Bundle BCU Health Board 24 September 2026

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- 26.181b FINAL - Board - PMM Self-Assessment 2026 24.09.2026

1.2 26.183 Supporting Papers for Urgent and Emergency Care Progress Report

- 26.183 BCUHB UEC Improvement Plan 2026-27 0.12 FINAL

1.3 26.191 Supporting Papers for Board Assurance Framework 2026-2027

- 26.191.1 Appendix 1 - Portal - Board Assurance Framework - HB Sept 26 - V1.0
- 26.191.2 Appendix 2 - Extant Open BAF Actions - Mapping to new BAF to carry over (5)

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Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Health Board

QUARTER 1 REPORT ON ANNUAL DELIVERY PLAN (ADP)

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Report Author name and title	Emma Lea, Assistant Director of Corporate Planning (Interim) Geraint Parry, Assistant Director of Transformation (Interim)
Lead Executive Team Member name and title	Paolo Tardivel, Executive Director of Transformation & Strategic Planning (Interim)

Report Purpose	For Assurance

Executive Summary

Quarter 1 presents a mixed picture. Progress has been made across several priority areas, with important benefits already being realised for the population of North Wales. Planned Care improvement work has resulted in validation of more than 31,000 patient pathways and closure of almost 8,000 pathways no longer requiring treatment, helping improve waiting list accuracy and access to care. Mental Health services have reduced out-of-area placements significantly beyond trajectory, key CAMHS access standards have been maintained, and all waits exceeding 104 weeks for Stage 1 menopause services have been eliminated. In addition, investment in frailty services, falls prevention, discharge improvement and community-based care continues to strengthen the foundations for long-term improvement.

Alongside these achievements, delivery against the 2026/27 Annual Delivery Plan deliverables remains below the level required. Of 48 deliverables due for completion during Quarter 1, 25 (52%) were achieved on time. Across the plan for the full year, 203 of 318 deliverables (64%) are currently assessed as complete or on track, while 115 (36%) are assessed as either at risk or having low delivery confidence. Whilst still relatively early in the year, this highlights the need for focused recovery action and strengthened oversight in a number of areas.

The most significant delivery risks continue to relate to Cancer and Diagnostics, Fragile Services, Dementia and elements of the capital and infrastructure portfolio. Cancer performance remains below the special measures de-escalation criteria and the national standard and diagnostic capacity, whilst improving, continues to constrain wider planned care and cancer recovery. Several fragile services remain dependent on locum, insourced and temporary workforce arrangements, raising concerns regarding long-term sustainability. In Dementia,

delivery of the planned emergency care pathway is at risk following the loss of specialist pathway resource and capital affordability challenges, together with ongoing national dependencies are affecting digital programmes such as LIMS, also continue to affect delivery confidence.

Overall, the organisation continues to make progress in establishing the conditions required for recovery and de-escalation from Special Measures. However, delivery performance and operational outcomes remain inconsistent, and successful recovery of delayed Quarter 1 deliverables during Quarter 2 will be critical to maintaining confidence in delivery of the Annual Delivery Plan by year end. The Quarter 1 position also highlights the importance of clear and effective assurance and governance arrangements to support delivery, recovery and accountability. Work is underway to review the most appropriate approach and governance route for ongoing monitoring of Annual Delivery Plan delivery, performance improvement and associated recovery actions.

The Committee is asked to note both the progress achieved and the risks identified and seek assurance that appropriate recovery actions are in place.

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	
BJC	Business Justification Case
COO	Chief Operating Officer
DHCW	Digital Health and Care Wales
IMTP	Integrated Medium-Term Plan
IRCF	Integration and Rebalancing Capital Fund
OBC	Outline Business Case
PPHP	Planning, Population Health and Partnerships
PMO	Portfolio Management Office
SRO	Senior Responsible Officer
SOC	Strategic Outline Case
WG	Welsh Government
UAT	User Acceptance Testing
DHCW	Digital Health and Care Wales

1. Introduction

The 2026/27 Annual Delivery Plan (ADP) sets out the actions that Betsi Cadwaladr University Health Board will undertake to deliver its strategic priorities, respond to national expectations and support continued improvement for the population of North Wales. This report provides the Board with an assessment of progress at the end of Quarter 1, highlighting achievements, areas of concern and the actions being taken to improve delivery confidence during the remainder of the year.

Quarter 1 has seen progress being made across several major transformation programmes including Urgent and Emergency Care, Planned Care, Foundations for the Future, Mental Health, Digital, Data and Intelligence. However, delivery performance across the Annual Delivery Plan has been mixed, with almost half of Quarter 1 milestones not completed within planned timescales and more than one-third of annual deliverables currently assessed as carrying delivery risk. This reflects the continuing operational, workforce, financial and infrastructure challenges facing the organisation.

While many programmes have established important foundations for future improvement, progress has not yet consistently translated into improved operational performance or delivery confidence. Sustained executive focus will therefore be required throughout the remainder of the year to recover delayed milestones, mitigate emerging risks and ensure delivery remains aligned to the organisation's improvement objectives and de-escalation ambitions.

The report therefore seeks to provide assurance on current delivery, identify areas requiring enhanced oversight and support timely intervention where additional action is required.

2. ADP Delivery Overview

This section provides an assessment of delivery against the Annual Delivery Plan at the end of Quarter 1. The position reflects updates submitted by programme and reporting leads following the closure of Quarter 1 and includes both completed deliverables and delivery confidence assessments for the remainder of the year. Full narrative updates are included within Appendix 2.

Table 1 - shows delivery performance against the 48 milestones scheduled for completion by the end of Quarter 1. Of these, 25 (52%) were completed within the planned timeframe. Whilst this represents progress across a substantial and ambitious programme of work, 23 deliverables (48%) were either incomplete, at risk or assessed as having low delivery confidence at the end of June. This position is below the level expected and indicates that delivery will need to accelerate during subsequent quarters if annual objectives are to be achieved in full.

Table 1 – 2026/27 Annual Delivery Plan Q1 Assurance Assessment.

Strategic Priorities	Complete (Q1 only)	On Track to deliver (Q1 only)	At risk of not completing by end of Quarter (Q1 only)	Unlikely to complete by end of Quarter (Q1 only)	Total
1. Focus on Health and Wellbeing	0	0	0	0	0

2. Enhance the co-ordination of care	1 (2%)	0	2 (4%)	1 (2%)	4 (8%)
3. Improve access, outcome and experiences for all	8 (17%)	2 (4%)	3 (6%)	6 (12%)	19 (40%)
4. Create a modern, people-centred healthcare system	16 (33%)	0	1 (2%)	8 (17%)	25 (52%)
Overall	**25 (52%)**	**2 (4%)**	**6 (12%)**	**15 (31%)**	**48**

The greatest concentration of Quarter 1 delivery challenges is within the strategic priorities relating to improving access, outcomes and experiences, and creating a modern, people-centred healthcare system. Several delayed milestones are linked to workforce constraints, programme mobilisation delays, national dependencies, affordability challenges and operational capacity limitations. Recovery plans are being developed through programme governance arrangements and will require ongoing executive oversight through Quarter 2.

Table 2 shows the current overall delivery confidence assessment across all 318 deliverables within the full year 2026/27 Annual Delivery Plan. While 64% of deliverables are currently assessed as complete or on track for delivery by year end, 115 deliverables (36%) are assessed as either at risk or having low delivery confidence. Although this remains an early-year assessment, the position highlights a significant level of delivery risk across the portfolio and reinforces the need for focused management action in a number of key programmes.

Table 2 – 2026/27 Annual Delivery Plan Overall Assurance Assessment

Strategic Priorities	Complete	On Track to deliver *(2026/27)*	At risk of not completing by end of *2026/27*	Unlikely to complete by end of *2026/27*	Total
1. Focus on Health and Wellbeing	0	29 (9%)	4 (1%)	0	33 (10%)
2. Enhance the co-ordination of care	1 (0%)	10 (3%)	14 (4%)	4 (1%)	29 (9%)
3. Improve access, outcome and experiences for all	9 (3%)	66 (21%)	39 (12%)	13 (4%)	127 (40%)
4. Create a modern, people-centred healthcare system	17 (5%)	71 (22%)	27 (8%)	14 (4%)	129 (41%)
Overall	**27 (8%)***	**176 (55%)**	**84 (26%)**	**31 (10%)**	**318**

*Two deliverables scheduled for completion later in the year, were completed ahead of schedule in Q1, therefore 27 deliverables are showing as complete in Table 2, versus the 25 indicated in Table 1 above.

Table 3 below shows the key priority areas within the ADP and the delivery confidence rating for achieving all the deliverables and full priority aims by the end of the year. Full quarter one narrative updates for each key priority can be seen in appendix 2.

Table 3 – Key priority areas end of year Delivery Confidence

Strategic Priorities	Key Priority Area	Executive Lead	Overall Delivery Confidence
1. Focus on Health and Wellbeing	1A Preventative approaches to Health & Wellbeing	Executive Director of Public Health	
	1B Proactive strategies for disease prevention, falls & frailty	Executive Director of Public Health	
	1C Health Inequalities	Executive Director of Public Health	
	1D Health Protection	Executive Director of Public Health	
2. Enhance the co-ordination of care	2A Primary Care	Chief Operating Officer	
	2B Community Care	Chief Operating Officer	
	2C Integrated Health & Well-being Hubs	Chief Operating Officer	
3. Improve access, outcome and experiences for all	3A Urgent and Emergency Care (UEC)	Chief Operating Officer	
	3B Planned Care, Cancer & Diagnostics	Chief Operating Officer	
	3C Fragile Services	Chief Operating Officer	
	3D Mental Health & Learning Disabilities	Executive Director of Allied Health Professionals and Health Science	
	3E Child and Adolescent Mental Health (CAMHs) & Neurodevelopment (ND)	Chief Operating Officer	
	3F Children and Young People Services	Chief Operating Officer	
	3G Women's Health	Chief Operating Officer	
	3H Pharmacy and Medicines Management	Executive Medical Director	
	3I Dementia	Executive Director of Nursing	
4. Create a modern, people-centred healthcare system	4A Foundations for the Future	Chief Executive	
	4B Strategy and Planning	Executive Director of Transformation & Strategic Planning	
	4C Clinical Services Planning, Leadership and Interprofessional Working	Executive Medical Director	
	4D Digital, Data and Intelligence	Director of Digital, Data & Intelligence	
	4E Research, Development and Innovation	Executive Medical Director	
	4F Education Partnership and Projects, Academic Careers and Strategic Alignment of Education	Executive Director of People Services & Organisational Development	
	4G Value & Sustainability	Executive Director of Finance	

	4H Quality	Executive Director of Nursing	
	4I Environment and Estates	Director of Environment & Estates	
	4J Workforce	Executive Director of People Services & Organisational Development	
	4K Finance & Commissioning	Executive Director of Finance	

Key Areas Requiring focus

Current reporting identifies a number of programmes requiring enhanced executive oversight due to delivery risk, low confidence or dependency on factors outside direct programme control. These include:

- Fragile Services, where workforce sustainability remains a significant concern.
- Cancer and Diagnostics, where performance remains below national expectations and workforce constraints continue to affect delivery.
- Dementia, where delivery of key pathway objectives is at significant risk due to the loss of specialist resource.
- Elements of the Health and Wellbeing Hubs programme, where affordability, funding and capital prioritisation challenges continue to affect progress.

The principal themes affecting delivery confidence across the portfolio are workforce fragility, operational capacity constraints, financial pressures, capital affordability, programme mobilisation challenges and national dependencies. These risks will continue to be monitored through programme governance arrangements and escalated where additional intervention is required.

3. Focus on Priority Areas

This section focuses on the organisation's priority areas, providing a quarterly assessment of progress and delivery. It offers an overarching appraisal of where programmes and services currently stand, highlighting areas requiring further attention, support, or intervention.

The detailed monthly service updates underpinning this assessment are provided in Appendix 2.

Major Change Programmes

Across the Health Board, there are four Major Change Programmes. This section outlines the progress during this quarter and delivery confidence against delivery of the full year's Annual Delivery Plan. Full details can be found in the appendix.

Programme	Progress against ADP	Delivery Confidence
Urgent & Emergency Care (3A)	During Q1, the Urgent and Emergency Care (UEC) Programme focused on strategic realignment following the introduction of the NHS Wales Three Pillars Framework, with the UEC Improvement Plan refreshed to prioritise Discharge to Recover and Assess (D2RA), Frailty and Clinical Engagement. Significant progress has been made in establishing the foundations for future improvement, including development of the Single Point of Access model, implementation of community falls services, strengthening Same Day Emergency Care and hospital flow arrangements, progressing WECDS implementation, and enhancing clinical engagement through a UEC Masterclass. Collaboration across partner organisations has also improved, supported by enhanced performance reporting and governance arrangements. Whilst there is positive momentum and stronger alignment to national priorities, the programme remains at an early stage of delivery, with most benefits yet to be fully realised. Sustained demand pressures across health and social care continue to impact key performance indicators, particularly delayed discharges and patient flow. The programme is therefore rated Amber, reflecting good progress in establishing the enablers for change while recognising the need to translate current development activity into measurable improvements in discharge performance, patient flow and UEC outcomes during the remainder of 2026/27.	
Planned Care (3B)	The Planned Care Programme continues to deliver a broad portfolio of transformation initiatives focused on reducing waiting times, improving access and enhancing patient experience across North Wales. During Q1, good progress was made in waiting list validation, electronic referrals, Community Health Pathways, the development of a pan-BCU One Waiting List approach, booking service modernisation, Surgical Hub Accreditation, theatre optimisation and expansion of Patient Initiated Follow-Up (PIFU) models. Notable achievements include validation of over 31,000 patient pathways, closure of almost 8,000 pathways, rollout of electronic referrals across 10 specialties, delivery of 228 Community Health Pathways, and continued success of teledermoscopy services. Whilst the programme is delivering measurable improvements in pathway management and service efficiency, significant challenges remain in translating transformation activity into sustained productivity and performance gains. Workforce constraints, consultant job-planning pressures, variable utilisation of additional capacity, and ongoing financial, digital and leadership dependencies present risks to delivery, including increasing waits for suspected skin cancer patients. The programme is therefore rated Amber, reflecting positive progress against planned milestones and recovery objectives, whilst recognising	

	the need to embed improvements, increase theatre throughput and strengthen delivery confidence during 2026/27.	
Clinical Services Plan (4C)	The Clinical Services Plan (CSP) Programme has focused during Q1 on establishing the strategic foundations for a clinically led, evidence-based approach to shaping future services across North Wales. Progress includes engagement with senior clinical leaders, development of a draft Fragile Services Framework to support service assessment and planning, learning from best practice with Hywel Dda University Health Board, and the preparation of a comprehensive Programme Initiation Document. Work has also highlighted the importance of aligning clinical service planning with enabling strategies, including workforce, digital, estates and value, to support the development of a sustainable and deliverable future clinical services model. Whilst good progress has been made in developing the programme approach and strengthening strategic alignment, delivery has been impacted by organisational capacity constraints, competing corporate priorities, leadership vacancies and the need to consider emerging national policy and strategy developments. As a result, some Annual Delivery Plan milestones have not been achieved within the original timescales. The programme is therefore best assessed as Amber, reflecting positive progress in programme design and stakeholder engagement, whilst recognising the need to agree a revised delivery approach, secure external support and translate strategic development activity into an approved and actionable Clinical Services Plan.	
Community by Design (2B)	The Community by Design (CbD) Programme has made good progress in establishing the foundations for delivering integrated primary and community care services aligned to national priorities. During Q1, strategic funding was secured to support key programme leadership appointments, governance arrangements were developed, and programme mobilisation activities progressed through the development of a Programme Initiation Document and identification of priority delivery areas. Early progress has also been made in advancing key initiatives, including Breathlessness Hubs, community frailty models and the exploration of Community Diagnostics opportunities, while bringing together existing community transformation activity within a single programme framework. Whilst the programme is well aligned to the national Community by Design agenda and has successfully established the structures required to support future delivery, the majority of workstreams remain in the early stages of development and measurable benefits have yet to be realised. The programme is therefore rated Amber, reflecting positive progress in mobilisation, workforce recruitment and governance arrangements, whilst recognising that successful implementation and delivery of community-based models of care will be required to demonstrate improvements in prevention, integrated care and reduced reliance on hospital services during the remainder of 2026/27.	

Key Programmes

Across the Health Board, there are Key Programmes. This section outlines the progress during this quarter and delivery confidence against delivery of the full year's Annual Delivery Plan. Full details can be found in the appendix.

Programme	Progress against ADP	Delivery Confidence
Ablett Mental Health Unit (3D.10)	The Adult and Older People Mental Health Unit Redevelopment Programme made positive progress during Quarter 1, securing Welsh Government approval to proceed with a revised capital budget of £108.1m. This has enabled continued development of the scheme, including preparations for the Supply Chain Partner procurement process and ongoing engagement with Welsh Government stakeholders. Discussions undertaken during the quarter have also provided reassurance that the programme's strategic objectives, including modernising inpatient facilities and improving access to care closer to home, remain aligned with current service needs. While approval to proceed represents an important milestone, the programme's trajectory remains dependent on resolving a number of significant risks. Clarity is required on the scope, timescales and implications of emerging All-Wales mental health bed planning work to confirm alignment with the proposed redevelopment. In parallel, focussed action is needed to manage procurement risks and develop affordable solutions to both capital and ongoing revenue pressures. Addressing these issues at pace, in partnership with Welsh Government, will be critical to maintaining programme momentum and providing confidence in the delivery of the scheme within agreed timescales and financial constraints.	
Electronic Health Record (3D.9) Mental Health (All Ages) Electronic Health Record	The Mental Health Electronic Health Record (MH EHR) Programme has made good progress during Quarter 1, achieving a significant milestone with the successful completion of procurement activity and Welsh Government approval to proceed to contract execution and implementation. Preparatory work has continued across Digital, Estates, Health and Safety, CAMHS and Adult Mental Health Services to support mobilisation and ensure alignment with wider transformational initiatives. These activities have strengthened organisational readiness for the introduction of a single all-age electronic health record, which remains a key enabler of more integrated, consistent and informed care delivery across mental health services. In order to maintain implementation momentum, the immediate priority is securing confirmation of Welsh Government funding through the Digital Priorities Investment Fund process, alongside completing contractual arrangements with the successful supplier. Continued focus is also	

	required on implementation planning, stakeholder engagement and organisational readiness to ensure deployment can commence promptly once funding is confirmed. While overall delivery remains achievable, progress at pace is dependent on resolving the current funding uncertainty and finalising contract execution, which continues to present the principal risk to programme timelines.	
Foundations for the Future (4A)	The Foundations for the Future Programme has delivered all Quarter 1 milestones and continues to make positive progress in strengthening organisational leadership, governance and workforce capability. Key achievements include completion of the Competency Framework and Integrated Leadership Development Framework, progression of the Operational Governance Framework, advancement of organisational design activity, and progression to transition the Quality Management System into business-as-usual arrangements. These developments have strengthened governance and accountability and generated positive staff engagement through culture and leadership improvement initiatives. To improve delivery confidence and return the programme to a green trajectory, priority must be given to progressing organisational consultation activity, accelerating implementation of the revised operating model, and advancing Phase 2 organisational design work, including reviews of structures below Band 8b and the integration of Mental Health and Learning Disabilities services. Continued focus is also required on embedding the Operational Governance Framework, delivering leadership and workforce initiatives, and maintaining effective programme oversight, risk management and stakeholder engagement. While the programme remains on course to deliver its long-term objectives, timely progress in these areas will be critical to sustaining momentum, realising planned benefits and mitigating the impact of delays within the structures workstream.	
Health & Wellbeing Hubs	The Health & Wellbeing Hubs Programme continues to support the Health Board's ambition to strengthen community-based care and deliver more integrated services closer to home. During Quarter 1, progress has been made across several schemes, including advancement of the Strategic Outline Case for Bangor, agreement of Heads of Terms for land acquisition at Waunfawr, and continued partnership development with the Isle of Anglesey County Council for the Holyhead Hub. Further development work has also progressed at Penygroes and Porthmadog, focusing on business case development, site planning and affordability assessments, demonstrating continued momentum across the portfolio despite a challenging financial environment. There are funding, affordability and capital prioritisation challenges that are affecting a number of schemes across the portfolio. This includes progressing decisions on Caledfryn, Denbigh, identifying viable funding solutions, and establishing a formal programme board structure to strengthen oversight, manage interdependencies and accelerate issue resolution across projects. Continued collaboration with Welsh Government and local authority partners, alongside the progression of	

	business cases and partnership agreements, is essential to maintaining momentum and achieving the long-term vision for integrated community services across North Wales.	
Laboratory Information Management System – LIMS (3B.19)	The LIMS Programme has continued to support operational services already deployed, with the Cellular Pathology and Mortuary modules functioning effectively and becoming embedded within routine practice. During Quarter 1, local teams-maintained progress through defect resolution testing, integration testing, end-user training, and participation in national configuration and testing activities for the Aliquots functionality. These activities have helped sustain organisational readiness and ensure that benefits from implemented modules continue to be realised despite wider programme challenges. To return the programme to a more stable trajectory, urgent priority is required at a national level to agree a recovery plan, confirm revised deployment timelines for future tranches, and resolve outstanding system defects. Locally, focus should remain on completing Aliquots configuration and testing, strengthening governance arrangements, addressing leadership capacity through the appointment of a substantive SRO, and mitigating risks associated with ageing legacy systems and ongoing resource pressures. Until there is greater certainty regarding funding, deployment schedules and the national route to delivery, significant risks will remain to programme timescales and benefit realisation.	
Llandudno Orthopaedic Hub (3C.15)	The Llandudno Orthopaedic Hub remains a key element of the Health Board's elective recovery plans and longer-term orthopaedic service sustainability. During Quarter 1, work continued to support mobilisation of the hub and the development of a High-Volume Low Complexity (HVLC) model of care, with preparatory activity progressing to improve theatre utilisation, standardise orthopaedic pathways and reduce unwarranted variation in clinical practice. These developments provide a strong foundation for increasing elective capacity and improving patient access once the hub becomes operational. The immediate priority is the opening and full mobilisation of the Llandudno Orthopaedic Hub, enabling the planned increase in elective orthopaedic activity and delivery of sustainable HVLC services. Focus is also required on achieving target theatre utilisation levels, implementing national orthopaedic pathways, addressing workforce and capacity constraints, and maximising the benefits of the additional capacity to support waiting list reduction. Timely delivery of these actions will be critical to restoring momentum, improving productivity and ensuring the hub delivers its anticipated contribution to elective recovery and service sustainability.	
Value & Sustainability (4G.12)	The Value & Sustainability Programme has made good progress during Quarter 1 in establishing the foundations required to support delivery of both financial and non-financial benefits across the organisation. Key achievements include the development of core workstreams covering	

	Clinical Variation, Non-Pay & Procurement, Medicines Management, Continuing Healthcare and Value-Based Healthcare, alongside the introduction of a comprehensive benefits framework to measure improvements beyond traditional cost improvement metrics. A portfolio of 136 schemes has been identified, with £43.7m of opportunities recognised and £24.1m currently rated Green for delivery, while early benefits are being demonstrated through Value-Based Healthcare initiatives including Lymphoedema services, Community Health Pathways and Prehabilitation programmes. Priority now needs to be given to accelerating delivery across the full portfolio of improvement and savings schemes, embedding the benefits framework, and progressing the national thematic workstreams. Continued focus is required on achieving recurrent savings targets, strengthening arrangements for identifying and prioritising value opportunities, and embedding value-based approaches within decision-making and service planning processes. Successful delivery of these actions will be critical to realising the anticipated financial, quality and sustainability benefits, maintaining organisational momentum, and supporting the Health Board's longer-term recovery and transformation ambitions.	

Fragile Services

The Fragile Services work in 2026/2027 comprises of two core elements; existing challenged services and the development of a Fragile Services Framework.

The special measures framework highlighted several clinical services which were fragile because of poor quality and patient experience; staffing levels; and sub-optimal outcomes and performance. The eight services identified included vascular, urology, ophthalmology, orthodontics, orthopaedics, dermatology, plastics and oncology. These services became known as ‘Challenged Services’ and were placed under enhanced scrutiny by Welsh Government (WG).

In the 2026-2029 IMTP, the terminology to describe at-risk services has changed to ‘fragile services’ with both Plastics and Oncology now removed and with Gastroenterology added.

Across Dermatology, Ophthalmology, Orthopaedics, Orthodontics, Urology and Vascular, services remain under sustained pressure, primarily due to workforce shortages, rising demand and constrained capacity. While there has been meaningful progress in reducing long waits and improving access, particularly in Dermatology, Urology and Vascular, this position remains fragile and heavily reliant on interim measures, including insourcing, locum staffing and temporary pathways, rather than sustainable service models.

Workforce fragility is the primary system risk, limiting both recovery and transformation, alongside infrastructure constraints such as delayed capital developments (notably the Orthopaedic hub) and limited estate capacity. Demand and backlog pressures continue to outstrip capacity, with some early gains beginning to reverse in areas such as Vascular, and ongoing patient safety risks evident

in high-backlog services like Orthodontics. Although transformation programmes and redesigned pathways are progressing, delivery remains constrained, and performance improvements are not yet stable or sustainable without decisive action on workforce, capacity and infrastructure investment.

As the organisation matures it is evident that the next step is to be in a position to identify fragile and/or at-risk services internally and provide a proportionate organisational response. A Fragile Services Framework is being developed to feed into the next iteration of the Quality Management System through a suite of fragility indicators. This work aims to understand the drivers behind service fragility and includes triangulation of workforce, performance, quality (patient safety, patient experience and clinical effectiveness), finance, staff engagement, as well as information on service standards.

Overall, whilst the work on the Fragile Services Framework is progressing well and on track, the scale of unresolved issues has resulted in an overall rating of Amber. If these issues remain unresolved as the year progresses, then there is a likelihood of this priority turning to Red.

The table below sets out the assurance rating and draws out key headlines that determine the overall rating as at the end of Q1. These may differ from the self-assessed delivery confidence in Appendix 2, which also includes further details from the service.

Programme	Progress against ADP	Delivery Confidence
Dermatology (3C)	Dermatology continues to experience increasing waiting times for suspected skin cancer patients, although Teledermoscopy is helping to improve access by enabling a high discharge rate (66%) and reducing unnecessary outpatient appointments. The service remains fragile due to ongoing difficulties recruiting substantive consultants, resulting in reliance on locum and interim staffing arrangements. Mitigations include a contracted insourcing arrangement with West IHC until September 2026, additional locum capacity, increased clinic capacity at Connah's Quay, and a restructuring of consultant capacity to prioritise urgent suspected cancer patients	
Gastroenterology (3C)	Gastroenterology has implemented an interim regional model for gastrointestinal bleed services, including weekend emergency endoscopy provision, while work continues to standardise referral and treatment pathways across primary and secondary care. However, the service lacks agreed clinical and operational leadership to drive improvement, and overnight endoscopy cover remains unavailable. Current mitigation relies on ongoing medical management of patients until endoscopy services become available the following day.	
Ophthalmology (3C)	Ophthalmology has delivered improvements through enhanced cataract pathways, Teach and Treat initiatives, and data quality improvements, while digital solutions including e-referrals and an electronic health record are being progressed. Despite this, long waiting times persist and workforce and leadership gaps continue	

Programme	Progress against ADP	Delivery Confidence
	to limit service transformation and pathway redesign. Mitigating actions include collaborative working across Integrated Health Communities, recruitment of a West IHC Ophthalmology Lead to strengthen leadership, and ongoing operational workforce planning.	
Orthodontics (3C)	Orthodontics has achieved a significant reduction in Stage 1 waiting times through insourcing activity, and proposals to improve access to Cone Beam CT scanning will strengthen diagnostic capability. However, the resulting increase in patients progressing to treatment has further stretched capacity, with a substantial and growing treatment backlog that exceeds current service capability. Mitigations include exploring additional capacity through external providers and strategic partnerships, undertaking workforce planning, and improving patient communications to better manage expectations regarding treatment delays.	
Orthopaedics (3C)	Orthopaedics has experienced delays in expanding capacity because the planned opening of the Llandudno Orthopaedic Hub did not take place during Q1 due to delays in completing capital works. As a result, anticipated increases in activity have not yet been realised. To mitigate this risk, the service continues to utilise available capacity at Abergele Hospital while awaiting confirmation of the hub opening date.	
Urology (3C)	Urology has made significant progress in reducing long waits for first appointments and diagnostics and has established a partnership with Arrowe Park to provide robotic-assisted prostatectomy procedures, reducing dependency on distant outsourced providers. Despite these improvements, the service remains vulnerable due to an unsustainable on-call model and the absence of a longer-term regional solution. The lack of a robotic platform in North Wales also limits the repatriation of cancer activity. Mitigations include the recruitment of locum staff to stabilise the on-call rota, commissioning arrangements with external providers to maintain access to robotic surgery, and a planned Rapid Quality Review in September 2026.	
Vascular (3C)	Vascular services have sustained improvements in reducing long waits through alternative access models, including nurse-led clinics and hot clinics for higher-acuity patients. Additional progress has been made in developing network governance arrangements and recruiting an Educational Clinical Lead to support the potential return of FY1 doctors. The principal challenge remains securing stronger clinical engagement in service governance to drive and embed improvements. Work is underway with clinical and operational leaders to develop options that increase engagement and strengthen oversight	

3. Change Control Requests

The following summary table categorises a number of change control requests which the Board is asked to give final approval to:

ADP Ref	Summary and Rationale for Change
2627 001 2B.4	Amendment of Executive Lead from Executive Director of Finance to Chief Operating Officer
2627 002 3H.9	Amendment of wording of deliverable and change of Executive Lead from Executive Medical Director to Director of Digital, Data & Intelligence

Further details regarding each of the changes summarised are included in Appendix 1.

4. Next Steps

The Board is asked to:

A) Take assurance and note the progress made to date including the challenges highlighted within the report.
B) Note and approve the Change Control Requests.

Appendix 1 – Change Control Requests

ADP Ref	Deliverable	Executive Lead	Change Requested
2627 001 2B.4	Develop a proposal for creating an investment fund for community groups and third sector organisations to work with the Health Board on community-based solutions to some of the largest challenges facing the system.	Executive Director of Finance	Amendment of Executive Lead from Executive Director of Finance to Chief Operating Officer
2627 002 3H.9	Deliver the risk prioritised components of Electronic Prescribing Service (EPS) that sustain safe, reliable digital services, covering devices, network/telephony, core infrastructure, and clinical platforms.	Executive Medical Director	Change of Executive Lead from Executive Medical Director to Director of Digital, Data & Intelligence. Amendment of wording of deliverable to the following (change in bold): Deliver the risk prioritised components of **Essential Services Programme (ESP)** that sustain safe, reliable digital services, covering devices, network/telephony, core infrastructure, and clinical platforms.

Appendix 2 – Full Quarter One Report

Annual Delivery Plan Quarter 1 - Overview by Key Priority				
KEY:	**High Delivery Confidence**	**Medium Delivery Confidence**	**Low Delivery Confidence**	**Complete**

1A Preventative approaches to Health & Wellbeing	Executive Director of Public Health	Overall Delivery Confidence
1A.1 Develop a proposal to support referrals to appropriate support following participation in Child Measurement Programme (e.g. to CAMHS, Children's, Dietetics, Weight Management).		Q3
1A.10 Embed Making Every Contact Count (MECC) brief intervention training into organisational processes to increase numbers of trained staff.		Q4
1A.2 Implementation of the recommendations in the Weight Management Review, increasing activity in Level 2 Adult weight services.		Q4
1A.3 Deliver approved Grant funded Programmes of work (Prevention and Early Years, Whole School Approach, Whole System approach to Healthy Weight)		Q4
1A.4 Provide education and targeted approaches to healthy choices through supporting schools, early years environments and families through Dietetics - early years programmes (Come & Cook, Tiny Tums).		Q4
1A.5 Act on the conditions that influence risk factors for ill-health (e.g. environmental, social or economic interventions), including promoting a state of good mental and physical health through assessment of impact including: 1) influence planning applications 2) work with the Alcohol Partnership Board and Public Service Boards (PSBs) to implement their plans 3) contribute to developing the environment through local development plans and Actif North Wales to consider green and blue spaces.		Q4
1A.6 Agree and commence a phased implementation of an enhanced Health Improvement offer within the Health Board and with partners across the health system that increases access to evidence-based opportunities to improve health and wellbeing outcomes.		Q4
1A.7 Produce gap analysis and opportunities from the potential and current state to shape the enhanced Health Improvement offer for services.		Q4

1A.8 Embed Health Improvement into the following areas: 1) delivery planning to support Statement 2 & 4 of the National Mental Health & Wellbeing Strategy (led by Mental Health Services / Public Health Wales), 2) refresh the Preconception Strategic Plan, 3) response plan developed from the weight management review recommendations.	Q4
1A.9 Healthy Travel Charter – increase the number of participating organisations each quarter, supporting Public Service Boards (PSBs) and wider partners to register organisational commitment at a regional and national level.	Q4

Overview

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. Encouraging healthy behaviours can prevent illness reducing demand across public services, including hospital services, GP appointments, emergency care, and long-term social care. It can also reduce costs of treatment over long periods and free up capacity in the health and care system to focus on more complex or urgent care needs. Population health and wellbeing is crucial for North Wales's socioeconomic resilience and the resilience of its communities. Preventative approaches empower people to take an active role in their own health including improving individual mental wellbeing, maintaining independence which can lead to a better quality of life as people age. Through whole system approaches, conditions can be created for good health through focused approaches which prevent problems arising in the future, build resilience, reduce the incidence of disease and encourage healthy behaviours. Much of this can be delivered outside of the acute setting and by working collaboratively across sectors.

Key Delivery Priority Quarterly Update

There are 10 deliverables within 1A all of which are to be delivered in Q4 except for 1A.1 due in Q3. All are currently reporting high delivery except for 1A.2 which is Amber due to the risk around timelines of a National digital development and the service capability and capacity to deliver. All deliverables have work underway to encourage healthy behaviours which contributes to both preventing ill health and improving the health of our population. The deliverables are grouped into 4 areas; Healthy Weight; Health Improvement; Healthy Travel Charter; MECC as per below:

1a) Healthy Weight (1A.1-1A.4) progressing, responding to the PHW review and 2026/27 ministerial priority on healthy weight and includes the prevention grant funded programmes and Healthy Weight, Whole System Approach. Q1 deliverables include: 1A.1: Strengthening of the Child Measurement Programme approach and development of a plan for the Tier 1 pathway 1A.3: MOUs developed and agreed for 26/27 with Service Leads. Quarterly review meetings held and reports received on delivery progress. 1A.4: Healthy eating programmes continue to be delivered.
1b) Health Improvement (1A.5-1A.8) underway which aims to maintain or improve people's health through a range of interventions. Q1 deliverables include 1A.5: physical activity pathway developed within the iCAN provision, planning applications and alcohol licencing applications continue to be reviewed in accordance with the agreed protocol, 1A.6: Development of a health improvement framework has seen the completion of a set of recommended priorities for all topic areas within the framework with stakeholder engagement. 1A.8: Weight management review recommendations included in the Healthy Weight Ministerial priority action plan for 26/27 with quarter 1 actions delivered.
1c) Healthy travel charter (1A.9) Regional Partnership has been formed. Engagement continues with the first regional meeting taken place in Q1 with clear actions for organisations to take away. Public Service Board summary report created and circulated to support.

1d) Making Every Contact Count (1A.10) developed MECC conversation cards that are to be piloted. Comms plan developed and in place. Two campaigns successfully delivered.

2a) Healthy Weight (1A.1-1A.4) work is designed to maximise the reach of the offer that is provided both through secondary care services and in the community, setting aligned to the WMS review and Ministerial Priorities. Impact on the population will not be evident until further implementation progress is made. A range of performance measures serve as proxy indicators whilst the firming up of outcomes, short, medium and long term are agreed.
2b) Health Improvement (1A.5-1A.8) – During quarter 1 the team responded to eight planning applications of which the impact has public health significance. Recent applications have seen conditions added re: opening hours and application use and applicants actioning public health recommendations.
2c) Healthy Travel Charter (1A.9) Improved collaboration across North Wales through the establishment of the regional partnership group, with positive feedback highlighting the value of the practical guidance and support provided to signatory organisations.
2d) MECC (1A.9) Increased awareness and engagement with MECC through targeted campaigns, co-developed conversation cards and a communications plan. Reach was further extended through promotion by colleagues across the Health Board, including Occupational Health (People Managers Forum) and Health Inequalities (Parkrun Practices), highlighting the value of partnership and matrix working.

3) Delivery oversight is based on a robust programme management approach utilising the portal to manage the plan in terms of milestones and task, risks and issues. Portal programme reports are presented at the Public Health Programme Group with escalations including deviations to plan, risks and issues for information or action and risks managed with mitigation action plans.

1B Proactive strategies for disease prevention, falls & frailty	Executive Director of Public Health	Overall Delivery Confidence
1B.2 Develop and launch a suite of health intelligence resources that support improved, evidence-based decision-making in service planning and help identify and reduce inequalities.		Q2
1B.1 Develop and agree a comprehensive road map that outlines priorities, roles, data requirements and phased delivery actions to support the development of the Population Health Management (PHM) Programme.		Q3
1B.10 Produce local plans to support new National Public Health Wales Human Papillomavirus (HPV) self-sampling programme.		Q3
1B.3 Establish a Population Health Management (PHM) programme with the Digital Team (DDAT) through development of a comprehensive road map, that will facilitate sustainable healthcare transformation in future years by targeting interventions that prevent ill health, improve care and support for people with ongoing health conditions, and reduce inequalities in health outcomes.		Q4
1B.4 Complete implementation of the focused Diabetes High Value High Impact pathway.		Q4
1B.5 Identify place-based approaches within Primary and Community care and develop options which respond to population need and deliver holistic patient centred care for people living with diabetes.		Q4
1B.6 Support improvement and reduce variation in performance and compliance in relation to Diabetes priorities including: 8 Care Processes and reducing variation.		Q4
1B.7 Implement appropriate best practice within the national Quality Statement for Diabetes.		Q4
1B.8 Support the introduction of the National Lung Screening Programme (commence 2027).		Q4
1B.9 Create a plan together with Public Health Wales to support delivery of the National screening uptake targets and improvement against National performance indicators and to reduce variation.		Q4

Overview
Over 60% of NHS activity is linked to chronic long-term conditions which impact significantly on capacity, and demand for services. Most care delivery in the NHS now relates to long-term conditions many of which are preventable or have risks that can be modified. The North Wales population is ageing and falls and frailty are a significant driver of demand across primary and acute NHS Services and is expected to increase. Preventing falls and frailty is crucial to the NHS because it protects people's health, preserves independence, and reduces avoidable pressure on already stretched services. In order to reduce the prevalence and impact of disease, falls and frailty on health services, it is vital to shift focus towards prevention, early intervention and detection, and the prevention of deterioration through greater use of population and clinical intelligence. This includes bringing together available academic evidence, local data and evidence (e.g. patient experience feedback) and stakeholder involvement to improve services and outcomes.

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.
Key Delivery Priority Quarterly Update During Quarter 1 the health board has delivered on key actions and milestones including commencing recruitment to PHM posts which will contribute to developing and strengthening the Health Board understanding of population needs and how best to address these needs. PHM posts will help to develop the population approaches to delivering improvement. High Value High Impact / Diabetes - task and finish group structures and governance structures to support delivery of the programmes of work have been developed. The structures provide the mechanisms and assurance to quality improvement and transformation work linked to Diabetes, prevention and care in North Wales with the aim of improving outcomes and reducing unwarranted variation in access an outcome of care.

1C Health Inequalities	Executive Director of Public Health	Overall Delivery Confidence
1C.2 Regional Vaccine Equity Plan co-developed and launched.		Q2
1C.5 Work with Local Authorities to secure jointly commissioned social prescribing services and expand creative offers with the Third Sector across North Wales.		Q2
1C.7 Based on the work in 2025/26 on the homelessness assessment, to comply with the new Homelessness and Social Housing Allocation (Wales) legislation and needs assessments on other inclusion groups, develop a comprehensive inclusion health offer for people in North Wales.		Q3
1C.1 Implement plans which 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. By utilising population health intelligence and evidence, target approaches to reduce variation and health inequalities within inclusion health groups and areas of deprivation.		Q4
1C.3 Regional Screening Equity Plan co-developed and launched.		Q4
1C.4 Work with primary care partners to reduce variation in vaccine uptake between primary care clusters.		Q4

1C.6 Supporting Marmot principles work towards a whole system shift to prevention and addressing inequalities by increasing the number of organisations/partnerships committing to, and evidencing early delivery against, the missions and Anchor Charter in the Regional Wellbeing, Prevention and Anchor Framework (missions: Environment, Communities, Housing, Food, Employment, Life-Long Learning, Active Lifestyles, Creative Lifestyles)	Q4

Overview

Healthy life expectancy is reducing and the gap in healthy life expectancy and life expectancy is widening. The gap between those in affluent areas and from non-vulnerable groups is widening too, compared to those from the least affluent areas and from inclusion groups (e.g. homeless, Gypsy, Roma, Traveller communities, etc). This could drive demand and increase costs for health services. The Health Board has a key role in reducing health inequalities by delivering equitable access, experience and care, and also to meet the requirements of the Wellbeing of Future Generations (Wales) Act 2015, The Equality Act (2010), the Public Sector Equality Duty and the Socio-economic Duty. Those living in the most deprived areas, and those experiencing extreme disadvantage (e.g. inclusion health groups) need services the most, however these groups experience poorer access which is driving widening inequalities in health outcomes. 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. To drive this change, the organisation must consider the role of health inequalities as a core component of prevention, early intervention and improving population health. 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. Working together through developments such as Community by Design and the integrated approach to Social Prescribing, the Health Board will work with local authority colleagues, primary care, the voluntary sector and stakeholders to develop effective offers at place level, improve the economy, provide better opportunities for accessing environments which promote wellbeing, provide fairer procurement, offer employment and improve housing availability and safety. Improving these factors can delay or prevent the onset of ill health and help the population to live well for longer in their communities. One of the way's the Health Board is contributing to this is through supporting Denbighshire County Council as one of the three places in Wales selected to work with the University College London Institute of Health Equity Wales Team to maximise benefits related to the Welsh Government's ambition to become a Marmot Nation.

Key Delivery Priority Quarterly Update

During Q1 a Health Needs Assessment for inclusion health groups has been completed which provides the basis for developing the Health Board offer to those populations that experience poor access to healthcare services. To further support improved access, planning documents supporting the vaccine equity plan and screening inequalities data have also been produced. A draft health equity checklist has been developed with key partners which provides a basis for services to utilise when carrying out planning.

New Social Prescribing contracts with Local Authorities are progressing well. These look to adopt co-commissioning approaches. There has been some delay experienced with a couple of Local Authorities, but detailed plans are in place to ensure the revised timescales are supported to deliver in year. Service specifications which have been co-produced with Local Authorities, BCUHB Public Health and Primary and Community Care are being finalised, having be reviewed by legal teams.

Engagement events have taken place with stakeholders and partners to further develop 'missions' within the Regional Wellbeing, Prevention and Anchor Framework which further supports health board contribution to addressing inequalities and supporting long-term wellbeing in our most vulnerable groups. As part of this, we continue to support Denbighshire County Council with the 'Marmot Nation' Health Equity Wales Local Authority funded project.

1D Health Protection	Executive Director of Public Health	Overall Delivery Confidence
1D.3 Implementation of phase 2 Childhood Immunisation Schedule recognising changes to the immunisation schedule for 2026, protecting children across a range of disease and illness.		Q3
1D.4 Deliver the funded Health Protection plan including establishing a Health Protection partnership with a Service Level Agreement in place with the 6 North Wales Local Authorities.		Q3
1D.1 Through targeted programmes of work for each vaccine / immunisation, implement the vaccine equity plan and work with partners (e.g. schools) to deliver the National Immunisation Framework targets to improve take up rates.		Q4
1D.2 Develop the GP and Identified Validated Sample (IVS) collaborative to improve uptake in the RSV 75 plus cohort.		Q4
1D.5 Enhance the delivery of health board services to protect people in North Wales against existing, new and emerging health protection threats and hazards by supporting screening and vaccination programmes, and disease elimination activities (Hepatitis B and C, and TB).		Q4
1D.6 Deliver evidence-based approaches to protecting and preventing ill health within specific sectors and settings e.g. delivery of infection prevention control interventions in residential Care Homes.		Q4

Overview
Health Protection is an important element of preventing and responding to the threat of communicable disease, environmental and other health risks. 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). There is also opportunistic screening and testing for disease such as blood borne viruses and sexually transmitted diseases to contribute to the control of further transmission and support the elimination of diseases like Hepatitis B and C, HIV and TB. Health Protection considers an 'all hazards' approach and includes environmental public health issues arising, zoonotic infection and vector-borne disease. Health protection supports the health and wellbeing of the whole population not just individuals and brings together a range of partners including Local Authorities, Environmental Health, Emergency planning, Public Health Wales and Community services to strengthen resilience across the whole system. It is essential for preventing harm, reducing inequalities, maintaining public confidence, and protecting healthcare capacity.

Key Delivery Priority Quarterly Update
During Quarter 1, significant progress has been made in supporting health board services to protect people in North Wales against communicable diseases, and to protect and prevent ill health within specific sectors and settings.

Between April and June, a number of proactive, preventative Infection Prevention Control (IPC) interventions have been undertaken across Residential Care Homes in North Wales. These have been enhanced with the delivery of monthly IPC Champions education sessions on key topics, and the provision of hand-hygiene training.
Also, the Health Protection Service has continued to support disease elimination agendas through blood borne virus sampling in key workplaces (major employers) and in other settings and services, including in Substance Misuse Services, Probation and Women's Centres. The service has also been deployed to provide TB sampling for Asylum Seekers in the East Area IHC.
In response to two significant High Consequence Infectious Disease threats, the Health Protection Service has led the coordination of preparedness measures within the Health Board whilst also engaging with wider partners. This has included a system briefing for all partners in North Wales, education sessions for medics, additional capacity for HCID PPE training, oversight of HCID plans and pathways, and the provision of information and advice for BCUHB staff. In addition, the Service coordinated and delivered a HCID response simulation exercise for the Health Board.
In quarter 1, the Health Protection Service has taken responsibility for the coordination of Rabies post exposure prophylaxis for individuals exposed to Rabies, e.g. animal bites/scratches in the UK and overseas.

The impact of the above activities include improved preparedness for HCIDs within the Health Board (including a greater number of staff trained in HCID PPE, formalized pathways for the identification, assessment, sampling and management of suspected or confirmed HCID cases), a greater understanding of Health Board areas of weakness for managing a potential HCID case and/or future pandemic, improved resilience within the residential care home sector for the control and management of communicable diseases, progress towards the elimination of Hepatitis B and C, and a reduced number of presentations to EDs for the provision of Rabies post-exposure prophylaxis

With regards the funded partnership between the Health Board and the six Local Authority Environmental Health teams, progress has stalled due to further requests for information from the Director of Finance and the Executive Committee. A further paper has been produced for the Executive Committee (due to be considered on the 15th July). This delay may impact on the achievement of some deliverables in year 1 of the partnership.

Campaigns across all Vaccination and immunisations are being developed or underway. A particular focus this year on reducing inequalities in uptake and this is being supported by the development of the Vaccine Equity Plan. The Health Board is focusing on delivery at scale and utilising the Primary Care partners to enhance delivery.

2A Primary Care	Chief Operating Officer	Overall Delivery Confidence
2A.1 Ensure the new General Dental Service (GDS) contract is in place and embedded, with a clear plan for the procurement of new services including commissioning of tier 2 dental services where appropriate.		Q2
2A.2 Undertake a review of primary care dental services to assess current capacity, patient access, and service utilisation. Work with commissioned providers and system partners to identify opportunities to increase access for patients.		Q2
2A.3 Procure a robust digital system within the Community Dental Service (CDS) to support the management of patient records, and replace the current outdated system.		Q2
2A.6 Develop a costed primary care-led frailty model to enable proactive, coordinated care closer to home, as part of the Community by Design work. Identify the impact that current initiatives are having on maintaining patients at home.		Q3
2A.4 Continue to deliver the Strategic Programme for Primary Care (SPPC) national 'Strategic Workforce Plan for Primary Care in Wales', with the aim of developing a sustainable, skilled workforce to meet the evolving healthcare needs of the population of North Wales over the next five years. Fully utilise the Work Based Learning Funding allocated to Primary Care to support delivery.		Q4
2A.5 The Health Board will strengthen the model of integrated primary and community care across North Wales by designing and delivering strategic priorities that align with the national Community by Design Transformation Programme. The key areas of focus will include urgent and same day care, management of chronic conditions in the community and prevention and population health management.		Q4
2A.7 Finalise a proposal to increase the use of the Audit Plus Frailty Tool in the community to ensure that patients receive proactive care in line with their agreed care plans.		Q4
2A.8 Support the implementation and roll-out of the NHS Wales app in primary and community care services by developing and implementing an action plan to promote the NHS app including patient education, staff training and monitoring of uptake.		Q4

Overview

In the NHS most patient contacts occur in Primary Care, making it the foundation of a sustainable and accessible healthcare system. It encompasses a broad range of community-based services that provide accessible, person-centred care, including general medical services (GP practices), community pharmacies, dental services, and optometry. Primary care also includes multi-disciplinary teams such as nurses, allied health professionals, social prescribers, and community mental health support, working together to deliver proactive, preventative care as well as care for people with longer term conditions. The Health Board recognises the importance of stable, resilient Primary Care services to ensure that the residents of North Wales receive care at the right time and in the right place, medicalised only when necessary. Primary Care plays a critical role in early intervention, prevention, and supporting people to manage their own health and wellbeing, thereby reducing avoidable demand on hospital and specialist services. Strengthening

Primary Care also helps tackle health inequalities by ensuring timely access to local, community-based support, particularly for those with complex needs or living in rural and deprived areas. A well-functioning Primary Care system is therefore 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. The areas within this objective will all align to and form part of the Community by Design Programme.
Key Delivery Priority Quarterly Update In quarter one the following has been delivered in Primary Care: - A review of primary care dental services is in progress. A plan has been agreed for recurrent and non-recurrent funding which will increase access for the population of North Wales. Plans with timelines are in place to ensure delivery of targets in 2026/7. - An outline business case has been approved to progress the procurement of a new digital system within the Community Dental Service. There is an agreed plan with time frame which supports the delivery of this project in 2026/7. - The SPPC national plan continues to be delivered across BCU with a focus on the Community by Design major change programme. A proposal for the SPPC has been agreed by BCU exec and is awaiting sign off by Welsh Government. - Community by Design programme continues to progress. A programme director and programme manager post has been agreed which will shape the leadership of the work, and a CbD programme board has been formed. Once fully established, the programme director and board will drive forward programmes of work which will see both a qualitative and quantitative impact on the population of North Wales. A programme plan will be created which will ensure delivery of the work streams

2B Community Care	Chief Operating Officer	Overall Delivery Confidence
2B.4 Develop a proposal for creating an investment fund for community groups and third sector organisations to work with the Health Board on community-based solutions to some of the largest challenges facing the system.		Q1
2B.12 Diagnostic Provision in the Community will be reviewed including undertaking a needs assessment for diagnostics and working with current providers to review and agree the most efficient delivery mechanism.		Q2
2B.2 Undertake a demand and capacity review to understand the levels of community nursing that are required across the Health Board, including weekend working.		Q2
2B.8 Undertake a review of urgent care services available in the community including general practice, optometry, dental and pharmacy. Identify how services may be optimised and expanded.		Q2
2B.11 Develop a proposal to establish local breathlessness hubs to provide specialised support and care for people experiencing chronic breathlessness.		Q3

2B.1 Develop Community by Design as a Major Change programme, working with partners to ensure it reflects national priorities and local needs.	Q4
2B.10 Implement appropriate best practice within the national Quality Statement for Older people and people living with frailty.	Q4
2B.3 Map current Enhanced Community Care services across North Wales, identifying where services are located and the differences. Develop a proposal that offers recommendations as to how to further reduce unnecessary hospital conveyance and admissions.	Q4
2B.5 Develop a strategic delivery plan for Palliative, End of Life and Bereavement Care (PEoLBC) in line with the All-Wales Service Specification for the delivery of Palliative and End of Life care in Wales and All Wales Competency Framework. This will include consideration of how to increase weekend capacity for specialist palliative care nursing.	Q4
2B.6 Agree an approved Quality Improvement Plan for End-of-Life Care Decision Making	Q4
2B.7 Implement appropriate best practice within the national Quality Statement for Palliative and End of Life Care.	Q4
2B.9 The Health Board will enhance the coordination of care for people with long term conditions and improve access to a broader range of community-based services, investing in integrated primary and community care.	Q4

Overview

The Health Board will continue to prioritise the delivery of care closer to home, recognising that 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. The Primary Care Model for Wales emphasises local delivery through integrated cluster working, enabling multidisciplinary teams to meet needs proactively within community settings and as this shifts toward a Community by Design approach this will be built upon. In parallel, the NHS Wales Decarbonisation Strategic Delivery Plan highlights the need for a shift toward nonacute, community delivered healthcare supported by expanded use of digital technology, including remote monitoring, virtual support, and enhanced homebased care. Increased use of community hubs and outreach models will support seamless health and social care closer to people's homes. By strengthening community services, the Health Board can ensure that hospital-based care is reserved for cases requiring more complex or escalating clinical intervention. This approach not only supports prudent healthcare principles but also improves service sustainability, reduces pressures on acute settings, and enables people across North Wales to receive timely, person-centred care within their own communities.

Key Delivery Priority Quarterly Update

The Community by Design Major Change Programme is being established and the existing workstreams are being aligned to the Programme. SPPC funding grant will support the appointment of the Programme Director and support. Workstreams aligned to the CbD programme include frailty, Enhanced Care and the establishment of Breathlessness Hubs. A proposal has been developed for an overarching group to coordinate the development of community frailty services. A decision on leadership of the group and to confirm its mandate is awaited. A group has also been established to deliver breathlessness hubs and a reference group is proposed to support the broader agenda of increasing access to diagnostics in community settings.

The proposals are in development phase, so limited impact to date.

The Associate Directors of Primary Care are working closely with colleagues in the Transformation team to establish the governance and groups to deliver the key objectives for 2026/27. Heads of Nursing for Community Nursing and for Palliative Care are continuing to progress service developments with their teams.

2C Integrated Health & Well-being Hubs	Chief Operating Officer	Overall Delivery Confidence
2C.2 Waunfawr Integrated Health & Well-being Centre – sign heads of terms to secure purchase of a site, progress the parallel elements of the programme plan.		Q1
2C.7 Holyhead Integrated Health & Well-being Centre – agree memorandum of understanding with Local Authority, thereafter progress the programme plan.		Q1
2C.8 Rhyl (Royal Alexandra Hospital - Phase 1) Integrated Health & Well-being Centre – commence construction, and progress the programme plan for delivery. Develop the case for Phase 2 later in the financial year.		Q1
2C.1 Bangor Integrated Health & Well-being Centre – work with partners on a strategic outline case		Q2
2C.4 Porthmadog Integrated Health & Well-being Centre – revise options appraisal for location, progress the parallel elements of the programme plan.		Q2
2C.5 Conwy West Integrated Health & Well-being Centre – finalise site location, progress the parallel elements of the programme plan.		Q2
2C.6 Denbigh (Caledfryn) Integrated Health & Well-being Centre – finalise funding strategy, thereafter progress the programme plan.		Q2
2C.3 Penygroes Integrated Health & Well-being Centre – develop an outline business case, progress the parallel elements of the programme plan.		Q3
2C.9 Finalise Integrated Rebalancing Capital Fund (IRCF) prioritisation.		Q3

Overview
Health and Wellbeing Hubs are essential to transforming how care is delivered across North Wales. With an ageing population, falling healthy life expectancy and widening inequalities, particularly in deprived and rural communities, a new model of care is required to ensure people receive timely, coordinated support closer to home. 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 health activity within local communities, they help address the wider determinants of

health, promote independence and reduce avoidable demand on acute services. This integrated model directly supports Welsh Government's A Healthier Wales vision and BCUHB's Strategic Intents to strengthen primary and community care and shift the balance towards prevention and early intervention. Several hub schemes are already underway across the region, such as Bangor, Holyhead, Caledfryn in Denbigh and the Royal Alexandra Wellbeing Hub in Rhyl, and each is being developed in partnership with Local Authorities, housing associations and third sector organisations, reflecting the multi-agency model required to deliver integrated, community-based care. The Health Board's IMTP prioritises a coordinated programme approach to ensure these developments are aligned to population need, strategically governed, and deliver maximum impact for the communities they serve.

Key Delivery Priority Quarterly Update

The Health and Wellbeing Hubs Programme remains a key component of BCUHB's strategy to transform community-based care across North Wales, supporting the shift towards prevention, early intervention and integrated service delivery closer to home. Progress has continued across a number of hub developments, with significant advancement in business case development, land acquisition, partnership arrangements and strategic planning with local authority and Welsh Government partners.

The Bangor Integrated Health and Wellbeing Centre has reached an important milestone, with the Strategic Outline Case nearing completion and expected to enter Health Board governance processes shortly. Engagement with Welsh Government and local partners has continued to address previous concerns regarding the Menai Centre lease arrangements and to strengthen the wider wellbeing, leisure and community offer within the hub, ensuring alignment with the vision for integrated community facilities.

Good progress has also been made at Waunfawr, where Heads of Terms for land acquisition have been agreed and are ready for signature. Development of procurement documentation and refinement of the Business Justification Case are advancing well, providing a solid foundation for progression to the next stage of the programme. Holyhead has similarly seen positive momentum, with the Memorandum of Understanding between the Health Board and Isle of Anglesey County Council approaching completion, strengthening the partnership arrangements required to progress delivery.

Development activity continues at Penygroes and Porthmadog. At Penygroes, discussions with Welsh Government have clarified the requirements for progressing the business case, while initial construction cost information has been obtained to inform future planning. In Porthmadog, work is ongoing to secure funding for business case development and design activity, alongside continued engagement with stakeholders to determine the preferred site location.

A number of schemes continue to experience challenges linked to funding availability, affordability and programme prioritisation. At Caledfryn, Denbigh, progression has been paused while funding options and the long-term revenue implications of the proposed service model are reviewed. The launch of public consultation activity has also been delayed pending resolution of these issues. Conwy West remains deferred until 2028 following previous capital prioritisation decisions, while Phase 2 of the Royal Alexandra Health and Wellbeing Hub in Rhyl have been placed on hold following direction from Welsh Government, although Phase 1 has been successfully completed.

3A Urgent and Emergency Care (UEC)	Chief Operating Officer	Overall Delivery Confidence
3A.1 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.		Q1
3A.12 Implement appropriate best practice within the Getting it Right First Time (GIRFT) Corridor care improvement guide.		Q1
3A.3 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.		Q1
3A.6 Provide more suitable pathways for frail patients that ensure they have shorter lengths of stay within acute hospitals in line with the national Acute Frailty Service (AFS) model. Undertake baseline assessment and gap analysis for current Acute Front Door Frailty Services across all acute sites, identifying current service provision, workforce utilisation, SDEC alignment and opportunities to strengthen early frailty assessment and intervention.		Q1
3A.13 Implement appropriate best practice within the national Quality Statement for Care in Emergency Departments.		Q2
3A.2 Reduce avoidable ambulance conveyances and ED admissions from the community through producing an options appraisal for the National Six Goals Team to support funding for St John's Level 1 falls training and lifting equipment for Community Resource Teams (CRTs), ensuring a consistent pan North Wales approach to community-based falls response.		Q2
3A.7 Adopt national best practice in relation to implementation of safe, fast, and consistent ambulance handover processes at the ED front door.		Q2
3A.8 Reduce ambulance hours lost, improve hospital-wide flow and ambulance handover times by standardising triage and streaming processes across all sites (majors, minors, SDEC, frailty).		Q2
3A.9 Reduce ambulance hours lost, improve hospital-wide flow and ambulance handover times by strengthening senior clinical decision-maker presence at the front door, especially during periods of high demand.		Q2
3A.10 Reduce the number of people delayed in hospital and their length of stay, thereby reducing the potential for deconditioning, by strengthening application of community Discharge to Recover and Assess (D2RA) pathways, ensuring faster discharge options for frail patients.		Q3
3A.5 Improve pathways of care delays out of the hospital through working more closely with the Local Authority Social Care Information Advice and Assistance (IAAs) team to improve referral pathways out of hospital.		Q3

3A.11 Reduce the number of people delayed in hospital and their length of stay, thereby reducing the potential for deconditioning, through implementation of Optimal Hospital Flow facilitators, utilisation of the Transport Coordination hub and enabling a 7-day discharge model across all acute sites.	Q4
3A.4 Reduce avoidable ambulance conveyances and ED admissions by transitioning from the current Single Integrated Clinical Assessment and Triage (SICAT) model to the Single Point of Access model (SPOA) with a broader Multi-Disciplinary Team (MDT) that is able to better sign post the most appropriate alternate to hospital treatment routes. This will ensure there is sufficient resource to operate the SPOA 7 days a week, 12 hours a day.	Q4

Overview
Urgent and Emergency Care (UEC) is vital to keeping people in North Wales safe, healthy and supported when they need help most. But growing demand and pressure across the system are creating delays throughout the whole pathway, with an impact of reducing hospital flow, and affecting patient experience and safety. These challenges also disrupt planned care, widen health inequalities, and contribute to the Health Board's ongoing Special Measures status. Improving UEC requires action across the whole pathway, including prevention and community support, efficient hospital processes, and safe and timely discharge. The potential of preventative actions in areas such as falls, frailty and inclusion health is important to reduce the growing demand for UEC services. No single part of the system can resolve this alone. Strong partnership working with the Welsh Ambulance Service (WAST), Local Authorities, primary and community care, and the voluntary sector is essential. At the same time, there are key improvements within the Health Board's direct control that must progress at pace, including better discharge coordination, strengthened clinical pathways, and more effective use of workforce and capacity. As one of the Health Board's Major Change Programmes, UEC underpins delivery of the national Six Goals for Urgent and Emergency Care. The aim is to build an integrated, responsive system where people receive the right care, in the right place, at the right time, supporting better outcomes, restoring confidence, and contributing to sustainable improvement across the whole Health Board. This area is being supported by the Intensive Support Team (sponsored by the partnership of the Health Board, Welsh Government and NHS Performance and Improvement). In addition to the workstreams and deliverables set out below there will be the development of detailed Operational Improvement Plans at both service level (currently Integrated Health Communities) and a pan BCU level. These Operational Improvement Plans are being informed by the work of the external experts

following the 6As assessment and the use of other diagnostic tools. The Operational Improvement Plans will have rapid cycle actions (90-day cycles) and will focus on the implementation of standards/protocols of practice (clinical and operational) across the system, improving safety and building sustainability. The use of best practice such as GIRFT Corridor Care Guidance (and other best practice standards) will drive the Operational Improvement Plan approach. Outputs from the Major Change Programme will also inform the rapid cycle actions to enable transfer and implementation from the Programme into practice.

Key Delivery Priority Quarterly Update

During Quarter 1, the programme focused on establishing the foundations required to deliver the Six Goals for Urgent and Emergency Care. Key achievements include:

- Progressing the transition to a Single Point of Access (SPoA) model, including governance, workforce planning and alignment with the national framework.
- Securing funding and commencing implementation of the Community-Based Falls Response Framework, including falls equipment procurement, CRT pilot activity and workforce modelling.
- Delivering falls management training and equipment programmes for care homes.
- Completing Acute Frailty baseline assessments and options appraisals across all acute sites.
- Re-establishing and strengthening SDEC governance, completing baseline reviews and developing improvement plans.
- Undertaking baseline work to improve ambulance handovers and strengthen collaboration with WAST.
- Establishing Optimal Hospital Flow Task and Finish Groups, recruiting Hospital Flow Facilitators and implementing delayed discharge dashboard pilots.
- Progressing discharge improvement initiatives, including development of the North Wales Trusted Assessor Memorandum of Understanding.
- Advancing WECDS implementation, with the programme approaching go-live.

As expected in the first quarter, activity has primarily focused on creating the infrastructure needed to deliver long-term improvements. Early impacts include:

Qualitative

- Improved collaboration between Health Board teams, Local Authorities, WAST and regional partners.
- Better visibility and management of delayed discharges through new dashboard reporting.
- Enhanced support for care homes through falls training, equipment provision and follow-up arrangements.
- Improved readiness to implement national UEC frameworks through strengthened governance, workforce planning and pathway development.

Quantitative

- Falls training programmes delivered across targeted care homes, with KPI monitoring established.
- An additional Optimal Hospital Flow Facilitator posts recruited.
- Delayed discharge dashboards implemented in pilot areas.
- WECDS implementation progressed to the final stages ahead of deployment.

Whilst there have been local improvements, system-wide performance measures such as Pathway of Care Delays have yet to demonstrate sustained improvement due to

continued demand pressures across health and social care.

To ensure delivery of the overarching aims, the programme will:
• Complete implementation of the SPoA model and associated referral pathways.
• Roll out the Community-Based Falls Response Service and care home falls initiatives across North Wales.
• Implement Acute Frailty Services supported by agreed workforce models and performance measures.
• Develop and embed a consistent BCU-wide SDEC model.
• Continue improvements to ambulance handover processes and H45 performance.
• Expand dashboard reporting and standardised operational processes across all Integrated Health Communities.
• Embed Optimal Hospital Flow initiatives, including Board Rounds, Red-to-Green and discharge planning improvements.
• Complete WECDS implementation and strengthen performance reporting arrangements.
• Develop sustainable workforce and financial plans to support long-term delivery.

Overall, the programme remains on track, with Quarter 1 focused on establishing the systems, governance and workforce foundations needed to deliver measurable improvements in urgent and emergency care outcomes by March 2027.

3B Planned Care, Cancer & Diagnostics	Chief Operating Officer	Overall Delivery Confidence
3B.15 WS6b – Diagnostics: Complete replacement of both Linear Accelerators at Ysbyty Glan Clwyd.		Q1
3B.20 Finalise delivery strategy and financial model for the Nuclear Medicine consolidation project, including PET-CT scanner for North Wales.		Q1
3B.7 Secure continuation of additional external capacity within dermatology, endoscopy, radiology and urology to meet existing demand into 2026/27. (Investment from Planned Care fund).		Q1
3B.10 Finalise the oncology clinical strategic plan for north Wales.		Q2
3B.13 Review outstanding requirements not yet met within the Cancer Quality Statement and produce proposals for implementations.		Q2
3B.14 Introduce a 'breast pain only' pathway to ensure women receive the most appropriate care in a timely manner. (Dependent on national funding).		Q2
3B.16 WS6b – Diagnostics: With the support of the NHS Wales Performance and Improvement (NHS Wales Performance & Improvement) 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.		Q2
3B.8 Agree the strategic model for the delivery of dermatology services in north Wales.		Q2
3B.9 Agree the strategic model for the development of robotic assisted surgery in north Wales.		Q2
3B.19 Continue to work with Digital Healthcare Wales (DHCW) and partners to implement the national Laboratory Information Management System (LIMS)		Q3
3B.5 WS5 – Follow-up Pathways: 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 Information Network (CIN) pathways and discharge protocols.		Q3
3B.1 WS1 – RTT Pathway Validation: 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.		Q4
3B.11 WS6a – Cancer: Increase compliance with national optimal pathways with particular focus on increasing straight to test rates.		Q4
3B.12 Deliver opportunities for streamlined follow-up to improve patient care (e.g. Patient Initiated Follow-up – PIFU or See on Symptoms – SOS).		Q4

3B.17 Progress national business justification case for digital cellular pathology, enabling the service to fully realise clinical and operational benefits, including overall increased reporting performance for routine cases in addition to those of higher clinical priority.	Q4
3B.18 Effective commissioning of additional diagnostic capacity in key specialties where core capacity and Waiting List Initiatives (WLIs) are insufficient to meet forecast demand.	Q4
3B.2 WS2 – Referral Pathway Refinement: A range of initiatives to support a reduction in referrals to outpatients in high volume specialities, 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.	Q4
3B.3 WS3 – Booking Services: 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.	Q4
3B.4 WS4 – Pre-operative & Operative Effectiveness: 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.	Q4
3B.6 Effective commissioning of planned care services in key specialties where core capacity and Waiting List Initiatives (WLIs) are insufficient to meet forecast demand.	Q4

Overview
Timely access to planned care, cancer services and diagnostics is central to improving outcomes, experience and confidence in health services across North Wales. Feedback from patients and communities highlights the consistently high quality of care delivered by staff, and our continued focus is on ensuring that people are able to access this care as

quickly and seamlessly as possible. Across planned care, cancer pathways and diagnostics, the past year has demonstrated that targeted action, strong leadership and collaborative working can deliver meaningful improvement, creating a strong foundation for the next phase of transformation. Work has also demonstrated many ways to improve efficiency and thus patient access. Demand continues to grow across all three areas, driven by demographic change, advances in treatment and increasing complexity of care. Cancer services exemplify this: the Health Board diagnoses nearly 5,000 new cases every year, with numbers rising, and earlier diagnosis supported by timely diagnostics offers the greatest opportunity to improve survival and reduce inequalities. Approximately 4,000 people each month following assessment including diagnostics are told they do not have cancer; an increasing trend. This volume of patients is putting pressure on capacity and hence mobilising new ways of working will continue to be a major part of how services adapt to this increase with little additional available resource. Planned care recovery likewise depends on efficient diagnostic pathways, with imaging, endoscopy and pathology capacity underpinning every stage of treatment planning and delivery. Diagnostics therefore sit at the heart of system improvement. Despite record levels of activity, demand has continued to outpace capacity, but the introduction of the new Radiology Information System (RISP) and the progression of major business cases create significant opportunities for service modernisation. Moving from short-term recovery solutions toward sustainable, year-round capacity will support more consistent performance and ensure diagnostics can meet future needs, including the growing role of genomics and AI-enabled technologies. A specific focus on diagnostics medium-term clinical and service plan will help identify key pathway efficiencies and modernisation opportunities from initial referral through to follow-up and surveillance. The Planned Care Major Change Programme provides the framework to integrate pathway redesign, national best practice, GIRFT recommendations and value-based healthcare principles. Strengthened clinical leadership, robust demand and capacity planning, and modernised diagnostic infrastructure will together enable more responsive pathways, improved patient experience and better outcomes for the population of North Wales, reflecting the organisation's commitment to continuous improvement and high-quality, sustainable services. This area is being supported by the Intensive Support Team (sponsored by the partnership of the Health Board, Welsh Government and NHS Performance and Improvement). In addition to the workstreams and deliverables set out below there will be the development of detailed Operational Improvement Plans at both service level (currently Integrated Health Communities, Womens, Diagnostics and Cancer Service Divisions) and a pan BCU level. These Operational Improvement Plans are being informed by the work of the external experts. The Operational Improvement Plans will have rapid cycle actions (90-day cycles) and will focus on the implementation of standards/protocols of practice (clinical and operational) across the system, improving effective deployment of resources and building sustainability. The use of best practice such as GIRFT Guidance (and other best practice standards) will drive the Operational Improvement Plan approach. Outputs from the Major Change Programme will also inform the rapid cycle actions to enable transfer and implementation from the Programme into practice.

Key Delivery Priority Quarterly Update
PLANNED CARE
1. What have we delivered so far this year towards the aim?

The Planned Care Programme is continuing to implement a coordinated portfolio of transformation initiatives focused on reducing waiting times, improving patient access and experience, and delivering more sustainable planned care services across North Wales. Following lessons learned from the 2025/26 programme, 15 priority projects were initially approved, with 1 additional project pilot approved to start in the July meeting, with further opportunities being developed and aligned to the emerging Planned Care Recovery Plan.

Key actions underway include:

- Expanding patient validation through the EBO chatbot and strengthening clerical and clinical validation processes to improve waiting list accuracy and identify patients who no longer require treatment.

- Increasing referral optimisation through the rollout of electronic referrals and Community Health Pathways, with work commenced to embed CHP clinical thresholds within secondary care triage, helping ensure patients are referred appropriately and capacity is prioritised for those with greatest clinical need.

- Increasing compliance with national optimal pathways through improving compliance with the gynaecology post-menopausal bleeding pathway, adopting the nationally and locally approved breast pain only pathway and increasing use of Teledermoscopy.

- Developing a pan-BCU "One Waiting List" approach to support more equitable access to care regardless of locality.

- Modernising booking processes through standardised services and a service level agreement, quality accreditation for administrative staff, and testing a return to partial booking to improve attendance rates and reduce wasted capacity.

