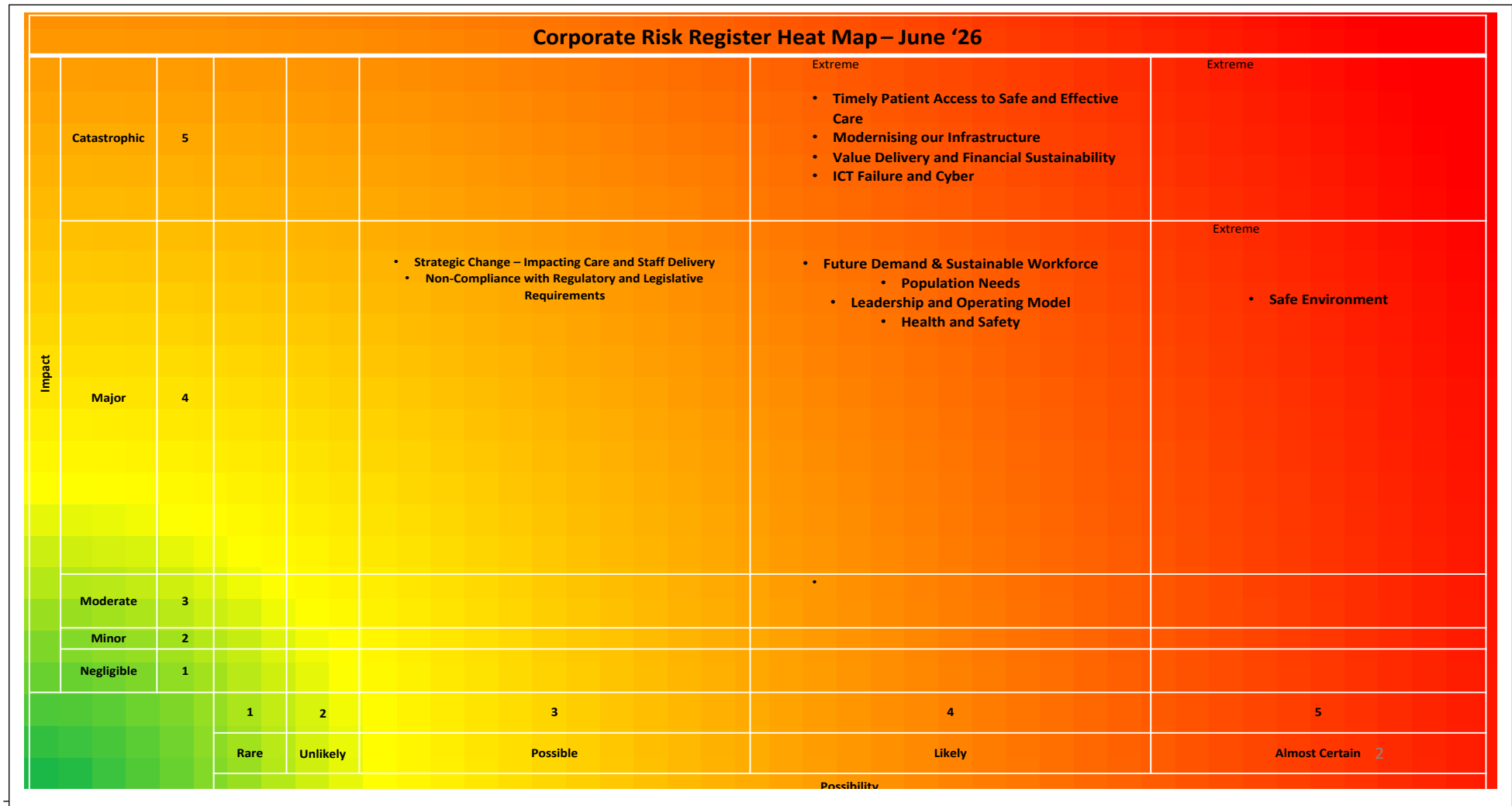
EDoF	CRR25-06	Value Delivery and Financial Sustainability	5x4 20	12	Financial (<15) Above Tolerance	Performance, Finance and Information Governance Committee	11	6	0	Risk updated by the service to reflect 26/07 financial year, 10 open actions all progressing
EDoW	CRR25-07	Leadership and Operating Model	4x4 16	8	Quality (<15) Above Tolerance	People & Culture Committee	9	0	0	Full review of the risk to be undertaken by the Executive Lead to update the risk. Deep Dive undertaken in May 2026.
DCG	CRR25-08	Non-Compliance with Regulatory and Legislative Requirements	4x3 12	8	Regulatory (<15) In Tolerance	Audit Committee	4	1	0	Deep Dive undertaken in April 2026 Current risk score reduced from 16 to 12 resulting in the risk now within Health Board risk appetite tolerance.
DoE	CRR25-09	Safe Environment	4x5 20	12	Regulatory (<15) Above Tolerance	Performance, Finance and Information Governance Committee	9	1	0	Review of the risk undertaken by the service to align to operational aspects of the risk
DoE	CRR25-10	Health and Safety	4x4 16	8	Regulatory (<15) Above Tolerance Above Tolerance	Performance, Finance and Information Governance Committee	11	3	0	Full review of the risk has been undertaken by the service to align to operational aspects of the risk, with proposal to move some actions to current operational risks.



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Appendix 2 - Corporate Risk Register Heat Map





Corporate Risk Register



Contents

CRR REF: 25-01 – Risk Title: Timely Patient Access to Safe and Effective Care 2

CRR REF: 25-02 - Risk Title: Future Demand & Sustainable Workforce.....6

CRR REF: 25-03 - Risk Title: Population Needs.....7

CRR REF: 25-05 - Risk Title: Strategic Change – Impacting Care and Staff Delivery.....19

CRR REF: 25-06 - Risk Title: Delivery of the 2026/27 Financial Plan and Financial Sustainability 21

CRR REF: 25-07 - Risk Title: Leadership and Operating Model.....24

CRR REF: 25-08 - Risk Title: Non-Compliance with Regulatory and Legislative Requirements 27

CRR REF: 25-09 - Risk Title: Safe Environment.....31

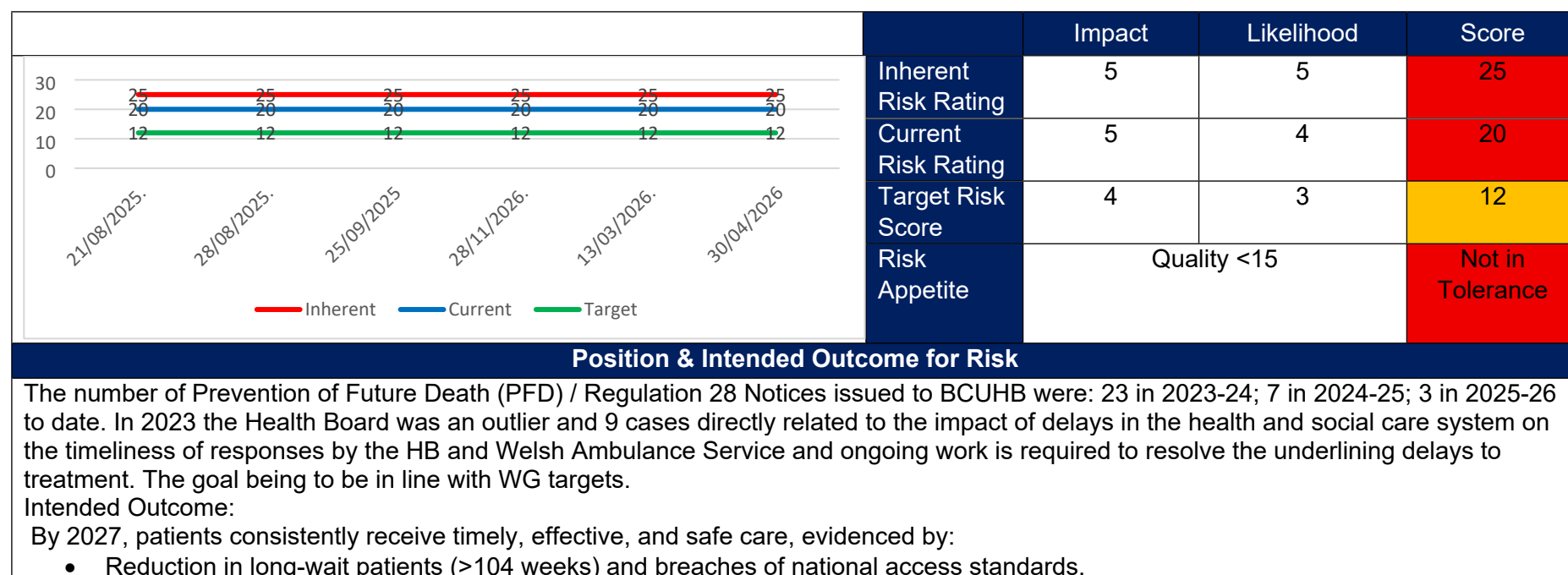
CRR REF: 25-10 - Risk Title: Health and Safety.....40

CRR REF: 25-01 - Timely Patient Access to Safe and Effective Care				
Director Lead: Chief Operating Officer			Date Opened: 21/08/2025	
Assuring Committee: Quality, Safety and Experience Committee			Date Last Committee Review: 05/03/2026	
Date Last Reviewed: 30/04/2026	Link to BAF: BAF24-07		Target Risk Date: 30/06/2027	
Risk Detail: There is a risk that patients may not receive timely access to the care they need; for planned care this may lead to a delay in definite treatment, deterioration in health or harm occurring whilst waiting, poor patient experience, and poorer outcome. In the unscheduled care pathway, patients may experience harm whilst waiting for ambulances in the community, may have prolonged waits for specialist medical care, this could lead to patient harm and poor patient experience. This may be caused by capacity and demand mismatch, lack of oversight of waiting lists, lack of validation, the need to transform services and service models and delays due to waiting for diagnostic tests in the unscheduled arena it may be caused by poor flow through the health and social system, poor discharge practices, lack of appropriate residential and nursing placement. This may lead to extended waiting lists, patient harm due to delays, and reputational or regulatory consequences.				
Mitigations/Controls in place				
1. System Resilience Hub in place with hospital escalation protocols, daily and weekend plans, and winter/festive plans. Daily Hub + rapid review + weekly executive oversight panels 2. 6 week rapid improvement plan with clinical and operational executive oversight 3. Quality, professional and operational standards 4. Major change programmes for Urgent and Emergency Care (UEC) and planned care aligned to the Six Goals for UEC framework and national objectives (such as timely access to care and building community capacity). Governance structure completed, all workstreams now all aligned. 5. Winter Resilience Plan complete evaluation and lessons learnt. 6. Revised Access policy to ensure standardised practice across the Health Board 7. Single Integrated Clinical Assessment Triage (SICAT) and GP Out of Hours (OOHs) joint model providing 24/7 triage and advice 8. Same Day Emergency Care (SDEC) services established at all acute sites 9. Routine clinical prioritisation of patients by risk in line with Referral to Treatment guidance 10. Outsourcing of radiology reporting and insourcing of CT, MRI, ultrasound 11. Diagnostic Quality Management System accreditation system embedded 12. Welsh Government short-term Neurodevelopment funding to support longest waiters, agency staff, overtime				
Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G1 Fragility of UEC (Urgent Emergency Care) and specialist workforce posts, reliance on locums' temporary posts.	A UEC clinical lead has been appointed as part of the UEC programme team as well as other clinical leads specifically focusing on the priorities of the 6 goals plan within specific workstreams.	UEC Programme Director	Complete	Complete
	ED staffing business case for medical and nursing requirements including whole time equivalent and costings to be drafted for Executive Committee endorsement. Task & Finish group to be established to progress at pace with key leads including clinical, nursing, workforce and transformation and progress through HB governance. Outcome: A stable, sustainable UEC and frailty workforce with reduced reliance on locums, improved service continuity, and consistent delivery across all sites. Metric: Reduction in locum usage and vacancy rates in UEC and frailty posts, Impact on risk: Likelihood of risk will reduce as permanent posts are filled with further reduction expected as locum reliance decreases and workforce stability improves	Chief Operating Officer	Q1 2026/27 – 30/06/2026	Progressing
Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G2 Fragility of social care provision causing delayed discharge and stranded patients	Implement reset 'sprint' fortnight 8-22 December focusing on improving number and timeliness of discharges, delivering 45-minute ambulance handover, and improve ED performance Second 'Sprint' undertaken 22 January – 4 February, supported by 3 diagnostics to target ongoing actions Action update: Further to competed actions, above, MADE events have been held on each site and further interventions have been identified including: >21-day length-of-stay reviews / 6As audits scheduled during March / April across all sites – findings will inform immediate and longer-term actions that strengthen	Chief Operating Officer	8/12/2025	Complete

	discharge processes and system-wide UEC flow – supported by external improvement and intensive support team.			
	Deliver December “Discharge Fortnight” - Intensive cross-sector focus to maximise discharge, unblock flow, reduce LOS, and significantly improve bed availability. Action update: Fortnightly regional realignment meetings in place with BCU / LA to maintain focus on discharges to support flow and patient outcomes	Chief Operating Officer	31/01/2026	Complete
G3 Need for demand and capacity modelling and specialty-level trajectories	Complete demand and capacity analysis across Planned Care to inform forward activity planning Demand & capacity (D&C) planning session held in April to review core demand and capacity planning across specialties within Q1 to confirm the position for 2026/27. A further session is scheduled in May with a specific focus on Cancer and Diagnostics to enable more detailed discussions on demand and capacity for 26/27. This will be supported by a ‘planned care sprint’ to improve booking of long waiters into core capacity and transfers of care to appropriate services Outcome Clear understanding of specialty level- demand and capacity, enabling improved activity planning, reduced long waits, and more efficient use of core capacity Metric Reduction in number of long waiting patients (aligned to IMTP trajectory) Impact on Risk: Likelihood decreases as clearer planning reduces backlog risk and improves ability to meet demand.	Chief Operating Officer	30/06/2026	Progressing (revised date from 31/03/2026)
Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G4 Inadequate Neurodevelopment (ND) capacity to manage waiting list	Eradicate all >3 year waits by end March 2026. Ministerial priority. At the end of March 2026 there were 646 over three year waits due to the private provider being unable to complete their contract assessment numbers. These referrals have now been allocated to another private provider for completion by the end of Quarter 1, families and schools have been updated. Additionally there will be 2,358 C&YP that will have waited over 3 years in 26/27, WG have allocated £2m to BCUHB to address the >3 year waiters, however this will be insufficient with a shortfall of approximately 490 assessment. WG are to be informed of this residual gap and options to manage reviewed Confirmation of funding allocation (£2m) from WG re 26-27 for ND funding for assessments, was received in April. Approval from Exec Committee & PFIG subsequently confirmed in April for the continued use and extension of the private provider contract for children’s ND assessments to support delivery against WG expectations for 2026/27. Outcome The capacity gap has reduced significantly, supported by a 63% increase in assessment activity in 2025/26. This has been achieved through a prudent delivery approach alongside commissioning of independent providers. Allocated funding will support backlog reduction for waits exceeding 3 years in Q1 26/27, whilst also contributing to longer term service sustainability. Metric Ministerial milestone. Deliver and sustain no >3 year waits at the end of March.	Associate Directors Childrens	Qtr 1 2026/27 – 30/06/2026	Progressing

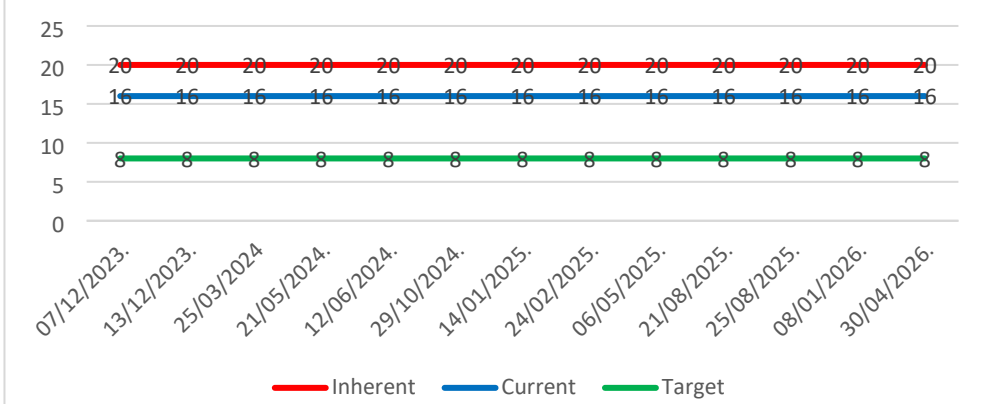
	Impact on Risk Failure to maintain increased assessment capacity and targeted backlog reduction may result in continued waits exceeding three years into 2026/27. This would lead to non-delivery of the ministerial milestone, prolonged delays for neurodevelopmental (ND) assessments, increased demand pressures on services, and potential deterioration in patient outcomes and experience			
G5 Outdated diagnostic IT systems causing inefficiencies in reporting and turnaround times with diagnostics.	- Strengthen and enhance monitoring of reportable diagnostics through implementation of upgraded systems including: - RISP (radiology) – completed RISP radiology system September 2025 completed. - LIMs 2.0 (pathology) – ongoing roll out to be completed by end Q3 - Ensure existing services have mechanisms in place to report urgent and unsuspected findings, including Welsh Clinical Portal (WCP). Enhanced / divisional monitoring of reportable diagnostics as a byproduct of planned care backlog recovery programmes. This will develop further with diagnostics division throughout 2026-27 to include UEC and urgent suspected cancer diagnostics Update Failure to act on Diagnostics Procedure to be presented at divisional meeting for discussion on the 10/10/2025 (NB: This action is delayed due to service focus on 8-week backlog reduction and supporting OPD programme. Proposed revise due date to Q1 2026-27) Outcome: improved oversight and strengthened reporting of findings / responsive actions Metric: reporting turnaround times maintained / improved, with outliers identified earlier for intervention Impact on Risk: overall reduction in likelihood of delayed diagnostic results to service users	Associate Director, North Wales Managed Clinical Services	30/06/2026 30/06/2026	Progressing
Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G6 Variation in acute medicine, SDEC (Same Day Emergency Care), frailty pathways across sites, No standardised model yet Workforce recruitment impacted by non-recurrent (6 Goals) funding	- Complete pan BCUHB- baseline and gap analysis to inform a standardised frailty service model, develop unified Acute (front door) Frailty Services pathways aligned with SDEC and community services (Q2), Baseline and gap analysis completed - Finalise financial and workforce modelling required to deliver the national AFS model (Q1). Outcome A consistent, standardised frailty model across all acute sites, improving early assessment, flow, and access to same-day and community alternatives Metric Completion of baseline & gap analysis. Agreement of standardised AFS model for each site. Progress against recruitment to frailty workforce roles. Impact of Risk Risk reduces as variation decreases and standardised models strengthen service reliability and pathway consistency through pan BCU standardised approach.	UEC Programme Director	30/09/2026 30/06/2026	Progressing

G7 Consistent application of "Our Next Patient Please" flow model.	Patient flow improvements: Implement "Our Next Patient Please" Move patients to wards ahead of predicted discharges; reduce ED congestion. Completed – Our next patient (forward waiting) is now BAU	Chief Operating Officer	31/01/2026	Completed
	- Develop draft Single Point of Access for alternative pathways & Primary Care redirection. Reduce unnecessary ED attendance; strengthen community pathways. Outcome Improved patient flow through earlier ward moves, reduced ED congestion, and strengthened use of alternative pathways and community services—leading to fewer unnecessary ED attendances and more efficient system-wide flow. Metric Reduction in ED congestion metrics (4 hour / 12 hour / time to triage / ambulance handover) - Reduction in LoS / POCD Impact on Risk Risk decreases as improved flow reduces system pressure, ED overcrowding, and delays in urgent and emergency care—lowering the likelihood and impact of service failure Action update: - Your Next Patient / Forward Waiting SOP developed - Accelerated Boarding in Extremis SOP developed	Chief Operating Officer	31/03/2027	Progressing
Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G8 Health Board improvement goal for Clostridium Difficile Infection (CDI) reductions in 2025/2026 to reduce the number of cases within the Health Board.	Implementation of Health Board improvement goal for CDI (Clostridium Difficile Infection) reductions in 2025/2026 <i>This action to reduce CDI is now based on the WHC Improvement Goals for 2025 – 2027. The Health Board has until March 2027 to reduce CDI by at least 25% against the 2024/2025 counts</i> Outcome Reduced incidence of Clostridioides difficile infection across the Health Board through strengthened infection prevention-, antimicrobial stewardship, and system-wide adherence to improvement measures. Metric CDI incidence rate per 100,000 population Impact on Risk Risk decreases as CDI rates fall, demonstrating improved infection control and reduced harm as performance moves towards the 2025/26 reduction target.	Deputy Director of Nursing Infection Prevention and Decontamination	31/03/2027	Progressing (revised date from 31/03/2026)



- Fewer harm events linked to delayed care.
- Improved quality metrics including length of stay, readmission rates, and patient-reported outcome measures (PROMs).
- Reduction in regulatory and legal cases associated with delayed access.
- A demonstrable shift in focus from access process metrics to sustained improvement in patient safety, experience, and outcomes.