- Preparing for Surgical Hub Accreditation and using specialty optimisation reviews to identify opportunities to improve theatre productivity and increase high-volume, low-complexity activity.

- Expanding Patient Initiated Follow-Up (PIFU) and See on Symptom (SOS) models to reduce unnecessary follow-up appointments and improve patient self-management in line with the adopted CIN self-management protocols

- Commenced with a programme of work to reduce the follow-up backlog and redress the balance between the follow-up to new ratio.

- Developing a single integrated planned care recovery and transformation framework, supported by specialty-level recovery planning and strengthened governance arrangements.

While workforce, funding and digital capacity constraints remain significant risks, mitigating actions are in place and the programme remains broadly on track to deliver the planned transformation objectives.

2. What impact (both qualitative and quantitative) has the work had on the population of North Wales compared to what it set out to achieve?

The programme has delivered measurable improvements in waiting list management, referral optimisation, access to care and patient experience during Q1.

Quantitative impacts include:

- Validation of 31,815 patient pathways during Q4 2025/26, resulting in: 7,978 pathway closures (25%) for patients waiting over 36 weeks. Closure of 2,823 pathways for patients waiting over 104 weeks. A 49% reduction in Stage 3 pathways. A 51% reduction in duplicate pathways.

- Expansion of electronic referral management to 10 priority specialties across BCUHB.

- Delivery of 228 Community Health Pathways, exceeding the Q1 target of 210.

- Teledermoscopy maintained a 66% discharge rate, reducing unnecessary outpatient appointments and improving access to specialist dermatology assessment.

- Validation of follow-up waiting lists resulted in 25% of an initial cohort of 805 gynaecology patients being appropriately discharged within the first two weeks of review activity.

Qualitative impacts include:

- Improved confidence in waiting list data and more accurate prioritisation of patients requiring treatment.

- Increased consistency in referral management and clinical thresholds across North Wales.

- Improved patient experience through digital validation tools, enhanced communication, and more flexible follow-up models such as PIFU and SOS.

- Greater equity of access through development of the One Waiting List approach and standardised pathways.

- Improved clinical decision-making and pathway efficiency through specialty optimisation reviews and cancer pathway redesign work.

Overall, the programme is demonstrating tangible benefits and is contributing to improved access, reduced unnecessary activity, and more effective use of available planned care capacity across North Wales.

3. What actions are we undertaking to ensure we are on track to deliver the full overarching aim and associated impact by the end of March 2027?

To maintain delivery momentum through to March 2027, the programme is focusing on a number of critical enabling actions:

- Recruiting additional validation staff to increase capacity and maintain waiting list quality.

- Accelerating rollout of the patient validation chatbot to long-waiting cohorts across multiple specialties.

- Implementing recommendations arising from national specialty optimisation reviews and GIRFT principles.

- Finalising and implementing the One Waiting List model and Booking Service Level Agreement.

- Progressing Surgical Hub Accreditation and strengthening theatre optimisation work.

- Expanding PIFU, SOS and follow-up validation activity to reduce avoidable outpatient demand.

- Developing options to sustain Community Health Pathways after national funding ends in 2027.

- Aligning programme governance with the emerging Planned Care Recovery Plan and confirming future senior leadership arrangements to maintain oversight and accountability.

Collectively, these actions are intended to ensure the programme delivers its overarching objective of improving access, outcomes and patient experience while establishing a more sustainable and equitable planned care model across North Wales by March 2027.

CANCER

A programme of service-level actions is being undertaken to improve cancer performance in north Wales, although progress continues to be constrained by significant structural pressures.

At a strategic level, the Foundations for the Future programme is reshaping the Health Board's operating model, with direct implications for how cancer services are governed and delivered. In parallel, a draft oncology clinical strategy and an emerging robotic-assisted surgery strategy are being developed as part of the wider Clinical Services Plan. These will be critical in modernising care delivery, maintaining service quality, and supporting workforce recruitment and retention, recognising that advanced technologies such as robotic surgery will become standard practice in the coming years.

Pathway improvements are being taken forward through close working with primary care, supported by targeted education and the Community Health Pathways software to enable more appropriate routing of patients into the system. Alongside this, a range of innovative services are being embedded, including nurse-led triage in colorectal services, teledermoscopy in dermatology and the expansion of self-management and patient-initiated follow-up pathways in gynaecology and skin which launched in Q1. Collectively, these approaches will improve pathway efficiency, reduce unnecessary activity, and support more timely access to care.

However, cancer waiting time performance remains significantly under target, with 53% achieved against the 75% standard, primarily due to constraints in diagnostic capacity and workforce availability. Diagnostic services, particularly endoscopy, continue to represent the most significant system bottleneck, with demand exceeding capacity despite mitigation measures such as additional modular facilities. Workforce fragility remains the most significant risk to sustainability. A number of key services, including dermatology and gastroenterology, are heavily reliant on insourced provision and locum staff. While this has enabled the maintenance of services in the short term, it is not financially or

operationally sustainable. In parallel, vacancies in clinical leadership roles, including Cancer Clinical Advisory Group chairs, are limiting the ability to drive consistent improvement and maintain strong strategic oversight.

There are also ongoing challenges in equity of access and patient experience. While services such as prehabilitation are delivering strong outcomes, access is currently limited geographically. Similarly, gaps in psychological support, are impacting patient experience and outcomes, with variation across the region. Communication between primary and secondary care remains a significant systemic issue, with continued reliance on paper-based processes leading to delays and fragmented care, although local improvement initiatives are underway.

Overall, while there is clear evidence of meaningful progress and innovation for the population of north Wales, the system is not yet operating within a stable or sustainable model. Delivery of the full overarching aim by March 2027 will depend on continued targeted investment in diagnostic capacity, workforce stabilisation through agreed models of sustainable service delivery across north Wales, and equitable access to supportive care services.

DIAGNOSTICS

Diagnostics remains a critical enabler of improvements across planned care and cancer services, with work continuing at pace to ensure the Health Board is on track to deliver its overarching objectives by March 2027. Building on the strategic action plan developed with NHS Wales Performance and Improvement, a comprehensive operational implementation plan is being developed to translate recommendations into measurable service improvements. This work is being aligned with the Intensive Support Team programme and the broader Planned Care Major Change Programme to ensure a coordinated approach to pathway redesign, capacity optimisation and performance improvement.

Alongside operational planning, a number of medium- and long-term sustainability initiatives are progressing. Key business cases are being developed to strengthen diagnostic infrastructure, modernise equipment and digital capability, and support the establishment of sustainable capacity models that reduce reliance on short-term recovery measures. These developments, together with the implementation of standardised operational and clinical practices, will support more efficient deployment of resources and improve resilience across diagnostic services.

The primary anticipated benefit for the population of North Wales is a reduction in diagnostic waiting times, supporting earlier diagnosis, faster access to treatment and improved patient experience. As diagnostic services underpin both cancer and planned care pathways, improvements in diagnostic timeliness are expected to have a wider system impact, contributing to reduced pathway delays and supporting delivery of national performance standards.

Qualitatively, the work has strengthened collaboration across services and established a clearer framework for operational improvement, informed by external expertise and best practice guidance. Quantitatively, the focus remains on reducing waits and improving flow through diagnostic pathways, with delivery plans and associated performance measures being developed through the operational implementation planning process to track progress towards the March 2027 objectives.

Over the coming year, priority actions will focus on implementing the operational improvement plan, progressing strategic business cases, embedding best practice standards and identifying further opportunities for productivity and pathway efficiencies. Collectively, these actions will support the transition from recovery-based approaches to sustainable service models, ensuring diagnostic services are equipped to meet growing demand while improving access, experience and outcomes for the population of North Wales.

3C Fragile Services	Chief Operating Officer	Overall Delivery Confidence

3C.1 Finalise and implement a network-wide plan to facilitate improvements in vascular theatre utilisation, ensuring GIRFT principles are maintained.	Q1
3C.15 Open Llandudno Orthopaedic hub	Q1
3C.33 Agree immediate model for out of hours Gastro-Intestinal (GI) bleed provision, in order to provide safe and high-quality care.	Q1
3C.36 Further development of QMS to provide structured view and understanding of the drivers behind fragile services, through the triangulation of broad range of key data points.	Q1
3C.39 Review and implement improvements to the governance surrounding services of concern, including establishment of both risks and separate issues logs.	Q1
3C.41 Build upon work already completed to create a central monitoring, oversight and reporting to ensure effective responses to recommendations from the Royal Colleges, HIW and other reviews, ensuring they are discharged and either verified or delivered or scheduled for delivery within the health board's longer-term improvement plan.	Q1
3C.7 Engagement and implementation of interim pan North Wales networked Dermatology service model, to better utilise resources (staff and funding) across North Wales. This is ahead of the full Clinical Services Plan work due to urgency around service sustainability especially in the West.	Q1
3C.2 Commence implementation of vascular service review as part of the first tranche of Clinical Services Plan reviews, to: -Help strengthen integrated working across hub and spoke sites, -Support development of a skilled, happy and sustainable workforce, -Improve patient outcomes across key pathways-Ensure greater alignment with national guidance and best practice.	Q2
3C.20 Complete outsourcing review to identify repatriation opportunities as well as long-term strategic partnerships.	Q2
3C.23 Full workforce review, succession planning, skills mix, expansion of roles such as Optometrists, Orthoptists, Advanced Clinical Practitioners, to support more sustainable services.	Q2
3C.24 Ensure sufficient nursing and Healthcare Support Workers to enable High Volume Low Complexity Theatre lists - Cataract 90% of lists to have 7 Cataracts per list.	Q2
3C.28 Develop plan and seek approval to support a sustainable model for flexible cystoscopies, to contribute to improvements in the Urology 8-week diagnostics.	Q2
3C.32 Standardisation of Gastroenterology referral and treatment pathways, supported by triage, across primary and secondary care, to ensure appropriate use of Health resources. Including access to Endoscopy.	Q2
3C.37 Use the new QMS capability to map the highest priority services of concern as part of the Clinical Services Plan work, capturing the main KPIs for each that will be tracked to measure improvement.	Q2

3C.40 Design and implement a support package for services of concern in order to support their improvement, incorporating learning from the Clinical Services Plan Phase 1 work on Challenged Services.	Q2
3C.9 Balancing Dermatology work between primary and community and secondary care – Further development of the Community Health Pathways and Teledermoscopy in order to reduce avoidable referrals into secondary care.	Q2
3C.11 Building upon the progress in improving this service to date, closing key vacancies and forming stronger multi-professional working, renewed recruitment efforts to appoint substantive consultants.	Q3
3C.14 Develop proposals to increase access to Cone Beam capable CT scanners, improving capacity and patient experience and travel.	Q3
3C.18 Rationalisation of hip and knee implants, reducing variation to those referenced in GIRFT reports, improving value for money. Starting in Llandudno and then rolling out across all sites.	Q3
3C.19 Implement national standard pathways for Orthopaedics across all sites, reducing pathway variation.	Q3
3C.21 Develop proposals for pan North Wales models of care for Ophthalmology, working within the Clinical Services Plan framework, including potential strategic partnerships.	Q3
3C.22 Improve data quality and completeness through standardised regional coding for all sub-specialties, clinical and non-clinical validation, to support improved reporting and service planning.	Q3
3C.26 Continue to work with DHCW and CAVHB to implement the national Eye Care referral and patient record systems.	Q3
3C.27 Present the final on call options appraisal to Operational Leadership Team (OLT) and Executive Committee and secure a preferred option decision, in order to address unsustainable use of locum consultants due to recruitment and retention issues related to an unattractive on-call rota.	Q3
3C.3 Review elective and emergency open AAA outcomes from November 2024 for patients treated at University Hospital North Midlands (UHNM). With support from the Vascular Society, Royal College of Surgeons and National Leads, make clear recommendations to the Health Board for the ongoing delivery of open Aortic Aneurysm surgery together and implement a clinical plan that will ensure delivery of best possible outcomes for the people of North Wales.	Q3
3C.30 Award of Vasectomy contract within North Wales via appropriate procurement routes and mobilisation of referrals to successful provider, in order to improve patient experience and care closer to home. Patients currently have to travel into England for this service.	Q3
3C.31 Develop sustainable Health Board processes for multi-professional delivery of Local Anaesthetic Transperineal Prostate (LATP) biopsies for diagnosis of prostate cancer.	Q3

3C.38 Ensure that services of concern monitoring, escalation and de-escalation processes, governance and reporting are adequately covered within the latest Performance and Accountability framework, covering both Executive and Board Member visibility. Including capturing how people's care and treatment outcomes are monitored and how they compare to similar services.	Q3
3C.10 Balancing Dermatology work between primary and community and secondary care – Directed enhanced service in place to allow low risk cancers to be managed in the community.	Q4
3C.12 Design of a clear service delivery model based on equity, sustainability, and estate capacity.	Q4
3C.13 Full workforce review, succession planning, skills mix, expansion of roles such as Dentists with special interests, Orthodontic Therapists, to support more sustainable services.	Q4
3C.16 Mobilise and deliver HVLC Orthopaedic activity in Llandudno - Deliver a sustained HVLC programme targeting 85% theatre utilisation.	Q4
3C.17 90% of elective arthroplasty lists to have 4 primary joints, supporting improvements in theatre utilisation.	Q4
3C.25 Deliver the next tranche of Teach and Treat course delivery to support hospital service demand reduction and care closer to home: with graduates providing extended "community first" workforce (Independent Prescribing, Glaucoma and Medical Retina capacity) within community optician practices.	Q4
3C.29 Develop proposal for strategic partnership as close to North Wales as possible, on major urology cancer service, including timelines for full Robotic Assisted Surgery (RAS) transition which will improve Urgent Suspected Cancer (USC) performance and patient experience through care closer to home. Patients are currently traveling to London for RAS prostatectomy and nephrectomy.	Q4
3C.34 Develop a regional Integrated Digestive Disease Service (IDDS) with strong multi-professional working, in order to provide a safe and effective care for patients with gastro-intestinal disease.	Q4
3C.35 Establish sustainable model for Endoscopy service provision across North Wales including Joint Advisory Group (JAG) accreditation (national accreditation). Including considering proposals for a new endoscopy unit and reducing reliance on insourcing and outsourcing.	Q4
3C.4 Reduce waiting times for new and review out-patient appointments by increasing the number of clinics delivered by our non-consultant workforce, in-line with vascular society guidance and professional standards.	Q4
3C.5 Embedding a culture of safe learning through adopting the 'Safe Learning Charter' across the network, both self-assessment via the associated maturity matrix as well as incorporating learning from HEIW's report on training and education and the PPA service review into culture and behaviour.	Q4
3C.6 Implement appropriate best practice within the national Quality Statement for Vascular Disease	Q4
3C.8 Involvement in the full Clinical Services Plan work to design the long-term sustainable Dermatology model.	Q4

Overview

The Health Board currently has a number of clinical services where maintaining a reliable and consistent service is challenging. The initial set of services were identified as part of the Special Measures escalation process, namely Urology, Vascular, Ophthalmology, Dermatology, Plastic Surgery, Oncology, Orthopaedics and Orthodontics. Since then, the Health Board has been both making improvements in those services and continuing to develop its approach to identifying and supporting other fragile services. The entry in this year's IMTP is a mixture of both services identified under Special Measures as well as one self-identified by the Health Board. Two of the services identified under Special Measures, Oncology and Plastics, have not been drawn out in the IMTP as they have addressed the identified issues sufficiently to be considered for de-escalation. Whilst at the time of writing that decision had not been made, the Health Board are satisfied that their service level plans are sufficient to monitor their progress, making space for those services identified by the Health Board. Work in this area has formed part of the first phase of the Clinical Services Plan (CSP), addressing issues that could not wait until the full CSP was underway. The CSP priority area will cover the longer-term transformational changes for these services, with this section continuing to focus on the short-term actions necessary to address the most urgent issues.

Key Delivery Priority Quarterly Update

Challenged Services: Across Dermatology, Ophthalmology, Orthopaedics, Orthodontics, Urology and Vascular, services remain under sustained pressure, primarily due to workforce shortages, rising demand and constrained capacity. While there has been meaningful progress in reducing long waits and improving access—particularly in Dermatology, Urology and Vascular—this position remains fragile and heavily reliant on interim measures, including insourcing, locum staffing and temporary pathways, rather than sustainable service models.

Workforce fragility is the primary system risk, limiting both recovery and transformation, alongside infrastructure constraints such as delayed capital developments (notably the Orthopaedic hub) and limited estate capacity. Demand and backlog pressures continue to outstrip capacity, with some early gains beginning to reverse in areas such as Vascular, and ongoing patient safety risks evident in high-backlog services like Orthodontics. Although transformation programmes and redesigned pathways are progressing, delivery remains constrained, and performance improvements are not yet stable or sustainable without decisive action on workforce, capacity and infrastructure investment.

Fragile Services Framework - A draft fragile services framework has been developed to feed into the next iteration of the QMS through a suite of Quality Planning metrics. This has been developed to understand the drivers behind fragile services and includes triangulation of workforce, performance, quality (patient safety, patient experience and clinical effectiveness), finance, staff engagement, as well as information on service standards.

Dermatology – ongoing inability to recruit substantive consultants, resulting in continued reliance on interim staffing.

Ophthalmology – workforce and leadership gaps are constraining delivery of transformation programmes, creating medium confidence in achieving regional model and pathway improvements.

Orthopaedics – delay to Llandudno Orthopaedic Hub opening preventing planned capacity and impacting elective recovery trajectory.

Orthodontics – significant and growing backlog (treatment) exceeding capacity, posing a sustained patient safety risk without fundamental service model and workforce solutions. Proposals to increase access to Cone Beam capable CT scanners are reported as complete, thus improving capacity and patient experience.

Urology – unsustainable reliance on locum workforce and fragile on-call model, creating financial pressure and long term service instability.

Vascular – unsustainable workforce model combined with long waiting lists, risking reversal of performance gains and impacting timely access to care.

Gastroenterology - An interim regional model for GI bleed provision has been established, with emergency endoscopy services coordinated through Ysbyty Glan Clwyd for patients across all three acute hospital sites. Patients from Ysbyty Gwynedd and Wrexham Maelor are transferred on a treat-and-return basis following early clinical assessment and stabilisation. The model provides a clear and consistent pathway for urgent GI bleed management, improving service resilience and patient safety. However, overnight endoscopy cover is not currently available, meaning some patients may require ongoing medical management until the service is available the following day.

3D Mental Health & Learning Disabilities	Executive Director of Allied Health Professionals and Health Science	Overall Delivery Confidence
3D.2 Train inpatient staff on the use of ReQol 10 Patient Reported Outcome Measures (PROMS) alongside the National Programme Safety team.		Q1
3D.3 Agree and develop with partners a phased Open Access Mental Health Service model with a view to implementing the demonstrator site by Q4 based on the international evidence base.		Q1
3D.8 Establish a digitally delivered specialist All-Wales gambling harm and treatment service.		Q2
3D.1 Engage with National Patient Safety Programme to improve quality and safety across services with the implementation Safe Discharge and 72-hour follow-up standards.		Q4
3D.10 Strengthen the strategic case for the development of the purpose-built, future-proof Adult and Older People Mental Health Unit at the Ysbyty Glan Clwyd site with the aim of presenting a full business case to Health Board for the approval by the end of Q4.		Q4
3D.11 Progress the 13 key areas supported by the Board in the Scope of Mental Health Oversight and Development Group, including but not exhaustively; strategic plan and models of care, outcomes framework, performance, service user engagement, standards of clinical practice, workforce planning, estate and physical environment, culture and organisational development, leadership and management, legacy reviews, finance, dementia care and psychological therapies.		Q4

3D.4 Engage with the National workstream to Improve Physical Health of People with Severe and enduring Mental Illness including review and alignment of the BCU MHLD physical health policy in line with national developments.	Q4
3D.5 Deliver a material reduction in the number of out of area placements through robust clinical and patient safety management (inclusive of community and acute staff) aligned to the implementation of the Crisis Care Model.	Q4
3D.6 Reduce Health Inequalities for people with learning disabilities by increasing the uptake of the annual health checks and public health screening initiatives across services.	Q4
3D.7 Define and formally adopt a tiered crisis response framework for LD services with clear pathways for prevention, early intervention, urgent response, intermediate care provision in partnership with the Local authorities and post-crisis stabilisation.	Q4
3D.9 Continue to progress the Electronic Healthcare Record (EHR) Transformation Programme which will reduce paper records and be a key enabler for service transformation, through commencing the implementation of the All Ages MHLD and continued engagement with WG regarding a wider EHR.	Q4

Overview
Adult Mental Health and Learning Disabilities (MH&LD) services are redesigning, expanding and improving services aligned to the national strategies for both Mental Health and Wellbeing and Learning Disability with support and direction from NHS Wales Performance and Improvement to deliver on the emerging Strategic Programme for Mental Health. This will enable the Health Board to deliver stepped care models across MH&LD services, ensuring service users receive the appropriate level of care based on their specific needs and circumstances including crisis and long-term needs. The development of an open access model with a focus on recovery along with the introduction of an electronic health record will be the most significant step in the redesign of our services since the implementation of the Mental Health Measure. Mental Health and Learning Disabilities will focus on improving the quality and safety of the care delivered within, community, inpatient and specialist services. Engagement with the distinct national quality and safety programmes will support training, embed learning and tools and introduce safety and outcome measures across services that will ensure we are delivering bilingual care that meets service user needs, addresses physical health care needs and reduces risk. It is important to reduce 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. We continue to invest in long term capital plans to improve mental health and learning disabilities environments, making them safer through, for example, ligature reduction measures and more therapeutic settings to support our engagement approaches with service users, visitors and staff. The Board has identified the continued improvement of mental health services as a key priority, with open and transparent public Board reporting of progress and challenges at least twice per year. The Royal College of Psychiatrists 'Review of Reviews' has featured strongly during 2024 and 2025. The Board in January 2026 approved the establishment of a Mental Health Oversight and Development Group, chaired by the Chief Executive with a 'whole-organisation' emphasis on improving sustainable, modern, high-quality services.

Key Delivery Priority Quarterly Update
Work to deliver the Strategic Programme for Mental Health continues, with the establishment of a working group to take forward the multi workstream elements of the Patient Safety Programme, this work is being aligned to the introduction of the Nursing and Midwifery Quality Standards dashboard that MHLD are piloting. Home Treatment teams are progressing the enhanced service provision as agreed within Phase 1 of the crisis care model. The enhanced service has supported the reduction in the use of OOA beds, as part of a number of measures taken to ensure daily oversight and management of bed utilisation, internally and externally. Development of the OAM model, is now being considered in terms of ambition and viability, this is being done alongside the wider development of the community mental health teams with phase 2 of the crisis care model at the heart of the work. The gambling harm service was successfully launched on 1st April 2026 with a minimum viable product. Staff have been recruited and are in post, supporting initial delivery with recruitment progressing for full-service complement planned in Qtr. 2.

Actions to reduce OOA bed usage has resulted in an end of June position of 2, which is an improvement on the agreed trajectory of 10 for Qtr. 1.
Gambling harms service is operational and actively delivering direct support to service users 24/7. @ 3rd June 2026 172 helpline contacts were recorded and the service supporting 46 individuals with active treatment.

All key workstreams are supported by a robust project management approach with clear performance management, reporting and escalation that feeds into and through our divisional governance process. Key project deliverables and risks are monitored with opportunities to escalate challenges built into the process along with seeking to accelerate any milestones where possible.
For shared deliverables such as the implementation of the all-ages Mental Health EHR and ligature reduction works, we continue to work with colleagues across Estates, Health and Safety, CAMHS and DDaT to progress.
The establishment of the MHODG is a critical oversight structure to ensuring delivery and progress at an organisational level advocating that mental health is everyone's business and that the division is enabled to connect more broadly for greater impact for North Wales citizens.

3E Child and Adolescent Mental Health (CAMHs) & Neurodevelopment (ND)	Chief Operating Officer	Overall Delivery Confidence
3E.5 Improved Access to Information, Guidance, and Assessment - Establish Clear, consistent access pathways in line with NEST/NYTH principles. Including streamline ND assessment prudent pathways to improve efficiency – introducing standard audit mechanisms and use of same day assessments for clear cases, enhance joint working across services and sectors - building links with education, CAMHS and third sector and piloting multi-agency ND input in schools.		Q2
3E.2 Improve access to CAMHS services by reducing and sustaining waiting times under the Mental Health Measure (MHM) and improving patient pathways to deliver better outcomes and experiences for Children and Young People (CYP). Including: exploring options for embedding Open Access principles, map and standardise pathways across the region using clinical guidelines and WG Community CAMHS service specification.		Q3

3E.1 Early Help - Strengthen Early Intervention and Prevention. Develop and embed CAMHS Early Help systems and processes within the new model with partners across IHCs and regionally, to align with Flexible Open Access Mental Health Support and NYTH/NEST. Including: integration of schools in-reach, establishing reliable data reporting and measurement of impact, and establishing plans for secondary prevention that targets those at greatest risk of developing mental health problems.	Q4
3E.3 Deliver a transformed and sustainable crisis model through full implementation and embedding of the crisis enhanced service model. Including working with adult mental health and partners on plans for an Open Access North Wales demonstrator project, develop and initiate plans for further Alternative to Admission, operationalisation of the 24/7 regional crisis consultation and advice line.	Q4
3E.4 Early Identification & Family Centred Support - Co-design new needs led model of care across children's neurodevelopmental (ND) services collaboratively with Children's Regional Partnership Board. Including: referral process review and improvement, roll out of standardised profile of need tool to be used prior to specialist ND referral is considered, ensure clear pathways and local points of access into ND services across all age groups, development of neuro affirmative communities.	Q4
3E.6 Improved post assessment/diagnostic support - Co-designed post-assessment support to ensure continuity, tailored interventions. Including: Map support offers regionally, align services to provide targeted post diagnostic support, ensure consistent signposting and referral pathways for support following diagnosis, develop ND transfer & transition protocols to provide seamless transition between child and adult services across agencies.	Q4

Overview

CAMHS provides specialist assessment, care and treatment for children and young people experiencing significant mental health difficulties. Delivered by multidisciplinary teams, including psychiatrists, psychologists, nurses, allied health professionals and therapeutic practitioners, CAMHS also supports the wider children's workforce to respond effectively to mental health needs. Rising complexity, increasing demand and pressure across pathways make CAMHS a key priority for service improvement. All service development is aligned with the National Strategic Mental Health Programme, ensuring more equitable access, improved safety, and high value pathways from early intervention through to inpatient care. A whole system approach is essential, with close collaboration through the Children's Regional Partnership Board (RPB) to reduce duplication, build shared learning and ensure responses wrap around children and young people's needs. Plans focus on enabling timely access to the right level of support, embedding trauma informed and rights-based practice, and delivering the Welsh Government's "no wrong door" approach. CAMHS will help children and young people achieve better outcomes, build resilience, and experience improved mental health and wellbeing across North Wales. ND services deliver multidisciplinary assessments for children and young people presenting with Autism Spectrum Disorder (ASD), Attention Deficit Hyperactivity Disorder (ADHD) and other neurodevelopmental differences. Demand for assessments has grown significantly, with waiting lists now exceeding 6,500 and some families waiting more than three years. These delays can negatively impact wellbeing and increase pressure on other services, including CAMHS. Improving ND services is therefore a critical priority. It is important to reduce the gap in health outcomes for young people with mental health and learning disabilities, supported by a focus on prevention, early intervention and reducing health inequalities. The ND Improvement Programme works in partnership with education and social services, supported by the Children's Regional Partnership Board (RPB), to meet the expectations of the National Neurodivergence Improvement Programme and the Code of Practice for the Delivery of Autism Services. A key focus is shifting from a diagnosis driven model to a needs led approach, ensuring timely early help, reasonable adjustments and consistent support for families. Priorities include reducing waiting times, redesigning pathways, strengthening workforce capability and improving post assessment support.

Delivering these improvements relies on strong cross sector collaboration and sustained whole system commitment to meeting the needs of neurodivergent children and young people in North Wales.

Key Delivery Priority Quarterly Update

3E.1

The implementation of the Early Help model and the national Schools in Reach specification is underway across the region governed via the Early Help sub-programme group.

The collation of data has been standardised across teams and an Early Help dashboard developed; this will support ongoing business planning and equity of service offer.

Planning is underway for the Body Project pilot to provide early support to young people with emerging concerns and/or at greater risk of developing an eating disorder, the pilot is supported nationally via the Mental Health Strategic Programme.

The embedding of the Schools in Reach service into local Early Help teams continues supported by the national specification and the regional Steering Group. Following a tender process, a contract has been awarded to Friends Resilience for licences to continue to deliver the Friends Resilience programme across education settings for the next three years, building resilience in children and young people to prevent escalation.

3E.2

The Mental Health Measure (MHM) Part 1A assessment target has been sustained over the last 12 months. The target for therapy (Part 1B) is more challenging to deliver and sustain however following a slight dip in April to 78%, the 1B target has been met regionally in May and June. The expansion of the group offer across teams has supported the delivery of the target and enhanced the service offer to children, young people and their families. A standard operating procedure has been finalised and is out for review to ensure that group provision is defined and equitable across the region.

Services leads are fully engaged with partners via the Regional Supporting Mental Wellbeing Group led by the Children's RPB, this will be the conduit to developing and exploring options to embed the Open Access principles going forward.

3E.3

The agreed enhanced service model is being embedded across the Unscheduled Care teams with key leadership roles in place; implementation of the regional hub team continues to support local teams as required which will allow for further extension of hours of operation. Funding for the Alternative to Admission scheme in the Central IHC has been extended for 2026-27, positive feedback received from children and young people and their families on the provision. Discussions are ongoing with Service and Estates leads in the West IHC on provision and locations for an Alternatives to Admissions hub in the area.

A standard operating procedure is being developed to ensure equity of provision across the region. Liaison with partners and stakeholders to take place regarding the consultation with plans to live to be developed. Engagement with AMH on the Open Access North Wales demonstrator project continues.

3.E4

A review of the current referral process has taken place with ND teams, referrers and families, findings are being reviewed and recommendations drafted with new referral from out for consultation.

ND Service Leads are fully engagement with the Children's RPB and partners to co-design a new needs led model of care via the Strategic Regional ND group and regular meetings with CRPB leads. Training for the profile of need tool continues with partners across the region led by the RPB, additional local trainers to be identified, following current round of training it will be paused to allow for evaluation to date and development of the guidance frameworks. Draft national ND standards have been received and are out for

review across the service and wider Children's Services, these will support the move towards a needs led model and a prudent assessment approach.

3.E5
The prudent assessment process was launched in Q3 of 2025-26, a review has taken place with findings and recommendations being produced. Job planning is underway in the teams with a standard job plan agreed across the region. NHS Performance and Improvement undertook a week-long visit to the teams, report and recommendations awaited, action plan to be developed. WG ND Improvement funding is being utilised to purchase additional assessments via the contract in place, additional funding streams to be explored for additional assessments to address all-over three-year waits.
Local Children's Area Group (CAG) meetings held with partners in each IHC Area to develop initiatives for new ways of working, utilising the agreed Information Sharing Protocol (ISP), overseen by Regional Strategic ND group led by CRPB.

3.E6
A review has been completed to map all third sector provision for ND support and shared with teams; this will inform teams with of signposting for support opportunities within their local area. A transition/transfer task and finish group has been established with colleagues from MHLD and IAS led by the CRPB; data is being collated and reviewed with a view to agreeing the transfer and transition of young people over and approaching 18 years of age and developing a policy. This will ensure that young people are assessed and signposted for support within the appropriate service.

3F Children and Young People Services	Chief Operating Officer	Overall Delivery Confidence
3F.3 Undertake a review of specialist nursing team roles and delivery of care for children with complex needs.		Q1
3F.8 Work with the Partnership Transformation Programme to commence the development of a strategic plan for children with a learning disability, and reduce inequalities for consultation.		Q1
3F.5 Ensure that children with diabetes have timely provision of insulin pumps and CGM		Q2
3F.2 Working with partners, undertake a gap analysis of the requirements to fully implement the Healthy Child Wales 2 Programme and submit proposals to the Health Board for implementation.		Q3
3F.4 Commence developing a service specification for delivery of community nursing care for children with complex care needs		Q3
3F.6 Assess compliance with Diabetes NICE Guidance in readiness for the launch of the Type 1 diabetes screening programme for children		Q3

3F.7 Set out the proposal to the Health Board based on the service specification gap analysis related to the submitted Paediatric Palliative Care in Wales self-assessment, including specialist palliative care nursing.	Q3
3F.9 Finalise and implement the Transition Pathways for children into adult services across all long-term conditions (respiratory, endocrine, cardiac and neurological conditions, cancer, CAMHS and Learning Disabilities).	Q3
3F.1 Delivery of school age immunisation programme by immunisation team with targeted work in low uptake areas.	Q4

Overview

Improving access, outcomes and experience for children and young people is fundamental to delivering high quality, high value and sustainable care across North Wales. As part of Strategic Intent 3, Children and Young People Services are prioritised because early life health is one of the strongest predictors of lifelong wellbeing, and timely, well-coordinated pathways can prevent escalation, reduce inequalities and improve long-term outcomes. Health inequalities have a significant and lasting influence on children's health. When children grow up in circumstances that limit access to healthy environments, stable housing, nutritious food, safe play, high quality early years provision, and timely healthcare, their health outcomes are measurably poorer. These inequalities increase the likelihood of low birth weight, delayed development, poorer mental health, chronic illness, and reduced educational attainment. Without targeted action, particularly prevention and early intervention, the gap in outcomes widens between the least and most deprived, as children grow, shaping long term health and wellbeing and contributing to preventable illness in adulthood. The Health Board's integrated model, spanning community care, hospital care and specialist care, supports children and their families up to age 18, and beyond where additional needs exist, ensuring continuity across critical developmental stages and transitions. By strengthening pathways, reducing unwarranted variation, enhancing multidisciplinary working, and delivering care as close to home as possible, the aim is to provide safe, compassionate and seamless services that respond to what matters to children and young people. This section sets out how the Health Board will align with national priorities, improve flow and access, embed evidence based clinical models, and modernise services so that every child and young person in North Wales can benefit from improved experiences, better outcomes and equitable, sustainable care.

Key Delivery Priority Quarterly Update

Children's Services continue to prioritise focus on early intervention within core services, with timely care throughout the pathways. During q1 the service has made progress on the following:

Targeted immunisation delivery in communities and schools where there is low uptake, with good uptake. Planned catch up sessions over the summer are fully booked some localities. Planning for delivery of Meningitis B programme completed with letters to eligible cohort sent.

Submission of the workforce gap analysis required related to implementation of the Healthy Child Wales Programme 2 has resulted in a national review of the timeline for implementation.

The Review of the Children's Community Nursing Team has commenced, further work is required to validate the workforce and financial data, and the review of the service offer is

being collated. This will assist in defining Levels of Care and the service offer, to ensure that there is equity across North Wales.

Children with diabetes are supported with their care in accordance with NICE guidance. Children are supported with insulin pumps and continuous glucose monitoring in a timely manner

Palliative care for children is provided by the community nursing teams and Consultant in palliative care, a business case is required to fund the gap in funding for this post and for a lead nurse as required by the national standards and evidenced within the self-assessment submitted by the Health Board.

Developing the strategy for children with learning disabilities has not progressed this quarter at the pace hoped for, the timeline for this is partially dependent on the Partnership Transformation Programme

Pathways supporting children to transition to adult services be that disease and treatment focussed or lifelong support is due to commence with leadership from the office of eth medical director.

3G Women's Health	Chief Operating Officer	Overall Delivery Confidence
3G.4 Develop an implementation plan to deliver the outstanding commitments in the National Perinatal Engagement Framework (2025), including a paid Chair for Maternity and Neonatal Voices Partnership.		Q2
3G.10 Participation in national digital and data development initiatives such as Women's Health Dashboard.		Q3
3G.2 Receive and analyse the findings of the Perinatal National Assurance Assessment Report (expected in Q4 2025/26), together with the key priorities outlined in the 2025 Quality Statement for Maternity and Neonatal Services, and develop a comprehensive proposal for local implementation inclusive of detailed costing.		Q3
3G.1 Progress the rollout of Phase 2 of the Digital Maternity Cymru System, with a focus on implementing maternity electronic health records to enhance the quality of care and improve communication for pregnant individuals.		Q4
3G.3 As part of the Clinical Services Plan, undertake a comprehensive review of the configuration of Pan–North Wales Perinatal Services to ensure the delivery of safe, high-quality and sustainable care.		Q4
3G.5 Collaborate with Health Education and Improvement Wales (HEIW) to prioritise year two service actions to ensure the Perinatal Strategic Workforce Plan is delivered within the Health Board.		Q4
3G.6 Support the local delivery of the NHS Wales Women's Health Plan across North Wales, to include work on Menstrual Health, Endometriosis and Adenomyosis, Contraception – Postnatal Contraception and Abortion Care, Preconception Health, Pelvic Health and Incontinence, Menopause, Violence Against Women – Domestic Abuse and Sexual Violence, Ageing Well and Long-Term Conditions and strengthening community pathways.		Q4
3G.7 Address variation in services such as Contraception, Menopause support and Pelvic Health.		Q4
3G.8 Deliver improvements to Women's Health prevention and early intervention, including preconception health and earlier identification of women's health conditions.		Q4
3G.9 Expand Women's Health service offering, currently focused via the Llandudno Womens Health Hub.		Q4

Overview
Women's Services within the Health Board are delivered through a comprehensive network which includes all three District General Hospitals, and Community and Primary Care settings. This integrated pathway approach ensures accessibility, continuity, and high-quality care for women and families across North Wales. The Service provides regional oversight and governance, working in close collaboration with Third Sector partners to deliver person-centred, safe, and effective services. The Health Board's commitment is to maintain and enhance standards of care, reduce health inequalities, and respond to the evolving needs of the population through innovation, workforce development, and

strategic planning. Health outcomes for women are worsening especially for women from the most deprived and disadvantaged communities, a focus on prevention and reducing the differences in women's access to health care and interventions is required to reverse this. The NHS Wales Women's Health Plan for Wales represents a significant commitment to improving health services for women, ensuring that their voices are heard and their health needs are prioritised. By addressing systematic inequalities and enhancing research and education the plan aims to create a more equitable health care system to enhance health outcomes for women locally and nationally. This plan details 64 measurable actions across 8 priorities to improve outcomes for women and girls across their lifetime. Specific key actions for the Service will continue to inform its priorities. The Maternity and Neonatal Quality Statement in Wales outlines the expected standards for maternity and neonatal services, emphasising the importance of high-quality care for women and their families. The statement aims to address the complexities of pregnancy, including the increasing prevalence of conditions such as diabetes and mental health issues and to improve outcomes for women ensuring that every child receives the best start in life. It also focusses on the need for inclusive policy making and the involvement of service users in shaping the services they need.

Key Delivery Priority Quarterly Update

1. What have we delivered so far this year towards the aim?

Significant progress has been made across the maternity, neonatal and women's health agenda during 2026/27, including:

• Completion of benchmarking exercise against the Perinatal National Assurance Assessment Report
• The findings of which were presented to the Executive Team and Quality, Safety and Experience (QSE) Committee in May and July.
• Incorporation of benchmarking findings into the Health Boards Annual Plan and Women's Services priorities for 26/27.
• Participation in the first Clinical Services Plan (CSP) workshop, ensuring maternity services are recognised as an essential service within future Health Board planning.
• Benchmarking against the National Perinatal Engagement Framework, including implementation of three of the five national maternity surveys, and the remaining two to be implemented in line with national discussion.
• Development of a proposal for a paid Maternity and Neonatal Voices Partnership (MNVP) Chair through the Women's Health Hub programme.
• Submission of detailed stakeholder feedback to HEIW on the draft Perinatal Strategic Workforce Plan Service Specification.
• Preparation and submission of a Women's Health Plan funding proposal to Welsh Government in May (expected outcome awaited in June).
• Completion of the Pathfinder Women's Health Hub phase and commencement of a formal evaluation to inform future service design.
• Improvement in menopause waiting times.

2. What impact (both qualitative and quantitative) has the work had on the population of North Wales compared to what it set out to achieve?

Qualitative Impact

• The benchmarking of national assurance recommendations has informed local services priorities for improvement, ensuring local services are aligned to national expectations for maternity and neonatal care.
• Service governance and assurance arrangements have been strengthened through presentation of findings to Executive and Board-level committees, promoting ward to Board reporting.
• Women's Health Hub development work has increased understanding of local need and informed future models of care that are intended to improve access, prevention, early intervention and integrated community-based services.

• Engagement with national programmes, including the Perinatal Engagement Framework and workforce planning initiatives, has ensured North Wales is actively contributing to and aligning with national policy developments.
• The menopause/ planned care improvement programme is delivering a better patient experience through reduced waits and improved access to specialist support.
Quantitative Impact
• 5 local benchmarking exercises completed against national reports pertaining to services and reported through Health Board governance structures.
• 3 of 5 national maternity surveys implemented, providing enhanced opportunities to capture women's experiences and inform service improvements.
• 100% elimination of waits exceeding 104 weeks for Stage 1 menopause services, achieving Welsh Government expectations in Q1.
• 2 regional funding proposal submitted to Welsh Government to support delivery of Women's Health Plan priorities and Phase 2 of the Digital Maternity Cymru.
• Multiple stakeholder responses submitted to influence the future Perinatal Strategic Workforce Specification.
• 1 Pathfinder Women's Health Hub evaluation commenced, providing evidence to support future service expansion across North Wales.

Whilst many programmes remain in the planning and implementation phase, the work undertaken has established the foundations required to deliver longer-term improvements in accessibility, quality, patient experience and health outcomes for women, babies and families.

3. What actions are we undertaking to ensure we are on track to deliver the full overarching aim and associated impact by the end of March 2027?
To ensure delivery remains on track, the following actions are being progressed:
• Implement and monitor actions arising from the Perinatal National Assurance Assessment Report through established committee structures.
• Develop detailed implementation plans and costed proposals linked to national maternity, neonatal and Health Board perinatal priorities identified through the assurance and benchmarking processes.
• Continue participation in the Clinical Services Plan workstreams to support future configuration and sustainability of perinatal services across North Wales.
• Complete implementation of the remaining national maternity surveys and progress delivery of the National Perinatal Engagement Framework, including development of arrangements for a paid MNVP Chair, subject to funding approval.
• Work with HEIW/ MatNeo Network and national partners to implement the agreed Perinatal Strategic Workforce Plan once the final specification is published.
• Complete evaluation of the Pathfinder Women's Health Hub and develop a revised business case aligned to Primary Care Clusters and the Health and Wellbeing Hub model.
• Progress Women's Health Plan priorities for the Service through the Welsh Government funding proposal (if approved), including workforce development, contraception services, pelvic health, menstrual health and postnatal care improvements.
• Continue delivery of the menopause recovery programme to further reduce waiting times and address variation in women's health services.
• Maintain oversight of funding availability and resource requirements and any risks if not secured to service sustainability.

As a minimum the above actions will support the maintenance of safe essential services.

3H Pharmacy and Medicines Management	Executive Medical Director	Overall Delivery Confidence
3H.1 Commission and publish a Pharmaceutical Needs Assessment (PNA) and agree an action plan from this to ensure pharmaceutical services are aligned to population need, address gaps in provision, and support equitable, sustainable care delivery.		Q3
3H.2 Support General Pharmaceutical Council (GPhC) Step 4 accreditation for the Bangor University MPharm programme (confirming regulatory provisional accreditation to deliver the programme) and enrol Cohort 2 to strengthen the local pharmacy workforce pipeline and support sustainable service provision.		Q3
3H.6 Following completion of implementation, fully embed Electronic Prescribing and Medicines Administration (ePMA) by establishing clear pharmacy clinical ownership to lead safe prescribing configuration, formulary oversight, system optimisation and structured change control.		Q3
3H.3 Launch and develop the North Wales Transforming Access to Medicines (TrAMs) programme, as one of three national transformation hubs, to modernise pharmacy technical services and strengthen regional collaboration, including scoping pharmacy provision to support advanced therapies within a national hub model.		Q4
3H.4 Continue to work with Community Pharmacy Wales (CPW) and Health Education and Improvement Wales (HEIW) to support community pharmacy contractors to expand the number of Pharmacies offering the Pharmacist Independent Prescribers Service (PIPS), strengthening prescribing capacity and improving access to care.		Q4
3H.5 Ensure full implementation of the High Value Medicines Value & Sustainability Board programme by supporting clinicians to adopt best-value prescribing practices, optimising procurement and product selection, reducing low-value prescribing, and strengthening performance oversight to deliver sustainable financial and quality benefits.		Q4
3H.7 Work with primary care and community services, via the Local Enhanced Clinical Effectiveness Service, to support evidence-based patient reviews that reduce inappropriate gabapentinoid prescribing in line with NICE guidance, extend periods of treatment, and increase the use of low Global Warming Potential inhalers in line with the All-Wales respiratory treatment pathway.		Q4
3H.8 Engage with national genomics leads and clinical networks to scope the potential role of pharmacogenomics in clinical pathways, explore opportunities to develop local champions, and raise awareness through shared learning and engagement.		Q4
3H.9 Deliver the risk prioritised components of Electronic Prescribing Service (EPS) that sustain safe, reliable digital services, covering devices, network/telephony, core infrastructure, and clinical platforms.		Q4

Overview

Pharmacy and medicines management are central to delivering high-quality, safe and sustainable healthcare. As demand rises and treatments become more complex and costly, we must maximise the clinical value of medicines, reduce unwarranted variation and ensure best use of resources while improving patient outcomes. A coordinated regional approach to technical services is needed to support specialised and emerging therapies, alongside clear oversight of population need and equitable access to pharmaceutical services. Continued digital development in prescribing and medicines intelligence will improve oversight, provide clearer information to support decision-making, and strengthen the safe and effective use of medicines across the system.

Key Delivery Priority Quarterly Update

1. What have we delivered so far this year towards the aim?

- Progressed implementation of the Pharmacy and Medicines Management Annual Delivery Plan, with clear workstreams in place to support delivery of key priorities.
- Transitioned ePMA into a sustainable business-as-usual model with strengthened governance, clinical safety, reporting and digital oversight. The programme is now moving towards formal closure in September.
- Progressed development of the North Wales Pharmacy Technical and Aseptic Hub (TrAMs), including agreement to advertise the Deputy Hub Lead post and continued development of the regional hub model.
- Progressed medicines value and sustainability work, including enhanced oversight of high-cost medicines, expansion of Blueteq implementation, and publication of Local Enhanced Clinical
- Effectiveness Service (LECES) notices on Sell2Wales. This enables work with primary care and community services to support evidence-based prescribing reviews, reduce inappropriate gabapentinoid prescribing and increase use of low Global Warming Potential inhalers in line with national guidance.
- Completed the first draft of the Pharmaceutical Needs Assessment and commenced the consultation phase.
- Continued collaboration with Bangor University to support development of the North Wales pharmacy workforce, with the first cohort successfully completing Year 1 of the MPharm programme.
- Strengthened regional and national collaboration on genomics and pharmacogenomics, with BCUHB now represented on national programmes. Planning is also underway for the National Genomics Showcase to be hosted in Llandudno on 19 November 2026.

2. What impact (both qualitative and quantitative) has the work had on the population of North Wales compared to what it set out to achieve?

- Moving ePMA into a business-as-usual setting has provided a more robust platform for prescribing and medicines administration across the Health Board, supporting safer care, reducing reliance on paper processes and strengthening oversight of medicines use.
- Expansion of Blueteq and strengthened oversight of high-cost medicines has improved our ability to ensure patients have equitable access to approved treatments whilst supporting effective use of NHS resources.
- Publication of the Local Enhanced Clinical Effectiveness Service (LECES) notices has enabled progressing commissioning of prescribing improvement work across primary care, supporting safer use of medicines, reducing inappropriate prescribing and promoting environmentally sustainable treatment choices.
- Completion of the draft Pharmaceutical Needs Assessment has provided a clearer understanding of the pharmaceutical needs of local communities, helping ensure future services are planned around population need and reduce inequalities in access.

- Progression of the North Wales TrAMs Hub programme is supporting long-term sustainability of specialist pharmacy technical services, helping ensure patients can continue to access complex and specialised medicines in North Wales.
- The first Bangor University MPharm cohort completing Year 1 represents an important step in developing a sustainable local pharmacist workforce, helping address future workforce challenges across North Wales.
- Increased participation in national genomics and pharmacogenomics programmes is helping position North Wales to benefit from advances in personalised medicine, enabling treatments to be better tailored to individual patients in the future.

Overall, Quarter 1 has focused on strengthening the systems, services and workforce needed to support safer use of medicines, more equitable access to pharmaceutical care, and better long-term outcomes for the population of North Wales.

3. What actions are we undertaking to ensure we are on track to deliver the full overarching aim and associated impact by the end of March 2027?
- Continue delivery of the Pharmacy and Medicines Management Annual Delivery Plan, with progress, risks and benefits monitored through established governance arrangements.
- Complete consultation and publication of the Pharmaceutical Needs Assessment and use the findings to inform future service and workforce planning across North Wales.
- Continue embedding and optimising ePMA within the business-as-usual environment, using system data and user feedback to drive improvement and support safer prescribing.
- Progress the North Wales TrAMs Hub through the North Wales Project Board, including recruitment to key posts, while continuing to work alongside South East and South West hub leads to develop an aligned all-Wales approach.
- Implement the Local Enhanced Clinical Effectiveness Services (LECES), supporting evidence-based prescribing reviews, medicines optimisation and delivery of agreed value and sustainability priorities.
- Continue expansion of Blueteq and strengthen oversight of high-cost medicines to support equitable access, reduce unwarranted variation and improve use of NHS resources.
- Track and monitor delivery of medicines value and sustainability programmes to ensure planned benefits are realised and sustained.
- Continue working with Bangor University and national partners to support development of the future pharmacy workforce in North Wales.
- Maintain active involvement in national genomics and pharmacogenomics programmes to ensure North Wales is well placed to adopt future innovations in patient care.

3I Dementia	Executive Director of Nursing	Overall Delivery Confidence

3I.1 Complete a review of existing dementia care provision within Emergency Departments to include benchmarking against areas of best practice.	Q1
3I.4 Undertake a review and training needs analysis of existing dementia training approaches and align national guidance and best practice standards, informing the development of a training programme for the workforce, building on the work completed for the bitesize training.	Q2
3I.6 Undertake environmental assessments to review the Health Board's current assessment of appropriate and suitable dementia friendly environments for all care settings and make proposals as appropriate.	Q2
3I.2 Review analyse and make recommendations to the Health Board on the requirements to implement a Dementia Care Pathway for Emergency Departments.	Q3
3I.3 Design and deliver bespoke dementia patient and carer experience review for ED.	Q3
3I.5 Design and implement a programme tailored to the needs of the workforce to enable a consistent service delivery through agreement of a core minimum standard of dementia education across the Health Board.	Q3
3I.7 Recommendations and proposals collated and presented to the Health Board, working with Estates, to align any recommended improvements to Estates strategy and available budget.	Q4
3I.8 Design and implement a staff campaign to raise awareness of prevention as it affects dementia.	Q4

Overview
Dementia is a major and growing priority for the Health Board due to the rapidly ageing population of North Wales and the significant impact the condition has on individuals, families, communities and the wider health and care system. Forecasts show substantial increases in both the 65+ and 85+ population, alongside rising multimorbidity and frailty, meaning many more people will live with dementia and increasingly complex needs in the years ahead. Dementia is identified nationally as one of the major neurological conditions driving demand across the NHS, and locally it already contributes to high levels of unplanned care, prolonged hospital stays and pressure on carers and community services. At the same time, inequalities across North Wales, particularly in areas of high deprivation, are associated with poorer dementia outcomes, later diagnosis and reduced access to support. Addressing dementia is therefore essential to improving population health, delivering person-centred, bilingual, compassionate care, strengthening community-based pathways, and ensuring the Health Board can meet future demand sustainably while supporting people to live well for longer. Dementia Care will be one of the areas that becomes a focus on the newly established Mental Health Oversight and Development Group, chaired by the Chief Executive, and will report to Board at least twice per year.

Key Delivery Priority Quarterly Update

1. Underpinning ground work has laid foundations for future improvement work. An ED Task group to coordinate ED improvement is in operation and meeting monthly; ED teams have undertaken their own scoping and ED tours have taken place with the Consultant Nurse for Dementia (Corporate Nursing) and Regional Dementia Improvement Manager. Furthermore, to monitor existing dementia practices, a bespoke template has been developed for use by all 3 EDs; Reps from each ED Team have planned visits to exemplar ED departments in the UK to identify best practice; good practices identified plus a plan to adopt/embed.

2. It is too early for impact and any impact from this kind of intervention/s cannot be expected to have discernible impact on population outcomes. Instead, they can be expected to impact in the longer term on such things as patient/family experience, reduction in complaints and concerns, safety, staff satisfaction, retention etc but again some of these are hard / impossible to measure with any rigour.

3. Extensive strategies are in place and working well to prepare and support teams for delivery, underpinned by strong governance. There is strong confidence that some aspects of the aim will be achieved but this only relates to those actions that are in the direct control of the Consultant Nurse for Dementia and key clinical staff in the ED settings e.g. review of literature, exemplar ED visits, patient experience review etc. Steps being taken include development of a bespoke data gathering tool to capture progress against deliverables from each IHC/Division which is being used to create the single combined IMTP Portal quarterly reports; regular Consultant Nurse Dementia meetings with each IHC/Division People's Experience Group and PSGQ groups to make clear what is needed; meetings with the dementia representatives in each IHC/Division; supporting teams with reporting and improvement planning, calendar reminders until April 2027, reminder emails, keeping relevant seniors sighted in IHCs/Divisions, a video of requirements created, monthly Emergency Department Task Group meetings set to April 2027.

However, the majority of the aim - development of a pathway for emergency care for people with dementia - is at significant risk of not being achieved by March 2027. The specialised Pathways Practitioner resource (0.6 WTE) has unexpectedly been reallocated to other BCU priorities This impact (failure of the aim) will occur in Q3 if no solution is found. The pathways resource is too specialised and large to be picked up by existing resources in Emergency Departments and the Consultant Nurse Dementia. This is being looked at through a Triple A alert through dementia governance processes, including the BCU strategic Dementia Delivery & Transformation group on 9.7.26 which reports to (QEDG) and if needed Safeguarding Governance & Performance group on 28.7.26.

A clinical pathway is a structured, evidence-based plan that outlines the step-by-step care for patients with a specific condition, detailing what happens, when, and by whom. Clinical pathways are designed to standardize care for a defined patient population over a specific period, translating clinical guidelines into actionable steps for healthcare teams. They cover diagnosis, treatment, and follow-up, and allow for deviations when patient-specific factors require alternative approaches. Pathways improve efficiency, reduce hospital stays, and enhance patient outcomes by providing a shared plan for all care providers.

4A Foundations for the Future	Chief Executive	Overall Delivery Confidence
4A.3 Complete the revised Integrated Leadership Development Framework.		Q1
4A.4 Complete Competency Frameworks, which includes the competencies and skills required for particular roles by banding, equipping staff with the skills to deliver their roles.		Q1
4A.9 Implement a new governance model as part of the revised operating model, ensuring sharper accountability, fewer/streamlined meetings, focusing on delivery and transparency.		Q2
4A.10 Publish to BCUHB Board the collated lessons learned from Phase 1, including outcomes from the consultation process, evaluation of performance and benefits measurement and how FFTF supports de-escalation by improving governance and accountability.		Q3
4A.11 Publish the Operating Framework, including how business partnering will operate with the Service Groups, and the directory of services reflecting the new organisational model.		Q3
4A.13 Co-produce with staff and partners an organisational approach to change framework that supports teams to successfully design, deliver and sustain change.		Q3
4A.5 Review and improve the Establishment Control Review (ECR) process, to ensure it is more streamlined and fully supported.		Q3
4A.6 Review and improve the process for creating, reviewing, and approving business cases.		Q3
4A.7 Implement the Foundations for the Future design and thereby establish a clear organisational structure led by an effective and complete executive team with the leadership capacity and capability to deliver high quality, sustainable care.		Q3
4A.1 Implement and deliver the year 1 actions from the Culture, Leadership and Engagement 3-year Improvement plan 2026-29. The delivery plan is structured into five areas. 1. Vision and Values, 2 Goals and Performance, 3. Learning and Innovation, 4. Support and Compassion, 5. Teamwork. Year one focusses on embedding systems and processes in these areas to improve leadership quality, employee engagement, psychological safety and practically embedding the agreed values and behaviours.		Q4
4A.12 Engage with partners (JCC, NWAS, Local Government, Third Sector) to review the operating model and identify changes to the ways we operate and define operating policies and/or updated MOUs where applicable.		Q4
4A.2 Complete the transition to new senior posts and establish new service groups and corporate directorates, supported by cross-functional operating agreements and ongoing team and leadership development.		Q4

4A.8 Complete the design of Phase 2. This will include reviewing the structures of the organisation at bands 8b and below, a plan for the effective integration of Mental Health and Learning Disabilities, and a rapid review of phase 1 implementation across all 5 pillars of the Programme.	Q4

Overview

Delivering high quality, equitable and sustainable services for the people of North Wales depends on BCUHB operating as a coherent, effective and agile organisation. A highly effective organisation aligns strategy, culture, people, processes and structures into a unified operating model that enables good governance, timely decision making and clear accountability. Strengthening these foundations is essential not only to improve services today, but to ensure the Health Board can adapt and respond to the complex demands of the future. Work undertaken to evaluate the Operating Model agreed in 2022 highlighted significant gaps as detailed in the Discovery Report developed in November 2024. While it examined structural arrangements, other critical elements of an effective operating model, including organisational culture, strategic alignment, people capability and process design, were not sufficiently addressed. Over time, it has become increasingly clear that aspects of the current model do not provide the flexibility expected of a large integrated Health Board. Challenges remain in achieving consistency across divisions, reducing duplication, ensuring equitable service provision, and enabling decisions to be taken at the right level and at the right time. These issues are not unique to this health board; across the UK, large healthcare organisations are seeking operating models that support system wide working, improve integration and better leverage scale. The Foundations for the Future Programme directly responds to this need. It applies a recognised organisational change methodology (Tushman and O'Reilly's 'Leading Organisational Change and Renewal') to create an operating model that strengthens ways of working as one Health Board. The programme provides greater clarity of purpose, enable more agile and accountable decision making, and embed the conditions required for sustainable improvement. By establishing clear foundations, strategically, culturally, structurally and operationally, the Health Board will be better equipped to deliver its strategic objectives and, most importantly, improve outcomes and experiences for the population of North Wales. This is a significant programme of change for the organisation and as such will continue to require refinement moving forward. The first phase of the Delivery will be implemented and next phase of the Programme will therefore get underway during 2026/27. It is envisaged that the programme will be complete by the final quarters of 2027/28.

Key Delivery Priority Quarterly Update

1. What have we delivered so far this year towards the aim?

The Competency Framework and the Integrated Leadership Development Framework have been completed (historically), delivering the Q1 Annual Delivery Plan milestones. Progress has also been made in:

- developing the Operational Governance Framework,
- embedding culture and leadership improvement activity,
- strengthening programme governance and risk management arrangements,
- progressing organisational design work,
- transitioning the Quality Management System into business-as-usual arrangements.

2. What impact (both qualitative and quantitative) has the work had on the population of North Wales compared to what it set out to achieve?

As an organisational transformation programme, benefits are expected to be realised over the medium and long term. During Q1, the programme has strengthened the foundations required to deliver sustainable improvement through:

- enhanced leadership capability,
- clearer governance arrangements,
- improved workforce planning,
- increased organisational readiness for change.

Early qualitative feedback from the culture change activity has demonstrated strong engagement and positive staff experience.

3. What actions are we undertaking to ensure we are on track to deliver the full overarching aim and associated impact by the end of March 2027?

During Q2, the programme will continue implementation of the Foundations for the Future programme through:

- progression of organisational consultation activity,
- further development of the Operational Governance Framework,
- continued delivery of culture, leadership and workforce initiatives,
- completion of operating model products,
- ongoing strengthening of programme governance, risk management and stakeholder engagement arrangements.

4B Strategy and Planning	Executive Director of Transformation & Strategic Planning	Overall Delivery Confidence
4B.1 Complete the Discovery Phase of the new 10-year Health Board Strategy by finalising evidence gathering, synthesising insights from key stakeholders, and undertaking structured engagement across the organisation and wider partners. This will culminate in an agreed Discovery Report, to inform the subsequent Design Phase of the Strategy. This work will also cover some specific requirements within the NHS Wales Planning Guidance:□A review of the organisation's Well-being objectives and how they fit within the Health Board's overarching strategic objectives. Provide clarity on the full suite of underpinning strategic plans (such as the Clinical Services Plan, Estates Strategic Plan and Digital Strategic Plan) and timelines for their development. Incorporate the Health Board's ambitions relating to Advanced Therapies and Genomics.		Q1
4B.4 Co-create a Third Sector Partnership Working Framework with Third Sector Partners to move to more proactive and strategic collaborative approach.		Q1
4B.5 Draw on support from NHS Performance and Improvement (NHS P&I) colleagues to develop proposals on an improved approach to a unified modelling across demand, capacity, skills mix, activity, performance, finance and workforce, incorporating benchmarking against other Health Boards – to be utilised in the 2027-30 IMTP planning cycle.		Q1
4B.6 Undertake an annual reflection and learning exercise in relation to the annual planning cycle, incorporating the planning maturity matrix self-assessment tool and involving internal and external stakeholders.		Q1
4B.8 Update the BCUHB Integrated Planning Framework and associated more detailed planning guidance in light of annual reflection and learning exercise, emphasising the importance of clinical leadership, Community by Design principles and patient feedback in service planning.		Q2
4B.9 Contribute to the broader organisational capability development work, specifically in relation to development of skills in planning.		Q2
4B.10 Develop an organisational approach to de-prioritisation and de-commissioning for teams to utilise in reaching and implementing decisions of this nature, ensuring the full range of clinical and operational perspectives are central to the approach.		Q3
4B.2 Complete the full strategy design phase by translating the insights from the discovery phase into a validated strategic framework, including defined goals, strategic priorities, delivery roadmaps, and governance model, culminating in a final Strategy ready for Board approval. This will include structured engagement with key stakeholders throughout the design process to test assumptions, refine options, and build organisational alignment, ensuring aspects such as the Marmot principles (relating to early childhood, education, employment, preventing ill-health, housing and community well-being) are covered within the scope.		Q3
4B.11 Support delivery of commitments set out in the IMTP through monthly monitoring and timely escalation of any risks to delivery as well as quarterly reporting of delivery against the IMTP and Special Measures de-escalation framework.		Q4

4B.3 Implementation of the strategy will be via key underpinning quality impact assessed strategic plans (e.g. Clinical Services Plan) and their key deliverables falling within the 2027-30 IMTP.	Q4
4B.7 Deliver improvements in the organisation's approach to planning through delivery of the planning capability action plan that is informed by feedback from key stakeholders, annual learning cycles and contains actions from the planning maturity matrix self-assessment. Aiming to progress to level 3 and above across all areas.	Q4

Overview

Developing a refreshed 10-Year Strategy and strengthening organisational planning are interdependent priorities that will shape how the Health Board responds to changing population needs, rising demand, workforce pressures and a challenging financial environment. Together, they provide the clarity, coherence and discipline needed to move from short-term reactive approaches to sustained, proactive transformation. The renewed strategy will build on the co-created strategic intents developed with partners in 2025/26 and will articulate a clear long-term direction that reflects the scale of challenge, the need for new models of care, and the importance of prevention, early intervention and reducing health inequalities. It will place population health and regional collaboration at its core, ensuring that future service design is informed by evidence, demographic trends and meaningful engagement with communities, clinicians and partners. Effective planning is the mechanism through which this strategic intent becomes deliverable action. Good planning translates ambition into clear decisions about resources, service change, workforce and financial trajectories, supported by robust risk and performance frameworks. By triangulating workforce, financial and activity modelling, planning ensures that long-term goals are realistic, affordable and operationally grounded. It also strengthens accountability, enabling the organisation to track progress, intervene early when delivery risks arise and maintain alignment with national policy and statutory obligations. Strong partnership working across North Wales, including with local authorities, the Third Sector and regional bodies, is essential to both the strategy and the planning process, ensuring shared priorities and coordinated solutions. A credible 10-Year Strategy, underpinned by mature, integrated planning, will provide the foundation for stability, consistent decision-making and sustainable improvement. This combined approach will support the Health Board to prioritise effectively, deploy limited resources where they have greatest impact, and communicate transparently with the public about the case for change. Ultimately, it will equip the organisation to deliver high-quality, resilient services that meet the needs of the population now and over the longer-term.

Key Delivery Priority Quarterly Update

1. What have we delivered so far this year towards the aim?

Progress has been made across all key workstreams supporting development of the refreshed 10-Year Strategy and strengthening organisational planning. A draft Strategic Discovery (Diagnosis) Report has been produced and discussed through governance forums, providing an emerging evidence base and stakeholder insight to inform the next phase of strategy development. Work has also commenced on developing a unified organisational modelling approach, including baseline mapping of data, analytical capability and existing modelling activity across workforce, finance, performance and operational functions. In addition, engagement has taken place with NHS Performance and Improvement colleagues to support future benchmarking and model development.

Partnership working has advanced through engagement with all North Wales County Voluntary Councils (CVCs), with arrangements in place to commence co-production of a

Third Sector Partnership Working Framework during Quarter 2.
The annual reflection and learning exercise for the 2026–29 planning cycle has been completed, including extensive stakeholder engagement, a Reflection and Learning Workshop, production of a draft learning report and a comprehensive refresh of the Planning Maturity Matrix self-assessment. This deliverable was achieved within Quarter 1 and provides important evidence base for future planning improvements.

2. What impact (both qualitative and quantitative) has the work had on the population of North Wales compared to what it set out to achieve?

The work is primarily focused on strengthening the organisation's planning, partnership and governance arrangements and therefore the impact to date has been largely indirect. Improvements have been made in stakeholder engagement, organisational learning, planning maturity and oversight of delivery, helping ensure future service plans are better aligned to population needs, clinical priorities and partner perspectives. Engagement has been undertaken across a range of internal and external forums, including Third Sector partners, providing a stronger foundation for collaborative, evidence-based planning and improved outcomes for the population of North Wales.

3. What actions are we undertaking to ensure we are on track to deliver the full overarching aim and associated impact by the end of March 2027?

Work is well underway on all areas that didn't quite complete within Q1, with all completing during Q2 and still supporting delivery of the overarching aim by March 2027. As the 10-year strategy work transitions into a formal programme approach, the work programme for the remainder of the year will be re-assessed to ensure it is deliverable in the timeframes that remain.

4C Clinical Services Planning, Leadership and Interprofessional Working	Executive Medical Director	Overall Delivery Confidence
4C.1 Agree the CSP methodology and first tranche of areas to be prioritised and establish the CSP Programme by developing the programme structure, governance, and delivery approach, supported by targeted internal engagement and awareness raising activities to build understanding and organisational buy in. Success will be demonstrated through formal approval of the methodology, confirmation of programme governance, and evidence of staff awareness and engagement across key teams including the first major engagement event held.		Q1
4C.5 Job descriptions with roles with responsibilities and appropriate remuneration in place for all clinical leadership posts with Foundations for the Future organisation structure, across primary, community and secondary care.		Q1
4C.9 Provide clarity over best practice clinical and operational multi-professional working, in line with the new operating model structures roll out, both roles and responsibilities and effective team working. Across primary, community and secondary care.		Q1
4C.2 Operationalise the CSP Programme by finalising detailed delivery plans for the process (pertaining to the first tranche of areas), establishing programme reporting and risk management processes, and initiating structured engagement with leads to prepare for CSP assessments. Success will be demonstrated through approved delivery plans, active reporting cycles, and evidence of areas' readiness to enter the CSP process in Q3.		Q2
4C.10 Provide organisation development support to ensure newly formed teams are working effectively together across clinical and operational inter-professional disciplines. Across primary, community and secondary care.		Q3
4C.3 Deliver the full CSP assessment process for the first tranche of priority services, including evidence gathering (including use of key population level intelligence, assessment workshops, option development and prioritisation. This will be supported by structured engagement with leads and clinical and operational teams from the full set of professional groups to ensure clarity, collaboration and high-quality outputs. Success will be demonstrated through completed CSP assessment documentation and agreed prioritisation outcomes for all first tranche areas that demonstrates Community by Design principles, maximise pathway redesign and strengthened joint working between primary and secondary care and partners.		Q3
4C.6 Commence implementation of a menu of formal training programmes informed by training and development needs analysis for all within clinical leadership positions, across primary, community and secondary care.		Q3
4C.4 Finalise and submit the first tranche of CSP service change proposals for formal approval by the CSP Programme Board. This will include refining proposals based on feedback, completing required documentation, and ensuring alignment with strategic, operational and financial considerations. Success will be demonstrated through Programme Board approval of all first tranche service change proposals and confirmation of readiness for wider Health Board governance approvals and implementation planning.		Q4
4C.7 Generalised upskilling related to modern NHS needs via Clinical Services Plan programme to include strategic planning, value-based health care, population health management etc, across primary, community and secondary care.		Q4

4C.8 Develop a clear and attractive career path and development package for those in or aspiring to Clinical Leadership position, drawing on internal and external expertise and support including NHS P&I and CMO. Across primary, community and secondary care.	Q4

Overview

Delivering sustainable, high-quality services for the people of North Wales requires a clear, forward-looking Clinical Services Plan (CSP) supported by strong, skilled and collaborative clinical leadership. Together, these elements provide the foundations for moving from reactive service management to a proactive, coherent approach that aligns strategic ambition with the realities of clinical practice, workforce capability and population need. The CSP sets out how services will evolve to provide person-centred, preventative and evidence-based care, reducing unwarranted variation and ensuring that models of care reflect the principles of Community by Design and the priorities of the Health Board's long-term strategy. Central to achieving this vision is empowered, multi-professional clinical leadership. Modern healthcare demands leaders who can balance quality, performance and sustainability, work across traditional boundaries, use data intelligently and make value-driven decisions. These skills are essential for guiding the redesign work underway through the first phase of the CSP work, where clinically led assessments of challenged or fragile services are informing options for consolidation, redesign or new models of care. This is being built upon in the 'Fragile Services' section of the IMTP, which will identify and address clinical services that meet the principles for fragility in the National Clinical Framework (AR-13). As the CSP progresses, effective leaders will be needed across all sectors; primary, community and secondary care, to drive change at pace, support colleagues through transition and ensure that service improvements translate into better outcomes for patients. To enable this, clearer role definitions, strengthened leadership development offers and more robust job planning and remuneration models will be required. Creating attractive, well-supported clinical leadership roles is essential to engaging clinicians in shaping the future of services and ensuring that redesign is grounded in practical experience and professional insight. By integrating structured clinical service planning with strong inter-professional leadership, the Health Board will be better equipped to make consistent, transparent decisions, strengthen regional working, improve workforce resilience and deliver sustainable, high-value care. This combined approach is critical to realising the ambitions of the 10-year strategy and creating a modern, resilient and equitable healthcare system for North Wales.

Key Delivery Priority Quarterly Update

The Clinical Services Planning (CSP) Programme remains a key strategic enabler for delivering the Health Board's long-term ambition to provide sustainable, high-quality and person-centred services across North Wales. During Q1, significant effort was invested in establishing the foundations required for a clinically led and evidence-based approach to service planning, with a particular focus on building a shared understanding of the organisation's history, current service challenges, future opportunities and lessons learned from previous transformation activity.

A major engagement event, supported by a series of follow-up focus groups, was successfully delivered and provided an important platform for increasing organisational awareness, engagement and understanding of the proposed approach to clinical service planning. This early engagement has strengthened relationships across professional groups and reinforced the importance of multi-professional leadership and collaboration as critical enablers of future service redesign.

Whilst initial engagement activity has been successfully completed, formal agreement of the CSP methodology, confirmation of the first tranche of priority service areas, and establishment of the full programme governance and delivery framework were not achieved within Q1. This reflected a deliberate decision to prioritise programme quality and organisational alignment over pace, ensuring that future CSP activity is built upon a robust understanding of current challenges, strategic priorities and workforce considerations.

As a consequence, the original Q1 milestone is not recoverable within the planned timescale and the establishment phase of the programme has extended into Q2.

The delay in finalising the programme foundations has impacted the critical path for subsequent deliverables, including operationalisation of the programme, commencement of formal service assessments and development of service change proposals. Consequently, there is a significant risk that the original scope and timescales for delivery during 2026/27 will require reprofiling. The extent of this impact is currently being assessed through development of the CSP Programme Initiation Document (PID), which will establish the programme methodology, governance arrangements, delivery model, prioritised scope, sequencing and milestones for the remainder of the year.

Work is progressing to develop a realistic and deliverable programme roadmap that reflects organisational capacity, competing priorities and the lead-in time required to mobilise clinical and operational colleagues. Importantly, the programme recognises that successful clinical service planning will require strong and credible clinical leadership, supported by experienced operational leadership, to drive change across organisational and professional boundaries. Future delivery will therefore be dependent upon securing sufficient programme capacity and identifying senior clinical leaders with the authority, influence and capability to support complex service redesign and decision-making.

Despite the challenges to timescales, the approach being taken remains closely aligned with the principles underpinning the Clinical Services Plan, Community by Design and the wider IMTP. The programme continues to strengthen the foundations for clinically led assessments of fragile and challenged services, ensuring that future decisions are informed by population need, service sustainability, workforce considerations, quality outcomes and opportunities for greater integration across primary, community and secondary care.

Overall, progress during Q1 has focused on establishing the conditions necessary for successful long-term delivery rather than progressing rapidly into formal assessment activity. Whilst this has created short-term delays and increased the likelihood that milestones will require reprofiling, it is expected to provide a stronger platform for sustainable clinical service planning and interprofessional leadership in future phases. Executive Team agreement of the CSP PID, governance arrangements and revised delivery plan during Q2 will be critical to enabling programme mobilisation, clarifying priorities and ensuring delivery remains aligned to the Health Board's strategic transformation objectives.

4D Digital, Data and Intelligence	Director of Digital, Data & Intelligence	Overall Delivery Confidence
4D.13 Implement a comprehensive Digital Skills Assessment and publish Training Needs Analysis and Academy plan on LMS landing page.		Q1
4D.14 Programme of training and development of resources around the principles of Making Data Count to enhance competency in use and presentation of data across the organisation.		Q1
4D.3 Develop and commence implementation a programme of data governance audits to provide assurance on data processing and reporting accuracy.		Q1
4D.6 Develop and implement a Clinical Coding quality dashboard to facilitate improved clinical coding error detection and correction.		Q1
4D.1 Identify and commence implementation of best practice and tools available to support improved organisation wide demand and capacity planning.		Q2
4D.16 To develop a Strategic Outline Case for the digitalisation of paper-based patient records that clearly defines the strategic need, benefits, risks, and options for the project.		Q2
4D.17 Completion of a gap analysis against the requirements of the newly released Cyber Assessment Framework (CAF) version 4 – this will be the tool used by our regulators to measure compliance.		Q2
4D.18 Create and establish a robust AI framework to ensure the appropriate processes, people and governance arrangements are in place. This will provide assurance that the approval/review process in place provides structure for the appropriate and safe use of AI tools which considers all 7 AI principles, covering safety, confidentiality, research, evaluation, partnership, ethics, transparency, and data quality.		Q2
4D.7 Undertake review around opportunity for AI and automation of clinical coding.		Q2
4D.11 Further enhance existing information products to introduce elements of Population Health Management (PHM) e.g. deprivation analysis, further identification of patient cohorts for targeted interventions. (Shared objectives with Public Health Team on PHM).		Q3
4D.4 Develop a data quality framework that makes clear the responsibilities and accountability associated with the collection and management of data across the health board.		Q3
4D.5 Develop proposals for a Robotic Process Automation (RPA) approach and associated implementation plan.		Q3
4D.10 Develop proposals for move from on premises to on cloud analytics, to improve processing speeds, reliability and enabling a broader suite of tools.		Q4
4D.12 Create a suite of population health measures based on existing approaches that will facilitate sustainable healthcare transformation by targeting interventions that prevent ill health, improve care & support for people with ongoing health conditions, and reduce inequalities in health outcomes.		Q4

4D.15 Progressively and systematically decommission and archive unsupported systems and devices in line with available resources, while maximising the efficient use of current supported systems to reduce technical debt, support costs, and safety risk.	Q4
4D.19 To review the organisational wide Digital Roadmap to take into account the 10-year strategy and Clinical Service Plan.	Q4
4D.2 Further development and roll out throughout the year of the data quality kite mark to provide assurance on data quality and accuracy.	Q4
4D.20 Ensure that digital clinical safety, cyber security and information governance risks in relation to digital are considered by the board, and undertake regular board development sessions to develop digital and data competence.	Q4
4D.8 Move to an internal specialty focused training plan for clinical coding trainees, that improves recruitment and retention as well as efficiency.	Q4
4D.9 Work with the Universities on potential applications of advanced analytics and mathematical modelling for use in service planning.	Q4

Overview

Strengthening the Health Board's Digital, data and intelligence capability is fundamental to delivering safer, more efficient and more personalised care across North Wales. Digital systems, high-quality data and robust analytical capability are mutually reinforcing; together, they enable clinicians and operational teams to access reliable information, support timely decision-making and create the foundations for modern, technology-enabled care pathways. As the organisation moves away from fragmented systems and paper-based processes, establishing interoperable, stable and user-centred digital platforms will provide the confidence and consistency needed to support day-to-day care while enabling future transformation. A core part of this shift is improving the quality, governance and usability of data. When data is accurate, standardised and linked across services and organisations, it becomes a powerful asset for population health management, pathway redesign and proactive care. Enhanced analytical tools and improved clinical coding will help unlock insight into patient journeys, variation in care, resource use and opportunities for prevention. This intelligence-led approach allows the Health Board to plan more effectively, reduce duplication, minimise administrative burden and better target interventions to meet the future needs of communities. Digital reliability and data integrity must sit alongside strong cyber security. With the increasing frequency and sophistication of cyber threats to healthcare, integration of resilient infrastructure, clear organisational response plans and strong staff awareness is essential to protect patient information and maintain public trust. A secure environment is also a prerequisite for harnessing innovation, whether through advanced analytics, AI-supported decision-making or more integrated digital pathways. Together, these developments form a coherent, interdependent programme of modernisation. By aligning digital improvement with strengthened data governance, intelligence capabilities and robust cyber security, the Health Board will create a more connected, insight-driven and resilient system landscape, supporting better clinical decisions, a more seamless patient experience and sustainable service improvement across North Wales.

Key Delivery Priority Quarterly Update

1. What have we delivered so far this year towards the aim?

• Developed and implemented a Clinical Coding Quality Dashboard covering approximately 75% of common coding errors.
• Expanded the Data Quality Kite Mark to key datasets, including Referral to Treatment and referrals.
• Established a programme of data governance audits and identified priority areas for review.
• Developed demand and capacity modelling, including a bed modelling pilot now being rolled out Health Board-wide.
• Completed an Robotic Process Automation proof of concept and developed draft proposals for future automation opportunities.
• Established collaboration with Bangor University to support advanced analytics and demand forecasting.
• Developed draft options appraisals for Artificial Intelligence in clinical coding and future clinical coder training models.

2. What impact has the work had on the population of North Wales?

• Improved confidence in the quality and accuracy of data used for operational and strategic decision-making.
• Enhanced clinical coding oversight, supporting more accurate reporting, planning and resource allocation.
• Improved understanding of demand and capacity pressures to support service planning and patient flow.
• Strengthened assurance around data quality, governance and reporting.

• Created foundations for future efficiencies through automation, advanced analytics and improved workforce capability.
While much of the work is foundational, it is helping to build the digital, data and intelligence capability required to improve patient care, service planning and organisational efficiency.

3. What actions are we undertaking to ensure we are on track to deliver by March 2027?

• Continue rollout of demand and capacity modelling across the Health Board.
• Extend the Data Quality Kite Mark and implement the data governance audit programme.
• Finalise and implement the Data Quality Framework.
• Complete RPA and Artificial Intelligence options appraisals and progress priority automation opportunities.
• Expand the Clinical Coding Quality Dashboard to cover all key error indicators.
• Develop and implement a sustainable clinical coding training model.
• Continue partnership working with Bangor University on advanced analytics, forecasting and research opportunities.
Overall, delivery remains on track, with governance arrangements in place and milestone plans supporting achievement of the March 2027 objectives.

4E Research, Development and Innovation	Executive Medical Director	Overall Delivery Confidence
4E.1 RD&I strategic plan and delivery plan approved, aligned to health board strategic intentions and national performance metric.		Q1
4E.2 Develop a proposal for a self-sustaining innovation centre, working with industry and academia, prioritising digital innovations and medical technology, aligned with the NHS Wales Technical Planning Guidance 2026-29 Digital and Innovation enabling plan, and Welsh Government's Innovation Strategy delivery plan.		Q3
4E.3 Work with People Services colleagues to develop and implement a plan to normalise research as a core part of clinical practice by embedding research expectations within job descriptions, appraisal objectives, and job plans for identified priority staff groups, supported by guidance and manager training.		Q4
4E.4 Increase the number of non-commercial and commercial research studies opened by the Health Board and recruitment to those studies, through proactive engagement with sponsors and streamlined feasibility and approval processes.		Q4
4E.5 Work with local academic partners to identify and implement to increase joint appointments and/or honorary contracts, closely working with the Academic Careers Community of Interest, ensuring that posts add value to research and innovation activity and support the above actions.		Q4

Overview Research, Development and Innovation (RD&I) is essential to the Health Board's ability to deliver high quality, modern and sustainable healthcare for the population of North Wales. It provides the evidence base for transforming services, improving outcomes and ensuring that clinical decisions and organisational priorities are grounded in what works. RD&I enables the Health Board to test new technologies, redesign pathways and adopt innovations that improve productivity, enhance safety and reduce unwarranted variation, which are key requirements for recovery, transformation and long-term sustainability. Research active organisations consistently achieve better patient outcomes, attract and retain skilled staff, and foster a culture of continual learning and improvement, all of which are critical for BCUHB as a University Health Board and as an organisation in Special Measures. RD&I also plays a vital role in addressing major system pressures by supporting new models of care, improving diagnostic and treatment options, and generating solutions that help meet rising demand within constrained resources. Strong RD&I capability supports national priorities such as A Healthier Wales and value-based healthcare, while expanding opportunities for citizens to access cutting edge treatments and innovative approaches. Embedding RD&I into everyday practice therefore strengthens organisational resilience, accelerates transformation and directly contributes to better outcomes and experiences for the people of North Wales.
Key Delivery Priority Quarterly Update Research and innovation continue to make an important contribution to service improvement, transformation and patient outcomes across the Health Board. Through research activity, innovation adoption and partnership working, we are supporting the development of new models of care, improving access to evidence-based interventions and helping to embed a culture of continuous improvement. Whilst challenges remain around research support service capacity, actions are underway through an agreed recovery plan to strengthen infrastructure and ensure sustainable delivery. We are also actively contributing to national and local initiatives to embed research and innovation within routine NHS practice, recognising their role in improving quality, supporting workforce development, driving transformation and delivering better outcomes for the population of North Wales.

4F Education Partnership and Projects, Academic Careers and Strategic Alignment of Education	Executive Director of People Services & Organisational Development	Overall Delivery Confidence

4F.1 Work with Further and Higher Education Partners to capture their contribution to the development of the Health Board's clinical services plan so that education provision across the region can reflect the future development of healthcare.	Q1
4F.6 Commence full business case for the North Wales Medical school in partnership with Bangor University.	Q1
4F.7 Conduct an analysis as to the key barriers in establishing academic careers and update the pathway framework accordingly.	Q2
4F.8 Having established an Academic Careers Community of Practice to bring together academics across BCUHB, develop a delivery plan which will outline how we should enhance their work and maximise its impact within BCUHB.	Q2
4F.9 Develop a proposal for an interprofessional governance structure setting out clear governance routes and alignment of education to strategic workforce planning and the quality, safety and experience of our services.	Q2
4F.2 Review and set out proposals to the Health Board on requirements to meet Memoranda of Understanding with Further and Higher Education Partners and reflect in delivery plans aligned to national programmes and strategies, with agreed key metrics and baselines.	Q3
4F.3 Review opportunities for BCUHB to support the Tertiary Alliance formed between Bangor University, Wrexham University, Grwp Llandrillo Menai and Coleg Cambria.	Q3
4F.10 Progress to the Design Phase for education and training, agreeing priorities together with the development of an underpinning Strategic Education Plan which aligns to HEIW and local commissioning of education and training.	Q4
4F.11 Collaboration with education colleagues to comply with the duties set out in the Additional Learning Needs and Education Tribunal (Wales) Act.	Q4
4F.4 Continue to support the development of the proposed Dental School and input into associated business cases.	Q4
4F.5 Submit an evaluation of progress against the aspirations set out in the Memoranda of Understanding with Further and Higher Education Partners, providing recommendations on how performance against key metrics may be enhanced.	Q4

Overview
As a University Health Board, we are proud of the opportunities and responsibilities that come with this status. In addition to research, development and innovation, being a university-designated organisation strengthens our commitment to high quality education and training, our partnerships with Higher and Further education and our development of academic careers. These areas are crucial for building a skilled workforce, improving the quality of our services, and making North Wales an appealing place for current and future healthcare professionals. Our approach is supported by clear internal governance and strong partnerships with universities and national bodies. These relationships help

ensure our work in education, research and innovation supports national expectations as well as local priorities. In Year 1 of this plan, we will build on the progress made in 2025/26, including our memoranda of understanding with universities and further education colleges, the creation of the Education Steering Group, and the establishment of the Academic Careers Community of Practice. Our focus will be on delivering key milestones, strengthening governance, commencing workforce planning to aid most effective working with Higher Education Partners to consolidate professional pipeline and creating the conditions for visible and meaningful improvements. This will build upon our Discovery Report as we progress our work through Design into the Delivery Phase. We will continue to play an active role in national programmes such as Health Care Research Wales (HCRW) academic careers programme and Health Education and Improvement Wales (HEIW) emerging education strategy. We also anticipate new opportunities from the Tertiary Alliance, which brings together further and higher education institutions across North Wales. Years 2 and 3 will consolidate our progress, strengthen our regional impact with partners and embed continuous improvement so that the delivery of education and development of academic careers remain central to how we deliver care. BCUHB has achieved University Designation Status, a Wales-wide accreditation awarded to organisations that demonstrate strong and purposeful activity in research, education, and innovation. This status reflects BCUHB's robust strategic partnerships, particularly with universities, which help shape shared priorities in training, research, and innovation. It also supports long-term academic collaborations that enhance staff development, attract and retain a skilled workforce, and ultimately improve patient care and outcomes. While centred on university partnerships, the designation also encompasses wider collaboration with both Higher and Further Education institutions, strengthening the pipeline of the future healthcare workforce. For BCUHB, University Designation Status reinforces its role as research active, education focused organisation and supports service quality, workforce sustainability, and better outcomes for the population it serves.

Key Delivery Priority Quarterly Update

Q1 has seen progress made across all areas for the deliverables under Education Partnership & Projects, Academic Careers and Strategic Alignment of Education.

Key areas of progress include:

- Agreement of Memoranda of Understanding (MoU) with all HE and FE partners.
- Establishment of Strategic Steering Groups to oversee the delivery of the aspirations laid out in the MoUs
- Positive responses to the planned engagement with HE and FE partners with regard to the Clinical Services Plan and opportunities that the North Wales Tertiary Alliance may bring.
- Governance structure and programme plan developed and implemented for the capital programme associated with the North Wales Medical School.
- Literature review undertaken to understand key barriers to embedding academic careers in the workforce.

The above puts in place the foundations for the future work under this strategic deliverable and, whilst there may be some lag between quarters, there is a high level of confidence in the overall delivery during 2026/27.

4G Value & Sustainability	Executive Director of Finance	Overall Delivery Confidence
4G.4 Develop a Clinical Variation programme to deliver against the core thematic, which have been identified through the national Clinical Variation & Service Reconfiguration Group, with a particular focus on reducing unwarranted clinical variation, minimising waste, improving efficiency and ensuring sustainable service configuration.		Q1
4G.5 Develop a Non-Pay & Procurement programme to deliver against the core thematic, which have been identified through the national Non-Pay & Procurement Value & Sustainability Group, with a particular focus on reducing clinical variation to maximise benefits in relation to price and product standardisation.		Q1
4G.6 Develop a Medicines Management programme to deliver against the seven priority areas, which have been identified through the Directors of Pharmacy's Medicines Value and Sustainability Delivery Assurance Group and endorsed by the NHS Value and Sustainability Board.		Q1
4G.7 Develop a CHC programme to deliver against the seven priority areas, which have been identified through the national CHC Value & Sustainability Group.		Q1
4G.9 Develop a robust benefits framework for the programme, which allows for the effective measurement of activity and resources linked to VBHC (clinical staff, administrative staff, budgets, buildings, energy etc) to improve patient outcomes, patient experience and resource efficiency to ensure value and patient-centred care.		Q1
4G.1 Review current progress with the implementation of the Value & Sustainability Board 'Bone Health' High Value High Impact (HVHI) pathway and produce a proposal to support further implementation.		Q2
4G.2 Review current progress with the implementation of the Value & Sustainability Board Diabetes' High Value High Impact (HVHI) pathway and produce a proposal to support further implementation. This is to be managed as part of the Primary Care IMTP plans.		Q3
4G.10 Use Value Based Health Care (VBHC) guidance for designing services, responding to key population level intelligence including OECD PaRIS report 2025 - Value in Health and through service level Patient Reported Outcome Measurements (PROMs), Patient Reported Experience Measurements (PREMs) and social value measures for procurement. This is to be managed as part of the Clinical Services Plan		Q4
4G.11 As part of our refined planning process, we will utilise the value-based approach that provides the discipline to stop low-value activity, shifting finite resources to prevention and earlier access, community-based care, better-value interventions, and supporting people to manage more of their own health. All of our major investment and dis-investment decisions should therefore be assessed according to their impact on outcomes, experiences, and the value generated from resources used. This is to be overseen by the Planning Team.		Q4

4G.12 Deliver a refreshed Value & Sustainability programme that realises the agreed recurrent savings target for 26/27, aligned with the national value and sustainability structure and associated priorities and which also ensures that savings and mitigations delivered in 2025/26 are maintained in full on a recurrent basis.	Q4
4G.3 Address variation reported in the National Outcomes Framework and National Clinical Audit and Outcome Review Programme.	Q4
4G.8 Develop a 'bottom-up' value programme for staff to register their value ideas/initiatives, with advice, guidance and resource provided where appropriate to mature ideas into delivery.	Q4

Overview
The Health Board supports the national focus on Value and Sustainability (V&S) and will implement V&S initiatives identified internally, by other Health Boards, or through the national Value and Sustainability Board. Focusing on the value of care helps ensure resources are used in ways that improve the outcomes that matter most to individuals. By weighing the costs against these outcomes, the Health Board can make decisions that deliver the greatest impact with available resources. Sustainability is a key part of Quality Planning. Services struggling with sustainability also often face challenges in Quality Control and the subsequent capacity to improve quality. The Health Board has made progress in developing a formal approach to its V&S goals, including embedding Value-Based Healthcare principles across the organisation. This approach focuses on workstreams that deliver better quality outcomes, experiences, and resource use, while contributing to and benefiting from the national Value and Sustainability Board's work. This national work covers six work-streams: 1) Clinical Variation, 2) Workforce, 3) Continuing Healthcare (CHC), 4) Medicines Management, 5) Non-Pay & Procurement and 6) Value Based Healthcare (VBHC).

Key Delivery Priority Quarterly Update
The V&S programme have identified a portfolio of projects (circa 136 schemes) to support the delivery of the Health Board's savings programme, with £43.7m of opportunities identified, of which £24.1m have transitioned to Green RAG delivery.

Work continues to transition the programme away from an exclusive CIP/Financial Recovery Programme and into a 'Value' programme, with equal emphasis on the other value lenses, particularly outcomes, experience & sustainability. To support this, a benefits framework has been developed to capture both financial and non-financial metrics of value.

A portfolio of Value-Based Health Care projects have been commissioned/funded through a ring-fenced value budget to support innovative practice, with schemes such as Lymphoedema showing demonstrable impact on reducing disease progression, through education and training, Community Health Pathways (CHP's) looking to improve referral quality, ensure patients transition to the right place, at the right time and reduce demand that is better managed in a non-acute setting and Prehab, which has a wealth of positive outcome data, including reductions in mortality.

To drive the long term direction of the programme (with a robust methodology and evidence-base), a Value Maturity Assessment Framework has been developed to assess organisational maturity and the score an insight will be used to drive the long term strategy.

4H Quality	Executive Director of Nursing	Overall Delivery Confidence
4H.4 Deliver on findings of internal audit of NICE compliance by focussing on areas where NICE guidance not implemented with clear process of reviewing impact and addressing if significant risk.		Q1
4H.5 Develop programme of Tier 2 audits based on current quality risks.		Q1
4H.1 Develop a comprehensive organisational plan, aligned to Foundations for the Future, to embed the QMS into all core business processes and fully onboard every service to the QMS Maturity App, enabling systematic identification and response to fragile services.		Q2
4H.11 We will reduce severe and catastrophic incident numbers and monitor improvement and learning through the Integrated concerns Hub.		Q2
4H.3 Re-design and implementation of quality governance framework to include implementation of quality issues log.		Q2
4H.8 Refresh of NatSSIPs programme to address recent Never Events and reintroduce a revised ward accreditation programme in line with the QMS methodology.		Q2
4H.9 Implement the new Listening to People Regulations and deliver on the 40% national performance target.		Q2
4H.10 Meet the nationally set Infection Prevention trajectories and reduce the incidents of infections (including C-Diff and E. coli) and associated harm, through implementation of the IPC improvement plan.		Q3
4H.12 We will reduce the number of avoidable falls and HAPU through continuing to implement the actions identified in the associated improvement groups.		Q3
4H.7 Develop a programme of work and governance framework to address digital safety.		Q3
4H.13 We will fully implement the learning repository and have clear outcomes with regard to robust and sustained organisational learning and how it positively impacts outcomes.		Q4
4H.14 Provide direction and oversight through the organisation's Quality governance for the application of appropriate best practice within the national Quality Statements - the ones not covered elsewhere in the plan are: Care of the critically ill, Respiratory Disease, Heart conditions, Kidney Disease, Liver Disease, Musculoskeletal health, Neurological conditions, Stroke, Infection prevention and control, Osteoporosis and bone health.		Q4
4H.2 Develop and begin implementation of a Health Board–wide Quality Accreditation Framework aligned to QMS and regulatory standards, recognising and incentivising excellence.		Q4

4H.6 Develop programme of work to address priority programmes and actions within National Patient Safety Strategy including key performance indicators to measure improvement.	Q4

Overview
High quality and safe care is the Health Board's foremost priority. Delivering safe, effective, compassionate and person-centred services is fundamental to building confidence, meeting statutory duties, and improving outcomes for the population we serve. Quality is not an isolated function; it is the collective responsibility of every part of the organisation and underpins our ability to meet safety standards, performance expectations, deliver value, and use our resources effectively. Sustained operational pressures, workforce constraints, financial challenge and rising demand all increase the risk of variable quality and unmet need. In this context, a consistent, transparent and well governed approach to quality is essential. A mature Quality Management System (QMS) provides the structure required to plan for high quality, intervene early where fragility exists, improve care where needed, control variation, and assure the Board and public of the standard of safe services delivered. Building on our current QMS, the organisation will systematically identify fragile and high risk services and ensure improvement plans are driven by real time intelligence and evidence of impact. Expanding quality control measures to include locally meaningful indicators will strengthen frontline ownership of quality, while reviewing and modernising our governance framework, aligned with internal audit recommendations, external scrutiny, and national policies, will reinforce interprofessional accountability. This includes the introduction of a Quality Issues Log to complement the risk framework and ensure clearer escalation, thematic analysis, and organisational learning. Quality and safety must also be rooted in learning. Strengthening our approach to mortality review, harm analysis, patient safety incidents and complaints will ensure that learning translates into meaningful improvement for patient safety, experience and

performance. Close partnership with operational teams is essential so that insights become action, and assurance reflects real change. 2026/27 brings several statutory and national changes that heighten the importance of a consistent approach to quality. These include: Listening to People Regulations, National Cleaning Standards, Duty of Quality and Duty of Candour and Infection Prevention national targets. Leadership in these areas is critical, along with ensuring that patients always have the option to converse through the medium of Welsh, which should also be considered an issue of quality and safety. The Health Board maintains strong governance structures aligned with the NHS Wales Safeguarding Network, which has highlighted national priorities such as improved child protection medical assessments, strengthened pathways for vulnerable groups, and enhanced support for professionals through reflective supervision. Embedding these requirements within our QMS and governance structures is essential to ensure compliance, transparency, and progress towards de-escalation from targeted intervention. Quality is therefore a critical enabler of organisational recovery, sustainable improvement, and the delivery of safe, effective and equitable care for our communities. Our 2026/27 priorities align to the statutory NHS Wales Planning Framework 2024–2027, which emphasises integrated, sustainable improvement within the constraints of unprecedented operational and financial pressures. These commitments support the Health Board's role in protecting the most vulnerable, reducing avoidable harm, and ensuring the safety and wellbeing of the population we serve. The Health Board is open regarding its biggest quality challenges, incorporating safety, effectiveness and experience. Access to services presents the single greatest quality problem in a number of areas, most visibly in urgent and emergency care pathways and in planned care, diagnostics and cancer pathways. Improving access will improve safety, effectiveness and experience and simultaneously will help improve colleagues' well-being and fulfilment in the workplace. This is why the Board places such emphasis on operational service planning and improvement in delivery, and the reason for external expertise being secured to help both target and accelerate the improvement work in this area.

Key Delivery Priority Quarterly Update

During Quarter 1, the Health Board has maintained its focus on strengthening quality and safety arrangements through the continued implementation of its Quality Management System (QMS). Work remains ongoing to ensure a consistent, transparent and evidence-based approach to quality governance, supporting organisational recovery, service improvement and assurance.

Progress has continued in the identification and oversight of fragile and high-risk services, with quality intelligence, performance information and risk data being reviewed through established governance arrangements. The Health Board has maintained a strong focus on ensuring that improvement actions are informed by real-time intelligence and evidence of impact, supporting earlier intervention where quality concerns emerge.

Development of the QMS continues, with ongoing work to strengthen quality control measures and promote greater ownership of quality at service level. Plans to enhance local quality indicators and improve the visibility of quality information remain on track, supporting a more proactive approach to improvement and assurance. Work is also continuing to review and modernise elements of the quality governance framework, ensuring alignment with internal audit recommendations, external scrutiny requirements and national policy expectations. The Quality Issues Log has been further embedded within governance processes to support escalation, thematic review and organisational learning.

The Health Board has sustained its commitment to learning from mortality reviews, patient safety incidents, complaints and harm events. Established mechanisms for sharing learning and monitoring improvement actions continue to support patient safety, quality of care and service experience. Close collaboration between quality and operational teams remains a key priority to ensure that learning translates into meaningful and measurable improvement.

Preparatory work and implementation activity relating to statutory and national requirements for 2026/27 continue to progress. This includes ongoing oversight of the Listening to People Regulations, National Cleaning Standards, Duty of Quality, Duty of Candour and Infection Prevention and Control requirements. Welsh language considerations continue to be promoted as an integral component of safe, person-centred and equitable care.

Safeguarding remains a priority area, with governance arrangements continuing to align with NHS Wales safeguarding expectations. Work is progressing to strengthen pathways

for vulnerable individuals, support professional practice and maintain compliance with national safeguarding requirements. Oversight through existing governance structures continues to provide assurance regarding delivery against national priorities.
Quality and safety continue to be recognised as critical enablers of organisational improvement and recovery. Quarter 1 has seen sustained focus on reducing avoidable harm, strengthening governance and embedding continuous improvement approaches across services.
The Health Board remains open about its most significant quality challenges. Access to services continues to represent the most significant quality risk across a number of pathways, particularly within urgent and emergency care, planned care, diagnostics and cancer services. While performance pressures remain considerable, improving access continues to be a major organisational priority, recognising the direct impact on patient safety, clinical outcomes, patient experience and staff wellbeing. Improvement programmes and operational recovery work remain underway, supported by external expertise where appropriate, with continued focus on improving performance and reducing variation across services.

4I Environment and Estates	Director of Environment & Estates	Overall Delivery Confidence
4I.3 Plas Gororau (Wrexham) Phase 2 - Commence construction.		Q1
4I.4 Develop and commence implementation of an organisation wide anti-ligature programme.		Q2
4I.7 Ensure strengthened actions are taken to improve estate utilisation including the appropriate repurposing & disposal of under-utilised estate and the reduction in the number of leases.		Q2
4I.8 Implement a computer aided facilities management system to support the management of the estate and the implementation of AI based energy management applications.		Q2
4I.9 Development of a pan-BCU approach to managing car parking for staff and patients.		Q2
4I.11 Maximising the access to grant funding through the Refit Framework to deliver a programme of works to support carbon reduction.		Q3
4I.6 Commence engagement regarding the potential future redevelopment of the Wrexham Maelor Hospital site.		Q3
4I.1 Develop long-term plans for the delivery of the key estates projects including 1) Business continuity scheme for Ysbyty Gwynedd, 2) Electrical infrastructure replacement scheme for Ysbyty Glan Clwyd, 3) Business Continuity scheme for Wrexham Maelor Hospital, 4) Replacement helipads at Ysbyty Gwynedd and Ysbyty Glan Clwyd.		Q4

4I.10 Develop a BCUHB Climate Adaptation plan aligned with the NHS Wales Decarbonisation Plan and in parallel implement estate decarbonisation programmes.	Q4
4I.12 Commence construction of the photo-voltaic array at Ysbyty Gwynedd as part of adopting renewable energy technologies.	Q4
4I.2 Royal Alexandra Hospital (Rhyl) Phase 2 – Complete the schedule of accommodation and strategic outline case	Q4
4I.5 Agree the approach to developing a revised Estates Strategic Plan, in line with the Health Board's 10-year Strategy and Clinical Services Plan.	Q4

Overview
The Health Board's estate is a valuable asset with the potential to create environments which are efficient and effective. The quality of the physical environment is a key element of the Health Board's strategic intent to create a modern, people-centred healthcare system. It is fundamental to the provision of patient care, and to staff well-being. The estate is ageing with over £240m of backlog maintenance recorded and therefore the Health Board should maximise opportunities to replace and refurbish estate using capital funding. In parallel, the Health Board should review the estate to explore opportunities to reduce space which can be undertaken allied to other objectives such as the move to community health care as well as prevention – a reduction in just 2% of the poorest or least used estate could support more cost-effective operations. The Health Board has a current Estate Strategy which was completed in January 2023 with many areas still relevant such as Rationalisation and the implementation of Health and Wellbeing Hubs, but it requires refreshing and potentially alignment with developing clinical service plans. The capital programme seeks to be a balance of investment in assets to address compliance, mitigate risks to service delivery and support the Health Board and Welsh Government priorities within the current plan. The programme contains capital projects that have followed a robust process of being evaluated and prioritised within the limited resources. The Health Boards capital programme comprises a number of potential funding sources, namely the All-Wales Capital Programme, project specific grant support, discretionary capital, property sale receipts and charitable funding. The Targeted Estates Fund has supported major refurbishments and energy efficiency programmes. The development of partnership schemes is important as part of the Health Board's obligations as an anchor institution in North Wales, as well as being part of the focus on health and wellbeing through every stage of life and supporting enhanced coordination of care. NHS Wales has a Decarbonisation Strategic Delivery Plan. The Health Board recognises the need to adapt to irreversible climate change and will respond at a range of levels aligned to the Plan. The response will include Buildings and land, Fleet, Staff Travel and Homeworking, Procurement and Supply Chain, Clinical Services and Waste utilising the relevant stakeholders

within the Health Board. The objective will be to develop strategies and progress decarbonising our operations as much as possible. Through coordinated and innovative approaches, we can deliver a fit for purpose, resilient, efficient and effective estate from which to deliver sustainable health care.

Key Delivery Priority Quarterly Update

The Environment and Estates Programme remain central to delivering the Health Board's ambition for a modern, sustainable and resilient healthcare estate capable of supporting future models of care. Progress has been made across a number of priority capital schemes, infrastructure developments and sustainability initiatives; however, several strategic programmes continue to face challenges associated with capacity, affordability and wider organisational dependencies.

Notable progress has been achieved within the capital programme. Construction activity has commenced on the replacement helipad programme, supporting improved resilience and emergency access arrangements at key acute hospital sites. Plas Gororau Phase 2 has also successfully progressed into delivery, with the construction contract awarded, the contractor now on site and completion scheduled for May 2027. In addition, preparatory work is underway for the proposed photovoltaic array at Ysbyty Gwynedd, with site valuation agreed and planning activities commencing, representing a significant step forward in the Health Board's renewable energy ambitions.

Work continues to progress on a number of strategic infrastructure priorities, including the development of long-term plans for major business continuity and infrastructure replacement schemes at Ysbyty Gwynedd, Ysbyty Glan Clwyd and Wrexham Maelor Hospital. Discussions with Welsh Government remain ongoing to establish future funding and delivery approaches for these significant investments, recognising their importance in addressing ageing infrastructure and mitigating operational risk across the estate.

A number of enabling programmes are also advancing. Initial work has commenced to strengthen estate utilisation through the development of space management and estate rationalisation approaches, supporting opportunities to improve efficiency, optimise asset use and reduce reliance on under-utilised accommodation and leased premises. Progress has also been made towards implementing a Computer Aided Facilities Management (CAFM) system, with market appraisal work underway and recruitment plans agreed for dedicated energy and sustainability leadership capacity. Stakeholder engagement has additionally commenced on the development of a pan-BCUHB approach to car parking management for staff and patients.

While progress has been made, several strategic deliverables remain at an early stage or are experiencing delays. Development of a revised Estates Strategic Plan has been constrained by the absence of an agreed Clinical Services Plan, alongside resource limitations affecting the ability to undertake the necessary planning and analytical work. Similarly, progress on the redevelopment of the Wrexham Maelor Hospital site remains limited, with financial considerations and broader stakeholder alignment continuing to present challenges despite ongoing engagement with Welsh Government.

The Health Board's sustainability and decarbonisation agenda has continued to move forward through ongoing discussions with the REFIT programme regarding potential grant funding opportunities to support carbon reduction initiatives. However, development of a comprehensive Climate Adaptation Plan remains delayed pending organisational decisions and the recruitment of dedicated resources to lead this agenda. Recruitment plans are in place and will be progressed once wider organisational programmes have concluded.

Overall, the programme reflects a mixed but positive position. Key capital projects are moving into delivery, strategic infrastructure planning is progressing, and important foundations are being established to improve estate utilisation, asset management and sustainability. Continued focus will be required to address resource constraints, strengthen alignment with emerging clinical strategies, secure future capital funding and accelerate progress on decarbonisation and long-term estate transformation priorities.

4J Workforce	Executive Director of People Services & Organisational Development	Overall Delivery Confidence
4J.1 Review of Consultant job plans – Operational Services to be targeted to reach >90% to ensure improved workforce productivity and alignment to demand and capacity. This will be measured through the Job Planning Dashboard and follows on from work undertaken in 2025/26.		Q2
4J.2 Review of agency expenditure. Operational Services to be targeted with a 30% reduction in agency expenditure. All services to be targeted with no off-contract agency use and not Admin and Clerical, Estates and Ancillary and Health care Support Worker agency use through effective workforce planning, optimising the benefits of the newly insourced medical bank resource and management controls. This will be measured through the Value & Sustainability (V&S) Group.		Q2
4J.3 Fully implement the actions outlined in the Variable Pay & Agency Control Framework Welsh Health Circular by continuing to reduce agency requirements and incentivise substantive positions through flexible working, effective rostering and employee health and wellbeing programmes of work.		Q4
4J.4 Work with operational and corporate directors to implement and deliver the Health Board's sickness absence delivery plan to improve workplace attendance levels and to meet national sickness absence and local stretch targets. Progress will be monitored through the People and Culture Committee.		Q4
4J.5 Implement and deliver the year 1 actions from the Culture, Leadership and Engagement 3-year Improvement plan 2026-29.		Q4
4J.6 Review and respond to staff survey feedback to support an improvement in staff engagement and satisfaction.		Q4
4J.7 Implement in partnership strategic workforce planning across the organisation, improving alignment with Clinical Service Plans, use of technology, Financial Plans linked to IMTP objectives. Progress will be measured through the Foundations for the Future programme board. Plans will proactively identify any workforce capacity, skills and talent gaps and set out initiatives to address these in order to meet organisational objectives.		Q4
4J.8 Prepare the annual social partnership report outlining what the Health Board has done to comply with the Social Partnership Duty, agreeing it with Trade Unions and submitting to the Social Partnership Council (SPC) as soon as possible after the end of the financial year.		Q4

Overview
Workforce planning is a core organisational priority because the Health Board's ability to deliver safe, effective and sustainable care depends on a workforce that is strategically aligned, with the right and capabilities, in roles designed to be adaptable to changing population needs. The system continues to face increased clinical complexity, rising demand

for services, complex population health needs and inequalities, all within a constrained financial environment. A structured, evidence-based approach to workforce planning is essential to ensuring that staffing models are directly aligned to service redesign, use of technology and the broader transformation ambitions underpinned by the Clinical Services Plan and Community by Design, as set out in the IMTP. Embedding Health Education and Improvement Wales' (HEIW) Six Steps Workforce Planning Methodology supports this strategic shift, enabling services to base decisions on robust data, demand modelling and integrated workforce, finance and activity assumptions. A clear example of the importance of this approach is the progress made within the qualified nursing workforce. Over the next three years, the Health Board expects to reach full establishment for registered nurses for the first time in over a decade, creating stability. As these pressures begin to ease, workforce planning allows the organisation to pivot toward emerging and persistent shortage areas, such as medical specialties with national supply challenges, mental health, primary care, and hard to recruit allied health and diagnostic professions. This shift will be supported by designing multidisciplinary teams around new roles, including Advanced Clinical Practitioners, ensuring that workforce models reflect the changing needs of patients/service users and the future direction of care delivery. Effective workforce planning also reduces reliance on agency staffing, strengthens job planning and improves quality, safety and productivity, supporting a more stable and attractive working environment. Ultimately, embedding workforce planning as a core organisational discipline ensures services remain clinically viable, financially sustainable and capable of delivering high quality, person-centred care for the population of North Wales, both now and in the years ahead.

Key Delivery Priority Quarterly Update

Workforce planning remains a critical enabling programme underpinning the Health Board's ability to deliver safe, sustainable and financially viable services. During the reporting period, progress has continued across a number of key workforce priorities aligned to the IMTP, Foundations for the Future Programme, Clinical Services Plan and wider organisational transformation agenda.

Strategic workforce planning activity has strengthened through direct support to Fragile Services, with workforce plans and associated action plans being developed to stabilise services and address workforce risks. Governance arrangements and standard operating procedures are being enhanced, with increased collaboration between Workforce, Transformation and Improvement teams to ensure workforce planning is embedded within service redesign activity. In parallel, the establishment of the Interprofessional Education Group is supporting greater alignment between workforce planning, education commissioning and future workforce supply requirements, whilst ongoing engagement with HEIW is informing the development of future workforce modelling and planning tools.

Delivery against workforce productivity priorities has continued, although progress has been impacted by delays in ratification of the revised Consultant Job Planning Policy. As a result, achievement of the target for over 90% consultant job plan compliance has been slower than anticipated, with compliance levels further affected by a significant number of historic job plans expiring at the end of March 2026. Operational teams continue to work towards improving compliance wherever possible, with progression expected once the policy is formally agreed and implemented.

Work to reduce temporary staffing reliance and optimise workforce deployment remains a key focus. Improved organisational visibility, scrutiny and challenge of long-term medical agency usage is now in place, supported by strengthened governance through the Value and Sustainability Programme. Actions are being taken alongside the insourced medical bank service to reduce agency dependence, with additional control measures identified through the Variable Pay and Agency Control Framework. Delivery remains achievable provided planned controls and workforce management interventions continue to be embedded over the coming months.

Workforce wellbeing and attendance continue to receive targeted attention. Enhanced localised sickness absence reporting has been introduced, enabling People Services and operational teams to focus interventions on identified hotspot areas. Progress is being monitored through local performance arrangements and the People and Culture Committee, supported by a detailed delivery plan aimed at improving attendance rates and achieving both national and local performance targets.

Progress has also been made in implementing the Culture, Leadership and Engagement Improvement Plan and responding to staff feedback. A number of foundational initiatives are now underway, including development and pilot testing of a values-based appraisal framework, strengthening organisational culture and behavioural expectations, enhancing induction and transition arrangements, reviewing governance processes to support more effective decision-making, and developing organisational metrics to measure cultural improvement and staff engagement. Further work is progressing on staff recognition, leadership role redesign and organisational development activities through the Foundations for the Future programme.

Social Partnership continues to be embedded as a core way of working, with engagement and partnership activity taking place throughout the year. Preparatory work for the Annual Social Partnership Report is progressing through routine workforce and partnership arrangements, ensuring compliance with statutory duties and continued collaboration with Trade Union partners.
Overall, progress demonstrates continued movement towards a more strategic, integrated and evidence-based approach to workforce planning. Whilst some key enablers, notably consultant job planning policy approval, have impacted the pace of delivery in specific areas, the Health Board is strengthening the systems, governance and workforce intelligence required to support sustainable workforce transformation, reduce temporary staffing dependence and align future workforce capacity and capability with service, financial and population health priorities.

4K Finance & Commissioning	Executive Director of Finance	Overall Delivery Confidence
4K.2 Contribute to the broader performance accountability agreements to ensure that budget owners are clear on their budget for the year and their accountabilities in relation to delivery within budget.		Q1
4K.1 Maintain financial control measures from start of financial year, with a view to step them down as assurance and confidence is being gained in delivery of the financial plan. Particularly important due to FFTF structure changes mid-year that could otherwise cause some disruption in delivery of financial plan.		Q2
4K.3 Contribute to all the workstreams within the Value & Sustainability programme with a particular focus on those that are more traditionally related to financial management such as non-pay and ensuring there is a focus and visibility associated to savings in non-core areas and overheads to prioritise front-line services.		Q2

4K.5 Develop and commence implementation of a Commissioning Strategic Approach for all externally commissioned healthcare activities, that provides direction to the organisation on the role of commissioned services as part of longer-term strategic planning. Forming strategic partnerships will be an important part of the Clinical Services Plan work.	Q2
4K.10 Develop robust commissioning plans for planned care services to secure additional capacity that addresses service backlogs and demand beyond internal capability. Establish and implement a comprehensive process that defines internal resource requirements and incorporates the full procurement, governance, and mobilisation pathway needed to deliver the required capacity.	Q3
4K.12 Work with the Joint Commissioning Committee (JCC) to develop a financially balanced plan for the delivery of specialist services for the Health Board's population. Ensure consistent and effective representation from BCU at all JCC meetings and support a constructive approach to handling challenges. Proactively engage with the JCC to contribute to: - Efficiency and productivity schemes that collaboratively manage demand and cost pressures e.g. referral management. - o New clinical models in relation to Emergency Ambulance Services. - Save a Life Cymru (SALC) defibrillator awareness. o New air bases for the Emergency Medical Retrieval Service (EMRTS).Adult Critical Care Transfer Service (ACCTS) in line with the Health Board's emerging Clinical Services Plan. o Non-Emergency Patient Transport Service (NEPTS) transformation. o Neonatal Transport (CHANTS) & Major Trauma pathways. o Clinical engagement and partnership in Sexual Assault Referral Centres (SARC). o Improved commissioning and strategic partnerships with hospices and the Voluntary Sector. o A strategic review of Mental Health, Learning Disabilities and Vulnerable Groups commissioning. o Strategic reviews and deep dives relating to specialised services commissioned services across Cancer & Blood, Cardiac, Kidney, Neurosciences and Women & Children's services.	Q3
4K.13 Prepare and commence execution of a robust and sustainable recovery plan, as detailed within Standing Financial Instructions, following submission of an in-year deficit outturn	Q3
4K.4 Repeat the exercise to quantify current spend on primary and community services to compare against the baseline produced in 2025/26, in order to ascertain whether the required strategic move to proportionately increasing investment into primary and community care when compared to secondary care is happening.	Q3
4K.6 Create an Integrated Commissioning Framework that includes commissioning assurance, and clarity of roles and responsibilities, ensuring that everyone across the organisation is clear on roles to enable effective commissioning with a focus on value, quality and patient outcomes.	Q3
4K.8 In advance of the annual review of all services, undertake a risk-based review of contracts to ensure they are delivering value against current population need.	Q3

4K.11 Complete a review of performance monitoring arrangements for all existing commissioned services, ensuring that an appropriately broad set of performance metrics are covered along with consistent periodic commissioned services partner review meetings.	Q4
4K.7 Individual services to undertake an annual review of all their commissioned and contracted services as part of the IMTP process to ensure that the right strategic decisions are made on what the organisation should provide or commission. This should trigger de-commissioning, re-commissioning, as well as commissioning of new services where that best meets the needs of the population.	Q4
4K.9 Undertake a review to provide assurance that the Health Board is operating in accordance with the national hospice commissioning guidance in relation to palliative and end of life care.	Q4

Overview

The core purpose of the Financial Plan is to reflect the financial impact of the decisions and service developments contained within the IMTP and support the fundamental aims and strategic objectives of the Health Board. As a Health Board there is a statutory duty to breakeven against the resource limit set by Welsh Government, over a three-year period. The financial planning element of the IMTP plays a critical role in ensuring the organisation can meet its obligations both to the public and to Welsh Government. A strong financial plan reflects the financial consequences of service choices, prioritises what can be delivered, and ensures that the organisation remains viable and resilient in the face of increasing pressure and demand. Given the financial climate facing the NHS, the priority placed on effective organisational planning, especially financial planning, now is greater than ever. As the Health Board enters 2026/27, it does so against a backdrop of ongoing financial challenge, with underlying deficits and rising service pressures continuing from 2025/26. Even with an uplift in funding, achieving financial sustainability requires robust financial governance, disciplined prioritisation, a credible savings programme, optimisation of resources, and a clear understanding of the three-year financial trajectory. The plan therefore focuses on delivering an ambitious but realistic position, whilst laying the foundations for a productive, efficient and financially sustainable workforce capable of delivering high quality care. The Health Board needs to strengthen its internal commissioning function to improve services contracted from other organisations, including healthcare providers, local authorities and third-sector partners. This will support the 'shift left' and de-medicalisation of some services in line with "A Healthier Wales." Following the pandemic, many services were contracted on a block basis, limiting the ability to focus on quality and outcomes. Moving towards a commissioning approach that better considers population needs, priorities, and quality monitoring will improve the value of these services and support local and third-sector involvement. A timely and systematic commissioning framework will also help partners plan and promote integrated care across North Wales. The Health Board has struggled to recover and improve the efficiency of planned care post-pandemic. Strengthening operational planning and applying commissioning principles will help improve this process. Prioritising these efforts will allow the Health Board to refocus contracts on value and quality, improving demand and capacity planning for better service procurement.

Key Delivery Priority Quarterly Update

1. What have we delivered so far this year towards the aim?

Significant progress has been made in strengthening the Health Board's commissioning and financial governance arrangements.
Key milestones delivered include:
• Approval of the Commissioning Assurance Framework (CAF) by the Board on 28 May 2026, establishing the governance framework for commissioning oversight and contract

assurance.
• Commencement of implementation planning for a dedicated Executive Commissioning and Contracts Group to oversee delivery of the CAF.
• Active participation in regional and national commissioning programmes, including specialist services through the Joint Commissioning Committee (JCC) and hospice commissioning through the North Wales Joint Commissioning Committee (NWJCC).
• Continuation of enhanced financial recovery and monitoring arrangements following submission of the Month 3 Monitoring Return, including strengthened divisional accountability, savings monitoring and executive scrutiny processes.
• Submission of the Month 3 Monitoring Return reporting a year-to-date deficit of £17.1m and implementation of recovery planning arrangements in accordance with Standing Financial Instructions.

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2. What impact (both qualitative and quantitative) has the work had on the population of North Wales compared to what it set out to achieve?
At this stage, the primary impact has been the establishment of the governance, assurance and commissioning infrastructure required to support longer-term service improvement and financial sustainability.
• Maintenance of the annual financial forecast aligned to the approved 2026/27 planned deficit of £43m, despite a reported year-to-date variance of £6.4m adverse to plan at Month 3.
As implementation remains in the early stages, direct population-level impacts on access, quality or outcomes are not yet evidenced and are expected to emerge through delivery of the commissioning review programme and associated service changes during 2026/27.

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3. What actions are we undertaking to ensure we are on track to deliver the full overarching aim and associated impact by the end of March 2027?
The Health Board is progressing the following actions:
• Implementing the Commissioning Assurance Framework across NHS-to-NHS, independent sector and subsequently wider commissioned services through a phased, risk-based approach.
• Establishing the Executive Commissioning and Contracts Group to provide strategic oversight and assurance of delivery.
• Undertaking annual reviews of commissioned services through the IMTP process to support commissioning, recommissioning and decommissioning decisions based on population need, quality and value.
• Continuing collaborative work with the JCC, NWJCC, local authorities, the voluntary sector and providers to strengthen commissioning arrangements and develop financially sustainable service models.
• Progressing work to align performance monitoring arrangements across commissioned services, including development of broader performance metrics and regular contract review processes.
• Maintaining enhanced financial recovery arrangements, including monthly executive scrutiny, divisional accountability processes, savings delivery monitoring and recovery planning actions.
Overall, delivery remains focused on establishing the governance, assurance, commissioning and financial management arrangements required to support improved value, service quality, integrated care and longer-term financial sustainability for the population of North Wales by March 2027.

ASSESSMENT	
Link to Strategic Priorities	4.Create a Modern, People Centred Healthcare System
	If more than one applies, please list below: 3. Improve Access, Outcomes and Experience
Design Principles	Consistency with Organisational Values If more than one applies, please list below: All design principles applied through the various key programmes.
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)
	Not Applicable
	If more than one applies, please list below:

IMPACT ASSESSMENTS		
Equality *Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)*	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	*Individual programmes will complete as appropriate.*
Socio-Economic Impact Assessment	Yes: ☐	No: ☒
	Outcome:	

Have you undertaken a Socio-Economic Impact Assessment	If no, please include rationale:	*Individual programmes will complete as appropriate.*
Have you undertaken a Quality Impact Assessment Screening?	**Enablers of Quality** All Apply	**Domains of Quality** All Apply
	If more than one applies, please list below:	If more than one applies, please list below:
Wellbeing of Future Generations Act – Wellbeing Goals	Not Applicable	
Environmental /Sustainability Impact (5Rs)	If more than one applies, please list below:	
	No - Not Applicable	
	If more than one applies, please list:	*Individual programmes will complete as appropriate.*
Armed Forces Covenant Due Regard Duty Have you considered the Armed Forces Covenant Due Regard Duty?	Yes: ☐	No: ☒
	Outcome:	*Individual programmes will complete as appropriate.*
	If no, please include rationale:	
Data Protection Impact Assessment *Have you undertaken a Data Protection Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	*Individual programmes will complete as appropriate.*
	Yes: ☐	No: ☒

Counter Fraud Impact Assessment *Have you considered the counter fraud impacts*	Outcome:	
	If no, please include rationale:	*Individual programmes will complete as appropriate.*
Legal	There are no specific legal implications related to the activity outlined in this report.	
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)*	There is no direct impact on resources as a result of the activity outlined in this report.	

Betsi Cadwaladr University Health Board (BCUHB)

NHS Wales Strategy and Planning Maturity Matrix (PMM)

2026 Organisational Self-Assessment: Evidence Review and Maturity Assessment

Document Control

Prepared by	Corporate Planning Team
Document Status	Approved by PPHP on behalf of the Board - for Board information prior to submission to Welsh Government
Version	V1.0 Board
Date	September 2026
Governance Route	SPSCG - PPHP - **Board**

Betsi Cadwaladr University Health Board - Strategy and Planning Maturity Matrix Self-Assessment - September 2026

Domain	Self-Assessment 2025	Self-Assessment 2026
A) **Strategy Development / Clarity of Purpose, Vision and Strategy** Key Enablers moved from score 2 to 3 but did not impact on overall score.	**2**	**2**
B) Strategy Alignment and Development of an IMTP • IMPT Development moved from score of 2 to 1* • Alignment between Clinical Services Strategy and Plan and the IMTP or Annual Plan moved from score 2 to 3 • Triangulation of services moved scored from 1 to 2 *unable to meet “approved IMTP” criteria	**2**	**2**
C) Dynamic & Engaged Planning	**3**	**3**
D) Operational Planning	**2**	**2**
E) Best Practice Approach to Improvement	**3**	**3**
F) Realistic & Deliverable • Risk Identification & Management score moved from 2 to 3 • Development of IMTP and track record score moved from 1 to 2	**2**	**2**

Overall Assessment

The Health Board's overall Planning Maturity Matrix scores remain unchanged from the previous assessment; however, this should not be interpreted as a lack of progress. Progress has been made across all domains, including strengthening strategic planning, governance, engagement, integrated planning arrangements, risk management and the development of the Clinical Services Plan and long-term strategy. Many of the foundations associated with higher levels of maturity are now in place and are increasingly being embedded across the organisation.

This refresh has adopted a more rigorous and evidence-based approach to scoring, placing greater emphasis on demonstrating implementation, impact and organisational outcomes rather than the existence of frameworks, processes or governance arrangements alone. The assessment therefore provides a more consistent, robust and defensible reflection of current maturity. Although the headline scores have remained stable, the Health Board is better positioned to demonstrate further progression as current programmes move from development into implementation and delivery.

A) Strategy Development / Clarity of Purpose, Vision and Strategy

A) Strategy Development/Clarity of Purpose, Vision and Strategy - Crieria					
	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
Strategy & Plan **(No Change)**	No CSS or delivery plan in place but strategic framework for its development in development.	Draft CSS developed or in development.	Agreed CSS and development of a co-designed clinical services plan underway, with evidence of strong clinical, stakeholder and public engagement throughout. A patient led approach is evident.	Approved CSS and CSP. Implementation underway. Organisation actively identifies risks and opportunities, outcomes are regularly monitored, and planning is informed by data, horizon scanning, and cross-functional collaboration.	The organisation has a fully implemented CSS and CSP that is continuously reviewed and refined using real-time data and predictive insights. Regular strategic reviews (at least twice annually) are in place that enable flexible adjustments in response to emerging trends and priorities, in-year performance, and long-term opportunities. Strategic planning is agile, outcome-focused, and aligned with system-wide priorities, to maximise opportunities driving measurable improvements in performance and population health.

Vision & Purpose **(No change)**	Organisation is developing its vision and purpose. Clear outcomes are not yet defined.	Vision and purpose, scope and methodology agreed with clear commitment and leadership at a Board and strategy programme level. Clear outcomes are in development.	Organisational vision and purpose with defined outcomes are affirmed in public and internal documents. Organisation demonstrates proactive leadership at Executive and Board level.	Annual Board discussion takes place on organisational vision and purpose ensuring alignment with CSS and enabling plans, intended outcomes and the identification of risks/issues.	Have regular board debate, at least twice annually, on organisational vision and purpose, ensuring alignment with organisational actions, CSS, outcomes and performance and how in-year achievements, issues or opportunities impact on this. Organisation is able to flexibly adjust its CSS to maximise opportunities and remain responsive, outcome-focused, and future-ready.
Alignment of National Policy and All-Level partnership priorities **(No change)**	National policies and national, regional, local and partnership priorities are understood but are not yet translated into organisational strategies and plans.	National policies and national, regional and local priorities have been translated into strategic intent and agreed with stakeholders. WBFG Act and AHW are apparent and embedded in the agreed approach.	Organisational strategies and plans reflect national policies and national, regional and local health and partnership priorities. WBFG Act and AHW principles and integrated throughout.	Strategies and plans are regularly reviewed. They are aligned and responsive to national policy and legislation, and national/regional/local partnership priorities with clear links to the Regional Partnership Board and Public Service Boards.	Strategies and plans are regularly and proactively reviewed and aligned to emerging national policy and legislation, and local, regional and national partnership priorities. RPB's and PSB's are regularly engaged and involved in process. CSS outcomes demonstrate a contribution to the wider local economy, improved health and well-being and operational effectiveness.

Key Enablers **(Increased from 2)**	Key enablers—such as quality, safety, workforce, finance, digital technology, and research—are identified but not yet aligned to strategic planning. Their role in enabling delivery is recognised but not actively managed or coordinated.	Key enablers are identified, with plans underway to align them with the organisations overarching CSS. Quality expectations are defined, and initial steps taken to coordinate enabler contributions across programmes.	Key enablers are fully aligned with strategic objectives. Their potential is well understood and actively explored to support delivery. Quality expectations are clearly defined and embedded in planning processes, with enablers contributing to strategic coherence.	Key enablers underpin the development and delivery of the CSS and CSP. Opportunities linked to enablers are translated into actionable deliverables. Quality is integrated throughout the key enabling strategies and plans driving performance and improvement.	Key enablers are embedded across all strategic functions and are delivering measurable improvements and are considered best practice. Their impact is tracked through performance metrics, and they are continuously optimised to support innovation, agility, and system-wide transformation. Quality is not only integrated but drives strategic refinement and outcome achievement.
Engagement in Development **(No change)**	The duties of the Health and Social Care (Quality and Engagement) (Wales) Act (the Act) are identified as integral to the development and implementation of the CSS.	Engagement plans are in place to support the development of CSS.	Engagement plans are agreed and reflect strong clinical leadership. Plans meet the requirements of the Act	Plans are being implemented effectively with robust processes in place to capture diverse voices (internal and external) with strong clinical leadership, and where appropriate and necessary, offers opportunities for stakeholder involvement in shaping the development of CSS.	Organisation operates best practice and continuous engagement with both internal and external stakeholders, exemplifying the values seen in the quality and engagement act, ensuring voices from all communities are heard and reflected in the annual review of the CSS.

Population Health Needs Assessment **(No change)**	Plans are in place to undertake a population health needs assessment.	A basic high level population health needs assessment has taken place and is being used to shape the CSS.	CSS and CSP development is informed by population and health needs assessments and incorporates the wider determinants of health.	There is a single, detailed and regularly updated population health needs assessment in place. Strategies are updated regularly to clearly reflect the outcome of the assessment.	Population health needs assessment is recognised as best practice and is recognised and used by partner organisations (such as PSB and RPB) to form a common and shared understanding. CSS/CSP is regularly tested against current, emerging, and future population health needs.
Priorities & Achievability **(No change)**	The organisation does not have a prioritisation methodology or a recorded list of priorities. Planning is reactive and lacks strategic direction.	The organisation has an approved prioritisation framework related to population health needs assessment and has basic understanding of its priorities but is not yet reflected in plans. health needs.	A prioritisation framework is fully implemented. Priorities are recorded and aligned to population health needs assessments and Cabinet Secretary expectations. Early progress is made to reflect priorities in plans, with initial monitoring arrangements in place.	The organisation has a published, best-practice prioritisation methodology. It is fully aligned to population health needs and Cabinet Secretary expectations. Prioritised services are proactively reviewed and updated, with robust monitoring and governance of decisions embedded in planning cycles.	Prioritisation is embedded across all planning and decision-making processes. The methodology is sector-leading based on the outcome of the population health needs assessment and Cabinet Secretary's expectations. It is co-produced with stakeholders, and continuously refined through evidence, evaluation, and engagement. Priorities are transparently linked to outcomes, resource allocation, and national policy, with real-time

					monitoring and adaptive planning in place.
Horizon Scanning **(Increased from 1)**	Horizon scanning is infrequent and informal, with no structured process or discussion at Executive or Board level. Strategic planning is reactive, lacking foresight into emerging risks, trends, or opportunities.	Annual horizon scanning is conducted to identify key risks and opportunities. Findings begin to inform strategic thinking, but integration into planning and governance remains limited.	Horizon scanning is carried out regularly and used to test and validate strategic plans against future trends and risks. Insights are reviewed annually and inform planning cycles, with growing Board-level engagement.	Horizon scanning is embedded into strategic planning and governance processes. Findings are discussed at Board level annually, and strategies are actively validated and adjusted based on emerging insights. The organisation uses structured methods to anticipate change and mitigate risk.	Horizon scanning is systematic, forward-looking, and published. It informs biannual Board-level strategic discussions and enables flexible, data-driven adjustments to CSS. Insights are used to anticipate future scenarios, align with system-wide priorities, and ensure the organisation remains agile, resilient, and future-ready.

A) Strategy Development/Clarity of Purpose, Vision and Strategy Self-Assessment[i]			
Domain	**Assessed level**	**Evidence Used**	**Any Supporting Narrative**
Strategy & Plan	**2** **(No change)** "Draft CSS developed or in development."	Long Term Strategy Diagnosis Report ▪ Diagnosis Report – July 26 ▪ Companion Document to Diagnosis Report V0.2 ▪ Strategic Intent Statements	The Health Board continues to strengthen its strategic planning framework through the coordinated development of the Clinical Services Plan (CSP), 10-Year Strategy, Strategic Intent Statements. The BCU 3 Year Plan 2026-29 has been designed around the emerging strategy and CSP work, and is framed on the four Strategic Intent Statements. Whilst the Clinical Services Plan remains under development, progress has been made in establishing the strategic foundations required to support long-term service transformation, organisational recovery and sustainable service delivery. The Foundations for the Future Programme, together with the CSP Programme, provides a structured programme for organisational redesign supported by formal governance, Executive oversight and Informal Board Sessions. The Diagnosis Report establishes a comprehensive evidence base that is informing future strategic priorities, service models and organisational change. The Diagnosis Report was considered by the Strategic Planning and Service Change Group (SPSCG) (4 and 24 June 2026) and the Planning, Population Health and Partnerships Committee (PPHP) (2 July 2026). The Health Board continues to build on its extant Clinical Services Strategy whilst developing a refreshed strategic framework through the CSP and 10-Year Strategy. Clinical, stakeholder and partner engagement has

			informed the development of these programmes, For example: Strategy Workshop on 8th October 2025 supported by the Bevan Commission, and with the Regional Partnership Board e.g. 19th November 2025. Further co-design, formal approval and implementation is required before progression to the next maturity level. **Maturity Justification** The Health Board remains assessed at **Level 2**. Evidence demonstrates continued development of coordinated strategic planning framework through the Clinical Services Plan, 10-Year Strategy and Strategic Intent Statements, supported by strengthened governance, and engagement. Whilst the strategic foundations are well established, the Clinical Services Plan remains under development and further co-design, formal approval and implementation are required before progression to **Level 3** can be evidenced.
Vision & Purpose	**2** **(No change)** Vision and purpose, scope and methodology agreed with clear commitment and leadership at	Draft organisational **Vision Statement.** ▪ FINAL Health Board Vision and Strategic Intentions paper January 2026_coversheet ENG ▪ FINAL Health Board Vision and Strategic Intentions Report January 2026 ENG	Whilst the Health Board does not yet have a formally approved and published Vision Statement Board and Executive led sessions and engagement is informing and shaping strategic planning, organisational priorities and future service transformation. Progress has been made in establishing a shared organisational purpose through the co-development of the four Strategic Intent Statements, which now provide the strategic framework for the IMTP 2026-29, organisational priorities, investment decisions and transformation programmes. The development of the 10-Year Strategy and Clinical Services Plan is supported by established

	a Board and strategy programme level. Clear outcomes are in development.		programme governance, Executive leadership and stakeholder engagement, demonstrating a clear organisational commitment to long-term strategic planning. Informal Board Sessions and Executive strategic planning discussions held both prior to and throughout the development of the 3-Year Plan on 11/12/2025 informed and shaped the emerging organisational vision, strategic priorities and long-term ambitions. Activities were planned in advance and scheduled through the Informal Board Sessions demonstrating clear and proactive commitment and leadership from the Board level and strategy programme level, strengthening a move towards Level 3. **Maturity Justification** The Health Board remains appropriately assessed at **Level 2**. Evidence demonstrates continued development of a clear organisational vision and purpose through the Strategic Intent Statements, the emerging 10-Year Strategy, Clinical Services Plan and strengthened Executive and Board leadership. Clear strategic outcomes are being developed and increasingly inform organisational planning. However, the organisational vision has not yet been formally approved or embedded within public and organisational documentation. Further implementation, organisational adoption and evidence of impact are required before progression to **Level 3** can be evidenced.

Alignment of National Policy and All-Level partnership priorities	**2 (No change)** National policies and national, regional and local priorities have been translated into strategic intent and agreed with stakeholders. WBFG Act and AHW are apparent and embedded in the agreed approach.	BCU 3 Year Plan 2026-29: ▪ BCUHB Narrative Plan 2026-29 Appendix 1 to the BCU 3 Year Plan – Mapping Document: ▪ Appendix 1- BCU 3 Year Plan Mapping Document Health Board Well-being Statement 2025-2026: ▪ FINAL Well-being Statement 300726	National, Regional and Local priorities are reflected within the co-created Strategic Intent Statements and form the basis of the development of the Health Board's 3 Year Plan. Planning Guidance issued to services sets out the strategic framework and assumptions leading to the development of service level plans. The 3-Year Plan, demonstrates clear alignment to A Healthier Wales, the NHS Wales Planning Framework, Technical Planning Guidance, Cabinet Secretary priorities, Special Measures de-escalation criteria and Ministerial Advisory Group recommendations. Strategic planning is increasingly informed through collaboration with the Regional Partnership Board (RPB), Public Services Boards (PSBs) and wider system partners (example in Strategy and Plan domain above). The ongoing refresh of the Regional Population Needs Assessment, together with the development of the Equality Outcomes Framework, strengthens the consideration of population need, health inequalities and partnership priorities within organisational planning. The Health Board continues to strengthen alignment with national policy through implementation of the Well-being Statement 2025-2026, statutory equality commitments and participation in national programmes (e.g. National Clinical Services Plan, National Service Change Framework) as well as participating in national programmes (e.g. Once for Wales programmes, including: Listening to People, Duty of Candour, Duty of Quality. These arrangements support

			increasing alignment between national direction, regional partnership priorities and organisational planning. Further work is being progressed to ensure wider partnership priorities are consistently reflected organisational strategies, service transformation and measurable planning outcomes across all planning programmes. **Maturity Justification** The Health Board remains appropriately assessed at **Level 2**. Evidence demonstrates that national, regional and partnership priorities have been translated into the Strategic Intent Statements, IMTP and wider organisational planning, with the principles of the Well-being of Future Generations (Wales) Act and *A Healthier Wales* clearly reflected in the Health Board's strategic approach. Whilst there is clear evidence of alignment with national policy and statutory priorities, further embedding across organisational strategies and demonstration of measurable impact will be required before progression to **Level 3** can be evidenced.
Key Enablers	**3** **(Increased from 2)** Key enablers are fully	BCU Integrated Planning Framework 2025-27: ▪ FINAL Integrated Planning Framework 2025-27 - Board 27-11-25 Planning Guidance 2025	The Health Board has strengthened the alignment of its key enabling functions with strategic planning through the Integrated Planning Framework and translated, via planning guidance issued, into the BCU 3 Year Plan 2026-29. Further progress has been made to embed enabling functions within organisational planning: The 3-Year Plan

	aligned with strategic objectives. Their potential is well understood and actively explored to support delivery. Quality expectations are clearly defined and embedded in planning processes, with enablers contributing to strategic coherence.	▪ FINAL Integrated_Planning_Guidance_2026_27 v3.3 Board Assurance Framework (BAF), Corporate Risk Register (CRR) and Risk Management Framework: ▪ 22.04.2026-BAF-update-as-of-May-2026 ▪ Corporate Risk Register July 2026 – Public ▪ Risk Management Framework	integrates enabling functions within the overarching plan, both in Section 4 “Strategic Priorities” and Section 5 “Delivering the Plan”. Enabling functions are fully aligned with the organisation’s strategic objectives (Strategic Intent Statements) within the plan and are clearly visible. A Collaborative Planning Group was established to support the coordination and collaboration of enabling departments (Finance, Workforce, Planning, Performance, DDaT, Quality, Equalities, and Estates) to support alignment of enabling functions within the overarching planning process providing a mechanism to align interdependent areas of working and contribute to delivery of organisational priorities. Quality expectations are more clearly visible and defined both within planning guidance and templates, as well as within the plan. For example, the plan includes references to the Quality Management System, Duty of Quality, Welsh Government Quality Statements and established governance arrangements. The Annual Delivery Plan (Year 1 of the 3 Year Plan) has been fully aligned to the Board Assurance Framework (BAF), aligning governance and strengthening organisational assurance, planning coherence and delivery confidence. **Maturity Justification** The Health Board is appropriately assessed at **Level 3.** Evidence demonstrates that key enabling functions including workforce, finance, digital, estates, quality, performance, equality and governance are aligned with

			organisational strategic objectives and are embedded within the IMTP, Integrated Planning Framework and supporting enabling strategies. Quality expectations are integrated throughout planning processes, and enabling functions increasingly support organisational coherence, delivery assurance and strategic decision-making. Continued evaluation of organisational impact, service outcomes and delivery benefits will further strengthen planning maturity.
Engagement in Development	**2 (No movement)** Engagement plans are in place to support the development of CSS.	Clinical Services Plan Strategic Engagement Workshop Report (8 October 2025. ▪ Strategy Workshop Output Report_8th October 2025 Community by Design (CbD) Engagement Report (16 December 2025). ▪ Community by Design Output Report _V 1.0 Clinical Services Plan Engagement Summary Report (May-June 2026). ▪ CSP event output report v3 Engagement through the Strategic Planning and Service Change Group (SPSCG), Board Committees and wider governance arrangements supporting strategic planning and organisational development. ▪ CSP Progress Report - SPSCG 26-06-04	Engagement is an important and integral part of the Health Boards approach in the development of the Strategy and Clinical Services Plan as well as other key service changes. The engagement programme reflects the principles of the Health and Social Care (Quality and Engagement) (Wales) Act 2020, with an emphasis on involving patients, staff and partners in the development of strategic plans. A number of events and engagement activities have been undertaken by the Health Board across internal and external partners, including: ▪ A Regional Workshop on 8th October 2025, widely attended by Health Board and key regional partners, led to the co-creation of the 4 Strategic Intent Statements. The outputs were outlined within the Clinical Services Plan Strategic Engagement Workshop Report, capturing stakeholder perspectives to inform the scope, strategic principles and direction of the Clinical Services Plan

		Informal Board Sessions supporting discussion of the Health Board's future strategic direction, organisational purpose and long-term ambitions. Regional Partnership Board (RPB) presentation 16 January 2026. ▪ FINAL RPB - IMTP 2026-01-16 Bilingual	▪ Extensive and varied engagement with clinicians, staff, partners, patients and wider stakeholders, supported by strong Executive clinical leadership through the Executive Medical Director has been undertaken to develop the emerging Clinical Services Plan (CSP), including ▪ Engagement through the Strategic Planning and Service Change Group (SPSCG), Board Committees and wider governance arrangements supporting strategic planning and organisational development. Informal Board Sessions supporting discussion of the Health Board's future strategic direction, organisational purpose and long-term ambitions. ▪ Engagement approaches adopted through the Tywyn and Penley Community Hospital programmes demonstrate effective collaboration with staff, communities and stakeholders, with the approach recognised by Llais as an example of effective engagement practice. ▪ Community by Design (CbD) Engagement Report (16 December 2025), brought together senior leaders to develop a shared understanding of integrated, community-based models of care and their contribution to the emerging Clinical Services Plan. Engagement and collaboration continue into 2026 for example:

			▪ Clinical Services Plan Engagement Summary Report (May-June 2026), summarising outputs from the CSP Engagement Event (5 May 2026) and subsequent Clinical Focus Groups that informed the emerging Case for Change, future service models and service transformation priorities. ▪ Ongoing collaboration on 10th July 2026 with the Regional Partnership Board, wider partners and organisational governance groups to continue to align priorities through its planning processes. These activities have established a shared understanding of current challenges, future opportunities and the principles that will inform the development of the Strategy and Clinical Services Plan. The Health Board acknowledges that whilst engagement activity is well established, further evidence is required to demonstrate how stakeholder engagement consistently influences strategic decision-making, service redesign and organisational priorities throughout the development and implementation of the Clinical Services Plan. **Maturity Justification** The Health Board remains appropriately assessed at **Level 2**. Evidence demonstrates that structured engagement arrangements are supporting the development of the Clinical Services Plan and wider strategic planning, underpinned by increasing clinical leadership and broad stakeholder involvement. Engagement activities reflect the

			principles of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 and are informing the development of future organisational priorities. However, further evidence is required to demonstrate that engagement consistently shapes strategic decision-making, service design and implementation before progression to **Level 3** can be evidenced.
Population Health Needs Assessment	**2** **(No change)** A basic high level population health needs assessment has taken place and is being used to shape the CSS.	Long-Term Strategy Diagnosis Report: **(evidenced above – Strategy & Plan sub-domain)**	The Long-Term Strategy Diagnosis Report (evidenced above) contains two sections on Population Need and Prevention. This Population health intelligence, including the wider determinants of health, is being used to directly inform strategic planning, priority setting and organisational decision-making. Public Health expertise, demographic analysis and population health evidence have supported the development of the Strategic Intent Statements and the emerging Clinical Services Plan (CSP), strengthening the consideration of population need, prevention and health inequalities within organisational planning. The Health Board is a key partner and contributor to the ongoing refresh of the Regional Population Needs Assessment (RPNA). This, together with development of the Health Equity Framework, provides an important opportunity to strengthen the systematic use of population health intelligence and the wider determinants of health within future strategic planning, service transformation and resource allocation. The Health Board continues to strengthen its evidence-based approach to planning. Development of the Clinical Services Plan methodology includes proposals for a

			Population Health Needs Checklist, supporting the consistent consideration of population need, prevention, health inequalities and wider determinants of health throughout the planning process. The Health Board's 3 Year Plan has a much stronger and visible narrative for population need. Population health data packs and needs profiles supporting Clinical Services Plan workshops, clinical focus groups and strategic planning discussions. In response to Welsh Government feedback, greater emphasis is being placed on demonstrating how population health intelligence informs organisational priorities and planning decisions, rather than simply evidencing the existence of population health assessments. Whilst evidence demonstrates increasing use of population health intelligence, further work is required to consistently demonstrate its influence on strategic decision-making, investment decisions and service redesign. Following the Reflection and Learning exercise within the Health Board, work is in progress to build in a stronger focus on population need led plans and alignment to Health Equity Checklist within its planning guidance and framework. **Maturity Justification** The Health Board remains appropriately assessed at **Level 2**. Evidence demonstrates that population health needs assessments and Public Health intelligence are increasingly informing the development of the IMTP,

			Strategic Intent Statements and the emerging Clinical Services Plan. The ongoing refresh of the Regional Population Needs Assessment and development of the Health Equity Framework provide a stronger foundation for needs-based planning and consideration of the wider determinants of health. However, further evidence is required to demonstrate the consistent application of population health intelligence across organisational strategies, service transformation and resource allocation before progression to **Level 3** can be evidenced.
Priorities & Achievability	**2 (No change)** "The organisation has an approved prioritisation framework related to population health needs assessment and has basic understanding of its priorities but is not yet reflected in plans. health needs."	Example of briefing sheets Chief Exec to 121 IMTP priority setting meeting dates: ▪ Briefing Sheet for Chief Digital & Information Officer v2.0 ▪ Briefing Sheet for Exec Director of Corporate Governance v2.0 ▪ Briefing sheet for Executive Director of Public Health v2.0 ▪ Briefing Sheet for Exec Director of Nursing and Midwifery v2.0 ▪ Briefing Sheet for Exec Director of Finance v2.0	The Health Board is in the process of establishing an organisational Prioritisation Framework. It has a Prioritisation Framework that it applied to decision making with regards to funding allocation of an investment pot where it was informed by organisational objectives, population health need, financial sustainability, workforce capacity and statutory requirements. The organisation acknowledges that it requires a formal prioritisation framework that is applied across the whole organisation and this is a deliverable within the BCU 3 Year Plan for 2026-27. Notwithstanding the absence of an approved organisation wide framework, the principles are increasingly being applied to support decision-making across planning, investment and service development. Prioritisation discussions have taken place through Executive review sessions (example of briefing sheets provided), Informal Board Sessions, Committee scrutiny and programme governance arrangements. This has

			enabled the Health Board to review competing priorities, consider affordability and capacity constraints, and focus planning on key organisational objectives, including Special Measures improvement and de-escalation priorities. During development of the BCU 3 Year Plan 2026-29, organisational priorities were consolidated under the Strategic Intent Statements, providing a clearer articulation of those areas judged to have the greatest strategic importance. The planning process required services and programmes to demonstrate alignment with these priorities, available resources and organisational planning assumptions, strengthening the link between prioritisation and planning decisions. The Health Board is also strengthening transparency by developing a Joint Decision-Making and Prioritisation Framework through the Foundations for the Future programme. Whilst not yet fully embedded, this work will support a more consistent organisational approach to prioritisation, including prioritisation, sequencing and where necessary de-prioritisation of activity. Prioritisation arrangements are increasingly being used to inform organisational planning and decision-making. However, further work is required to demonstrate their consistent application across all services and to evidence how prioritisation decisions directly influence investment choices, resource allocation, service redesign and monitoring arrangements.