CRR REF: 25-02 - Risk Title: Future Demand & Sustainable Workforce				
Director Lead: Executive Director of People and Organisational Development			Date Opened: 21/08/2025	
Assuring Committee: People & Culture Committee			Date Last Committee Review: 12/02/2026	
Date Last Reviewed: 30/04/2026	Link to BAF:		Target Risk Date: 31/03/2027	
Risk Detail: There is a risk that the Health Board does not have an effective, coherent workforce plan and workforce supply, that is based upon an incorrect funded establishment. This may be caused by the organisation not undertaking effective of demand and capacity planning, which may be compounded by high sickness rates and recruitment challenges. This may lead to staff burnout, reduced morale and retention and an inability to consistently deliver safe, high-quality care. This will likely place additional strain on services and impacting patient outcomes.				
Mitigations/Controls in place				
1. A new workforce planning framework has been agreed 2. A Healthy Workforce group is in place overseeing a comprehensive range of actions to improve sickness rates and employee wellbeing 3. The Foundations for the Future (FFTF) Board is in place to oversee the development of the future workforce model 4. The Board has approved the three-year culture change programme 5. A Value & Sustainability programme is in place, overseeing a range of initiatives to improve productivity and financial efficiencies 6. A recently introduce Medical & Dental policy advisory service is in place 7. Work around retention initiatives has seen a reduction in avoidable turnover				
Gaps in Controls/	Action	Action Owner	Due Date	Progression Analysis
G1 Implement a system-wide Workforce Planning service with reportable workforce plans across key services	Adoption of the workforce planning framework, based on the results of the demand and capacity review in conjunction with the clinical services plan	Chief Operating Officer, Executive Medical Director and Executive Director of Transformation and Improvement	31/03/2027	Will commence fully once D&C has been completed
G2 Demand and Capacity (D&C) forecasting	Full demand and capacity review that will identify true gaps in the workforce model	Finance and Performance	31/03/2027	Progressing
G3 An establishment review is required following D&C review	Undertake establishment reviews based on the outputs of the Demand & Capacity review	Finance and Performance	31/03/2027	Will commence fully once D&C has been completed
G4 An agreed operating model for the Health Board through the FFTF programme	Consultation and Implementation of the new operating model leadership structure. The first phase is Band 8c +	Senior Associate Director of People & Organisational Development(OD)	31/03/2027	Progressing
G5 Clinical Service plan that outlines workforce requirements	Engagement sessions are being held in May 26, a draft outline plan has been shared.	Executive Medical Director (Kamela Williams, support in Planning)	01/04/2027	Progressing
G6 M&D leadership and engagement is not fully effective	Strengthen the governance arrangements for the Medical Workforce Group, to report into the new Executive Delivery Group for People & OD	Senior Associate Director of People & OD	30/09/2026	Progressing
	To scope and put forward proposals for a wider Medical Staffing function in the People Service directorate	Senior Associate Director of People & OD	31/03/2027	Progressing
G7 M&D Job Planning policy	To approve and publish the new Job Planning procedure and meet the target of achieving 90% of M&D Job Plans being in place.	Executive Medical Director	31/03/2027	Progressing
G8 More effective workforce pipelines in fragile services	Within the overarching OD plan, Values Based Recruitment (VBR), values based induction and transition are being	Exec Director People & Organisational Development(POD)	31/03/2027	Progressing

	introduced as part of the new Health Board values implementation				
G9 Absence and sickness management to deliver on ministerial targets and enabling actions	Targeted management of sickness absence. A 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.	Deputy Director, People & Organisational Development	31/03/2027	Progressing	
	A range of actions are being worked on through this group, which are expected to be delivered by the end of 2026/27				
	A sickness deep dive paper was tabled at December 2025 People & Culture Committee which incorporates a series of initiatives that will help reduce sickness absence rates. The planned delivery for these is March 2027	Deputy Director, People & Organisational Development	31/03/2027	Progressing	
			Impact	Likelihood	Score
		Inherent Risk Rating	4	5	20
		Current Risk Rating	4	4	16
		Target Risk Score	4	2	8
		Risk Appetite	Quality <15	Not in Tolerance	
Position & Intended Outcome for Risk					
KPIs to that inform our risk in this area as at February 2026; Overall Vacancy rate of 8.1%; Target 8%. M&D, Add Clin Services, Healthcare Sciences, E&F and A&C above target Turnover stands at 7.1% and continues its downward trend from 7.9% this time last year. Sickness rates currently 6.08%; Target 4.2% Time to Hire currently 77 days; target 71 days					

CRR REF: 25-03 - Risk Title: Population Needs		
Director Lead: Executive Director of Public Health		Date Opened: 21/08/2025 (version 2 refined from 2023)
Assuring Committee: Planning, Population Health & Partnership Committee		Date Last Committee Review: 05/03/2026
Date Last Reviewed: 29/06/2026	Link to BAF: BAF24-06/07	Target Risk Date: 31/03/2028
Risk Detail: 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 embed appropriate health prevention responses including 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		
1. Recurrent funding secured for Healthy Weight / Healthy Wales programmes 2. Diabetes Programme established 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 (Community Health Council) teams and community escalation frameworks in place 7. Welsh Government Neurodevelopment transformation programme funding to support longest waiters 8. National referral pathways in orthodontics and Dentist with Enhanced Skills / Tier 2 provision. 9. Prevention, Population Health & Early Intervention Executive Delivery Group provides oversight of delivery. 10. The IMTP and National Planning Guidance 26/27 outline the requirement for health board focus on the development of population health intelligence and the submitted health board plan responds to this – Strategic Intent 1 11. Development of the Health Board Strategy, Clinical Services Plan and major programmes such as Community by Design and Foundations for the Future provide opportunity to integrate Prevention and Population Health into plans and are informed by identified population health priorities. 12. Regional Wellbeing, Prevention and Anchor Framework agreed by Health Board and Partners 13. Improvement on uptake against National Immunisation Framework achieved 25/26.		

14. Health Needs Assessment and a scoping/insight review completed to understand the health needs and experiences of inclusion health groups (including Homelessness, Sex Workers and Asylum Seekers and Refugees). 15. Homelessness Insights paper prepared with recommendations to the Health Board for the upcoming duty to Ask, Act, and Cooperate within the Homelessness and Social Housing Bill (Welsh Government, 2026) 16. A community outreach offer designed to improve access to prevention and early intervention services for inclusion health groups. 17. Evaluation framework designed to measure the impact of the primary care continuity of care pathway for prison leavers. 18. Identification of unauthorised Encampments across North Wales and their proximity to GP practices, to increase access to primary care provision for Gypsy, Roma and Traveller people. 19. Health Equity Checklist to support the Health Board's strategic planning by ensuring that services are designed and delivered in ways that address health inequalities. 20. Inclusion of Prevention and population health priorities are implicit in Strategic intent priorities 2,3 and 4 and the Corporate Risk has been updated to reflect gaps in controls which are addressed through integrated deliverables throughout the Health Board Annual Delivery Plan.				
Gaps in Controls	Actions	Action Owner	Due Date	Progression Analysis
Limited system-wide prevention leadership and prevention not consistently prioritised	Weight Management Steering Group to develop a plan which addresses recommendations from the BCUHB Weight Management Service review Outcome: Improved organisational oversight of provision to support weight management and improvement of population healthy weight priorities Metric: Access to services and success rates Expected Impact on Risk Score Reduction: Services reflect the needs of the population with a prevention and health improvement focus. Action Update: 29/4/26 Report received outlining recommendations, which will inform 26/27-28/29 IMTP plans. next steps in terms of the plan have been incorporated into the Draft delivery plan which supports the IMTP 26.27. Identify variation across North Wales in service delivery. 26/6/26 – (links to Annual Delivery Plan 1A.2) Programme Group established, reporting progress against Annual Delivery Plan. Awaiting outcomes of national work in relation to digital weight management offer which will support progress, however we continue to move forward with level 2 and level 3 digital offers locally.	IHC Director – Weight Management Services	31/03/2026	Progressing
Gaps in Controls	Actions	Action Owner	Due Date	Progression Analysis
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	Health Board can demonstrate robust plans are in place and tested for Communicable disease outbreak management across its services and functions. Outcome: Improved preparedness for the identification and management of communicable disease threats. Metric: The Health Board response to communicable disease threats, the existence of plans and pathways for the management of communicable disease threats, the numbers of staff trained in preparedness measures (including HCID PPE training, and FFP3 face fit testing), the existence and delivery of health board simulation exercises. The evaluation of data on disease incidence and infection rates within BCUHB settings. Expected Impact on Risk Score Reduction: Strengthened preparedness within the Health Board for the identification and management of communicable disease threats. Action Update:	Assistant Director Of Health Protection, Public Health	30/09/2026	Progressing

	29/04/2026 (links to Annual Delivery Plan 1D) - The Strategic Communicable Disease Preparedness Group continues to meet with an agreed ToR however attendance is poor and the group remains un-quorate despite being in existence for 12 months. No response following submission of a paper to QSE in March 2026. HCID PPE trolleys are available in each of the 3 IHC hospitals but training in the use of the HCID PPE ensemble remains low with 22 staff trained across the Health Board (including 2 trainers). There is only 1 staff member trained in the West IHC where engagement appears particularly poor. Independent GP practices continue to lack fit testing for FFP3 masks, continuing the additional risk that GP practices will refer patients with suspected communicable diseases to secondary care. The revised pathway for Rabies Post-Exposure Prophylaxis remains un-approved despite being submitted for approval in Dec/Jan. There has been no progress on a national level to review GP contracts to include health protection medicines. BCUHB areas of weakness identified by recent cases and incidents include the ability (or lack of) to provide post-exposure vaccination to the contacts of Hepatitis A cases, or Invasive Meningococcal Disease cases. These were brought to the attention of the Chief Executive during a corporate directorate review on the 24th April 2026 where it was agreed that further executive level discussion was required. A successful HCID/pandemic preparedness exercise took place on the 15th April and was represented by a number of services from across the Health Board and Welsh Government and Public Health Wales. The findings from the event will help develop the Health Boards pandemic plan and encourage IHCs to re-instate their HCID preparedness meetings (IHC East met on 28th April 2026). 29/6/26 – As a result of two high profile health protection incidents (Andes Hantavirus outbreak on board the MV Hondius, and an outbreak of Ebola in the Democratic Republic of Congo and Uganda), a number of activities have taken place since early May to improve preparedness measures for communicable diseases (with a focus on High Consequence Infectious Diseases in particular). Activities included the convening of a BCUHB IMT (Initially for Andes Hantavirus, and subsequently HCIDs), the development of plans and pathways within YGC for managing symptomatic contacts of Andes Hantavirus, improving the numbers of staff trained in the HCID PPE ensemble. The consideration of paediatrics, maternity and MHLDD into HCID planning and preparedness. Whilst each of the 3 IHCs are at different stages in their preparedness, the international focus on HCID has resulted in improved focus on this particular issue. However, despite the increased interest and attention, attendance at the Strategic Communicable Disease Preparedness group remains poor, and the group is likely to be disbanded and incorporated into the Strategic Infection Prevention Group (this is yet to be approved).			

	The plans and pathways for HCID will be tested with a 'mystery shopper' exercise in July. An education session on HCID was provided to medical staff in YGC with teams links to East and West. The Rabies Post Exposure Prophylaxis pathway has been approved and has been used successfully. A response to a case of Hepatitis A in a primary school class room assistant resulted in approximately 90 contacts within the setting (children and teachers) requiring Hep A vaccine. The response was successful and will be used to develop a vaccination outbreak response pathway for BCUHB. Welsh Government have made contact with BCUHB following the simulation exercise that took place on the 15th April. Welsh Gov want to incorporate a short overview of this exercise in a national evaluation of Exercise Pegasus in Wales			
Gaps in Controls	Actions	Action Owner	Due Date	Progression Analysis
Inconsistent commissioning approach across community and primary care services.	Develop a Community and CHC Strategic Plan with Local Authorities. <i>*Legacy item 24/25 CRR Framework - This does not form control for this Corporate Risk*</i>	Acting Assistant Director Care Homes Support & CHC Commissioning	31/03/2026	Progressing
	Implement surge and escalation plans with Local Authority partners for community flow <i>*Legacy item 24/25 CRR Framework - This does not form control for this Corporate Risk*</i>	Acting Assistant Director Care Homes Support & CHC Commissioning	31/03/2026	Progressing
Fragility of Neurodevelopment workforce and reliance on temporary funding	Management of CYP (Children and Young People) needs, ND workforce business case submitted to the Executive Team, decision on the case deferred pending a broader review of funding priorities No approval received in relation to business case submitted, focus for this financial year is on utilising additional non-recurrent funding received from WG to reduce longest waiters Two private providers commissioned for ND assessments over 3 years, one provider delivering as per contract, the other provider is in breach of contract in relation to the assessments completed, as such there will be approximately 700 over 3-year waiters at the end of March. Awaiting communication from WG re 26-27 ND funding for assessments, plan is to continue use of one provider, all procurement and contract arrangements are in place. A briefing update has been shared with WG colleagues. <i>*Legacy item 24/25 CRR Framework - This does not form control for this Corporate Risk - this is a service level issue*</i>	CAMHS Programme Management Business Lead, Child & Adolescent Health	31/03/2026	Progressing (revised date from 31/12/2025)

Gaps in Controls	Actions	Action Owner	Due Date	Progression Analysis
Lack of restorative dentistry service and workforce pipeline	Undertake a dental diagnostic deep dive to inform strategy - In 2025 a review of the primary care dental service was undertaken to look at the current challenges in both General Dental Services (GDS) and the Community Dental Service (CDS). Key issues were identified in areas including leadership, performance, process, finance and people management. Progress within the service is now being monitored at a senior level via the IPEDG group, and a senior clinical review of the service is being planned for earlier 2026. <i>*Legacy item 24/25, 25/26 CRR Framework - This does not form control for this Corporate Risk - this is a service level issue - Restorative Dentistry service is not part of this risk.*</i>	Assistant Director Of Primary Care (Dental)	31/03/2026	Progressing
Develop and improve system-wide prevention through consistent prioritisation and integration with a focus on health improvement	1) Progress Strategic Intent Priority 1 deliverables ‘Focus on Health and Wellbeing’ Workstream 1A – Preventative Approaches to health & wellbeing Outcome: Healthier communities with fewer people smoking, more people with healthy weight and in better physical and mental health. Greater preventative focus across the life course. Metric: • Percentage of adult smokers who made a quit attempt via smoking cessation services who are CO-validated as quit at 4 weeks. • % Improvement in Breastfeeding rates at birth and at 10 days • Increase the proportion of children in Wales who are a healthy weight by halting the rise, and contributing to a year-on-year decrease in the levels of overweight and of obesity as measured and reported through the National Child Measurement Programme, focusing on those most disadvantaged. • Level 2 Adult weight service – increase activity rates • Tiny Tums – increase number of settings who achieve Tiny Tums award • Increase family programmes via schools – Come and Cook Expected Impact on Risk Score: Most care delivery in the NHS now relates to long-term conditions the majority of which have significant preventable factors. Preventable health measures should consider all stages across the life course – from pre-conception and into older age. This can reduce the likelihood and severity of chronic illness, reducing flow towards acute settings 25/6/26 – 1A.3 - Grant funding confirmation for Prevention and Early years, Whole Schools Approach and Healthy Weight Healthy Wales received into the health board. Agreements and plans in place – focus on weight, smoking, breastfeeding and early years.	Consultant in Public Health (Health Improvement Programme)	31/03/2027	Progressing

	1A.6 – Health Improvement offer is under development which considers where opportunities lie to implement changes and improvements to delivery and health outcomes within the health board. 1A.9 – 15 organisations across North Wales are now engaged with the Healthy Travel Charter 1A.10 – Organisational campaign planned to improve uptake of ‘Make Every Conversation Count’ training			
Gaps in Controls	2) Actions	Action Owner	Due Date	Progression Analysis
Develop and improve system-wide prevention through consistent prioritisation and integration with a focus on Healthcare Public Health including disease prevention and managing health outcomes	2) Progress Strategic Intent Priority 1 ‘Focus on Health and Wellbeing’ Workstream 1B – Proactive strategies for disease prevention, frailty & falls Outcome: More proactive care of frail people, reducing falls and the need for healthcare services. Increased screening services for cancer improving early identification and management. Fewer complications linked to diabetes due to improved monitoring and management. Health Board can demonstrate a clear prevention and health inequalities focus in its major strategic plans and services. Metric: - Percentage of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes. - Percentage of patients (aged 12 years and over) with diabetes who have had foot surveillance recorded within last 15 months. - Percentage of patients (aged 12 years and over) with diabetes who have had their urine albumin recorded within last 15 months. - National screening targets. Expected Impact on Risk Score: Falls and frailty are a significant driver of demand across primary and acute NHS Services and is expected to increase. Applying data and evidence through population health management will allow the organisation to target action within identified population groups towards where there is a strong likelihood of a health risk occurring, develop tailored interventions to prevent or reduce the impact of health risks which would contribute to preventing further deterioration, and optimise how the early stages of disease is detected. Intervening in the early stages of disease can prevent the disease from progressing, allows people to self-manage their health, improves health outcomes, prevents the individual developing other health conditions and ensures that people can continue to live their lives fully within their families and communities. 26/06/26 – 1B.1 – Population Management post advertised – this is a senior post with focus on development population health intelligence which will inform service and organisational planning. 1B.5 – Diabetes programme structure to support place based approaches for Diabetes are being established with initial practice level work being	Consultant in Public Health (Health Care Public Health & Population Health Management Programmes)	31/03/2027	Progressing

	initiated. Initial work underway to understand challenges and opportunities at a cluster and GP level 1B.6 – Diabetes 8 Care processes - Work underway to establish access to GP level data and to establish offer to practices that have the lowest levels of uptake.			
Gaps in Controls	Actions	Action Owner	Due Date	Progression Analysis
Develop and improve system-wide prevention through consistent prioritisation and integration with a focus on reducing health inequalities	3) Progress the Strategic Intent Priority 1 ‘Focus on Health and Wellbeing’ Workstream 1C – Health Inequalities Outcome: Reduced risk factors linked to the wider determinants of health such as environmental, social and economic factors. Improved equity of access between most and least deprived areas in relation to vaccinations, screening and diabetes care. All services and strategic plans should have metrics that enable them to assess the potential health inequalities in delivery. Metric: • Reduce inequity in the uptake in the most and least deprived areas in preventing ill-health especially in relation to vaccination, screening and Diabetes prevention and care. • National screening uptake targets - reduction in variation, increase in uptake from inclusion groups • Vaccination targets - reduction in variation, increase in uptake from inclusion groups • Diabetes 8 Care Processes – reduction in variation, increase in uptake from inclusion groups Expected Impact on Risk Score: Inequalities will continue to widen if we do not embed population health approaches in pathways and service plans that can enable the organisation to target resources proportionate to need. Through understanding the needs of communities, the Health Board can better enable provision of care in the right way, in the right place, and at the right time. The Health Board cannot reduce health inequalities alone. Many factors which impact on health and wellbeing require commitment and coordinated action across public sector organisations, enabled through the organisation’s role and opportunity as an Anchor institute. Together, the right social, economic and environmental conditions can be created that allow health and wellbeing to flourish. 26/6/26 - 1C.2 – Vaccine Equity Plan in draft and 1C.4 engagement plan for primary care partners drafted 1C.3 – Screening inequalities data sourced and reviewed to inform Screening Equity Plan 1C.6 – Anchor Charter – systems engagement events have taken place and findings alongside ‘Missions’ for focus presented to Regional Partnership Board 1C.7 - Homelessness insights implementation plan developed. Community prevention outreach offer developed for the Traveller community.	Consultant in Public Health (Health Inequalities Programme)	31/03/2027	Progressing

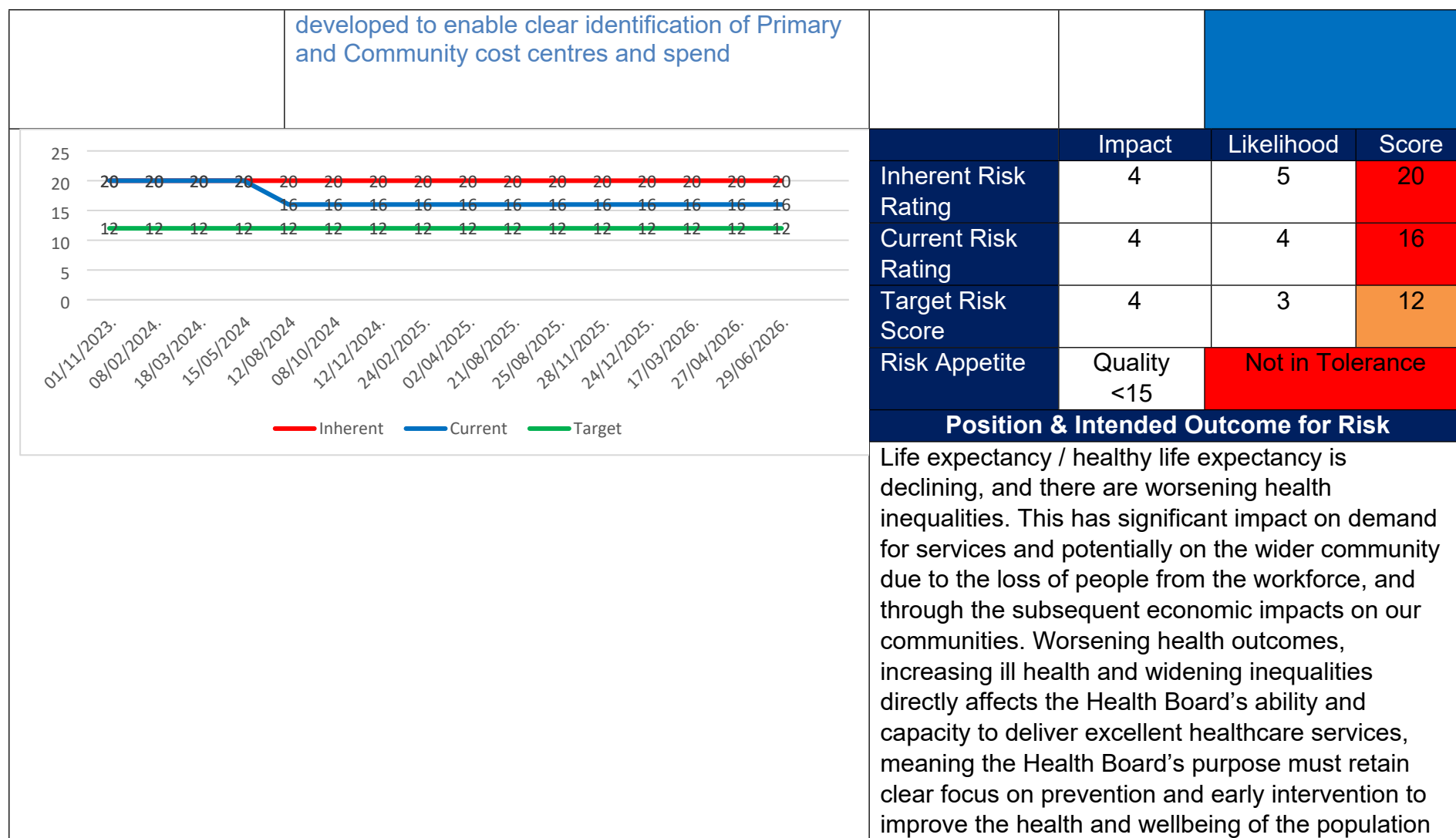
Gaps in Controls	Actions	Action Owner	Due Date	Progression Analysis
Develop and improve system-wide prevention through consistent prioritisation and integration with a focus on health protection	4) Progress the Strategic Intent Priority 1 ‘Focus on Health and Wellbeing’ Workstream 1D – Health Protection Outcome: More people in the population are protected from increased uptake of vaccinations with a particular focus on vulnerable groups. People are protected against existing, new and emerging health hazards. Communicable outbreak plan developed and tested, providing assurance to the Health Board and partners. Metric: • <i>Percentage uptake of the following targeted measures:</i> • Children who are up to date with all routine scheduled vaccinations by age 5. • Children receiving the Human Papillomavirus (HPV) vaccination by the age of 15. • Influenza vaccination amongst adults aged 65 years and over Applicable during: 01.09.2026 - 31.03.2027. • Respiratory Syncytial Virus (RSV) vaccination for those turning 75 years old. • Influenza <65 at risk • Influenza - Staff • MenACWY Cml (Y10) Expected Impact on Risk Score: Health Protection focuses on preventing harm before it happens and keeps communities safe from communicable and other notifiable illness that could affect large numbers of the population at scale. Risk of infectious diseases include Flu, Measles, and M-Pox, with disease outbreaks having a significant impact on closed settings such as care homes and schools. Health Protection includes the management of vaccine preventable disease risks such as measles, outbreak control planning, and training and education in settings to support Infection Prevention Control (IPC). 26/06/26 – 1D.1 School Immunisation Programme : The e-consent app is on track to be introduced for the School based Flu immunisation programme for winter 2026-2027. RSV older adult programme : Reflecting on lower uptake within this cohort and an expansion to the eligibility , the integrated vaccination service and primary care partners have adopted a cohort specific co-administrated focus for the Covid-19 Spring programme to optimise delivery alongside improving RSV uptake rates 1D.5 – increased sampling and new vaccination pathways established 1D.6 - Annual residential Care Homes IP&C reviews have commenced.	Assistant Director Health Protection / Deputy Director Vaccs & Imms	31/03/2027	Progressing

Gaps in Controls	Actions	Action Owner	Due Date	Progression Analysis
Develop and improve system-wide prevention through consistent prioritisation and integration with a focus on Primary and Community Care	5) Progress against the Strategic Intent Priority 2 - Enhanced Co-ordination of Care deliverables which will directly contribute to improving population health and keeping people well for longer. This includes focused deliverables: - <i>Development of Health and Wellbeing Hubs</i> - <i>Primary Care contracting inc Dental</i> - <i>Progression of Community by Design</i> - <i>Delivery of Frailty and falls prevention models</i> - <i>Delivery of Weight Management and smoking cessation services</i> - <i>Diabetes management</i> - <i>Health and wellbeing of Children & Young People</i> Outcome: More co-ordinated care in the community for people with long term conditions. Better access to community based preventative care. Metrics: • Percentage of population (adult) receiving NHS dental care over a 24-month period - General Dental Services (GDS) • Percentage of population (child) receiving NHS dental care over a 12-month period - General Dental Services (GDS) • Percentage of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes. • Percentage of patients (aged 12 years and over) with diabetes who have had foot surveillance recorded within last 15 months. • Percentage of patients (aged 12 years and over) with diabetes who have had their urine albumin recorded within last 15 months. • Percentage of individuals identified via the Audit Plus Frailty Tool (or its replacement) to receive proactive care in line with their agreed care plans. • Number of staff undertaking MECC Expected impact on Risk Score: A well-functioning Primary Care system is essential to improving population health outcomes, supporting the shift towards prevention and early intervention, and delivering a more sustainable, prudent healthcare model for the future. Community-based services are essential to improving outcomes through prevention, early intervention, and supported self-management. Providing care within local communities makes services more accessible, improves user experience, and helps reduce inequity by removing practical, geographical, and socioeconomic barriers to care-based services which is essential to improving outcomes through prevention, early intervention, and supported self-management. Health and Wellbeing Hubs bring together physical health, mental health, social care and community wellbeing services in one accessible location, creating a “no wrong door” approach that enables earlier intervention, smoother referrals and more holistic care. By embedding prevention and public	AD Primary & Community Care	31/03/2027	Progressing

	health activity within local communities, they help address the wider determinants of health, promote independence and reduce avoidable demand on acute services. 26/6/26 - 2A.7 – development of plans in relation to use of the Adult Plus Frailty tool 2B – Community by Design is progressing as expected through the ‘Discovery’ phase 2C – Health & Wellbeing hubs programme continues to make progress against plans for implementation – different stages for different hubs			
Gaps in Controls	Actions	Action Owner	Due Date	Progression Analysis
Develop and improve system-wide prevention through consistent prioritisation and integration with a focus on secondary care, clinical pathways and specialist services	6) Progress against the Strategic Intent Priority 3 - Improve Access, outcomes and experience for all deliverables which will directly contribute to improving population health and keeping people well for longer. This includes deliverables which focus on: – BCU community falls response resource – Providing falls prevention training across Care Homes – BCU MHL D physical health policy in line with national developments. – Reducing inequality and variation in access to services and pathways – Digitally delivered specialist All-Wales gambling harm and treatment service – CAMHS Early Help systems and processes – Healthy Child Wales 2 Programme – Childhood diabetes – prevention and management – Women’s Health - prevention and early intervention, including preconception health and earlier identification of women’s health conditions – Support the National Lung Screening Programme and other National screening programmes including reducing of variation – Support staff to complete MECC training Outcomes: People who fall in the community are treated outside of acute hospitals where they are more likely to de-condition. Patients are directed to the most appropriate service, freeing up resources such as ambulances and emergency departments. . A modern, people-centred healthcare system A clear long-term vision and strategy for our clinical services across North Wales, and an organisational structure that enables its delivery. Improved quality of maternity services including reduced perinatal mortality rates. Improved waiting times for people of all ages with Mental Health, Learning Disabilities and Neurodevelopment. More people supported with substance misuse. Metrics: • Reduce avoidable ambulance conveyances and ED admissions from Care Homes through providing falls lifting equipment and level one falls prevention training to be delivered to 30 Care Homes across North Wales.	ADs / Programme Leads – UEC, Planned Care, C&YP CAMHS, MH & LD, Womens	31/03/2027	Progressing

	• Reduce avoidable ambulance conveyances and ED admissions from the community by developing a proposal to use Six Goals Programme funding to increase Community Resource Teams (CRT) capacity, focused on mobilising Band 3 therapy support staff as a dedicated pan BCU community falls response resource. • Reduce Health Inequalities for people with learning disabilities by increasing the uptake of the annual health checks and public health screening initiatives across services. • Percentage of people who have been referred to health board services who have completed treatment for substance misuse (drugs or alcohol) • Percentage of patients offered an index colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioner assessment appointment • National screening targets • Childhood Measurement Programme participants • Percentage of C&YP waiting less than 26 weeks to start neurodevelopment assessment • Number of staff undertaking MECC Expected impact on risk score: Earlier diagnosis leading to better health outcomes. Prevention of deterioration and ill health or worsening conditions which impact on health and wellbeing. Reducing the gap in health outcomes for people with mental health and learning disabilities, supported by a focus on prevention, early intervention and reducing health inequalities. An integrated, responsive system where people receive the right care, in the right place, at the right time. Reduction in health inequalities and variation within clinical pathways of care. 26/06/26 – 3A – Falls prevention training and Falls lifting equipment delivery plan finalised for Care homes 3D.6 reduce inequalities for LD patients - Patient-facing support focusing on facilitating the uptake and delivery of health checks for patients, particularly those in hard-to-reach locations, through our Health Liaison Team and 'Lab in a Bag' initiatives. 3F.8 - Development of a strategic plan for children with a learning disability, and reduce inequalities for consultation - on track following meeting with Childrens CCAG 3F.2 - gap analysis of the requirements to fully implement the Healthy Child Wales 2 Programme 3G.6 local delivery of the NHS Wales Women's Health Plan across North Wales - Confirmed funding allocation both locally and nationally to expand on the Women's Health Hub as detailed within the National Women's Health plan 2025-2035			

Gaps in Controls	Actions	Action Owner	Due Date	Progression Analysis
Develop and improve system-wide prevention through consistent prioritisation and integration with a focus on system-wide approaches, Enabling services, strategy and pan BCU delivery	10)Progress against the Strategic Intent Priority 4 - Create a modern people centred healthcare system deliverables which will directly contribute to improving population health and keeping people well for longer. This includes deliverables which focus on: - <i>Population health management</i> - <i>Development of key plans and strategies</i> - <i>Embedding prevention as a core component and enabler of major programmes</i> - <i>Develop organisational understanding of population health needs and priorities</i> - <i>Develop collaborative partnership working which tackles wider factors which impact on population health and wellbeing such as employment and environment.</i> - <i>Funding models which support movement of services towards primary and community settings</i> Outcomes: Improved and more resilient systems, data and insights to support better day to day delivery of safe services and their improvement. More research and innovation projects and collaboration with education partners to provide improved health care for the future. Improved value for money services ensuring that precious resources are spent to deliver maximum benefit to the population. Better experience and outcomes for the population. Metrics: • Develop the measures of success in relation to both population and patient outcomes as well as the strategy development process. • Planning maturity matrix self-assessment scores (Population Needs Assessment is part of this) • Develop the measures of success in relation to both population and patient outcomes as well as the CSP process for those areas selected in the first tranche of the CSP. • High Value High Impact pathway analysis • Increase proportionate spend on Primary and Community Services Expected Impact on risk score: The Health Board can evidence informed decision making based on population health management data and intelligence. The Health Board can demonstrate response to population need and the impact on service delivery and resourcing. 26/6/26 – 4B – Development of Strategy continues through Discovery phase, considers prevention and population health. 4D.12 – Facilitate transformation through targeted activity - Early milestones relates use of data to inform a regional Warm Homes initiative in collaboration with local government and progressing recruitment to newly developed Population Health Management Team roles 4K – quantify current spend on primary and community services re strategic move to proportionately increasing investment into primary and community care - database is being is being	AD Planning / DDAT, Transformation , Estates, Finance, VBH	31/03/2027	Progressing



CRR REF: 25-05 - Risk Title: Strategic Change – Impacting Care and Staff Delivery				
Director Lead: Executive Director of Transformation and Strategic Planning		Date Opened: 21/08/2025 (version 2 refined from 2023)		
Assuring Committee: Planning, Population Health & Partnership Committee		Date Last Committee Review: 05/03/2026		
Date Last Reviewed: 05/05/2026	Link to BAF: BAF24-02		Target Risk Date: 26/11/2026	
Risk Detail: 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, patient harm from long waiting times, delays, and backlog reviews, and increased frustration or disengagement among staff tasked with delivering change.				
Mitigations/Controls in place				
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, 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. 9. Continued development of the portfolio management and reporting approach for all priority change programmes, including monthly monitoring of high risks across all priority programmes. 10. Mobilisation of the Challenged Services oversight group that will report into the SP&SC Group.				
Gaps in Controls	Actions	Action Owner	Due Date	Progression Analysis
G1 Completion of the strategy development work, moving into the	Complete Strategic Intent for North Wales with partners, presenting to Health Board for approval Expected Impact on Risk Score Reduction: Impact rating not expected to change. Overall likelihood is expected to reduce from 3 to 2 when all 6 actions are complete but individual	Head of Health Strategy and Planning, Transformation &	31/01/2026	Completed

execution phase.	actions alone will not affect the score. Action Update: COMPLETED. Four Strategic Intent Statements were co-created, tested and refined with key partners. They were reviewed by PPHP on the 14th of January and subsequently approved by the Board on the 29th of January. Following Board approval, the Statements were used to provide the strategic planning framework for the 2026/29 three-year plan replacing the previous five Strategic Priorities.	Strategic Planning		
G2 Organisational approach to change management to be developed and implemented.	Organisational approach to change developed as one of the enabling products within Foundations for The Future programme Expected Impact on Risk Score Reduction: Impact rating not expected to change. Overall likelihood is expected to reduce from 3 to 2 when all 6 actions are complete but individual actions alone will not affect the score. Action Update: Further work has been scheduled into 26/27 as part of the service level plan, to ensure full engagement in this work. Successful sessions have been held with the Executive team and the Stakeholder Reference Group. A discovery phase report is being finalised for presentation to the Strategic Planning and Service Change group on the 4 th June, and a time-limited group of key stakeholders is forming around the design elements. This will lead to an organisational change framework which is scheduled for completion in Q3.	Assistant Director of Transformation and Improvement (Interim), Transformation & Strategic Planning	26/11/2026	Progressing (revised date from 31/03/2026)
Gaps in Controls/	Action	Action Owner	Due Date	Progression Analysis
G3	Complete the diagnosis phased of the Health Board's 10 Year Strategy, including an implementation plan for the remaining programme of work Expected Impact on Risk Score Reduction: Impact rating not expected to change. Overall likelihood is expected to reduce from 3 to 2 when all 6 actions are complete but individual actions alone will not affect the score. Action Update: Due to competing pressures with the strategic intent and capacity constraints this work has rolled into 26/27 and will complete before the end of Q1. This will include endorsement through governance and be supplemented by a detailed and time-bound implementation plan for the delivery phase of the 10yr Strategy.	Head of Health Strategy and Planning, Transformation & Strategic Planning	30/06/2026	Progressing (revised date from 31/03/2026)
G4	Complete preparations for phase 2 of the Clinical Services Planning (CSP) work, including an implementation plan Expected Impact on Risk Score Reduction: Impact rating not expected to change. Overall likelihood is expected to reduce from 3 to 2 when all 6 actions are complete but individual actions alone will not affect the score. Action Update: A CSP engagement event with senior clinical leaders is taking place on the 5 th May. Preparatory work underway, with initial CSP engagement event scheduled for 5 th May. This event is one of the final steps in the preparation phase which is now expected to complete by the end of Q1. The day is designed to build a shared purpose and initiate the development of a new CSP for BCUHB. The CSP has now been adopted as a major change programme during 26/27 and a fully programme plan will be put in place.	Head of Health Strategy and Planning, Transformation & Strategic Planning	30/06/2026	Progressing (revised date from 31/03/2026)
G5	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. <i>Work is now complete and will continue to evolve as part of business as usual. Iterative changes have been made and the reporting has been very well received by Board Members for both Key Programmes and Challenged Services, with Board members stating that they feel more assured. Highlight reports in place for each programme/service in scope with summarised reporting through the Strategic Planning and Service Change Group and onwards to PPHP and Board.</i> Expected Impact on Risk Score Reduction: Impact rating not expected to change. Overall likelihood is expected to reduce from 3 to 2 when all 6 actions are complete but individual actions alone will not affect the score. Action Update: No further update in this period as now complete.	Assistant Director of Transformation and Improvement (Interim), Transformation & Strategic Planning	31/12/2025	Complete

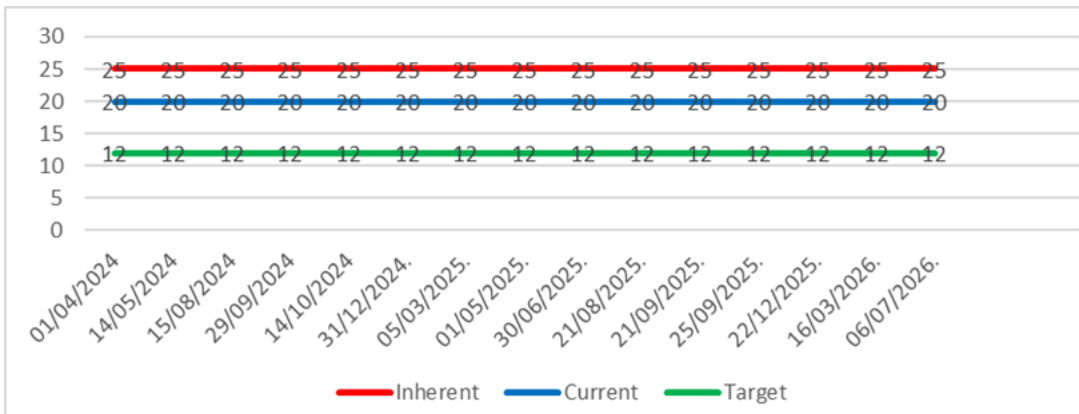
G6	Mobilise the Challenged Services oversight group that will report into the SP&SC GroupThis is complete. The first meeting was held on the 28th November with the next meeting scheduled for the 26th January, with the group developing plans for the regionalisation of services and transitioning into broader Clinical Services Plan work. Expected Impact on Risk Score Reduction: Impact rating not expected to change. Overall likelihood is expected to reduce from 3 to 2 when all 6 actions are complete but individual actions alone will not affect the score. Action Update: No further update in this period as now complete.	Assistant Director of Transformation and Improvement (Interim), Transformation & Strategic Planning	31/12/2025	Complete																						
<table><thead><tr><th>Date</th><th>Inherent</th><th>Current</th><th>Target</th></tr></thead><tbody><tr><td>21/08/2025</td><td>16</td><td>12</td><td>8</td></tr><tr><td>01/10/2025</td><td>16</td><td>12</td><td>8</td></tr><tr><td>31/12/2025</td><td>16</td><td>12</td><td>8</td></tr><tr><td>05/05/2026</td><td>16</td><td>12</td><td>8</td></tr></tbody></table>		Date	Inherent	Current	Target	21/08/2025	16	12	8	01/10/2025	16	12	8	31/12/2025	16	12	8	05/05/2026	16	12	8					
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CRR REF: 25-06 Risk Title: Delivery of the 2026/27 Financial Plan and Financial Sustainability		
Director Lead: Executive Director of Finance		Date Opened: 01/04/2026
Assuring Committee: Performance, Finance and Information Governance Committee		Date Last Committee Review:
Date Last Reviewed: 06/07/2026	Link to BAF: BAF24-03 / financial sustainability	Target Risk Date: 31/03/2027
There is a risk that the Health Board will be unable to deliver the 2026/27 financial plan and to demonstrate a credible route to longer-term financial sustainability. The plan is set within a zero-investment framework and includes a planned deficit of £43.0m, a recurrent savings requirement of £46.0m and significant reliance on delivery of savings, grip and control, and receipt/retention of anticipated Welsh Government allocations. This may be caused by inflation and unavoidable cost pressures exceeding the 1.11% allocation uplift; recurrent impacts from 2025/26 cost pressures; growth and price pressures in commissioned services, prescribing, secondary care drugs and CHC; unfunded national pressures including Welsh Risk Pool, digital/Microsoft licensing and additional NWJCC contributions; pressures in Out of Area Mental Health placements and escalated capacity; and insufficiently mature savings and disinvestment plans. This may lead to failure to achieve the planned deficit trajectory and key financial duty, loss or non-retention of conditionally recurrent strategic funding, reduced ability to fund essential services and transformation priorities, further escalation and scrutiny, and increased risk to safe, timely and high-quality care.		
Mitigations/Controls in place		
- Monthly financial reporting to Welsh Government through the Monthly Monitoring Return and internal Health Board reporting, including forecast outturn, risks and opportunities. - Performance, Finance and Information Governance Committee oversight, with financial and performance information shared routinely. - Executive and divisional governance over targeted investment allocations, including Performance and Transformation, Planned Care, Value-Based Healthcare, Further Faster and other specific Welsh Government allocations. - Continuation of 2025/26 Grip and Control measures into 2026/27, including additional non-pay expenditure controls for non-clinical categories, scrutiny of Travel Bureau requests and Stores orders, procurement review of pending Oracle requisitions and cancellation where not critically urgent. - Pay controls and added oversight over non-clinical external recruitment and clinical posts prior to recruitment, with scrutiny of temporary workforce use through Clinical Executive leadership. - Value and Sustainability thematic savings model across Clinical Value, Workforce, Continuing Healthcare, Medicines Management and Non-Pay & Procurement. - Savings identification and monitoring through the Green/Amber/Red pipeline, with Welsh Government action point deadlines for schemes to meet required classification by 30 June 2026 and conversion requirements by 30 September 2026. - Continued scrutiny of agency, locum and variable pay, including delivery against the Cabinet Secretary enabler target of a 30% agency cost reduction. - Ongoing review of reserves, central budgets, virements and forecast categorisation to improve transparency of cost pressures, mitigations and underlying deficit. - 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.		

- 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
- Integrated Performance and Accountability Framework 2026-29 adopted by Board on 28 May 2026
- Escalation meetings in place with key budgets holders and Chief Executive for July 2026 for those services / divisions that have not underwritten their savings targets at the end of June 2026.

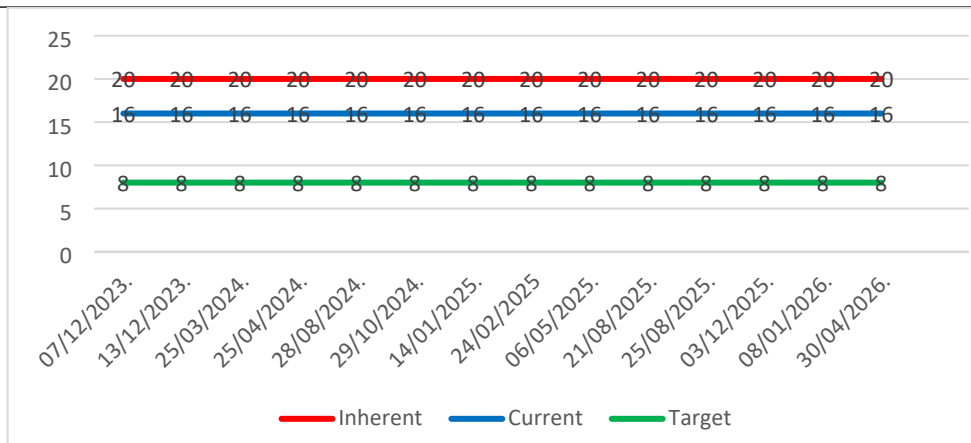
Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G1 The Month 2 position is adverse to plan, with an in-month deficit of £5.6m, £2.0m adverse to profile, a year-to-date deficit of £10.9m and cumulative savings shortfall of £5.0m.	Maintain enhanced monthly financial recovery and run-rate review through Executive, IP-EDG and PFIG Committee oversight. Outcome In-month deficit and year-to-date adverse variance are contained and brought back towards the profiled planned deficit trajectory. Metric In-month variance to plan; cumulative deficit to plan; run-rate movement by division. Impact on Risk Reduces likelihood of further deterioration and supports delivery of the £43.0m planned deficit.	Executive Director of Finance / Chief Executive Officer	Monthly to 31/03/2027	Progressing
G2 The plan relies on retention of conditionally recurrent strategic Welsh Government funding; loss of this funding is identified as an £82.0m risk and would materially worsen the underlying position.	Maintain evidence against conditions attached to strategic funding and ensure clear escalation where delivery or de-escalation requirements are at risk. Outcome Conditions for retention are explicitly tracked and risks escalated early. Metric Condition tracker RAG; evidence of delivery; value of funding at risk. Impact on Risk Protects critical income and reduces exposure to a significantly larger underlying deficit.	Executive Director of Finance / Executive Team	Monthly to 31/03/2027	Progressing
G3 Savings plans are not yet sufficiently mature to bridge the full requirement: £13.3m Green schemes were identified at Month 2 against a £46.0m target, with £31.9m Red schemes and pipeline opportunities still to be converted.	Accelerate conversion of pipeline and Red/Amber schemes to Green, with recurring/non-recurring split and delivery confidence reviewed monthly. Outcome A greater proportion of the £46.0m savings requirement becomes assured and deliverable. Metric Green schemes £m and % of target; recurring savings £m; YTD delivery against profile; pipeline conversion rate. Impact on Risk Reduces risk of unachieved savings and reliance on non-recurrent mitigations.	Executive Director of Finance / Value & Sustainability Leads / Divisional CFOs	30/09/2026 and monthly thereafter	Progressing
G4 Unplanned cost pressures are being reported and offset by unplanned spend reductions after virements, indicating volatility and complexity in interpreting run-rate, recurrent impact and genuine mitigations.	Strengthen monitoring return reconciliation and recurrent/non-recurrent classification, with monthly CFO check-and-challenge on cost pressures, spend reductions and virements. Outcome Improved clarity of the underlying position and fewer late adjustments. Metric Reconciliation issues resolved; value of items moved to correct category; forecast accuracy.	Executive Director of Finance / Central Finance / Divisional CFOs	Monthly to 31/03/2027	Progressing

	Impact on Risk Improves financial grip and enables earlier corrective action.			
G5 Inflationary and cost pressures exceed available allocation uplift, particularly CHC, Prescribing, Secondary Care Drugs, commissioned services, NWJCC/cross-border contracts, Welsh Risk Pool and digital pressures.	Maintain targeted pressure reviews and confirm mitigations/disinvestment proposals for high-risk categories, supported by benchmarking and contract scrutiny. Outcome Material pressures are quantified, mitigated and escalated through the financial governance route. Metric Pressure value by category; mitigation value identified; residual forecast variance. Impact on Risk Reduces likelihood that unavoidable pressures destabilise the plan.	Executive Director of Finance / Central Finance / Divisional CFOs	Monthly to 31/03/2027	Progressing
G6 Grip and Control measures may not deliver sufficient recurrent impact or may not be fully captured in the financial plan.	Quantify the impact of continued Grip and Control measures across non-pay, procurement, pay and temporary workforce, and report delivery through monthly returns. Outcome Savings and run-rate reductions attributable to Grip and Control are evidenced and sustained. Metric Value of requisitions cancelled/approved; non-pay reduction; recruitment controls impact; temporary workforce spend trend. Impact on Risk Supports run-rate containment and reduces reliance on unidentified mitigations.	Executive Director of Finance / Executive Directors / Procurement and Workforce Leads	Monthly to 31/03/2027	Progressing
G7 Agency and variable pay remain material risks, with Month 2 agency spend of £2.6m and variable pay of £8.5m, and 2026/27 variable pay forecast increasing from Month 1.	Maintain executive scrutiny of agency, locum, bank and overtime, including action plans against the 30% agency reduction enabler and temporary workforce controls. Outcome Agency and variable pay are reduced where clinically safe and affordable. Metric Agency spend £m/% of pay; variable pay forecast; delivery against 30% reduction target. Impact on Risk Reduces pay overspend and supports workforce affordability.	Executive Director of Finance / Executive Director of Workforce / Clinical Executive Leads	Monthly to 31/03/2027	Progressing
G8 Conditionally funded performance and transformation schemes are forecast to spend £42.0m in full, creating a need for strong benefits tracking and clear disinvestment/alternative funding where relevant.	Track programme spend, benefits and recurrent consequences for Performance and Transformation, Planned Care, Value-Based Healthcare and Further Faster allocations. Outcome Strategic funding supports agreed priorities without creating unfunded recurrent commitments. Metric Spend vs forecast; benefits delivery; recurrent consequence assessment completed. Impact on Risk Protects affordability and value for money while supporting transformation.	Director of Transformation / Executive Director of Finance / Programme SROs	Quarterly to 31/03/2027	Progressing
G9 Forecast assumptions depend on full receipt of anticipated income,	Continue monthly confirmation of RRL assumptions and anticipated allocations with Welsh Government, including pay	Executive Director of Finance /	Monthly to 31/03/2027	Progressing

including pay award funding and other RRL assumptions; misalignment with Welsh Government allocations would increase forecast risk.	award estimates and working balances support. Outcome Income assumptions are validated, and any funding gaps are escalated early. Metric Confirmed vs anticipated RRL; value of unconfirmed allocations; pay award estimate variance. Impact on Risk Reduces risk of unidentified income shortfalls affecting forecast outturn.	Deputy Director of Finance			
G11 Risks and opportunities identifies total quantified risks and no / low quantified opportunities	Maintain monthly risk and opportunity review to ensure risks are reflected in forecast where clear and evidenced. Outcome The forecast position remains aligned to the risk register and MMR Table A2. Metric Quantified risks/opportunities £m; movements since prior month; forecast inclusion status. Impact on Risk Improves transparency and supports early mitigation or escalation.	Executive Director of Finance / Central Finance	Monthly to 31/03/2027	Progressing	
			Impact	Likelihood	Progressing
		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					
At Month 2, the Health Board is reporting material financial sustainability risk for 2026/27. The plan is not balanced and is forecasting delivery of the planned £43.0m deficit, supported by receipt of anticipated income, retention of conditionally recurrent strategic funding and delivery of a £46.0m savings requirement. The year-to-date position is already adverse to plan, with savings delivery below profile.					
The intended outcome is to contain the run-rate, strengthen the recurrent savings pipeline, improve confidence in forecast assumptions and demonstrate clear evidence that savings, grip and control, disinvestment and value-based opportunities can reduce the forecast risk over the year. The target risk score remains outside the Financial/VfM appetite until there is sufficient assurance that recurrent savings are deliverable, conditional funding is secure and the forecast deficit is aligned with a credible route to financial balance.					