			Maturity Justification The Health Board remains appropriately assessed at **Level 2**. Evidence demonstrates the existence of an approved prioritisation approach and a growing organisational understanding of strategic priorities, reflected through the Strategic Intent Statements and the development of the BCU 3 Year Plan 2026-29. Prioritisation considerations are increasingly informing planning discussions, resource decisions and organisational focus. However, evidence of consistent organisational application, documented prioritisation and de-prioritisation decisions, and routine integration within planning, investment and performance management arrangements remains at an early stage. Further implementation and demonstrable impact will be required before progression to **Level 3** can be evidenced
Horizon Scanning	**2 (increased from Level 1)** Annual horizon scanning is conducted to identify key risks and opportunities. Findings begin to inform strategic	**Informal Board Sessions** ▪ FINAL - Informal Board Sessions - IMTP 2025-12-11 **Workforce planning** ▪ Strategic-Workforce-Planning-Framework-2026 **Reflection and Learning:** ▪ FINAL - IMTP - Reflection & Learning Report - July 2026	The Health Board recognises Horizon Scanning as an important component of mature planning and is strengthening its approach through the development of a Horizon Scanning Discussion Paper alongside the Unified Modelling proposal. This work has established a baseline assessment of current capability, identified organisational strengths and development opportunities, and is informing a more coordinated approach to the identification and interpretation of emerging risks, opportunities and future trends. Evidence demonstrates that Horizon Scanning activities are undertaken across a range of corporate, clinical and operational functions, although these have largely developed independently in response to local planning,

	thinking, but integration into planning and governance remains limited.		professional and statutory requirements rather than through a single organisational methodology. Examples include: ▪ Informal Board Sessions that consider long-term strategic direction, emerging risks, future opportunities and organisational sustainability. ▪ Strategic Intent Statements and development of the emerging 10-Year Strategy, supported by population health intelligence and evidence-based consideration of future service sustainability. ▪ Workforce planning activities, including nurse staffing reviews and succession planning, which take account of legislative, social, economic and political developments affecting future workforce sustainability. ▪ Demand and capacity modelling within the Integrated Planning Framework, supporting consideration of future service demand, workforce requirements and resource implications. These activities are increasingly informing strategic thinking and future planning priorities. However, the application of horizon scanning intelligence remains variable across the organisation and is not yet consistently embedded within governance, decision-making and planning processes. **Maturity Justification** **Level 2** assessment is appropriate. Evidence demonstrates that Horizon Scanning is undertaken across a range of corporate, clinical and

			operational functions to identify emerging risks, opportunities and future trends relevant to strategic planning, workforce sustainability and service development. Activities such as Informal Board Sessions, Strategic Intent development, workforce planning and demand modelling show that forward-looking intelligence is beginning to influence organisational thinking and planning priorities. The Horizon Scanning Discussion Paper has provided a baseline assessment of current organisational capability and identified opportunities to strengthen consistency, coordination and organisational learning. While horizon scanning intelligence is increasingly informing strategic discussions and future planning activity, a formal organisational methodology, systematic application across planning cycles, and stronger integration into governance and decision-making processes are still developing. The evidence demonstrates that Horizon Scanning has moved beyond an ad hoc approach and is increasingly informing strategic thinking. However, it is not yet sufficiently integrated across the organisation to support progression to **Level 3.**
Overall Judged Score	**2**	The Health Board has continued to strengthen its strategic planning arrangements through development of the Strategic Intent Statements, 10-Year Strategy and Clinical Services Plan. However, much of the evidence demonstrates strategic development activity rather than implementation and impact. Whilst Key Enablers have progressed, with two of the eight component areas increasing by one level, the remaining six demonstrate continued development. The majority of component areas remain at Level 2, making an overall assessment of **Level 2 (Early Progress)** appropriate.	

Strategy Development/Clarity of Purpose, Vision and Strategy Actions						
Domain	**Assessed level 2026**	**Aspired Position**	**Action(s)**	**Timelines / Milestones**	**Evidence to be used**	**Impact Measurement**
Strategy & Plan	**2**	3	Complete and approve the 10-Year Strategy and Clinical Services Plan	Discovery Phase concludes **Q1** 2026/27; Draft Strategy Summer/Autumn 2026; Final approval by end 2026; CSP Discovery Report Sept 2026	Approved Strategy Approved CSP Board approval Delivery roadmap	CSP priorities reflected in the IMPT and Directorate plans
Vision & Purpose	**2**	3	Finalise and embed the organisational vision and strategic outcomes within planning, governance and decision-making processes	Final Vision as output of Strategy Discovery Phase during 2026	Approved Vision Statement; Board approval; committee papers; planning guidance; directorate plans.	Strategic outcomes routinely referenced in business cases, plans and Board decision-making.
Alignment of National Policy and All-Level partnership priorities	**2**	3	Strengthen the translation of national, regional and partnership priorities into organisational planning and service redesign activity.	Ongoing throughout IMTP period	IMTP mapping documents; planning guidance; policy alignment reviews.	Evidence of organisational priorities and deliverables linked to national and partnership priorities.

Key Enablers	**3**	4	Strengthen alignment between enabling strategies and organisational priorities through the Integrated Planning Framework and planning cycle.	2026-29	Workforce, finance, estates, digital and quality strategies; planning submissions.	Evidence of enabling functions informing prioritisation, planning assumptions and delivery plans.
Engagement in Development	**2**	3	Continue engagement through Strategy and CSP development and strengthen recording of how feedback informs proposals.	Ongoing	Engagement reports; workshop outputs; consultation summaries.	Evidence of stakeholder feedback influencing strategic priorities or service model development.
Population Health Needs Assessment	**2**	3	Strengthen the use of population health and health inequalities intelligence within planning and prioritisation processes.	Health intelligence resources Q2 2026/27; PHM roadmap Q3 2026/27; PHM programme established Q4 2026/27	RPNA outputs; population profiles; Health Equity Framework; planning templates.	Increased evidence of population need informing priorities, service reviews and planning decisions.
Priorities & Achievability	**2**	3	Review and implement the organisational prioritisation framework as part of planning and investment decision-making.	Review and Recommendations by Q3 Approval to implement Q4	Prioritisation Framework; Executive and Board papers; investment decisions.	Clearer evidence of prioritisation, sequencing and resource allocation decisions.

Horizon Scanning	**2**	2	Develop a consistent approach to horizon scanning to inform future planning assumptions and strategic discussions.	Q4 2026/27	Horizon Scanning papers; Informal Board Sessions outputs; planning assumptions.	Emerging risks and opportunities reflected within strategic planning activity.

B) Strategy Alignment and Development of an IMTP

B) Strategy Alignment and Development of an IMTP - Criteria					
	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
IMTP Development **1** (decreased from 2)	Organisation has an annual plan which responds to some but not all elements of planning framework and cannot provide a financially balanced plan over 3 years.	Organisation has an approved IMTP that aligns with the core elements of the planning framework. The plan demonstrates a structured approach to strategic priorities and is informed by baseline data. It includes initial consideration of risks, outcomes, and resource requirements.	IMTP meets almost all policy expectations and is tailored to deliver clear service transformation aligned with an agreed CSP and reflects a shift from operational delivery to strategic impact. Growing maturity in linking planning to measurable impact, return on investment, and strategic priorities. Risks are clearly identified, with evidence of controls and early mitigation strategies.	The IMTP meets all policy expectations and is consistently delivering against the quadruple aim and is embedded across the organisation and transforming services through the CSP. Risks across quality, access, workforce, and finance are actively managed with evidence of controls and mitigation and demonstrates clear alignment between planning, performance, and transformation.	The IMTP exceeds all national policy expectations. It is recognised as a benchmark for excellence, driving system-wide transformation and delivering sustained impact across the quadruple aim. The plan is co-produced, future-focused, and underpinned by robust evidence, innovation, and adaptive governance. It demonstrates clear and advanced triangulation, delivery timelines and milestones, and integrated risks and mitigation.

Alignment between Clinical Services Strategy and Plan and the IMTP or Annual Plan **3** (increased from 2)	Some alignment is visible between the annual plan and CSS with the organisation planning on a continuous annual cycle.	Alignment is clear and coherent between the IMTP and CSS with the organisation planning on a continuous annual cycle.	The IMTP is tailored to deliver clear service transformation in line with an agreed Clinical Services Plan. Plans are directly linked to quality, performance and accountability and informed by detailed and future facing modelling.	Coherent aligned plans, including a commissioning plan are performance managed, with staff owning, adapting, acting on and learning from variation.	Planning is owned by all staff and fully integrated and aligned across organisational tiers and system partners. There is a clear golden thread between local, national and regional strategies and partnerships with dynamic alignment to the CSS and Plan, IMTP, commissioning intentions, resulting from horizon scanning results, detailed population health needs assessment and enabling strategies (e.g. workforce, digital, estates).
Triangulation of Services **2** (increased from 1)	Basic high-level triangulation is taking place between services, activity, workforce and finance.	Clear triangulation between services, activity workforce and finance.	Detailed triangulation between services, activity workforce and finance at service level. Triangulation between risk management and development of IMTP	Clear detailed and robust triangulation and analysis of activity, workforce and finance which considers other holistic requirements such as training and working regionally.	Triangulation is system-wide, predictive, and continuously refined through real-time data and advanced analytics. It informs strategic decision-making, resource optimisation, and service redesign across organisational boundaries. The organisation demonstrates a proactive approach to managing interdependencies, future workforce needs, financial sustainability, and service demand, with clear links to population health, regional collaboration, and innovation.
Commissioning	The Board sets out high level commissioning	The organisation has an approved	Commissioning decisions are	The organisation has a clear, transparent	Commissioning is strategically embedded across the organisation

1 **(No change)**	intentions primarily focused on statutory requirements and broad service categories. Commissioning is reactive, with limited strategic alignment or stakeholder engagement.	and operational commissioning process. Intentions begin to reflect service priorities and are informed by basic population health data and stakeholder input.	prioritised based on service need, population health data, and performance metrics. The impact of commissioned and supporting organisations is actively considered.	commissioning plan that includes a transparent prioritisation framework and actions for both commissioning and decommissioning ensuring risk to patients are minimised. Decisions are evidence-based, responsive to changing needs and communicated effectively to stakeholders.	and system, with clear alignment to the population health needs assessment, clinical priorities, and service transformation goals. The process is co-produced with stakeholders with a clear and transparent prioritisation framework, underpinned by robust evidence, and includes pro-active decommissioning where appropriate with detailed communication strategies. Commissioning decisions are transparent, equitable, and continuously evaluated for impact on quality, access, and outcomes.

B) Strategy Alignment, and Development of an IMTP – Self Assessment			
Domain	**Assessed level**	**Evidence Used**	**Any Supporting Narrative**
IMTP Development	**1** **(Decreased from 2)** Organisation has an annual plan which responds to some but not all elements of planning framework and cannot provide a financially balanced plan over 3 years.	**Board-approved IMTP 2025** ▪ FINAL - BCUHB 2025-28 IMTP **3 Year Plan 2026-29 (Submitted)** ▪ BCUHB Narrative Plan 2026-29	The Health Board submitted its first Board-approved, financially balanced IMTP 2025-28 in March 2025. Whilst approval was subsequently withdrawn following deterioration in the underlying financial position, the process represented progress in organisational planning maturity and demonstrated the organisation's ability to develop an integrated medium-term plan. The Planning Maturity Matrix criterion for IMTP Development is explicitly linked to the existence of an approved IMTP. As the Health Board was unable to secure approval of its 2026-29 IMTP, it is unable to evidence achievement of the Level 2 descriptor at the point of assessment and therefore remains assessed at Level 1. The assessment reflects compliance with the criterion rather than a deterioration in organisational planning capability. Notwithstanding the assessment outcome, the Health Board has continued to strengthen its planning arrangements during the development of the 2026-29 Plan. Improvements include:

			▪ strengthened Planning Guidance and supporting tools to improve the quality and consistency of service-level planning; ▪ improved alignment between strategic priorities, deliverables, impacts, milestones and risks; ▪ clearer integration of workforce, finance, quality, performance and operational planning considerations; ▪ enhanced mapping of Planning Framework requirements and Welsh Government priorities within the submitted plan; ▪ clearer alignment between the Strategic Intent Statements and organisational priorities contained within the plan. Planning maturity has also been strengthened through the introduction of the Continuous Planning Cycle, implementation of the Integrated Planning Framework, organisational Reflection and Learning processes, and greater emphasis on year-round planning, monitoring and review rather than an annual planning exercise. Feedback received through Welsh Government review processes and the Rapid Assessment identified areas requiring further improvement but also recognised progress in the structure, format and overall development of the Health Board's planning approach. The organisation

			continues to use this feedback to strengthen future planning cycles and improve the credibility, deliverability and integration of future plans. Further development will focus on improving organisational planning capability, strengthening planning governance, embedding collaborative planning approaches, and ensuring planning assumptions are supported by increasingly robust intelligence, modelling and delivery assurance arrangements. **Maturity Justification** The Health Board is appropriately assessed at **Level 1**. The assessment reflects the absence of an approved IMTP at the point of review and therefore the organisation's inability to fully meet the Level 2 criterion. However, evidence demonstrates continued improvement in the quality and maturity of the planning process through strengthened governance, integrated planning arrangements, enhanced planning guidance, the introduction of a Continuous Planning Cycle and greater alignment between strategic, operational, workforce, quality and financial planning. Whilst these developments provide a stronger foundation for future IMTP submissions, sustained delivery and successful progression to an approvable IMTP will be

			required before advancement to **Level 2** can be evidenced.
Alignment between Clinical Services Strategy and Plan and the IMTP or Annual Plan	**3** **(no change)** "The IMTP is tailored to deliver clear service transformation in line with an agreed Clinical Services Plan. Plans are directly linked to quality, performance and accountability and informed by detailed and future facing modelling."	BCU 3 Year Plan 2026-29 **(evidenced above)**	Noting the comments and starting point for both the Strategy development and the Clinical Services Plan, the Health Board has been able to demonstrate alignment between its strategic planning, service planning and operational delivery. The BCU 3 Year Plan 2026-29 is structured around the Strategic Intent Statements with its organisational priorities aligned to those statements. The Strategic Intent Statements provide the overarching framework for organisational planning, service transformation and strategic decision-making. Through the delivery of the Plan, the emerging CSP and Strategy will inform and shape the next planning cycle. Whilst the Clinical Services Plan remains under development, robust programme governance, mobilisation arrangements and supporting evidence have been established. The Strategic Intent Statements have provided a consistent 'golden thread' throughout the development of the Health Board's planning, aligning strategic priorities, transformation programmes, planning assumptions and service redesign activity.

			The newly introduced ‘continuous planning cycle’ will provide a structure and predictable timeline to ensure alignment between planning and strategy development (including the CSP) remain in step and drives plan development. The IPF provides the governance and planning architecture linking strategic planning, service planning and organisational delivery. In turn the Planning Guidance, informed from the Reflections and Learning work, will continue to strengthen this approach. Informal Board Sessions, Executive oversight and Strategic Planning and Service Change Group (SPSCG) governance supporting the development and alignment of the Clinical Services Plan and long-term strategy. **Maturity Justification** The Health Board is appropriately assessed at **Level 3**. Evidence demonstrates a clear and systematic alignment between the Strategic Intent Statements, the emerging Clinical Services Plan, the 10-Year Strategy and the IMTP. Although the Clinical Services Plan has not yet been finalised, established programme governance, strategic alignment and integrated planning arrangements provide sufficient

			evidence that planning is being undertaken within a coherent and structured strategic framework.
Triangulation of Services	**2 (increased from 1)** Clear triangulation between services, activity workforce and finance.	▪ BCU 3 Year Plan (Section 4) **Minimum Data Set (MDS)** ▪ MDS 2026-27_v17.04.26 ▪ Derived Demand Tool Foundation 2627 (Jan-Dec25)	The Health Board has strengthened the triangulation of planning, formalising this expectation within the IPF, and Planning Guidance and Templates. The expectation for services to work closely with enabling departments to triangulate demand, capacity activity, workforce, finance, performance, quality, risk and service planning within the Plan development process. This is supporting improved organisational visibility of interdependencies and more data led decision making. There is clear evidence of triangulation between services, activity, workforce and finance within the plan (Section 4). Further work to progress with a Unified Modelling approach to its demand, activity, finance, digital, estates and workforce is identified within the Plan for delivery in 2026. This will provide the groundwork to support and bolster planning infrastructure, providing stronger foundations for integrated and intelligence-led decision-making and future service planning. These developments demonstrate increasing maturity in the organisation's approach to triangulation. This will support the organisation in demonstrating its

			achievement of Level 3, before the end of the financial year. Weekly Planning Huddles (involving operational, planning and corporate leads from across the organisation) together with the Collaborative Planning Group, provide forums integrated planning, bringing together workforce, finance, performance, quality, risk and service planning to support the development and oversight of plans. Regular demand and capacity meetings to oversee the alignment to and development of the MDS took place throughout Quarter 3 and 4, informing trajectories and performance expectations. Example Trajectories meetings held 19/01/2026, 21/01/2026, 23/01/26, 28/01/26 **Maturity Justification** The Health Board is appropriately assessed at **Level 2**. Evidence demonstrates increasing maturity in the triangulation of workforce, finance, performance, quality, risk and service planning through the IMTP process and supporting planning arrangements. Whilst triangulation is becoming more systematic, further evidence is required to demonstrate its consistent application in strategic decision-making and organisational planning before progression to the next maturity level can be

			evidenced.
Commissioning	**1** **(No change)** The Board sets out high level commissioning intentions primarily focused on statutory requirements and broad service categories. Commissioning is reactive, with limited strategic alignment or stakeholder engagement.	Commissioning Assurance Framework ▪ Commissioning Assurance Framework (CAF) ▪ Refer to CE Briefing Sessions evidenced above. ▪ Refer to BCU Planning Guidance evidenced above	The Health Board establishes high-level commissioning intentions through its annual planning process, informed by Welsh Government priorities, Ministerial expectations, NHS Wales Planning Framework requirements, performance expectations and statutory obligations. As part of the development of the BCUHB Three-Year Plan (2026-29), the Chief Executive facilitated a series of Executive Team discussions to review national policy direction, planning guidance, performance challenges, financial constraints and emerging strategic priorities. These discussions were used to agree organisational priorities and planning assumptions to guide the development of plans across corporate and operational areas. The agreed priorities and commissioning intentions were subsequently reflected within organisational planning guidance issued to services, providing a consistent framework against which plans were developed. This included consideration of:

			▪ Welsh Government planning and accountability requirements. ▪ Ministerial priorities and NHS Wales strategic expectations. ▪ Performance and quality improvement requirements. ▪ Financial sustainability and affordability challenges. ▪ Population health needs and service transformation ambitions. ▪ Partnership and regional working requirements. The Health Board also undertakes commissioning and contracting activity across a range of services through local, regional and national arrangements, working with organisations including the North Wales Joint Commissioning Committee (NWJCC), Regional Partnership Board (RPB), NHS Wales Shared Services Partnership (NWSSP) and local authority partners. Whilst commissioning activity is well established, organisational arrangements remain primarily focused on delivering statutory requirements, service provision and contractual management. Commissioning intentions are increasingly informing planning discussions and service transformation priorities; however,

			further development is required to establish a systematic strategic commissioning approach that consistently aligns commissioning decisions with population health needs, long-term service transformation and integrated planning objectives. The development of a corporate Commissioning Framework, alongside the Foundations for the Future programme, provides an opportunity to strengthen the alignment between commissioning intentions, planning priorities and resource allocation. **Maturity Justification** **Level 1** is currently appropriate. The Health Board has established arrangements for identifying and communicating high-level commissioning intentions through the annual planning process. Executive-led discussions consider Welsh Government expectations, Ministerial priorities, performance requirements, financial challenges and statutory obligations, with agreed planning assumptions reflected in organisational planning guidance. These arrangements provide a basis for services to develop plans aligned to corporate priorities.

			However, commissioning remains largely focused on responding to statutory requirements, performance pressures and operational service needs. While there is evidence of collaborative commissioning activity and increasing consideration of strategic priorities within planning processes, a fully developed strategic commissioning approach, supported by systematic stakeholder engagement and clear alignment between commissioning decisions, population health need and long-term service transformation, has not yet been consistently implemented. The development of a corporate Commissioning Framework provides a basis for strengthening organisational commissioning maturity but further implementation and evidence of impact will be required before progression to **Level 2** can be demonstrated.
Overall Judged Score	**2**	The Health Board has continued to strengthen strategic alignment, planning processes and integrated planning arrangements. However, the absence of an approved IMTP, limited evidence of organisation-wide triangulation and the early maturity of commissioning arrangements indicate that the organisation remains at **Level 2 (Early Progress)** overall, with evidence of continued development across several elements.	

Strategy Alignment and Development of an IMTP - Actions						
Domain	**Assessed level 2026**	**Aspired Position**	**Action(s)**	**Timelines/Milestones**	**Evidence to be used**	**Impact Measurement**
IMTP Development	**1**	2	Continue implementation of the Integrated Planning Framework and Continuous Planning Cycle to strengthen future IMTP development.	Throughout 2026-29	Planning guidance; Continuous Planning Cycle documentation; Reflection and Learning outputs.	Improved quality, integration and assurance of future IMTP submissions.
Alignment between Clinical Services Strategy and Plan and the IMTP or Annual Plan	**3**	3	Strengthen alignment between emerging CSP priorities and future planning cycles.	CSP Discovery Report Sept 2026; detailed design late 2026.	CSP outputs; IMTP documentation; transformation programme plans.	Clear line of sight between strategic priorities, service transformation and IMTP deliverables.
Triangulation of Services	**2**	2	Progress Unified Modelling arrangements to strengthen triangulation of workforce, activity, finance and performance information.	Development during 2026/27	Unified Modelling outputs; planning assumptions; trajectories and demand modelling reports.	Increased evidence of planning decisions informed by triangulated information.

Commissioning	**1**	2	Develop organisational commissioning arrangements and strengthen links between commissioning intentions, planning and population need.	GDS contract Q2 2026/27; Social prescribing Q1-Q2 2026/27	Commissioning Framework; commissioning intentions; partnership agreements.	Improved alignment between commissioning activity and strategic priorities.

C) Dynamic and Engaged Planning

C) Dynamic and Engaged Planning - Criteria					
	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
Stakeholder Engagement **3** **(No change)**	Staff and partners are aware of CSS/CSP and there is a public commitment in place to undertake stakeholder engagement.	Organisational engagement is evident in practice and reflected in the CSS/CSP. Broad engagement to inform Equality Impact Assessments and Socio-Economic Duty Assessments.	Stakeholders are engaged in and co-design priority setting using the 'engagement cycle' model and a person-centred approach. Staff engagement at an organisation level is increasing.	Full and proactive continuous engagement including diverse communities which informs, owns and tests all impact assessments. Feedback from engagement activities influences and challenges the plan. Planning is also embedded and co-ordinated throughout the organisation.	Internal continuous engagement sees a fully engaged and informed workforce who are able to co-produce. Feedback and learning from continuous engagement activities including protected characteristic groups and socio-economic disadvantaged groups informs local priority setting and the development of the CSS/CSP.
Service Delivery Risk and Issue Management Approach **3** **(No change)**	Organisation has a service risk management approach in place, but it has not been fully adopted across all areas.	Organisation has service risk management approach embedded across all areas of the organisation and has robust plans in place to address / mitigate risks	A risk management approach is evident and consistent across organisation. The organisations top fragile services are identified.	The risk management approach enables the early identification of fragile or soon to be fragile services allowing for early intervention to ensure service sustainability. Organisation sees	Potential fragile services identified early and robust risk management across organisation pre-emptively responding to emerging service risks and the organisation is able to flexibly adjust plan. The Board are informed and regularly updated on fragile services and organisation rarely sees urgent service changes.

				less urgent service changes.	
Service Model / Regional Design **2** **(No change)**	Organisation has no route, or route is ineffective to discuss potential opportunities or joint risks. Regional collaboration is minimal, ad hoc, and lacks strategic intent.	Strengthened partnership working arrangements are in place. A methodology for working together is developed, with early efforts to align priorities and build trust.	Opportunities for regional working and shared solutions are identified and developed collaboratively. Planning is increasingly aligned across organisations, with joint priorities and resource sharing.	Agreed proposals for robust regional service models (e.g. consolidation, shared services) are in place and delivery is underway. Governance structures support joint accountability and performance management.	Regional collaboration is fully embedded, strategically led, and continuously evolving. The organisation is a proactive system leader, driving the development, implementation, and optimisation of shared service models and regional solutions. Collaboration is underpinned by co-produced strategies, shared governance, and dynamic intelligence. The organisation anticipates future needs, fosters innovation, and delivers measurable improvements in equity, efficiency, and outcomes across the region.

C) Dynamic and Engaged Planning - Self-Assessment			
Domain	**Assessed level**	**Evidence Used**	**Any Supporting Narrative**
Stakeholder Engagement	**3** **(No change)** Stakeholders are engaged in and co-design priority setting using the 'engagement cycle' model and a person-centred approach. Staff engagement at an organisation level is increasing.	**Stakeholder engagement programme supporting the development of the Clinical Services** ▪ Board and Committee Report_HB_August 4th 2022_Clinical Strategy V 1.0 ▪ Clinical services strategy V1.1_post Board **Plan (CSP), including Phase 1 challenged services and Phase 2 programme development.** ▪ 5.1 Clinical Services Phase 1 Learning and Transition Report **Learning and Reflections Report 2026** ▪ FINAL - IMTP - Reflection & Learning Report - July 2026	The Health Board continues to strengthen stakeholder engagement as a core component of strategic planning and decision-making. Engagement increasingly supports the co-development of strategic priorities, service transformation and organisational planning, rather than acting solely as a consultation exercise. Development of the 3 Year Plan, Strategic Intent Statements and Clinical Services Plan has involved clinicians, operational services, corporate functions, partner organisations and wider stakeholders. Established governance arrangements provide structured opportunities to challenge, refine and validate planning assumptions. Examples include: ▪ Learning and Reflections Report on 2026-29 Planning Process ▪ Strategic engagement events and reports informing the development of the Strategic Intent Statements, emerging 10-Year Strategy and IMTP. ▪ Clinical Services Plan engagement involving clinicians, staff, partners and key stakeholders.

			▪ Staff engagement and organisational feedback, including Staff Survey outcomes. ▪ Strategic Equality Plan (2024-2028), Equality Stakeholder Group and Equality Duties Scrutiny Group supporting inclusive engagement. ▪ Regional Partnership Board (RPB) engagement and collaboration with partner organisations through existing committees and forums ▪ Engagement through the Strategic Planning and Service Change Group (SPSCG), Public Health Planning Forum, Local Planning Forum and other planning governance arrangements. ▪ Working with services and operational leads across the organisation to develop the 3-Year Plan (informed by engagement with operational services, corporate functions and partner organisations.) ▪ Informal Board Sessions supporting strategic discussion, organisational learning and long-term planning. ▪ Stakeholder feedback informing planning priorities, service redesign and programme development. In response to Welsh Government feedback, greater emphasis has been placed on demonstrating how stakeholder engagement informs planning decisions, organisational priorities and service development. Evidence increasingly demonstrates that engagement

			contributes to organisational learning and the development of strategic programmes. Whilst stakeholder engagement continues to mature, further work is required to consistently evaluate its impact and demonstrate how feedback influences planning decisions and measurable organisational outcomes. **Maturity Justification** The Health Board remains appropriately assessed at **Level 3.** Stakeholder engagement is increasingly embedded within strategic planning and supported by structured governance, partnership working and collaborative programme development. Whilst evidence demonstrates a more integrated and evidence-informed approach, further evaluation is required to consistently demonstrate the impact of engagement on organisational decision-making and planning outcomes before progression to the next maturity level can be evidenced.
Service Delivery Risk and Issue Management Approach	**3** **(No change)** A risk management approach is evident and consistent across	▪ Gastroenterology Review Rapid Quality Review ▪ Health Board: Risk Management Framework ▪ Board Assurance Framework (BAF)**,**	The Health Board has mechanisms in place to identify fragile services within the Health board, which applies a risk management approach. In April of this year (2026) using this methodology, the Health Board was able to confirm that Gastroenterology was a fragile service via the Rapid Quality Review. This work has helped inform the development of a framework (currently

	organisation. The organisations top fragile services are identified.	▪ Corporate Risk Register (CRR) and Directorate risk registers	in draft) to support early identification of fragile or soon to be fragile services within the Health Board. The Health Board has established a structured approach to risk and issue management through an organisational Risk Management Framework, supported by comprehensive training, programme governance and portfolio management arrangements. The Board Assurance Framework (BAF) and Corporate Risk Register (CRR) are aligned to the 3-Year Plan and Strategic Intent Statements, demonstrating Executive Team, Board and Committee level oversight of strategic risks and organisational performance through IPEDG, PFIG and SPSCG. This provides a clear oversight of strategic risks and organisational priorities and line of sight through the Plan and BAF. Risk identification, escalation and mitigation are embedded within strategic planning, programme delivery and governance processes. Planning and performance review arrangements provide regular visibility of strategic risks, interdependencies and delivery challenges, enabling informed decision-making and timely management action. Risk management is embedded into the planning process, with risks and mitigations clearly

			identified withing the plan. Major Change and Key Programmes, including the Clinical Services Plan**,** Foundations for the Future and Special Measures improvement programme, are supported by established programme governance and risk management arrangements identifying strategic risks, interdependencies and delivery challenges. The Health Board offers Risk management training, guidance and organisational policies and has received national recognition for its Risk Management Framework and organisational risk management training at the CIR Awards. In response to Welsh Government feedback, greater emphasis is being placed on evidencing how risk information informs planning decisions, resource allocation and organisational learning, rather than solely demonstrating the existence of governance frameworks. **Maturity Justification** The Health Board remains appropriately assessed at **Level 3.** Risk management is embedded within organisational governance, strategic planning and programme delivery, supported by established assurance, escalation and oversight arrangements. Evidence demonstrates that risk information increasingly informs planning decisions and organisational priorities. Continued evaluation of the impact of

			risk management on organisational performance and learning will further strengthen maturity.
Service Model / Regional Design	**2** **(No change)** Strengthened partnership working arrangements are in place. A methodology for working together is developed, with early efforts to align priorities and build trust.	▪ Strategy Workshop October 2025 referred to above	The Health Board continues to strengthen service model development through collaboration across organisational, geographical and partnership boundaries. Strategic planning increasingly reflects a whole-system approach, supported by the Regional Partnership Board (RPB), Integrated Health Communities (IHCs) and wider partnership arrangements. Integrated Health Community (IHC) planning arrangements supporting place-based service design and delivery and cross-organisational service redesign involving clinical, operational and corporate teams for example the Community by Design Programme, Planned Care and Urgent Emergency Care Programmes. Development of regional clinical pathways and transformation programmes in collaboration with partner organisations for example the Llandudno Orthopaedic Hub, Stroke services etc. The Foundations for the Future Programme and emerging Clinical Services Plan (CSP) provide the strategic framework for future service models, organisational redesign and workforce planning. These programmes support greater consistency across the East, Central and West Integrated

			Health Communities whilst recognising local population needs and service delivery challenges. In response to Welsh Government feedback, greater emphasis has been placed on strengthening collaboration across the Health Board as a single integrated system. Shared planning processes, regional service redesign and cross-organisational programme governance are supporting a more coordinated approach to service planning and transformation. Service model development is increasingly informed by population health intelligence, regional collaboration and partnership working. Whilst further implementation is required, the evidence demonstrates continued progress towards more integrated and sustainable models of care. **Maturity Justification** The Health Board remains appropriately assessed at **Level 2**. Evidence demonstrates increasing maturity in collaborative service model development through strengthened regional planning, Integrated Health Community arrangements and organisational transformation programmes. The implementation of the Clinical Services Plan and continued development of integrated service models will provide further evidence to support progression to the next

			maturity level.
Overall Judged Score	**3**	Stakeholder engagement and risk management have become increasingly embedded within organisational planning and transformation activity. There is growing evidence that engagement, governance and risk processes are informing organisational priorities and service change. Whilst regional service model development remains at an earlier stage, the overall evidence supports an assessment of **Level 3**	

C) Dynamic and Engaged Planning - Actions						
Domain	**Assessed level**	**Aspired Position**	**Action(s)**	**Timelines/Milestones**	**Evidence to be used**	**Impact Measurement**
Stakeholder Engagement	**3**	**4**	Strengthen arrangements for demonstrating how engagement feedback influences planning and service development.	Throughout 2026-29	Engagement reports; consultation summaries; stakeholder feedback logs.	Increased evidence of service, programme or planning changes resulting from engagement activity.
Service Delivery Risk and Issue Management Approach	**3**	**4**	Continue to strengthen fragile service identification and service sustainability planning arrangements.	Ongoing	Risk registers; challenged service reviews; BAF and CRR reports.	Earlier identification of service risks and implementation of mitigating actions.
Service Model / Regional Design	**2**	**3**	Progress priority regional and cross-organisational service redesign programmes through existing partnership arrangements.	Hub milestones Q1-Q3 2026/27; Community by Design programme throughout 2026/27	Programme reports; partnership papers; business cases.	Delivery of agreed service improvements through collaborative working and regional planning.

D) Operational Planning

D) Operational Planning - Criteria					
	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
Demand & Capacity Modelling **2** **(No change)**	Basic demand and capacity work is undertaken and contains an appropriate level of detail to support service delivery	Demand and capacity planning undertaken at speciality level to support the design of current and future services. Data is more structured and used to inform service-level decisions	Robust and profiled projections of demand and capacity are used to inform the development of individual service plans, the Clinical Services Plan, and the IMTP. Planning is increasingly data-driven and cross-functional.	The organisation uses detailed and advanced modelling capability to support strategic planning. Demand and capacity modelling is embedded in the IMTP and informs transformation, workforce, and financial planning. Predictive analytics and AI tools support long-term planning.	Demand and capacity modelling including modelling projections is at the core of planning processes across the organisation. Predictive analytics and AI tools support long-term planning. Modelling triangulates resources, staff, finance and activity. It is able to undertake modelling at all levels of prevention and illustrates scenarios for improvement for the IMTP.
Clinical Leadership & Input **2** **(No change)**	Clinical leads are identified and their roles are defined. Engagement is limited to basic consultation or information sharing	Clinical leads begin to inform service planning and contribute to performance improvement discussions. Their input is considered but not yet central.	Clinical leads are embedded early in the planning cycle to ensure that service design is clinically credible and patient-centred. Clinical leads co-produce plans and provide leadership in	Clinical leadership is embedded in operational planning. Clinical teams actively shape service direction in alignment contributing to future direction services in line with clinical services plan.	Clinical leadership sits at the heart of planning and performance with a strong focus on quality and improvement. Clinical leaders co-produce plans and drive the future direction of plans through developing a culture of quality, innovation, and continuous improvement, fostering deep engagement and ownership across clinical teams.

			development processes. Their involvement is structured and increasingly strategic.		
Planning Process **2** **(No change)**	Organisation has basic operational plans and planning process in place.	Operational plans are regularly reviewed and remedial action undertaken.	Operational plans have robust triangulation and modelling of plans based on a clear and consistent approach to demand and capacity modelling across the organisation	Coherent aligned and triangulated plans with clear links to CSS and CSP, including, with staff owning, adapting, acting on and learning from variation and inequity.	Operational plans are fully aligned and integrated into the development of IMTP and CSP. Staff own the process and act on opportunities and learning to improve holistic service provision and patient experience.

D) Operational Planning - Self-Assessment			
Domain	**Assessed level**	**Evidence Used**	**Any Supporting Narrative**
Demand & Capacity Modelling	**2** **(No change)** Demand and capacity planning undertaken at speciality level to support the design of current and future services. Data is more structured and used to inform service-level decisions	Minimum Data Set **evidenced** above Demand and capacity modelling ▪ 202627 104 Wk Trajectories - March End Position. ▪ Derived Demand Tool Foundation 2627 (Jan-Dec25). ▪ Capacity Numbers Comparisons Example workforce planning: ▪ Strategic-Workforce-Planning-Framework-2026 Specialist service planning: ▪ 20250507 Skin Cancer Innovation	In addition to narrative and evidence in support of the Horizon Scanning and Triangulation of Services domains above. Demand and capacity modelling is increasingly informing operational and strategic planning across the Health Board, although the Health Board is cognisant that more work is required in this area to a) increase the consistency and application of demand modelling in its trajectory setting and decision-making processes; and b) spread the methodology more widely to support services outside of the traditional areas of Planned Care, Cancer etc. Pockets of good approaches to, and use of, demand and capacity modelling are predominantly evidenced in operational and clinical (predominantly surgical) based services such as planned care, and cancer services including skin cancer innovation. Demand and capacity analysis is informing planned care recovery, service planning and commissioning decisions. This modelling was used to set the trajectories for performance reflected in both the Plan (Section 4) and the Minimum Data Set.

			Demand analysis and modelling supporting the development of the Clinical Services Plan (CSP) and future service models. Development of a unified modelling approach for the Health Board (referenced above) is a key area of work being progressed in 2026 to strengthen demand and capacity modelling, and the triangulation of intelligence across the whole system to support strategic and operational planning and intelligence led decision making. This includes performance, activity, workforce, financial and productivity data informing planning assumptions and service delivery. Whilst modelling capability continues to mature, further work is required to embed consistent methodologies, strengthen analytical capability and demonstrate the systematic application of modelling across all services. This remains a key area of development within the Continuous Planning Cycle and Clinical Services Plan programme. **Maturity Justification** The Health Board remains appropriately assessed at **Level 2**. Demand and capacity modelling is increasingly supporting operational and strategic planning through improved integration of activity, workforce, finance and performance information. Whilst modelling capability continues to strengthen,

			further evidence is required to demonstrate consistent organisational application and its influence on strategic decision-making before progression to the next maturity level can be evidenced.
Clinical Leadership & Input	**2** **(No change)** **“**Clinical leads begin to inform service planning and contribute to performance improvement discussions. Their input is considered but not yet central.”	**HPF Planning Presentation (Dec):** ▪ HPF Presentation - IMTP Planning Approach 26-29 FINAL **HPF Presentation May 2026:** ▪ FINAL - HPF - IMTP Update 2026-03-06	Clinical leadership has strengthened over the past year through the appointment of a substantive Executive Medical Director and increased clinical leadership across strategic planning, service transformation and the Clinical Services Plan (CSP) programme. Clinical leadership has been central to the development of the Challenged Services Plans and wider Special Measures improvement programme. Clinical representation within the Strategic Planning and Service Change Group (SPSCG), Executive governance arrangements and Informal Board Sessions. There is evidence of improved Clinical expertise reflected within organisational planning through programme governance, Integrated Health Communities, Executive oversight and the Strategic Planning and Service Change Group (SPSCG). For example:

			▪ Clinical leaders are playing a greater role in shaping service models, planning assumptions and organisational priorities. ▪ Whole-organisational Culture, Leadership and Engagement Programme supporting the development of organisational values, behaviours and leadership capability. ▪ Interprofessional Education Group established to strengthen multidisciplinary education, workforce development and organisational capability across BCUHB. Whilst Clinical Lead input is sought, it is not yet a central component in plan development and is not yet consistently represented across all facets of organisational planning. Improvements have been made: ▪ involving clinical leads earlier in the process, seeking Clinical input to inform planning assumptions, service priorities and organisational decision-making throughout the IMTP planning process ▪ working through Executive Director Leads; ▪ promoting clinical engagement at the service level of planning (setting clear expectations and assumptions within the IPF and Planning Guidance and Tools); ▪ Multidisciplinary clinical engagement supporting service redesign, demand and capacity planning, and future service models.

			▪ seeking clinical input from relevant committees and groups e.g., Healthcare Professional Forum. but not yet central. Further work to consistently embed Clinical leads are early in the planning cycle to ensure that service design is clinically credible and patient-centred is being progressed in 2026 through the Planning cycle and guidance and tools which will strengthen expectations of clinical lead roles in co-producing plans and providing leadership in development processes. Notwithstanding that, the 3-Year Plan contains a much stronger representation of the clinical voice throughout the plan and specifically with sections dealing with Clinical Leadership. ▪ This is particularly reflected in work around the development of the Clinical Services Plan, demonstrating strengthened multidisciplinary clinical engagement through strategic workshops, clinical focus groups and challenged service reviews, providing a stronger clinical evidence base for future service transformation. The Executive Medical Director is the nominated executive lead for the Clinical Services Plan programme, despite the area of work falling under the ED for Strategy and Planning, indicating the important the organisational places on clinical leadership. ▪ This is complemented by organisational initiatives to strengthen leadership, culture and

			workforce capability, including the Culture, Leadership and Engagement Programme and the Interprofessional Education Group, which support collaborative leadership and continuous professional development. Whilst clinical leadership is increasingly embedded within strategic planning and organisational decision-making, further work is required to ensure consistent clinical leadership and multidisciplinary involvement across all planning programmes and services. **Maturity Justification** The Health Board remains appropriately assessed at **Level 2.** Evidence demonstrates continued development in embedding clinical leadership within strategic planning, governance and service transformation, supported by strengthened Executive clinical leadership, multidisciplinary engagement and organisational leadership development. Whilst clinical leadership is increasingly influencing organisational priorities and decision-making, further evidence of consistent implementation and organisational impact across all planning activities is required before progression to **Level 3** can be evidenced.

Planning Process	**2** **(No change)** "Operational plans are regularly reviewed and remedial action undertaken"	**ADP Monthly Status Update** ▪ FINAL ADP month 2 report for SPSCG ▪ FINAL - SPSCG - ADP Q1 27.07.26 ▪ 2.1 SPSCG Minutes 26-02-16 v0.3 APPROVED **Forward Governance Plan – Corporate Planning:** ▪ 26.27 Reporting Calendar	There are robust mechanisms in place to ensure that the Health Board Plan is reviewed regularly and remedial action is taken. Monthly Status Updates against the Annual Delivery Plan (Section 4 of the 3-Year Plan) are provided to Executive Director Leads as an early warning, providing them with a high-level oversight on the status of deliverables within their areas of responsibility. The Status Update specifically calls attention to area's which are off track or indicating that they will not be achieved in the relevant quarter. This enables them to work with their teams to take appropriate remedial action to bring actions back on track before a formal Quarterly ADP Report is produced. Moving forward, the Health Board, learning from the previous planning and reporting cycles, taking into account wider feedback from across stakeholders and Welsh Government, in addition to it has significantly strengthened its planning and reporting processes: Moving forward, the Health Board is applying learning from previous planning and reporting cycles, together with feedback from stakeholders and Welsh Government, and has continued to strengthen its planning and reporting processes through: ▪ introducing a Continuous Planning Cycle and development of supporting planning

			infrastructure. Planning is now embedded as a year-round organisational process rather than a discrete annual exercise. ▪ Formalised a Reflection and Learning stage, to include undertaking the PMM Self-Assessment early in the year to support improving planning maturity and reflect and apply this learning to future planning cycles. ▪ Implemented monthly ADP Status Updates, supplementing the existing Quarterly Reporting. ▪ Established governance and review arrangements, including Directorate Performance Reviews, Corporate Directorate Reviews and Service Accountability Reviews, provide regular opportunities to monitor delivery, identify emerging risks, escalate issues and refine planning assumptions. These arrangements strengthen organisational accountability and support continuous improvement. The Health Board is also investing in organisational capability, recognising that effective planning depends upon strong leadership, programme management, analytical capability and organisational change. Work to improve planning literacy, supported by revised guidance, templates and the Planning Portal**,** is helping to strengthen consistency and engagement across the organisation.

			Whilst further work is required to fully embed continuous planning across all services, the evidence demonstrates a more integrated, coordinated and systematic approach to organisational planning. **Maturity Justification** The Health Board remains appropriately assessed at Level 2. Progress has been made in strengthening planning processes, governance and organisational capability through the Continuous Planning Cycle, Integrated Planning Framework and supporting review arrangements. However, the organisation is not yet able to fully demonstrate robust triangulation and modelling based on a clear and consistent approach to demand and capacity across the organisation. Further implementation and evidence of consistent organisational application are required before progression to **Level 3** can be evidenced**.**
Overall Judged Score	**2**	Operational planning arrangements continue to develop through strengthened governance, demand and capacity work, planning processes and increasing clinical involvement. However, demand modelling, clinical leadership and operational planning processes are not yet consistently embedded across all services. The overall assessment therefore remains at **Level 2 (Early Progress),** with evidence of continued development across all three component areas.	

D) Operational Planning - Actions						
Domain	**Assessed level 2026**	**Aspired Position**	**Action(s)**	**Timelines/Milestones**	**Evidence to be used**	**Impact Measurement**
Demand & Capacity Modelling	**2**	3	Roll out a more consistent demand and capacity modelling approach across priority services - linked to Unified Modelling action	2026/27	Modelling outputs; trajectory reports; service plans; workforce reviews.	Planning assumptions and trajectories increasingly informed by modelling evidence.
Clinical Leadership & Input	**2**	3	Strengthen early clinical involvement in planning, CSP development and challenged service reviews.	Ongoing through 2026-29	Clinical focus group outputs; challenged service reports; CSP documentation.	Increased evidence of clinical input informing planning assumptions and service redesign proposals.
Planning Process	**2**	3	Continue embedding the Continuous Planning Cycle, planning guidance and organisational planning capability development.	Throughout IMTP period	Planning guidance; training records; planning reviews; Directorate plans.	Improved consistency and quality of planning submissions across the organisation.

E) Best Practice Approach to Improvement

E) Best Practice Approach to Improvement - Criteria					
	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
Engagement **2** **(No Change)**	Engagement is minimal and reactive. Feedback is collected from patients and staff, but there is no structured approach to measuring the effectiveness of engagement activities or approach. Insights are rarely used to inform decision-making.	The organisation has a visible commitment to best practice, supported by training and an improvement strategy. Engagement with national programmes is active, and structured methods for collecting feedback and measuring impact are in place, though not yet fully embedded.	Organisation is developing an engagement strategy/plan and is proactive in identifying and learning from best practice in engagement to ensure voices are captured from all stakeholders especially clinical, minority and diverse voices.	Engagement is embedded across all organisational activities—planned and unplanned. The engagement strategy ensures robust inclusion of diverse and clinical voices, supported by strong data collection and analysis. Feedback directly informs action, driving continuous improvement.	Stakeholder engagement is transformational—co-designed and co-led by patients, staff, and communities. Real-time feedback tools enable adaptive responses, while inclusive practices ensure diverse voices shape decisions. The organisation is nationally recognised for its leadership in engagement, with a clear link between stakeholder input and measurable improvements
Benchmarking **2** **(No Change)**	Organisation is beginning to explore value-based healthcare principles, but planning remains reactive and output-focused. Benchmarking is ad hoc,	Value-based planning is gaining traction, and regular benchmarking is conducted with other NHS	Benchmarking processes are formalised, consistently applied, and span across Wales and the UK. The	Benchmarking is fully integrated into planning and performance cycles. Staff across the organisation actively lead benchmarking	Demonstrates full integration of benchmarking and value-based planning across strategic, operational, and clinical areas. Advanced analytics, including predictive and real-time data, drive proactive improvements and

	with limited structure or consistency. There is minimal understanding of how comparative data can drive improvement, and benchmarking is not yet linked to strategic goals.	organisations. The organisation begins to use structured benchmarking methods to identify best practice, though application is inconsistent. Staff awareness is growing, and benchmarking is starting to inform service reviews and improvement discussions.	organisation uses comparative data to identify performance gaps and inform strategic planning. Benchmarking is aligned with value-based healthcare principles, and results are used to prioritise improvement initiatives. Staff are engaged in interpreting data and applying insights to their areas.	and improvement initiatives, using data to drive decisions and measure impact. There is a strong culture of ownership and continuous learning. Benchmarking includes qualitative and quantitative measures, peer comparisons, and outcome-focused metrics aligned with patient value. Insights are shared across teams and used to scale best practice.	innovation. Recognised as a leader in the NHS, the organisation shapes best practice while fostering a culture where staff lead continuous improvement and scalable innovation.
Governance **3** **(No Change)**	Governance arrangements are informal, fragmented, or unclear. Oversight of IMTP development is minimal, with limited accountability, transparency, or alignment to strategic priorities. There is no structured process for risk management, stakeholder involvement,	A governance structure has been established to provide direction and oversight for IMTP development. Roles and responsibilities are defined, and basic reporting mechanisms are in place. There is	A formal governance and accountability framework is in place for IMTP development and monitoring at programme level. IMTP and CSS/CSP governance is aligned with	Governance is embedded across the organisation, with a mature CSS and oversight mechanisms that are reviewed annually for relevance and effectiveness. IMTP and CSS/CSP governance structures support cross-functional	Governance is fully integrated, agile, and strategically aligned across all levels. Oversight of the IMTP, CSS and CSP is co-produced with clinical leaders and stakeholders, supported by real-time data, predictive analytics, and dynamic risk intelligence. IMTP/CSS/CSP governance structures are benchmarked against national best practice, continuously refined, and used to drive innovation, accountability, and system-wide

	or performance monitoring.	growing awareness of the need for structured governance, but integration with programme-level planning and delivery is still emerging.	strategic objectives, includes defined escalation routes, and supports performance tracking. IMTP Governance is periodically tested for improvements.	collaboration, robust data use, and continuous improvement. Governance is constantly and pro-actively tested for improvements.	impact. Decision-making is transparent, inclusive, and outcome-focused.

E) Best Practice Approach to Improvement - Self-Assessment			
Domain	**Assessed level**	**Evidence Used**	**Any Supporting Narrative**
Engagement	**2** **(No Change)** The organisation has a visible commitment to best practice, supported by training and an improvement strategy. Engagement with national programmes is active, and structured methods for collecting feedback and measuring impact are in place, though not yet fully embedded.	**Annual programme of public, patient and community engagement**: ▪ Engagement Team Annual Delivery Plan 2026 - Evidence for Maturity Matrix **Example - Board Citizen Experience report:** ▪ Citizen Experience Board Paper_Health Board 2026 ▪ Citizen Experience Board Paper_Health Board May 2026 ▪ Citizens Experience Board Paper_September 2025	Engagement is being supported by structured mechanisms that capture, review and apply stakeholder feedback informing strategic direction and priorities. This includes continued implementation of the Values, Behaviours and Culture Change Leaders programme to strengthen staff engagement and organisational culture. In addition to the areas of Engagement reflected in the above Domains, the Health Board continues to strengthen (internal and external to the organisation) stakeholder engagement through a coordinated programme of public, patient, staff and partner engagement that supports strategic planning, service transformation and organisational development. ▪ Recent examples include the Tywyn and Penley service change programmes, ▪ Work on development of the Strategy and CSP E.G. o development of the Strategic Intent Statements, o the Clinical Services Plan and

			o ongoing Board engagement through the Citizen Experience programme. The Health Board encourages full participation in the National Staff Survey, and actively uses those results to engage with and work with its workforce in identifying areas for improvement. The IMTP Reflection and Learning Review, Planning Maturity Matrix (PMM) self-assessment, Directorate Reviews and Informal Board Sessions provide regular opportunities to evaluate feedback and ensure it informs future planning, service development and organisational priorities. Learning from Welsh Government feedback, programme reviews, organisational diagnostics and stakeholder engagement is increasingly informing planning, governance and continuous improvement. The Continuous Planning Cycle further strengthens this approach by embedding engagement and feedback throughout the planning process rather than relying on discrete consultation exercises. Whilst engagement is well established, further work to strengthen the visibility of

			how stakeholder feedback influences planning decisions, service redesign and measurable organisational outcomes is underway. **Maturity Justification** The Health Board remains appropriately assessed at **Level 2**. Evidence demonstrates that structured engagement with patients, staff, partners and stakeholders is increasingly embedded within strategic planning and organisational decision-making. Established mechanisms capture and apply stakeholder feedback to inform planning, service development and continuous improvement. Whilst progress has been made, further evidence is required to demonstrate the consistent impact of engagement on organisational decisions, service transformation and measurable outcomes before progression to **Level 3** can be evidenced.
Benchmarking	**2** **(No Change)** Value-based planning is gaining traction, and regular benchmarking is	▪ Benchmarking Tool Screenshot ▪ Month 3 - Comparison Non-Pay + ▪ A&E Efficient Benchmarking 24.25 ▪ PFIG Corporate Service Benchmarking June 25 23.05 v7 ▪ DDAT Benchmarking activity data elements that helps feed the NHSBN submissions	The Health Board continues to strengthen its approach to benchmarking through participation in the NHS Benchmarking Network, national planning forums and comparative analysis across NHS Wales. Benchmarking is increasingly supporting organisational learning, service reviews and value-based planning.

	conducted with other NHS organisations. The organisation begins to use structured benchmarking methods to identify best practice, though application is inconsistent. Staff awareness is growing, and benchmarking is starting to inform service reviews and improvement discussions.	▪ NHSBN Emergency Care 2025 Overview Report ▪ NHSBN CYPMHS 2025 Overview Report ▪ NHSMH AOPMH 2025 Overview Report	The Value and Sustainability Programme has strengthened the use of benchmarking across areas including productivity, costing, expenditure, efficiency and clinical variation. A dedicated Data and Analytics Working Group is supporting the use of comparative intelligence and best practice to identify opportunities for improvement and inform planning discussions. Learning from Welsh Government feedback, external reviews, peer organisations and national benchmarking activity is increasingly informing organisational planning and improvement priorities. Comparative information is beginning to influence planning discussions, challenge existing practice and identify opportunities to improve value and performance. Whilst benchmarking activity is becoming more structured, its application remains variable across the organisation. Further work is required to establish a consistent organisational approach and demonstrate how comparative intelligence routinely informs strategic planning, resource allocation and service transformation. **Maturity Justification**

			The Health Board remains appropriately assessed at **Level 2.** Evidence demonstrates that benchmarking and comparative analysis are becoming more structured and are increasingly supporting service reviews, planning discussions and value-based improvement. Participation in national benchmarking arrangements and the growing use of comparative intelligence provide a stronger foundation for organisational learning. However, benchmarking is not yet consistently embedded across all planning processes, and further evidence is required to demonstrate its systematic application in strategic planning, resource allocation and organisational decision-making before progression to **Level 3** can be evidenced.
Governance	**3** **(No change)** "A formal governance and accountability framework is in place for IMTP development and monitoring at programme level.	Example of Plan tabled: **PPHP 05 March 2026** ▪ PPHP Committee Agenda Bundle 05.03.26 V1.0 (Public) ▪ Minutes from PPHP Committee 05.03.26 V1.0 (Public) Confirmed **Board on 26 March 2026 (approval to submit)**	The Health Board has established a formal governance and accountability framework to support the development, delivery and monitoring of the Plan. The Integrated Planning Framework defines clear governance arrangements, roles, responsibilities and reporting mechanisms, providing a structured approach to organisational planning and assurance.

	IMTP and CSS/CSP governance is aligned with strategic objectives, includes defined escalation routes, and supports performance tracking. IMTP Governance is periodically tested for improvements.”	▪ Health Board Agenda Bundle 26.03.26 V5.0 Public_opt ▪ Minutes from Health Board Meeting 26.03.26 V1.0 (Public) Confirmed	This is aligned to the organisation’s Boards and Committee Structure providing Executive Team, Board Committees and Board oversight of strategic planning, organisational performance and delivery. The BCU 3 Year Plan was submitted through the following governance routes before Board sign off on 26 March 2026 (SPSCG, PPHP, Board, as well as through non committee forums such as SRG, PFIG, Executive Committee, WG Touchpoint meetings, Informal Board sessions) Governance arrangements for the Clinical Services Plan (CSP), Foundations for the Future Programme and the IMTP are increasingly aligned through established programme governance, Executive oversight and Board assurance processes. Defined governance routes provide clear mechanisms for performance monitoring, escalation of risks and organisational decision-making. Routine reporting through the Strategic Planning and Service Change Group (SPSCG), Executive Team, Planning, Population Health and Partnerships Committee (PPHP) and Board provides regular oversight of delivery, organisational

			performance, programme risks and strategic priorities. Governance arrangements increasingly integrate planning, workforce, finance, quality, risk and performance, strengthening organisational alignment and delivery confidence. Governance arrangements continue to evolve through the development of the Organisational Approach to Change, strengthened programme management arrangements and investment in organisational capability. Regular review of governance structures supports continuous improvement and ensures governance remains aligned to organisational priorities and strategic transformation. **Maturity Justification** The Health Board remains appropriately assessed at **Level 3**. A formal governance and accountability framework is established to support the development, delivery and monitoring of the IMTP and associated strategic programmes. Governance arrangements provide clear oversight, defined escalation routes and integrated performance monitoring aligned

			to organisational priorities. Evidence demonstrates that governance supports effective planning, assurance and organisational decision-making. Continued refinement of governance arrangements and evaluation of their effectiveness will further strengthen organisational maturity.
Overall Judged Score	**3**	The Health Board demonstrates a structured approach to governance, continuous improvement and organisational learning. Governance arrangements are well established and support planning, assurance and delivery. Whilst benchmarking and engagement require stronger evidence of impact; sufficient evidence exists to support an overall assessment of **Level 3 (Initial Results)**.	

E) Best Practice Approach to Improvement - Actions						
Domain	**Assessed level 2026**	**Aspired Position**	**Action(s)**	**Timelines/Milestones**	**Evidence to be used**	**Impact Measurement**
Engagement	**2**	**3**	Strengthen evaluation of engagement activity and use learning to inform planning and service improvement.	Throughout 2026-29	Citizen Experience reports; engagement evaluations; action plans.	Increased evidence of learning from engagement informing organisational decisions.
Benchmarking	**2**	**3**	Strengthen the use of benchmarking, comparative intelligence and improvement methodologies to support service improvement.	Throughout 2026-29	NHS Benchmarking Network reports; GIRFT reviews; Value and Sustainability outputs.	Evidence of benchmarking findings informing improvement actions and service reviews.
Governance	3	4	Continue to refine governance and assurance arrangements supporting planning, delivery and organisational improvement.	Throughout 2026-29	Governance reviews; committee reports; BAF and assurance reports.	Improved oversight of delivery, risk and organisational priorities through governance structures.

F) Realistic & Deliverable

F) Realistic & Deliverable - Criteria					
	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
Risk Identification & Management **3 (Increased from Level 2)**	Risk identification and management are inconsistent and reactive. Risks to IMTP delivery are not systematically captured or monitored. There is limited ownership or visibility of delivery risks.	A formal risk management process exists and is applied to IMTP delivery at a high level. Risks are identified at the planning stage and tracked through basic registers and reviewed periodically. Ownership is clearer, but integration with delivery assurance is limited. Escalation processes in place but not always followed.	Risk identification and management are embedded in IMTP development and delivery processes. Risks are identified early and linked to specific objectives, milestones, and outcomes. Controls are monitored, and mitigation actions are tracked. Risk registers are dynamic and inform delivery with clear ownership.	Risk management is proactive, strategic, and forward-looking with an agreed and clear risk appetite. Risks are anticipated and identified through horizon scanning, sensitivity analysis and scenario planning. The organisation adapts delivery plans in response to emerging risks with regular reviews. Lessons learnt informs future IMTP cycles.	Risk management is fully embedded across the organisation and system partners and is triangulated across workforce, finance, digital and clinical lenses. It is predictive, real-time, and continuously informs IMTP delivery through live dashboards and predictive analysis. The organisation leads in using risk intelligence to drive improvement, resilience, and transformation. The organisation operates continuous learning and is recognised for excellence in risk-informed delivery assurance.

Development of IMTP and track record **2 (increased from Level 1)**	The organisation has a track record of submitting annual plans that do not meet the requirements of the planning framework, Cabinet Secretary expectations or provide a financially balanced plan over 3 years. Planning is largely operational and short-term, with limited strategic integration and has limited clinical or financial planning alignment and limited stakeholder engagement.	The organisation consistently develops robust annual plans that build assurance as a key step toward an approvable IMTP. Plans begin to reflect medium term priorities, include a finance and delivery framework, and show early signs of strategic alignment including financial forecasts and delivery milestones.	The organisation has developed an approvable, outcomes-focused IMTP that reflects strategic priorities, enabling plans and clinical service plans. A robust 3-year sustainable financial plan is included, with clear links to service transformation (with milestones and timelines) with clearly articulated risks and mitigations.	The organisation has a history of submitting high quality IMTP's that are strategically integrated and includes a comprehensive delivery and assurance framework. It demonstrates alignment across all enabling strategies and is informed by detailed modelling, population health intelligence, and with significant stakeholder input.	The organisation is recognised for excellence in IMTP delivery and assurance and has a long history of developing and submitting high quality IMTP's which surpass policy expectations and is recognised as a system-leading exemplar. It is co-produced and informed by detailed analysis and predictive tools to drive transformation across the health system, delivers the quadruple aim.
Monitoring and Delivery **2 (No change)**	Monitoring of annual plan or IMTP delivery is ad hoc and reactive and focused on immediate operational issues. There is limited visibility of progress, and reporting is inconsistent. Accountability is unclear and delivery risks are not systematically managed.	The organisation has a structured approach to monitoring annual plan or IMTP delivery with ownership of delivery emerging across services. Key milestones and actions are tracked, and reporting mechanisms are in	Monitoring of IMTP delivery is consistently seen as business as usual and integrated with performance management reviews and risk assurance processes. Progress is tracked	IMTP delivery is monitored through a robust, outcome-focused framework which includes impact evaluation. The organisation adapts delivery plans based on performance insights, emerging risks, and system pressures. Staff are engaged in owning	IMTP monitoring and delivery are embedded in real-time, system-wide performance and governance structures. The organisation demonstrates strategic leadership in delivery assurance, advanced triangulation, using predictive analytics, scenario planning, and co-produced improvement plans. Delivery is continuously optimised to achieve the quadruple aim. Continuous improvement cycles

		place through basic dashboards and reported to the Board regularly. Accountability is improving, but integration with performance and risk management is limited.	against outcomes, and corrective actions are taken. Delivery is supported by enabling functions and aligned with strategic priorities. Delivery is starting to inform future planning.	and delivering IMTP priorities.	are embedded, with clear evidence of impact and the

Realistic & Deliverable - Self-Assessment			
Domain	**Assessed level**	**Evidence Used**	**Any Supporting Narrative**
Risk Identification & Management	**3 (increased from 2)** Risk identification and management are embedded in IMTP development and delivery processes. Risks are identified early and linked to specific objectives, milestones, and outcomes. Controls are monitored, and mitigation actions are tracked. Risk registers are dynamic and inform delivery with clear ownership.	▪ BCU 3 Year Plan **evidenced above**. ▪ Health Board Risk Management Framework **evidenced above** ▪ Board Assurance Framework (BAF) and Corporate Risk Register (CRR) **evidenced above**	The Health Board has embedded risk management within strategic planning, programme delivery and organisational governance. The Risk Management Framework, Board Assurance Framework (BAF) and Corporate Risk Register (CRR) provide a structured and consistent approach to identifying, assessing, escalating and managing strategic risks aligned to the IMTP and organisational priorities. Risk management is integrated throughout the planning process. Risks are identified during the development of the IMTP, Clinical Services Plan (CSP) and major transformation programmes, linked to strategic objectives and delivery priorities, and monitored through established governance arrangements. Controls, mitigating actions and delivery risks are routinely reviewed to support delivery assurance and organisational resilience. Risks associated with the Plan are visible in the BCU 3 Year Plan 2026/29 Routine governance through the Strategic Planning and Service Change Group (SPSCG), Executive Team, Board

			Committees and Board provides clear ownership, oversight and escalation of strategic risks. Risk information increasingly informs planning decisions, prioritisation, programme delivery and resource allocation, supporting a more proactive approach to managing delivery risks. In response to Welsh Government feedback, greater emphasis has been placed on demonstrating how risk management supports delivery rather than simply evidencing the existence of risk frameworks. The Health Board continues to strengthen the visibility of delivery risks, mitigation actions and assurance arrangements within strategic planning processes. **Maturity Justification** The Health Board is appropriately assessed at **Level 3.** Risk identification and management are embedded within IMTP development, programme delivery and organisational governance through established risk management, assurance and escalation arrangements. Risks are increasingly linked to organisational priorities, monitored through routine governance processes and used to inform

			planning, prioritisation and delivery decisions. Continued development of predictive risk management, organisational learning and risk-informed planning will support progression towards the next maturity level.
Development of IMTP and track record	**2 (increased from 1)** "The organisation consistently develops robust annual plans that build assurance as a key step toward an approvable IMTP. Plans begin to reflect medium term priorities, include a finance and delivery framework, and show early signs of strategic alignment including financial forecasts and delivery milestones."	**BCU IMTP 2025-28 (submitted):** ▪ FINAL BCUHB 2025-28 IMTP **Welsh Government Feedback on BCU IMTP 25-28** ▪ 20250902 SE to PT - BCUHB IMTP Feedback **BCU 3 Year Plan - 2026-29 (submitted)** ▪ BCUHB Narrative Plan 2026-29 **Welsh Government Rapid Assessment Feedback submitted plan:** ▪ 20260413 CEONHSW to CEOBCUHB - Rapid Assessment of BCU Plan 2026-29	The Health Board has strengthened its approach to IMTP development through implementation of the Integrated Planning Framework, Continuous Planning Cycle and Strategic Intent Statements, improving alignment between strategic priorities, operational delivery and medium-term planning. The Board-approved IMTP 2025-28 represented progress in planning maturity, providing a financially balanced three-year plan. Welsh Government feedback recognised improvements in the quality, coherence and development of the plan, providing a stronger foundation for future IMTP submissions. The feedback received was used to further improve and inform the development of the BCU 3 Year Plan for 2026-29. The IMTP is supported by an integrated finance and delivery framework, linking strategic objectives with medium-term financial forecasts, workforce and service

			planning assumptions, and clear delivery expectations. IMTP priorities are structured around deliverables, impacts and performance measures, providing a clear framework for monitoring progress and demonstrating how planned actions contribute to improved outcomes. This approach supports delivery assurance through defined milestones and measurable indicators. Directorate Delivery Plans, supported by the Integrated Performance and Accountability Framework, strengthen organisational oversight of delivery through regular monitoring of progress, performance, risks and corrective actions. Executive Team, Planning, Population Health and Partnerships Committee and Board oversight provide ongoing assurance of plan implementation. These arrangements demonstrate increasing planning maturity, with annual plans increasingly aligned to medium-term priorities and supported by strengthened financial planning, delivery assurance and governance.

			Maturity Justification The Health Board is appropriately assessed at **Level 2.** Evidence demonstrates that annual and medium-term plans are developed through a structured and integrated planning process, supported by clear governance, financial planning and delivery assurance arrangements. Plans align strategic priorities with financial forecasts, delivery milestones, performance measures and expected impacts, providing a stronger basis for organisational assurance and future approvable IMTPs. Whilst further evidence of sustained delivery and successive approvable IMTPs would be required at higher maturity levels, the organisation demonstrates the characteristics expected at **Level 2**.
Monitoring and Delivery	**2** **(No change)** "The organisation has a structured approach to monitoring annual plan or IMTP delivery with ownership of	Quarterly **Annual Delivery Plan (ADP)** Report: ▪ ADP 26-27 ▪ FINAL - SPSCG - ADP Q1 27.07.26 ▪ Example showing ADP reviewed at SPSCG, PPHP and Board **evidenced above**	The Health Board has established a structured approach to monitoring delivery of the IMTP through quarterly Annual Delivery Plan (ADP) reporting, Directorate Performance Reviews, Corporate Directorate Reviews and operational service reviews. These arrangements provide regular oversight of delivery, performance, organisational priorities and emerging risks.

	delivery emerging across services. Key milestones and actions are tracked, and reporting mechanisms are in place through basic dashboards and reported to the Board regularly. Accountability is improving, but integration with performance and risk management is limited”		The Continuous Planning Cycle has strengthened monitoring by introducing regular opportunities to review progress, challenge performance and refine delivery plans throughout the year. Monitoring arrangements increasingly support the identification of delivery issues, enabling timely corrective action and greater organisational accountability. Performance, quality, workforce, finance and risk information is reviewed through established governance arrangements, including the Strategic Planning and Service Change Group (SPSCG), Executive Team, Planning, Population Health and Partnerships Committee (PPHP) and Board. These arrangements provide greater visibility of organisational performance and strengthen oversight of IMTP delivery. Whilst monitoring arrangements are well established, further work is required to strengthen the integration of monitoring with performance management and risk assurance, and to consistently demonstrate how delivery information informs future planning, organisational decision-making and service improvement.

			o Special Measures monitoring and assurance arrangements supporting organisational recovery. o Programme governance supporting delivery of major transformation programmes, including the Clinical Services Plan (CSP) and Foundations for the Future. o Routine monitoring of delivery milestones, actions, performance, risks and mitigating actions using integrated quality, workforce, finance and performance information. **Maturity Justification** The Health Board remains appropriately assessed at **Level 2**. Evidence demonstrates a structured and increasingly coordinated approach to monitoring IMTP delivery through established governance, performance reporting and organisational accountability arrangements. Delivery milestones, actions and performance are routinely monitored, with improving ownership across services. Further integration of monitoring with performance management, risk assurance and future planning will be required before

			progression to **Level 3** can be evidenced.
Overall Judged Score	**2**	Risk management arrangements provide evidence to support the assessment of Level 3 for that individual element. The organisation has also demonstrated improvement in the quality and integration of its planning processes, including implementation of the Integrated Planning Framework, Continuous Planning Cycle and strengthened delivery assurance arrangements. However, the absence of an approved IMTP, a limited track record of sustained delivery against medium-term plans and the continued development of monitoring and delivery arrangements mean that the domain overall remains aligned to **Level 2 (Early Progress).** The Health Board demonstrates several characteristics of Level 3, but these are not yet consistently evidenced across the whole domain.	