CRR REF: 25-07 Risk Title: Leadership and Operating Model		
Director Lead: Executive Director of People and Organisational Development		Date Opened: 21/08/2025
Assuring Committee: People & Culture Committee		Date Last Committee Review: 12/02/2026
Date Last Reviewed: 30/04/2026	Link to BAF: 25-04	Target Risk Date: 31/03/2027
Risk Detail: There is a risk that the Health Board does not deliver high quality patient care aligned to operational plans, or not meeting HB targets or adhering to legislative requirements. This may be caused by not building and maintaining an effective culture and leadership environment, or developing the necessary skills and knowledge of our leaders. This may lead to poor organisational culture and behaviours which in turn will lead to low staff morale, poor patient care and inefficient services for the population of North Wales.		
Mitigations/Controls in place		

1. Speak Out Safely Multi Disciplinary Team (MDT) and Work in Confidence platform for staff to raise concerns 2. Organisational Culture Change Plan and Behaviours Framework approved by Board and is being deployed 3. Integrated Leadership Development Framework (ILDF) in place 4. Improved nurse retention results over the last 2 years 5. Clear top-down commitment to reinforce leadership culture that prioritises staff wellbeing, inclusion, and psychological safety (Pledge signed) 6. Increased uptake on the 2025/26 staff survey 7. 60% of senior staff trained in leadership through conferences and masterclasses 8. New all Wales Flexible Working policy in place – monitored at the People and Culture Committee 9. Organisational Development (OD) plans are in place in 2026/27 to support recruiting well and joining well, for example Values Based Recruitment and Corporate induction				
Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G1 - Leadership development pathways not fully integrated	Further embed ILDF and measure effectiveness HEIW will release a Management Competency Framework due to be launched April 2026. This will be used to inform the mid-level management ILDF leadership courses / resources design. There has been a delay in HEIW launch of Management Competency Framework Mid level pilot to commence in May 26 this has been delayed due to financial restrictions on training. Evaluation of programmes completed for Q1 & Q2 with Q3 & Q4 due May 26. People Managers forum evaluation underway for first 12 month roll out	Head of Organisational Development Workforce & Organisational Development	30/09/2026	Progressing
G2 Outdated PADR process and system in place	A new values and behaviours based PADR system will be deployed in 2026. It is expected this programme will show results within the first year following the launch	Head of Organisational Development, People & OD	30/09/2027	Progressing
G3 Leadership taking on board and acting on staff survey results	Assess and agree the actions based on the 2025 staff survey results. The preliminary results are in. The next phase is for each service to confirm the localised actions in place to address the necessary actions in their areas	Head of Employee Engagement and Experience - Corporate Office	31/12/2026	Progressing
	A paper detailing the key findings from the NHS Wales Staff Survey 2025 and suggested next steps in response to feedback (including areas of focussed action) will go to the Board in May 2026. Directors received the results for their areas of responsibility in early March to inform discussions and action and teams across the organisation have access to HEIW'S survey dashboard to review performance and identify improvement opportunities. Briefings have also been held through established forums including local People and Culture Committees.	Head of Employee Engagement and Experience – Corporate Office	30/06/2026	Progressing
Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G4 Capacity in delivering planned programmes of work alongside FFtF without any additional resource in OD, this may impact on the timelines for delivery	Review and prioritise workload in the OD function in 2026/27 to accommodate FFtF	Deputy Director, People & OD	30/09/2026	Progressing
G5 Fully implemented culture change programme that will demonstrate improved KPIs	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. A new approach to recognise 25 & 40 years service will be ratified in the April 2026 P&CC	Head of Employee Engagement and Experience - Corporate Office	31/12/2026	Progressing

	Staff survey champions will be trained to support local monitoring and reporting				
	Deliver Culture Change Plan with Comms and Engagement rollout. P&CC received an update on the plan in February 2026 and it was agreed a revised plan would be submitted back to P&CC in June 2026	Head of Organisational Development,	30/06/2026	Progressing	
	Quarterly Culture, Leadership & Engagement Plans finalised and monitored P&CC received an update on the plan in February 2026 and it was agreed a revised plan would be submitted back to P&CC in June 2026	Head of Organisational Development, Workforce & Organisational Development	30/06/2026	Progressing	
G6 Regular culture performance reporting at IHC/Directorate level	Introduce culture reporting at IHC level. A new dashboard to be deployed in Q1 26/27 to track Y1 performance against corporate and divisional target	Deputy Director, People & OD	30/09/26	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					
The general feeling is culture and engagement had improved with the recent workstreams, however, the FFtF change programme is expected to impact this and will test organisational resilience KPIs to that inform our risk in this area as at February 2026; Staff retention 91.4% compared to 90.7% last year. PADR compliance 80%, compared to 78.95% last year The number of Grievance cases is 5 compared to 13 this time last year The percentage of stress & anxiety absences remains high at 1.8% which is over 1.2% this time last year The trend of speak out safely cases have remains static, but shows a 40% decrease from this time last year					

CRR REF: 25-08 Risk Title: Non-Compliance with Regulatory and Legislative Requirements				
Director Lead: Director of Corporate Governance		Date Opened: 21/08/2025		
Assuring Committee: Audit Committee		Date Last Committee Review: 06/11/2025		
Date Last Reviewed: 16/07/2026	Link to BAF: BAF24-01	Target Risk Date: 31/03/2027		
Risk Detail: There is a risk that the Health Board may fail to comply with regulatory and legislative requirements, which could directly or indirectly impact the safety, quality, and accessibility of patient care. This may be caused by inefficiencies in managing regulatory complexities and changes at pace, ineffective relationship management with regulators and statutory bodies, inadequate monitoring and reporting of actions and progress, including escalation, and insufficient operational assurance. This may lead to enforcement action, impact patient safety, financial penalties, impact on workforce, and loss of public and stakeholder confidence.				
Mitigations/Controls in place				
1. Internal and external audit reviews identifying and reporting areas of non-compliance with legislation and regulation. 2. Report on progress on some regulatory compliance submitted to the Regulatory Assurance Group, Executive Quality and Delivery Group, and Quality, Safety and Experience Committee via the Integrated Quality Report. 3. An update on progress on some regulatory compliance from the Integrated Quality Report also included in the Statutory Compliance Report to Executive Committee and Audit Committee. 4. Monitoring of regulations and legislation by various groups, such as: – Medical Devices Governance & Assurance Group oversees procurement, selection, risk management and safety communication – Estates and Health & Safety Committee oversee areas of non-compliance and tracking of action plans. – Pharmacy Technical Services and monitoring of compliance in relation to Controlled Drugs. Regulatory Assurance Group for some clinical regulations. (Oversight and gap analysis of all groups required and reflected in the action plan/gaps in controls)				
Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G1 The Health Board currently lacks a complete and consolidated picture of its regulatory and statutory relationships, leading to limited visibility over roles, responsibilities, and engagement practices.	Capture current relationship management practices and arrangements around Health Board regulators and statutory bodies Complete a structured mapping exercise of all regulators and statutory bodies across the Health Board to identify lead Executive Team member, operational lead, and current relationship with these bodies 16/07/2027 – The latest version of the Regulatory Relationship Management Matrix was presented to the inaugural meeting of the Governance and Regulatory Executive Delivery Group on 7 July 2026. Executive Team members have been asked to review the information contained within the Matrix and provide any comments, amendments or additional information as required. Initial discussions indicated that the Matrix is largely comprehensive and captures the majority of known regulatory, statutory, professional and oversight body relationships. The Group agreed to use the Matrix as the primary mechanism for oversight of external regulatory and professional body relationships. A programme of rolling review will be established, with the Group identifying priority regulators and bodies for detailed discussion at future meetings to ensure appropriate governance, assurance and relationship management arrangements are in place. As the Matrix has been developed, presented to the Group and adopted as a tool to support ongoing oversight and monitoring, it is recommended that this action be closed, with future review and maintenance of the Matrix being undertaken through the Governance and Regulatory Executive Delivery Group.	Head of Statutory Compliance and Inquiries	31/07/2026	Completed

	Outcome • A clear, consolidated view of how the Health Board currently manages relationships with regulators and statutory bodies • A baseline understanding that supports improved coordination, compliance, and strategic engagement • Clarity, visibility, and baseline understanding. Metric • Confirmation from each Executive Team member that details of all regulators and statutory bodies under their portfolio have been captured Impact on Risk • Increased visibility of current relationship management practices with its regulators and statutory bodies across the Health Board • Increased visibility of the current reporting and monitoring practices relating to regulator and statutory body information across the Health Board • Increased visibility of roles and responsibilities relating to regulators and statutory bodies.			
Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G2 There is no fully reliable or validated register of regulatory relationships and statutory obligations, creating uncertainty around ownership, assurance, and compliance oversight	Review of regulatory and statutory body relationship management, reporting and monitoring arrangements 16/07/2027 – The Regulatory Relationship Management Matrix was presented to the inaugural meeting of the Governance and Regulatory Executive Delivery Group on 7 July 2026. The Group noted that, whilst the Matrix contains a significant amount of information relating to regulatory, statutory, professional and oversight bodies, some sections remain incomplete. In many cases, this reflects the absence of formal processes or arrangements rather than missing information. As such, the Matrix will remain a live document and will continue to be reviewed and updated as governance arrangements mature and additional information becomes available. The Group agreed that the Matrix will be used to inform its programme of work, with regulators and other external bodies being identified for focused review and discussion at future meetings. This will form part of the Group's routine cycle of business and will support ongoing oversight, assurance and the continual development of relationship management arrangements across the Health Board. Review the Relationship Management Matrix. Outcome • A strengthened, authoritative information set that can be used confidently by the Board, Executive Team Members, and operational teams • Identification of strengths, gaps, inconsistencies, and duplication in governance practices	Head of Statutory Compliance and Inquiries	28/08/2026	Progressing

	- An assessment of whether the existing information is sufficient to support assurance, compliance oversight, and regulatory engagement - A foundation for designing a more consistent, risk-aligned regulatory engagement framework Metric - Completeness — proportion of regulators/statutory bodies for which full information exists - Clarity of ownership — proportion of entries with clearly assigned responsible officers or teams. Impact on Risk When the information is complete and reliable: - Regulatory risk decreases because the Health Board has a clear, accurate understanding of all obligations and expectations - Ability to identify gaps in the improvements required to strengthen our processes - A verified, up-to-date record of all regulatory relationships and obligations, with inaccuracies corrected and gaps identified.			
Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G3 There is no formalised executive-led forum providing consistent oversight, coordination, and escalation of governance, statutory compliance, and regulatory issue	Executive Governance and Regulatory Group Formalise a multi-disciplinary Governance and Regulatory Group to provide routine scrutiny, coordination, and escalation. 16/07/2027 – The first meeting of the Governance and Regulatory Executive Delivery Group was held on 7 July 2026 and was well attended by Executive and senior colleagues. Constructive discussions took place regarding the future direction, priorities and governance arrangements for the Group. In response to feedback received, the duration of future meetings has been increased to allow sufficient time for discussion and oversight. Meetings have also been scheduled for the remainder of 2026/27. The Group's Terms of Reference were reviewed and discussed at the inaugural meeting, with feedback incorporated into a revised draft. The updated Terms of Reference will be presented for further consideration at the next meeting. At the next meeting on 15 September 2026, the Chair will present a forward workplan and standing agenda items for future meetings. Due to this, the due date for this action has been extended. Outcome A formalised, multi-disciplinary Executive Led Group to ensure consistent oversight, aligned decision-making, and timely escalation across governance, statutory compliance, and organisational assurance domains Metric	Head of Statutory Compliance and Inquiries	15/09/2026	Progressing

	- Group established with agreed terms of reference - Clear, defined and documented reporting and escalation processes - Attendance and representation across disciplines. Impact on Risk Formalising this Group will have a material positive impact on organisational risk exposure, the key improvements include: - Clearer escalation routes ensure strategic risks receive timely executive attention - More coordinated oversight supports consistent compliance across operational divisions - Improved accountability reduces drift, variability, and unmanaged exposures - Systematic monitoring ensuring the Health Board maintains compliance with statutory duties and regulatory frameworks - Provides clearer lines of sight for Board Committees			
Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G4 The Health Board lacks a centralised system to record, monitor, and assure compliance with legislative and regulatory requirements, resulting in fragmented and inconsistent oversight.	Compliance Management System Implement a centralised compliance management system to capture and enable the monitoring of Health Board-wide legislative and regulatory requirements 16/07/2026 - Work continues on the scope within DDaT to include the IT security, infrastructure and integration requirements. Once this has been finalised, the procurement process can commence. Outcome Implementation of a centralised electronic system provides a single source of information for all legislative, statutory, and regulatory requirements, linked directly to named accountabilities and real-time assurance. Metric - System procured - System live by agreed date Impact on Risk Implementation of the system will have a significant positive effect on reducing organisational risk in multiple categories. - Ensures the organisation maintains a live, accurate register of all legislative and regulatory duties - Strengthens evidence trails for external inspections (for example Health Inspectorate Wales, Audit Wales, Health and Safety Executive) - Clear ownership of responsibilities reduces operational ambiguity and the risk of requirements being missed - Real-time visibility enables early escalation of compliance risks before becoming significant failures - Moves the Health Board from reactive to proactive compliance management - Reduces inconsistencies across directorates, improving confidence in assurance processes	Head of Statutory Compliance and Inquiries	31/03/2027	Progressing

	• Supports Board Committees by providing reliable, validated, accessible assurance information • Demonstrates to regulators and external stakeholders a systematic, robust approach to compliance • Automated reporting reduces human error, version-control issues, and information gaps • Ensures a clear audit trail for decisions, updates, accountability, and evidence.				
			Impact	Likelihood	Score
		Inherent Risk Rating	4	5	20
		Current Risk Rating	4	3	12
		Target Risk Score	4	2	8
		Risk Appetite	Regulatory/Compliance <15		In Tolerance
Position & Intended Outcome for Risk					
Governance and regulatory EDG to be set up to oversee compliance, and to track non-compliance to ensure risks are mitigated, reporting areas of non-compliance to the Executive Committee. This risk has been developed into a more strategic risk, which will encompass overarching compliance to statutory requirements across the Health Board.					

CRR REF: 25-09: Risk Title: Safe Environment		
Director Lead: Director of Environment and Estates		Date Opened: 04/01/2024
Assuring Committee: Performance, Finance and Information Governance Committee		Date Last Committee Review: 24/02/2026
Date Last Reviewed: 22/06/2026	Link to BAF: BAF24-03	Target Risk Date: 31/03/2030
Risk Detail: 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 estate's strategy. This may lead to safety incidents, non-compliance with statutory duties, and barriers to service modernisation.		
Mitigations/Controls in place		
- Estates Strategy developed and approved by the Health Board in January 2023. - Internal Governance for capital allocation in place within the Health Board. - Business Cases to Welsh Government to resolve major infrastructure issues in line with the Estates Strategy - 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. - 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 - 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. - Operational Estates Safety Groups in place to provide assurance, the safety groups are as detailed below and oversee risks relevant to the groups: - Fire Management - Asbestos Management - Water Safety, - Ventilation Safety - Electrical Safety - Welsh Government Capital Resource Meetings in place to provide route for escalation. - Estates and Facilities Performance Management System (EFPMS) reporting template and recording of backlog maintenance - Capital Allocation from Welsh Government – additional capital funding of allocated to the Health Board to focus on Backlog Maintenance - 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 align with the capital prioritisation form that we will submit to Welsh Government. - 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. - 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				
Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G1 6-facet surveys 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.	Facet Survey Undertake actions to deliver a facet survey across the Health Board over the next 2 years. Due to financial constraints within the Health Board a review of the facet survey programme is being undertaken to confirm which facets are a priority for the Health Board. Facet 1 - Physical Condition Survey (Fabric and M&E) Facet 2 - Statutory Requirements (Risk Based Methodology for Establishing and Managing Backlog) Facet 3 – Space Utilisation (Scope to be finalised) Outcome Deliver a phased, prioritised partial Facet Survey Programme across the Health Board over the next 2 years, ensuring a comprehensive understanding of estate condition, statutory compliance, space utilisation and backlog risk. Due to financial constraints, conduct a review to determine which facets are critical to informing investment decisions, focusing initially on Facet 1 (Physical Condition: Fabric & M&E) and Facet 2 (Statutory Requirements / Risk-Based Backlog). The outcome is to produce accurate, site-wide data that underpins capital planning, operational risk management, and strategic estate development. Metric Programme Scope & Completion - Completion of Facet 1 and Facet 2 surveys for all major acute, community, and mental health sites within 3 years. Data Quality & Integration - Survey data validated and uploaded into estates asset management systems (e.g., MICAD and future CAFM plans). Buildings or zones with complete, up-to-date backlog and condition profiles Backlog & Statutory Risk Assessment - Reduction in “unknown” condition/risk items within asset registers (target: elimination). Development of a risk-based statutory compliance backlog for Facet 2. Alignment With Capital Plans - Capital bids or business cases supported by validated facet data. Use of Facet 1 and 2 outputs to prioritise high-risk backlog items in annual capital allocation. Alignment with developing clinical service plans – to ensure optimum utilisation of the retained Estate and disposal opportunities for lease hold properties and redundant or obsolete Estate Impact on Risk Delivering this programme will: Reduce strategic and financial risk by ensuring investment decisions are based on validated, prioritised, and risk-driven estate data rather than assumptions or incomplete surveys. Mitigate statutory non-compliance through a clear understanding of high-risk areas within Facet 2, enabling timely intervention and reducing exposure to regulatory enforcement. Lower operational risk by identifying critical M&E, structural, and fabric issues early, preventing service disruption, safety incidents, or unplanned ward/department closures.	Head Of Operational Estates	31/03/2028 (Subject to funding)	Progressing Due date extended from 31/03/2027 to 31/03/2028

	Improve organisational assurance, giving the Board confidence that estate condition, backlog maintenance, and statutory risks are transparently understood and being managed in a structured, evidence-based manner. Strengthen long-term planning, ensuring the estate strategy, clinical strategies, and capital programme are all informed by a consistent, Health Board-wide dataset. Reduce reputational risk, demonstrating responsible stewardship of the estate and a proactive approach to addressing backlog and compliance issues before they compromise patient care.			
Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G2 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.	Develop ToR Develop a standardised Terms of Reference to be considered and endorsed by Capital Investment Group Outcome A standardised, comprehensive, and governance-compliant Terms of Reference (ToR) is developed and endorsed by the Capital Investment Group. This ensures consistent governance, clarity of responsibilities, improved decision-making, and strengthened assurance for capital planning, prioritisation, and delivery across the Health Board. Metric Development & Approval - Revised ToR to be drafted and aligned with SFI and SoRD - ToR reviewed by required stakeholders (Capital Planning, Finance, Clinical, Estates). - ToR formally endorsed by the Capital Investment Group. Quality & Governance Compliance - Alignment with HB governance framework and Welsh Government capital governance. - Evidence of clear roles, responsibilities, delegated authority, and reporting lines within the ToR. Implementation - ToR published and communicated to all relevant stakeholders within agreed timescale. Impact on Risk Governance Risk Reduction - Reduces ambiguity around decision-making, leading to robust capital approval process - Ensures consistent application of governance standards across capital schemes. - Strengthens audit trail and assurance for internal/external scrutiny (WG, Audit Wales). Strategic & Operational Risk Reduction - Ensures that roles, responsibilities, and authority for capital decisions are clearly defined, minimising project delays or misaligned decisions.	Director of Environment and Estates	31/09/2026	Progressing Due date extended from 31/03/2026 to 30/09/2026 to reflect Foundations for the future structure, and review of capital processes.

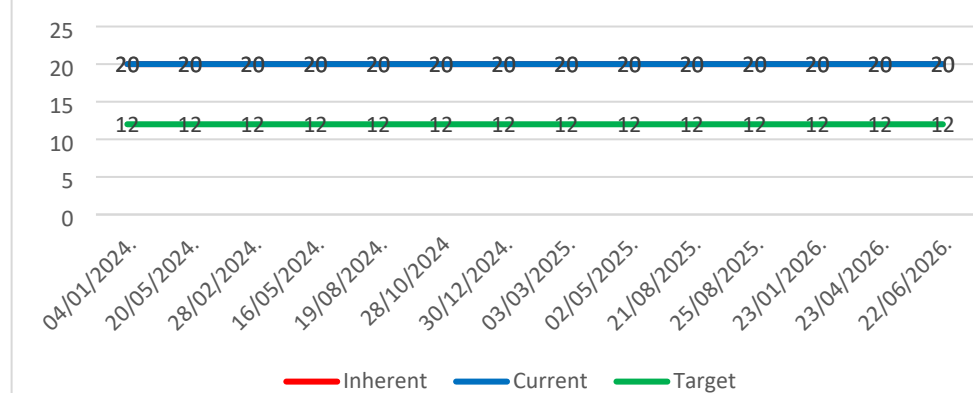
	- Enhances reliability of capital programme delivery through improved oversight. Compliance & Regulatory Risk Reduction - Reduces likelihood of non-compliance with Welsh Government capital governance requirements. - Supports consistent, well-governed business case progression.			
Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G3 Ensure that the Health Board has an Estates rationalisation programme in place that will support the capital prioritisation programme and reduce backlog maintenance.	Estates Rationalisation Programme 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. Outcome Deliver a comprehensive Health Board-wide Estates Rationalisation Programme that identifies, prioritises, and progresses opportunities for estate disposal, consolidation, and optimisation, utilising information received from the HB Clinical Plans and Estates Condition Survey. This includes producing a fully developed Estates Rationalisation Plan—currently in draft—to be reviewed by a multidisciplinary group and ratified by the Capital Investment Group (CIG), with formal presentation scheduled for September 2026. The programme will be updated to incorporate approved disposals within financial year. Metric: Programme Development & Governance - Draft Rationalisation Programme completed and submitted to the multidisciplinary review group. Final Estates Rationalisation Plan to be approved by the Board. Delivery of Approved Disposals - Number and value (£) of estate disposals completed. Progress planned disposal opportunities for 2026–2030. Estate Consolidation & Space Efficiency - Total reduction in estate footprint through rationalisation. Under-utilised space to be identified and addressed through disposal, consolidation, or repurposing. Financial Impact - Revenue savings delivered through reduction of lease, utility, security, and maintenance costs (year-on-year increase). Capital receipts generated from disposal of surplus estate (reported annually). Impact on Risk Delivering the Estates Rationalisation Programme will: Reduce financial risk - Lowering the cost of maintaining under-utilised, poor-condition, or non-compliant estate assets, and by generating capital receipts that can be reinvested in priority clinical infrastructure.	Head Of Operational Estates	30/03/2028	Progressing Due date extended from 31/03/2026 to 30/03/2028. Aligned with Facet Survey Programme

	Mitigate operational risk, ensuring that estate resources are focused on the most functional, safe, and strategically aligned sites, reducing exposure to failures in aged or inefficient buildings. Lower compliance and statutory risk by enabling the Health Board to phase out high-risk assets where the investment required to achieve compliance is disproportionate to clinical benefit. Improve organisational assurance, Demonstrating to CIG, the Board, and regulators that the estate is being actively and responsibly managed through structured, risk-based rationalisation. Reduce reputational risk, as proactive rationalisation demonstrates efficiency, and commitment to improving the quality and sustainability of the estate.			
Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G4 Internal Audit review of Fire Safety – Agreed Management Action Plan being implemented and being managed through the Fire Safety Management Group	Non-Compliance with Fire Safety Ensure the HB is fully compliant with Fire Safety Infrastructure on all sites (acute and Community) YG - Health Board submitted a PBC to address the Fire Safety and Infrastructure compliance issues on the Ysbyty Gwynedd site through the Welsh Government Infrastructure Board. In response to Programme Business Case Welsh Government have asked the Health Board to identify within the Programme Business Case those elements that relate to Fire safety only. Wrexham Maelor - Health Board submitted a PBC to address the infrastructure compliance issues on the Ysbyty Maelor site (Wrexham Resilience Programme) through the Welsh Government Infrastructure Board. In response to Programme Business Case, Welsh Government have asked the Health Board to identify high risk priority improvement projects Outcome Achieve full statutory compliance with fire safety legislation across the Health Board estate by implementing all required actions identified in the Fire Safety Audit/Firecode compliance assessment. This includes ensuring fire precautions, compartmentation, detection and alarm systems, evacuation procedures, maintenance regimes, training, and governance arrangements fully meet regulatory and NHS Firecode standards to protect life, property, and continuity of clinical services. Metric Fire Audit Action Completion Rate - Fire safety audit actions completed within agreed timescales WHTM 05 Compliance Level - Measured compliance against HTM 05-01/02/03 requirements, including structural fire precautions, fire alarm and suppression systems, and management arrangements (target: full compliance or approved derogations). Fire Safety Training Compliance - staff completing mandatory fire safety training and evacuation drills. Number of Fire Incidents & Unwanted Fire Signals (UWFS) - Reduction in fire incidents and UWFS across the estate (target: continual reduction and compliance with national UWFS targets). Impact on Risk	Head Of Operational Estates	31/03/2030	Progressing

	Significantly reduce risk to life - by ensuring effective fire detection, containment, and evacuation arrangements for patients, staff, and visitors. Mitigate legal and regulatory risk, - ensuring compliance with the Regulatory Reform (Fire Safety) Order 2005 and NHS Firecode, preventing enforcement notices, prosecutions, or reputational harm. Improve estate resilience, - reducing the likelihood of fire-related service disruption, ward closures, or damage to critical clinical infrastructure. Strengthen organisational assurance, - providing the Board with confidence that fire safety across the estate is being effectively managed, monitored, and continuously improved.			
Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G5 Timely progression of major Capital Schemes which address Estates Safety such as Wrexham Maelor Continuity Plan – Phase and Ysbyty Gwynedd PBC	PBC Developments Ensure the HB has a strategic plan of major Capital Schemes which address Estates Safety such as Wrexham Maelor Continuity Plan – Phase and Ysbyty Gwynedd PBC Outcome A comprehensive, Board-approved strategic pipeline of major capital schemes is produced, ensuring that critical Estates Safety, infrastructure resilience, and service continuity risks across Wrexham Maelor and Ysbyty Gwynedd are clearly defined, prioritised, and supported by robust, compliant PBCs. This enables the HB to progress to SOC and subsequent business case stages with confidence, in alignment with WG capital requirements and timelines. Metric PBC Development & Approval - Review of Wrexham Maelor Continuity Plan PBC within agreed timeline. - Review of Ysbyty Gwynedd PBC within agreed timeline. Strategic Alignment & Quality - Compliance with WG Capital Guidance and Five-Case Model requirements. - Number of key risks and constraints captured and mitigations identified in PBCs. Impact on Risk Estates Safety Risk Reduction - High-risk backlog maintenance reduced through planned major capital interventions. - Clear identification and prioritisation of statutory and infrastructure compliance issues (e.g. fire safety, electrical resilience, water systems). - Enables proactive replacement of life-expired critical infrastructure (HV/LV, ventilation, medical gases, roofs, drainage etc.). Service Continuity & Resilience - Reduced risk of unplanned service outages at Wrexham Maelor and Ysbyty Gwynedd. - Improved resilience for essential acute and emergency services.	Director of Environment and Estates	30/09/2026	Progressing Due date extended from 31/03/2026 to 30/09/2026 to reflect Foundations for the future structure

	- Lower likelihood of business continuity incidents due to infrastructure failure. Strategic & Financial Risk Reduction - Reduces risk of WG capital bids failing due to incomplete or misaligned business cases. Governance & Assurance - Improved transparency and auditability through structured PBC documentation. - Ensures HB meets statutory obligations for safe, sustainable estate provision.			
Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G6 Assurance around the progress made with the BCUHB Estates Strategy and the lack of clarity around the BCUHB Clinical Strategy.	BCUHB Estates Strategy Progress with delivering an updated Estates Strategy by engagement with stakeholders across BCUHB and identifying a number of common themes around strategic ambitions for the estate that aligns with the Health Board's Clinical Strategy. Outcome Deliver meaningful progress on the Health Board's Estates Strategy by actively engaging with key stakeholders across BCUHB to identify shared priorities, establish common themes, and ensure that estates planning aligns directly with the Health Board's Clinical Strategy. This includes producing a clear, evidence-based strategic direction for the estate that supports clinical service transformation, improves functionality and resilience, and informs future investment decisions. Metric Stakeholder Engagement Completion -Divisions, Clinical Boards, and Corporate Departments engaged as part of the Estates Strategy programme Themes & Strategic Priorities Identified - Number of common themes captured and validated across stakeholder groups (e.g., capacity, clinical adjacencies, digital enablement, estate condition, sustainability). Alignment with Clinical Strategy - Evidence of mapped alignment between Estates Strategy themes and the Health Board's Clinical Strategy goals (target: full alignment across all major programmes). Strategic Output Deliver - Completion of key strategy documents (e.g., Strategic Outline Programme, Estate Development Priorities Schedule, site-specific masterplans) within agreed timescales Incorporation Into Planning & Capital Process - strategic priorities formally integrated into capital plans, business cases, or service transformation programmes. Impact on Risk Reduce strategic misalignment risk, ensuring estate development directly supports the Clinical Strategy rather than evolving in isolation. Mitigate investment and Financial risk (Capital and Revenue) by providing a clear, prioritised plan that supports informed capital decision-making and reduces the likelihood of unsuccessful business cases or inefficient expenditure.	Director of Environment and Estates	30/09/2026	Progressing Revised date from 31/03/2026

	Lower operational and service delivery risk by identifying estate constraints early and planning improvements that enhance flow, capacity, and resilience across clinical environments. Improve organisational assurance, demonstrating that the Estates Directorate is actively engaging service leaders and shaping a modern, fit-for-purpose estate that supports safe, effective care. Reduce reputational and regulatory risk, ensuring that estate challenges—condition, compliance, functional suitability, sustainability—are addressed through a transparent and collaboratively developed long-term plan. Strengthen future readiness, ensuring the estate is aligned to changing service models, population health needs, digital transformation, and sustainability commitments.			
Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G8 NWSSP Authorising Engineer – Water – Audit on water safety undertaken and agreed action developed to improve compliance which are reported at the Water Safety Group	Legionella Management and Control Ensure the Health Board is compliant with its statutory duty to manage water systems across the estate by addressing all findings reported as part of the AE audit of water systems and operational management Outcome Achieve full statutory compliance in the management and control of Legionella across the Health Board estate by implementing all required actions identified in the Authorising Engineer (Water) audit. This includes ensuring safe operation, monitoring, testing, maintenance, and governance of water systems to minimise the risk of Legionella proliferation and protect patients, staff, and visitors. Metric: AE (Water) Audit Action Completion Rate - Audit actions completed within the agreed timeframe (target: 100%). Compliance score against ACoP L8, - WHTM 04-01 Part B, and internal Water Safety Plan standards (target: full compliance or approved derogations in place). Legionella and Pseudomonas Sampling Compliance - Routine water sampling and microbiological monitoring completed on schedule. Impact on Risk Reduce the risk of Legionella growth, lowering the likelihood of Legionnaires' disease outbreaks, safeguarding vulnerable patient groups and clinical operations. Mitigate statutory non-compliance, reducing exposure to enforcement action from regulators (HSE), legal claims, and reputational damage. Improve system reliability, ensuring cold and hot water systems remain within safe operating parameters. Strengthen organisational assurance through robust water safety governance, clear maintenance regimes, and evidence-based compliance reporting. Reduce operational disruptions, preventing ward closures, service interruptions, and emergency remedial works due to water safety failures.	Head Of Operational Estates	30/09/2026	Progressing Revised date from 31/03/2026
Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G9 NWSSP Authorising Engineer – Electrical– Audit on Electrical	Electrical and Mechanical Infrastructure on the Wrexham Maelor Hospital Site Ensure the Health Board is compliant with its statutory duty to manage electrical systems across the estate by	Head Of Operational Estates	31/03/2028	Progressing

Systems undertaken and agreed action developed to improve compliance which are reported at the Electrical Safety Group		addressing all fundings reported as part of the AE audit of electrical systems and operational management Outcome Achieve full statutory compliance for electrical systems across the Wrexham Maelor Hospital site by implementing all required actions arising from the Authorising Engineer (AE) electrical audit. This includes ensuring safe operation, maintenance, resilience, and governance of electrical infrastructure, thereby supporting continuity of clinical services and reducing risk to patients, staff, and the organisation. Metric Statutory Compliance - Measured improvement against HTM 06-01 / BS 7671 compliance requirements (target: full compliance or approved derogations in place). Risk Reduction Achievement - Reduction in high- and medium-risk items recorded on the electrical risk register (target: 0 high risks, 50% reduction in medium risks within 12 months). Unplanned Outage Incidents - Year-on-year reduction in electrical infrastructure failures or unplanned interruptions impacting clinical services (target: continual reduction). Impact on Risk Significantly reduce risks associated with electrical system failure , including power loss to critical clinical areas, unsafe equipment operation, or potential electrical fires. Mitigate organisational statutory non-compliance risk , preventing enforcement action, regulatory escalation, or reputational harm. Improve resilience of electrical infrastructure , reducing vulnerability during peak clinical load, emergency events, or equipment failure. Lower health and safety risks to patients, staff, and contractors through improved control of isolation, testing, and operational procedures. Strengthen assurance to the Board , demonstrating that the Estates function is effectively managing safety-critical infrastructure in line with HTMs, legislation, and AE recommendations.			
					

years. This will be a significant part of the estate's 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 align 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 2026. 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.

[Internal Audit review of Asbestos Management has been completed which reported Substantial Assurance, due to this outcome action G7 'Internal Audit review of Asbestos Management – Agreed Management Action Plan developed and managed through the Asbestos Management Group' has been completed.](#)

[Estates Rationalisation programme being reviewed to identify any quick wins that can deliver financial savings quicker.](#)

CRR REF: 25-10: Risk Title: Health and Safety				
Director Lead: Director of Environment and Estates (DoE&E)		Date Opened: 21/08/2025		
Assuring Committee: Performance, Finance and Information Governance Committee		Date Last Committee Review: 24/02/2026		
Date Last Reviewed: 30/04/2026	Link to BAF: BAF24-03	Target Risk Date: 31/03/2027		
Risk Detail: There is a risk that the organisation may fail to maintain a safe environment for staff, patients, service users and visitors in line with health and safety legislation. This may be caused by • Inadequate governance, leadership oversight or assurance of health and safety arrangements. • Insufficient resources (financial, staffing or time) allocated to health and safety management. • Poor compliance with statutory inspections, maintenance schedules or risk assessments. • Lack of staff competence, training or awareness of health and safety responsibilities. • Failure to learn from incidents, near misses or external safety alerts. • Ageing estate, infrastructure failures or unsafe plant and equipment. • Inconsistent application of policies and procedures across sites or services. This may lead to • Injury, ill-health or fatalities involving staff, patients or visitors. • Increased incidents, near misses and reportable accidents (RIDDOR). • Regulatory enforcement action (e.g. HSE or CQC notices, prosecutions or fines). • Civil claims, increased insurance costs and reputational damage. • Reduced staff morale, increased sickness absence and staff turnover. • Service disruption, ward closures or loss of public confidence. • Failure to meet statutory duties and corporate objectives.				
Mitigations/Controls in place				
Governance and Leadership (Links to ACR1) • HS01 Health and Safety Policy approved and reviewed at Board level • Director of Environment and Estates Designated Executive Lead for Health and Safety • Health and Safety Committee (Strategic Occupational Safety and Health Group) with staff side representation, which escalates up to People and Culture Committee. Health and Safety Risk Management (Links to ACR2) • Annual gap analysis using the NHS Employer Health and Safety Standards used to assess compliance against current health and safety legislation and standards • HS03 General Risk Assessment Procedure • Local Health and Safety File • Routine workplace risk assessments (e.g. slips and trips, manual handling, COSHH, etc.) • Incident reporting systems and investigation processes Training and Competence (Links to ACR3) • Mandatory health and safety training for all staff • Accredited Health and Safety Training courses (e.g. NEBOSH) • In-house taught Health and Safety Training courses (e.g. Risk Assessment, COSHH, RIDDOR) • Health and Safety webpages on BetsiNet Monitoring and Assurance (Links to ACR4&5) • Proactive: Scheduled health and safety reviews/audits that incorporate workplace inspection • Reactive: Ad hoc visits in response to incidents				
Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
ACR1: Governance and Leadership (PLAN)				
ACR1a A review of resources required following the internal audit	A review of resources within the Health, Safety and Security Service is required following the internal audit findings. Produce a documented resource review paper and proposed structure for Leadership consideration. Complete a business case if necessary ready for approval. Initial structure review and remodelling completed; progress dependent on the outcome of the Foundations for the Future program, which will inform final decisions. Addresses audit recommendations to ensure adequate resourcing and supports delivery of Health and Safety objectives across BCUHB. Complete the resource review and business	DoE&E	31/03/2027	Progressing

	case by September 2026, following confirmation of Foundations for the Future outcomes. Outcome An appropriately resourced Health, Safety and Security Service that meets internal audit recommendations and supports statutory compliance across BCUHB. Metric • Resource review paper and proposed structure completed by September 2026. • Business case (if required) completed and submitted for approval by November 2026. • Final structure aligned with outcomes of the Foundations for the Future programme. Impact on Risk Completing the review and securing the required resources will reduce the likelihood of non-compliance, improve assurance, and strengthen organisational safety governance.			
Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
ACR1b A review of the Terms of Reference, Cycle of Business and Escalation and De-escalation Routes	Undertake a comprehensive review and update of the Terms of Reference, Cycle of Business, and escalation and de-escalation routes to ensure clarity of roles, responsibilities, decision-making authority and timely escalation of health and safety risks. Outcome Clear, consistent and well-understood governance arrangements that support effective oversight, assurance and timely management of health and safety risks at all levels of the organisation. Metric • Revised Terms of Reference, Cycle of Business and escalation framework formally approved • Evidence of dissemination and staff awareness • Auditable compliance with escalation timescales and reporting routes • Reduction in delayed or inappropriate escalations identified through reviews or audits Impact on Risk Improves governance and assurance, reducing the likelihood of unmanaged or unrecognised health and safety risks, and lowering the overall risk of failing to maintain a safe environment for staff and patients.	DoE&E	31/03/2027	Progressing
ACR2: Health and Safety Risk Management (DO)				
ACR2a Review of HS03 General Risk Assessment Procedure	Undertake a review and update of the HS03 General Risk Assessment Procedure to ensure it remains current, legally compliant, clearly articulated and consistently applied across all services and sites. Outcome A robust, clear and standardised risk assessment procedure that supports effective identification, evaluation and control of health and safety risks and promotes consistent practice across the organisation. Metric • HS03 procedure formally reviewed, updated and approved • Evidence of implementation and dissemination to managers and staff • Increased compliance identified through audits and assurance reports • Improved quality and consistency of risk assessments reviewed Impact on Risk Reduces the likelihood of poorly identified or inadequately controlled hazards, strengthening organisational compliance with health and safety legislation and lowering the overall risk of harm to staff and patients.	Head of Health, Safety and Security	31/03/2027	To commence
Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
ACR2b Implement an Electronic Document Management System (EDMS) across BCUHB to centralise health and safety compliance reporting and house risk management documentation, to support a health and safety management framework	Source or develop and implement a digital technology solution to support the health and safety risk management framework, enabling consistent recording, monitoring, escalation and assurance of risks, actions and controls across the organisation. Outcome A single, reliable and transparent system that improves the visibility, consistency and timeliness of health and safety risk management, supporting informed decision-making and effective organisational assurance. Metric • Technology solution procured/developed and fully implemented • Percentage of services using the system for health and safety risk management • Improved completeness, timeliness and quality of risk and action data • Reduction in manual processes and duplicated reporting	Head of Health, Safety and Security	31/03/27	To commence

	Impact on Risk Strengthens risk identification, monitoring and escalation, reducing the likelihood of unmanaged or poorly controlled health and safety risks and improving the organisation's ability to maintain a safe environment for staff and patients.			
Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
ACR2c Reviewing and updating the Health and Safety Risk Assessment Training Course	Review, update and re-launch the Health and Safety Risk Assessment Training Course to ensure it reflects current legislation, organisational procedures and best practice, and is accessible to all staff with health and safety responsibilities. Outcome Improved staff knowledge, competence and confidence in completing suitable and sufficient health and safety risk assessments, leading to more consistent and effective risk control across the organisation. Metric - Updated training course approved and implemented - Percentage of relevant staff completing the updated training - Improved quality of risk assessments identified through audit and review - Reduction in errors, omissions or repeat findings linked to risk assessments Impact on Risk Reduces the likelihood of hazards being poorly identified or inadequately controlled by improving workforce competence, thereby lowering the overall risk of harm to staff and patients and improving compliance with health and safety legislation.	Head of Health, Safety and Security	31/03/2027	To commence
ACR3: Training and Competence (DO)				
G3a A pan BCUHB Health, Safety and Security Training Needs Analysis is required.	Health, Safety and Security Training Needs Analysis under development. Outcome A comprehensive, pan-BCUHB Health, Safety and Security Training Needs Analysis that clearly identifies statutory, mandatory, role-specific and risk-based training requirements across the organisation. The completed TNA will provide a clear framework for training provision, resource planning and compliance monitoring, ensuring consistent and appropriate training delivery across all services. Metric - Approval of the TNA by relevant governance groups (e.g., SOSHG and Executive Committee). - Identification of training gaps and development of an implementation or delivery plan. - Measurable improvements in training compliance rates across Health, Safety and Security subjects. - Reduction in variation of training requirements or delivery between Divisions. Impact on Risk A robust, organisation-wide TNA reduces the risk of non-compliance with statutory and mandatory training requirements, improves clarity for managers and staff, and supports safer practice across the organisation.	Head of Health, Safety and Security	31/12/2026	Progressing
Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G3b BCUHB Executive Team and Board of Directors to complete health and safety training.	NEBOSH HSE Certificate in Health and Safety Leadership Excellence 1-day accredited course. Outcome Executive Team and Board members will have the required level of Health and Safety knowledge and assurance to fulfil their statutory duties, demonstrate effective organisational oversight, and meet internal audit expectations. Metric - Agreement of the proposal by the Director of Estates and Director of Governance. - Approval and scheduling of the training programme. 100% completion of the required Health and Safety training by Executive Team and Board members within the agreed timeframe. Impact on Risk Completing Health and Safety training for Executive and Board members will enhance understanding at senior levels reduces risks relating to poor decision-making, inadequate oversight, regulatory non-compliance, and potential enforcement action.	DoE&E	31/03/2027	Progressing

Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis	
G3c Intranet pages for Health, Safety and Security Services require development.	Outcome A comprehensive, accessible and up-to-date Health, Safety and Security intranet site aligned to the NHS Employer Health and Safety Standards that provides staff with clear guidance, policies, procedures, training information and support resources. The developed intranet pages will improve organisational visibility, enhance staff access to essential information, and support consistent practice across BCUHB. Metrics - Increased staff access and usage (measured via intranet analytics, where available). - Reduction in staff queries related to information that is now accessible online. Impact of Risk Improved access to accurate and current Health, Safety and Security information reduces the likelihood of procedural errors, non-compliance, and inconsistent practice. Clear guidance supports safer working environments, reduces the risk of incidents, strengthens organisational assurance, and improves staff confidence in accessing essential safety information.	Head of Health, Safety and Security	31/03/27	Progressing	
			Impact	Likelihood	Score
25 20 15 10 5 0 01/12/2023. 06/12/2023. 20/12/2023. 04/03/2024. 21/05/2024. 23/08/2024. 25/10/2024. 16/12/2024. 25/02/2025. 08/05/2025. 21/08/2025. 25/10/2025. 11/12/2025. 30/04/2026. — Inherent — Current — Target		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 and 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 on 31/03/2025, with Health and Safety moving from Workforce Directorate to a new role of Director of Environment, reporting directly to CEO (Chief Executive Officer).					

Additional Controls required	Action	Action Owner	Due Date	Progression Analysis
ACR1: Governance and Leadership (PLAN)				
ACR1c Determine the Organisations H&S policy/Plan for implementation: Review of health and safety policies within the next 12-24 months.	Policy tracker presented to SOSHG quarterly and updates specific to Policies provided to Executive Policy Oversight Group, with further oversight by Policy and Compliance Team. Outcome A fully reviewed, up-to-date, and compliant suite of Health and Safety policies that reflect current legislation, national guidance, internal audit expectations, and organisational requirements. The policy tracker provides structured oversight and assurance to SOSHG, ensuring visibility of progress and governance throughout the review cycle. Metric - Regular updates of the policy tracker and presentation to SOSHG. - Reduction in overdue policies or those requiring exception reporting. Impact on Risk Timely review and updating of health and safety policies reduces the likelihood of non-compliance with statutory requirements, inconsistent practice across the organisation, and potential legal or regulatory challenge. Up-to-date policies strengthen governance, provide clarity for staff, and ensure that safe systems of work are based on current, accurate guidance.	DoE&E	28/04/27	Complete
ACR2: Health and Safety Risk Management (DO)				
ACR2a A Health and Safety Management Framework needs developing.	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. Standards and guidance are available; resources and stakeholder engagement will be secured through the Health & Safety governance structure. Supports	Head of Health, Safety & Security	31/12/25	Complete

	compliance, improves governance, and provides a structured mechanism for monitoring and continuous improvement of health and safety performance. Framework to be developed, approved, and implemented by April 2025 with first performance report issued by June 2025. This is complete. The standards are in use and the Health and Safety Team are completing the second Cohort of the self-assessment exercise that this action is built around. Paper went to Executive Committee 12/11/2025 and People and Culture Committee 04/12/2025.			
ACR4&5: Governance and Leadership (PLAN)				
ARCR4&5 A Health and Safety Management Framework needs developing.	A process to monitor and review department self-assessments is under development and will be issued in readiness for the April Self-Assessment Cycle. Complete see action point 1 above and the paper that went to EC (Executive Committee) and P&CC (People & Culture Committee)	Director of Estates	31/12/25	Complete



Health Board

RESPONSE TO UK COVID 19 INQUIRY MODULES 2, 3 AND 4: HEALTH BOARD POSITION AND LEARNING

Dyddiad y Cyfarfod Date of Meeting	30 July 2026
Statws Cyhoeddi Publication Status	Open/ Public
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Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Reena Cartmell, Director of Nursing Quality Assurance and Learning Glesni Driver, Head of Statutory Compliance and Inquiries
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Pam Wenger, Director of Corporate Governance
Pwrpas yr Adroddiad Report Purpose	For Noting

Crynodeb Gweithredol **Executive Summary**

The UK Covid-19 Inquiry Modules 2 (Core UK Decision-Making and Political Governance), 3 (Impact on Healthcare Systems) and 4 (Vaccines and Therapeutics) provide important learning for health services across the UK. Collectively, the reports highlight the importance of preparedness, resilience, effective governance, workforce sustainability, high-quality intelligence, equitable access to services, community engagement, and organisational learning.