F) Realistic & Deliverable - Actions						
Domain	**Assessed level 2026**	**Aspired Position**	**Action(s)**	**Timelines/Milestones**	**Evidence to be used**	**Impact Measurement**
Risk Identification & Management	**3**	3	Continue to strengthen the use of risk information within planning, prioritisation and delivery decision-making processes.	Throughout 2026-29	Board Assurance Framework (BAF); Corporate Risk Register (CRR); Directorate Risk Registers; SPSCG and Committee reports.	Evidence that risks influence planning assumptions, prioritisation decisions and mitigating actions across programmes and services.
Development of IMTP and track record	**2**	3	Continue embedding the Integrated Planning Framework and Continuous Planning Cycle to strengthen integrated planning, delivery confidence and future IMTP submissions.	Throughout 2026-29	IMTP submissions; Reflection and Learning reports; Planning Guidance; Welsh Government feedback.	Independent feedback demonstrates improved confidence in the quality, integration and deliverability of organisational plans.
Monitoring and Delivery	**2**	3	Strengthen integration between delivery monitoring, performance management and risk assurance arrangements.	Throughout 2026-29	Annual Delivery Plan reports; Directorate Reviews; SPSCG, PPHP and Board reports.	Evidence that issues identified through monitoring lead to remedial action, revised delivery plans or escalation through governance processes.

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Right care, right place, first time

Urgent and Emergency Care Improvement Plan

Betsi Cadwaladr University Health Board Plan — 2026/27

Document Information	
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1. Executive Summary

The Urgent and Emergency Care (UEC) Improvement Plan 2026/27 sets out Betsi Cadwaladr University Health Board's strategic direction for improving urgent and emergency care services across North Wales. The plan is focused on delivering sustainable improvements in patient flow, reducing avoidable delays, improving length of stay, and strengthening whole-system collaboration across health, social care, ambulance services and the third sector.

At the heart of this plan is a commitment to ensuring patients receive the right care, in the **right place, at the right time**. By increasing the number of patients discharged within 48 hours of becoming clinically optimised, the Health Board will release much-needed inpatient capacity, reduce Emergency Department overcrowding, minimise ambulance handover delays, and improve both patient outcomes and experience.

The plan brings together the strategic and operational context for urgent and emergency care, the findings and recommendations arising from the recently commissioned independent review (completed between January and April 2026), and the current positions of each Integrated Health Community (IHC). Collectively, these elements provide a clear assessment of current challenges and opportunities and establish a coordinated approach to delivery across the Health Board during 2026/27.

Recognising the need for immediate action alongside longer-term transformation, the plan includes 90-day delivery plans for each of the three Integrated Health Communities. These plans provide assurance regarding the actions required in the short term, the outcomes expected, and the timelines for delivery. Progress will be monitored through robust governance arrangements and regular performance review by the Health Board.

The Health Board has identified three immediate priorities that will have the greatest impact on improving patient flow and reducing pressure across the urgent and emergency care pathway, these were identified from intensive support and diagnostics during spring 2026:

1. **Discharge to Recover and Assess (D2RA):** accelerating discharge and reducing unnecessary length of stay by supporting patients to continue their recovery in the most appropriate setting.
2. **Frailty:** implementing systematic approaches to the identification, assessment and management of frail patients, reducing avoidable admissions and improving outcomes.
3. **Clinical Engagement:** strengthening clinical leadership, ownership and accountability to drive sustainable improvement across the system.

Alongside these immediate priorities, the Health Board has identified three transformational priorities that will support longer-term improvement and system resilience. Delivery of these priorities is dependent on establishing the foundations created through the immediate priorities:

- **Single Point of Access (SPOA):** simplifying access to services and ensuring patients are directed to the most appropriate care pathway first time.
- **Same Day Emergency Care (SDEC):** expanding ambulatory models of care to reduce avoidable admissions and support patients to be assessed, treated and discharged on the same day where clinically appropriate.
- **Falls Prevention and Response:** strengthening prevention, community response and integrated pathways to reduce falls-related admissions and associated demand on urgent care services.

Collectively, the actions within this plan are designed to improve performance against six key outcome measures that reflect the effectiveness of the urgent and emergency care system:

- Reduction in ambulance handover waits exceeding 45 minutes.
- Increased proportion of ambulance handovers completed within 15 minutes.
- Improved performance against the 12-hour target within major and minor emergency care settings.
- Reduced median time to assessment by a senior clinical decision maker in Emergency Departments.
- Reduction in the number of patients experiencing delayed pathways of care.
- Reduction in total delayed bed days associated with delayed pathways of care.

This plan represents a whole-system commitment to improving urgent and emergency care performance, enhancing patient experience, and delivering sustainable change across the Health Board. Through focused delivery, strong clinical leadership and effective partnership working, the Health Board will improve flow throughout the system, maximise available capacity, and ensure that patients receive timely, high-quality care whenever they need it.

2. Strategic Context

2.1 Ministerial Priorities

The Welsh Government has set out five Ministerial priorities for in 2026/27.

UEC1	Implement Community – Based Falls Response Framework. Deliver, as a minimum, all principles set out in the six goals for urgent and emergency care programme community-based falls response framework and, in support, implement a focus on prevention and early intervention in line with policy statement on population health management.
UEC2	Implement the 'Single Point of Access (SPoA) Framework to deliver, as a minimum, all principles set out in the six goals for urgent and emergency care programme single point of access (SPoA) framework to ensure people with urgent care needs receive timely and appropriate support, minimising unnecessary escalation to emergency ambulance conveyance or hospital admission. Prioritise tailored interventions for frail and older adults, scaling "call before convey" as a business-as-usual model and referrals to community nursing services enabling urgent response. Strengthen integration with key system partners, including WAST and Local Authorities, to deliver coordinated and effective care across the urgent care pathway.
UEC3	Implement the Acute Front Door Frailty Service (AFS) Framework – Deliver medical same day emergency care (SDEC) and acute frailty services at the front door of hospitals in line with all principles set out in the national SDEC policy and strategy documents, and the six goals for urgent and emergency care programme Front Door Acute Frailty Service (AFS) Framework for Acute Hospitals.
UEC4	Ambulance Patient Handover (H45) Through effective streaming of patients on arrival at the front door allied to a focus on safe, efficient and early discharges, deliver all ambulance patient handovers within a maximum of 45 minutes, aiming for achievement of >90% in 15 minutes by the end of 2026/27. Further details are provided in **Appendix A**, the H45 (Hospital Handover Plan).
UEC5	Implement the Optimal Hospital Flow Framework Deliver, as a minimum, all principles set out in the six goals for urgent emergency care programme Optimal Hospital Flow Framework with a focus on 7-day working with leaner acute hospital processes and more efficient discharge transport services to facilitate earlier discharges and increasing weekend discharges.

2.2 Transforming urgent and emergency care services in England (2015)

The NHS England Urgent and Emergency Care programme set out a vision for a more integrated and responsive urgent and emergency care system, focused on ensuring patients

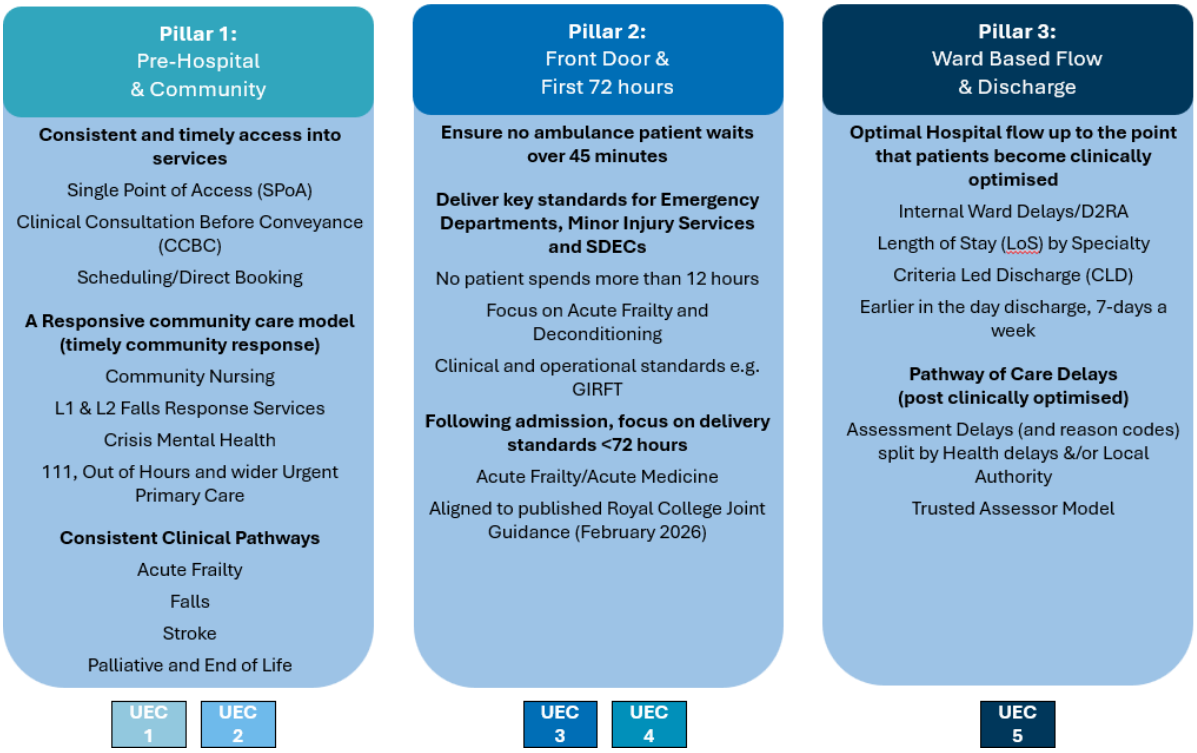
receive the right care in the right place at the right time. It provides an important foundation for current urgent and emergency care policy and aligns closely with the more recently Welsh Government policy directions. The programme emphasised whole-system working, improved patient flow and more effective use of ambulance services, principles which continue to underpin the UEC Three Pillars Programme.

2.3 UEC Three Pillars Framework

The National Programme is built around three pillars of urgent and emergency care improvement:

- **Pillar 1**: Support at the Individual's Front Door: co-ordination, planning and support for populations at greater risk of needing urgent or emergency care, and signposting people with urgent care needs to the right place, first time.
- **Pillar 2:** Hospital Front Door and Flow: clinically safe alternatives to admission to hospital, rapid response in a physical or mental health crisis, and optimal hospital care and discharge practice from the point of admission.
- **Pillar 3:** Discharge to the Community: a home first approach that reduces the risk of readmission.

Although the Ministerial priorities are expressed as five UEC frameworks (UEC1–UEC5), they collectively deliver all three pillars:



Appendix B provides a visual overview of the alignment between the Urgent and Emergency Care (UEC) Ministerial Priorities, The Three Pillars, and BCUHB's Integrated Medium Term Plan (IMTP), illustrating how strategic objectives and delivery priorities are interconnected.

2.4 Right sizing community services to support discharge from hospital (2020)

The Right sizing community services to support Discharge from hospital (2020) report, developed using Professor John Bolton's model, provides an important evidence base for BCUHB's approach to reducing Pathway of Care Delays (POCD) and strengthening Discharge to Recover then Assess (D2RA) pathways. The report highlights the need for health and social care partners to develop sufficient community capacity, implement consistent discharge arrangements and support timely discharge through integrated working across Regional Partnership Board (RPB) footprints. BCUHB's response to the recommendations within the report are being progressed jointly with the North Wales Local Authorities through the Regional Partnership Board's Shared Purpose programme.

2.5 Health Inspectorate Wales (HIW) report (2026)

Following an unannounced inspection of the Emergency Department at Ysbyty Glan Clwyd (YGC) in May 2026, Healthcare Inspectorate Wales (HIW) designated the service as requiring Significant Improvement and issued an Immediate Assurance and Improvement Plan. The findings highlighted a range of concerns relating to patient safety, operational effectiveness, leadership, workforce culture and the clinical environment, requiring urgent and coordinated action by the Health Board.

In response, the Health Board has established a comprehensive improvement programme designed to deliver rapid and sustainable improvements in the quality, safety and performance of the service. The programme is underpinned by strengthened governance arrangements, including daily operational oversight, weekly performance reviews and formal monthly assurance processes. Senior leadership visibility and presence within the department have been significantly enhanced to support timely decision-making, proactive risk management and escalation of emerging issues.

A key focus of the improvement programme is the development of a positive, accountable and psychologically safe culture in which staff feel empowered to raise concerns, contribute to service improvement and challenge unsafe practice. This is being supported through leadership development, clear behavioural standards, strengthened accountability arrangements and improved mechanisms for listening to and responding to staff feedback. Workforce wellbeing has also been prioritised through targeted support, regular staff

engagement and enhanced monitoring of workforce indicators, recognising the critical relationship between staff experience, retention and patient care.

Operationally, the programme includes a range of actions to improve patient flow, reduce delays and strengthen compliance with clinical standards across the urgent and emergency care pathway. Particular emphasis has been placed on ensuring timely assessment, treatment and escalation of patients within the Emergency Department, improving specialty response times, and strengthening capacity management processes to reduce overcrowding and associated patient safety risks.

The improvement plan also addresses specific areas identified by HIW, including paediatric safety, safeguarding arrangements, medicines management, equipment compliance and the reliability of the clinical environment. Actions are being implemented to strengthen assurance, improve adherence to policies and standards, and ensure that clinical practice is supported by robust audit and quality improvement processes.

In addition, environmental and security risks are being mitigated through enhanced access control measures, improved estates responsiveness and strengthened oversight of identified infrastructure issues. Progress against the improvement programme is being closely monitored through a comprehensive performance and assurance framework, incorporating key quality, safety, workforce and operational indicators, including incident trends, compliance measures, patient flow metrics, waiting times and staff feedback.

Collectively, these actions are intended not only to address the immediate concerns identified by HIW, but also to create the conditions for sustained improvement, ensuring the delivery of safe, effective and high-quality urgent and emergency care services for the population of North Wales.

3. Evidence – Need for change

3.1 Independent UEC Advisor Review

During 2025/26, BCUHB commissioned Independent UEC Advisors to undertake a comprehensive review of urgent and emergency care pathways, patient flow and discharge arrangements across the organisation. Over a three-month period, the advisors collected evidence through detailed ward-based observations, multidisciplinary engagement, pathway reviews and analysis of patient level flow data.

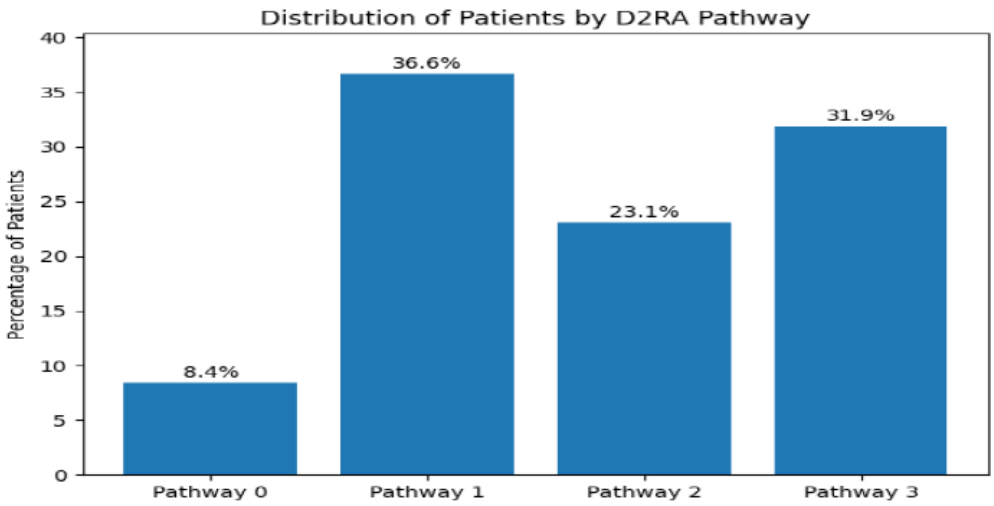
The review included a focused assessment of patients experiencing long lengths of stay through the 21-Day LOS reviews, alongside a thematic audit of practice against the 6 A's

methodology and observations undertaken through the MADE programme. The findings provided a consistent and compelling picture of delays within the system and identified significant opportunities to improve patient flow, reduce unnecessary hospital stays and improve patient outcomes.

The evidence demonstrated that a substantial proportion of patients occupying acute and community hospital beds no longer required that level of care. Across the review period, between 64% and 75% of patients reviewed within the 21-day length of stay cohort was assessed as not requiring an acute or community hospital bed, whilst approximately 20% of emergency admissions and conveyances were considered avoidable. The review also identified variation in discharge practices, delays associated with assessment processes, limited adoption of Home First principles, and a system culture that often-favoured assessment within hospital settings rather than recovery and assessment at home.

3.1.1 Lack of a Consistent D2RA/Home First Model.

There is no system-wide adoption of D2RA. Assessments are often carried out before recovery and there is significant over-use of Pathway 3 (bed-based care). Pathway 3 (24-hour bed-based care) is intended for only the most complex cases (see below illustration). Welsh D2RA guidance states that Pathway 3 should be used only when an individual's needs rule out recovery and assessment at home and that no more than about 15 % of people requiring further support should be transferred to a bedded community facility. New admissions to residential or nursing care (pathway 3) should be under 4 %, with roughly 85 % of discharged patients supported at home. The 21-day length of stay review found far higher use of Pathway 3 beds, indicating a need to redirect patients to home-based Pathway 1 or short-term Pathway 2 services wherever possible. Below are the percentages of patients with a length of stay 21 days or greater and their allocated pathways (as recorded on their electronic patient record).



3.1.2 MADE events

The MADE feedback across BCUHB consistently highlights a need for stronger leadership visibility, clearer accountability, and more effective operational grip, particularly within urgent and emergency care pathways. Common themes include pressures on patient flow leading to prolonged waiting times, inconsistent escalation processes, and variability in adherence to standard operating procedures. Staff reported challenges relating to workforce shortages, wellbeing pressures, and a lack of psychological safety in some areas, with concerns not always being fed back or acted upon consistently.

Positively, there was recognition of committed staff, opportunities to strengthen teamwork, and examples of good practice where multidisciplinary collaboration was effective. The events emphasised the importance of improving communication, embedding a supportive and open culture, standardising processes, and strengthening governance arrangements to ensure timely decision-making and safer, more reliable care delivery.

Key staff concerns identified from the MADE events in BCUHB included:

- Lack of visible and consistent leadership, particularly during periods of high operational pressure
- Patient flow challenges, with overcrowding, long waits, and delays in assessment and admission
- Workforce pressures, including staffing shortages, skill mix concerns, and reliance on temporary staff
- Staff wellbeing and burnout, with fatigue, stress, and limited opportunity for breaks

- Psychological safety issues, where some staff felt unable to raise concerns or lacked confidence these would be acted upon
- Inconsistent communication and feedback, especially around escalation decisions and outcomes
- Variation in processes and adherence to SOPs, leading to inefficiencies and risks to patient care
- Concerns about safety in waiting areas, including monitoring of deteriorating patients

Overall, staff highlighted a need for stronger leadership, clearer processes, better communication, and greater support for wellbeing and speaking up.

3.1.2 Findings from the 6 A's Audit

The 6 A's audit highlighted recurring barriers to effective patient flow and discharge, including:

- Lack of anticipation and proactive discharge planning from day one.
- Delays in assessment and decision-making processes.
- Limited accountability for progressing patients through pathways.
- Inconsistent application of D2RA principles across sites.
- Variation in operational practice between hospital sites and local authority areas.
- Insufficient challenge of prolonged hospital stays for medically optimised patients.

The audit findings reinforced the need for a whole-system approach to patient flow, underpinned by clear ownership, standardised processes and stronger community alternatives to hospital admission and bed-based care.

3.1.3 Shared Purpose

The Shared Purpose was developed in partnership through facilitation from the regional partnership board (RPB), it sets out a collective commitment to ensuring that people receive the right care in the most appropriate setting, avoiding unnecessary hospital admissions wherever safe alternatives exist. It prioritises timely and effective discharge, including discharge to D2RA pathways within 48 hours of clinical optimisation and same-day discharge for Pathway 0 patients by midday. The approach emphasises maintaining independence, preventing deconditioning, and ensuring care packages are proportionate to need. Decisions about long-term care will not be made in acute settings unless clearly appropriate, supporting a recovery-focused model of care. Overall, partners will work together to improve patient flow,

support safe and timely discharge, and deliver a coordinated, efficient system that achieves the best outcomes for the population. BCUHB and Local Authorities have signed up to this commitment for the population of North Wales and this plan will foster that commitment moving forward.

3.1.4 Implications for the Improvement Plan

The work undertaken by the Independent UEC Advisors provides a significant proportion of the evidence base for this Improvement Plan. The recommendations arising from the 21-Day LOS reviews, MADE work and 6 A's audit directly inform the actions outlined within this plan, particularly those focused on:

- Embedding D2RA and Home First principles.
- Provision of a Frailty Model
- Reducing the number of patients with a length of stay greater than 21 days.
- Improving discharge planning from the point of admission.
- Reducing process-driven delays and unnecessary assessments.
- Strengthening accountability for patient flow at all levels of the organisation.
- Increasing community capacity and alternatives to hospital care.
- Standardising discharge and escalation processes across BCUHB and partner organisations

The evidence indicates that transformational rather than incremental change is required if BCUHB is to sustainably improve patient flow, reduce avoidable occupancy and deliver better outcomes and experiences for patients and staff. This will therefore become a programme priority in line with the 3 Pillars of UEC.

4. Metrics

Current performance against the 6 metrics within the WG performance framework are below target; in addition, the targets set within the de-escalation criteria are not being met. The below table sets out current HB performance and the performance of each IHC.

The 6 national metrics are used to track the impact of the three strategic shifts. Improvements in flow (D2RA), admission avoidance (Frailty), and decision making (Clinical Engagement) will collectively improve performance across all measures. The programme and indeed this plan

will consistently prioritise actions against these metrics and ensure clear correlation within the IHC 90 day plans.

Metric	Primary Driver
12-hour performance	D2RA (flow), Clinical Engagement
Handover 45 (H45)	D2RA + Clinical Engagement
Time to clinician	Clinical Engagement
POCD	D2RA, Clinical Engagement
Clinical pathway effectiveness (<admission / LoS; >flow)	Frailty, Clinical Engagement
Patient Experience	Frailty, D2RA, Clinical Engagement

4.1 Performance Trajectories

Performance trajectories in this plan are drawn from two complementary sources. BCUHB-wide trajectories are taken from the Health Board's Integrated Medium Term Plan (IMTP) 2026/27, setting the agreed baseline and improvement targets against which system-level progress is tracked (the six P01–P06 metrics). Localised IHC metrics are taken from the Central, East and West 90-day plans which will be written and monitored inline with improvement methodology, and will include the starting position, pace and priorities specific to each community. Together, these form the performance foundation of this Improvement Plan: IMTP trajectories provide the consistent, Health Board-wide measure of improvement, while the 90-day IHC targets ensure that performance is monitored, and variation addressed, at the pace and level of detail each community requires.

BCUHB Performance Trajectories from the 2026/27 IMTP

ID	Performance Expectation	Ref	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
P01	Reduce ambulance handover waits over 45 mins	DE-01 SM-17 MAG-09 IPT-02	2417	2367	2318	2186	2055	1923	1709	1496	1282	1171	1061	950
P02	Ambulance handovers in < 15 mins	EA-08 MAG-09	537	604	670	720	769	819	918	1018	1117	1341	1564	1788
P03	Reduce 12 hour waits in major and minor emergency care setting	DE-02 SM-19	3614	3401	3189	3040	2892	2743	2594	2446	2297	2148	1999	1850
P04	Reduce median time to assessment by senior clinical decision maker	SM-18	160	160	160	153	147	140	140	140	140	123	107	90
P05	Reduce delayed pathways of care - number of people who are delayed in hospital	DE-10 SM-20 IPT-05	297	279	260	247	234	221	200	179	158	158	158	158
P06	Reduce delayed pathways of care - total days delayed for these patients	DE-10 IPT-03	13329	12479	11628	11061	10493	9926	8981	8035	7090	7090	7090	7090

West IHC - Ysbyty Gwynedd Performance Trajectories (inc revised HO45)

ID	Performance Expectation	Ref	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
P01	Reduce ambulance handover waits over 45 mins	DE-01 SM-17 MAG-09 IPT-02	806	741	747	756	745	659	571	492	444	362	334	300
	Reduce ambulance handover waits over 45 mins (%, 8am-7:59pm)	DP-01			20%	20%	13%	7%	0%	0%	0%	0%	0%	0%
P02	Ambulance handovers in < 15 mins	EA-08 MAG-09	174	165	180	188	194	221	244	276	288	348	386	493
P03	Reduce 12 hour waits in major and minor emergency care setting	DE-02 SM-19	946	883	893	807	850	736	670	606	522	484	500	446
P04	Reduce median time to assessment by senior clinical decision maker	SM-18	160	160	160	153	147	140	140	140	140	123	107	90
P05	Reduce delayed pathways of care - number of people who are delayed in hospital	DE-10 SM-20 IPT-05	82	84	74	77	72	74	60	58	50	46	49	49
P06	Reduce delayed pathways of care - total days delayed for these patients	DE-10 IPT-03	2904	3518	3467	3933	3798	4063	3282	3013	2838	2578	2921	3079

Central IHC - Ysbyty Glan Clwyd Performance Trajectories (inc revised HO45)

ID	Performance Expectation	Ref	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
P01	Reduce ambulance handover waits over 45 mins	DE-01 SM-17 MAG-09 IPT-02	936	840	857	807	657	684	541	559	430	411	375	341
	Reduce ambulance handover waits over 45 mins (%)	DP-01				12.9%	6.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
P02	Ambulance handovers in < 15 mins	EA-08 MAG-09	179	254	277	301	355	375	421	387	511	573	750	689
P03	Reduce 12 hour waits in major and minor emergency care setting	DE-02 SM-19	1704	1562	1391	1341	1238	1247	1121	1067	966	919	832	786
P04	Reduce median time to assessment by senior clinical decision maker	SM-18	160	160	160	153	147	140	140	140	140	123	107	90
P05	Reduce delayed pathways of care - number of people who are delayed in hospital	DE-10 SM-20 IPT-05	103	87	80	76	65	57	60	47	48	45	46	47
P06	Reduce delayed pathways of care - total days delayed for these patients	DE-10 IPT-03	3952	3682	2938	2463	2137	1815	1934	1633	1391	1333	1398	1501

East IHC – Wrexham Maelor Performance Trajectories (inc revised HO45)

ID	Performance Expectation	Ref	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
P01	Reduce ambulance handover waits over 45 mins	DE-01 SM-17 MAG-09 IPT-02	675	786	713	624	653	580	597	444	408	398	352	309
	Reduce ambulance handover waits over 45 mins (%)	DP-01				30%	15%	0%	0%	0%	0%	0%	0%	0%
P02	Ambulance handovers in < 15 mins	EA-08 MAG-09	185	184	212	231	220	223	253	354	318	420	428	606
P03	Reduce 12 hour waits in major and minor emergency care setting	DE-02 SM-19	963	956	905	892	804	760	803	772	809	745	667	618
P04	Reduce median time to assessment by senior clinical decision maker	SM-18	160	160	160	153	147	140	140	140	140	123	107	90
P05	Reduce delayed pathways of care - number of people who are delayed in hospital	DE-10 SM-20 IPT-05	112	107	106	94	97	90	81	74	61	67	63	62
P06	Reduce delayed pathways of care - total days delayed for these patients	DE-10 IPT-03	6473	5279	5223	4664	4558	4048	3764	3389	2861	3179	2771	2511

5. Critical Strategic Enablers

There are three immediate priorities; D2RA, Frailty and Clinical Engagement, improving these priorities is dependent on three critical, cross-cutting enablers being addressed. Without sustained investment and Executive support in each of these areas, the sustained improvements required will not be delivered.

5.1 Digital

Reliable, real-time data is foundational to all priority areas: the community falls dashboard, the SPoA dataset specification, AFS performance monitoring, the Breathing Problems Dashboard,

and POCD validation all depend on consistent digital infrastructure and consistent data definitions across the three IHCs. Continued investment in shared operational dashboards, automated data capture, and interoperability between Health Board and Local Authority systems is essential to sustaining the pace of improvement beyond Q2 2026/27. In addition, data systems and efficiency initiatives such as EPMA need further refinement to ensure the intended benefits to efficiency are achieved.

5.2 System Leadership

Sustainable improvement in Urgent and Emergency Care cannot be delivered through process change alone. Experience across the three IHCs confirms that the pace and durability of improvement is determined as much by the quality of system leadership as by the specific interventions applied. Good system leadership is therefore treated as a foundational enabler underpinning all priorities within the plan, rather than a discrete workstream.

What we will aim to achieve:

- Creating 'One Source of Truth' to the UEC 'newsfeed' including metrics, performance trajectories and maintaining well managed version control for all communications, policy releases and bulletins
- Undertake a review and audit of current system and tactical arrangements
- Describe good System Leadership, which is both sustainable, supportive but also drives strategic enablers
- Develop an Operating Plan that has UEC Core Operational Delivery at the centre
- Establish shared ownership of UEC performance across all clinical and operational teams, rather than risk being held solely by ED, Patient Flow or by a single IHC
- Ensure escalation and de-escalation of operational pressures is both streamlined and supported by trusted relationships between all operational pillars and with clear guidelines on roles and responsibilities timeframes.
- Ensure all Escalation policies have been approved through local governance so that they are fit for purpose, by site and by service, and are well communicated
- Consistent translation of Board-level assurance expectations into day-to-day operational practice, and vice versa, ensuring the Board has a true picture of risk, receives qualified recommendations to ensure that they can approve decisions in a timely manner

Suggestions for delivery:

This Plan's IHC-level 90-day actions are deliberately designed to strengthen system leadership behaviours alongside their operational content, including:

- Triangulated ownership of risk between IHC Directors, Clinical Leads, Local Authorities and site teams, supported by consistent reporting lines into the MCP Programme.
- UEC Director aligned to both MCP and Operational delivery of UEC in BCUHB.
- System leadership model implementation is vital to enable the constant monitoring of system resilience and interdependencies of system improvements.
- Visible, consistent leadership presence at the interfaces where flow most often breaks down (e.g. SDEC/ED interface, D2RA, community step-down).

Ensure that our internal experts i.e OD, Communications, HR etc are included in our plans for recovery.

5.4 Culture

The Health Board's ability to deliver a single, pan-BCU UEC Operating Model rather than three IHC-specific approaches, depends on a shared organisational culture of accountability, transparency and willingness to standardise practice through this UEC Improvement plan and how we interface together.

Sustaining this cultural shift including consistent adoption of and implementation of Operational activities, daily rhythm, Red2Green, board round protocols and a shared lexicon for flow conversations, is a precondition for the workforce and digital enablers above to deliver their full benefit.

6. Corporate Enablers

In addition to the three critical strategic enablers, three corporate-level enablers are required to support consistent delivery across the Health Board's three IHCs.

6.1 Options Framework

A consistent options framework, setting out the alternatives to hospital admission and conveyance that are offered to patients and their families at the point of need, underpins both UEC1 (Community-Based Falls Response) and UEC2 (Single Point of Access). Where low-acuity fallers or urgent care callers are offered a genuine and clinically safe choice between ambulance conveyance, community response, or self-management with safety-netting, conveyance avoidance and unnecessary hospital attendance both reduce. Embedding a

consistent, well-communicated options framework across all six North Wales Local Authority areas, and across all three IHCs, is a corporate-level commitment that sits above any single workstream.

6.2 Patient Choice Policy

A recurring theme identified across the reviews conducted at Betsi Cadwaladr University Health Board (BCUHB) is the impact of patient choice on timely discharge and effective flow through the urgent and emergency care pathway, across all three Integrated Health Communities (IHCs). While the right of patients and their families to express a preference regarding ongoing care arrangements, such as a preferred care home or place of care, is fully respected, exercising this choice can, in some circumstances, result in patients remaining in an acute bed at Ysbyty Glan Clwyd, Ysbyty Gwynedd or Wrexham Maelor Hospital beyond the point at which they are medically fit for discharge.

This presents a tension between respecting individual preference and BCUHB's system-wide imperative to ensure acute beds are available for those who require them. In line with the Discharge to Recover and Assess (D2RA) principles embedded within the UEC Three Pillars National Programme, the Improvement Plan supports a shift towards assessing patients' ongoing care needs away from the acute setting wherever it is safe and appropriate to do so, reducing the extent to which choice-related delays impact capacity across the Health Board.

Work under this Plan, overseen through the UEC Programme governance structure, will include:

- Develop a robust Patient Choice Policy, with defined flowcharts and letters, to enable clinical staff to hold conversations with patients and their families from the point of admission to enable discharge as soon as care within a hospital is no longer required.
- Develop an audit process to monitor the effectiveness of the Patient Choice Policy and address areas requiring improvement.
- Influence national guidance on patient choice to ensure consistent application of reasonable preference across all IHCs and Directorates and to evidence that decisions are transparent, fair, and clinically informed, regardless of which hospital site a patient is cared for at.
- Working with North Wales local authorities and community/social care partners to increase the range and availability of community-based alternatives, reducing instances where limited local choice availability extends a patient's stay.
- Monitoring the impact of patient choice on delayed transfers of care through the IHC and Board-level UEC performance dashboards.

6.3 Escalation Policy

NHS Performance and Improvement (NHS P& I) are updating the All-Wales UEC escalation framework and incorporating OPEL (NHS England) to have quantitative triggers to standardise escalation across Wales. Once the National Framework is finalised, each HB will need to then develop detailed actions plans that will support de-escalation. NHS P&I are also reviewing the risk scoring and the training requirements for operational staff.

They are working with HB digital teams to automate the daily data required as much as possible and agree what manual data will need to be submitted daily.

Work under this Plan, overseen through the UEC Programme governance structure, will include:

- Review HB approach to system wide leadership for the development and delivery of daily escalation processes and oversight.
- Review the Hospital Full Protocol and alignment with local IHC and Directorate plans, with reference to the feedback from the external review.
- Determine the processes for system wide responses to escalation, utilising the defined HB leadership structure, to provide daily oversight, coordination and progress of required actions.

7. Health Board Priorities

BCUHB has established 3 immediate priorities which are aligned to the national ministerial priorities to reflect both deliverability and the scale of patient safety and flow risk each currently presents.

The five Ministerial priorities (UEC1–UEC5) are delivered through three core strategic shifts. D2RA, Frailty and Clinical Engagement and represent the primary focus for 2026/27, with SPoA, SDEC and Falls enabling sustainable system improvement.

Priorities have been ranked using a consistent set of criteria rather than service preference or historical precedent. Each priority was assessed against:

i. The scale and immediacy of patient safety risk,

ii. The strength of evidence linking the priority to flow, handover and 12-hour breach performance,

iii. Deliverability within current workforce and funding envelopes,

iv. The degree to which BCUHB can influence outcomes directly versus being dependent on whole-system partners, including pace of projects.

BCUHB recognises that several of the priorities set out in this plan, particularly around discharge flow, frailty provision and clinical accountability, have been identified as areas for improvement for some time. We are not presenting these as new problems, but as long-standing challenges that now require sustained grip, focus and delivery discipline. This Improvement Plan, together with the 90-day plans developed by each IHC, is designed to provide exactly that: clear ownership, measurable milestones, and a consistent mechanism for tracking progress and holding delivery to account. By combining a clear strategic rationale with short, focused delivery cycles, we intend to move from repeated identification of these issues to demonstrable, sustained improvement.

Each priority below sets out what we are aiming to achieve, how we will achieve it, and confirms that detailed delivery actions, milestones and trajectories will be set out within each IHC's 90-day plan, developed and monitored in line with this Improvement Plan.

This plan focuses on three immediate system priorities which are D2RA, Frailty and Clinical Engagement. These are required to stabilise performance. SPoA, SDEC and Community Falls remain critical enabling priorities and will be progressed in parallel where capacity allows.

As part of the IHC 90-day plans, all three areas will be required to establish or expand an Urgent Treatment Centre (UTC) service to divert appropriate patients away from the Emergency Department. This will support the assessment and treatment of patients with urgent, but non-life-threatening, needs outside of the ED, directly reducing ED overcrowding and mitigating the associated patient safety risks identified across all sites. Each IHC’s 90-day plan must set out:

- **Current UTC provision** at the site, including operating hours and clinical scope.
- **Specific actions, milestones and timelines** for establishing or expanding UTC capacity within the 90-day period.
- **Expected impact** on ED attendances, 12-hour performance and patient safety indicators.
- **Named clinical and operational leads** accountable for delivery.

Progress against this requirement will be monitored through the UEC governance and reporting structure alongside the other 90-day plan actions.

Immediate Priorities 2026/27		
Priority 1	D2RA	**Board-wide approach to discharge management and accelerating the transition to a Discharge to Recover and Assess (D2RA) model.** **What we are achieving:** A Board-wide, standardised approach to discharge management, accelerating the transition to a Discharge to Recover and Assess (D2RA) model across all three IHCs. Current Patients with No Criteria to Reside (POCD) levels of 108–163 patients represent the largest single contributor to 12-hour waits and ambulance handover delays, with beds occupied by patients no longer meeting criteria to reside remaining unavailable for new admissions. **How we will achieve it:** Using recognised improvement methodology, we will standardise operational practice for discharge planning across all three sites, improve daily discharge flow through structured board rounds and criteria-led discharge, and shift assessment of longer-term care needs from the acute setting into the community. This reduces avoidable bed occupancy, minimises patient deconditioning, increases bed availability, and improves flow throughout the whole urgent and emergency care pathway. By **31 March 2027**, complete the MADE event, 6As audit, 21-day length of stay review, and site management/escalation review across all three Integrated Health Communities (IHCs); produce a baseline diagnostic report for each IHC identifying priority opportunities to improve flow and discharge. Establish and convene a D2RA/Board Round Task & Finish Group, with representation from Home First, operational and clinical leads, MCPs and Optimal Hospital Flow Facilitators, and agree a prioritised improvement plan with defined actions, leads and milestones. **Optimal outcomes:** • Standardised Board Round and Criteria-to-Reside processes implemented across all three IHCs. • D2RA/Home First pathways redesigned and implemented to increase same-day discharge and reduce discharge delays. • Long-stay patient management process established, reducing patients with a LOS greater than 21 days. By **31 January 2027**, embed a standardised D2RA/Integrated Discharge Hub operating model, including weekly board round review of clinically optimised patients, across Central, East and West IHCs, increasing patients discharged within 48 hours of optimisation from 10% to 20%, verified through UEC Dashboard **Optimal outcomes**

		• Standardised D2RA/board round template and SOP rolled out across all three IHCs • Weekly compliance audit/dashboard tracking board round attendance and 48-hour discharge rates by IHC • Task & Finish Group sign-off on the phased implementation timeline and escalation route for non compliant sites **Delivery mechanism:** *Each IHC's 90-day plan will translate this priority into specific, measurable actions including local D2RA pathway design, discharge trajectory targets, and named improvement milestones, tracked through the UEC governance structure.*
Priority 2	Frailty	**Implement comprehensive frailty assessment services across all three acute hospital sites, ensuring that frail older adults have equitable access to timely Comprehensive Geriatric Assessment (CGA) at the point of presentation.** **What we are achieving:** Comprehensive frailty assessment services implemented consistently across all three acute hospital sites, ensuring frail older adults have equitable access to timely Comprehensive Geriatric Assessment (CGA) at the point of presentation, regardless of which site they attend. **How we will achieve it:** We will secure sustainable via re-prioritisation or disinvestment of funding to re-establish and embed the frailty service at Ysbyty Glan Clwyd following cessation of the pilot in March 2026, and standardise the frailty offer via model requirements Health Board-wide at the other acute sites through focused workstream leadership via the Programme. This includes developing dedicated frailty pathways, building workforce capacity, and embedding consistent operational processes for specialist assessment and intervention. This directly addresses a significant patient safety risk by reducing delays in identifying, assessing and managing frail older adults, improving outcomes, reducing unnecessary admissions and length of stay, and supporting same-day care where clinically appropriate. **December 2026**, complete a baseline assessment and gap analysis of the Acute Front Door Frailty Service across Central, East and West IHCs, with: Frailty front door data collection (provision, pathways, workforce utilisation) scoped and initiated alongside each IHC's 90-day plan submission by **1 October 2026**

		Draft IHC-level baseline findings shared for validation by **30 November 2026** Final baseline and gap analysis report, including prioritised, impact-rated opportunities per IHC, presented to [Programme Board/relevant governance forum] by **31 December 2026** Prioritised opportunities feeding into IHC improvement plans and the Q4 delivery phase running to **31 March 2027** • IHC-level baseline report on current frailty front door provision and pathways • Workforce utilisation analysis (establishment vs. actual deployment vs. demand) by IHC • Prioritised, impact-rated list of opportunities to strengthen early frailty assessment/intervention, feeding into the 90-day plan cycle By **31 March 2027**, achieve full operationalisation of the standardised AFS model at Wrexham Maelor, with active roll-out underway at Ysbyty Glan Clwyd and Ysbyty Gwynedd and increase Same Day Emergency Care (SDEC) utilisation to 35% of acute take across BCUHB, with: • SDEC utilisation baseline established by IHC by **31 October 2026** • AFS model fully operational at Wrexham Maelor (staffing in post, pathway live, front door integration complete) by **31 March 2027** • AFS roll-out to Ysbyty Glan Clwyd and Ysbyty Gwynedd initiated by **31 March 2027** • SDEC utilisation trajectory tracked monthly, reaching 35% of acute take **Delivery mechanism:** *Each IHC's 90-day plan will set out the specific frailty pathway actions, workforce milestones, and local implementation timeline required to reach a standardised model at that site.*
Priority 3	Clinical Engagement	**Strengthen Clinical Engagement and Accountability to Improve Patient Flow** **What we are achieving:** Strengthened clinical engagement and accountability for patient flow across all specialties, through agreed length-of-stay targets (from the intervention work carried out in Spring 2026), embedded Criteria Led Discharge protocols, and clear clinical ownership of admission, review and discharge decisions. **How we will achieve it:** We will standardise board round processes across all sites to ensure timely decision-making, proactive discharge

		planning, and effective escalation during periods of operational pressure. We will deliver consistent senior clinical decision-making at key points across the pathway, ED, Same Day Emergency Care and inpatient wards, and reduce unwarranted variation in clinical practice by setting clear expectations for flow responsibility at specialty, divisional and site level. As a critical enabler of both D2RA and Frailty, this work ensures improvements in admission avoidance, discharge and flow are embedded and sustained, not one-off gains. This will be supported by partnership working with Organisational Development and Communications to strengthen staff engagement and leadership capability, and by establishing an annual UEC Summit to share best practice and build shared ownership of improvement across the system. By **31 March 2027**, achieve >75% compliance with the agreed board round standard across Central, East and West IHCs, confirmed through monthly audit, with weekly review of clinically optimised patients embedded as a standing item within board round processes in all three IHCs, with: 1. Board round standard and audit checklist agreed and rolled out by 31 October 2026 2. Weekly clinically-optimised-patient review embedded as a standing board round agenda item in all IHCs by 30 November 2026 3. Baseline compliance audit complete by 30 November 2026, with monthly audits thereafter reported through the existing Highlight Report structure 4. Q3 checkpoint (31 December 2026) reviewing trajectory and addressing any IHC below target 5. >75% compliance achieved and sustained for two consecutive audit cycles by 31 March 2027 Outcomes : • Agreed board round standard and monthly audit checklist, consistent across all three IHCs • Weekly clinically-optimised-patient review embedded as a standing board round agenda item, with attendance/completion tracked • Monthly compliance audit with RAG reporting by IHC, feeding into the 90-day plan/Highlight Report cycle

		By 31 March 2027, establish consistent senior clinical decision-maker (Trusted to Assess/T2A) presence at the front door across Central, East and West IHCs, and standardise escalation and decision-making practices during periods of operational pressure, with: • Front door T2A staffing model and decision-making protocol agreed by 31 November 2026 • Rota/cover model for consistent senior clinical decision-maker presence live in the first IHC by 31 December 2026, remaining two IHCs by 28 February 2027 • Standardised escalation/decision-making protocol for periods of operational pressure (linked to the escalation framework) agreed and briefed to teams by 31 January 2027 • Compliance audit (rota fill rate and protocol adherence during escalation periods) complete by 31 March 2027 **Delivery mechanism:** *Each IHC's 90-day plan will define local senior review models, board round standards, and length-of-stay/discharge accountability actions specific to that site's specialties and services.*
Longer term priorities 2027/28		
Priority 4	Single Point of Access	**Develop and implement a phased Single Point of Access (SPoA) model, building on the existing SICAT service to provide a consistent, seven-day service and create a simpler, more integrated route into community-based care.** **What we are achieving:** A phased Single Point of Access model, building on the existing SICAT service, providing a consistent, seven-day route into community-based care. **How we will achieve it:** We will streamline access by reducing fragmentation across SICAT, UPCC and Community Resource Teams, prioritising development of a 'call before convey' approach to support clinical decision-making and reduce avoidable ambulance conveyances and hospital attendances, particularly for frail and older adults. Implementation will be phased in line with workforce capacity and available funding, maximising existing resources within the current SICAT model, strengthening community-based alternatives to admission and improving system coordination.

		Delivery mechanism: *Phasing and local implementation actions will be defined within future 90-day plans as this priority progresses toward delivery in 2027/28. Also, the UEC programme will monitor the implementation of this via the workstream model. Funding must be sustained for achieved goal.*
Priority 5	Community Based Falls Response	**Implement a standardised community falls response model across North Wales by expanding Care Home training, increasing access to falls response equipment, and establishing a consistent Community Resource Team (CRT) service across all localities.** **What we are achieving:** A standardised community falls response model across North Wales, enabling more people to be safely assessed and managed at home following a fall. **How we will achieve it:** We will expand Care Home training, increase access to falls response equipment, and establish a consistent Community Resource Team (CRT) service across all localities. This strengthens early intervention and community-based support, reducing reliance on ambulance conveyance or ED attendance for low-acuity falls, and reduces variation in access and outcomes across the region. **Delivery mechanism:** *Local implementation actions and workforce/equipment milestones will be defined within future 90-day plans as this priority is mobilised. Also, the UEC programme will monitor the implementation of this via the workstream model. Funding must be sustained for achieved goal.*

This Improvement Plan sets the strategic direction and improvement rationale for each priority. Some of these priorities are not new, they have been recognised for some time, but the discipline of this plan, delivered through IHC-owned 90-day plans, is what will ensure the grip, accountability and pace of delivery needed to finally embed lasting change. The 90-day plans are the delivery vehicle, translating each 'how' into specific, time-bound, measurable actions, owned locally and monitored through the UEC governance, programme and reporting structure.

7.1 Table of Health Board Deliverables

The Table of Health Board Deliverables **(Appendix C)** uses the UEC Three Pillars Health Board Delivery Plan as its basis, with quality and outcome impacts added alongside the primary measurable target, and the relevant UEC pillar (as defined in Section 1.2) identified for each priority. The detail for the deliverables can be found in **Appendix D**.

8. IHC Descriptors

BCUHB delivers urgent and emergency care through three Integrated Health Communities (IHCs), each aligned to one of the Health Board's acute hospital sites: the West IHC (YG), the Central IHC (YGC) and the East IHC (WXM). It has to be noted that all three IHCs are starting 2026/27 from different positions, with different levels of existing infrastructure, workforce and funding allocations. This plan acknowledges that the action required, and the pace at which each IHC can move, will differ, and each IHC will likely end the year in a different relative position against the metrics, this will be highlighted within the 90-day planning cycles for each IHC.

Each IHC plan is in line with the Health Board priorities, and the overarching plan will support a level of consistency to ensure unwarranted variation across the Health Board is addressed at pace.

8.1 West IHC Performance Baseline and Target

The West IHC Priorities are drawn from Q1/2 2026/27 diagnostics: a 6As audit of 21 emergency admissions (28% potentially inappropriate, 42% inappropriate conveyance); a 21-day LOS review of 156 patients at Ysbyty Gwynedd plus 79 in community hospitals (71% no longer needing an acute or community bed); and an escalation review that found an outdated, ineffective escalation policy, unclear cross-directorate accountability for flow, descriptive rather than action-focused site meetings, and a normalisation of high escalation levels carrying patient-safety risk.

The evidence from Quarter 1 / 2 2026/ 27 reviews, triangulated with the performance metrics and targets set out within the IMTP and by NHS PI have determined the priority areas of focus within the plan.

The metrics below are the six IMTP metrics (P01-P06), aligned to three national UEC pillars for delivery (NHS PI 2026 / 2007 improvement plan):

#	Metric	Baseline (Jan 2026)	IMTP Target	West IHC 90-day Target (end of Q2)
P01	Reduce ambulance handover waits over 45 minutes	70%	Decrease to 22% by Q4	July: 8am – 8pm - 20%

#	Metric	Baseline (Jan 2026)	IMTP Target	West IHC 90-day Target (end of Q2)
				Sept: 24/7 – 0%
P02	Ambulance handover waits under 15 minutes	13%	Increase to 46% by Q4	Increase to 20%
P03	Reduce 12-hour wait in major and minor emergency care	19%	Decrease to 10% by Q4	Decrease to 15%
P04	Reduce the median time to assessment by senior clinical decision maker in ED	83 mins	Reduce to <60 mins by Q4	Reduce to <75 mins
P05	Reduce delayed pathway of care - number of patients delayed in hospital	98	50% Reduction in Q4(49)	25% Reduction (73)
P06	Reduce delayed pathway of care - total bed days delayed	3,117 days	50% Reduction in Q4 (1586 days)	25% Reduction (2338 days)

8.2 Central IHC Performance and Baseline Target

Central has the richest diagnostic foundation of the three IHCs, drawn from January–April 2026: a Multi-Agency Discharge Event (MADE); a 6As audit of 24 emergency admissions (21% potentially inappropriate, 16% inappropriate conveyance, and only 16% with healthcare-professional contact before admission); a 21-day LOS review of 112 patients at Ysbyty Glan Clwyd plus 82 in community hospitals (~75% no longer needing an acute or community bed); a site management and escalation review; and the recent HIW inspection flagging overcrowding and capacity pressure. The defining finding was the absence of a consistently applied D2RA model the system still operating an 'assess to discharge' approach with large volumes of assessment in the acute setting.

The following metrics are the six IMTP metrics (P01-P06), aligned to three national UEC pillars for delivery (NHS PI 2026 / 2007 improvement plan):

#	Metric	Baseline (Jan 2026)	IMTP Target	Central IHC 90-day Target (end of Q2)
P01	Reduce ambulance handover waits over 45 minutes	57%	Reduce over-45-minute waits to **25%** by 31 March 2026	Reduce over-45-minute waits to **0%** by 30 September 2026
P02	Ambulance handover waits under 15 minutes	10%	Increase under-15-minute handovers to **46%** by 31 March 2026	Increase under-15-minute handovers to **28%** by 30 September 2026
P03	Reduce 12-hour wait in major and minor emergency care	32%	Reduce 12-hour waits to **20%** by 31 March 2026	Reduce 12-hour waits to **20%** by 30 September 2026
P04	Reduce the median time to assessment by senior clinical decision maker in ED	130 mins	Reduce median time to **<90 mins** by 31 March 2026	Reduce median time to **<110 mins** by 30 September 2026
P05	Reduce delayed pathway of care - number of patients delayed in hospital	75 patients	No more than **47** patients delayed by 31 March 2026	No more than **57** patients delayed by 30 September 2026
P06	Reduce delayed pathway of care - total bed days delayed	1,806	No more than **1,588** bed days by 31 March 2026	No more than **2,100** bed days by 30 September 2026

Drawn from January–April 2026: a Multi-Agency Discharge Event (MADE); a 6As audit of 24 emergency admissions (21% potentially inappropriate, 16% inappropriate conveyance, and only 16% with healthcare-professional contact before admission); a 21-day LOS review of 112 patients at Ysbyty Glan Clwyd plus 82 in community hospitals (~75% no longer needing an acute or community bed); a site management and escalation review; and the recent HIW inspection flagging overcrowding and capacity pressure. The defining finding was the absence

of a consistently applied D2RA model the system still operating an 'assess to discharge' approach with large volumes of assessment in the acute setting.

8.3 East IHC Performance and Baseline Target

An evidence-led plan reducing avoidable delay, length of stay and discharge barriers through six led workstreams, prioritising front-door frailty, clinical engagement and D2RA.

End-Q2 ambitions include 45-minute handovers rising 27%→70% (P01), median time to senior assessment falling 138→<90 mins (P04), and patients delayed over 7 days down 143→48 (P05), tracked weekly with formal 30/60/90-day reviews.

The East IHC is the most advanced of the three sites against the UEC3 (AFS) priority and is currently the only site able to provide a front-door frailty assessment model. There are several known barriers including workforce capacity to scale the existing model beyond its current footprint; sustaining senior clinical decision-maker presence at the front door during periods of peak demand.

The following metrics are the six IMTP metrics (P01-P06), aligned to three national UEC pillars for delivery (NHS PI 2026 / 2007 improvement plan):

#	Metric	Baseline (Jan 2026)	IMTP Target	Central IHC 90-day Target (end of Q2)
P01	Reduce ambulance handover waits over 45 minutes	73%	Decrease to 22% by Q4	30% of handovers over 45 minutes (working towards 0%, 24/7 by September 2026)
P02	Ambulance handover waits under 15 minutes	12.65%	Increase to 46% by Q4	15% completed within 15 minutes of arrival by 90 days
P03	Reduce 12-hour wait in major and minor emergency care	27%	Decrease to 10% by Q4	Decrease to 10%
P04	Reduce the median time to assessment by senior clinical decision maker in ED	134 mins	Reduce to <60 mins	Reduce to <90 mins
P05	Reduce delayed pathway of care - number of patients delayed in hospital	143 patients delayed over 7 days	50% reduction in Q4 (72)	33% reduction (48)

P06	Reduce delayed pathway of care - total bed days delayed	6,528 bed days at 7 days	50% reduction in Q4 (3,264 days)	25% reduction (1,632 days)

9. Financial Summary 2026/27

9.1 Investments Already Made

The Health Board has already made substantial investment in Urgent and Emergency Care services to improve resilience, patient flow and service quality across the UEC pathway. Most notably, in June 2026 the Board approved recurrent investment of up to £6.65 million to strengthen medical, nursing and healthcare support worker capacity within Emergency Departments across North Wales. This investment is intended to reduce reliance on temporary staffing, support workforce sustainability and improve operational performance. In addition, c £12m has been invested in recent years to Nursing and Health Care Support Workers for Acute Wards which come within the Nurse Staffing Act

9.2 2026/27 Investments Approved

Alongside this investment, a number of further service developments have been identified through the Ministerial UEC priorities and have been scoped and costed. These include community falls response services, a Single Point of Access model, frailty services and initiatives to improve hospital flow. Whilst indicative investment requirements have been identified, detailed service modelling, gap analysis and implementation planning remain necessary to confirm the quantum, affordability and phasing of any future investment.

The UEC Improvement Plan was not considered as part of the Emergency Department business case approved in May 2026. Accordingly, the Health Board's financial planning assumptions do not include any further investment beyond the significant investment already approved.

A key de-escalation criterion for the Health Board is achievement of its statutory financial duty to break even. To support this, the Health Board is developing a one-year financial recovery plan; therefore, the principle that any further investment must be revenue neutral remains fundamental.

For **2026/27**, the focus will be on strengthening operational delivery, governance, performance management and benefits realisation across the UEC programme. **There will be no additional expenditure above the current approved run-rate during 2026/27**, and all activity will be delivered within existing approved resources.

On this basis the following utilisation plan for allocation is proposed for 2026/27

2 Utilisation plan for allocation approved in 2026/27

Ref	Workstream(s)	Budget 2026/27	Forecast Outurn 2026/27
		£000's	£000's
1	Implement the Community Based Falls Response Framework	506	506
2	implement the Optimal Hospital Flow Framework*		329
3	Local Six Goals Programme Team *		209
4	SDEC - Centre	479	479
5	SDEC - West	359	359
6	SDEC - East	679	679
7	Six Goals Triumvirate Team	148	167
8	3 x Band 6 Goals Programme support	141	0
9	IVAS & IV Suite - Centre	227	227
10	UPCC & MSK - East*	711	52
Total		**3,250**	**3,006**

*Funding associated with UPCC & MSK recycled to support Local 6 Goals team and optimal Hospital Flow

9.3 Future Developments for Consideration – Not Approved At This Time

Any proposals requiring additional investment will only be considered where:

- existing expenditure can be disinvested or released through service redesign;
- recurrent efficiencies have been identified; or
- an alternative funding source has been secured.

Any future investment proposals will be supported by robust business cases demonstrating affordability, deliverability and measurable benefits before approval is sought.

The following table shows those areas which will be subject to future business cases before agreement to progress.

3 Additional initiatives that would be considered subject to business cases and identification of funding

Ref	Workstream(s)	UEC Improvement proposed plan
		£000's
1	Implement the Community Based Falls Response Framework	767
2	Single Point of Access (UEC " - SPOA)	1,306
3	Implement an Acute Front Door Frailty Service (AFS) Framework	683
Total		**2,756**

10. Risks and Mitigations

Appendix E provides a summary of the principal risks that could impact delivery of the BCUHB Urgent and Emergency Care (UEC) Improvement Plan 2026/27 and achievement of the Welsh Government Ministerial Priorities (UEC1 to UEC5). It identifies the key threats to successful implementation, the controls and mitigation actions in place to reduce those threats, and the level of risk before and after mitigation.

Workstream-specific risks and mitigations are also set out alongside each priority in Section 6 and within the detailed Plans on a Page maintained by each Workstream Group.

11. Governance and Reporting

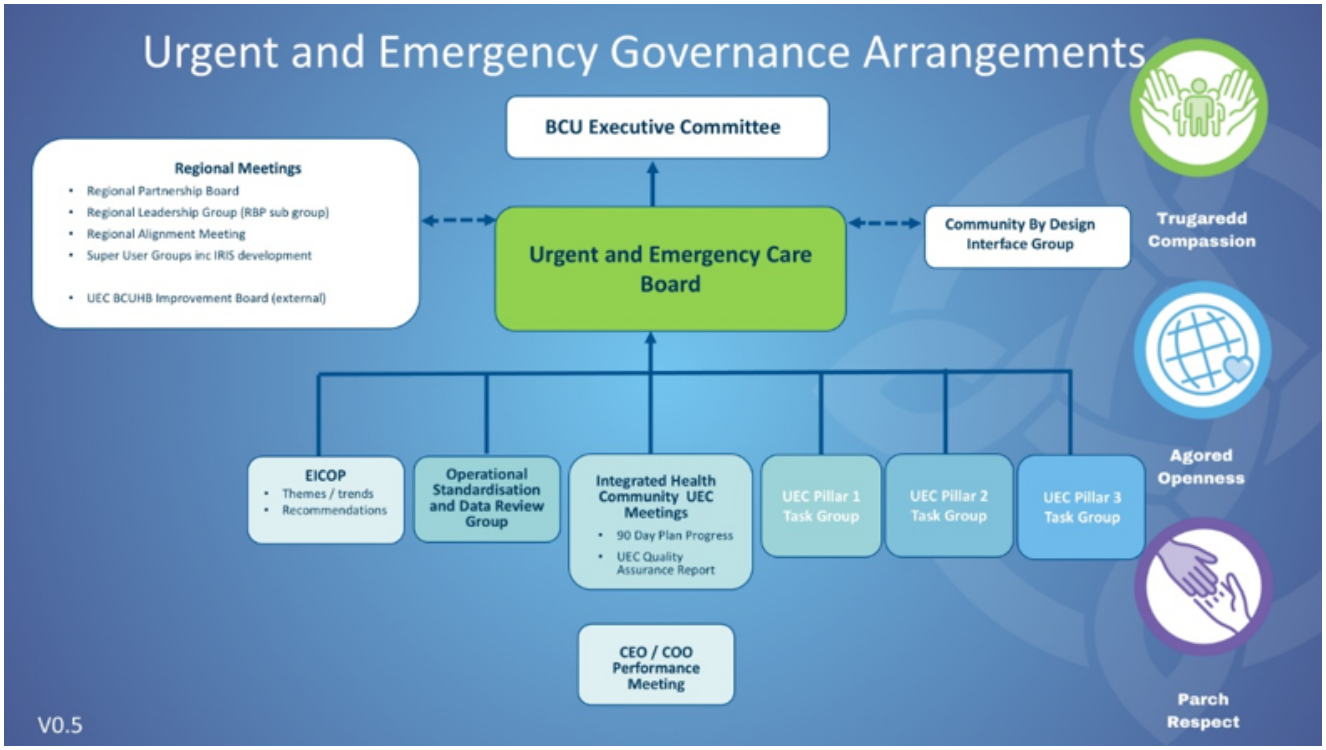
Delivery of this plan is governed through the structure set out in the UEC Three Pillars Programme / Governance Infrastructure: four Workstream Groups (aligned to the three pillars in Section 1.2) report into the UEC Task Group, which reports into the UEC Programme Board (Internal), which in turn reports to the Health Board's Executive Committee and Performance, Finance & Information Governance Committee (PFIG), and externally to the UEC Three Pillars National Programme Board. The internal UEC Programme Board meets monthly, with Workstream Group meetings, Highlight Reports and agenda papers following the published 2026/27 reporting schedule.

11.1 UEC Three Pillars Programme Team

UEC Programme Role	Name	Role Title
UEC Lead Director	Bridget Elliott	UEC Recovery Director
Executive Lead / SRO	TBC	Chief Operating Officer
Programme Lead	Liz Wedley	Programme Director, Urgent and Emergency Care
Clinical Lead	Karen Mottart	UEC Clinical Lead
Pillar 1 Lead	Naomi Holder	Interim Deputy EDoN

UEC Programme Role	Name	Role Title
Pillar 2 Lead	TBC	TBC
Pillar 3 Lead	Nesta Mclusky	Director of AHP's East
Programme Manager	Julie Parry	Programme Manager, Urgent and Emergency Care
Pillar 1 Improvement Support	Bethan Bailey	Service Improvement Senior Manager
Pillar 2 Improvement Support	Claire Manuel	Service Improvement Manager
Pillar 3 Improvement Support	Caroline Williams	Service Improvement Manager

11.2 UEC Board Governance Structure (Draft)



Appendices

Appendix A - HO45 Plan

Handover 45 (HO45) delivery

1. **Purpose and Context:**

The requirement to introduce HO45 is set nationally. NHS Wales Performance & Improvement (NHSWP&I) require partnership arrangements between Health Boards and WAST to ensure rapid implementation plans to support delivery.

A Strategic, deep dive, collaborative meeting between BCUHB and WAST to discuss delivery of HO45 as per the NHSWP&I letter dated 1st May was held on 22nd May with BCUHB COO, Head of EPRR, WAST Executive DOO, ADO EMS, SM and HOS Integrated Care. Site visits with Wrexham Maylor (WM) Ysbyty Gwynedd (YG) and WAST clinical and operational leads followed to review progression of plans to achieve H045 and identify barriers and risk to delivery.

Focus of the joint meetings and site visits has centred on what needs to be in place locally to achieve ambulance handovers within 45 minutes, in line with the All-Wales Ambulance Release Protocol and wider Urgent and Emergency Care priorities.

Consideration of how national pathways into 111 and out of hours GP, together with timely access for WAST into primary care was raised as a barrier to reducing alternative conveyance and inappropriate self-presentations to EDs.

It was recognised that any further actions to deliver H045 must be seen within the wider context and timelines of the agreed Special Measures De-escalation Plan, UEC 6 Goals / UEC Major Change Programme, associated workstreams and activities including the IHC 90-day improvement cycles. It should also be acknowledged that the BCUHB IMTP had set a performance improvement trajectory to support both 45 and 15 minute ambulance handover performance as per *figure 1* below. The H045 delivery plan timeframe therefore supersedes these trajectories.

figure 1

Reduce ambulance handover waits over 45 minutes

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] 12% improvement in 1 hour ambulance handover. * This area will be supported by the Welsh Government and NHS Performance and Improvement Integration Team

Appendix B – Strategic Alignment

Ministerial Priorities: UEC Enabling Actions	NHS Wales P&I Three Pillars		BCUHB IMTP Deliverables	
	Pillar	Project	Ref	Deliverable
UEC1: Implement the Community-Based Falls Response Framework	**Pillar 1:** Pre-Hospital & Community	Care Homes Falls Management	3A.01	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.
		Community Based Falls Response Framework	3A.02	Reduce avoidable ambulance conveyances and ED admissions from the community through producing an options appraisal for the National Six Goals Team to support funding for St John's Level 1 falls training and lifting equipment for Community Resource Teams (CRTs), ensuring a consistent pan North Wales approach to community-based falls response.
			3A.03	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.
UEC2: Implement the 'Single Point of Access' SPOA Framework	**Pillar 1:** Pre-Hospital & Community	Single Point of Access	3A.04	Reduce avoidable ambulance conveyances and ED admissions by transitioning from the current Single Integrated Clinical Assessment and Triage (SICAT) model to the Single Point of Access model (SPOA) with a broader Multi-Disciplinary Team (MDT) that is able to better sign post the most appropriate alternate to hospital treatment routes. This will ensure there is sufficient resource to operate the SPOA 7 days a week, 12 hours a day.
		7 Day Working		
		Referral Pathways		
UEC3: Implement the Acute Front Door Frailty Service	**Pillar 2:** Front Door & First 72 Hours	Acute Front Door Frailty Service	3A.06	Provide more suitable pathways for frail patients that ensure they have shorter lengths of stay within acute hospitals in line with the national Acute Frailty Service (AFS) model. Undertake baseline assessment and gap analysis for current Acute Front Door Frailty Services across all acute sites, identifying current service provision, workforce utilisation, SDEC alignment and opportunities to strengthen early frailty assessment and intervention.
UEC4: Ambulance Patient Handover(H45)	**Pillar 2:** Front Door & First 72 Hours	Ambulance Patient Handover (H45)	3A.07	Adopt national best practice in relation to implementation of safe, fast, and consistent ambulance handover processes at the ED front door.
			3A.08	Reduce ambulance hours lost, improve hospital-wide flow and ambulance handover times by standardising triage and streaming processes across all sites (majors, minors, SDEC, frailty).
			3A.09	Reduce ambulance hours lost, improve hospital-wide flow and ambulance handover times by strengthening senior clinical decision-maker presence at the front door, especially during periods of high demand.
UEC5: Implement the Optimal Hospital Flow Framework	**Pillar 3:** Ward Based Flow & Discharge	Optimal Hospital Flow	3A.11	Reduce the number of people delayed in hospital and their length of stay, thereby reducing the potential for deconditioning, through implementation of Optimal Hospital Flow facilitators, utilisation of the Transport Coordination hub and enabling a 7-day discharge model across all acute sites.
		Pathway of Care Delays	3A.05	Improve pathways of care delays out of the hospital through working more closely with the Local Authority Social Care Information Advice and Assistance (IAAs) team to improve referral pathways out of hospital.
		Trusted Assessor	3A.10	Reduce the number of people delayed in hospital and their length of stay, thereby reducing the potential for deconditioning, by strengthening application of community Discharge to Recover and Assess (D2RA) pathways, ensuring faster discharge options for frail patients.