The Health Board has reviewed the findings from all three modules and considered their relevance to local services, recognising that many of the issues identified reflect wider national and system-level challenges. The findings nevertheless provide an important opportunity to reflect on organisational preparedness, resilience and the effectiveness of existing arrangements to respond to future public health emergencies.

The review has identified a number of themes that align with existing organisational priorities, including emergency preparedness, governance and decision-making, workforce resilience, population health intelligence, health inequalities, infection prevention and control, communication and engagement,

vaccination preparedness, partnership working and organisational learning. The Health Board has also identified opportunities to strengthen assurance in a number of these areas through continued improvement activity and integration of learning within existing programmes of work.

Following consideration by Executive Committee in May 2026, a structured approach to organisational learning is being coordinated through the Office of the Executive Nurse, with oversight through the Organisational Learning Forum and established governance arrangements. This will ensure that relevant recommendations, learning themes and emerging national requirements are systematically reviewed, prioritised and embedded within existing strategic, operational and assurance frameworks.

The Board can take reasonable assurance that arrangements are being established to identify, assess and embed learning arising from Inquiry Modules 2, 3 and 4. Further work will continue to ensure that this learning is demonstrably translated into sustainable improvements in organisational resilience, preparedness and future emergency response arrangements, with progress monitored through existing governance processes.

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

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

Acronymau / Rhestr Termiau
Acronyms / Glossary of Terms

BCUHB	Betsi Cadwaladr University Health Board
PPE	Personal Protective Equipment
IPC	Infection Prevention and Control
OLF	Organisational Learning Forum

RESPONSE TO UK COVID 19 INQUIRY (MODULE 3): HEALTH BOARD POSITION AND LEARNING

1. Y SEFYLLFA SITUATION

- 1.1 This paper provides assurance to the Board on the Health Board's consideration of the learning arising from the UK Covid-19 Inquiry Modules 2, 3 and 4 and sets out the arrangements established to ensure that relevant findings are systematically reviewed, reflected upon and embedded within existing organisational priorities and governance frameworks.
- 1.2 Collectively, the three Inquiry modules examine key aspects of the UK's response to the Covid-19 pandemic, including decision-making and governance (Module 2), the impact on healthcare systems (Module 3), and the development, deployment and delivery of vaccines and therapeutics (Module 4). Together, they identify common themes relating to preparedness and resilience, leadership and governance, workforce sustainability, data and intelligence, protection of vulnerable populations, communication and public trust, health inequalities, partnership working and organisational learning.
- 1.3 While many of the issues identified by the Inquiry reflect wider system-level challenges and national policy decisions, the findings provide important learning for all NHS organisations. The Health Board has therefore undertaken a review of the themes emerging across the three modules in order to understand their relevance to local services, identify areas of organisational strength, and determine where further development or assurance may be required.
- 1.4 The Health Board recognises that effective preparedness for future public health emergencies extends beyond emergency planning arrangements alone and requires a whole-system approach that integrates governance, population health intelligence, workforce resilience, infection prevention and control, community engagement, equitable access to services, research and innovation, and partnership working across organisational boundaries.
- 1.5 This paper therefore outlines the Health Board's position in relation to the learning identified through Inquiry Modules 2, 3 and 4 and describes the arrangements being progressed through the Office of the Executive Nurse and the Organisational Learning Forum (OLF) to ensure that relevant learning is incorporated into existing improvement, assurance and preparedness activities.

2. Y CEFNDIR BACKGROUND

- 2.1 The UK Covid-19 Inquiry was established to examine the UK's preparedness for, and response to, the Covid-19 pandemic and to identify lessons to strengthen future resilience. This paper considers the findings arising from Module 2 (Core UK Decision-Making and Political Governance), Module 3 (Impact on Healthcare Systems) and Module 4 (Vaccines and Therapeutics), each of which has direct relevance to NHS organisations and public services.
- 2.2 Module 2 examined political and administrative decision-making across the four nations of the United Kingdom. The Inquiry concluded that the pandemic response was affected by delays in escalation, limitations in preparedness planning, weaknesses in data and intelligence arrangements, and a lack of consistent consideration of vulnerable groups within decision-making processes. The report emphasises the importance of strong governance, clear accountability, high-quality intelligence, effective communication, partnership working and timely decision-making during emergencies.
- 2.3 Module 3 examined the impact of the pandemic on healthcare systems across England, Scotland, Wales and Northern Ireland. The Inquiry found that healthcare systems entered the pandemic with significant pre-existing pressures, including workforce shortages, constrained capacity, ageing infrastructure and limited resilience. Although services were maintained through exceptional efforts by healthcare workers, the report highlighted important learning relating to workforce wellbeing, infection prevention and control, urgent and emergency care, patient safety, healthcare capacity and inequalities in access and outcomes.
- 2.4 Module 4 examined the development, procurement, regulation, delivery and uptake of vaccines and therapeutics. The Inquiry recognised the vaccination programme and therapeutic response as significant achievements but identified opportunities to strengthen future preparedness through improved community engagement, greater public trust, better use of data, enhanced identification of vulnerable populations, equitable access to services and stronger arrangements for research, innovation and clinical trials. The report also highlighted the importance of addressing health inequalities and ensuring that future pandemic responses are informed by robust population health intelligence.

- 2.5 Across all three modules, several common themes emerge. These include the need for stronger preparedness and resilience, improved use of intelligence and data, effective leadership and governance, workforce sustainability, protection of vulnerable populations, equitable access to services, clear and accessible communications, community engagement and organisational learning. The Inquiry consistently emphasises that future resilience depends not only on emergency response arrangements but on a whole-system approach that integrates health services, public health, social care, communities and partner organisations.
- 2.6 The Health Board recognises that many of the issues identified by the Inquiry relate to broader system-wide and national challenges. However, the findings provide an important opportunity to reflect on local experience, assess current arrangements and identify opportunities to strengthen preparedness, service resilience and organisational learning. The Health Board has therefore reviewed the collective learning arising from Modules 2, 3 and 4 and considered how it should inform future improvement activity, assurance arrangements and strategic planning.

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

3.1 **Approach**

- 3.1.1 The Health Board has considered the findings arising from UK Covid-19 Inquiry Modules 2, 3 and 4 collectively, recognising that the reports are interconnected and provide complementary learning across governance and decision-making, healthcare system resilience, and the development and delivery of vaccines and therapeutics.
- 3.1.2 The Health Board has approached the Inquiry findings on the basis that, whilst many of the issues identified were systemic and national in nature, there remains a responsibility to understand local impact, identify opportunities for improvement and ensure that relevant learning is embedded within organisational practice.
- 3.1.3 The thematic structure of this paper reflects the principal areas of learning that emerge consistently across all three Inquiry modules. These include preparedness and resilience, governance and decision-making, workforce sustainability, data and intelligence, communication and engagement, protection of vulnerable populations, equitable access to services, infection prevention and control, healthcare capacity, research and innovation, community trust and organisational learning.

- 3.1.4 This approach supports a whole-system assessment of organisational resilience and ensures that learning is considered in the context of current organisational priorities, existing governance arrangements and future preparedness planning.

3.2 Response to Key Themes

3.2.1 Preparedness, Resilience and Emergency Response

- 3.2.1.1 Across all three modules, the Inquiry emphasised the importance of preparedness, resilience and the ability to respond rapidly to emerging threats. The Health Board demonstrated significant organisational agility during the pandemic through the establishment of command structures, service reconfiguration, vaccination delivery programmes and partnership working. Learning from the Inquiry reinforces the importance of maintaining robust emergency preparedness arrangements, strengthening organisational resilience and ensuring readiness for a range of future scenarios.

3.2.2 Governance, Leadership and Decision-Making

- 3.2.2.1 Module 2 highlighted the importance of clear governance arrangements, effective challenge, robust accountability and timely decision-making. The Health Board has reflected on its governance arrangements during emergency response activity and recognises the importance of maintaining clear command structures, documented decision-making processes and effective organisational oversight during periods of sustained operational pressure.

3.2.3 Workforce Resilience and Sustainability

- 3.2.3.1 The Inquiry identified that healthcare services relied heavily upon the commitment, flexibility and resilience of staff throughout the pandemic. The Health Board continues to recognise the importance of workforce wellbeing, succession planning, workforce sustainability and psychological support arrangements as key components of future resilience.

3.2.4 Data, Intelligence and Population Health

- 3.2.4.1 All three modules identified the importance of high-quality intelligence and data to support decision-making, identify vulnerable populations and target interventions effectively. The Health Board has reflected on the importance of strengthening data integration, population health intelligence and the use of data to support operational, clinical and strategic decision-making. Continued work is underway to improve visibility of health inequalities,

vulnerability and service demand across the population served by the Health Board.

3.2.5 **Protection of Vulnerable Populations and Health Inequalities**

- 3.2.5.1 A common theme across the Inquiry reports was the disproportionate impact of the pandemic on vulnerable populations. The Inquiry identified the need for earlier identification of vulnerable groups and greater consideration of inequalities in decision-making and service delivery. The Health Board recognises the importance of strengthening population health approaches, improving identification of at-risk groups and ensuring that future emergency planning incorporates health inequalities, equality impacts and safeguarding considerations from the outset.

3.2.6 **Communication, Community Engagement and Public Trust**

- 3.2.6.1 The Inquiry highlighted the importance of clear, accessible and consistent communication during public health emergencies. Module 4 in particular identified the relationship between trust, community engagement and uptake of public health interventions. The Health Board recognises the need to maintain effective communication arrangements, accessible information and strong relationships with communities and partner organisations to support confidence, engagement and equitable access to services.

3.2.7 **Healthcare Capacity, Infection Prevention and Safe Care**

- 3.2.7.1 Module 3 highlighted the pressures experienced across healthcare systems in relation to workforce availability, urgent and emergency care, infection prevention and control, infrastructure and hospital capacity. While services were maintained under extraordinary pressure, the Inquiry reinforces the need to strengthen organisational resilience, safe environments and surge planning arrangements. These remain important areas of ongoing improvement activity within the Health Board.

3.2.8 **Vaccination, Therapeutics and Access to Services**

- 3.2.8.1 Module 4 recognised the success of vaccination and therapeutic programmes whilst identifying opportunities to strengthen future preparedness. The Health Board recognises the importance of equitable access, clear delivery pathways, community engagement and robust data systems in supporting future vaccination and treatment programmes. Learning from the Inquiry will inform future public health planning and preparedness arrangements.

3.2.9 **Research, Innovation and Organisational Learning**

- 3.2.9.1 The Inquiry highlighted the value of established research infrastructure, innovation and evidence-based decision-making in responding to Covid-19. The Health Board recognises the importance of supporting research-active services, maintaining relationships with academic partners and embedding organisational learning within routine governance and improvement arrangements.

3.2.10 **Overall Assessment**

- 3.2.10.1 Taken together, Modules 2, 3 and 4 demonstrate that effective preparedness for future public health emergencies requires a whole-system approach that extends beyond traditional emergency planning arrangements. The Inquiry consistently highlights the importance of preparedness, leadership, robust governance, workforce resilience, intelligence-led decision-making, public trust, equitable service delivery and partnership working.

- 3.2.10.2 The Health Board recognises that many of the challenges described by the Inquiry reflected wider system-level constraints. Nevertheless, the organisation demonstrated significant commitment, adaptability and resilience throughout the pandemic. The Inquiry findings provide an important opportunity to further strengthen organisational preparedness, resilience and learning.

- 3.2.10.3 The Board can therefore take assurance that arrangements are being established to ensure that learning from Modules 2, 3 and 4 is systematically reviewed, prioritised and embedded within existing governance, improvement and preparedness frameworks.

3.2.11 **Governance Arrangements for Inquiry Learning**

- 3.2.11.1 In response to the action agreed by Executive Committee, the Health Board is progressing a coordinated organisational learning approach led by the Executive Director of Nursing and Midwifery through the Office of the Executive Nurse.

- 3.2.11.2 This approach will encompass learning arising from Modules 2, 3 and 4 and will be overseen through the Organisational Learning Forum (OLF), ensuring that relevant themes are systematically reviewed, assessed and incorporated into existing improvement and assurance arrangements.

- 3.2.11.3 A time-limited multidisciplinary learning forum will bring together clinical, operational and corporate leads to consider the Inquiry findings in the context of the Health Board's current position, identify priority areas for

action and ensure that learning is integrated within existing programmes of work.

3.2.11.4 This approach focuses on embedding learning within established organisational priorities including emergency preparedness, governance, workforce resilience, infection prevention and control, urgent and emergency care, population health, health inequalities, communications, research and organisational learning.

3.2.11.5 The Office of the Executive Nurse will coordinate implementation and oversight, with progress reported through established governance arrangements including Executive Committee and the Quality, Safety and Experience Committee.

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

4.1 While there are no recommendations directly assigned to Health Boards within Modules 2, 3 or 4 of the UK Covid-19 Inquiry, it is likely that NHS organisations will be expected to contribute to and operate within revised national frameworks, standards, guidance and preparedness arrangements arising from the Inquiry recommendations. These may be progressed through Welsh Government, UK Government, Public Health Wales, NHS Wales and other relevant agencies. The Health Board must therefore be prepared to respond to emerging requirements and ensure that its own preparedness and improvement activity remains aligned with national expectations.

4.2 There is a risk that learning arising from the Inquiry is not fully identified, coordinated, prioritised, embedded or evidenced across the organisation due to competing priorities, capacity constraints and reliance on existing governance arrangements. Failure to effectively implement and sustain learning could reduce organisational resilience and limit the Health Board's ability to demonstrate that it has appropriately considered and responded to the Inquiry findings.

4.3 The Inquiry highlights the importance of preparedness, effective governance and timely decision-making during periods of uncertainty. There is therefore a risk that weaknesses in organisational intelligence, escalation arrangements, documentation of decision-making, or emergency preparedness processes could reduce the Health Board's ability to respond effectively to future major incidents or public health emergencies.

4.4 The Inquiry also identified the disproportionate impact of the pandemic on vulnerable and disadvantaged populations. There is a risk that limitations in population health intelligence, data quality or identification of vulnerable groups could reduce the Health Board's ability to target support effectively,

address health inequalities and ensure equitable access to services during future emergencies.

- 4.5 Modules 3 and 4 further highlight risks associated with workforce sustainability, healthcare capacity, infection prevention and control, communication, community trust and access to care. Failure to strengthen resilience across these areas may affect the Health Board's ability to maintain services, protect patients and staff and deliver effective public health interventions during future periods of significant operational pressure.
- 4.6 There is also a risk that opportunities to strengthen partnership working, community engagement, research capability, vaccination preparedness and therapeutic pathways are not maximised. Failure to embed learning in these areas could limit organisational readiness for future infectious disease outbreaks and reduce the effectiveness of future response arrangements.

4.7 Overall Risk Assessment

- 4.7.1 The principal strategic risk arising from Modules 2, 3 and 4 is that the Health Board does not sufficiently embed the collective learning relating to preparedness, governance, workforce resilience, population health intelligence, health inequalities, communication, vaccination and therapeutics, resulting in reduced organisational resilience and preparedness for future public health emergencies. The governance arrangements described within this report are intended to mitigate this risk through systematic review, oversight and integration of learning within existing organisational priorities and assurance frameworks.

5 ARGYMHELLION RECOMMENDATIONS

- 5.1 The Board is asked to:
- **NOTE** the findings of the UK Covid-19 Inquiry Modules 2, 3 and 4 Reports.
 - **ACKNOWLEDGE** the distinction between system-wide constraints and organisational response.
 - **RECOGNISE** the strengths demonstrated by the Health Board.
 - **ENDORSE** the Executive Nurse-led approach to organisational learning.
 - **SUPPORT** the governance arrangements and next steps.

APPENDIX 1 – ALIGNMENT OF INQUIRY LEARNING TO BCUHB ASSESSMENT

Purpose

This appendix demonstrates how the Health Board has aligned its assessment with the key learning themes emerging across UK Covid-19 Inquiry Modules 2 (Core UK Decision-Making and Political Governance), 3 (Impact on Healthcare Systems) and 4 (Vaccines and Therapeutics). The Health Board has used a cross-cutting thematic framework to ensure that learning from all three modules has been considered in a consistent and integrated manner, providing assurance that relevant findings have been reflected within organisational priorities, preparedness arrangements and improvement activity.

Cross-cutting Inquiry Learning Theme	Principal Module(s)	Summary Position
Preparedness and Organisational Resilience	2, 3, 4	Resilience and preparedness arrangements under continual review
Strategic Governance and Decision-Making	2	Governance and accountability arrangements continue to be strengthened
Workforce Resilience and Sustainability	2, 3	Workforce wellbeing and sustainability remain strategic priorities
Data, Intelligence and Population Health	2, 4	Greater integration and population health insight required
Healthcare Capacity and System Flow	3	Significant pressures recognised; improvement work ongoing
Infection Prevention and Safe Environments	3	Strong governance arrangements with continued development
Vulnerable Populations and Health Inequalities	2, 3, 4	Targeted approaches and population health intelligence developing
Communication, Community Engagement and Public Trust	2, 4	Accessible communication and community relationships strengthening
Vaccination and Therapeutics Preparedness	4	Future preparedness and equitable access considerations identified
Research, Innovation and Evidence-Based Practice	4	Existing capability recognised and to be sustained
Multi-Agency and Cross-Border Working	2	Strong partnerships maintained and further development planned
Organisational Learning and Continuous Improvement	2, 3, 4	Learning to be embedded through established governance arrangements

APPENDIX 2 – CROSS-CUTTING PRIORITY LEARNING THEMES FROM INQUIRY MODULES 2, 3 AND 4

1 PURPOSE

This appendix sets out the key learning themes arising from UK Covid-19 Inquiry Modules 2 (Core UK Decision-Making and Political Governance), 3 (Impact on Healthcare Systems) and 4 (Vaccines and Therapeutics). These themes will guide the Health Board's approach to organisational learning and support the integration of relevant findings within existing governance, improvement and preparedness arrangements.

2 PRIORITY LEARNING THEMES

The Health Board will focus on:

2.1 Preparedness and Organisational Resilience

Ensuring emergency preparedness arrangements are regularly reviewed, tested and capable of supporting a rapid and sustained response to future public health emergencies.

2.2 Strategic Governance and Decision-Making

Strengthening governance arrangements, accountability, documentation of decision-making, escalation processes and organisational oversight during periods of significant operational pressure.

2.3 Workforce Resilience and Sustainability

Supporting workforce wellbeing, retention, succession planning, surge capacity and long-term workforce resilience.

2.4 Data, Intelligence and Population Health

Improving intelligence systems, data integration and the use of population health information to support operational, clinical and strategic decision-making.

2.5 Healthcare Capacity and System Flow

Strengthening health system resilience through improvements in urgent and emergency care, hospital capacity, patient flow and service continuity arrangements.

2.6 **Infection Prevention and Safe Care Environments**

Embedding learning relating to infection prevention and control, ventilation, safe environments and preparedness for emerging infectious diseases.

2.7 **Protection of Vulnerable Populations and Health Inequalities**

Improving identification of vulnerable groups and ensuring equality, health inequality and safeguarding considerations are embedded within planning, decision-making and service delivery.

2.8 **Communication, Community Engagement and Public Trust**

Strengthening accessible communications, community engagement and relationships with stakeholders to support confidence, trust and effective public health interventions.

2.9 **Vaccination and Therapeutics Preparedness**

Ensuring future plans include equitable access to vaccination and treatment programmes, supported by clear delivery pathways and population health intelligence.

2.10 **Research, Innovation and Evidence-Based Practice**

Maintaining research capability, supporting innovation and ensuring the organisation can contribute effectively to future research activity and evidence generation during emergencies.

2.11 **Multi-Agency and Cross-Border Partnership Working**

Strengthening collaboration with local authorities, Public Health Wales, NHS Wales organisations, social care and other partners to support coordinated emergency response arrangements.

2.12 **Organisational Learning and Continuous Improvement**

Ensuring learning from the Inquiry is systematically reviewed, prioritised, embedded and evidenced through existing governance, assurance and improvement frameworks.

3 SUMMARY

The learning arising from Modules 2, 3 and 4 highlights the need for a whole-system approach to preparedness, resilience and service delivery. Collectively, the Inquiry findings emphasise the importance of effective governance, timely decision-making, workforce sustainability, high-quality intelligence, equitable access to services, community trust and organisational learning.

These priority themes provide a structured framework for embedding learning across the Health Board and will be progressed through a coordinated approach led by the Office of the Executive Nurse, with oversight through the Organisational Learning Forum, ensuring alignment with existing strategic priorities, assurance arrangements and improvement programmes.

ASESIAD / ASSESSMENT

Cysylltiad â'r Bwriadau Strategol	3. Improve Access, Outcomes and Experience
Link to Strategic Intentions	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Yr Egwyddorion Dylunio Design Principles	Simplify, Standardise, and Adopt Best Practices Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	Not applicable

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS

Equality Act 2010 Public Sector Equality Duty: Has BCUHB provided evidence of 'Due Regard' to compliance with the three parts of the Public Sector Equality Duty (General Duty): Public Sector Equality Duty [HTML] GOV.WALES	Do/Yes: ☒	Naddo/No: ☐
	Canlyniad/Outcome:	No impact
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Equality Act 2010 - Socio-economic Duty <i>Has BCUHB provided evidence of 'Due Regard' to compliance of ther Socio-economic Duty when making strategic decisions?</i>	Do/Yes: ☒	Naddo/No: ☐
	Canlyniad/Outcome:	No impact
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
<i>Have you completed an Integrated Equality Impact Assessment WP8a?</i> WP8a Template	Canlyniad/Outcome: Do/Yes:	Naddo/No:
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale: Canlynaid/Outcome:	No impact

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

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

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Health Board

CORPORATE GOVERNANCE REPORT

Dyddiad y Cyfarfod Date of Meeting	30 July 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Philippa Peake-Jones, Head of Corporate Governance
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Pam Wenger, Director of Corporate Governance
Pwrpas yr Adroddiad Report Purpose	Endorse for Board Approval

Crynodeb Gweithredol Executive Summary

This Corporate Governance Report provides the Board with a comprehensive update on key governance activities undertaken since the last meeting, demonstrating continued strengthening of governance arrangements while the Health Board remains in Special Measures. The report confirms that statutory and regulatory requirements are being met through the effective application of Standing Orders, appropriate use of Chair's Actions, and transparent reporting of decisions taken in private session.

The Corporate Policy Management Policy is presented to the Board for ratification, accompanied by the Corporate Policy Management Procedure having both followed Health Board-wide consultation and review through the appropriate governance pathway. The Policy establishes a clear and consistent framework for the development, approval, publication, review, and management of corporate policy-related documents across the Health Board, ensuring compliance with statutory and regulatory requirements and strengthening organisational governance. The accompanying Procedure provides the detailed processes and guidance to support implementation and ongoing management of policy-related documents across the organisation.

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

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

Acronymau / Rhestr Termiau
Acronyms / Glossary of Terms

DoT	Declaration of Trust
SO	Standing Orders
SoRD	Scheme of Reservation and Delegation
CHC	Continuing Health Care
RLW	Real Living Wage
PPO	Periodical Payment Order
WCBC	Wrexham County Borough Council
APB	Area Planning Board
BCUHB	Betsi Cadwaladr University Health Board
IIAST	Integrated Impact Assessment Screening Tool
PGD	Patient Group Direction
DTG	Drugs and Therapeutics Group

CORPORATE GOVERNANCE REPORT

1. Y SEFYLLFA SITUATION

- 1.1 The purpose of this report is to provide the Board with an update on key corporate governance matters.

2 Y CEFNDIR BACKGROUND

- 2.1 The Health Board is required to act according to its Standing Orders. This report contains information to allow the Health Board to conform to this.
- 2.2 It is essential that the Board has robust arrangements in place for Corporate Governance and failure to do so could have legal implications for the Health Board.

3 MATERION PENODOL I'W HYSTYRIED SPECIFIC MATTERS FOR CONSIDERATION

3.1 SUMMARY OF BUSINESS DISCUSSED IN THE PRIVATE SESSION OF THE HEALTH BOARD ON 28 MAY 2026

In accordance with Standing Orders 7.5.3 the Health Board is required to report any decisions made in private session to the next available public meeting of the Board.

The following items were discussed during the private Board meeting held on 28 May 2026:

Agenda Item	Subject (including narrative)	Board Resolution	Rationale for item in Private
26.116	Continuing Health Care Fee Setting	APPROVED the following recommendations, recognising the significant legal, financial, operational and market sustainability considerations associated with Continuing Health Care fee settings for 2026/27. ➤ Approve the CHC Funding Uplift for 2026/27 Agree the application of	Business Sensitive

Agenda Item	Subject (including narrative)	Board Resolution	Rationale for item in Private
		a 5.7% uplift to CHC fees for 2026/27, based on the national pay award, Real Living Wage (RLW) requirements and inflationary pressures, with domiciliary care rates adjusted to fully reflect RLW compliance, recognising the immediate need to support provider stability, patient safety and system flow. ➤ Confirm Compliance with the National Commissioning Framework Note that the proposed uplift and fee-setting approach has been explicitly developed with reference to the National Framework for the Commissioning of Care and Support in Wales: Code of Practice (2024), particularly Standards 7 and 8, and agree that ongoing and enhanced actions are required to further strengthen demonstrable compliance. ➤ Acknowledge and Accept the Ongoing Risk Profile Formally note the continued high level of risk, including the	

Agenda Item	Subject (including narrative)	Board Resolution	Rationale for item in Private
		materially increased risk of judicial review, market instability and impact on patient flow, and accept that approval of the uplift does not remove, but helps mitigate, those risks in the short term. ➤ Endorse Continued Risk Mitigation and Strategic Commissioning Actions Support ongoing and planned mitigation actions, including: ▪ variable and bespoke fee arrangements where objectively justified by acuity, complexity or specialist provision; ▪ continued development of the CHC Commissioning Strategy, including block purchasing and outcome-based commissioning; ▪ robust governance through the Complex / High Cost CHC Panel; and ▪ active engagement in national work on commissioning tools, tariffs and Direct Payments implementation.	
26.117	Barrett's Oesophagus Surveillance Look-	➤ COMMENTED on the identified risks and proposed mitigation	Draft Status

Agenda Item	Subject (including narrative)	Board Resolution	Rationale for item in Private
	back Review (IHC – West)	arrangements for the Barrett’s oesophagus surveillance look back review. ➤ SUPPORTED the continuation of the look back review in line with the agreed protocol, including additional resource and capacity solutions required to complete audit, recall, and data management safely. ➤ AGREED ongoing Board oversight, including receipt of regular progress updates and escalation of any significant patient safety, capacity, or assurance concerns.	
26.118	Contracts and Tender Approval Report	➤ NOTED the report. ➤ APPROVED the Contract Award for Physical Site Security Provision with a total cost £4,095,002.88 ex VAT for 3-years + 1-year optional extension. ➤ APPROVED the Endoscopy Insourcing Contract extension to a maximum of £3.5m. ➤ APPROVED the Royal Mail Correspondence Hub £1,400,000.00 Ex VAT for one year.	Business Sensitive
26.119	Approval of Contracts for the North Wales Substance Misuse	➤ APPROVED the Income Generation Agreement between Betsi	Business Sensitive

Agenda Item	Subject (including narrative)	Board Resolution	Rationale for item in Private
	Services (SMS), Harm Reduction and Enhancing Lives Services	Cadwaladr University Health Board (BCUHB) and Wrexham County Borough Council (WCBC), acting on behalf of the North Wales Area Planning Board (APB). ➤ DELEGATED AUTHORITY to the Executive Director of Allied Health Professions & Health Science, in conjunction with the Executive Director of Finance, to sign the contract on behalf of the Health Board.	
26.120	Confidential Quality Report	➤ NOTED the content of the report.	Person Identifiable
26.121	High Value Claims	➤ APPROVED authority to negotiate and conclude settlement of three high value clinical negligence claims in accordance with legal advice and the Health Board's Scheme of Reservation and Delegation.	Personal Identifiable Information Legally Privileged
26.122	Executive Committee	It was resolved that the Board: ➤ NOTED the report from the Executive Committee.	Confidential Items shared
26.123	Nursing and Midwifery Council Case	No resolution – verbal briefing received	Confidential Items shared

3.2 INFORMAL BOARD – 25 JUNE 2026

The Board met in an informal development session on 25 June 2026. During the session, members participated in a facilitated discussion with representatives of the Youth Board, providing an opportunity to better understand the experiences and perspectives of young people across North Wales. The Board also considered the Financial Savings Plan in detail, reviewing the challenges, risks and proposed mitigations associated with delivering the required savings. In addition, members agreed the key priorities for the Board and its Committees for the remainder of the 2026/27 financial year, ensuring focus on areas of greatest strategic importance and organisational risk.

3.3 AFFIXING OF THE COMMON SEAL

In-line with Standing Orders, a routine report on documents to which the common seal has been affixed is required. The Board is asked to note that the Health Board Seal has been affixed on the documents listed below.

No.	Title	Approval Route	Date Signed & Sealed	Seal No.
246	St Kentigens Renewal	Approved at CIG 07.09.23	15.06.26	729
247	North Denbighshire Community Health Care Project - RAH Phase 1 Build - Stage 1 - JCT Pre Construction Service Agreement	Health Board 25.09.2025 & WG funding award 13.02.26	2 copies – 15.06.26 & 25.06.26	730 & 733
248	North Denbighshire Community Health Care Project - RAH Phase 1 Build - Stage 2 - JCT Design and Build Contracts	Health Board 25.09.2025 & WG funding award 13.02.26	2 copies – 15.06.26	731 & 732
249	Declaration of Trust - BCU Charity	Health Board 28.05.26	25.06.26	734

3.4 CORPORATE POLICY MANAGEMENT

The Corporate Policy Management Policy is being presented to the Board for ratification in accordance with the Health Board's Scheme of Delegation, following extensive development, governance review, and Health Board-wide consultation. The Policy establishes a consistent and robust framework for the development, approval, publication, review, and management of all corporate policy-related documents across the Health Board, ensuring compliance with statutory, regulatory, and national requirements while

supporting effective organisational governance. It introduces clear arrangements for policy ownership, executive accountability, consultation (including Trade Union engagement), mandatory impact assessments, approval routes, and ongoing monitoring and review, supported by centralised document control through the Corporate Governance Directorate.

The Policy has undergone a comprehensive governance pathway, including consideration by Executive Committee and Audit Committee, consultation via BetsiNet, and approval by the Executive Policy Oversight Group, with feedback incorporated into the final version. The accompanying Corporate Policy Management Procedure provides the detailed operational process and guidance for the development, approval, implementation, publication, review, and control of corporate policy-related documents. Together, the Policy and Procedure will strengthen governance arrangements, reduce operational and compliance risks, and promote a standardised, accessible, evidence-based approach to policy management across the organisation. No adverse impacts were identified through the required impact assessments.

A copy of the Policy and its associated Procedure are included in Appendices 1 and 2 respectively.

3.5 **APPROVED CLINICIANS AND SECTION 12(2) DOCTORS**

The Board is asked to note and ratify the approvals in line with the requirements of the Welsh Government Guidance Document “Mental Health Act 1983 Approval of Approved Clinicians (Wales) July 2018 for Approved Clinicians”, the NHS Wales Mental Health Act 1983 (Approved Clinicians) (Wales) Directions 2018 and the “All Wales Section 12(2) Process and Criteria Document for S12(2) Approved Doctor approvals” document.

The following appendices are included in the supporting pack.

Appendix 3.1: Approved Clinicians (All Wales)

Appendix 3.2: Section 12(2) Doctors (All Wales).

3.6 **SHARED SERVICES PARTNERSHIP COMMITTEE**

Attached as Appendix 4 is the Assurance Report from the 14 May and 25 June 2026 meetings of the Shared Services Partnership Committee

3.7 **TRANSFER LOG REPORTING**

To enhance transparency and strengthen the Board’s oversight of matters considered by its Committees, the Corporate Governance Team has developed a formal Transfer Log process. The Transfer Log provides a mechanism for Committees to escalate significant issues, risks, decisions



and matters requiring Board attention, whilst also enabling the Board to refer matters to Committees for further consideration where appropriate. Following a period of development and implementation, Transfer Logs will be submitted to the Board as an attachment to the Corporate Governance Report from September 2026 onwards. This will provide Board Members with a consolidated view of key matters transferred between Committees and the Board, supporting effective assurance, reducing duplication of reporting, and improving visibility of actions and decisions across the Committees of the Board.

3.8 **PROTOCOL FOR MANAGING QUESTIONS FROM MEMBERS OF THE PUBLIC**

A Protocol for Managing Questions from Members of the Public has been developed to establish a formal and transparent process for the receipt, consideration and response to questions submitted to the Health Board, Board and individual Board Members. The protocol sets out clear responsibilities, governance arrangements and response timescales, including the maintenance of a central Public Questions Log to provide oversight, accountability and an auditable record of enquiries and actions. Subject to Board approval, the protocol will support consistent handling of public questions and strengthen arrangements for reporting themes, trends and performance through the Corporate Governance Report to the Board.

4 **RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO KEY RISKS BOARD ASSURANCE FRAMEWORK / MATTERS FOR ESCALATION**

There are no risks or matters for escalation.

5 **ARGYMHELLION RECOMMENDATIONS**

5.1 Members are asked to:

- **NOTE** the contents of the Corporate Governance Report;
- **NOTE** the decisions taken in private session and the affixing of the Common Seal;
- **RATIFY** the approvals of Approved Clinicians and Section 12(2) Doctors in line with national requirements;
- **NOTE** the assurance provided through the NHS Wales Shared Services Partnership Committee;
- **RATIFY** the Corporate Policy Management Policy as set out in Appendix 1, noting that it has completed the required governance pathway, consultation process and approval through the Executive Policy Oversight Group.

- **NOTE** the accompanying Corporate Policy Management Procedure contained at Appendix 2, which provides the operational framework supporting implementation of the Policy across the Health Board.
- **APPROVE** the Protocol for Managing Questions from Members of the Public, attached as Appendix 5.

ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol Link to Strategic Priorities	4.Create a Modern, People Centred Healthcare System
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Yr Egwyddorion Dylunio Design Principles	Simplify, Standardise, and Adopt Best Practices Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	BAF24-01 Building an Effective and Accountable Organisation CRR-16 – Leadership/Special Measures

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Cydraddoldeb <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not required for this report
Asesiad o'r Effaith Economaidd-gymdeithasol <i>A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?</i> Socio-Economic Impact Assessment <i>Have you undertaken a Socio-Economic Impact Assessment</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not required for this report
<u>Ansawdd</u> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i>	Galluogwyr Ansawdd Enablers of Quality Leadership	Meysydd Ansawdd Domains of Quality All Apply

<u>Quality</u> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
<u>Deddf Llesiant</u> <u>Cenedlaethau'r Dyfodol -</u> <u>Nodau Llesiant</u> <u>Wellbeing of Future</u> <u>Generations Act – Wellbeing</u> <u>Goals</u>	Not Applicable	

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

Asesiad o Effaith ar Atal Twyll <i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i> Counter Fraud Impact Assessment <i>Have you considered the counter fraud impacts</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not required for this report
Cyfreithiol Legal	Yes (Include further detail below)	
	There are legal implications within the High Value Claims items reported	
Enw Da Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith ar Adnoddau <i>(Pobl / Ariannol)</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	



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DIRECTORATE OF CORPORATE GOVERNANCE

PROTOCOL FOR MANAGING QUESTIONS FROM MEMBERS OF THE PUBLIC TO THE HEALTH BOARD AND BOARD MEMBERS

Purpose

This protocol sets out the arrangements for receiving, logging, triaging, responding to and reporting questions submitted by members of the public to Betsi Cadwaladr University Health Board, the Board, or individual Board Members. It supports open, transparent and accountable engagement while ensuring that questions are managed consistently, fairly, efficiently and within agreed timescales.

Scope

This protocol applies to questions submitted by members of the public to the Health Board, the Board, or individual Board Members, including questions submitted outside formal meetings, ahead of Public Board meetings, or in relation to the Annual General Meeting. It does not replace established processes for complaints, concerns, Freedom of Information requests, Subject Access Requests, patient-specific matters, or other statutory routes.

Principles

Questions will be handled in accordance with the following principles: openness, transparency, fairness, consistency, professionalism, timeliness, confidentiality where required, and appropriate escalation where a question falls outside the remit of this protocol.

Routes for Submitting Questions

Questions may be submitted during the year by email, written correspondence, or other approved channels. Questions for the Annual General Meeting may also be submitted in advance or during the meeting in accordance with meeting arrangements. The email address for questions is bcu.obs@wales.nhs.uk. Written correspondence should be sent to: Directorate of Corporate Governance, Betsi Cadwaladr University Health Board, Carlton Court, St Asaph, Denbighshire, LL17 0JG.

Submission Requirements

Individuals submitting questions should provide their name, contact details, the question being asked, and whether the question is intended for a specific meeting or requires a written response. Questions should be clear, concise and relevant to the remit of the Health Board.



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Receipt, Logging and Triage

All questions received will be recorded by the Corporate Governance Team, acknowledged within three working days where contact details are available, and triaged to determine the appropriate route for response. Where a question relates to another formal process, the individual will be signposted to the correct route.

Members of the Public Questions Log

The Corporate Governance Team will maintain a central Public Questions Log to provide a clear audit trail of questions received, allocation decisions, response deadlines, progress updates and closure.

Date Received	Name of Person Asking Question	Question Raised	Question Allocated To	Date Allocated	Due Date for Response	Date Response Sent to Member of the Public	Comments
Date	Name	Question Summary	Executive Lead	Date	Date	Date	Updates / Closure Notes

The Directorate of Corporate Governance is responsible for maintaining the log, monitoring deadlines, requesting updates, escalating overdue responses, identifying themes and reporting performance to the Director of Corporate Governance.

Preparation and Approval of Responses

Responses will be prepared by the relevant Executive Director, service area, or nominated lead. Draft responses must be accurate, clear, proportionate and approved by the appropriate lead before issue. The Corporate Governance Team will coordinate the process and ensure responses are issued in line with this protocol.

Responding to Questions

Responses will normally be issued within seven working days of receipt, unless the question is complex, requires input from multiple areas, or needs to be redirected to another formal process. Where a response cannot be provided within the standard timeframe, the individual should be advised of the expected response date. A summary of questions received and responses provided will be included in the Corporate Governance Report to the Board, where appropriate.

Governance Tracking, Action Log and Reporting

Each question or related action will have a named owner, target date, progress update and closure record. The Directorate of Corporate Governance



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will monitor progress until the matter is closed and will escalate overdue or unresolved actions to the Director of Corporate Governance where required.

Publication and Transparency

Questions and responses relating to the Annual General Meeting will be appended to the relevant minutes where appropriate. Other questions will be logged and may be summarised within the Corporate Governance Report to the Board to support transparency, subject to confidentiality, data protection and legal considerations.

Questions that Cannot be Considered

The Health Board may decline, redirect or manage through another route questions that relate to individual patient care, complaints, confidential or personal information, legal proceedings, defamatory content, commercially sensitive matters, matters outside the Health Board's remit, or issues already being considered through another formal process.

Monitoring and Assurance

The Directorate of Corporate Governance will oversee implementation of this protocol, maintain the Public Questions Log, monitor timeliness, review themes and trends, and provide assurance through established governance reporting arrangements. The protocol will be reviewed periodically to ensure it remains effective and aligned with Health Board requirements.

Roles and Responsibilities

Role	Responsibility
Directorate of Corporate Governance / nominated Corporate Governance Officer	Own the process; maintain the log; acknowledge and triage questions; coordinate responses; monitor deadlines; escalate overdue actions; and prepare reporting summaries.
Executive Directors, Service Areas or Nominated Leads	Prepare accurate, timely and appropriate responses; provide updates when deadlines are at risk; and confirm closure when the response has been issued.
Director of Corporate Governance	Provide oversight, receive escalations, ensure assurance reporting to the Board as required, and approve any changes to the protocol.



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Health Board Key Issues Report

Board Date		30/07/2026	
Date of Committee		14/07/2026	Report of: Remuneration Committee
Quoracy met:		Yes	
1	Agenda	A meeting of the Remuneration Committee took place on 14.07.26. All Remuneration Committee meetings are held in private session due to personal identifiable subject matter.	
2a	Alert	The Remuneration Committee wish to alert members of the Board that: 1. Recruitment activity for 4 senior organisational roles needed to be agreed in order to ensure continued and balanced capability within the Executive Team and other strategically important delivery roles 2. Approval was agreed to appointments to the role of an interim Planned Care Recovery Director and the interim role of Urgent and Emergency Care Recovery Director 3. Consideration of extensions to senior roles were discussed to provide alignment with consultation and implementation of the organisation's Foundations for the Future programme.	
2b	Assurance	The Remuneration Committee wish to assure members of the Board that 1. Considered discussion took place to 1.1. Agree appointment of external recruitment agency 1.2. Provide opportunity to propose potential alternative solutions to very senior management roles and support.	
2c	Advise	The Remuneration Committee wish to advise members of the Board that 1. Updates on recruitment activity in regard to the following roles was shared and approvals agreed where appropriate. This included interim arrangements where necessary. 1.1. Executive Director of Nursing & Midwifery 1.2. Executive Director of Strategy, Planning and Partnerships 1.3. Executive Director of Finance 1.4. Chief Operating Officer 1.5. Deputy Chief Executive Officer 2. Extension of acting arrangements had been agreed: 2.1. Director of Digital, Data and Technology 3. Interim and Secondment opportunities were approved in relation to the roles of	

		3.1. Divisional Director of Mental Health and Learning Disabilities 3.2. Deputy Executive Director of Nursing
2d	Review of Risks	Risks were discussed in regard to • potential capacity gaps within critical executive team roles should there be an absence of timely, successful recruitment consideration. • Support to very senior roles. • Recruitment and retention following Welsh Government's commissioning of Well Led Review and recent Ministerial Targeted Intervention.
2e	Sharing of learning	None
3	Actions to be considered by the People & Culture Committee	Organisational succession planning



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Health Board Key Issues Report			
Board Date		30/07/2026	
Date of Committee		02/07/2026	Report of: Planning, Population Health & Partnerships Committee
Quoracy met:		Yes	
1	Agenda	The Planning, Population Health & Partnerships Committee (PPHP) continues to meet bi-monthly. The Committee considered an agenda which is attached: PPHP Committee - BCUHB	
2a	Alert	The PPHP Committee wish to Alert members of the Board that: 1. Delays in Welsh Government decisions regarding both the Electronic Healthcare Record (EHR) and Mental Health Electronic Healthcare Record (MHEHR) programmes continue to present a significant risk to service transformation, digital enablement and patient safety improvements. Members expressed concern regarding the absence of funding confirmation for MHEHR, despite previous commitments and the impact this is having on programme delivery. 2. Clinical engagement undertaken as part of the Clinical Services Plan identified concerns relating to organisational culture, including perceptions of limited delegated authority, risk aversion, complex governance arrangements and slow decision-making processes, which may inhibit transformation and service redesign. 3. The Committee received a review of climate adaptation and decarbonisation arrangements and noted that, whilst there are examples of good practice across the organisation, there is currently no overarching organisational framework or dedicated resource to coordinate activity and support delivery of statutory decarbonisation and climate adaptation requirements.	
2b	Assurance	The PPHP Committee wish to Assure members of the Board that: 1. Progress continues to be made in developing the Ten-Year Strategy, Clinical Services Plan and supporting planning framework, including completion of the strategic discovery phase, establishment of clinical engagement arrangements and development of a fragile services framework to support service planning and improvement. 2. The Committee received assurance that learning from the 2025/26 Integrated Medium Term Plan process is being	

		systematically reviewed and incorporated into future planning arrangements, with particular focus on strengthening integration between planning, finance, workforce, performance and delivery. 3. Members were assured that population health programmes and Welsh Government-funded prevention grants continue to be actively managed, with strengthened oversight arrangements, improved grant governance and delivery of key prevention initiatives across North Wales.
2c	Advise	The PPHP Committee wish to Advise members of the Board that: 1. Accelerated action is required to secure resolution of the EHR and MHEHR funding position, including escalation through existing Welsh Government and NHS Wales governance arrangements and consideration of contingency options should national decisions remain unresolved. 2. A strategic Board discussion is required regarding the Foundations for the Future programme to determine which elements should proceed in the short term to address critical organisational capacity, leadership and decision-making issues. 3. Further work is required to develop a coordinated organisational approach to decarbonisation and climate adaptation, including consideration of governance arrangements, accountability and resource requirements.
2d	Review of Risks	1. Risk 2503 (Strategic Planning and Service Transformation) has been refreshed to better align with the Health Board's strategic planning, clinical services planning and organisational change programmes. The Committee noted revised actions and timescales. 2. Risk 2504 (Communicable Diseases and Public Health Preparedness) remains a significant area of focus. The Committee received assurance regarding ongoing preparedness activity, including planning for high consequence infectious diseases, but noted continuing work to strengthen organisational compliance and accountability arrangements. 3. Members discussed the need for greater corporate oversight of risk management arrangements to ensure that actions are progressing sufficiently to reduce risk exposure over time
2e	Sharing of learning	N/A

3	Actions to be considered by other Committees	1. People and Culture Committee to review the perception that staff do not feel enabled to make the transformation required to change clinical services. 2. Foundations for the Future strategic discussion required at Board level to discuss whether it would be possible to continue with the full Organisational Change Programme or move faster with some changes to ensure some stability and capacity for performance and service improvement and change. 3. Performance, Finance and Information Governance Committee to look at zero based budgeting to ensure that budgets are fit for purpose moving forward and consider the Audit Wales position. 4. Executive Committee to consider the Decarbonisation Strategy and return to the Planning, Population Health and Partnerships Committee with a suggested way forward.