Appendix C – Table of Health Board Deliverables

Priority	SRO	Outcome	Delivery Mechanism	Impact	Deliverable	Quarter for delivery	Ministerial Priority	Pillar
Corporate Enabler	COO	Publish one Options Framework for adoption across the whole HB	Corporate-level options Framework policy, co-produced with clinical teams and applied consistently across all three IHCs and six North Wales Local Authority areas; monitored through the UEC Programme Board.	Reduced unnecessary ambulance conveyance and hospital attendance; reduced choice-related delays to transfer of care; more consistent patient experience of choice across sites.	.By **31 March 2027**, achieve 90%+ audit-confirmed compliance with the Options Framework across Central, East and West IHCs, through a standardised monthly audit built into the existing 6As/MADE audit cycle, with a baseline audit complete by **30 November 2026** and targeted remediation for non-compliant areas ongoing thereafter. • Baseline audit establishing current Options Framework adoption/compliance levels by IHC, run alongside the 6As audit — complete by **30 November 2026** • Standardised audit checklist with monthly RAG reporting by IHC, feeding into existing programme reporting structures • Targeted training/1:1 support for underperforming areas, with re-audit to confirm sustained improvement by **31 March 2027**	Q2 Q3/4	Underpins UEC1 (Community-Based Falls Response) & UEC2 (SPoA)	1

Critical Strategic Enabler	COO	Clear, shared ownership of UEC performance across clinical and operational teams, rather than risk being held solely by ED or by a single IHC	Triangulated ownership of risk between IHC Directors, Clinical Leads and site teams, with consistent reporting lines into the MCP Programme; a UEC Director role aligned across both MCP and operational delivery; visible, consistent leadership presence at the interfaces where flow most often breaks down (SDEC/ED interface, D2RA, community step-down).	Performance risk no longer concentrated on ED or a single IHC; faster, more effective escalation and de-escalation of operational pressures; more accurate Board-level assurance of system risk; greater staff confidence to test and scale improvement at pace.	By **January 2027** design, test and roll out a bed management app across Central, East and West IHCs, providing real-time bed and escalation visibility, reducing unnecessary delays by 25% verified via the UEC Dashboard and escalation policy actions. By **31 March 2027**, review and standardise BCU-wide operational processes, including the Hospital Full Protocol, to ensure consistent application across Central, East and West IHCs during periods of operational pressure, with: • Review of the current Hospital Full Protocol and wider operational processes (site management, escalation, mutual aid) complete by **31 October 2026** • Revised, standardised protocol drafted and consulted on with IHC leads and site management teams by **31 December 2026** • Board-approved BCU-wide protocol live across all three IHCs by **31 January 2027** • Compliance audit (protocol invoked appropriately, actions followed) complete by **31 March 2027** Review report identifying inconsistencies in current Hospital Full Protocol/operational process application across IHCs Board-approved, standardised BCU-wide Hospital Full Protocol, aligned to the escalation framework Compliance audit confirming consistent application across all three IHCs	Q3	UEC5: Optimal Hospital Flow Framework	3

					By **31 March 2027**, standardise escalation processes and tolerance triggers in line with the OPEL framework across Central, East and West IHCs, with the framework agreed by **31 October 2026**, live in all three IHCs by **28 November 2026**, achieving 90%+ compliance with defined escalation actions which will be measured via site sitrep audit/spot-check, verified by **31 March 2027.** • Board-approved escalation SOP with defined OPEL triggers, actions and accountable roles per level • Training/briefing roll-out to site management teams across all three IHCs • Compliance audit/spot-check process with an escalation route for non-compliant sites			

D2RA	COO	Shift BCUHB's discharge model from assess-to-discharge to Discharge to Recover and Assess (D2RA), reducing Pathway of Care Delays (POCD) to <80 patients (acute) by Q3.	Standardised board rounds, Trusted Assessor roll-out, Integrated Discharge Hub (Shared Purpose workstream), 7-day discharge model, Optimal Hospital Flow Facilitators (OHFF).	↓ Length of stay; ↓ 12-hour waits; reduced deconditioning; improved Red2Green compliance; consistent BCUHB-wide operating model; stronger LA/RPB partnership.	By **31 March 2027**, complete the MADE event, 6As audit, 21-day length of stay review, and site management/escalation review across all three Integrated Health Communities (IHCs); produce a baseline diagnostic report for each IHC identifying priority opportunities to improve flow and discharge. Establish and convene a D2RA/Board Round Task & Finish Group, with representation from Home First, operational and clinical leads, MCPs and Optimal Hospital Flow Facilitators, and agree a prioritised improvement plan with defined actions, leads and milestones. • Standardised Board Round and Criteria-to-Reside processes implemented across all three IHCs. • D2RA/Home First pathways redesigned and implemented to increase same-day discharge and reduce discharge delays. • Long-stay patient management process established, reducing patients with a LOS greater than 21 days	Q4	UEC5: Optimal Hospital Flow Framework	3

					By **31 January 2027**, embed a standardised D2RA/Integrated Discharge Hub operating model , including weekly board round review of clinically optimised patients, across Central, East and West IHCs, increasing patients discharged within 48 hours of optimisation from 10% to 20%, verified through UEC Dashboard.. • Standardised D2RA/board round template and SOP rolled out across all three IHCs • Weekly compliance audit/dashboard tracking board round attendance and 48-hour discharge rates by IHC • Task & Finish Group sign-off on the phased implementation timeline and escalation route for non-compliant sites	Q3		

					By **31 March 2027**, roll out the Care Home Trusted Assessor MOU across all three IHCs and commence drafting of further MOU(s) with the Regional Partnership Board and Local Authorities, reducing discharge delays attributable to care home assessment waits, with: • Trusted Assessor MOU scoped and included within each IHC's 90-day plan submission by **1 October 2026** • MOU signed and live in the first IHC by **31 December 2026**, remaining two IHCs by **28 February 2027** • Scoping paper for further MOU topics tabled at Regional Partnership Board by **31 January 2027** • Baseline and re-measure of care-home-attributable discharge delay complete by **31 March 2027** Signed Trusted Assessor MOU live and operational in each IHC, with a nominated lead per site, embedded within existing D2RA/discharge processes Baseline and tracked reduction in discharge delays attributable to care home assessment waits, reported through the existing IHC 90-day plan/Highlight Report structure Scoping paper identifying priority further MOU topics (e.g. reablement, intermediate care, care package sourcing), tabled at Regional Partnership Board for agreement	Q4		

					By **31 March 2027**, reduce acute POCD to fewer than 80 patients across BCUHB, sustained for two consecutive reporting periods, with: • Current POCD baseline and reduction trajectory agreed and built into each IHC's 90-day plan submission by **1 October 2026** • Interim milestone review at Q3 (**31 December 2026**), checking progress against trajectory and adjusting IHC-level actions • Trusted Assessor model expansion progress paper (or documented justification for alternative arrangements) tabled by **31 January 2027** • Follow-up Trusted Assessor audit complete by **28 February 2027** • POCD <80 sustained across **February and March 2027** reporting periods, confirmed by **31 March 2027** Weekly POCD tracking by IHC against the reduction trajectory, reported through existing Highlight Report/90-day plan structures Trusted Assessor follow-up audit report confirming embedding/compliance since original roll-out Paper setting out progress on additional Trusted Assessor models, or rationale	Q3		

					where expansion isn't viable, tabled at the appropriate governance forum			
					Develop a sustainable board round / flow implementation model covering all acute sites and embed automated Trusted Assessor activity reporting.	Q4		

Frailty	COO	Deliver Front Door Acute Frailty Service (AFS) Framework for Acute Hospitals	Phased AFS roll-out (Wrexham Maelor → Ysbyty Glan Clwyd → Ysbyty Gwynedd); SDEC integration; MDT frailty training programme; standardised frailty screening tools (e.g. CFS) at ED triage.	Reduced avoidable admissions for frail patients; improved patient experience; equitable access to frailty assessment across all three acute sites.	By **31 December 2026**, complete a baseline assessment and gap analysis of the Acute Front Door Frailty Service across Central, East and West IHCs, with: Frailty front door data collection (provision, pathways, workforce utilisation) scoped and initiated alongside each IHC's 90-day plan submission by **1 October 2026** Draft IHC-level baseline findings shared for validation by **30 November 2026** Final baseline and gap analysis report, including prioritised, impact-rated opportunities per IHC, presented to [Programme Board/relevant governance forum] by **31 December 2026** Prioritised opportunities feeding into IHC improvement plans and the Q4 delivery phase running to **31 March 2027** • IHC-level baseline report on current frailty front door provision and pathways • Workforce utilisation analysis (establishment vs. actual deployment vs. demand) by IHC • Prioritised, impact-rated list of opportunities to strengthen early frailty assessment/intervention, feeding into the 90-day plan cycle	Q1	UEC3: Acute Front Door Frailty Service (AFS) Framework	2/3
					Forge links with Local Authority IAAs and put in place agreed referral pathways.	Q2		

					By **31 March 2027**, agree and begin phased implementation of a standardised Acute Frailty Service (AFS) model across all three acute sites, Wrexham Maelor, Ysbyty Glan Clwyd, then Ysbyty Gwynedd including recruitment to address identified staffing gaps and development of standardised AFS pathways, with: • AFS service model and standardised pathway design agreed (informed by the front door frailty baseline/gap analysis) by **31 January 2027** • AFS model live at **Wrexham Maelor** by **31 March 2027**, with **Ysbyty Glan Clwyd** and **Ysbyty Gwynedd** phased in during 2027/28 • Standardised AFS pathway documentation complete and ready for roll-out to the second and third sites by **31 March 2027**	Q2		
					By **31 March 2027**, achieve full operationalisation of the standardised AFS model at Wrexham Maelor, with active roll-out underway at Ysbyty Glan Clwyd and Ysbyty Gwynedd and increase Same Day Emergency Care (SDEC) utilisation to 35% of acute take across BCUHB, with: • SDEC utilisation baseline established by IHC by **31 October 2026** • AFS model fully operational at Wrexham Maelor (staffing in post, pathway live, front door integration complete) by **31 March 2027** • AFS roll-out to Ysbyty Glan Clwyd and Ysbyty Gwynedd initiated by **31 March 2027** • SDEC utilisation trajectory tracked monthly, reaching 35% of acute take BCUHB-wide by	Q3/Q4		

Clinical Leadership	COO	Establish consistent senior clinical decision-making and leadership at key points across the UEC pathway (ED, SDEC and inpatient wards);	Board round standardisation (Task & Finish Group); Optimal Hospital Flow Facilitators (OHFF); T2A senior clinical decision-maker rostering at the	↓ ED waits; increased discharges before 12 noon; improved consistency of clinical decision-making and board round quality.	Standardise board round format, attendance requirements and escalation process across all Central, East and West IHC inpatient wards, with daily board rounds operating consistently across all inpatient areas.	Q2	Cross-cutting – underpins UEC3 (AFS) & UEC5 (Optimal Hospital Flow); supports UEC4 (Ambulance Handover, H45)	2/3

		standardise board round processes and clarify clinical accountability for length of stay and discharge decisions.	front door; monthly compliance audit.		By **31 March 2027**, achieve >75% compliance with the agreed board round standard across Central, East and West IHCs, confirmed through monthly audit, with weekly review of clinically optimised patients embedded as a standing item within board round processes in all three IHCs, with: 1. Board round standard and audit checklist agreed and rolled out by 31 October 2026 2. Weekly clinically-optimised-patient review embedded as a standing board round agenda item in all IHCs by 30 November 2026 3. Baseline compliance audit complete by 30 November 2026, with monthly audits thereafter reported through the existing Highlight Report structure 4. Q3 checkpoint (31 December 2026) reviewing trajectory and addressing any IHC below target 5. >75% compliance achieved and sustained for two consecutive audit cycles by 31 March 2027 Outcomes : • Agreed board round standard and monthly audit checklist, consistent across all three IHCs • Weekly clinically-optimised-patient review embedded as a standing	Q3/4		

					board round agenda item, with attendance/completion tracked • Monthly compliance audit with RAG reporting by IHC, feeding into the 90-day plan/Highlight Report cycle			
					By 31 March 2027, establish consistent senior clinical decision-maker (Trusted to Assess/T2A) presence at the front door across Central, East and West IHCs, and standardise escalation and decision-making practices during periods of operational pressure, with: • Front door T2A staffing model and decision-making protocol agreed by 31 November 2026 • Rota/cover model for consistent senior clinical decision-maker presence live in the first IHC by 31 December 2026, remaining two IHCs by 28 February 2027 • Standardised escalation/decision-making protocol for periods of operational pressure (linked to the escalation framework) agreed and briefed to teams by 31 January 2027 • Compliance audit (rota fill rate and protocol adherence during escalation periods) complete by 31 March 2027	Q3		

Appendix D – UEC Plan 2026/27

UEC1: Implement the Community-Based Falls Response Framework: Deliver, as a minimum, all principles set out in the six goals for urgent and emergency care programme community-based falls response framework and, in support, implement a focus on prevention and early intervention in line with the policy statement on population health management.

Workstreams: Title & Overview	Key Quarterly Deliverables			
	Q1	Q2	Q3	Q4
Care Homes Falls Management In 2025/2026 BCUHB have provided **falls lifting equipment** and level one training to 30 Care Homes with the highest attendances and conveyances to our Emergency Departments across BCUHB.	Evaluation and mop up training sessions delivered. Full pan-BCU schedule for Level 1 St John's Falls Training issued.	Digital data-capture requirement agreed (incident, lift use, outcome) and early adopters identified.	Early evaluation of utilisation of equipment (lift frequency, appropriateness, timeliness). Evaluation of early impact on ED attendance/conveyance patterns for trained/equipped homes. Quality assurance review of digital data submitted by Care Homes. Refresh of training schedule and equipment maintenance plan for 2027/28.	Full year evaluation report on fall-related ED attendance reduction, equipment utilisation, and training compliance. Alignment confirmed between Care Homes falls work and wider community falls response pathway via CRTs.

Workstreams: Title & Overview	Key Quarterly Deliverables			
	Q1	Q2	Q3	Q4
Community based Falls Response Framework St John's Level 1 falls training and lifting equipment for Community Resource Teams (CRTs) across BCUHB, ensuring a consistent, pan BCU approach to community-based falls response. BCUHB will utilise the £767,194 UEC1 allocation to establish and sustain a clinically safe, mixed skill community falls response model, delivered through the CRTs. Funding will support: • Clinical posts providing advanced assessment, governance, and oversight. • Responder workforce providing operational on-the-ground response to community fallers. • Operational costs supporting pan BCU roll-out, governance, evaluation and pathway integration. • Strengthening alignment with WAST and SPoA to ensure low-acuity fallers receive a timely alternative to ambulance conveyance. This approach enables a cost-effective, sustainable, clinically robust service aligned to national expectations and BCUHB strategy.	BCUHB-wide engagement workshop held to agree CRT workforce model, hours of operation, referral pathways, and interface with WAST/SPoA. Training plan by areas agreed (Centre → West → East). St John Level 1 training delivered to CRT teams in Central area. Equipment distribution to Central CRTs begins (lifting devices, assessment kits). Recruitment plan developed (timeline, job descriptions, locality priorities). Development of WAST–CRTs joint Standard Operating Procedure (SOP) covering: Falls stack triage, call category eligibility, triage thresholds, response times, feedback loops. MOU drafted between BCUHB and WAST including call handling, decision support, data sharing and operational expectations. CRT–WAST joint huddle established with oversight from APP desk. Integration with SPoA agreed for direct referral of community fallers not requiring 999. Go live of phased rollout	St John Level 1 training delivered to CRT teams in the West. Ongoing equipment distribution to West CRTs. Refinement of CRT operating model following early learning from Central area. Development of integrated documentation tools (checklists, clinical record template) for pan BCU use. Live delivery extended to West area using learning from Central. Real-time management of falls on WAST stack begins (APP review + push to CRT). CRT responders co-located (physically or virtually) with WAST APP desk for two-way clinical conversations. Direct CRT referral pathway activated via SPoA with automated routing to correct locality. Operational dashboards implemented focusing on: Response times, cases handled, non-conveyance rate, Repeat calls Safety-netting compliance Joint quality assurance audit undertaken with WAST on first 3 months of model. Further strengthening of integration with WAST clinical desk for improved identification of low-acuity fallers.	St John Level 1 training delivered to CRT teams in the East. Full equipment deployment across all CRTs (Central, West, East). Full model roll-out to **East**, completing pan BCU coverage. Operational escalation pathways implemented for high-risk cases (frequent fallers, complex mobility issues, polypharmacy). Workforce evaluation of the model including clinical quality, span of control, demand matching, roster stability. Mid-year evaluation of impact on ambulance conveyance, response times, and ED attendances.	Community Falls Response fully embedded across all three CRT regions with consistent governance and operating procedures. Annual evaluation completed with WAST including: 999 demand impact, non-conveyance outcomes, recontact within 72 hours, patient experience, safety audit Integration of CRT community falls response into broader falls pathway (Care Homes, Community Health, Third Sector). Workforce and sustainability plan completed for 2027/28

Risks	Mitigations
• Variability in Care Home engagement and training uptake • Procurement or supply delays for lifting equipment • Digital data capture tools not adopted consistently • Delays in national funding decisions impacting CRT roll-out • Workforce availability to support Band 3 CRT responder model	• Close liaison with Care Home Leads; clear scheduling; targeted support for low engagement homes • Early procurement actions; identification of alternative suppliers; prioritisation of high need areas • Early submission of options appraisal; regular engagement with National Six Goals Team; phased approach to implementation • Recruitment campaign planning; flexible deployment across localities; upskilling existing CRT staff where appropriate

UEC2: Implement the 'Single Point of Access' (SPoA) Framework: Deliver, as a minimum, all principles set out in the six goals for urgent and emergency care programme single point of access (SPOA) framework to ensure people with urgent care needs receive timely and appropriate support, minimising unnecessary escalation to emergency ambulance conveyance or hospital admission.

Workstreams: Title & Overview	Key Quarterly Deliverables			
	Q1	Q2	Q3	Q4
Single Point of Access (SPoA) Embed previous SICAT model with SPOA with enhanced MDT workforce availability. Ensure that the SPOA is positioned within the organisational structure under the appropriate service area to support effective operational and clinical accountability.	Ensure all approvals are in place as per the organisation's governance and accountability framework and review requirements for EQIA. Review previous SICAT operating model including hours of opening and location with other interdependent services. Start to test the priority 1 data collection as per the SPOA dataset specification. Review and expand existing SICAT pathways to link with current active community pathways that may not have been previously in scope under the SPoA ethos. Integration with SPoA agreed for direct referral of community fallers not requiring 999.	Identification of further pathways to be implemented within current resourcing including the current access for care homes and response model available. Work with WAST to ensure as appropriate flow from 999 and 111 services into the SPoA and direct access for GMS/Community Nursing and care homes. Direct CRT referral pathway activated via SPoA with automated routing to correct locality for falls.	Undertake scoping with the home first hubs to understand which discharge pathways could be utilised as admission prevention pathways .	

Workstreams: Title & Overview	Key Quarterly Deliverables			
	Q1	Q2	Q3	Q4
SPoA – 7 Day Working Ensure there is sufficient resource to operate the SPoA seven days a week, 12 hours a day.	Scope workforce plan against the SPOA framework requirements.	Develop a sustainable workforce plan to include financial considerations. Prepare business case to address any identified deficits within the workforce plan.	Submit workforce plan business case for approval.	Recruitment and implementation of full workforce model.
SPoA – Referral Pathways Forge links with Local Authority IAAs and put in place agreed referral pathways	Gain support from all 6 LAs for mapping of BCU SPOA processes and pathways alongside LA processes and pathways to assessor gaps, commonalities and opportunities.	Strengthening and development of new pathways into Local Authority IAAs.	Develop joint reporting with Local Authorities to evidence mutual benefits of collaborative working.	

Risks	Mitigations
• Sustainable funding model • Readily available workforce • Organisational restructure	• Review and transitioning of existing services to form BCU SPOA • Completion of workforce plan • Funding support from national programme (nonrecurrent) • Align with ECR principles to support timely recruitment • Engage with the Foundations for the Future team to ensure that both operational and receiving services for SPOA are clearly defined, and to explore opportunities for alignment within the new operating model.

UEC3: Implement the Acute Front Door Frailty Service (AFS) Framework: Deliver medical same day emergency care (SDEC) and acute frailty services at the front door of hospitals in line with all principles set out in national SDEC policy and strategy documents, and the six goals for urgent and emergency care programme Front Door Acute Frailty Service (AFS) Framework for Acute Hospitals.

Workstreams: Title & Overview	Key Quarterly Deliverables			
	Q1	Q2	Q3	Q4
Acute Front Door Frailty Service: Baseline assessment and gap analysis for Acute Front Door Frailty Services completed in Q1 across all acute sites, identifying current service provision, workforce utilisation, SDEC alignment and opportunities to strengthen early frailty assessment and intervention. Detailed financial modelling and workforce costings required to deliver the nationally-defined AFS model are being developed for presentation to the Programme Board	Baseline assessment & gap analysis completed in Q1 across all acute sites. Costings and financial modelling completed for Programme Board. At present, YG and YGC cannot confirm that they can deliver an Acute Front Door Frailty Service aligned to the national framework due to ongoing funding and workforce constraints. **YGC**: The pilot will cease at end of March 2026 due to lack of funding. Q1 will focus on capturing evaluation, defining risks, and identifying essential functions that could be maintained *only if funding becomes available*. **YG**: Unable to offer an AFS model. Current provision is limited to a short stay COTE service with no dedicated medical cover for front door frailty. Q1 will focus on identifying what minimal could be adopted *if additional resources were secured*. The only site currently able to provide a timely frailty assessment model is Wrexham Maelor Hospital (WMH).	Service model agreed for each acute site, informed by Q1 baseline and gap analysis findings (workforce, SDEC integration, assessment tools, hours of operation). Recruitment processes initiated to address identified staffing gaps (ANPs, frailty consultants, therapists, pharmacists). Development of standardised AFS pathways including early identification of frailty, rapid assessment, same-day interventions and access to community alternatives. MDT training programme developed focusing on frailty assessment, CGA, and early intervention. Establishment of KPIs and measurement plan (e.g. avoided admissions, time-to-assessment, SDEC utilisation).	Phased implementation of AFS at acute sites, starting with Wrexham Maelor and Ysbyty Glan Clwyd, with Ysbyty Gwynedd to follow. Embedding frailty screening tools (e.g., CFS) at ED triage and front door entry points. Strengthening links with community D2RA pathways to ensure rapid discharge options for frail patients. Initiation of real-time data collection and performance monitoring aligned to the national AFS framework. Mid-year evaluation of operational impact and refinement of staffing rotas and process flows.	Full operationalisation of the AFS model across all BCUHB acute sites. Delivery of full-year evaluation report capturing outcomes, resource utilisation, patient experience, and system impact. Integration of AFS learnings into wider hospital flow improvement programmes (SDEC, Red2Green, POCD reviews). Development of long-term sustainability plan, including workforce stabilisation and digital support for frailty tracking.

Risks	Mitigations
• Delays in the release or confirmation of Six Goals funding affect recruitment, implementation and sustainability • Lack of dedicated assessment space for frailty teams within the ED/SDEC environment delays early intervention. • Workforce instability caused by persistent vacancies and absence of contingency cover • Current resource gaps mean the full Frailty Framework model cannot yet be delivered as intended • High ED/SDEC demand reduces frailty MDT capacity to deliver timely assessments and interventions	• Develop a strong business case with costed options and impact modelling • Identify flexible shared clinical areas and protect frailty spaces through proactive estates planning • Address service gaps and workforce shortages through targeted recruitment and flexible roles.

UEC4: Ambulance Patient Handover (H45): Through effective streaming of patients on arrival at the front door allied to a focus on safe, efficient and early discharges, deliver all ambulance patient handovers within a maximum of 45 minutes, aiming for achievement of >90% in 15 minutes by the end of 2026/2027

Workstreams: Title & Overview	Key Quarterly Deliverables			
	Q1	Q2	Q3	Q4
Ambulance Patient Handover (H45) Leadership, Baseline, Governance. Standardise and implement safe, fast, and consistent handover processes at the ED front door. Reduce ambulance hours lost, improve hospital-wide flow and prevent breaches of the 45-minute maximum. Ensure sustained compliance with 15-minute handovers and eliminate delays >45 minutes, supported by a winter-ready system.	Complete a baseline audit of current handover performance, identifying delays vs. national standards. Refresh local escalation plans and joint HB–WAST protocols in line with WG guidance. Conduct capacity assessment using GIRFT SEDIT tool to identify gaps in ED flow, cubicle availability and staffing. Review and strengthen alternative pathways with WAST (RICS, hear-and-treat, see-and-treat) to improve conveyance avoidance.	Implement immediate booking-in on arrival for all WAST-conveyed patients, ensuring ePCRs are processed promptly. Standardise triage and streaming processes across all sites (majors, minors, SDEC, frailty). Strengthen senior clinical decision-maker presence at the front door, especially during escalation. Embed HAS dual-PIN handover verification or equivalent for rapid (<15 minutes) patient transfer.	Increase use of direct-to-service pathways other than ED (e.g., SDEC, frailty units). Work with WAST to strengthen remote integrated care service (RICS) and increase consult-and-close management to reduce unnecessary conveyances. Implement mandatory 30-minute escalation actions, including: • Immediate notification of WAST ODU + hospital operations • Clinician-led risk assessment and movement into a safe clinical space.	Implement full winter surge plans and escalate ambulance diverts when clinically appropriate. Complete annual workforce review to ensure ED and receiving areas have safe, sustainable staffing models. Produce end-of-year report summarising compliance, audits, improvement outcomes and recommended changes for 2027–28. Validate alignment with national programmes: JCC expectations, MAG-45 recommendations and hospital handover guidance.

Workstreams: Title & Overview	Key Quarterly Deliverables			
	Q1	Q2	Q3	Q4
Ambulance Patient Handover (H45) (Continued)		Audit all conditions "direct to speciality receiving units" other than hospital ED (i.e. stroke, STEMI, burns, obstetric emergencies Audit all pre-arrival communication processes, to ensure all pre-alerts follow national guidance. Ensure connectivity into the Health Board's single point of access (SPOA) for redirection and community alternatives.	Collaborate across the UEC Workstreams to increase hospital-wide "pull" mechanisms to relieve ED congestion (early discharge, flow coordination). Develop risk-managed surge capacity areas to accommodate peak demand. Conduct mid-year audit of pathway compliance and address gaps in specialist pathway delivery. Review, update and communicate all specialist pathways and directories of services to WAST ahead of winter.	

Risks	Mitigations
• Insufficient hospital capacity & poor patient flow leading to delays • Delays in triage, booking in, or initial assessment • Workforce shortages / lack of seniority at ED front door • Poor coordination between WAST and the Health Board • Non-compliance with specialist pathways (STEMI, stroke, burns, etc.) • WAST crews left monitoring patients due to delays / unsafe offload processes • Delays exceed 30–45 minutes (MAG threshold breach) • Late or ineffective escalation during pressure periods • Patient safety risks during overcrowding (infection control, deconditioning, etc.) • Lack of organisational engagement or cultural adoption • Weak monitoring, audit and data visibility	Use GIRFT SEDIT tool for ED capacity planning: • Strengthen whole-system flow with increased ward "pull" at peak times • Create risk-managed surge areas • Implement winter surge plans early and pressure-test • Implement immediate booking-in workflows + ePCR processing • Ensure senior clinical decision-maker presence at ED front door • Standardise triage and streaming (majors/minors/SDEC/frailty) • Provide staff training for triage and handover best practice • Develop flexible and cross-cover staffing models • Hold regular HB/WAST pathway performance reviews • Ensure all specialist pathways are updated and communicated to WAST • Align escalation and decision-making across HB and WAST.

UEC5: Implement the Optimal Hospital Flow Framework: Deliver, as a minimum, all principles set out in the six goals for urgent and emergency care programme Optimal Hospital Flow Framework with a focus on 7-day working with leaner acute hospital processes and more efficient discharge transport services to facilitate earlier discharges and increasing weekend discharges.

Workstreams: Title & Overview	Key Quarterly Deliverables			
	Q1	Q2	Q3	Q4
Optimal Hospital Flow & Seven-Day working	Continue the role of Optimal Hospital Flow Facilitators to assist in implementation of the actions described in the Optimal Hospital Flow Framework. Recruitment of 2 x OHFFs. Core group to be established to get formal plan in place: to include Home first rep, key operational and clinical leads, MCP reps, OHFF.		Review impact via presentation to board of improvement since implementation.	Develop a sustainable implementation model moving forward to cover all acute sites.
Agree Board Round protocol and ensure robust review	Review board round purpose as a key event underpinning flow for all patients across acute and community. Establish robust lexicon to underpin board round script. Review stream parameters in line with board round purpose to ensure we can meet national data sets and underpin live accurate data for use across health and social care. Ensure a robust approach is given consideration from the GIRFT and MADE event recommendations. Review feedback from MADE events, 21-day LOS and 6As audits - pulling out key lessons / themes to inform the pan BCU project.	Report to Internal Programme Board on development of Task & Finish group. Agree clinical standards to provide the foundation for defining 'What Good Looks Like' Establish KPI baselines and measure current peformance against the agreed standards. Create Board Round Plan on a Page to provide clarity on expectations and how success will be measured		Review performance and group deliverables. See improvement in decision making.

Workstreams: Title & Overview	Key Quarterly Deliverables			
	Q1	Q2	Q3	Q4
Pathway of Care Delays (PoCD)	Adopt a single North Wales approach to validating delays. Utilise feedback from MADE events to drive and embed change through local and PAN BCUHB actions. Audit the use of discharge letters / leaflets following pilot in East area. Extend and embed the care home contact project to include 7 day working and MH&LD. Scope out opportunities to reduce longest length of stay (e.g. LD). Develop measures of performance and set trajectory.	Drive and embed change through local and PAN BCUHB actions. Targeted approach to highest number of delays e.g. best interest Complete mapping exercise of discharge processes / pathways Continue implementation of inter organisational Memorandum of Understanding with RPB and Local Authorities to support discharge. Agreed inter-organisational winter plan in place. Continuous improvement on Q1 actions.	Continuous improvement on Q2 actions.	
Trusted Assessor	Roll out and embed Care Home Trusted Assessor Memorandum of Understanding. Commence MOU for other initiatives (Recommendation 1 & 2 of report). Scope out training opportunities to introduce a blended approach to provide training and awareness of Trusted Assessor roles across Health and Social Care.	Demonstrate progress in adopting additional Trusted Assessor models or provide clear justification for alternative arrangements that deliver equal or greater benefit to their local population. Commence follow-up trusted assessor audit (Recommendation 4). Agree way forward for training to introduce a blended approach to provide, spread and scale training and awareness of Trusted Assessor roles across Health and Social Care	Develop robust automated reporting arrangements for TA activity and development of baseline. Increase the number of Trusted Assessor-led assessments in the right setting to reduce the number of / amount of time people are delayed.	Continue to increase the number of Trusted Assessor-led assessments in the right setting to reduce the number of / amount of time people are delayed.

Risks	Mitigations
• Delays in the release or confirmation of Six Goals funding affect recruitment, implementation and sustainability • Lack of dedicated assessment space for frailty teams within the ED/SDEC environment delays early intervention • Workforce instability caused by persistent vacancies and absence of contingency cover • Current resource gaps mean the full Frailty Framework model cannot yet be delivered as intended • High ED/SDEC demand reduces frailty MDT capacity to deliver timely assessments and interventions • Fail to identify and implement trusted assessor roles and reduce PoCD due to interorganisational working and competing priorities	• Develop a strong business case with costed options and impact modelling • Identify flexible shared clinical areas and protect frailty spaces through proactive estates planning • Address service gaps and workforce shortages through targeted recruitment and flexible roles • Working with Regional Partnership Board to support interorganisational working

Appendix E - UEC Improvement Plan 2026/27 Risk Register

Risk ID	Risk Description	Existing Controls / Mitigations	Likelihood	Impact	Inherent Score	Risk Rating	Residual Score	Risk Owner
UEC-R01	Confirmation of Ysbyty Glan Clwyd (YGC) Acute Frailty Service (AFS) funding is delayed beyond Q1, risking cessation of the existing pilot before a sustainable model is agreed.	Early submission of costed options and impact modelling to Programme Board; secure interim funding bridge; escalation via UEC Improvement Group if unresolved by end of Q1.	4	5	20	Extreme	16	COO / Frailty Workstream Lead
UEC-R02	Workforce shortages, particularly ANPs, frailty consultants, therapists and pharmacists, constrain implementation of the AFS and SPoA models across all three IHCs.	Targeted recruitment campaigns; flexible deployment of staff; workforce upskilling; phased implementation aligned to workforce availability.	4	4	16	High	12	Workforce Lead / Workstream Leads
UEC-R03	Variability in Care Home and Local Authority engagement delays implementation of the Community-Based Falls Response Framework across North Wales.	Engagement through Regional Partnership Board structures; Trusted Assessor workshops; targeted locality support; phased implementation approach.	3	4	12	Moderate	8	Pillar 1 Lead / RPB Lead
UEC-R04	Procurement or supply chain delays result in insufficient availability of falls lifting equipment for Care Homes and Community Resource Teams.	Early procurement planning; identification of alternative suppliers; prioritisation of highest-risk localities and care homes.	3	3	9	Moderate	6	Community Falls Lead
UEC-R05	Digital data capture and reporting tools are not adopted consistently across sites, limiting the ability to monitor performance and demonstrate benefits.	Phased implementation; early adopter sites; data quality audits; prioritisation through the Digital Strategic Enabler programme.	4	3	12	Moderate	8	Digital Lead
UEC-R06	Ambulance handover performance (UEC4) fails to improve because upstream patient flow constraints and discharge delays (UEC5) are not resolved in parallel.	Joint governance of UEC4 and UEC5; shared GIRFT/SEDIT assessments; joint HB-WAST performance reviews; regular monitoring of interdependencies.	4	5	20	Extreme	16	COO / UEC Programme Board
UEC-R07	Inter-organisational working with Local Authorities on Trusted Assessor implementation and POCD reduction is slowed by competing regional priorities.	Regional Partnership Board governance; Memorandum of Understanding; shared reporting and accountability arrangements.	3	4	12	Moderate	8	Shared Purpose Lead / RPB Lead

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

Board Assurance Framework 2026-29

Drivers
Population Needs Assessment
Key Organisational Risks
Strategy Development
Performance Expectations
Financial Context
Anchor Institution
Strategic Priorities
1 Focus on Health and Wellbeing
Through every stage of life - enabling a greater emphasis on, and increased development and delivery of preventative, proactive strategies, working with partners rooted in communities.
1A Preventative approaches to Health & Wellbeing
1B Proactive strategies for disease prevention, falls & frailty
1C Health Inequalities
1D Health Protection
2 Enhance the co-ordination of care
For people with long-term conditions and improve access to a broader range of community-based services by investing in integrated primary and community care and working collaboratively with partners.
2A Primary Care
2B Community Care
2C Integrated Health & Wellbeing Hubs
3 Improve access, outcomes and experience for all
Developing and enhancing high-quality, high-value, and sustainable pathways of care for the region, delivered in partnership.
3A UEC
3B Planned Care, Cancer & Diagnostics
3C Fragile Services
3D MH & LD
3E CAMHS & ND
3F Childrens
3G Womens
3H Pharmacy & Medicines Management
3I Dementia
4 Create a modern, people-centred healthcare system
That is future-focused, maximising opportunities of digital care, research, innovation, and improvement, investing in workforce development and wellbeing and strengthening our role as an anchor institution for North Wales.
4A FFTF
4B Strategy & Planning
4C CSP, Clinical Leadership & Interprofessional Working
4D Digital, Data & Intelligence
4E Research, Development & Innovation
4F Education
4G Value & Sustainability
4H Quality
4I Environment & Estates
4J Workforce
4K Finance & Commissioning
Delivering the Plan
Population Health Management
Working with Regional Partners
Citizen Engagement
Organisational Approach to Change
Performance & Accountability
Governance & Risk Management

APPENDIX 1

Key to lead committee assurance ratings:

Substantial Assurance	The Committee is satisfied that there is reliable evidence supporting the effectiveness of the current risk treatment strategy in mitigating the threat, with minimal gaps in control. While the majority of actions have been addressed, some minor actions may still require completion before the risk score is reduced. However, the Committee has good assurance regarding action progress. Likelihood of risk materialising: Low.
Reasonable Assurance	The Committee has seen sufficient evidence that the most significant actions to reduce the risk have been completed. There is assurance that the planned actions within the current risk treatment strategy are appropriate, with the majority of control and assurance gaps having been addressed. Likelihood of risk materialising: Low to moderate.
Limited Assurance	The Committee does not have sufficient evidence for assurance that the current risk treatment strategy is effectively mitigating the threat. There remains to be some key gaps in controls that require management attention, and further external validation is needed. Until further controls are in place, there remains a number of actions to reduce the score. Likelihood of risk materialising: Moderate.
Unsatisfactory Assurance	The Committee has no/little evidence for assurance that the current risk treatment strategy is effectively managing the threat. There remains to be several key gaps in controls that require management attention, and further external validation is needed. Until further controls are in place, there remains a number of actions to reduce the score. Likelihood of risk materialising: High

Principal risk (What could prevent us achieving this strategic objective)	**Failure to deliver improved population health and reduced inequalities**			
Lead Committee	**Planning, Population Health & Partnerships Committee**		**Risk Type**	**Quality**
Risk Lead	**Executive Director of Public Health**		**Risk Appetite**	**<15**
Related Corporate Risks:	**CRR25-01 – Timely Patient Access to Safe and Effective Care** **CRR25-02 – Future Demand & Sustainable Workforce** **CRR25-03 – Population Needs** **CRR25-05 – Strategic Change – Impacting Care and Staff Delivery** **CRR25-06 – Value Delivery and Financial Sustainability**			
Risk Rating			**Review Dates**	
	Current Exposure	**Target**		
Consequence	**4**	**3**	**Initial assessment**	**19/07/2026**
Likelihood	**4**	**3**	**Last Committee review**	**17/08/2026**
Risk Rating	**16**	**9**	**Last Executive Review**	**28/07/2026**

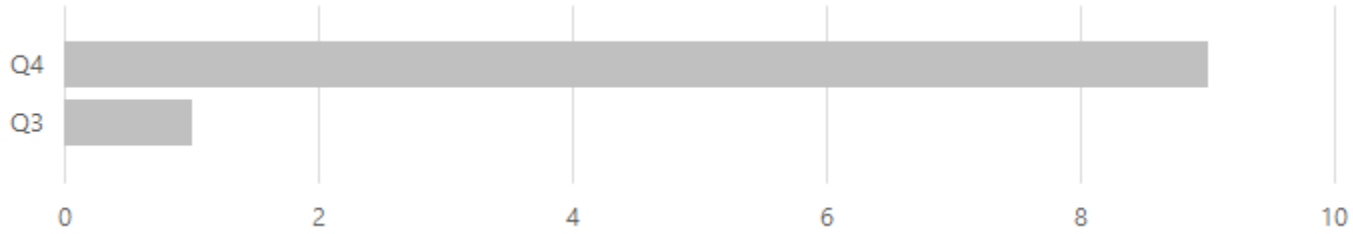
Priority:	1A Preventative approaches to Health & Wellbeing

Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to improve population health and wellbeing due to increasing prevalence of preventable long term conditions, insufficient uptake of preventative interventions, and limited impact of early intervention programmes, leading to increased demand on acute and community services and widening health inequalities.

Accountable:	Executive Director of Public Health

Primary risk controls:	Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating
• Delivery of Healthy Weight programmes (children and adults) • Implementation of Weight Management Review recommendations • Delivery of grant funded prevention programmes • Development of Health Improvement offer across the system • Delivery of early years and school-based prevention interventions • Embedding Making Every Contact Count (MECC) training • Partnership working with: - Public Service Boards - PSBs) - Local Authorities - Third Sector	G1 - Limited scale and impact of preventative interventions across the population G2 - Workforce capability and capacity to plan for and deliver prevention consistently (e.g. MECC undertaken by patient facing staff) G3 - Increasing prevalence of obesity and lifestyle-related conditions G4 - Limited intelligence to fully target prevention activity G5 - Population Health improvement is dependent on whole system approach	**Management Assurance** IMTP monitoring of 1A.1–1A.10 deliverables Performance metrics: • Smoking cessation targets • Access to weight management services and healthy weight • Improved Breastfeeding rates • Number of staff completing MECC training Programme governance (Health Improvement / Public Health programmes) **Risk & Compliance Assurance** Alignment to: • National Public Health strategies • Weight Management Review recommendations • National Mental Health & Wellbeing Strategy • Internal programme reviews **Independent Assurance** • Welsh Government oversight • Public Health Wales reporting (grants) • Public Health Outcomes Framework • Regional Partnership Board reporting	A1 - Limited assurance of long-term behaviour change outcomes A2 - Limited independent validation of impact of prevention programmes A3 - Data limitations on prevention and early intervention impact A4 - Limited real-time evidence linking interventions to reduced demand A5 - Limited assurance on reduction of inequalities at pace A6 - Limited assurance on workforce consistency and capability	

Plans to improve control :



Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
1A.1	Develop a proposal to support referrals to appropriate support following participation in Child Measurement Programme (e.g. to CAMHS, Children's, Dietetics, Weight Management).	G1 G3 G4	A1 A4	Executive Director of Public Health	**Q3** **High Delivery Confidence** **Last Update: Aug 26**
1A.2	Implementation of the recommendations in the Weight Management Review, increasing activity in Level 2 Adult weight services.	G1 G3 G4	A1 A5	Executive Director of Public Health	**Q4** **Moderate Delivery Confidence** **Last Update: Aug 26**
1A.3	Deliver approved Grant funded Programmes of work (Prevention and Early Years, Whole School Approach, Whole System approach to Healthy Weight)	G1 G5	A4 A5	Executive Director of Public Health	**Q4** **High Delivery Confidence** **Last Update: Aug 26**
1A.4	Provide education and targeted approaches to healthy choices through supporting schools, early years environments and families through Dietetics - early years programmes (Come & Cook, Tiny Tums).	G1 G3	A1 A5	Executive Director of Public Health	**Q4** **High Delivery Confidence** **Last Update: Aug 26**
1A.5	Act on the conditions that influence risk factors for ill-health (e.g. environmental, social or economic interventions), including promoting a state of good mental and physical health through assessment of impact including: 1) influence planning applications 2) work with the Alcohol Partnership Board and Public Service Boards (PSBs) to	G3 G5	A4 A5	Executive Director of Public Health	**Q4** **High Delivery Confidence** **Last Update: Aug 26**

	implement their plans 3) contribute to developing the environment through local development plans and Actif North Wales to consider green and blue spaces.				
1A.6	Agree and commence a phased implementation of an enhanced Health Improvement offer within the Health Board and with partners across the health system that increases access to evidence-based opportunities to improve health and wellbeing outcomes.	G1 G5	A1 A4 A5	Executive Director of Public Health	**Q4** **High Delivery Confidence** **Last Update: Aug 26**
1A.7	Produce gap analysis and opportunities from the potential and current state to shape the enhanced Health Improvement offer for services.	G4	A3 A4	Executive Director of Public Health	**Q4** **High Delivery Confidence** **Last Update: Aug 26**
1A.8	Embed Health Improvement into the following areas: 1) delivery planning to support Statement 2 & 4 of the National Mental Health & Wellbeing Strategy (led by Mental Health Services / Public Health Wales), 2) refresh the Preconception Strategic Plan, 3) response plan developed from the weight management review recommendations.	G1 G2	A1 A6	Executive Director of Public Health	**Q4** **High Delivery Confidence** **Last Update: Aug 26**
1A.9	Healthy Travel Charter – increase the number of participating organisations each quarter, supporting Public Service Boards (PSBs) and wider partners to register organisational commitment at a regional and national level.	G5	A5	Executive Director of Public Health	**Q4** **High Delivery Confidence** **Last Update: Jul 26**
1A.10	Embed Making Every Contact Count (MECC) brief intervention training into organisational processes to increase numbers of trained staff.	G2	A6	Executive Director of Public Health	**Q4** **Moderate Delivery Confidence** **Last Update: Jul 26**

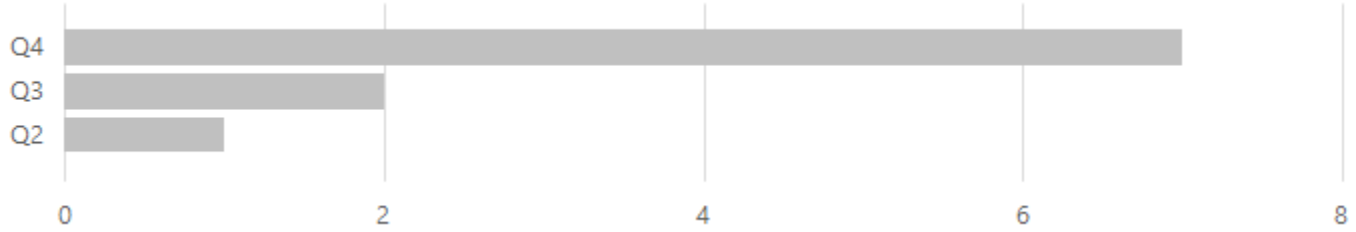
Priority:	1B Proactive strategies for disease prevention, falls & frailty

Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to reduce the prevalence and impact of disease, falls and frailty due to increasing demand from an ageing population, variation in clinical outcomes (e.g. diabetes), insufficient uptake of screening programmes, and limited use of population health intelligence, leading to avoidable deterioration in health outcomes, increased service demand, and widening health inequalities.

Accountable:	Executive Director of Public Health

Primary risk controls:	Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating
• Delivery of Diabetes High Value High Impact pathway (1B.4) • Development and implementation of Population Health Management (PHM) programme (1B.1–1B.3) • Delivery of screening improvement plans and uptake initiatives (1B.8–1B.10) • Improvement programmes to reduce variation in diabetes care processes (1B.6–1B.7) • Place-based care models through Primary and Community Care (1B.5) • Partnership working with Public Health Wales and national screening programmes • Performance monitoring against diabetes and screening indicators	G1 - Limited maturity and implementation of Population Health Management (PHM) approach G2 - Variation in clinical performance and outcomes (e.g. diabetes care processes) G3 - Insufficient uptake and variation in screening programmes G4 - Limited early identification and targeting of at-risk populations G5 - Increasing demand from ageing population (frailty and long-term conditions) G6 - Limited integration of data across systems to support proactive care	**Management Assurance** IMTP monitoring of 1B deliverables (1B.1–1B.10) - Performance indicators: Diabetes care processes and screening metrics - Programme governance arrangements **Risk & Compliance Assurance** - Alignment to national diabetes and screening standards - Internal reviews and compliance checks **Independent Assurance** - Welsh Government oversight - Public Health Outcomes Framework	A1 - Limited assurance of long-term impact of disease prevention and frailty reduction A2 - Limited independent validation of effectiveness of PHM interventions A3 - Data limitations impacting ability to track outcomes at population level A4 - Limited real-time linkage between preventative action and reduced demand A5 - Limited assurance on reduction of variation in clinical outcomes A6 - Limited evidence of sustained improvement in screening uptake	

Plans to improve control :



Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
1B.1	Develop and agree a comprehensive road map that outlines priorities, roles, data requirements and phased delivery actions to support the development of the Population Health Management (PHM) Programme.	G1 G2 G3 G4 G5 G6	A1 A2 A3 A4 A5	Executive Director of Public Health	**Q3** **High Delivery Confidence** **Last Update: Sep 26**
1B.2	Develop and launch a suite of health intelligence resources that support improved, evidence-based decision-making in service planning and help identify and reduce inequalities.	G1 G2 G3 G4 G5 G6	A1 A2 A3 A4 A5	Executive Director of Public Health	**Q2** **High Delivery Confidence** **Last Update: Sep 26**
1B.3	Establish a Population Health Management (PHM) programme with the Digital Team (DDAT) through development of a comprehensive road map, that will facilitate sustainable healthcare transformation in future years by targeting interventions that prevent ill health, improve care and support for people with ongoing health conditions, and reduce inequalities in health outcomes.	G1 G2 G3 G4 G5 G6	A1 A2 A3 A4 A5	Executive Director of Public Health	**Q4** **High Delivery Confidence** **Last Update: Sep 26**
1B.4	Complete implementation of the focused Diabetes High Value High Impact pathway.	G2 G4 G5	A5	Executive Director of Public Health	**Q4** **High Delivery Confidence** **Last Update: Aug 26**
1B.5	Identify place-based approaches within Primary and Community care and develop options which respond to population need and deliver holistic patient centred care for people living with diabetes.	G2 G4 G5	A1 A5	Executive Director of Public Health	**Q4** **High Delivery Confidence** **Last Update: Aug 26**
1B.6	Support improvement and reduce variation in performance and compliance in relation to Diabetes priorities including: 8 Care Processes and reducing variation.	G2 G4 G5 G6	A5	Executive Director of Public Health	**Q4** **High Delivery Confidence** **Last Update: Aug 26**

1B.7	Implement appropriate best practice within the national Quality Statement for Diabetes.	G2	A5	Executive Director of Public Health	**Q4 High Delivery Confidence Last Update: Aug 26**
1B.8	Support the introduction of the National Lung Screening Programme (commence 2027).	G3 G4 G5	A6	Executive Director of Public Health	**Q4 High Delivery Confidence Last Update: Aug 26**
1B.9	Create a plan together with Public Health Wales to support delivery of the National screening uptake targets and improvement against National performance indicators and to reduce variation.	G3 G4	A5 A6	Executive Director of Public Health	**Q4 High Delivery Confidence Last Update: Aug 26**
1B.10	Produce local plans to support new National Public Health Wales Human Papillomavirus (HPV) self-sampling programme.	G3	A6	Executive Director of Public Health	**Q3 Moderate Delivery Confidence Last Update: Aug 26**

Priority:	**1C Health Inequalities**

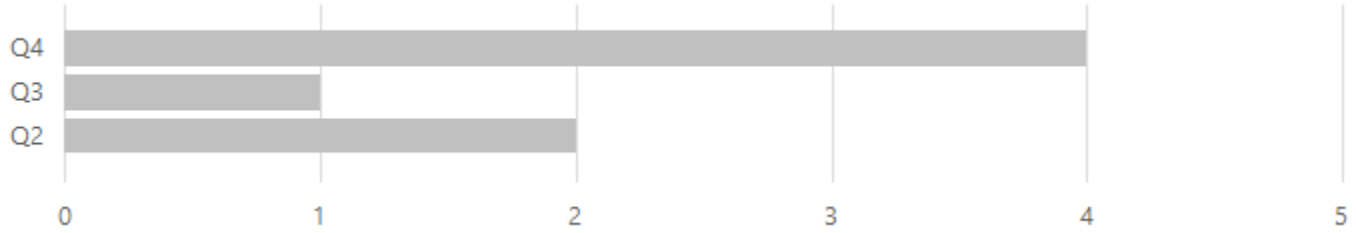
Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to reduce health inequalities due to insufficient partner commitment to the Prevention, Anchor and Wellbeing Framework, and continued variation between the most and least deprived populations in access, uptake and outcomes. This may lead to widening health inequalities, poorer health outcomes for vulnerable and inclusion groups, and increased demand on health and care services.

Accountable:	Executive Director of Public Health

Primary risk controls:	**Gaps in control:**	**Sources of assurance:**	**Gaps in assurance:**	**Assurance Rating**
• Implementation of targeted plans to reduce inequity in uptake of vaccination, screening and diabetes prevention and care (1C.1) • Development and delivery of Regional Vaccine Equity Plan and Screening Equity Plan (1C.2–1C.3) • Partnership working with Primary Care to reduce variation in uptake (1C.4) • Development of jointly commissioned social prescribing services with Local Authorities and Third Sector (1C.5) • Implementation of Marmot / Anchor framework and	G1 - Limited system-wide adoption and prioritisation of Prevention / Anchor Wellbeing Framework across partners G2 - Continued variation in access, uptake and outcomes between most and least deprived areas/groups G3 - Insufficient targeting of interventions for inclusion health groups and vulnerable populations	**Management Assurance** IMTP monitoring of 1C deliverables (1C.1–1C.7) Performance monitoring: Vaccination uptake across deprivation quintiles Screening uptake and variation Diabetes care process delivery by cluster	A1 - Limited assurance of sustained reduction in health inequalities over time A2 - Limited validation of impact of health inequality and prevention programmes A3 - Data limitations affecting measurement of outcomes across deprivation and inclusion groups A4 - Limited real-time evidence linking interventions to improved access and outcomes	

system-wide prevention approaches (1C.6) • Development of inclusion health offer for vulnerable groups (1C.7) • Use of population health intelligence to target interventions in deprived and inclusion groups	G4 - Limited integration of population health intelligence to inform inequality reduction strategies G5 - Requirement for whole system approach to tackle health inequalities and wider determinants of health G6 - Unable to implement at scale actions to address health inequalities	Programme governance (Public Health, Inequalities, Prevention programmes) **Risk & Compliance Assurance** Alignment with: Wellbeing of Future Generations (Wales) Act Equality Act 2010 and Socio-economic Duty National Public Health and Equity strategies Internal reviews of equity plans and targeted programmes **Independent Assurance** Welsh Government oversight Regional Partnership Board reporting External benchmarking of inequality and equity measures	A5 - Limited assurance of whole system approach to reducing health inequalities A6 - Limited evidence of scale and spread of effective interventions which reduce health inequalities	

Plans to improve control :



Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
1C.1	Implement plans which 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. By utilising population health intelligence and evidence, target	G4	A1 A4 A6	Executive Director of Public Health	**Q4** **High Delivery Confidence** **Last Update: Aug 26**

	approaches to reduce variation and health inequalities within inclusion health groups and areas of deprivation.				
1C.2	Regional Vaccine Equity Plan co-developed and launched.	G2 G3 G4	A1 A3 A4 A5 A6	Executive Director of Public Health	**Q2** **Low Delivery Confidence** **Last Update: Sep 26**
1C.3	Regional Screening Equity Plan co-developed and launched.	G2 G3 G4	A3 A4 A5 A6	Executive Director of Public Health	**Q4** **High Delivery Confidence** **Last Update: Aug 26**
1C.4	Work with primary care partners to reduce variation in vaccine uptake between primary care clusters.	G2 G3 G4 G5	A1 A2 A3 A4 A5 A6	Executive Director of Public Health	**Q4** **High Delivery Confidence** **Last Update: Aug 26**
1C.5	Work with Local Authorities to secure jointly commissioned social prescribing services and expand creative offers with the Third Sector across North Wales.	G1 G5	A1 A2 A3 A4 A5 A6	Executive Director of Public Health	**Q2** **Moderate Delivery Confidence** **Last Update: Aug 26**
1C.6	Supporting Marmot principles work towards a whole system shift to prevention and addressing inequalities by increasing the number of organisations/partnerships committing to, and evidencing early delivery against, the missions and Anchor Charter in the Regional Wellbeing, Prevention and Anchor Framework (missions: Environment, Communities, Housing, Food, Employment, Life-Long Learning, Active Lifestyles, Creative Lifestyles)	G1 G5	A5 A6	Executive Director of Public Health	**Q4** **High Delivery Confidence** **Last Update: Aug 26**
1C.7	Based on the work in 2025/26 on the homelessness assessment, to comply with the new Homelessness and Social	G2 G5	A1 A2 A3	Executive Director of Public Health	**Q3** **High Delivery Confidence**

	Housing Allocation (Wales) legislation and needs assessments on other inclusion groups, develop a comprehensive inclusion health offer for people in North Wales.		A4 A5 A6		**Last Update: Aug 26**

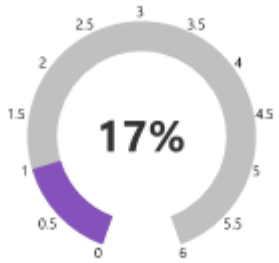
Priority:	**1D Health Protection**

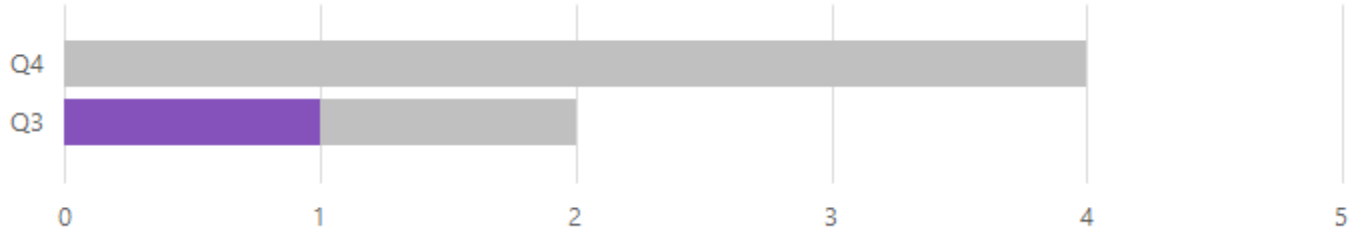
Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to protect the population from communicable disease and other health protection threats due to suboptimal vaccination uptake, increasing vaccine hesitancy, and ineffective management of environmental and societal risks. This may lead to increased spread of infectious disease, higher demand on services, and adverse population health outcomes.

Accountable:	Executive Director of Public Health

Primary risk controls:	Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating
•Delivery of vaccination and immunisation programmes aligned to National Immunisation Framework (1D.1–1D.3) •Implementation of Vaccine Equity Plan and targeted uptake initiatives •Development of GP and IVS collaborative to improve uptake (1D.2) •Delivery of Health Protection Plan and establishment of Local Authority partnerships (1D.4) •Delivery of disease prevention, screening and elimination programmes (1D.5) •Infection prevention and control interventions across high-risk settings (1D.6) •Partnership working with Public Health Wales and Local Authorities	G1 - Suboptimal vaccination uptake, particularly due to opt-out consent models G2 - Increasing vaccine hesitancy driven by misinformation and lack of trust G3 - Variation in vaccine uptake across communities and population groups G4 - Limited targeting of high-risk and underserved populations G5 - Requirement for Partner organisations to strengthen key aspects of health protection G6 - Limited system-wide coordination of environmental and societal risk management	**Management Assurance** IMTP monitoring of 1D deliverables (1D.1–1D.6) Performance indicators: Childhood vaccination uptake HPV vaccination uptake Flu and RSV vaccination uptake Programme governance (Immunisation, Health Protection programmes) **Risk & Compliance Assurance** Alignment with: National Immunisation Framework Health Protection Framework (Wales) IPC standards and guidance Internal compliance reviews **Independent Assurance** Welsh Government oversight Public Health Wales monitoring of transmissible disease External benchmarking of vaccination uptake and disease control	A1 - Limited assurance of achieving sustained herd immunity levels A2 - Limited independent validation of vaccine uptake improvement interventions A3 - Data limitations affecting targeting and monitoring of vaccination uptake A4 - Limited real-time visibility of emerging health protection risks A5 - Limited assurance of consistency in delivery across partners and communities A6 - Limited evidence of long-term reduction in disease transmission and outbreaks	

Plans to improve control :





Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
1D.1	Through targeted programmes of work for each vaccine / immunisation, implement the vaccine equity plan and work with partners (e.g. schools) to deliver the National Immunisation Framework targets to improve take up rates.	G1 G2 G3 G4	A1 A3 A5	Executive Director of Public Health	**Q4 High Delivery Confidence Last Update: Aug 26**
1D.2	Develop the GP and Identified Validated Sample (IVS) collaborative to improve uptake in the RSV 75 plus cohort.	G2 G3 G4 G5	A1 A5	Executive Director of Public Health	**Q4 High Delivery Confidence Last Update: Aug 26**
1D.3	Implementation of phase 2 Childhood Immunisation Schedule recognising changes to the immunisation schedule for 2026, protecting children across a range of disease and illness.	G1 G2 G3	A1 A2 A3 A4 A5	Executive Director of Public Health	**Q3 (Complete)**
1D.4	Deliver the funded Health Protection plan including establishing a Health Protection partnership with a Service Level Agreement in place with the 6 North Wales Local Authorities.	G5 G6	A4 A5	Executive Director of Public Health	**Q3 High Delivery Confidence Last Update: Aug 26**

1D.5	Enhance the delivery of health board services to protect people in North Wales against existing, new and emerging health protection threats and hazards by supporting screening and vaccination programmes, and disease elimination activities (Hepatitis B and C, and TB).	G4 G5 G6	A4 A6	Executive Director of Public Health	**Q4** **High Delivery Confidence** **Last Update: Aug 26**
1D.6	Deliver evidence-based approaches to protecting and preventing ill health within specific sectors and settings e.g. delivery of infection prevention control interventions in residential Care Homes.	G5 G6	A1 A6	Executive Director of Public Health	**Q4** **High Delivery Confidence** **Last Update: Aug 26**

Principal risk (What could prevent us achieving this strategic objective)	**Failure to deliver enhanced coordination of care for people with long term conditions and improve access**		
Lead Committee	**Planning, Population Health and Partnerships Committee**	**Risk Type**	**Quality**
Risk Lead	**Chief Operating Officer** **Executive Director of Finance**	**Risk Appetite**	**<15**
Related Corporate Risks:	**CRR25-01 – Timely Patient Access to Safe and Effective Care, CRR25-02 – Future Demand & Sustainable Workforce** **CRR25-04 – Modernising Digital Infrastructure to Enable Safe, Integrated Care, CRR25-05 – Strategic Change Impacting Care and Staff Delivery, CRR25-06 – Delivery of the 2026/27 Financial Plan and Financial Sustainability**		

Risk Rating			**Review Dates**	
	Current Exposure	**Target**		
Consequence	**4**	**4**	**Initial assessment**	**19/07/2026**
Likelihood	**4**	**3**	**Last Committee review**	**17/08/2026**
Risk Rating	**16**	**12**	**Last Executive Review**	**28/07/2026**

Priority:	2A Primary Care

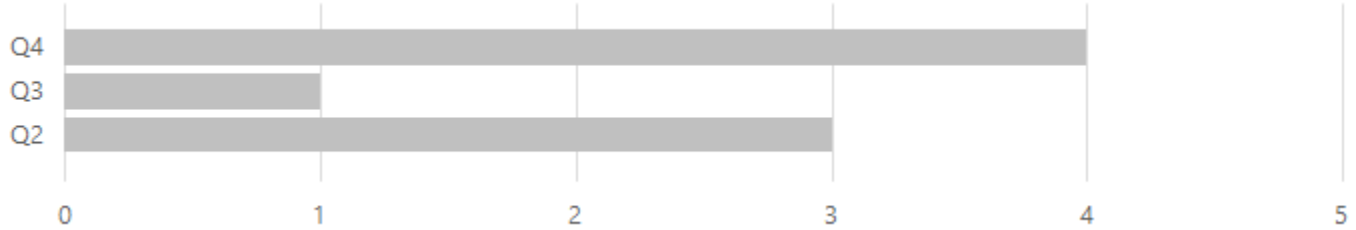
Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to deliver enhanced coordination of care for people with long-term conditions and improve access to primary and community-based services due to workforce challenges, service capacity constraints, contractual limitations, and the early maturity of transformation programmes. This may lead to reduced access to services, increased variation in care, poorer patient outcomes, and increased demand on acute services

Accountable:	Chief Operating Officer

Primary risk controls:	Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating
Implementation and embedding of new GDS contract and dental service commissioning (2A.1–2A.2) Digital transformation of Community Dental Services (2A.3) Delivery of Primary Care Workforce Strategy (2A.4) Implementation of Community by Design programme (2A.5) Development of frailty model and proactive care approaches (2A.6–2A.7) Roll-out and promotion of NHS Wales App to improve access (2A.8) Performance monitoring of access, activity and outcomes	G1 - Workforce capacity and sustainability challenges across primary care services G2 - Variation in access to primary care services (e.g. dental, frailty care, chronic conditions) G3 - Early maturity of Community by Design programme limiting delivery at scale G4 - Limited contractual levers to drive change and improvement in primary care G5 - Limited digital maturity and patient uptake of digital access solutions G6 - Insufficient proactive management of long-term conditions within community settings	**Management Assurance** IMTP monitoring of 2A deliverables (2A.1–2A.8) Performance indicators: Dental access rates (P01–P02) Frailty management metrics (P03) Diabetes care processes (P05–P08) NHS App uptake (P09) Programme governance (Primary Care, Community by Design) **Risk & Compliance Assurance** Alignment with: National Primary Care Model for Wales Strategic Workforce Plan Contractual frameworks (GDS, GP services) Internal reviews and compliance monitoring **Independent Assurance** Welsh Government oversight External benchmarking of primary care access and	A1 - Limited assurance of sustained improvement in access to primary care services A2 - Limited independent validation of impact of Community by Design programme A3 - Limited data integration across primary and community care systems A4 - Limited evidence linking primary care interventions to reduced acute demand A5 - Limited assurance on reduction of variation across clusters and regions A6 - Limited assurance on workforce sustainability and long-term capacity	

		outcomes Audit and regulatory review		

Plans to improve control :



Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
2A.1	Ensure the new General Dental Service (GDS) contract is in place and embedded, with a clear plan for the procurement of new services including commissioning of tier 2 dental services where appropriate.	G2 G2 G4	A5	Chief Operating Officer	**Q2 High Delivery Confidence Last Update: Aug 26**
2A.2	Undertake a review of primary care dental services to assess current capacity, patient access, and service utilisation. Work with commissioned providers and system partners to identify opportunities to increase access for patients.	G2	A1	Chief Operating Officer	**Q2 Moderate Delivery Confidence Last Update: Aug 26**
2A.3	Procure a robust digital system within the Community Dental Service (CDS) to support the management of patient records, and replace the current outdated system.	G5	A3	Chief Operating Officer	**Q2 Moderate Delivery Confidence Last Update: Sep 26**
2A.4	Continue to deliver the Strategic Programme for Primary Care (SPPC)	G1	A6	Chief Operating Officer	**Q4**

	national 'Strategic Workforce Plan for Primary Care in Wales', with the aim of developing a sustainable, skilled workforce to meet the evolving healthcare needs of the population of North Wales over the next five years. Fully utilise the Work Based Learning Funding allocated to Primary Care to support delivery.				**High Delivery Confidence Last Update: Aug 26**
2A.5	The Health Board will strengthen the model of integrated primary and community care across North Wales by designing and delivering strategic priorities that align with the national Community by Design Transformation Programme. The key areas of focus will include urgent and same day care, management of chronic conditions in the community and prevention and population health management.	G3 G6	A3 A4	Chief Operating Officer	**Q4 High Delivery Confidence Last Update: Aug 26**
2A.6	Develop a costed primary care-led frailty model to enable proactive, coordinated care closer to home, as part of the Community By Design work. Identify the impact that current initiatives are having on maintaining patients at home.	G6	A4 A5	Chief Operating Officer	**Q3 Moderate Delivery Confidence Last Update: Jun 26**
2A.7	Finalise a proposal to increase the use of the Audit Plus Frailty Tool in the community to ensure that patients receive proactive care in line with their agreed care plans.	G6	A4	Chief Operating Officer	**Q4 High Delivery Confidence Last Update: Aug 26**
2A.8	Support the implementation and roll-out of the NHS Wales app in primary and community care services by developing and implementing an action plan to promote the NHS app including patient education, staff training and monitoring of uptake.	G5	A1 A3	Chief Operating Officer	**Q4 Moderate Delivery Confidence Last Update: Sep 26**

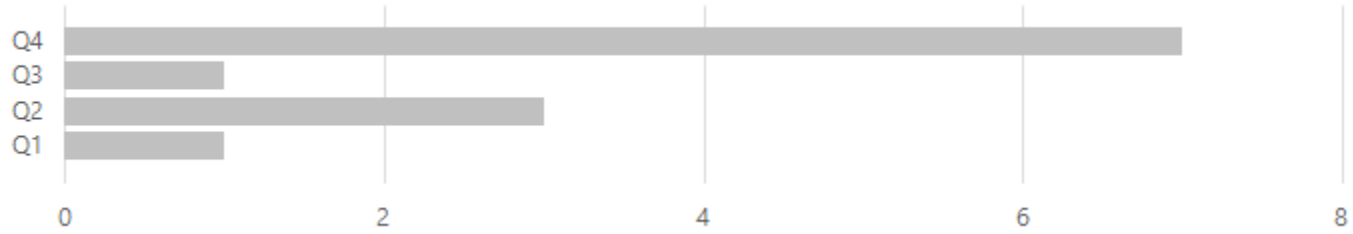
Priority:	2B Community Care

Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to deliver coordinated, accessible, and high-quality community-based care for people with long-term conditions due to insufficient strategic planning, workforce and resource constraints, and lack of an agreed system-wide frailty and community care model. This may result in fragmented service delivery, increased variation in care, reduced access to services, increased demand on acute settings, and poorer patient outcomes

Accountable:	Chief Operating Officer

Primary risk controls:	Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating
Development and delivery of Community by Design programme (2B.1) Demand and capacity review of community nursing services (2B.2) Mapping and redesign of Enhanced Community Care services (2B.3) Development of community investment fund with partners (2B.4) Strategic delivery plan for Palliative and End of Life Care (2B.5–2B.7) Review and optimisation of urgent community-based care services (2B.8) Delivery of coordinated care model for long-term conditions (2B.9) Implementation of frailty model and best practice standards (2B.10) Development of community diagnostic and breathlessness hubs (2B.11–2B.12)	G1 - Lack of a fully agreed and embedded system-wide strategic plan for community care G2 - Workforce and capacity constraints across community and primary care services G3 - Early maturity of Community by Design programme limiting impact at scale G4 - Variation in access and service provision across localities G5 - Reliance on partner organisations and external providers G6 - Limited integration and coordination of care for frailty and long-term conditions	**Management Assurance** IMTP monitoring of 2B deliverables (2B.1–2B.12) Performance metrics: Frailty pathway delivery Community nursing capacity Reduced hospital admissions and conveyance Programme governance (Community by Design, Frailty, Palliative Care) **Risk & Compliance Assurance** Alignment with: National Quality Statements (Frailty, End of Life Care) Community Care and Primary Care Models Internal service reviews and programme oversight **Independent Assurance** Welsh Government oversight External benchmarking of community services Regional partnership and system oversight	A1 - Limited assurance of consistent delivery and access across all localities A2 - Limited independent validation of Community by Design programme impact A3 - Limited data integration and benchmarking of community services A4 - Limited real-time evidence linking community interventions to reduced hospital demand A5 - Limited assurance of consistent implementation of national standards A6 - Limited evidence of sustainability of workforce and service models	

Plans to improve control :



Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
2B.1	Develop Community by Design as a Major Change programme, working with partners to ensure it reflects national priorities and local needs.	G1 G3 G5	A2 A5	Chief Operating Officer	**Q4** **Moderate Delivery Confidence** **Last Update: Aug 26**
2B.2	Undertake a demand and capacity review to understand the levels of community nursing that are required across the Health Board, including weekend working.	G2 G4	A1 A6	Chief Operating Officer	**Q2** **Moderate Delivery Confidence** **Last Update: Sep 26**
2B.3	Map current Enhanced Community Care services across North Wales, identifying where services are located and the differences. Develop a proposal that offers recommendations as to how to further reduce unnecessary hospital conveyance and admissions.	G4 G6	A4 A5	Chief Operating Officer	**Q4** **High Delivery Confidence** **Last Update: Aug 26**
2B.4	Develop a proposal for creating an investment fund for community groups and third sector organisations to work with the Health Board on community based solutions to some of the largest challenges facing the system.	G3 G5	A1 A5	Chief Operating Officer	**Q1** **Low Delivery Confidence** **Last Update: Aug 26**
2B.5	Develop a strategic delivery plan for Palliative, End of Life and Bereavement Care (PEoLBC) in line with the All Wales Service Specification for the delivery of Palliative and End of Life care in Wales and All Wales Competency Framework.	G1 G6	A1 A5	Chief Operating Officer	**Q4** **Moderate Delivery Confidence** **Last Update: Aug 26**

	This will include consideration of how to increase weekend capacity for specialist palliative care nursing.				
2B.6	Agree an approved Quality Improvement Plan for End-of-Life Care Decision Making	G6	A1 A5	Chief Operating Officer	**Q4 Moderate Delivery Confidence Last Update: Aug 26**
2B.7	Implement appropriate best practice within the national Quality Statement for Palliative and End of Life Care.	G6	A5	Chief Operating Officer	**Q4 Moderate Delivery Confidence Last Update: Aug 26**
2B.8	Undertake a review of urgent care services available in the community including general practice, optometry, dental and pharmacy. Identify how services may be optimised and expanded.	G2 G4	A1 A4	Chief Operating Officer	**Q2 Low Delivery Confidence Last Update: Aug 26**
2B.9	The Health Board will enhance the coordination of care for people with long term conditions and improve access to a broader range of community-based services, investing in integrated primary and community care.	G1 G3 G6	A2 A4 A6	Chief Operating Officer	**Q4 Moderate Delivery Confidence Last Update: Aug 26**
2B.10	Implement appropriate best practice within the national Quality Statement for Older people and people living with frailty.	G6	A1 A5	Chief Operating Officer	**Q4 Moderate Delivery Confidence Last Update: Aug 26**
2B.11	Develop a proposal to establish local breathlessness hubs to provide specialised support and care for people experiencing chronic breathlessness.	G2 G6	A1 A4	Chief Operating Officer	**Q3 High Delivery Confidence Last Update: Aug 26**
2B.12	Diagnostic Provision in the Community will be reviewed including undertaking a needs assessment for diagnostics and			Chief Operating Officer	**Q2**

	working with current providers to review and agree the most efficient delivery mechanism.				**Moderate Delivery Confidence** **Last Update: Sep 26**

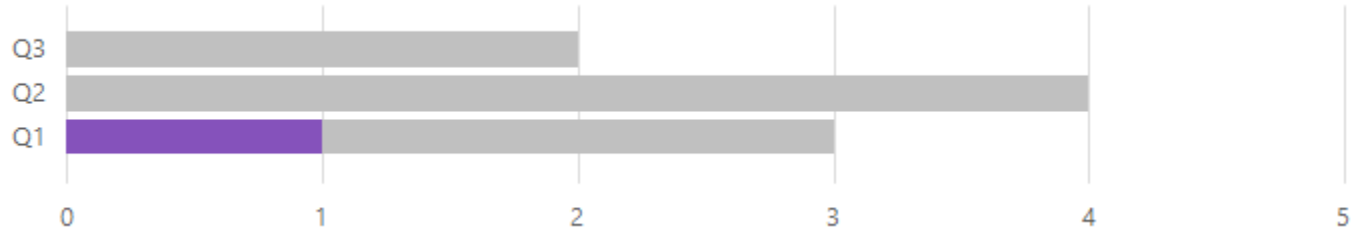
Priority:	**2C Integrated Health & Well-being Hubs**

Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to deliver Integrated Health & Well-being Hubs at pace and scale due to insufficient funding, workforce capacity constraints, and changing system priorities. This may result in delays to implementation, reduced access to integrated community-based services, missed opportunities to improve coordination of care, and continued pressure on acute services.

Accountable:	Chief Operating Officer

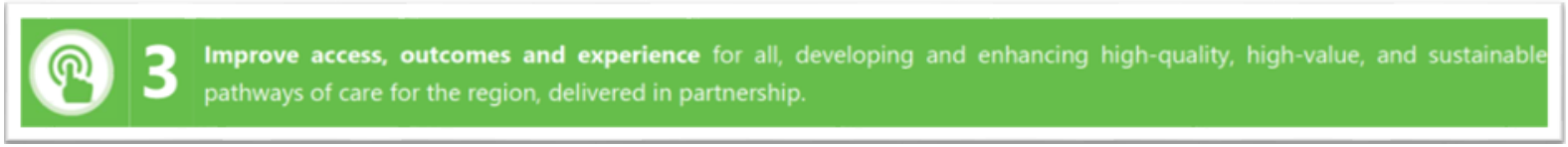
Primary risk controls:	**Gaps in control:**	**Sources of assurance:**	**Gaps in assurance:**	**Assurance Rating**
Delivery of Integrated Health & Well-being Hub programme across multiple sites (2C.1–2C.8) Strategic partnership working with Local Authorities, housing associations and third sector Development and approval of business cases and programme plans for hubs Governance through programme and capital planning frameworks Prioritisation through Integrated Rebalancing Capital Fund (IRCF) (2C.9) Alignment with Community by Design and wider strategic intent	G1 - Funding constraints impacting pace and scale of hub development G2 - Workforce capacity and contractor engagement challenges G3 - Dependency on multi-agency partners and external decision-making G4 - Risk of changing political or strategic priorities affecting delivery G5 - Early stage of programme maturity across multiple sites G6 - Limited capacity to scale integrated models consistently across North Wales	**Management Assurance** IMTP monitoring of 2C deliverables (2C.1–2C.9) Programme governance (Integrated Hubs Programme) Monitoring against programme milestones and timelines **Risk & Compliance Assurance** Alignment with: Health Board Strategy and Capital Programme National "A Healthier Wales" policy direction Internal programme and financial governance **Independent Assurance** Welsh Government oversight of capital and transformation programmes External scrutiny of business cases and funding approvals Partner organisation governance and reporting	A1 - Limited assurance of delivery at pace across all hub developments A2 - Limited independent validation of long-term impact of integrated hub model A3 - Limited visibility of real-time progress across multiple programmes A4 - Limited evidence linking hub delivery to improved outcomes and reduced demand A5 - Limited assurance of consistent partner commitment across all sites A6 - Limited assurance of sustainability of funding and workforce models	

Plans to improve control :



Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
2C.1	Bangor Integrated Health & Well-being Centre – work with partners on a strategic outline case	G1 G3 G5	A1 A3	Chief Operating Officer	**Q2 High Delivery Confidence Last Update: Sep 26**
2C.2	Waunfawr Integrated Health & Well-being Centre – sign heads of terms to secure purchase of a site, progress the parallel elements of the programme plan.	G1 G3	A1 A3	Chief Operating Officer	**Q1 Moderate Delivery Confidence Last Update: Sep 26**
2C.3	Penygroes Integrated Health & Well-being Centre – develop an outline business case, progress the parallel elements of the programme plan.	G1 G5	A1 A3	Chief Operating Officer	**Q3 Moderate Delivery Confidence Last Update: Aug 26**
2C.4	Porthmadog Integrated Health & Well-being Centre – revise options appraisal for location, progress the parallel elements of the programme plan.	G1 G4	A1 A3	Chief Operating Officer	**Q2 Moderate Delivery Confidence Last Update: Sep 26**
2C.5	Conwy West Integrated Health & Well-being Centre – finalise site location, progress the parallel elements of the programme plan.	G1 G5	A1 A3	Chief Operating Officer	**Q2 Low Delivery Confidence Last Update: Aug 26**
2C.6	Denbigh (Caledfryn) Integrated Health & Well-being Centre – finalise funding	G1 G2 G5	A1 A6	Chief Operating Officer	**Q2 Low Delivery Confidence**

	strategy, thereafter progress the programme plan.				**Last Update: Aug 26**
2C.7	Holyhead Integrated Health & Well-being Centre – agree memorandum of understanding with Local Authority, thereafter progress the programme plan.	G3 G5	A5	Chief Operating Officer	**Q1 Moderate Delivery Confidence** **Last Update: Sep 26**
2C.8	Rhyl (Royal Alexandra Hospital - Phase 1) Integrated Health & Well-being Centre – commence construction, and progress the programme plan for delivery. Develop the case for Phase 2 later in the financial year.	G1 G2 G5	A1 A3 A6	Chief Operating Officer	**Q1 (Complete)** **Last Update: Jun 26**
2C.9	Finalise Integrated Rebalancing Capital Fund (IRCF) prioritisation.	G1 G4	A1 A3	Chief Operating Officer	**Q3 Low Delivery Confidence** **Last Update: Aug 26**



Principal risk (What could prevent us achieving this strategic objective)	**Failure to Improve access, outcomes and experience**		
Lead Committee	**Performance Finance and Information Governance Committee Quality, Safety Experience Committee**	**Risk Type**	**Quality**
Risk Lead	**Chief Operating Officer, Executive Director of Allied Health Professions & Health Science, Executive Medical Director & Executive Director of Nursing**	**Risk Appetite**	**<15**
Related Corporate Risks:	**CRR25-01 – Timely Patient Access to Safe and Effective Care, CRR25-02 – Future Demand & Sustainable Workforce, CRR25-04 – Modernising Digital Infrastructure to Enable Safe, Integrated Care, CRR25-05 – Strategic Change Impacting Care and Staff Delivery, CRR25-06 – Delivery of the 2026/27 Financial Plan and Financial Sustainability**		

Risk Rating			**Review Dates**	
	Current Exposure	**Target**		
Consequence	**5**	**5**	**Initial assessment**	**28/07/2026**
Likelihood	**4**	**3**	**Last Committee review**	**17/08/2026**
Risk Rating	**20**	**15**	**Last Executive Review**	**28/07/2026**

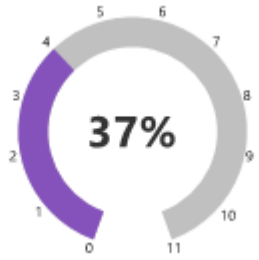
Priority:	3A Urgent and Emergency Care (UEC)

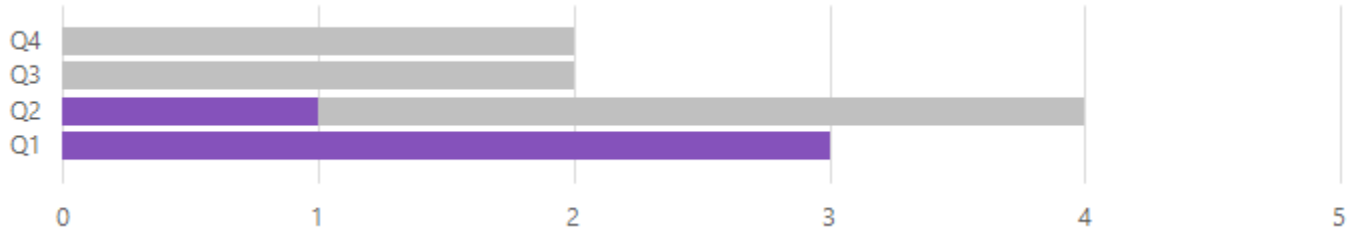
Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to deliver sustained improvements in urgent and emergency care access, outcomes and patient experience due to constraints in recurrent funding, system capacity, workforce limitations and reliance on partner organisations, particularly during periods of increased demand

Accountable:	Chief Operating Officer

Primary risk controls:	Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating
UEC Improvement Programme and IMTP deliverables (3A.1–3A.13) Programme governance including UEC Programme Board and NHS Wales oversight 90-day Operational Improvement Plans informed by 6As and GIRFT Daily–monthly operational escalation and performance monitoring Adoption of national best practice (triage, streaming, ambulance handover, senior decision making) Strengthened discharge pathways (D2RA and 7-day discharge model) Partnership working with WAST, Local Authorities and community services	G1 - No confirmed recurrent funding for key UEC models (e.g. SDEC) G2 - Insufficient 7-day and MDT capacity (SPOA, discharge, workforce) G3 - Limited community capacity (CRT, falls response, D2RA resilience) G4 - Dependence on non-recurrent funding and partner contribution G5 - Variation in front-door processes, triage and workforce deployment G6 - Inconsistent system-wide alignment and escalation during surge	**Management Assurance** Programme Board oversight of IMTP deliverables and system performance Ongoing operational reporting and improvement plan delivery **Risk & Compliance Assurance** Monitoring against national UEC standards (handover, 12-hour waits, etc.) Compliance with GIRFT and ED Quality Statement Internal audit review of governance and controls **Independent Assurance** NHS Wales Performance & Improvement oversight Welsh Government monitoring against trajectories External validation (6As, GIRFT benchmarking)	A1 - Limited evidence on sustainability of improvements (particularly SDEC and surge) A2 - Insufficient independent assurance on community capacity and CRT models A3 - Weak triangulation of system-wide data (acute, WAST, partners) A4 - Limited assurance on cross-organisational delivery (e.g. SPOA sustainability) A5 - Insufficient independent validation of workforce and senior clinical cover A6 - Limited evidence that 7-day and discharge models are consistently embedded	

Plans to improve control :





Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
3A.1	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.	G3	A2	Chief Operating Officer	**Q1 (Complete)**
3A.2	Reduce avoidable ambulance conveyances and ED admissions from the community through producing an options appraisal for the National Six Goals Team to support funding for St John's Level 1 falls training and lifting equipment for Community Resource Teams (CRTs), ensuring a consistent pan North Wales approach to community-based falls response.	G3 G4	A2	Chief Operating Officer	**Q2 (Complete)**
3A.3	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.	G2 G3	A2	Chief Operating Officer	**Q1 (Complete)**
3A.4	Reduce avoidable ambulance conveyances and ED admissions by transitioning from the current Single Integrated Clinical Assessment and Triage (SICAT) model to the Single Point of Access model (SPOA) with a broader Multi-Disciplinary Team (MDT) that is able to better sign post the most appropriate alternate to hospital treatment routes. This will ensure there is sufficient resource to operate the SPOA 7 days a week, 12 hours a day.	G2 G4 G6	A1 A4	Chief Operating Officer	**Q4 Moderate Delivery Confidence Last Update: Aug 26**

3A.5	Improve pathways of care delays out of the hospital through working more closely with the Local Authority Social Care Information Advice and Assistance (IAAs) team to improve referral pathways out of hospital.	G2 G4 G6	A3 A4	Chief Operating Officer	**Q3 High Delivery Confidence Last Update: Aug 26**
3A.6	Provide more suitable pathways for frail patients that ensure they have shorter lengths of stay within acute hospitals in line with the national Acute Frailty Service (AFS) model. Undertake baseline assessment and gap analysis for current Acute Front Door Frailty Services across all acute sites, identifying current service provision, workforce utilisation, SDEC alignment and opportunities to strengthen early frailty assessment and intervention.	G1 G6	A1 A3	Chief Operating Officer	**Q1 (Complete)**
3A.7	Adopt national best practice in relation to implementation of safe, fast, and consistent ambulance handover processes at the ED front door.	G5 G6	A1	Chief Operating Officer	**Q2 Moderate Delivery Confidence Last Update: Sep 26**
3A.8	Reduce ambulance hours lost, improve hospital-wide flow and ambulance handover times by standardising triage and streaming processes across all sites (majors, minors, SDEC, frailty).	G5 G6	A1 A2	Chief Operating Officer	**Q2 Moderate Delivery Confidence Last Update: Sep 26**
3A.9	Reduce ambulance hours lost, improve hospital-wide flow and ambulance handover times by strengthening senior clinical decision-maker presence at the front door, especially during periods of high demand.	G2 G5	A5	Chief Operating Officer	**Q2 Moderate Delivery Confidence Last Update: Aug 26**
3A.10	Reduce the number of people delayed in hospital and their length of stay, thereby reducing the potential for deconditioning, by strengthening application of community Discharge to Recover and Assess (D2RA) pathways,	G2 G3 G6	A1 A2	Chief Operating Officer	**Q3 Moderate Delivery Confidence Last Update: Aug 26**

	ensuring faster discharge options for frail patients.				
3A.11	Reduce the number of people delayed in hospital and their length of stay, thereby reducing the potential for deconditioning, through implementation of Optimal Hospital Flow facilitators, utilisation of the Transport Coordination hub and enabling a 7-day discharge model across all acute sites.	G2 G3 G6	A1 A6	Chief Operating Officer	**Q4 Moderate Delivery Confidence Last Update: Aug 26**

Priority:	**3B Planned Care, Cancer & Diagnostics**

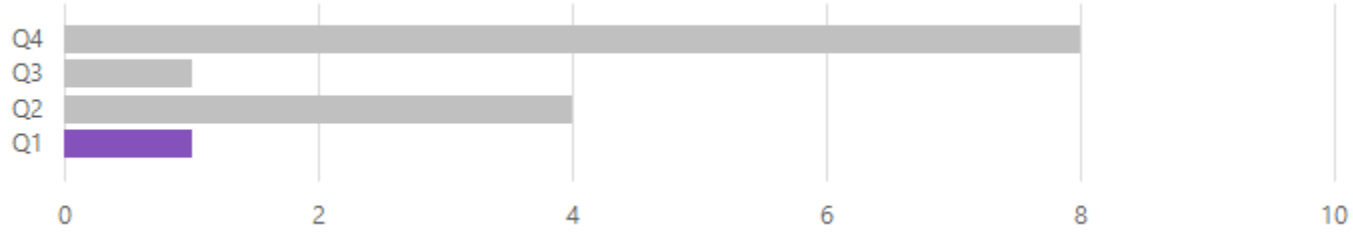
Strategic Threat and Risks: There is a risk that the Health Board is unable to deliver timely and sustainable improvements in planned care, cancer and diagnostics access, outcomes and patient experience due to challenges in achieving clinical consensus on service models, pace of pathway transformation (including PIFU/SOS), and workforce capacity and recruitment constraints

Accountable:	Chief Operating Officer

Primary risk controls:	Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating
Planned Care Major Change Programme governance Clinical Services Planning (CSP) Programme driving system-wide models Follow-up transformation workstream (PIFU/SOS – 3B.5, 3B.12) National guidance (GIRFT, CIN pathways, Cancer standards) Demand and capacity modelling supporting pathway design External support from Intensive Support Team (IST) Workforce redesign and fragile service improvement plans Investment in external capacity to protect performance	G1 - Variation in specialty engagement and readiness to adopt change G2 - Lack of standardised pathways and models across sites G3 - Workforce capacity constraints limiting delivery pace G4 - Data quality and variation impacting decision-making G5 - Inconsistent integration across primary, community and secondary care G6 - Fragility of key services limiting ability to stabilise workforce and models	**Management Assurance** Programme Board and CSP governance oversight Monitoring of IMTP deliverables (3B.1–3B.20) Specialty-level reporting on performance and transformation **Risk & Compliance Assurance** Monitoring against RTT, diagnostics and cancer standards Compliance with GIRFT, CIN pathways and national accreditation (e.g. JAG) Internal audit oversight of pathway and governance processes **Independent Assurance**	A1 - Limited assurance that consensus is achieved across all specialties A2 - Insufficient independent validation of new service models A3 - Weak triangulation of performance, quality and pathway data A4 - Limited assurance that redesigned pathways are embedded consistently A5 - Insufficient evidence that transformation will deliver improvement at pace A6 - No full external assurance on long-term sustainability of workforce and models	

		Intensive Support Team (IST) and national programme oversight External clinical networks and benchmarking Welsh Government performance monitoring		

Plans to improve control :



Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
3B.1	WS1 – RTT Pathway Validation: 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.	G3 G4	A3	Chief Operating Officer	**Q4 Low Delivery Confidence Last Update: Aug 26**
3B.2	WS2 – Referral Pathway Refinement: A range of initiatives to support a reduction in referrals to outpatients in high volume specialities, 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.	G1 G2 G5	A1 A4	Chief Operating Officer	**Q4 Moderate Delivery Confidence Last Update: Aug 26**
3B.3	WS3 – Booking Services: Reduce variation in outpatient waiting times and improve communication with	G2 G4	A4 A5	Chief Operating Officer	**Q4 High Delivery Confidence**

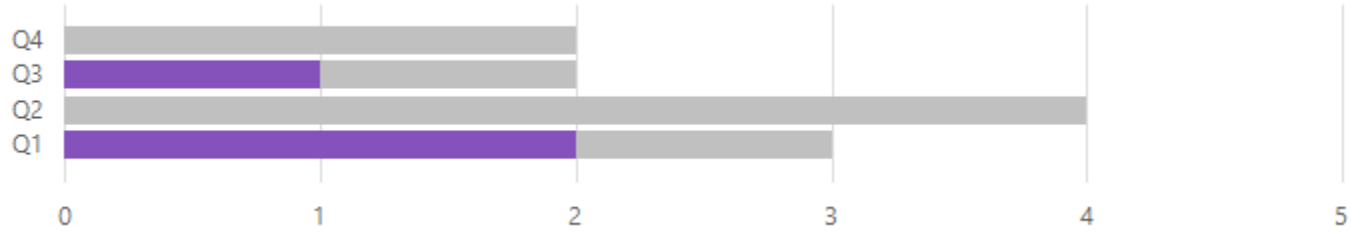
	patients on the waiting lists by adopting best practice including modernisation and standardisation of centralised booking services.				**Last Update: Aug 26**
3B.4	WS4 – Pre-operative & Operative Effectiveness: Adopt best practice in theatre management through standardising pre-operative assessment process, and driving theatre productivity across North Wales. Undertake the national Surgical Hub Accreditation to support improved efficiencies and High Volume Low Complexity listings.	G2 G3	A2 A5	Chief Operating Officer	**Q4 Moderate Delivery Confidence Last Update: Aug 26**
3B.5	WS5 – Follow-up Pathways: 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 Information Network (CIN) pathways and discharge protocols.	G1 G2 G3	A1 A3 A5	Chief Operating Officer	**Q3 High Delivery Confidence Last Update: Aug 26**
3B.6	Effective commissioning of planned care services in key specialties where core capacity and Waiting List Initiatives (WLIs) are insufficient to meet forecast demand.	G3	A2 A5	Chief Operating Officer	**Q4 Moderate Delivery Confidence Last Update: Aug 26**
3B.7	Secure continuation of additional external capacity within dermatology, endoscopy, radiology and urology to meet existing demand into 2026/27. (Investment from Planned Care fund).	G3	A2 A5	Chief Operating Officer	**Q1 (Complete)**
3B.8	Agree the strategic model for the delivery of dermatology services in north Wales.	G2 G6	A2 A6	Chief Operating Officer	**Q2 Low Delivery Confidence Last Update: Sep 26**

3B.9	Agree the strategic model for the development of robotic assisted surgery in north Wales.	G2	A2 A6	Chief Operating Officer	**Q2** **Moderate Delivery Confidence** **Last Update: Sep 26**
3B.10	Finalise the oncology clinical strategic plan for north Wales.	G2 G5	A1 A2 A6	Chief Operating Officer	**Q2** **High Delivery Confidence** **Last Update: Sep 26**
3B.11	WS6a – Cancer: Increase compliance with national optimal pathways with particular focus on increasing straight to test rates.	G4	A4	Chief Operating Officer	**Q4** **Moderate Delivery Confidence** **Last Update: Aug 26**
3B.12	Deliver opportunities for streamlined follow-up to improve patient care (e.g. Patient Initiated Follow-up – PIFU or See on Symptoms – SOS).	G1 G2 G3	A1 A6	Chief Operating Officer	**Q4** **High Delivery Confidence** **Last Update: Aug 26**
3B.16	WS6b – Diagnostics: With the support of the NHS Wales Performance and Improvement (NHS Wales Performance & Improvement) 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.	G4 G5	A2 A4	Chief Operating Officer	**Q2** **High Delivery Confidence** **Last Update: Sep 26**
3B.17	Progress national business justification case for digital cellular pathology, enabling the service to fully realise clinical and operational benefits, including overall increased reporting performance for routine cases in addition to those of higher clinical priority.	G4	A2 A6	Chief Operating Officer	**Q4** **Moderate Delivery Confidence** **Last Update: Aug 26**

Priority:	3C Fragile Services
Strategic Threat and Risks: There is a risk that the Health Board is unable to deliver safe, sustainable and equitable fragile services due to workforce constraints, financial limitations, challenges in agreeing service models, and operational pressures impacting delivery and resilience	
Accountable:	Chief Operating Officer

Primary risk controls:	Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating
Clinical Services Planning (CSP) Programme driving sustainable service models Fragile Services Programme governance and oversight Adoption of national guidance (GIRFT, Royal College standards, clinical networks) Workforce planning, succession planning and skill mix redesign Quality Management Systems (QMS) development across fragile services Networked service models across North Wales to share workforce and expertise Investment in external capacity where required Performance and quality oversight through IMTP delivery monitoring	G1 - Ongoing workforce shortages and limited pipeline for key specialties G2 - Lack of sustainable workforce models and over-reliance on traditional roles G3 - Financial constraints limiting service redesign and sustainability G4 - Fragmentation of services across sites limiting efficient use of capacity G5 - Limited capacity to deliver transformation due to operational pressures G6 - Variation in pathway design, quality systems and data maturity	**Management Assurance** CSP Programme and Fragile Services governance oversight Monitoring of IMTP deliverables (3C actions) Divisional reporting on workforce, performance and service delivery **Risk & Compliance Assurance** Compliance with GIRFT recommendations and Royal College standards Monitoring of RTT, diagnostics and specialty-specific performance measures Development and implementation of Quality Management Systems **Independent Assurance** External clinical networks and professional body reviews NHS Wales Performance & Improvement support and benchmarking Welsh Government oversight and reporting	A1 - Limited assurance that workforce models will deliver long-term sustainability A2 - Insufficient independent validation of redesigned service models A3 - Gaps in data quality and consistency across specialties A4 - Limited evidence that service changes will improve resilience and outcomes A5 - Insufficient assurance on reduction of reliance on locum/external capacity A6 - Limited visibility of long-term financial sustainability across fragile services	

Plans to improve control :



Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
3C.2	Commence implementation of vascular service review as part of the first tranche of Clinical Services Plan reviews, to:-Help strengthen integrated working across hub and spoke sites, -Support development of a skilled, happy and sustainable workforce,-Improve patient outcomes across key pathways-Ensure greater alignment with national guidance and best practice.	G2 G4 G6	A1 A2 A6	Chief Operating Officer	**Q2 Moderate Delivery Confidence Last Update: Aug 26**
3C.7	Engagement and implementation of interim pan North Wales networked Dermatology service model, to better utilise resources (staff and funding) across North Wales. This is ahead of the full Clinical Services Plan work due to urgency around service sustainability especially in the West.	G4 G6	A2 A4	Chief Operating Officer	**Q1 Low Delivery Confidence Last Update: Jul 26**
3C.8	Involvement in the full Clinical Services Plan work to design the long-term sustainable Dermatology model.	G4 G6	A2 A4	Chief Operating Officer	**Q4 Low Delivery Confidence Last Update: Jul 26**
3C.9	Balancing Dermatology work between primary and community and secondary care – Further development of the Community Health Pathways and Teledermoscopy in order to reduce avoidable referrals into secondary care.	G2 G4 G6	A2 A4	Chief Operating Officer	**Q2 Moderate Delivery Confidence Last Update: Jun 26**

3C.13	Full workforce review, succession planning, skills mix, expansion of roles such as Dentists with special interests, Orthodontic Therapists, to support more sustainable services.	G1 G2 G5	A1 A5	Chief Operating Officer	**Q4** **Low Delivery Confidence** **Last Update: Aug 26**
3C.14	Develop proposals to increase access to Cone Beam capable CT scanners, improving capacity and patient experience and travel.	G3 G6	A2 A4	Chief Operating Officer	**Q3** **(Complete)**
3C.23	Full workforce review, succession planning, skills mix, expansion of roles such as Optometrists, Orthoptists, Advanced Clinical Practitioners, to support more sustainable services.	G1 G2 G5	A1 A5	Chief Operating Officer	**Q2** **Moderate Delivery Confidence** **Last Update: Sep 26**
3C.36	Further development of QMS to provide structured view and understanding of the drivers behind fragile services, through the triangulation of broad range of key data points.	G6	A3 A4	Chief Operating Officer	**Q1** **(Complete)**
3C.37	Use the new QMS capability to map the highest priority services of concern as part of the Clinical Services Plan work, capturing the main KPIs for each that will be tracked to measure improvement.	G6	A3 A4	Chief Operating Officer	**Q2** **Moderate Delivery Confidence** **Last Update: Sep 26**
3C.38	Ensure that services of concern monitoring, escalation and de-escalation processes, governance and reporting are adequately covered within the latest Performance and Accountability framework, covering both Executive and Board Member visibility. Including capturing how people's care and treatment outcomes are monitored and how they compare to similar services.	G6	A3 A4	Chief Operating Officer	**Q3** **High Delivery Confidence** **Last Update: May 26**
3C.39	Review and implement improvements to the governance surrounding services	G6		Chief Operating Officer	**Q1** **(Complete)**

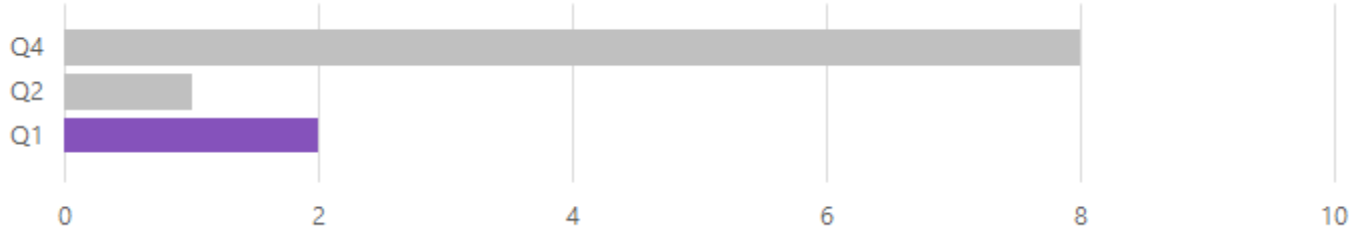
	of concern, including establishment of both risks and separate issues logs.				

Priority:	**3D Mental Health & Learning Disabilities**
Strategic Threat and Risks: There is a risk that the Health Board is unable to deliver timely, safe and high-quality mental health and learning disability services due to workforce capacity constraints, increasing demand and complexity, limitations in digital infrastructure, and challenges in implementing system-wide transformation and sustainable service models	
Accountable:	Executive Director of Allied Health Professions & Health Science (with CEO oversight for MH Oversight Programme)

Primary risk controls:	Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating
Mental Health Oversight and Development Group governance National Patient Safety Programme implementation (Safe discharge, 72-hour follow-up) Crisis Care Model implementation Development of Open Access Mental Health Service model Engagement with national workstreams (MH strategy, physical health, LD frameworks) Electronic Healthcare Record (EHR) Transformation Programme Performance monitoring through national Mental Health Measure standards Partnership working with Local Authorities and Regional Partnership Board	G1 - Workforce capacity constraints impacting delivery and transformation G2 - Lack of fully implemented and standardised service models (e.g. Open Access) G3 - Continued reliance on out-of-area placements due to capacity issues G4 - Incomplete digital infrastructure (EHR not fully embedded) G5 - Variation across pathways and integration with partners G6 - Estate and infrastructure limitations affecting service delivery	**Management Assurance** Mental Health Oversight & Development Group monitoring delivery IMTP deliverables tracking (3D.1–3D.11) Performance monitoring against Mental Health Measure targets Programme reporting for EHR, crisis model and safety initiatives **Risk & Compliance Assurance** Compliance with national safety standards (72-hour follow-up, safe discharge) National MH & LD programme alignment and reporting Internal audits and governance reviews Monitoring out-of-area placements and patient safety incidents	A1 - Limited assurance that transformation (e.g. Open Access model) will be delivered at pace A2 - Insufficient independent validation of new service models A3 - Gaps in digital and data visibility (pending EHR implementation) A4 - Limited triangulation of quality, safety and performance outcomes A5 - Limited assurance that out-of-area placements will be sustainably reduced A6 - Insufficient evidence of long-term sustainability (workforce and estates)	

		Independent Assurance Welsh Government oversight and reporting NHS Wales Performance & Improvement support External inspections/reviews (e.g. HIW, Royal Colleges where applicable)		

Plans to improve control :



Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
3D.1	Engage with National Patient Safety Programme to improve quality and safety across services with the implementation Safe Discharge and 72-hour follow-up standards.	G2 G5	A3 A4	Executive Director of Allied Health Professionals and Health Science	**Q4 High Delivery Confidence Last Update: Aug 26**
3D.2	Train inpatient staff on the use of ReQol 10 Patient Reported Outcome Measures (PROMS) alongside the National Programme Safety team.	G2	A3	Executive Director of Allied Health Professionals and Health Science	**Q1 (Complete)**
3D.3	Agree and develop with partners a phased Open Access Mental Health Service model with a view to implementing the demonstrator site by Q4 based on the international evidence base.	G1 G2 G5		Executive Director of Allied Health Professionals and Health Science	**Q1 (Complete)**
3D.4	Engage with the National workstream to Improve Physical Health of People with Severe and enduring Mental Illness	G1 G2 G5	A1 A2 A5	Executive Director of Allied Health Professionals and Health Science	**Q4 High Delivery Confidence**

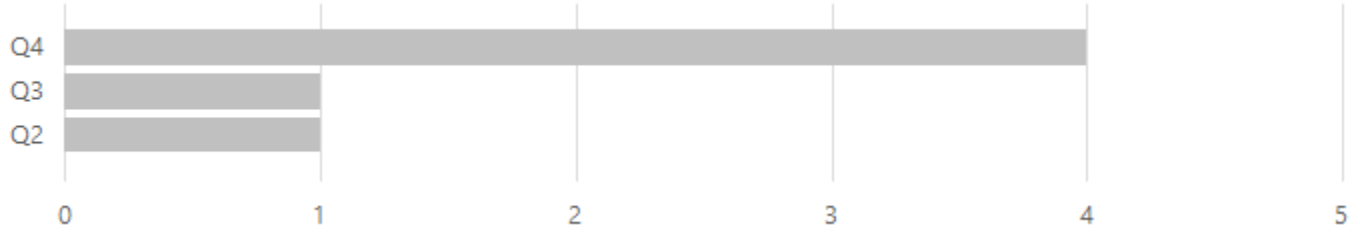
	including review and alignment of the BCU MHLD physical health policy in line with national developments.				**Last Update: Aug 26**
3D.5	Deliver a material reduction in the number of out of area placements through robust clinical and patient safety management (inclusive of community and acute staff) aligned to the implementation of the Crisis Care Model.	G2 G5	A2 A4	Executive Director of Allied Health Professionals and Health Science	**Q4** **High Delivery Confidence** **Last Update: Aug 26**
3D.6	Reduce Health Inequalities for people with learning disabilities by increasing the uptake of the annual health checks and public health screening initiatives across services.	G1 G5	A4	Executive Director of Allied Health Professionals and Health Science	**Q4** **High Delivery Confidence** **Last Update: Aug 26**
3D.7	Define and formally adopt a tiered crisis response framework for LD services with clear pathways for prevention, early intervention, urgent response, intermediate care provision in partnership with the Local authorities and post-crisis stabilisation.	G2 G5	A2 A4	Executive Director of Allied Health Professionals and Health Science	**Q4** **High Delivery Confidence** **Last Update: Aug 26**
3D.8	Establish a digitally delivered specialist All-Wales gambling harm and treatment service.	G4	A2	Executive Director of Allied Health Professionals and Health Science	**Q2** **High Delivery Confidence** **Last Update: Sep 26**
3D.9	Continue to progress the Electronic Healthcare Record (EHR) Transformation Programme which will reduce paper records and be a key enabler for service transformation, through commencing the implementation of the All Ages MHLD and continued engagement with WG regarding a wider EHR.	G4 G6	A3 A6	Executive Director of Allied Health Professionals and Health Science	**Q4** **High Delivery Confidence** **Last Update: Aug 26**
3D.10	Strengthen the strategic case for the development of the purpose-built, future-proof Adult and Older People Mental Health Unit at the Ysbyty Glan Clwyd site with the aim of presenting a	G3 G6	A2 A6	Executive Director of Allied Health Professionals and Health Science	**Q4** **High Delivery Confidence** **Last Update: Aug 26**

	full business case to Health Board for the approval by the end of Q4.				
3D.11	Progress the 13 key areas supported by the Board in the Scope of Mental Health Oversight and Development Group, including but not exhaustively; strategic plan and models of care, outcomes framework, performance, service user engagement, standards of clinical practice, workforce planning, estate and physical environment, culture and organisational development, leadership and management, legacy reviews, finance, dementia care and psychological therapies.	G1 G2 G6	A1 A6	Executive Director of Allied Health Professionals and Health Science	**Q4** **High Delivery Confidence** **Last Update: Aug 26**

Priority:	**3E Child and Adolescent Mental Health (CAMHs) & Neurodevelopment (ND)**			
Strategic Threat and Risks: There is a risk that the Health Board is unable to deliver timely, equitable and effective CAMHS and neurodevelopment services due to increasing demand, workforce capacity constraints, long waiting times, and challenges in redesigning pathways towards a needs-led model and integrated system-wide approach				
Accountable:	Chief Operating Officer			
Primary risk controls:	**Gaps in control:**	**Sources of assurance:**	**Gaps in assurance:**	**Assurance Rating**
CAMHS transformation aligned to national Mental Health Strategy Neurodevelopment (ND) Improvement Programme Partnership working through Children's Regional Partnership Board Early Help / Open Access model development Crisis model redesign and implementation National guidance (NEST/NYTH framework, ND Code of Practice) Pathway standardisation and redesign across CAMHS and ND	G1 - Workforce capacity constraints limiting service delivery G2 - Long waiting lists and backlog in neurodevelopment assessments G3 - Delays in access to CAMHS services and variation in pathways G4 - Incomplete shift from diagnosis-led to needs-led model G5 - Fragmentation across health, education and social care partners G6 - Limited capacity for early intervention and prevention	**Management Assurance** CAMHS and ND programme governance Monitoring of IMTP deliverables (3E.1–3E.6) Performance reporting against Mental Health Measure and ND waiting times Regional partnership oversight (RPB) **Risk & Compliance Assurance** Alignment with national frameworks (NEST/NYTH, ND	A1 - Limited assurance that waiting times will reduce at required pace A2 - Insufficient independent validation of pathway redesign effectiveness A3 - Limited consistent data across ND pathways A4 - Weak evidence of improved outcomes following transformation A5 - Limited assurance of whole-system integration across partners A6 - Insufficient evidence of long-term sustainability of workforce models	

Performance monitoring (waiting times, Mental Health Measure)		Programme) Monitoring of waiting times and access standards Internal governance and pathway compliance reviews **Independent Assurance** Welsh Government oversight NHS Wales Performance & Improvement support Regional Partnership Board scrutiny External programme reporting (ND Improvement Programme)		

Plans to improve control :



Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
3E.1	Early Help - Strengthen Early Intervention and Prevention. Develop and embed CAMHS Early Help systems and processes within the new model with partners across IHCs and regionally, to align with Flexible Open Access Mental Health Support and NYTH/NEST. Including: integration of schools in-reach, establishing reliable data reporting and measurement of impact, and establishing plans for	G5 G6	A4 A5	Chief Operating Officer	**Q4** **High Delivery Confidence** **Last Update: Aug 26**

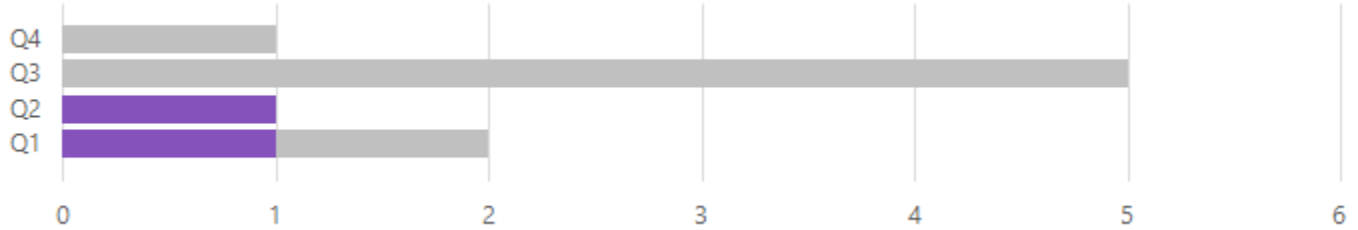
	secondary prevention that targets those at greatest risk of developing mental health problems.				
3E.2	Improve access to CAMHS services by reducing and sustaining waiting times under the Mental Health Measure (MHM) and improving patient pathways to deliver better outcomes and experiences for Children and Young People (CYP). Including: exploring options for embedding Open Access principles, map and standardise pathways across the region using clinical guidelines and WG Community CAMHS service specification.	G1 G3	A1 A2	Chief Operating Officer	**Q3** **High Delivery Confidence** **Last Update: Aug 26**
3E.3	Deliver a transformed and sustainable crisis model through full implementation and embedding of the crisis enhanced service model. Including working with adult mental health and partners on plans for an Open Access North Wales demonstrator project, develop and initiate plans for further Alternative to Admission, operationalisation of the 24/7 regional crisis consultation and advice line.	G1 G3 G5	A1 A2 A5	Chief Operating Officer	**Q4** **High Delivery Confidence** **Last Update: Aug 26**
3E.4	Early Identification & Family Centred Support - Co-design new needs led model of care across children's neurodevelopmental (ND) services collaboratively with Children's Regional Partnership Board. Including: referral process review and improvement, roll out of standardised profile of need tool to be used prior to specialist ND referral is considered, ensure clear pathways and local points of access into ND services across all age groups, development of neuro affirmative communities.	G4 G5	A4 A5	Chief Operating Officer	**Q4** **High Delivery Confidence** **Last Update: Aug 26**
3E.5	Improved Access to Information, Guidance, and Assessment - Establish	G2 G3	A1 A3	Chief Operating Officer	**Q2**

	Clear, consistent access pathways in line with NEST/NYTH principles. Including streamline ND assessment prudent pathways to improve efficiency – introducing standard audit mechanisms and use of same day assessments for clear cases, enhance joint working across services and sectors - building links with education, CAMHS and third sector and piloting multi-agency ND input in schools.				**High Delivery Confidence** **Last Update: Aug 26**
3E.6	Improved post assessment/diagnostic support - Co-designed post-assessment support to ensure continuity, tailored interventions. Including: Map support offers regionally, align services to provide targeted post diagnostic support, ensure consistent signposting and referral pathways for support following diagnosis, develop ND transfer & transition protocols to provide seamless transition between child and adult services across agencies.	G3 G5	A4 A5	Chief Operating Officer	**Q4** **High Delivery Confidence** **Last Update: Aug 26**

Priority:	**3F Children and Young People Services**			
Strategic Threat and Risks: There is a risk that the Health Board is unable to deliver timely, equitable and high-quality services for children and young people due to health inequalities, workforce capacity challenges, gaps in community and specialist provision, and delays in implementing integrated pathways and preventative models of care				
Accountable:	Chief Operating Officer			
Primary risk controls:	**Gaps in control:**	**Sources of assurance:**	**Gaps in assurance:**	**Assurance Rating**
Integrated Children's Services model (community, hospital and specialist services) Partnership working with Regional Partnership Board and Local Authorities Delivery of national programmes (Healthy Child Wales Programme, immunisation programmes) Development of transition pathways from children to adult	G1 - Health inequalities affecting outcomes and access to services G2 - Workforce capacity constraints across specialist paediatric services G3 - Gaps in community nursing provision for children with complex needs G4 - Delays in access to specialist care and interventions G5 - Incomplete development of	**Management Assurance** Monitoring of IMTP deliverables (3F.1–3F.9) Performance reporting across child health indicators (immunisation, diabetes, etc.) Programme oversight for children's services and partnership delivery	A1 - Limited assurance that inequalities will be reduced at pace A2 - Insufficient independent validation of new service models A3 - Limited data maturity across children's services A4 - Limited evidence of improved outcomes following interventions A5 - Limited assurance of effective integration across partners	

services Specialist service reviews (complex needs, palliative care, community nursing) Compliance with national guidance (NICE, WG frameworks) Performance monitoring (vaccination uptake, diabetes care, child health measures)	integrated pathways across organisations G6 - Limited progress in prevention and early intervention models	**Risk & Compliance Assurance** Compliance with national frameworks (Healthy Child Wales, NICE guidance) Monitoring of access, waiting times and service provision Internal governance and service reviews **Independent Assurance** Welsh Government oversight Regional Partnership Board scrutiny External inspections/reviews where applicable (e.g. HIW)	A6 - Insufficient clarity on long-term sustainability of service models	

Plans to improve control :



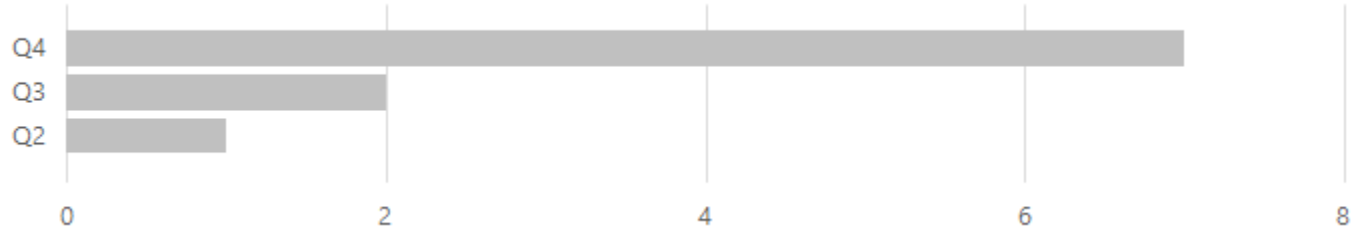
Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
3F.1	Delivery of school age immunisation programme by immunisation team with targeted work in low uptake areas.	G1 G6	A1 A6	Chief Operating Officer	**Q4 High Delivery Confidence Last Update: Aug 26**
3F.2	Working with partners, undertake a gap analysis of the requirements to fully implement the Healthy Child Wales 2 Programme and submit proposals to the Health Board for implementation.	G1 G5 G6	A1 A2 A5	Chief Operating Officer	**Q3 Moderate Delivery Confidence Last Update: Aug 26**
3F.3	Undertake a review of specialist nursing team roles and delivery of care for children with complex needs.	G2 G3 G4	A2 A4	Chief Operating Officer	**Q1 Low Delivery Confidence**

					Last Update: Sep 26
3F.4	Commence developing a service specification for delivery of community nursing care for children with complex care needs	G3 G4 G5	A2 A4	Chief Operating Officer	**Q3 High Delivery Confidence Last Update: Aug 26**
3F.5	Ensure that children with diabetes have timely provision of insulin pumps and CGM	G2 G4	A4	Chief Operating Officer	**Q2 (Complete)**
3F.6	Assess compliance with Diabetes NICE Guidance in readiness for the launch of the Type 1 diabetes screening programme for children	G2 G4	A2 A4	Chief Operating Officer	**Q3 High Delivery Confidence Last Update: Aug 26**
3F.7	Set out the proposal to the Health Board based on the service specification gap analysis related to the submitted Paediatric Palliative Care in Wales self-assessment, including specialist palliative care nursing.	G3 G4 G6	A2 A6	Chief Operating Officer	**Q3 Moderate Delivery Confidence Last Update: Aug 26**
3F.8	Work with the Partnership Transformation Programme to commence the development of a strategic plan for children with a learning disability, and reduce inequalities for consultation.	G1 G5	A1 A5	Chief Operating Officer	**Q1 (Complete)**
3F.9	Finalise and implement the Transition Pathways for children into adult services across all long-term conditions (respiratory, endocrine, cardiac and neurological conditions, cancer, CAMHS and Learning Disabilities).	G4 G5 G6	A2 A4 A5	Chief Operating Officer	**Q3 Moderate Delivery Confidence Last Update: Aug 26**

Priority:	**3G Women's Health**
Strategic Threat and Risks: There is a risk that the Health Board is unable to deliver equitable, safe and high-quality women's health services across the life course due to increasing demand, health inequalities, workforce and capacity constraints, and challenges in implementing national strategies, improving outcomes and reducing variation in access to services	
Accountable:	Chief Operating Officer

Primary risk controls:	Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating
Implementation of NHS Wales Women's Health Plan (2025–2035) Delivery of Maternity and Neonatal Quality Statement (2025) Clinical Services Planning (CSP) for perinatal services Digital Maternity Cymru System rollout (electronic maternity record) Partnership working with HEIW and third sector organisations Local delivery of women's health pathways (menstrual health, menopause, contraception etc.) Expansion of Women's Health Hub model (e.g. Llandudno) Participation in national digital/data programmes (Women's Health Dashboard)	G1 - Health inequalities impacting outcomes for women (especially deprived groups) G2 - Workforce capacity and sustainability challenges in maternity and gynaecology G3 - Variation in access and provision of key services (contraception, menopause, pelvic health) G4 - Increasing complexity of care (e.g. diabetes, mental health in pregnancy) G5 - Incomplete implementation of national strategies and frameworks G6 - Limited maturity of digital and data systems across women's health pathways	**Management Assurance** Monitoring of IMTP deliverables (3G.1–3G.10) Programme oversight for Women's Health Plan delivery Maternity service performance reporting (incl. perinatal outcomes) CSP programme oversight for perinatal services **Risk & Compliance Assurance** Compliance with national quality standards (Maternity & Neonatal Quality Statement) Monitoring against national indicators (perinatal mortality, patient experience) Internal governance, audits and service reviews **Independent Assurance** Welsh Government oversight and performance reporting HEIW workforce planning and assurance National programme boards (Women's Health, Maternity & Neonatal) External inspections/reviews (e.g. HIW)	A1 - Limited assurance improvements will reduce inequalities at pace A2 - Insufficient independent validation of new models of care (e.g. Women's Health hubs A3 - Limited national data and KPIs currently defined (dashboard still emerging) A4 - Limited evidence linking interventions to improved outcomes A5 - Limited assurance of consistency across regions and pathways A6 - Uncertainty around long-term sustainability (workforce, funding, infrastructure)	

Plans to improve control :

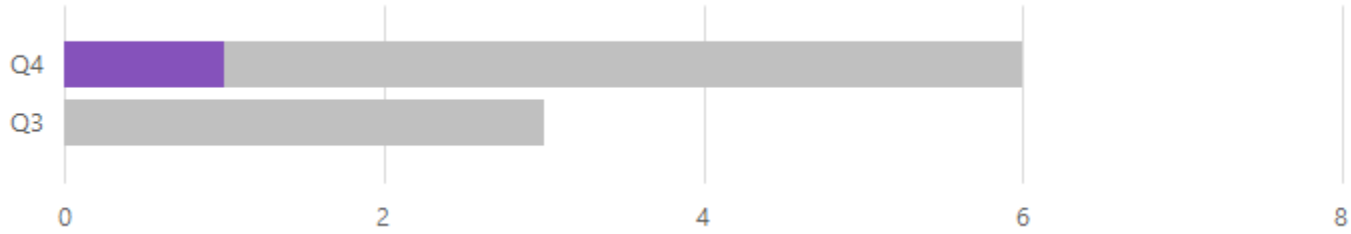


Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
3G.1	Progress the rollout of Phase 2 of the Digital Maternity Cymru System, with a focus on implementing maternity electronic health records to enhance the quality of care and improve communication for pregnant individuals.	G4 G6	A3 A4	Chief Operating Officer	**Q4** **Moderate Delivery Confidence** **Last Update: Aug 26**
3G.2	Receive and analyse the findings of the Perinatal National Assurance Assessment Report (expected in Q4 2025/26), together with the key priorities outlined in the 2025 Quality Statement for Maternity and Neonatal Services, and develop a comprehensive proposal for local implementation inclusive of detailed costing.	G2 G5	A2 A4	Chief Operating Officer	**Q3** **High Delivery Confidence** **Last Update: Aug 26**
3G.3	As part of the Clinical Services Plan, undertake a comprehensive review of the configuration of Pan–North Wales Perinatal Services to ensure the delivery of safe, high-quality and sustainable care.	G2 G5 G6	A2 A5	Chief Operating Officer	**Q4** **High Delivery Confidence** **Last Update: Aug 26**
3G.4	Develop an implementation plan to deliver the outstanding commitments in the National Perinatal Engagement Framework (2025), including a paid Chair for Maternity and Neonatal Voices Partnership.	G3 G5	A2 A5	Chief Operating Officer	**Q2** **Moderate Delivery Confidence** **Last Update: Aug 26**
3G.5	Collaborate with Health Education and Improvement Wales (HEIW) to prioritise year two service actions to ensure the Perinatal Strategic Workforce Plan is delivered within the Health Board.	G2 G6	A6	Chief Operating Officer	**Q4** **High Delivery Confidence** **Last Update: Aug 26**
3G.6	Support the local delivery of the NHS Wales Women's Health Plan across North Wales, to include work on Menstrual Health, Endometriosis and Adenomyosis, Contraception – Postnatal Contraception and Abortion	G1 G3 G6	A1 A4 A5	Chief Operating Officer	**Q4** **Moderate Delivery Confidence** **Last Update: Aug 26**

	Care, Preconception Health, Pelvic Health and Incontinence, Menopause, Violence Against Women – Domestic Abuse and Sexual Violence, Ageing Well and Long-Term Conditions and strengthening community pathways.				
3G.7	Address variation in services such as Contraception, Menopause support and Pelvic Health.	G3 G5	A1 A5	Chief Operating Officer	**Q4** **High Delivery Confidence** **Last Update: Aug 26**
3G.8	Deliver improvements to Women's Health prevention and early intervention, including preconception health and earlier identification of women's health conditions.	G1 G6	A1 A4	Chief Operating Officer	**Q4** **High Delivery Confidence** **Last Update: Jun 26**
3G.9	Expand Women's Health service offering, currently focused via the Llandudno Womens Health Hub.	G3 G5	A2 A5	Chief Operating Officer	**Q4** **Moderate Delivery Confidence** **Last Update: Jul 26**
3G.10	Participation in national digital and data development initiatives such as Women's Health Dashboard.	G6	A3 A4	Chief Operating Officer	**Q3** **Moderate Delivery Confidence** **Last Update: Aug 26**

Priority:	3H Pharmacy and Medicines Management
Strategic Threat and Risks: There is a risk that the Health Board is unable to deliver safe, effective and sustainable pharmacy and medicines management services due to increasing demand, workforce capacity constraints, variation in prescribing practices, and challenges in implementing digital systems, optimising medicines use and supporting emerging therapies	
Accountable:	Executive Medical Director

Primary risk controls:	Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating
Implementation of High Value Medicines programme Medicines optimisation through prescribing governance and NICE guidance Development of Transforming Access to Medicines (TrAMs) programme Expansion of Pharmacist Independent Prescribing Service (PIPS) Electronic Prescribing and Medicines Administration (ePMA) implementation Collaboration with HEIW and Bangor University to strengthen workforce pipeline Pharmaceutical Needs Assessment (PNA) and service planning Engagement with national genomics and advanced therapies programmes	G1 - Workforce capacity and sustainability challenges G2 - Variation in prescribing practice across primary and secondary care G3 - Increasing demand and complexity of medicines use G4 - Incomplete digital maturity (ePMA / prescribing systems) G5 - Limited capacity to support emerging therapies and innovation G6 - Challenges in medicines optimisation and cost sustainability	**Management Assurance** Monitoring of IMTP deliverables (3H.1–3H.9) Performance reporting on prescribing metrics (e.g. PIPS uptake, prescribing rates) Pharmacy programme governance (TrAMs, ePMA, Value & Sustainability Board) **Risk & Compliance Assurance** Compliance with NICE guidance and national prescribing standards Monitoring of high-value medicines and prescribing variation Internal audit and medicines governance processes **Independent Assurance** Welsh Government oversight National pharmacy and medicines optimisation programmes All Wales Therapeutics and Toxicology Centre (AWTTC) reporting (where applicable) External regulatory oversight (e.g. GPhC for education and workforce)	A1 - Limited assurance that prescribing variation will reduce consistently A2 - Insufficient independent validation of new service models (TrAMs, PIPS expansion) A3 - Limited maturity of prescribing data and digital analytics A4 - Limited evidence linking medicines optimisation to improved outcomes A5 - Limited assurance of future workforce sustainability A6 - Uncertainty around delivery of advanced therapies and innovation capacity	
Plans to improve control :				



Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
3H.1	Commission and publish a Pharmaceutical Needs Assessment (PNA) and agree an action plan from this to ensure pharmaceutical services are aligned to population need, address gaps in provision, and support equitable, sustainable care delivery.	G1 G2 G6	A1 A5	Executive Medical Director	**Q3** **High Delivery Confidence** **Last Update: Jul 26**
3H.2	Support General Pharmaceutical Council (GPhC) Step 4 accreditation for the Bangor University MPharm programme (confirming regulatory provisional accreditation to deliver the programme) and enrol Cohort 2 to strengthen the local pharmacy workforce pipeline and support sustainable service provision.	G1	A5	Executive Medical Director	**Q3** **High Delivery Confidence** **Last Update: Jul 26**
3H.3	Launch and develop the North Wales Transforming Access to Medicines (TrAMs) programme, as one of three national transformation hubs, to modernise pharmacy technical services and strengthen regional collaboration, including scoping pharmacy provision to support advanced therapies within a national hub model.	G3 G5	A2 A6	Executive Medical Director	**Q4** **Moderate Delivery Confidence** **Last Update: Jul 26**
3H.4	Continue to work with Community Pharmacy Wales (CPW) and Health Education and Improvement Wales (HEIW) to support community pharmacy contractors to expand the number of Pharmacies offering the	G1 G2	A1 A5	Executive Medical Director	**Q4** **Moderate Delivery Confidence** **Last Update: Jul 26**

	Pharmacist Independent Prescribers Service (PIPS), strengthening prescribing capacity and improving access to care.				
3H.5	Ensure full implementation of the High Value Medicines Value & Sustainability Board programme by supporting clinicians to adopt best-value prescribing practices, optimising procurement and product selection, reducing low-value prescribing, and strengthening performance oversight to deliver sustainable financial and quality benefits.	G4 G6	A1 A4	Executive Medical Director	**Q4 (Complete)**
3H.6	Following completion of implementation, fully embed Electronic Prescribing and Medicines Administration (ePMA) by establishing clear pharmacy clinical ownership to lead safe prescribing configuration, formulary oversight, system optimisation and structured change control.	G4 G6	A3 A4	Executive Medical Director	**Q3 High Delivery Confidence Last Update: Aug 26**
3H.7	Work with primary care and community services, via the Local Enhanced Clinical Effectiveness Service, to support evidence-based patient reviews that reduce inappropriate gabapentinoid prescribing in line with NICE guidance, extend periods of treatment, and increase the use of low Global Warming Potential inhalers in line with the All-Wales respiratory treatment pathway.	G1 G2 G3 G4 G6	A1 A4	Executive Medical Director	**Q4 Moderate Delivery Confidence Last Update: Jul 26**
3H.8	Engage with national genomics leads and clinical networks to scope the potential role of pharmacogenomics in clinical pathways, explore opportunities to develop local champions, and raise awareness through shared learning and engagement.	G5	A2 A6	Executive Medical Director	**Q4 High Delivery Confidence Last Update: Aug 26**

3H.9	Deliver the risk prioritised components of Electronic Prescribing Service (EPS) that sustain safe, reliable digital services, covering devices, network/telephony, core infrastructure, and clinical platforms.	G4	A3 A6	Executive Medical Director	**Q4 Low Delivery Confidence Last Update: Aug 26**

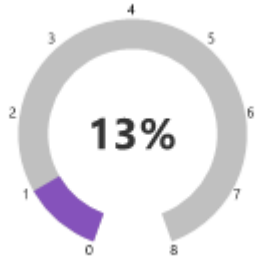
Priority:	**3I Dementia**

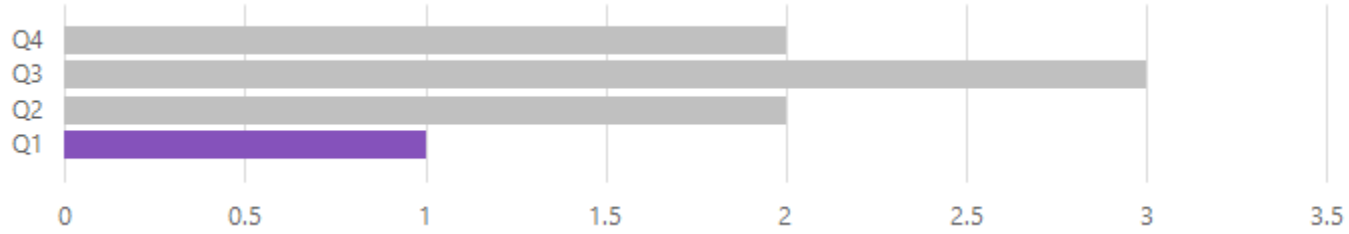
Strategic Threat and Risks: There is a risk that the Health Board is unable to deliver timely, equitable and high-quality dementia services due to increasing demand, workforce capacity constraints, delays in diagnosis and access to services, variation in care pathways, and challenges in delivering integrated care across health, social care and third sector partner

Accountable:	Executive Director of Nursing

Primary risk controls:	Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating
Implementation of the All-Wales Dementia Care Pathway of Standards Memory Assessment Services and diagnostic pathways Community dementia services and multidisciplinary teams Partnership working with Local Authorities and third sector organisations Dementia workforce training and development programmes Performance monitoring (diagnosis rates, waiting times) Carer support services and post-diagnostic support programmes	G1 - Delays in diagnosis and access to memory assessment services G2 - Workforce capacity and capability gaps G3 - Variation in service provision and access across North Wales G4 - Limited data quality and performance visibility G5 - Lack of fully integrated system-wide pathways G6 - Challenges in hospital flow and discharge for dementia patients G7 - Limited staff development and education within BCU funded care homes . Lack of admission avoidance initiatives for care homes residents	**Management Assurance** Monitoring of IMTP deliverables (3I.1–3I.8) Dementia programme governance and reporting Performance monitoring (diagnostic rates, waiting times, service access) **Risk & Compliance Assurance** Alignment with All-Wales Dementia Standards Internal audits and service reviews Monitoring compliance with national dementia pathways **Independent Assurance** Welsh Government oversight and performance reporting Regional Partnership Board scrutiny External inspections (e.g. HIW where applicable)	A1 - Limited assurance that diagnostic waiting times will improve at pace A2 - Limited independent validation of service redesign A3 - Data limitations impacting assurance reliability A4 - Limited evidence of improved outcomes from interventions A5 - Limited assurance of effective partnership integration A6 - Limited assurance of workforce sustainability	

Plans to improve control :





Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
3I.1	Complete a review of existing dementia care provision within Emergency Departments to include benchmarking against areas of best practice.	G1 G3	A1 A2 A4	Executive Director of Nursing	**Q1 (Complete)**
3I.2	Review analyse and make recommendations to the Health Board on the requirements to implement a Dementia Care Pathway for Emergency Departments.	G1 G3 G5	A1 A2 A5	Executive Director of Nursing	**Q3 Moderate Delivery Confidence Last Update: Aug 26**
3I.3	Design and deliver bespoke dementia patient and carer experience review for ED.	G1 G3	A2 A4	Executive Director of Nursing	**Q3 High Delivery Confidence Last Update: Aug 26**
3I.4	Undertake a review and training needs analysis of existing dementia training approaches and align national guidance and best practice standards, informing the development of a training programme for the workforce, building on the work completed for the bitesize training.	G2	A5 A6	Executive Director of Nursing	**Q2 High Delivery Confidence Last Update: Sep 26**
3I.5	Design and implement a programme tailored to the needs of the workforce to enable a consistent service delivery through agreement of a core minimum standard of dementia education across the Health Board.	G2 G5	A5 A6	Executive Director of Nursing	**Q3 Moderate Delivery Confidence Last Update: Aug 26**

3I.6	Undertake environmental assessments to review the Health Board's current assessment of appropriate and suitable dementia friendly environments for all care settings and make proposals as appropriate.	G3 G6	A2 A4	Executive Director of Nursing	**Q2** **Moderate Delivery Confidence** **Last Update: Sep 26**
3I.7	Recommendations and proposals collated and presented to the Health Board, working with Estates, to align any recommended improvements to Estates strategy and available budget.	G3 G6	A2 A6	Executive Director of Nursing	**Q4** **Moderate Delivery Confidence** **Last Update: Aug 26**
3I.8	Design and implement a staff campaign to raise awareness of prevention as it affects dementia.	G1 G5	A1 A4	Executive Director of Nursing	**Q4** **High Delivery Confidence** **Last Update: Aug 26**

4 **Create a modern, people-centred healthcare system that is future-focused**, maximising opportunities of digital care, research, innovation, and improvement, investing in workforce development and wellbeing and strengthening our role as an anchor institution for North Wales.

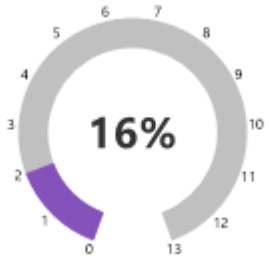
Principal risk (What could prevent us achieving this strategic objective)	**Failure to deliver and create a modern, people centred heath care system that is future focused**		
Lead Committee	**People & Culture Committee; Planning, Population Health & Partnerships ; Quality, Safety Experience Committee; Performance, Finance & Information Governance Committee**	**Risk Type**	**Innovation**
Risk Lead	**Executive Director of People Services & OD Executive Director of Nursing Executive Director of Transformation and Strategic Planning Executive Medical Director Chief Digital & Information Officer Director of Corporate Governance Director of Partnerships Executive Director of Finance Director of Estates**	**Risk Appetite**	**<20**
Related Corporate Risks:	**CRR25-02 – Future Demand & Sustainable Workforce, CRR25-04 – Modernising Digital Infrastructure to Enable Safe, Integrated Care, CRR25-05 – Strategic Change Impacting Care and Staff Delivery, CRR25-06 – Delivery of the 2026/27 Financial Plan and Financial Sustainability, CRR25-07 – Leadership and Operating Model, CRR25-08 – Non-Compliance with Regulatory and Legislative Requirements, CRR25-09 – Safe Environment, CRR25-10 – Health and Safety, CRR25-11 – ICT Failure and Cyber**		

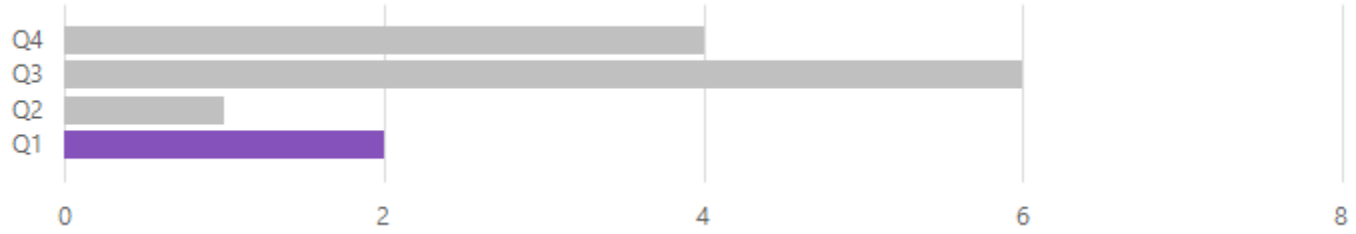
Risk Rating			**Review Dates**	
	Current Exposure	**Target**		
Consequence	**5**	**5**	**Initial assessment**	**19/07/2026**
Likelihood	**4**	**3**	**Last Committee review**	**17/08/2026**
Risk Rating	**20**	**15**	**Last Executive Review**	**28/07/2026**

Priority:	4A Foundations for the Future
Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to establish a coherent, effective and agile operating model due to challenges in organisational culture, workforce capability, governance, and process alignment. This may lead to inconsistent decision-making, lack of accountability, fragmented service delivery, and reduced organisational performance, impacting the delivery of high-quality, sustainable healthcare services.	
Accountable:	Executive Director of People / Executive Director of Nursing & Midwifery / Director of Corporate Governance / Executive Director of Transformation & Strategic Planning (shared programme leadership)

Primary risk controls:	Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating
Implementation of Culture, Leadership and Engagement programme (4A.1) Transition to new organisational structure and service groups (4A.2, 4A.7–4A.8) Development of leadership and competency frameworks (4A.3–4A.4) Improvement of governance, business case and ECR processes (4A.5–4A.6) Implementation of revised governance model and operating framework (4A.9–4A.11) Partner engagement to align operating model across system (4A.12) Development of organisational approach to change framework (4A.13)	G1 - Risk of over-focus on structural change at expense of culture, people and processes G2 - Workforce uncertainty and reduced morale during transition periods G3 - Delays in implementation due to complexity of consultation and change processes G4 - Limited maturity of governance and decision-making processes under new model G5 - Limited organisational capability in delivering large-scale change consistently G6 - Dependency on partner alignment and system-wide adoption of operating model	**Management Assurance** IMTP monitoring of 4A deliverables (4A.1–4A.13) Programme governance (Foundations for the Future Programme Board) Performance measures: Staff engagement index Evidence of team effectiveness and collaboration **Risk & Compliance Assurance** Governance reviews and internal audit of processes Alignment with: Workforce frameworks Governance and accountability frameworks Monitoring of implementation of new operating model **Independent Assurance** Welsh Government oversight (Special Measures framework) External audit and governance reviews Staff survey benchmarking	A1 - Limited assurance of sustained impact of organisational change on outcomes A2 - Limited independent validation of cultural and leadership A3 - Limited real-time insight into impact of transition on service delivery A4 - Limited evidence linking operating model changes to improved performance A5 - Limited assurance of consistency across divisions and services A6 - Limited assurance of workforce stability and engagement during transition	

Plans to improve control :





Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
4A.1	Implement and deliver the year 1 actions from the Culture, Leadership and Engagement 3-year Improvement plan 2026-29. The delivery plan is structured into five areas. 1. Vision and Values, 2 Goals and Performance, 3. Learning and Innovation, 4. Support and Compassion, 5. Teamwork. Year one focusses on embedding systems and processes in these areas to improve leadership quality, employee engagement, psychological safety and practically embedding the agreed values and behaviours.	G1 G2 G5	A1 A2 A6	Chief Executive	**Q4 High Delivery Confidence Last Update: Aug 26**
4A.2	Complete the transition to new senior posts and establish new service groups and corporate directorates, supported by cross-functional operating agreements and ongoing team and leadership development.	G2 G4	A3 A5	Chief Executive	**Q4 High Delivery Confidence Last Update: Aug 26**
4A.3	Complete the revised Integrated Leadership Development Framework.	G5	A5	Chief Executive	**Q1 (Complete)**
4A.4	Complete Competency Frameworks, which includes the competencies and skills required for particular roles by banding, equipping staff with the skills to deliver their roles.	G2 G5	A6	Chief Executive	**Q1 (Complete)**

4A.5	Review and improve the Establishment Control Review (ECR) process, to ensure it is more streamlined and fully supported.	G4	A5	Chief Executive	**Q3 High Delivery Confidence Last Update: May 26**
4A.6	Review and improve the process for creating, reviewing, and approving business cases.	G4	A5	Chief Executive	**Q3 High Delivery Confidence Last Update: Aug 26**
4A.7	Implement the Foundations for the Future design and thereby establish a clear organisational structure led by an effective and complete executive team with the leadership capacity and capability to deliver high quality, sustainable care.	G1 G2 G4	A3 A5	Chief Executive	**Q3 Moderate Delivery Confidence Last Update: Aug 26**
4A.8	Complete the design of Phase 2. This will include reviewing the structures of the organisation at bands 8b and below, a plan for the effective integration of Mental Health and Learning Disabilities, and a rapid review of phase 1 implementation across all 5 pillars of the Programme.	G3 G5	A1 A4	Chief Executive	**Q4 High Delivery Confidence Last Update: Aug 26**
4A.9	Implement a new governance model as part of the revised operating model, ensuring sharper accountability, fewer/streamlined meetings, focusing on delivery and transparency.	G4	A4 A5	Chief Executive	**Q2 High Delivery Confidence Last Update: Aug 26**
4A.10	Publish to BCUHB Board the collated lessons learned from Phase 1, including outcomes from the consultation process, evaluation of performance and benefits measurement and how FFTF supports de-escalation by improving governance and accountability.	G3 G5	A1 A4	Chief Executive	**Q3 High Delivery Confidence Last Update: Aug 26**
4A.11	Publish the Operating Framework, including how business partnering will operate with the Service Groups, and	G4	A5	Chief Executive	**Q3 High Delivery Confidence Last Update: Aug 26**

	the directory of services reflecting the new organisational model.				
4A.12	Engage with partners (JCC, NWAS, Local Government, Third Sector) to review the operating model and identify changes to the ways we operate and define operating policies and/or updated MOUs where applicable.	G6	A5	Chief Executive	**Q4 High Delivery Confidence Last Update: Aug 26**
4A.13	Co-produce with staff and partners an organisational approach to change framework that supports teams to successfully design, deliver and sustain change.	G5	A2 A6	Chief Executive	**Q3 High Delivery Confidence Last Update: Aug 26**

Priority:	**4B Strategy and Planning**

Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to develop, align and deliver a robust long-term strategy and integrated planning framework due to operational pressures, limited stakeholder engagement, and external uncertainty. This may result in lack of strategic clarity, poor alignment between plans and resources, reduced organisational ownership, and inability to deliver sustainable transformation and improved outcomes.

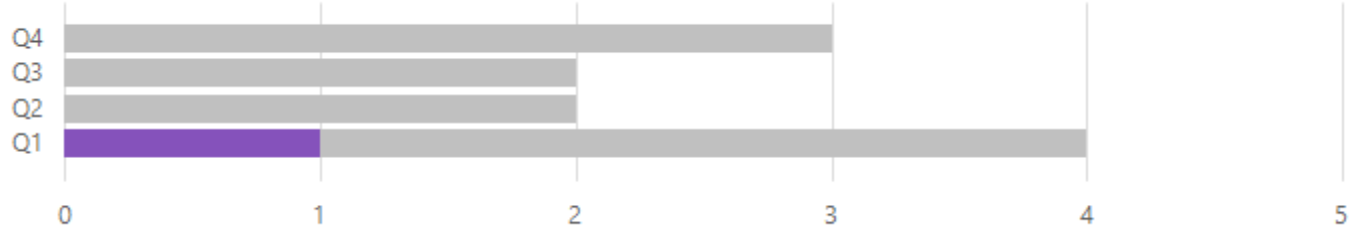
Accountable:	Executive Director of Transformation

Primary risk controls:	**Gaps in control:**	**Sources of assurance:**	**Gaps in assurance:**	**Assurance Rating**
Delivery of 10-Year Strategy development (discovery, design and delivery phases) (4B.1–4B.3) Structured stakeholder engagement across organisation and partners Development of partnership frameworks (e.g. Third Sector collaboration) (4B.4) Implementation of improved planning and modelling capability (4B.5, 4B.7–4B.9) Establishment of annual reflection and learning cycles (4B.6) Strengthened IMTP delivery monitoring and reporting (4B.11)	G1 - Risk of insufficient stakeholder engagement impacting ownership of strategy G2 - Operational pressures limiting capacity to deliver strategic planning activity G3 - Uncertainty in external environment (political / policy changes) G4 - Limited maturity of integrated planning processes across organisation G5 - Limited capability in modelling, forecasting and strategic decision-making G6 - Risk of misalignment between strategy, resources and delivery plans	**Management Assurance** - Board-approved 10-Year Strategy and associated strategic objectives. - Approved Integrated Medium Term Plan (IMTP) and annual planning cycle. - Integrated Planning Framework and planning guidance. - Strategy & Planning Programme governance and reporting arrangements. - Quarterly performance reports demonstrating delivery against strategic priorities and IMTP commitments. - Executive performance reviews	A1 - Limited assurance of full organisational and partner ownership of strategy A2 - Limited independent validation of strategy effectiveness and impact A3 - Limited real-time visibility of planning alignment and delivery A4 - Limited evidence linking strategy to improved performance outcomes A5 - Limited assurance of consistency in planning approaches across organisation A6 - Limited assurance of sustainability of delivery within financial constraints	

Development of integrated planning and decommissioning approaches (4B.8, 4B.10)		and accountability arrangements. - Strategic planning milestones and delivery monitoring. - Resource allocation and investment decision making processes aligned to strategic priorities **Risk & Compliance Assurance** - Assessment against NHS Wales Planning Framework requirements. - Planning Maturity Matrix self-assessment and improvement programme. - Internal reviews of planning, prioritisation and governance processes. - Compliance with Well-being of Future Generations duties and organisational planning requirements. - Monitoring of alignment between strategic, workforce, financial, digital and estate plans. **Independent Assurance** - Welsh Government review and oversight of Strategy and IMTP submissions. - Internal Audit reviews of planning, governance and strategic decision-making processes. - Audit Wales reviews relating to planning, governance and organisational resilience. - NHS Performance & Improvement reviews - External benchmarking of planning maturity and		

		organisational performance. - Stakeholder and partner feedback regarding strategic engagement and alignment.		