Health Board Key Issues Report			
Board Date		30/07/2026	
Date of Committee		11/06/2026	Report of: People and Culture Committee
Quoracy met:		Yes	
1	Agenda	The People and Culture (P&C) Committee continues to meet bi-monthly. The Committee considered an agenda which is attached: People & Culture Committee - BCUHB	
2a	Alert	The P&C Committee wish to Alert members of the Board that: 1. Sickness absence remains above target (circa 6%), with delivery of the agreed improvement actions impacted by resource constraints, workforce pressures and increased employee relations workload, requiring a reset of the action plan to align with deliverable priorities. 2. Workforce operational and contractual risks remain, including challenges in implementing Resident Doctor contract reform (with partial rota compliance and potential industrial relations risk) and Senior Doctor job planning variations which may create significant implications. 3. The Foundations for the Future Programme is progressing but continues to carry significant delivery risk linked to workforce capacity and resource prioritisation, with potential requirement for additional resource or reprioritisation impacting business-as-usual activity. (These discussions align to action PF26.40.2, with the Committee maintaining active oversight of the Foundations for the Future Programme to ensure appropriate governance and scrutiny of programme delivery and workforce implications).	
2b	Assurance	The P&C Committee wish to Assure members of the Board that: 1. Structured plans are in place to strengthen organisational culture, leadership and engagement, with positive progress reported including development of a culture improvement framework and expansion of the Culture Change Leaders network, supporting longer-term organisational improvement. 2. Performance management and workforce indicators are improving in key areas, including: ○ PADR compliance increasing to over 80% ○ Reduction in recruitment shortlisting times following targeted improvement work	

		○ Continued reduction in agency spend against planned targets 3. Governance and workforce assurance arrangements continue to be strengthened, including oversight of professional standards (revalidation), risk management refinement, and alignment of reports to appropriate committees to ensure comprehensive assurance coverage. 4. The Committee is reviewing improvement actions to reduce recruitment shortlisting delays through enhanced processes and engagement with managers. (These discussions align to action PF25.96 from the Performance, Finance and Information Governance Committee)
2c	Advise	The P&C Committee wish to Advise members of the Board that: 1. Cultural and leadership factors are central to addressing workforce challenges, including sickness absence and staff wellbeing, with emphasis placed on manager capability, team culture and early intervention rather than reliance solely on policy compliance or service provision. 2. Staff wellbeing requires a more integrated and preventative approach, with the Committee advising a shift towards embedding wellbeing into day-to-day leadership practice, supported by clearer metrics, strengthened management capability, and system-wide alignment of services. 3. Welsh Language and cultural initiatives provide a strong model for organisational change, demonstrating the value of staff-led improvement, leadership visibility and structured programmes to embed behaviours and strengthen service quality.
2d	Review of Risks	There were no risks specifically highlighted in the meeting for escalation, multiple workforce and delivery risks were discussed across agenda items, including sickness absence, workforce capacity, and programme delivery.
2e	Sharing of learning	Learning from the Staff Story – Welsh Language Champions Programme 1. Demonstrates that empowering and recognising staff leads to measurable improvements in service delivery, including increased availability and quality of Welsh language services. 2. Highlights the importance of leadership role modelling and organisational visibility in embedding cultural change and encouraging staff confidence. 3. Reinforces that structured networks (e.g. Champions), shared learning, and practical toolkits support

		consistency and sustainability of improvement across diverse services.
3	Actions to be considered	No actions to be considered or referred.

Health Board Key Issues Report			
Board Date		30/07/2026	
Date of Committee		02/06/2026	Report of: Charitable Funds Committee
Quoracy met:		Yes	
1	Agenda	The Charitable Fund Committee (CFC) continues to meet quarterly. The Committee considered an agenda which is attached: Charitable Funds Committee - Betsi Cadwaladr University Health Board	
2a	Alert	The Charitable Funds Committee wish to Alert members of the Board that: • The Committee received a powerful presentation on the impact funding had ~~had~~ on the Equality and Diversity activity. • Some approved charitable commitments remain under-utilised or undelivered, with instances of funding being returned, highlighting risks to impact and value for money. • Donations remain skewed toward high-profile services, reducing flexibility to support wider organisational priorities. • The Committee identified the need for clearer forward planning to ensure effective use of cash reserves (c. £2.4m).	
2b	Assurance	The Charitable Funds Committee wish to Assure members of the Board that: • Charitable funding is delivering demonstrable impact, particularly in staff wellbeing, equality, and inclusion, with evidence of improved staff experience and engagement. • Significant impact has been achieved through: ○ Equality and diversity initiatives ○ Neurodiversity training and toolkit development ○ Suicide prevention training ○ Staff network development • Financial governance remains robust, with net assets increasing (c. £14.4m), growth in investment income, and active monitoring of expenditure and commitments. • Investment management arrangements continue to provide appropriate oversight and long-term stability, with performance monitored despite market volatility.	

2c	Advise	The Charitable Funds Committee wish to Advise members of the Board that: • A medium-term charitable funds strategy (2–3 years) is required to align expenditure, income and investment with Health Board priorities. • There is a need to increase flexibility in funding arrangements, including use of general-purpose funds to support cross-cutting priorities such as staff wellbeing. • Improved visibility and promotion of charitable impact would support engagement and future income generation. • Charitable funding should be further aligned with IMTP and organisational priorities.
2d	Review of Risks	• No risks identified other than those identified in the Investment Management Report.
2e	Sharing of learning	No learning to be shared.
3	Actions to be considered	No actions to be shared.



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Health Board Key Issues Report

Board Date		30/07/2026	
Date of Committee		01/06/2026	Report of: Stakeholder Reference Group
Quoracy met:		No	
1	Agenda	The Stakeholder Reference Group continues to meet quarterly. The Committee considered an agenda which is attached: Stakeholder Reference Group (SRG) - Betsi Cadwaladr University Health Board	
2a	Alert	The Stakeholder Reference Group wish to alert members of the Board that: The theme of the meeting was the importance of establishing better links with local authorities to ensure more participation.	
2b	Assurance	The Stakeholder Reference Group wish to assure members of the Board that: - The meeting demonstrated a clear shift towards prevention, inequalities and population health. - System-wide collaboration and co-production. - Continuous data-informed planning to ensure plans turn into visible action.	
2c	Advise	The Stakeholder Reference Group wish to advise members of the Board of: - Gareth Jones confirmed as Vice Chair. - Success will depend on sustained genuine partnership working and addressing capacity, workforce and infrastructure constraints. - Community hubs identified as a key solution for local delivery.	
2d	Review of Risks	N/A	
2e	Sharing of learning	N/A	
3	Actions to be considered by the	No actions to be considered by other Committees or the Board.	

Health Board Key Issues Report

Board Date		30/07/2026	
Date of Committee		05/06/2026	Report of: Healthcare Professionals Forum
Quoracy met:		Yes	
1	Agenda	Healthcare Professionals Forum continues to meet quarterly. The Committee considered an agenda which is attached: Healthcare Professionals Forum - Agenda: 5 June 2026	
2a	Alert	The Healthcare Professionals Forum wish to alert members of the Board that: 1. Concern continues regarding primary/secondary care interface, especially unclear prescribing responsibilities and pathway gaps; concerns that these issues need further consideration as part of Integrated Medium Term Plan and Clinical Services Plan. 2. Dissolution of local eye care groups creates governance and patient safety risks, with no structured engagement between Optometry and Ophthalmology. 3. Concerns raised by both Community and Acute Pharmacy representatives regarding ongoing supply chain issues and resulting increased costs. 4. Continued concerns regarding future sustainability of NHS dentistry. 5. AHP representative highlighted potential risks associated with reduced training commissions and the absence of a national Chief AHP Officer.	
2b	Assurance	The Healthcare Professionals Forum wish to assure members of the Board that: 1. Digital transformation progressing well including EPMA, RISP and forthcoming BadgerNet go-live in Maternity despite staff pressures. 2. Stroke pathway innovations (community-based rehabilitation programmes) show positive impact though workforce fragility remains.	

		- Electronic discharge summaries now improving Discharge Medicines Review (DMR) processes across Community Pharmacy. - Community pharmacy representative highlighted a number of positive developments including: - National recognition for pharmacy staff presenting at the Clinical Pharmacy Congress. - Progression of Bangor University Pharmacy School partnerships. - Increased engagement with schools and future workforce initiatives. - There are continued efforts to progress the outstanding action regarding Specialist and Tertiary Care Representation.
2c	Advise	The Healthcare Professionals Forum wish to advise members of the Board that: - While digital improvement was welcomed and has brought numerous positive changes, significant concerns remain across a number of services regarding functionality, integration and patient safety risks associated with inconsistent adoption across organisations. - Need for strengthened engagement with clinical leaders regarding the IMTP, Clinical Services Plan and Foundations for the Future programme. - HPF seeks early involvement in People Services strategy development. - Members of HPF to explore opportunities to support expansion of clinical academic and joint Health Board/University roles.
2d	Review of Risks	- Inpatient detoxification risk presents urgent need for interim mitigation planning to avoid service interruption. - Workforce fragility across stroke rehabilitation, orthotics and other areas remains a concern affecting service resilience. - Cultural issues across services persist, requiring improved triangulation of intelligence to identify hotspots and target interventions.
2e	Sharing of learning	Learning from national Patient Reported Experience Measures (PREMs) and perinatal assurance assessments continues to drive improvement activity in Maternity and Neonatal Services.



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		2. Community by Design continues to progress and provides examples of impactful good practice. 3. Recognition of significant achievements, including Bevan Exemplar projects and completion of Higher Specialist Scientist Training.
3	Actions to be considered by the Executive Committee	1. Escalate concerns regarding visibility of the Clinical Services Plan within planning processes and limited prominence of primary care. 2. Escalate longstanding Optometry/Ophthalmology leadership concerns.

Health Board

EXECUTIVE COMMITTEE REPORT

Dyddiad y Cyfarfod Date of Meeting	30 July 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Catrin Williams
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Pam Wenger, Director of Corporate Governance

Pwrpas yr Adroddiad Report Purpose	For Noting

Crynodeb Gweithredol **Executive Summary**

Since the last report the Executive Committee has convened on 6th May, 20th May, 3rd June and 18th June and 1st July. These meetings have focused on strategic service developments, governance enhancements, and financial oversight aligned with the Health Board's priorities.

The Executive Committee meets in private and therefore there may be some items of business that are considered to be confidential in accordance with the Health Board Standing Orders.

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

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

EXECUTIVE COMMITTEE REPORT

Since the last report the Executive Committee has convened on 6th May, 20th May, 3rd June and 18th June and 1st July. These meetings have focused on strategic service developments, governance enhancements, and financial oversight aligned with the Health Board's priorities.

The Executive Committee meets in private and therefore there may be some items of business that are considered to be confidential in accordance with the Health Board Standing Orders.

1.0 Meeting held on 6th May

1.1 Contracts and Capital Approvals

Items are reported in private paper

1.2 Governance and Risk

1.2.1 Internal Audit Report – Speaking Up Safely

The Committee considered the Internal Audit Report which received a Limited Assurance rating. Discussion focused on organisational culture, psychological safety and improving staff confidence in raising concerns. Resolution: The Committee noted the report and supported delivery of the associated improvement plan.

1.3 Quality Reports

The Committee reviewed quality reports including never events, complaints, Ombudsman cases, incident investigations and quality governance arrangements. Discussion focused on organisational learning, quality assurance and improving the effectiveness of governance processes. Resolution: The Committee noted the reports and supported further work to strengthen quality governance and reporting arrangements.

1.4 Annual Assurance Report of Nurse Staffing Levels

The Committee received the statutory Annual Assurance Report on Nurse Staffing Levels and considered the outcome of staffing assessments undertaken across relevant inpatient areas. Assurance was provided that staffing levels remained compliant with legislative requirements and supported safe care. Resolution: The Committee approved the report for submission to Board.

1.5 Registered Nursing and Midwifery Establishment Alignment – September 2026 Graduates

The Committee considered proposals to maximise recruitment opportunities for newly qualified nurses and midwives and reduce reliance on temporary staffing arrangements. Members supported the proposed workforce approach as a

sustainable means of strengthening future workforce supply. Resolution: The Committee approved the proposed recruitment and establishment alignment arrangements.

1.6 Urgent and Emergency Care Report

The Committee received an update on urgent and emergency care performance across the Health Board, including variation in performance between sites and the impact of system pressures on service delivery. Members requested a strengthened Board report with clearer evidence of performance trajectory, quality indicators and the impact of improvement actions. Resolution: The Committee noted the report and agreed that a revised report would be developed for Board consideration.

1.7 Scan for Safety

The Committee reviewed progress relating to Scan for Safety and considered proposals to strengthen ownership, governance and implementation arrangements. Members recognised the potential benefits for patient safety, standardisation and device traceability. Resolution: The Committee approved the proposed implementation approach and governance arrangements.

1.8 Resident Doctors Contract Reform and Local Implementation

The Committee reviewed the emerging risks associated with implementation of Resident Doctors Contract Reform. Discussion focused on the level of organisational risk and the need for continued oversight. Resolution: The Committee noted the position and agreed that implementation would continue under regular Executive Committee oversight.

1.9 Emerging Themes from the 2025 NHS Wales Staff Survey

The Committee considered emerging themes arising from staff survey feedback and discussed opportunities to improve staff engagement and organisational culture. Members emphasised the importance of translating feedback into measurable improvement actions. Resolution: The Committee noted the findings and supported development of directorate action plans.

1.10 Continuing Healthcare Fee Setting

The Committee considered the proposed Continuing Healthcare fee uplift for 2026/27. Members discussed affordability, market conditions and alignment with approaches being developed elsewhere in Wales. Resolution: The Committee approved the proposed fee uplift for onward Board consideration.

2.0 Meeting held on 20th May

2.1 Contracts and Capital Approvals

Items are reported in private paper

2.2 Governance and Risk

2.2.1 Covid-19 Inquiry Update

The Committee received an update on emerging findings from the UK Covid-19 Inquiry and considered implications for the Health Board. Discussion focused on preparedness, workforce resilience, emergency planning and organisational learning. Resolution: The Committee noted the update and agreed that a coordinated organisational response should be developed.

2.2.2 Corporate Risk Register

The Committee reviewed the Corporate Risk Register and discussed concerns that risks were being reported without sufficient evidence of risk reduction. Members emphasised the need for stronger mitigation activity and clearer links between risks and delivery plans. Resolution: The Committee supported a more action-focused approach to risk management.

2.3 Staff Engagement – Display Boards Across Key Sites

The Committee considered proposals to introduce staff recognition display boards across Health Board sites to support staff engagement and recognition. Members emphasised the importance of maintaining current content and ensuring the initiative formed part of a wider engagement programme. Resolution: The Committee approved the proposal and supported future development of digital solutions.

2.4 Staff Engagement – Long Service Recognition Approach

The Committee considered a revised approach to long service recognition designed to improve consistency and staff experience. Members supported a more equitable process, including automatic identification of eligible staff and continued recognition events. Resolution: The Committee approved the revised long service recognition approach.

2.5 National Patient Safety Plan Review

The Committee reviewed the Health Board's position against the National Patient Safety Plan and considered priority areas for improvement. Members emphasised that patient safety should be embedded within wider quality management arrangements rather than delivered through a standalone programme. Resolution:

The Committee endorsed the identified priorities and supported development of a detailed implementation plan.

2.6 Supporting Delivery of the NHS Wales Women's Health Plan

The Committee considered proposals to support implementation of the NHS Wales Women's Health Plan within the available funding allocation. Members supported development of a sustainable "hub without walls" model embedded within existing services. Resolution: The Committee approved the programme for submission to Welsh Government and supported development of a longer-term sustainable model.

2.7 Planned Care Major Change Programme

The Committee received an update on the Planned Care Major Change Programme and reviewed progress against strategic objectives. Discussion focused on theatre productivity, programme impact and strengthening reporting arrangements. Resolution: The Committee requested further work to improve assurance reporting and define the organisation's approach to theatre utilisation.

2.8 Urgent and Emergency Care Major Change Programme

The Committee reviewed progress in developing the Urgent and Emergency Care Major Change Programme. Members highlighted the need for clearer distinction between operational performance activity and longer-term transformation priorities. Resolution: The Committee requested further development of programme scope, structure and reporting arrangements.

2.9 Mental Health Oversight Delivery Group

The Committee received an update on the Mental Health Oversight Delivery Group and emerging workstreams. Discussion focused on strengthening performance reporting, outcomes measurement and understanding the impact of psychological therapies. Resolution: The Committee supported further development of performance and outcomes reporting.

2.10 Public Health Wales Sexual Health Incident

The Committee reviewed actions taken in response to the Public Health Wales sexual health incident and associated recommendations. Members received assurance regarding actions completed locally whilst expressing ongoing concerns about national data governance arrangements. Resolution: The Committee noted the assurance provided and supported continued escalation of concerns through Executive engagement.

3.0 Meeting held on 3rd June

3.1 Contracts and Capital Approvals

Items reported in private paper

3.2 Governance and Risk

3.2.1 Annual Quality Report

The Committee reviewed the draft Annual Quality Report ahead of consideration through formal governance routes. Members requested further refinement to ensure the report accurately reflected both progress and continuing challenges. Resolution: The Committee received the report and supported further refinement prior to final approval.

3.2.2 Quality Governance External Audit Review

The Committee considered the findings of the external review of quality governance arrangements. Discussion focused on strengthening oversight, organisational quality priorities and collective Executive ownership of quality improvement. Resolution: The Committee noted the findings and agreed that strengthening quality governance would remain a priority.

3.3 Resident Doctors Contract Reform and Local Implementation

The Committee received an update on implementation of the new Resident Doctors Contract and emerging compliance risks across services. Discussion focused on workforce implications, operational risk and uncertainty regarding financial impact. Resolution: The Committee agreed to establish a formal Rota Compliance and Workforce Programme and requested further updates.

3.4 Digital, Data and Technology Project Prioritisation

The Committee reviewed the proposed Digital, Data and Technology prioritisation framework and portfolio for 2026/27. Discussion focused on delivery capacity, strategic alignment and ensuring resources remain focused on organisational priorities. Resolution: The Committee approved the prioritisation framework and associated delivery priorities.

3.5 Business Cases Approach

The Committee reviewed proposals to strengthen the organisational business case process and governance arrangements. Discussion focused on improving prioritisation, financial clarity and alignment with planning processes. Resolution: The Committee supported the proposed direction of travel subject to further refinement.

3.6 Connah's Quay Health Centre Minor Operating Facility

The Committee considered proposals to utilise the Minor Operating Facility to increase internal planned care capacity. Members recognised the opportunity to reduce waiting times and reliance on external providers whilst further work is undertaken on the longer-term model. Resolution: The Committee approved time-limited funding for a 12-month period.

4.0 Meeting held on 18th June

4.1 Contracts and Capital Approvals

Items are reported in private paper

4.2 Governance and Risk

4.2.1 Annual Report

The Committee received the Health Board Annual Report ahead of Audit Committee and Board consideration. Members noted the balanced narrative and audit review process undertaken during development. Resolution: The Committee noted the report.

4.2.2 Corporate Risk Register

The Committee reviewed the Corporate Risk Register and ongoing developments to strengthen risk management arrangements. Discussion focused on risk reframing, mitigation and future Board development sessions. Resolution: The Committee approved the Corporate Risk Register and reviewed the adequacy of controls and mitigating actions.

4.2.3 Standards of Business Conduct Internal Audit Review

The Committee received the Internal Audit Review through the consent agenda process. Resolution: The Committee noted the annual report and associated findings.

4.2.4 Executive Committee Internal Audit

The Committee reviewed the Internal Audit findings relating to Executive Committee governance arrangements. Resolution: The Committee supported the proposed programme of work to strengthen governance and assurance arrangements.

4.3 Controlled Drugs Accountable Officer Report

The Committee received the annual statutory report on Controlled Drugs governance arrangements. Discussion focused on learning from incidents, strengthening system-wide assurance and sustaining improvements in governance processes. Resolution: The Committee noted the report and agreed the proposed improvement priorities for 2026/27

4.4 Emergency Department Business Case

The Committee considered a business case aimed at improving workforce stability within Emergency Departments. Members recognised the patient safety and service

risks associated with current staffing arrangements: The Committee endorsed the preferred option in principle and requested a revised proposal before Board consideration

4.5 Grip and Control Assessment

The Committee reviewed the Grip and Control assessment and associated action plans. Members felt a more detailed Executive discussion was required to support understanding and assurance. Resolution: The Committee deferred consideration and requested a dedicated Executive session.

4.6 External Review of Research, Development and Innovation

The Committee considered proposals to commission an external review of Research, Development and Innovation arrangements. Resolution: The Committee approved the external review and noted development of the associated Terms of Reference.

4.7 Planned Care Programme Board Key Issues Report

The Committee received the Planned Care Programme Board Report and considered key risks, alerts and assurances. Resolution: The Committee noted the report.

5.0 Meeting held on 1st July

5.1 Contracts and Capital Approvals

Items are reported in private paper

5.3 Proposal for the Deployment of Strategic Programme for Primary Care Funding

The Committee considered proposals to utilise remaining strategic primary care funding to support development of the Community by Design programme. Members supported the strategic intent whilst recognising further work was required regarding detailed deployment arrangements. Resolution: The Committee approved the funding allocation and establishment of a Programme Director post.

5.4 LIMS 2.0 Position Update

The Committee received an update on continuing delays affecting the national LIMS 2.0 programme and associated risks to Blood Transfusion services. Discussion focused on contingency planning and service continuity arrangements. Resolution:

The Committee approved interim funding, contract extensions and development of contingency options.

5.5 Quality and Safety Reports

The Committee received a suite of quality and safety reports, including Ombudsman findings, Healthcare Inspectorate Wales inspections, quality governance updates and emergency department assurance metrics. Members focused on strengthening organisational learning, assurance and quality oversight arrangements. Resolution: The Committee noted the reports and supported continued development of quality governance and assurance arrangements.

5.6 Resident Doctors Contract Reform and Local Implementation

The Committee reconsidered the implementation challenges associated with the Resident Doctors Contract. Members were not satisfied that the financial, workforce and service impacts were sufficiently clear to approve the preferred option. Resolution: The Committee approved compliant rotas that required no additional resources and requested a revised proposal for further consideration.

5.7 Job Planning Protocol – Payment of Part Sessions

The Committee considered proposals relating to payment of part sessions within the wider Job Planning Protocol. Discussion focused on job planning compliance, productivity and governance arrangements. Resolution: The Committee supported the proposal in principle and requested further work regarding implementation and approvals.

5.8 Data Quality, Governance and Assurance

The Committee received a report relating to a data quality issue affecting reported emergency department performance information. Members reviewed the actions undertaken to strengthen governance, assurance and data integrity arrangements. Resolution: The Committee noted the report and welcomed the planned external review.

5.9 Supreme Court Judgment – Deprivation of Liberty Safeguards

The Committee considered the implications of the recent Supreme Court judgment relating to Deprivation of Liberty Safeguards. Members discussed operational, governance and training implications arising from the revised legal position. Resolution: The Committee approved the interim organisational approach pending national guidance.

5.10 People and Culture Executive Delivery Group Terms of Reference

The Committee reviewed the draft Terms of Reference for the People and Culture Executive Delivery Group. Discussion focused on governance alignment, membership and policy responsibilities. Resolution: The Committee approved the Terms of Reference subject to amendment.

5.11 Strategic Planning and Service Change Group AAA Report

The Committee received the Strategic Planning and Service Change Group report and considered progress against the Integrated Medium-Term Plan and associated transformation programmes. Resolution: The Committee noted the report.

5.12 Provider Selection Regime Compliance – Medicines Management Enhanced Services

The Committee reviewed arrangements to align primary care services with the Provider Selection Regime (Wales) Regulations 2025. Members received assurance regarding the proposed Direct Award Process approach. Resolution: The Committee endorsed progression of the proposed arrangements.

ASESIAD / ASSESSMENT	
Cysylltiad â'r Bwriadau Strategol	4.Create a Modern, People Centred Healthcare System
Link to Strategic Intentions	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Yr Egwyddorion Dylunio Design Principles	Simplify, Standardise, and Adopt Best Practices Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Cydraddoldeb <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	<i>Not Applicable</i>
Asesiad o'r Effaith Economaidd-gymdeithasol <i>A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?</i> Socio-Economic Impact Assessment <i>Have you undertaken a Socio-Economic Impact Assessment</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	<i>Not Applicable</i>
<u>Ansawdd</u> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i> <u>Quality</u> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Galluogwyr Ansawdd Enablers of Quality All Apply	Meysydd Ansawdd Domains of Quality
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
<u>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant</u> <u>Wellbeing of Future Generations Act – Wellbeing Goals</u>		
Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	

	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog: Armed Forces Covenant Due Regard Duty Have you considered the Armed Forces Covenant Due Regard Duty?	Do/Yes: ☐	Naddo/No: ☐
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Asesiad o Effaith ar Ddiogelu Data A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data? Data Protection Impact Assessment Have you undertaken a Data Protection Impact Assessment Screening?	Do/Yes: ☐	Naddo/No: ☐
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Asesiad o Effaith ar Atal Twyll A ydych chi wedi ystyried yr effeithiau ar atal twyll? Counter Fraud Impact Assessment Have you considered the counter fraud impacts	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	<i>Not Applicable</i>
Cyfreithiol Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw Da Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith ar Adnoddau (Pobl / Ariannol) Resource Impact (People / Financial)	There is no direct impact on resources as a result of the activity outlined in this report.	