Plans to improve control :



Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
4B.1	Complete the Discovery Phase of the new 10-year Health Board Strategy by finalising evidence gathering, synthesising insights from key stakeholders, and undertaking structured engagement across the organisation and wider partners. This will culminate in an agreed Discovery Report, to inform the subsequent Design Phase of the Strategy. This work will also cover some specific requirements within the NHS Wales Planning Guidance:▪ A review of the organisation's Well-being objectives and how they fit within the Health Board's overarching strategic objectives. Provide clarity on the full suite of underpinning strategic plans (such as the Clinical Services Plan, Estates Strategic Plan and Digital Strategic Plan) and timelines for their development.▪ Incorporate the Health	G1 G2 G4	A1 A3	Executive Director of Transformation & Strategic Planning	**Q1** **Low Delivery Confidence** **Last Update: Aug 26**

	Board's ambitions relating to Advanced Therapies and Genomics.				
4B.2	Complete the full strategy design phase by translating the insights from the discovery phase into a validated strategic framework, including defined goals, strategic priorities, delivery roadmaps, and governance model, culminating in a final Strategy ready for Board approval. This will include structured engagement with key stakeholders throughout the design process to test assumptions, refine options, and build organisational alignment, ensuring aspects such as the Marmot principles (relating to early childhood, education, employment, preventing ill-health, housing and community well-being) are covered within the scope.	G1 G6	A1 A4	Executive Director of Transformation & Strategic Planning	**Q3** **Moderate Delivery Confidence** **Last Update: Aug 26**
4B.3	Implementation of the strategy will be via key underpinning quality impact assessed strategic plans (e.g. Clinical Services Plan) and their key deliverables falling within the 2027-30 IMTP.	G4 G6	A4 A6	Executive Director of Transformation & Strategic Planning	**Q4** **Moderate Delivery Confidence** **Last Update: Aug 26**
4B.4	Co-create a Third Sector Partnership Working Framework with Third Sector Partners to move to more proactive and strategic collaborative approach.	G1 G3	A1 A5	Executive Director of Transformation & Strategic Planning	**Q1** **High Delivery Confidence** **Last Update: Sep 26**
4B.5	Draw on support from NHS Performance and Improvement (NHS P&I) colleagues to develop proposals on an improved approach to a unified modelling across demand, capacity, skills mix, activity, performance, finance and workforce, incorporating benchmarking against other Health Boards – to be utilised in the 2027-30 IMTP planning cycle.	G5	A3 A6	Executive Director of Transformation & Strategic Planning	**Q1** **Moderate Delivery Confidence** **Last Update: Sep 26**

4B.6	Undertake an annual reflection and learning exercise in relation to the annual planning cycle, incorporating the planning maturity matrix self-assessment tool and involving internal and external stakeholders.	G4 G5	A2 A5	Executive Director of Transformation & Strategic Planning	**Q1 (Complete)**
4B.7	Deliver improvements in the organisation's approach to planning through delivery of the planning capability action plan that is informed by feedback from key stakeholders, annual learning cycles and contains actions from the planning maturity matrix self-assessment. Aiming to progress to level 3 and above across all areas.	G4 G5	A5	Executive Director of Transformation & Strategic Planning	**Q4 High Delivery Confidence Last Update: Aug 26**
4B.8	Update the BCUHB Integrated Planning Framework and associated more detailed planning guidance in light of annual reflection and learning exercise, emphasising the importance of clinical leadership, Community by Design principles and patient feedback in service planning.	G4 G6	A3 A5	Executive Director of Transformation & Strategic Planning	**Q2 High Delivery Confidence Last Update: Sep 26**
4B.9	Contribute to the broader organisational capability development work, specifically in relation to development of skills in planning.	G5	A6	Executive Director of Transformation & Strategic Planning	**Q2 High Delivery Confidence Last Update: Sep 26**
4B.10	Develop an organisational approach to de-prioritisation and de-commissioning for teams to utilise in reaching and implementing decisions of this nature, ensuring the full range of clinical and operational perspectives are central to the approach.	G6	A4 A6	Executive Director of Transformation & Strategic Planning	**Q3 High Delivery Confidence Last Update: Aug 26**
4B.11	Support delivery of commitments set out in the IMTP through monthly monitoring and timely escalation of any risks to delivery as well as quarterly reporting of delivery against the IMTP	G2 G4	A3 A4	Executive Director of Transformation & Strategic Planning	**Q4 High Delivery Confidence Last Update: Aug 26**

	and Special Measures de-escalation framework.				

Priority:	**4C Clinical Services Planning, Leadership and Interprofessional Working**

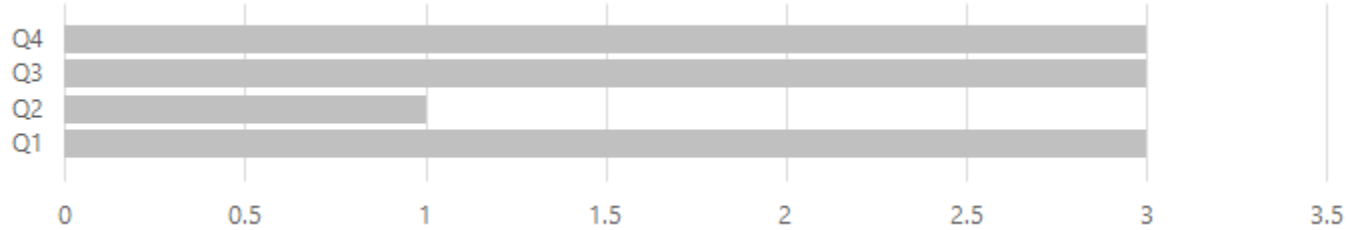
Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to effectively develop and deliver the Clinical Services Plan (CSP), alongside strong clinical leadership and interprofessional working, due to organisational change, insufficient resources, external uncertainty, and limited clinical engagement in leadership roles. This may result in delayed or ineffective service transformation, lack of clinical ownership, inconsistent leadership capacity, and an inability to deliver sustainable, high-quality, person-centred care aligned to strategic objectives and population needs.

Accountable:	Executive Medical Director / Executive Director of Transformation

Primary risk controls:	**Gaps in control:**	**Sources of assurance:**	**Gaps in assurance:**	**Assurance Rating**
• Establishment of CSP Programme governance, delivery plans and reporting structures (4C.1–4C.2) • Delivery of CSP assessment process including evidence gathering, population health intelligence and option appraisal (4C.3) • Development and approval of CSP service change proposals (4C.4) • Implementation of clinical leadership roles, job descriptions and remuneration models (4C.5) • Delivery of clinical leadership training and development programmes (4C.6–4C.7) • Development of clinical leadership career pathways (4C.8) • Strengthening interprofessional working through clear roles, responsibilities and OD support (4C.9–4C.10)	G1 - CSP programme at early stage of development and not fully embedded across all services G2 - Variable engagement across clinical, operational and partner stakeholders G3 - Limited clinical leadership pipeline and capacity across services G4 - Insufficient prioritisation of resources (time and funding) to support CSP delivery G5 - Dependencies on operating model changes affecting programme coordination and engagement G6 - Interprofessional working arrangements not consistently embedded across teams	**Management Assurance** • IMTP monitoring of 4C deliverables (4C.1–4C.10) • CSP Programme governance and reporting arrangements • Evidence of completed CSP assessments and approved service change proposals • Workforce metrics including clinical leadership vacancies and training uptake • Staff engagement and organisational development feedback **Risk & Compliance Assurance** • Alignment with Clinical Services Plan requirements, IMTP and 10-year strategy • Internal governance and performance reporting frameworks • Oversight of workforce and leadership development programmes **Independent Assurance** • Welsh Government oversight of IMTP delivery and service	A1 - Limited assurance of consistent engagement and ownership across all services and partners A2 - Limited independent validation of CSP effectiveness and decision-making outcomes A3 - Limited real-time visibility of CSP delivery progress and alignment with strategy A4 - Limited evidence linking CSP delivery to improved population and service outcomes A5 - Limited assurance of leadership capacity and capability development impact A6 - Limited assurance of sustainability of delivery within available resources	

		transformation • External benchmarking and learning from other Health Boards • Stakeholder and partner feedback on CSP engagement and proposals		

Plans to improve control :



Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
4C.1	Agree the CSP methodology and first tranche of areas to be prioritised and establish the CSP Programme by developing the programme structure, governance, and delivery approach, supported by targeted internal engagement and awareness raising activities to build understanding and organisational buy in. Success will be demonstrated through formal approval of the methodology, confirmation of programme governance, and evidence of staff awareness and engagement across key teams including the first major engagement event held.	G1 G2 G5	A1 A3	Executive Medical Director	**Q1 Low Delivery Confidence Last Update: Aug 26**
4C.2	Operationalise the CSP Programme by finalising detailed delivery plans for the process (pertaining to the first tranche of areas), establishing programme reporting and risk management processes, and initiating structured engagement with leads to prepare for	G1 G4	A3	Executive Medical Director	**Q2 Moderate Delivery Confidence Last Update: Aug 26**

	CSP assessments. Success will be demonstrated through approved delivery plans, active reporting cycles, and evidence of areas' readiness to enter the CSP process in Q3.				
4C.3	Deliver the full CSP assessment process for the first tranche of priority services, including evidence gathering (including use of key population level intelligence, assessment workshops, option development and prioritisation. This will be supported by structured engagement with leads and clinical and operational teams from the full set of professional groups to ensure clarity, collaboration and high-quality outputs. Success will be demonstrated through completed CSP assessment documentation and agreed prioritisation outcomes for all first tranche areas that demonstrates Community by Design principles, maximise pathway redesign and strengthened joint working between primary and secondary care and partners.	G1 G2	A3 A4	Executive Medical Director	**Q3** **Moderate Delivery Confidence** **Last Update: Aug 26**
4C.4	Finalise and submit the first tranche of CSP service change proposals for formal approval by the CSP Programme Board. This will include refining proposals based on feedback, completing required documentation, and ensuring alignment with strategic, operational and financial considerations. Success will be demonstrated through Programme Board approval of all first tranche service change proposals and confirmation of readiness for wider Health Board governance approvals and implementation planning.	G1 G6	A4	Executive Medical Director	**Q4** **Moderate Delivery Confidence** **Last Update: Aug 26**
4C.5	Job descriptions with roles with responsibilities and appropriate	G3	A5	Executive Medical Director	**Q1**

	remuneration in place for all clinical leadership posts with Foundations for the Future organisation structure, across primary, community and secondary care.				**Low Delivery Confidence Last Update: Aug 26**
4C.6	Commence implementation of a menu of formal training programmes informed by training and development needs analysis for all within clinical leadership positions, across primary, community and secondary care.	G3	A5	Executive Medical Director	**Q3 Low Delivery Confidence Last Update: Aug 26**
4C.7	Generalised upskilling related to modern NHS needs via Clinical Services Plan programme to include strategic planning, value-based health care, population health management etc, across primary, community and secondary care.	G3	A5	Executive Medical Director	**Q4 Low Delivery Confidence Last Update: Aug 26**
4C.8	Develop a clear and attractive career path and development package for those in or aspiring to Clinical Leadership position, drawing on internal and external expertise and support including NHS P&I and CMO. Across primary, community and secondary care.	G3	A5	Executive Medical Director	**Q4 Low Delivery Confidence Last Update: Aug 26**
4C.9	Provide clarity over best practice clinical and operational multi-professional working, in line with the new operating model structures roll out, both roles and responsibilities and effective team working. Across primary, community and secondary care.	G6	A1	Executive Medical Director	**Q1 Low Delivery Confidence Last Update: Aug 26**
4C.10	Provide organisation development support to ensure newly formed teams are working effectively together across clinical and operational inter-professional disciplines. Across primary, community and secondary care.	G2 G6	A1	Executive Medical Director	**Q3 Low Delivery Confidence Last Update: Aug 26**

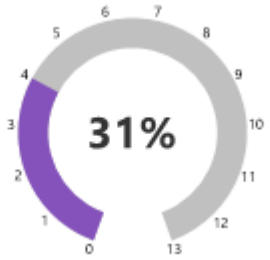
Priority:	4D Digital, Data and Intelligence

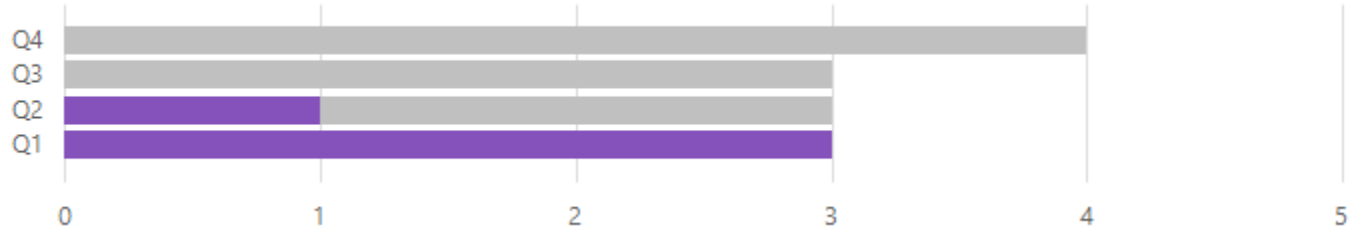
Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to deliver a robust, integrated digital, data and intelligence capability due to insufficient funding prioritisation, dependencies on internal and external partners, and limited clinical and operational capacity. This may result in delayed digital transformation, poor data quality and intelligence, reduced ability to support decision-making, and an inability to deliver safe, efficient and modern technology-enabled healthcare

Accountable:	Chief Digital & Information Officer

Primary risk controls:	Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating
Development and implementation of demand and capacity planning tools (4D.1) • Rollout of data quality kite mark and data governance programme (4D.2–4D.4) • Development of data governance audits and frameworks to improve data accuracy and accountability (4D.3–4D.4) • Implementation of clinical coding quality dashboards and improvement initiatives (4D.6–4D.8) • Development of population health intelligence and analytics capabilities (4D.11–4D.12) • Implementation of digital skills assessment and training programmes (4D.13–4D.14) • Programme of decommissioning legacy systems and reducing technical debt (4D.15) • Development of AI governance framework and digital roadmap aligned to CSP and strategy (4D.18–4D.19) • Strengthening cyber security and compliance through Cyber Assessment Framework gap analysis (4D.17)	G1 - Funding not consistently prioritised across digital and data initiatives G2 - Dependencies on national programmes, partners and internal transformation limiting delivery G3 - Limited clinical and operational capacity to support digital transformation G4 - Variable data quality and governance maturity across organisation G5 - Digital and analytical capability not fully embedded across services G6 - Legacy systems and infrastructure impacting efficiency and integration	**Management Assurance** • IMTP monitoring of 4D deliverables (4D.1–4D.20) • Digital programme governance and reporting arrangements • Data quality kite mark assessments and data governance audits • Clinical coding performance dashboards and reporting • Digital skills training uptake and workforce development metrics **Risk & Compliance Assurance** • Compliance with Cyber Assessment Framework (CAF) requirements • Information governance and data quality frameworks • Oversight of digital clinical safety and cyber risks at Board level (4D.20) **Independent Assurance** • Welsh Government oversight of digital transformation and IMTP delivery • External benchmarking and national digital programmes • Audit and review of data governance, cyber security and system performance	A1 - Limited assurance that digital investment decisions are prioritised and deliver expected benefits A2 - Limited visibility and control over dependencies impacting delivery timelines A3 - Limited assurance of clinical engagement and capacity to support digital implementation A4 - Limited confidence in consistency and quality of data across organisation A5 - Limited evidence of impact of digital transformation on service outcomes A6 - Limited assurance over full integration and sustainability of digital systems	

Plans to improve control :





Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
4D.1	Identify and commence implementation of best practice and tools available to support improved organisation wide demand and capacity planning.	G3 G5	A3 A5	Director of Digital, Data & Intelligence	**Q2 Moderate Delivery Confidence Last Update: Sep 26**
4D.2	Further development and roll out throughout the year of the data quality kite mark to provide assurance on data quality and accuracy.	G4	A4	Director of Digital, Data & Intelligence	**Q4 Moderate Delivery Confidence Last Update: Aug 26**
4D.3	Develop and commence implementation a programme of data governance audits to provide assurance on data processing and reporting accuracy.	G4	A4	Director of Digital, Data & Intelligence	**Q1 (Complete)**
4D.4	Develop a data quality framework that makes clear the responsibilities and accountability associated with the collection and management of data across the health board.	G4 G5	A4	Director of Digital, Data & Intelligence	**Q3 High Delivery Confidence Last Update: Aug 26**
4D.5	Develop proposals for a Robotic Process Automation (RPA) approach and associated implementation plan.			Director of Digital, Data & Intelligence	**Q3 High Delivery Confidence Last Update: Aug 26**
4D.6	Develop and implement a Clinical Coding quality dashboard to facilitate	G4	A4	Director of Digital, Data & Intelligence	**Q1 (Complete)**

	improved clinical coding error detection and correction.				
4D.11	Further enhance existing information products to introduce elements of Population Health Management (PHM) e.g. deprivation analysis, further identification of patient cohorts for targeted interventions.(Shared objectives with Public Health Team on PHM).	G5	A5	Director of Digital, Data & Intelligence	**Q3 High Delivery Confidence Last Update: Aug 26**
4D.13	Implement a comprehensive Digital Skills Assessment and publish Training Needs Analysis and Academy plan on LMS landing page.	G3 G5	A3	Director of Digital, Data & Intelligence	**Q1 (Complete)**
4D.15	Progressively and systematically decommission and archive unsupported systems and devices in line with available resources, while maximising the efficient use of current supported systems to reduce technical debt, support costs, and safety risk.	G6	A6	Director of Digital, Data & Intelligence	**Q4 Moderate Delivery Confidence Last Update: Aug 26**
4D.17	Completion of a gap analysis against the requirements of the newly released Cyber Assessment Framework (CAF) version 4 – this will be the tool used by our regulators to measure compliance.	G2	A2	Director of Digital, Data & Intelligence	**Q2 (Complete)**
4D.18	Create and establish a robust AI framework to ensure the appropriate processes, people and governance arrangements are in place. This will provide assurance that the approval/review process in place provides structure for the appropriate and safe use of AI tools which considers all 7 AI principles, covering safety, confidentiality, research, evaluation, partnership, ethics, transparency, and data quality.	G2 G5	A2 A6	Director of Digital, Data & Intelligence	**Q2 High Delivery Confidence Last Update: Aug 26**
4D.19	To review the organisational wide Digital Roadmap to take into account	G1 G2	A1 A2	Director of Digital, Data & Intelligence	**Q4**

	the 10 year strategy and Clinical Service Plan.				**Moderate Delivery Confidence Last Update: Aug 26**
4D.20	Ensure that digital clinical safety, cyber security and information governance risks in relation to digital are considered by the board, and undertake regular board development sessions to develop digital and data competence.	G2 G3	A2 A3 A6	Director of Digital, Data & Intelligence	**Q4 High Delivery Confidence Last Update: Aug 26**

Priority:	**4E Research, Development and Innovation**

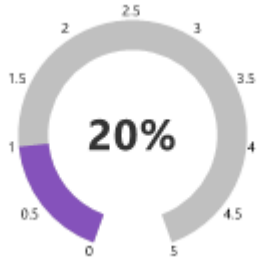
Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to effectively grow and sustain research, development and innovation (RD&I) activity due to limited pipeline of studies, insufficient capacity to support research delivery, and challenges in securing external funding. This may result in reduced research activity, missed opportunities for innovation, limited access to funding and partnerships, and an inability to improve patient outcomes, workforce development and organisational learning.

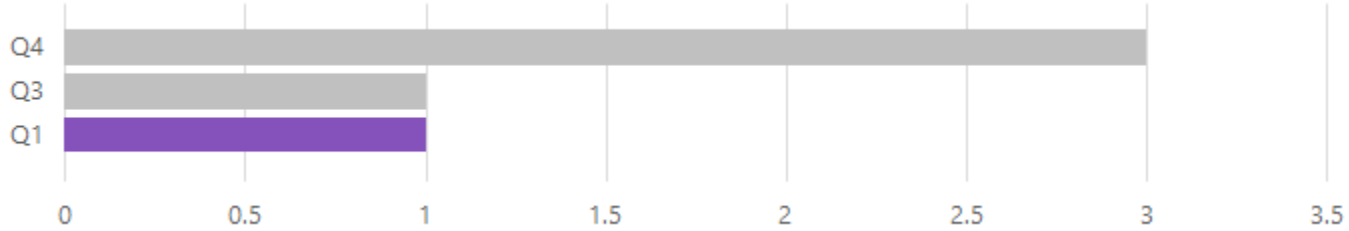
Accountable:	Executive Medical Director

Primary risk controls:	Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating
Approval and delivery of RD&I strategic plan aligned to Health Board priorities and national expectations (4E.1) Development of proposals for an innovation centre in partnership with industry and academia (4E.2) Embedding research expectations into clinical roles, job plans and appraisals (4E.3) Increasing research study activity and recruitment through improved processes and engagement (4E.4) Strengthening academic partnerships and joint appointments to support research and innovation (4E.5)	G1 - Limited pipeline of research studies and opportunities G2 - Insufficient capacity (PI, workforce and support services) to deliver research activity G3 - Limited capability and capacity for bid writing and securing external funding G4 - Research and innovation not fully embedded as core part of clinical practice G5 - Dependency on external partners and funding environment G6 - Limited coordination and visibility of RD&I activity across the organisation	**Management Assurance** • External review through research networks and academic partners • Benchmarking against national research activity and funding metrics • Oversight and requirements from Welsh Government and Health and Care Research Wales **Risk & Compliance Assurance** • Alignment with Health and Care Research Wales and national policy requirements • Governance oversight of research activity and compliance processes • Monitoring of research performance metrics	A1 - Limited assurance on sustainability and growth of research pipeline A2 - Limited visibility of capacity constraints impacting research delivery A3 - Limited assurance over success rates for funding and bid quality A4 - Limited evidence of impact of RD&I activity on patient outcomes and service improvement A5 - Limited assurance that research is consistently embedded into clinical practice and workforce roles	

		(recruitment to target, study delivery timelines) **Independent Assurance** • IMTP monitoring of 4E deliverables (4E.1–4E.5) • RD&I programme governance and reporting • Metrics on number of studies opened and recruitment levels • Monitoring of research funding applications and awards		

Plans to improve control :





Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
4E.1	RD&I strategic plan and delivery plan approved, aligned to health board strategic intentions and national performance metric.	G4 G6	A1 A5	Executive Medical Director	**Q1 (Complete)**
4E.2	Develop a proposal for a self-sustaining innovation centre, working with industry and academia, prioritising digital innovations and medical technology, aligned with the NHS Wales Technical Planning Guidance 2026-29 Digital and Innovation enabling plan, and Welsh Government's Innovation Strategy delivery plan.	G3 G5	A3 A4	Executive Medical Director	**Q3 High Delivery Confidence Last Update: Aug 26**
4E.3	Work with People Services colleagues to develop and implement a plan to normalise research as a core part of	G2 G4	A2 A5	Executive Medical Director	**Q4 High Delivery Confidence**

	clinical practice by embedding research expectations within job descriptions, appraisal objectives, and job plans for identified priority staff groups, supported by guidance and manager training.				**Last Update: Aug 26**
4E.4	Increase the number of non-commercial and commercial research studies opened by the Health Board and recruitment to those studies, through proactive engagement with sponsors and streamlined feasibility and approval processes.	G1 G2	A1 A2	Executive Medical Director	**Q4 Moderate Delivery Confidence Last Update: Aug 26**
4E.5	Work with local academic partners to identify and implement to increase joint appointments and/or honorary contracts, closely working with the Academic Careers Community of Interest, ensuring that posts add value to research and innovation activity and support the above actions.	G2 G5	A2 A5	Executive Medical Director	**Q4 High Delivery Confidence Last Update: Aug 26**

Priority:	**4F Education Partnership and Projects, Academic Careers and Strategic Alignment of Education**

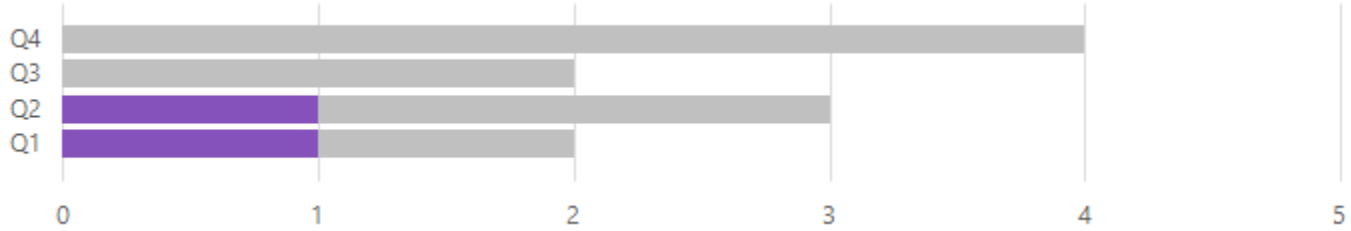
Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to effectively develop and deliver its education partnerships, academic career pathways and strategic alignment of education due to dependency on national programmes, limited operational capacity for placements, and challenges in aligning education with service transformation. This may result in reduced workforce pipeline, limited development of academic careers, and failure to align education provision to future service and workforce needs.

Accountable:	Executive Director of People Services & Organisational Development

Primary risk controls:	Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating
Engagement with Further and Higher Education partners to align education provision with Clinical Services Plan (4F.1) • Development and monitoring of Memoranda of Understanding (MoUs) and partnership delivery plans (4F.2, 4F.5) • Exploration of opportunities through regional partnerships including the Tertiary Alliance (4F.3) • Development of Academic Careers pathways and	G1 - Dependencies on national programmes and timelines impacting local delivery G2 - Limited operational capacity to support student placements across services G3 - Academic career pathways not fully embedded or developed	**Management Assurance** • IMTP monitoring of 4F deliverables (4F.1–4F.11) • Education Steering Group and governance reporting • Monitoring of MoU delivery plans and partnership activity • Workforce and education	A1 - Limited assurance of alignment between education provision and future service needs A2 - Limited visibility of placement capacity and impact on workforce pipeline A3 - Limited evidence of effectiveness of academic career pathways A4 - Limited assurance over consistency and quality of partnership delivery	

Community of Practice (4F.7–4F.8) • Establishment of governance structures for education aligned to workforce and service needs (4F.9) • Development of Strategic Education Plan aligned to HEIW and national priorities (4F.10) • Compliance with national legislative and education requirements (4F.11)	G4 - Inconsistent alignment between education provision and service/workforce needs G5 - Limited coordination and oversight of partnerships and education delivery G6 - Variable engagement across services in supporting education and training	metrics (placements, recruitment pipelines) **Risk & Compliance Assurance** • Alignment with HEIW strategies and national education frameworks • Compliance with statutory requirements (e.g. Additional Learning Needs Act) • Oversight of education governance and workforce planning alignment **Independent Assurance** • External partner feedback from universities and FE providers • National oversight through HEIW and Welsh Government • Evaluation of partnership effectiveness and student pipeline outcomes	A5 - Limited assurance of sustainability of education models within operational constraints	

Plans to improve control :



Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
4F.1	Work with Further and Higher Education Partners to capture their contribution to the development of the Health Board's clinical services plan so that education provision across the	G4 G6	A1 A4	Executive Director of People Services & Organisational Development	**Q1** **Low Delivery Confidence** **Last Update: Sep 26**

	region can reflect the future development of healthcare.				
4F.2	Review and set out proposals to the Health Board on requirements to meet Memoranda of Understanding with Further and Higher Education Partners and reflect in delivery plans aligned to national programmes and strategies, with agreed key metrics and baselines.	G5	A4	Executive Director of People Services & Organisational Development	**Q3 High Delivery Confidence Last Update: Aug 26**
4F.3	Review opportunities for BCUHB to support the Tertiary Alliance formed between Bangor University, Wrexham University, Grwp Llandrillo Menai and Coleg Cambria.	G1 G5	A4	Executive Director of People Services & Organisational Development	**Q3 High Delivery Confidence Last Update: Aug 26**
4F.4	Continue to support the development of the proposed Dental School and input into associated business cases.	G2 G6	A2	Executive Director of People Services & Organisational Development	**Q4 High Delivery Confidence Last Update: Aug 26**
4F.5	Submit an evaluation of progress against the aspirations set out in the Memoranda of Understanding with Further and Higher Education Partners, providing recommendations on how performance against key metrics may be enhanced.	G5	A4	Executive Director of People Services & Organisational Development	**Q4 High Delivery Confidence Last Update: Aug 26**
4F.6	Commence full business case for the North Wales Medical school in partnership with Bangor University.	G2 G5	A2 A4	Executive Director of People Services & Organisational Development	**Q1 (Complete)**
4F.7	Conduct an analysis as to the key barriers in establishing academic careers and update the pathway framework accordingly.	G3	A3	Executive Director of People Services & Organisational Development	**Q2 (Complete)**
4F.8	Having established an Academic Careers Community of Practice to bring together academics across BCUHB, develop a delivery plan which will outline how we should enhance their work and maximise its impact within BCUHB.	G3 G6	A3	Executive Director of People Services & Organisational Development	**Q2 Moderate Delivery Confidence Last Update: Sep 26**

4F.9	Develop a proposal for an interprofessional governance structure setting out clear governance routes and alignment of education to strategic workforce planning and the quality, safety and experience of our services.	G4 G5	A1 A4	Executive Director of People Services & Organisational Development	**Q2 Low Delivery Confidence Last Update: Sep 26**
4F.10	Progress to the Design Phase for education and training, agreeing priorities together with the development of an underpinning Strategic Education Plan which aligns to HEIW and local commissioning of education and training.	G4	A1	Executive Director of People Services & Organisational Development	**Q4 Moderate Delivery Confidence Last Update: Aug 26**
4F.11	Collaboration with education colleagues to comply with the duties set out in the Additional Learning Needs and Education Tribunal (Wales) Act.	G2	A2	Executive Director of People Services & Organisational Development	**Q4 High Delivery Confidence Last Update: Aug 26**

Priority:	**4G Value & Sustainability**

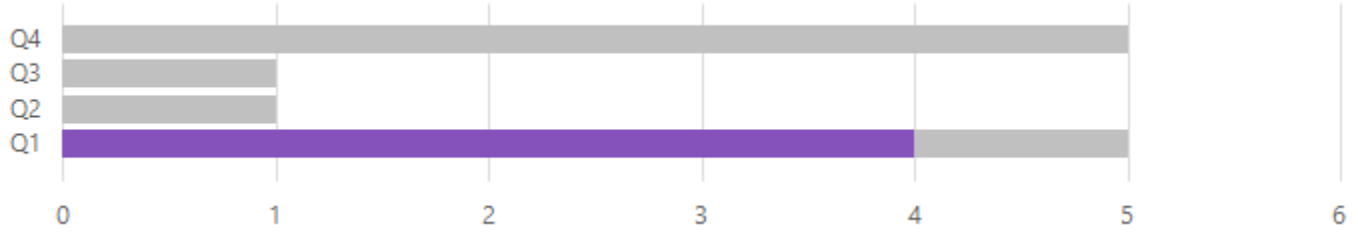
Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to deliver a sustainable Value & Sustainability programme due to insufficient identification and delivery of recurrent savings, disruption from organisational change, and competing operational pressures. This may result in increased financial deficits, reduced ability to invest in transformation, failure to shift resources to higher-value care, and an inability to deliver efficient, high-quality and sustainable services.

Accountable:	Executive Director of Finance

Primary risk controls:	**Gaps in control:**	**Sources of assurance:**	**Gaps in assurance:**	**Assurance Rating**
Development of Value & Sustainability programme aligned to national priorities and Board objectives (4G.1–4G.12) • Implementation of clinical variation programmes to reduce unwarranted variation and improve efficiency (4G.1–4G.4) • Development of non-pay and procurement programmes to optimise resource use (4G.5) • Implementation of medicines management programme aligned to national priorities (4G.6) • Development of continuing healthcare (CHC) programme to manage demand and cost pressures (4G.7) • Implementation of value-based healthcare approaches to improve outcomes and resource use (4G.8–4G.11)	G1 - Insufficient pipeline of savings opportunities to meet recurrent targets G2 - Disruption from operating model changes impacting programme delivery G3 - Operational pressures limiting focus on transformation and prevention G4 - Inconsistent identification and delivery of value opportunities across services G5 - Limited embedding of value-based healthcare principles in	**Management Assurance** • IMTP monitoring of 4G deliverables (4G.1–4G.12) • Value & Sustainability Programme governance and reporting • Monitoring of savings delivery against agreed targets • Performance and productivity metrics **Risk & Compliance Assurance** • Alignment with national Value & Sustainability Board priorities	A1 - Limited assurance of delivery of recurrent savings at required scale A2 - Limited visibility of impact of operating model changes on savings delivery A3 - Limited assurance that transformation and prevention programmes are being prioritised A4 - Limited evidence linking value initiatives to improved outcomes and efficiency A5 - Limited assurance of consistent application of value-based decision-making across organisation	

• Delivery of agreed savings targets through refreshed Value & Sustainability programme (4G.12)	decision-making G6 - Limited capacity and capability to deliver efficiency and productivity improvements	• Financial governance and reporting frameworks • Oversight of programme delivery through Finance and Performance governance **Independent Assurance** • Welsh Government oversight of financial performance and IMTP delivery • External benchmarking of productivity and efficiency • Audit review of savings programmes and financial controls		

Plans to improve control :



Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
4G.1	Review current progress with the implementation of the Value & Sustainability Board 'Bone Health' High Value High Impact (HVHI) pathway and produce a proposal to support further implementation.	G4 G5	A4	Executive Director of Finance	**Q2 Moderate Delivery Confidence Last Update: Sep 26**
4G.2	Review current progress with the implementation of the Value & Sustainability Board Diabetes' High Value High Impact (HVHI) pathway and produce a proposal to support further implementation. This is to be managed as part of the Primary Care IMTP plans.	G4 G5	A4	Executive Director of Finance	**Q3 High Delivery Confidence Last Update: May 26**

4G.3	Address variation reported in the National Outcomes Framework and National Clinical Audit and Outcome Review Programme.	G4	A4	Executive Director of Finance	**Q4 Moderate Delivery Confidence Last Update: Aug 26**
4G.4	Develop a Clinical Variation programme to deliver against the core thematic, which have been identified through the national Clinical Variation & Service Reconfiguration Group, with a particular focus on reducing unwarranted clinical variation, minimising waste, improving efficiency and ensuring sustainable service configuration.	G4 G5	A4	Executive Director of Finance	**Q1 Low Delivery Confidence Last Update: Sep 26**
4G.5	Develop a Non-Pay & Procurement programme to deliver against the core thematic, which have been identified through the national Non-Pay & Procurement Value & Sustainability Group, with a particular focus on reducing clinical variation to maximise benefits in relation to price and product standardisation.	G1 G6	A1	Executive Director of Finance	**Q1 (Complete)**
4G.6	Develop a Medicines Management programme to deliver against the seven priority areas, which have been identified through the Directors of Pharmacy's Medicines Value and Sustainability Delivery Assurance Group and endorsed by the NHS Value and Sustainability Board.	G1 G6	A1	Executive Director of Finance	**Q1 (Complete)**
4G.7	Develop a CHC programme to deliver against the seven priority areas, which have been identified through the national CHC Value & Sustainability Group.	G1	A1	Executive Director of Finance	**Q1 (Complete)**
4G.8	Develop a 'bottom-up' value programme for staff to register their value ideas/initiatives, with advice, guidance and resource provided where	G4 G6	A3 A5	Executive Director of Finance	**Q4 High Delivery Confidence Last Update: Jul 26**

	appropriate to mature ideas into delivery.				
4G.9	Develop a robust benefits framework for the programme, which allows for the effective measurement of activity and resources linked to VBHC (clinical staff, administrative staff, budgets, buildings, energy etc) to improve patient outcomes, patient experience and resource efficiency to ensure value and patient-centred care.	G5	A4	Executive Director of Finance	**Q1 (Complete)**
4G.10	Use Value Based Health Care (VBHC) guidance for designing services, responding to key population level intelligence including OECD PaRIS report 2025 - Value in Health and through service level Patient Reported Outcome Measurements (PROMs), Patient Reported Experience Measurements (PREMs) and social value measures for procurement. This is to be managed as part of the Clinical Services Plan	G5	A4	Executive Director of Finance	**Q4 High Delivery Confidence Last Update: May 26**
4G.11	As part of our refined planning process, we will utilise the value-based approach that provides the discipline to stop low-value activity, shifting finite resources to prevention and earlier access, community-based care, better-value interventions, and supporting people to manage more of their own health. All of our major investment and dis-investment decisions should therefore be assessed according to their impact on outcomes, experiences, and the value generated from resources used. This is to be overseen by the Planning Team.	G3 G5	A3 A4	Executive Director of Finance	**Q4 High Delivery Confidence Last Update: May 26**
4G.12	Deliver a refreshed Value & Sustainability programme that realises the agreed recurrent savings target for 26/27, aligned with the national value	G1 G2	A1 A2	Executive Director of Finance	**Q4 High Delivery Confidence Last Update: Jul 26**

	and sustainability structure and associated priorities and which also ensures that savings and mitigations delivered in 2025/26 are maintained in full on a recurrent basis.				

Priority:	**4H Quality**

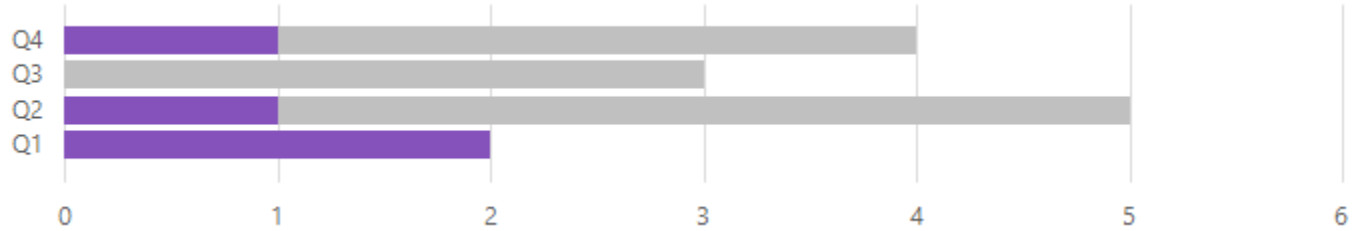
Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to consistently deliver safe, effective and high-quality care due to challenges in embedding the Quality Management System (QMS), organisational change, and ongoing operational challenges particularly within UEC and Planned care , workforce and financial pressures . This may result in variability in care quality, increased patient harm, failure to meet statutory and regulatory requirements, and reduced confidence from patients, staff and stakeholders.

Accountable:	Executive Director of Nursing

Primary risk controls:	**Gaps in control:**	**Sources of assurance:**	**Gaps in assurance:**	**Assurance Rating**
• Development and implementation of a Quality Management System (QMS) and maturity framework (4H.1) • Development of a Health Board-wide Quality Accreditation Framework (4H.2) • Redesign and strengthening of quality governance framework including quality issues log (4H.3) • Implementation of audit programmes and NICE compliance improvements (4H.4–4H.5) • Delivery of national patient safety strategy and digital safety programmes (4H.6–4H.7) • Implementation of Listening to People Regulations and ward accreditation programmes (4H.8–4H.9) • Implementation of infection prevention and safety improvement plans (4H.10–4H.12) • Development of organisational learning systems and repository (4H.13) • Oversight of national quality standards and best practice (4H.14)	G1 - QMS not yet fully embedded across all services G2 - Limited dedicated capacity to sustain QMS and quality improvements G3 - Risk of reduced focus on quality during organisational change G4 - Ongoing operational pressures particularly in UEC and planned care is impacting ability to prioritise quality improvement G5 - Inconsistent application of quality governance processes across services G6 - Limited integration of learning and improvement across the organisation	**Management Assurance** • IMTP monitoring of 4H deliverables (4H.1–4H.14) • QMS maturity metrics and reporting • Quality governance reporting and quality issues log • Audit programmes and compliance reporting • Performance indicators (infection rates, incidents, complaints, mortality data) Major change programme in place for both UEC and planned care improvement CIVICA patient experience data measured and monitored **Risk & Compliance Assurance** • Compliance with national quality frameworks and standards (e.g. NICE, Patient Safety Strategy) • Monitoring against statutory requirements including Duty of Quality and Duty of Candour • Infection prevention and control performance reporting	A1 - Limited assurance that QMS is fully embedded and consistently applied A2 - Limited visibility of sustainability of quality improvements over time A3 - Limited assurance of impact of organisational change on quality outcomes A4 - Limited evidence linking quality improvement activity to patient outcomes A5 - Limited assurance of consistency of quality governance and oversight across services A6 - Limited assurance that organisational learning is embedded and driving improvement	

		Integrated quality reports reported through QSE to Board **Independent Assurance** • Welsh Government oversight and Special Measures framework • Health Inspectorate Wales (HIW) inspections and reviews • External audit and regulatory reviews		

Plans to improve control :



Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
4H.1	Develop a comprehensive organisational plan, aligned to Foundations for the Future, to embed the QMS into all core business processes and fully onboard every service to the QMS Maturity App, enabling systematic identification and response to fragile services.	G1 G2	A1 A2	Executive Director of Nursing	**Q2 (Complete)**
4H.2	Develop and begin implementation of a Health Board–wide Quality Accreditation Framework aligned to QMS and regulatory standards, recognising and incentivising excellence.	G1 G5	A1 A5	Executive Director of Nursing	**Q4 Moderate Delivery Confidence Last Update: Aug 26**

4H.3	Re-design and implementation of quality governance framework to include implementation of quality issues log.	G5 G6	A5 A6	Executive Director of Nursing	**Q2** **High Delivery Confidence** **Last Update: Aug 26**
4H.4	Deliver on findings of internal audit of NICE compliance by focussing on areas where NICE guidance not implemented with clear process of reviewing impact and addressing if significant risk.	G5	A2	Executive Director of Nursing	**Q1** **(Complete)**
4H.5	Develop programme of Tier 2 audits based on current quality risks.	G5	A2	Executive Director of Nursing	**Q1** **(Complete)**
4H.6	Develop programme of work to address priority programmes and actions within National Patient Safety Strategy including key performance indicators to measure improvement.	G4 G5	A4	Executive Director of Nursing	**Q4** **High Delivery Confidence** **Last Update: Aug 26**
4H.7	Develop a programme of work and governance framework to address digital safety.	G5	A5	Executive Director of Nursing	**Q3** **Moderate Delivery Confidence** **Last Update: Aug 26**
4H.8	Refresh of NatSSIPs programme to address recent Never Events and reintroduce a revised ward accreditation programme in line with the QMS methodology.	G5 G6	A4 A6	Executive Director of Nursing	**Q2** **Moderate Delivery Confidence** **Last Update: Sep 26**
4H.9	Implement the new Listening to People Regulations and deliver on the 40% national performance target.	G4	A4	Executive Director of Nursing	**Q2** **High Delivery Confidence** **Last Update: Aug 26**
4H.10	Meet the nationally set Infection Prevention trajectories and reduce the incidents of infections (including C-Diff and E.Coli) and associated harm, through implementation of the IPC improvement plan.	G4	A4	Executive Director of Nursing	**Q3** **High Delivery Confidence** **Last Update: Aug 26**

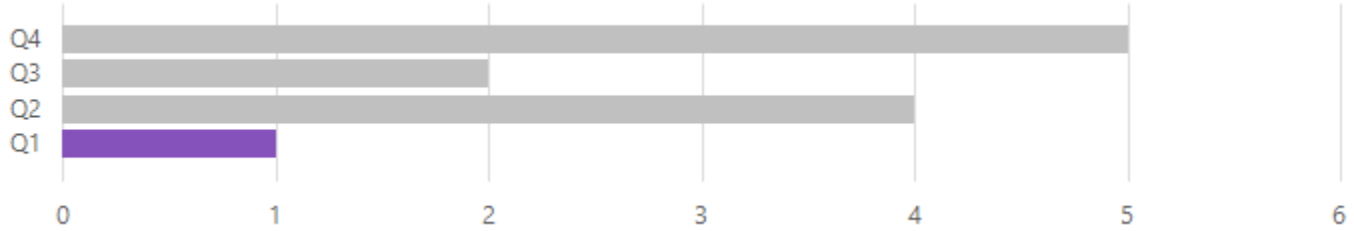
4H.11	We will reduce severe and catastrophic incident numbers and monitor improvement and learning through the Integrated concerns Hub.	G6	A6	Executive Director of Nursing	**Q2 High Delivery Confidence Last Update: Sep 26**
4H.12	We will reduce the number of avoidable falls and HAPU through continuing to implement the actions identified in the associated improvement groups.	G4	A4	Executive Director of Nursing	**Q3 High Delivery Confidence Last Update: Jul 26**
4H.13	We will fully implement the learning repository and have clear outcomes with regard to robust and sustained organisational learning and how it positively impacts outcomes.	G6	A6	Executive Director of Nursing	**Q4 (Complete)**
4H.14	Provide direction and oversight through the organisation's Quality governance for the application of appropriate best practice within the national Quality Statements - the ones not covered elsewhere in the plan are: Care of the critically ill, Respiratory Disease, Heart conditions, Kidney Disease, Liver Disease, Musculoskeletal health, Neurological conditions, Stroke, Infection prevention and control, Osteoporosis and bone health.	G5 G6	A5 A6	Executive Director of Nursing	**Q4 Low Delivery Confidence Last Update: Aug 26**

Priority:	**4I Environment and Estates**
Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to deliver a safe, efficient and sustainable estate and environment due to external uncertainty, competing priorities and limited resources to deliver climate adaptation and estate transformation programmes. This may result in deterioration of estate quality, reduced service resilience, inability to support service transformation, and failure to meet environmental and decarbonisation targets.	
Accountable:	Director of Environment & Estates

Primary risk controls:	Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating

Development of long-term estate plans for major infrastructure and business continuity schemes (4I.1) • Progression of key capital projects and estate developments (4I.2–4I.3) • Implementation of safety improvement programmes (e.g. anti-ligature) (4I.4) • Development of revised Estates Strategic Plan aligned to 10-year strategy and CSP (4I.5) • Engagement on future estate redevelopment and planning (4I.6) • Programmes to improve estate efficiency and utilisation (4I.7–4I.9) • Development and implementation of climate adaptation and decarbonisation plans (4I.10–4I.12)	G1 - Dependence on external strategic direction (e.g. Welsh Government/Senedd decisions) G2 - Limited capacity and prioritisation to deliver climate adaptation and decarbonisation programmes G3 - Ageing estate and backlog maintenance challenges G4 - Limited availability of capital funding and competing investment priorities G5 - Incomplete alignment between estate strategy and service transformation plans G6 - Variable estate utilisation and efficiency across sites	**Management Assurance** • IMTP monitoring of 4I deliverables (4I.1–4I.12) • Estates Programme governance and reporting • Capital programme monitoring and delivery reporting • Estate performance metrics (utilisation, maintenance backlog, efficiency) **Risk & Compliance Assurance** • Compliance with estate safety standards and statutory requirements • Monitoring against NHS Wales Decarbonisation Strategic Delivery Plan • Oversight of capital planning and prioritisation processes **Independent Assurance** • Welsh Government oversight of capital programmes and estate strategy • External audit and inspection (e.g. estates, safety compliance) • Benchmarking against NHS Wales estate performance and sustainability metrics	A1 - Limited assurance over impact of external strategic changes on estate planning A2 - Limited visibility of delivery progress of climate adaptation and decarbonisation plans A3 - Limited assurance of long-term sustainability of estate within funding constraints A4 - Limited evidence linking estate improvements to service outcomes A5 - Limited assurance that estate strategy is fully aligned to service transformation plans	

Plans to improve control :



Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action

4I.1	Develop long-term plans for the delivery of the key estates projects including 1) Business continuity scheme for Ysbyty Gwynedd, 2) Electrical infrastructure replacement scheme for Ysbyty Glan Clwyd, 3) Business Continuity scheme for Wrexham Maelor Hospital, 4) Replacement helipads at Ysbyty Gwynedd and Ysbyty Glan Clwyd.	G3 G4	A3	Director of Environment & Estates	**Q4 High Delivery Confidence Last Update: Aug 26**
4I.2	Royal Alexandra Hospital (Rhyl) Phase 2 – Complete the schedule of accommodation and strategic outline case	G4	A3	Director of Environment & Estates	**Q4 Low Delivery Confidence Last Update: Sep 26**
4I.3	Plas Gororau (Wrexham) Phase 2 - Commence construction.	G4	A3	Director of Environment & Estates	**Q1 (Complete)**
4I.4	Develop and commence implementation of an organisation wide anti-ligature programme.	G3	A4	Director of Environment & Estates	**Q2 Low Delivery Confidence Last Update: Sep 26**
4I.5	Agree the approach to developing a revised Estates Strategic Plan, in line with the Health Board's 10-year Strategy and Clinical Services Plan.	G5	A5	Director of Environment & Estates	**Q4 Moderate Delivery Confidence Last Update: Aug 26**
4I.6	Commence engagement regarding the potential future redevelopment of the Wrexham Maelor Hospital site.	G1 G5	A1 A5	Director of Environment & Estates	**Q3 Moderate Delivery Confidence Last Update: Aug 26**
4I.7	Ensure strengthened actions are taken to improve estate utilisation including the appropriate repurposing & disposal of under-utilised estate and the reduction in the number of leases.	G6	A4	Director of Environment & Estates	**Q2 Moderate Delivery Confidence Last Update: Sep 26**

4I.8	Implement a computer aided facilities management system to support the management of the estate and the implementation of AI based energy management applications.	G2 G6	A2	Director of Environment & Estates	**Q2 Low Delivery Confidence Last Update: Sep 26**
4I.9	Development of a pan-BCU approach to managing car parking for staff and patients.	G6	A4	Director of Environment & Estates	**Q2 Low Delivery Confidence Last Update: Sep 26**
4I.10	Develop a BCUHB Climate Adaptation plan aligned with the NHS Wales Decarbonisation Plan and in parallel implement estate decarbonisation programmes.	G2	A2	Director of Environment & Estates	**Q4 High Delivery Confidence Last Update: Sep 26**
4I.11	Maximising the access to grant funding through the Refit Framework to deliver a programme of works to support carbon reduction.	G4	A3	Director of Environment & Estates	**Q3 Moderate Delivery Confidence Last Update: Aug 26**
4I.12	Commence construction of the photo-voltaic array at Ysbyty Gwynedd as part of adopting renewable energy technologies.	G2	A2	Director of Environment & Estates	**Q4 Low Delivery Confidence Last Update: Sep 26**

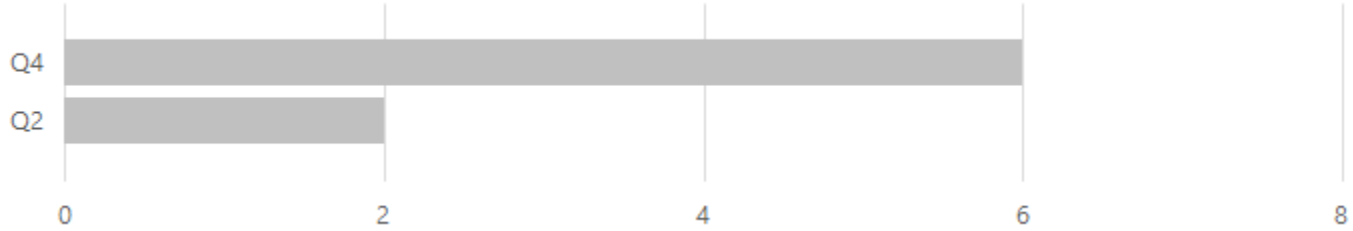
Priority:	4J Workforce

Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to deliver a sustainable, skilled and resilient workforce due to insufficient capacity and capability for workforce planning, continued reliance on agency staffing, and operational pressures. This may result in reduced workforce stability, increased costs, inability to deliver safe and effective care, and failure to support service transformation and strategic objectives.

Accountable:	Executive Director of People Services & OD

Primary risk controls:	Gaps in control:	Primary risk controls:	Gaps in control:	Assurance Rating
Review and improvement of consultant job planning and workforce productivity (4J.1) • Reduction of agency spend through workforce planning and control frameworks (4J.2–4J.3) • Implementation of sickness absence improvement plans (4J.4) • Delivery of Culture, Leadership and Engagement programme (4J.5–4J.6) • Implementation of strategic workforce planning aligned to service transformation (4J.7) • Compliance with Social Partnership Duty and reporting requirements (4J.8)	G1 - Insufficient dedicated capacity and capability to deliver job planning sustainably G2 - Limited capacity and systems to reduce agency usage and reliance G3 - Workforce planning not fully embedded across all services G4 - Operational pressures impacting delivery of workforce initiatives G5 - Limited workforce data integration and visibility for planning decisions G6 - Culture and engagement improvements not yet fully embedded	Review and improvement of consultant job planning and workforce productivity (4J.1) • Reduction of agency spend through workforce planning and control frameworks (4J.2–4J.3) • Implementation of sickness absence improvement plans (4J.4) • Delivery of Culture, Leadership and Engagement programme (4J.5–4J.6) • Implementation of strategic workforce planning aligned to service transformation (4J.7) • Compliance with Social Partnership Duty and reporting requirements (4J.8)	G1 - Insufficient dedicated capacity and capability to deliver job planning sustainably G2 - Limited capacity and systems to reduce agency usage and reliance G3 - Workforce planning not fully embedded across all services G4 - Operational pressures impacting delivery of workforce initiatives G5 - Limited workforce data integration and visibility for planning decisions G6 - Culture and engagement improvements not yet fully embedded	

Plans to improve control :



Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
4J.1	Review of Consultant job plans – Operational Services to be targeted to	G1 G3	A1 A3	Executive Director of People Services & Organisational Development	Q2

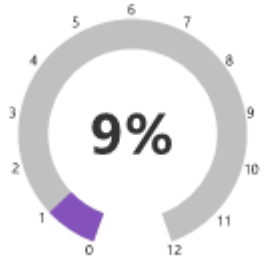
	reach >90% to ensure improved workforce productivity and alignment to demand and capacity. This will be measured through the Job Planning Dashboard and follows on from work undertaken in 2025/26.				**Moderate Delivery Confidence Last Update: May 26**
4J.2	Review of agency expenditure. Operational Services to be targeted with a 30% reduction in agency expenditure. All services to be targeted with no off-contract agency use and not Admin and Clerical, Estates and Ancillary and Health care Support Worker agency use through effective workforce planning, optimising the benefits of the newly insourced medical bank resource and management controls. This will be measured through the Value & Sustainability (V&S) Group.	G2 G3	A2 A3	Executive Director of People Services & Organisational Development	**Q2 Moderate Delivery Confidence Last Update: May 26**
4J.3	Fully implement the actions outlined in the Variable Pay & Agency Control Framework Welsh Health Circular by continuing to reduce agency requirements and incentivise substantive positions through flexible working, effective rostering and employee health and wellbeing programmes of work.	G2	A2 A5	Executive Director of People Services & Organisational Development	**Q4 High Delivery Confidence Last Update: May 26**
4J.4	Work with operational and corporate directors to implement and deliver the Health Board's sickness absence delivery plan to improve workplace attendance levels and to meet national sickness absence and local stretch targets. Progress will be monitored through the People and Culture Committee.	G4	A4	Executive Director of People Services & Organisational Development	**Q4 High Delivery Confidence Last Update: May 26**
4J.5	Implement and deliver the year 1 actions from the Culture, Leadership and Engagement 3-year Improvement plan 2026-29.	G6	A4 A5	Executive Director of People Services & Organisational Development	**Q4 Moderate Delivery Confidence**

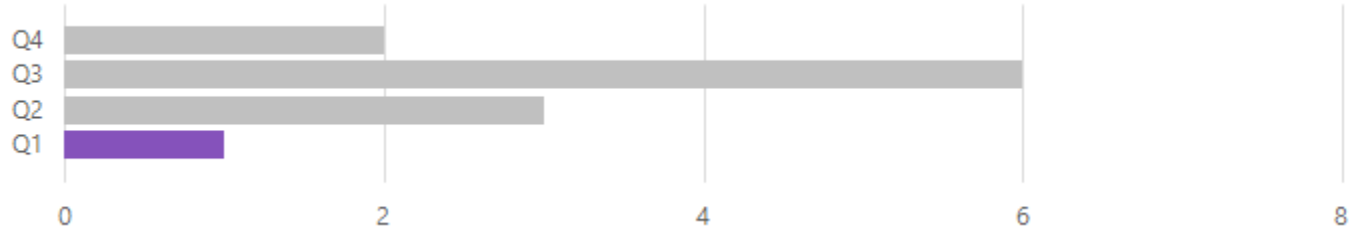
					Last Update: Jul 26
4J.6	Review and respond to staff survey feedback to support an improvement in staff engagement and satisfaction.	G6	A4	Executive Director of People Services & Organisational Development	**Q4 High Delivery Confidence Last Update: Sep 26**
4J.7	Implement in partnership strategic workforce planning across the organisation, improving alignment with Clinical Service Plans, use of technology, Financial Plans linked to IMTP objectives. Progress will be measured through the Foundations for the Future programme board. Plans will proactively identify any workforce capacity, skills and talent gaps and set out initiatives to address these in order to meet organisational objectives.	G5 G5	A3 A5	Executive Director of People Services & Organisational Development	**Q4 High Delivery Confidence Last Update: Sep 26**
4J.8	Prepare the annual social partnership report outlining what the Health Board has done to comply with the Social Partnership Duty, agreeing it with Trade Unions and submitting to the Social Partnership Council (SPC) as soon as possible after the end of the financial year.	G3	A3	Executive Director of People Services & Organisational Development	**Q4 High Delivery Confidence Last Update: Sep 26**

Priority:	4K Finance & Commissioning
Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to deliver a financially sustainable position and effective commissioning arrangements due to organisational change, external financial pressures, and limited capacity within services. This may result in failure to achieve a balanced financial plan, ineffective allocation of resources, reduced value from commissioned services, and an inability to deliver strategic service transformation aligned to population needs.	
Accountable:	Executive Director of Finance

Primary risk controls:	Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating
Implementation of financial control environment and governance arrangements (4K.1) • Establishment of accountability agreements for budget holders (4K.2) • Delivery of Value & Sustainability programme to support financial recovery (4K.3) • Monitoring and analysis of investment shifts towards primary and community care (4K.4) • Development of commissioning strategic approach and partnerships (4K.5) • Implementation of integrated commissioning framework and governance arrangements (4K.6) • Annual review of commissioned services and contracts (4K.7–4K.8) • Strengthening commissioning performance monitoring and oversight (4K.10–4K.11) • Engagement with Joint Commissioning Committee and national partners (4K.12) • Development and delivery of financial recovery plan (4K.13)	G1 - Organisational change impacting financial governance and accountability G2 - Challenging financial environment limiting ability to shift investment to priority areas G3 - Limited capacity within services to support commissioning reviews and decision-making G4 - Incomplete maturity of commissioning frameworks and processes G5 - Limited integration between financial planning, service planning and commissioning G6 - Variability in contract management and performance monitoring arrangements	**Management Assurance** • IMTP monitoring of 4K deliverables (4K.1–4K.13) • Financial performance reporting and budget monitoring • Value & Sustainability Programme reporting • Commissioning and contract performance monitoring **Risk & Compliance Assurance** • Compliance with Standing Financial Instructions and governance frameworks • Oversight of financial control measures and accountability agreements • Monitoring against Welsh Government financial requirements **Independent Assurance** • Welsh Government oversight of financial plans and IMTP delivery • External audit and financial assurance reviews • Benchmarking and national commissioning and financial frameworks	A1 - Limited assurance that financial plan delivery is sustainable over medium term A2 - Limited visibility of impact of organisational changes on financial performance A3 - Limited assurance of capacity and capability to deliver commissioning changes A4 - Limited evidence that commissioning decisions are delivering improved value and outcomes A5 - Limited assurance of alignment between financial planning, commissioning and strategic priorities	

Plans to improve control :





Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
4K.1	Maintain financial control measures from start of financial year, with a view to step them down as assurance and confidence is being gained in delivery of the financial plan. Particularly important due to FFTF structure changes mid-year that could otherwise cause some disruption in delivery of financial plan.	G1	A2	Executive Director of Finance	**Q2 Low Delivery Confidence Last Update: Sep 26**
4K.2	Contribute to the broader performance accountability agreements to ensure that budget owners are clear on their budget for the year and their accountabilities in relation to delivery within budget.	G1	A2	Executive Director of Finance	**Q1 (Complete)**
4K.3	Contribute to all the workstreams within the Value & Sustainability programme with a particular focus on those that are more traditionally related to financial management such as Non-Pay and ensuring there is a focus and visibility associated to savings in non-core areas and overheads to prioritise front-line services.	G2 G5	A1	Executive Director of Finance	**Q2 Moderate Delivery Confidence Last Update: Sep 26**
4K.4	Repeat the exercise to quantify current spend on primary and community services to compare against the baseline produced in 2025/26, in order to ascertain whether the required strategic move to proportionately	G2	A1	Executive Director of Finance	**Q3 High Delivery Confidence Last Update: Aug 26**

	increasing investment into primary and community care when compared to secondary care is happening.				
4K.5	Develop and commence implementation of a Commissioning Strategic Approach for all externally commissioned healthcare activities, that provides direction to the organisation on the role of commissioned services as part of longer-term strategic planning. Forming strategic partnerships will be an important part of the Clinical Services Plan work.	G4 G5	A4 A5	Executive Director of Finance	**Q2** **High Delivery Confidence** **Last Update: Jul 26**
4K.6	Create an Integrated Commissioning Framework that includes commissioning assurance, and clarity of roles and responsibilities, ensuring that everyone across the organisation is clear on roles to enable effective commissioning with a focus on value, quality and patient outcomes.	G4	A4 A5	Executive Director of Finance	**Q3** **High Delivery Confidence** **Last Update: Jun 26**
4K.7	Individual services to undertake an annual review of all their commissioned and contracted services as part of the IMTP process to ensure that the right strategic decisions are made on what the organisation should provide or commission. This should trigger de-commissioning, re-commissioning, as well as commissioning of new services where that best meets the needs of the population.	G3 G4	A3	Executive Director of Finance	**Q4** **High Delivery Confidence** **Last Update: Aug 26**
4K.8	In advance of the annual review of all services, undertake a risk-based review of contracts to ensure they are delivering value against current population need.	G3 G6	A3 A4	Executive Director of Finance	**Q3** **High Delivery Confidence** **Last Update: Aug 26**
4K.10	Develop robust commissioning plans for planned care services to secure additional capacity that addresses service backlogs and demand beyond	G3 G6	A3 A4	Executive Director of Finance	**Q3** **Low Delivery Confidence** **Last Update: Aug 26**

	internal capability. Establish and implement a comprehensive process that defines internal resource requirements and incorporates the full procurement, governance, and mobilisation pathway needed to deliver the required capacity.				
4K.11	Complete a review of performance monitoring arrangements for all existing commissioned services, ensuring that an appropriately broad set of performance metrics are covered along with consistent periodic commissioned services partner review meetings.	G6	A4	Executive Director of Finance	**Q4 High Delivery Confidence Last Update: Aug 26**
4K.12	Work with the Joint Commissioning Committee (JCC) to develop a financially balanced plan for the delivery of specialist services for the Health Board's population. Ensure consistent and effective representation from BCU at all JCC meetings and support a constructive approach to handling challenges. Proactively engage with the JCC to contribute to:- Efficiency and productivity schemes that collaboratively manage demand and cost pressures e.g. referral management.- New clinical models in relation to Emergency Ambulance Services.- Save a Life Cymru (SALC) defibrillator awareness. ▪ New air bases for the Emergency Medical Retrieval Service (EMRTS).▪ Adult Critical Care Transfer Service (ACCTS) in line with the Health Board's emerging Clinical Services Plan.▪ Non-Emergency Patient Transport Service (NEPTS) transformation.▪ Neonatal Transport (CHANTS) & Major Trauma pathways.▪ Clinical engagement and partnership in Sexual Assault Referral	G2 G5	A1 A4	Executive Director of Finance	**Q3 Moderate Delivery Confidence Last Update: Aug 26**

	Centres (SARC).▪ Improved commissioning and strategic partnerships with hospices and the Voluntary Sector.▪ A strategic review of Mental Health, Learning Disabilities and Vulnerable Groups commissioning.▪ Strategic reviews and deep dives relating to specialised services commissioned services across Cancer & Blood, Cardiac, Kidney, Neurosciences and Women & Children's services.				
4K.13	Prepare and commence execution of a robust and sustainable recovery plan, as detailed within Standing Financial Instructions, following submission of an in year deficit outturn	G1 G2	A1 A2	Executive Director of Finance	**Q3** **High Delivery Confidence** **Last Update: Jul 26**

Principal risk (What could prevent us achieving this strategic objective)	**BAF 05 - Failure to achieve long-term financial sustainability**		
Lead Committee	**Performance, Finance and Information Governance Committee**	**Risk Type**	**Financial**
Risk Lead	**Executive Director of Finance**	**Risk Appetite**	**<15**
Related Corporate Risks:	**CRR25-02 – Future Demand & Sustainable Workforce, CRR25-05 – Strategic Change Impacting Care and Staff Delivery, CRR25-06 – Delivery of the 2026/27 Financial Plan and Financial Sustainability, CRR25-07 – Leadership and Operating Model**		

Risk Rating			**Review Dates**	
	Current Exposure	**Target**		
Consequence	**5**	**4**	**Initial assessment**	**16/08/2026**
Likelihood	**4**	**3**	**Last Committee review**	**17/08/2026**
Risk Rating	**20**	**12**	**Last Executive Review**	**28/07/2026**

Priority:	Financial Sustainability and Organisational Resilience

Strategic Threat and Risks: The financial climate is challenging, with no further allocations expected to offset adverse performance. The first financial duty is to attain a break-even financial position over a rolling three years period. In not achieving break even the organisation suffers; A regulatory breach from Failure to achieve the key duty results in a regulatory Qualification.
Failure to achieve breakeven places at risk future receipt of conditionally recurrent allocations and/or the ability to attract prospective allocations.
Cash depletion and a potential lack of ability to pay employees and suppliers of goods and services. This potentially leading to late payment interest charges and difficulty in securing continued supply.

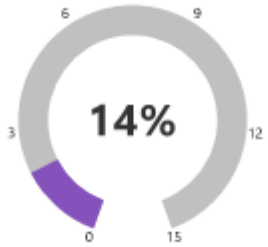
The Health Board will still be required to meet its statutory duty to break-even, resulting in a need to reduce costs and potentially reduce access to services

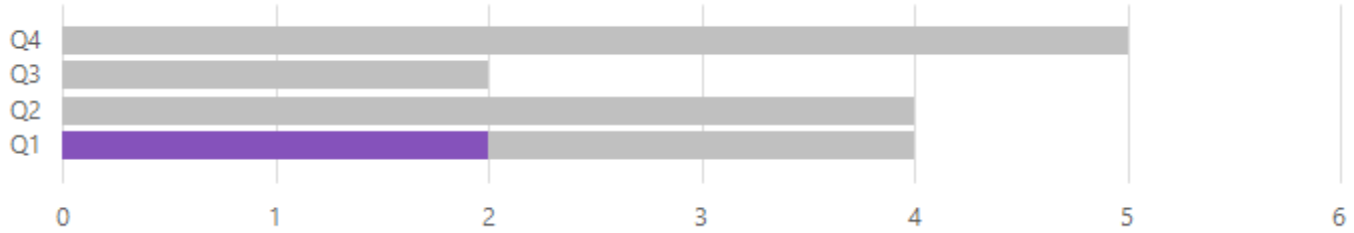
Accountable:	Chief Executive

Primary risk controls:	Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating
Annual Plan details requirements for further controls and required controls detailed in 'Gaps in controls' Monthly reporting of financial performance, articulating risk to delivery, drivers of any financial risk and suggested actions in place to mitigate risk Monthly reporting to Welsh Government financial performance each month, again articulating drivers of risk to delivery and mitigating actions Corporate risk for shorter term sustainability in place A key element of delivery centres upon savings realisation, the Value & Sustainability programme formed to support mitigation of shortfalls and place focus on improvements driving financial sustainability. The Executives have been allocated lead Executive status for each of the five programmes, the aim being to deliver improvement. Whilst not a financial programme it is expected through enhanced oversight and a drive to deliver improved productivity and efficiencies this programme will support a movement to financial balance.	G1 - Financial governance framework aligned with the organisation's strategic priorities G10 - Productivity and efficiency improvements are not yet delivering at the scale required to offset financial pressures and support long-term sustainability. G11 - Financial sustainability is dependent on successful delivery of major organisational transformation and service redesign programmes, the benefits of which have not yet been fully realised. G2 - Clinical Services Plan and associated demand, capacity and workforce modelling are not yet fully developed and implemented. G3 - A refreshed Estates Strategic Plan aligned to the emerging Clinical Services Plan and 10-Year Strategy is not yet in place. G4 - Long-term financial planning arrangements are not yet fully integrated with strategic service transformation and organisational change programmes. G5 - Integration of financial planning with performance and risk management processes G6 - Insufficient recurrent savings and	**Management Assurance** Budget setting policy & Financial Reporting monthly, budgetary controls in place and Accountability Agreements signed off. Integrated Performance – The Executive, the Executive Delivery Group (IP-EDG) with oversight through the Performance, Finance & Information Governance Committee **Risk & Compliance Assurance** Oversight by Audit Committee Internal Audit, Annual audit of financial governance effectiveness (to include budgetary control) The Performance Framework endorsed by the Health Board for 2026/27, facilitating regular review of financial performance as part of the balanced scorecard approach. **Independent Assurance** Budget setting policy & Financial Reporting monthly, budgetary controls in place and Accountability Agreements	A1 - Limited Assurance Internal Audit report for Delivery of Health Board Transformational Savings A2 - Limited independent assurance regarding delivery and sustainability of recurrent savings schemes and productivity benefits A3 - Head of Internal Control Opinion articulating limited assurance over systems of internal control A4 - Positive assurance for budgetary control environment. No changes from draft accounts to final submission following External Audit scrutiny A5 - Audit Wales issued a "true and fair" audit opinion on the 2024/25 accounts but gave a Qualification for regulatory breach for not attaining the key financial duty to break-even. A6 - Limited independent assurance that planned benefits from transformation and service redesign programmes will be realised within the required timeframe.	

	inability to fully mitigate emerging inflationary, pay, CHC, medicines and commissioning cost pressures. G7 - Inconsistent alignment between financial planning and strategic service goals G8 - A triangulation of activity, workforce modelling and finances. This leading to miss-alignment of the overall plans for the Health Board G9 - Limited ability to influence externally commissioned services expenditure and demand growth, particularly CHC, specialised services, prescribing and commissioning arrangements.	signed off. Integrated Performance – The Executive, the Executive Delivery Group (IP-EDG) with oversight through the Performance, Finance & Information Governance Committee		

Plans to improve control :





Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
4A.9	Implement a new governance model as part of the revised operating model, ensuring sharper accountability, fewer/streamlined meetings, focusing on delivery and transparency.	G1 G5 G7	A3	Chief Executive	**Q2 High Delivery Confidence Last Update: Aug 26**
4B.5	Draw on support from NHS Performance and Improvement (NHS P&I) colleagues to develop proposals on an improved approach to a unified modelling across demand, capacity, skills mix, activity, performance, finance and workforce, incorporating benchmarking against other Health	G5 G8	A3 A5	Executive Director of Transformation & Strategic Planning	**Q1 Moderate Delivery Confidence Last Update: Sep 26**

	Boards – to be utilised in the 2027-30 IMTP planning cycle.				
4B.8	Update the BCUHB Integrated Planning Framework and associated more detailed planning guidance in light of annual reflection and learning exercise, emphasising the importance of clinical leadership, Community by Design principles and patient feedback in service planning.	G5 G7	A3	Executive Director of Transformation & Strategic Planning	**Q2** **High Delivery Confidence** **Last Update: Sep 26**
4B.11	Support delivery of commitments set out in the IMTP through monthly monitoring and timely escalation of any risks to delivery as well as quarterly reporting of delivery against the IMTP and Special Measures de-escalation framework.	G1 G5 G7	A1 A2 A5	Executive Director of Transformation & Strategic Planning	**Q4** **High Delivery Confidence** **Last Update: Aug 26**
4C.1	Agree the CSP methodology and first tranche of areas to be prioritised and establish the CSP Programme by developing the programme structure, governance, and delivery approach, supported by targeted internal engagement and awareness raising activities to build understanding and organisational buy in. Success will be demonstrated through formal approval of the methodology, confirmation of programme governance, and evidence of staff awareness and engagement across key teams including the first major engagement event held.	G2 G7	A3	Executive Medical Director	**Q1** **Low Delivery Confidence** **Last Update: Aug 26**
4C.2	Operationalise the CSP Programme by finalising detailed delivery plans for the process (pertaining to the first tranche of areas), establishing programme reporting and risk management processes, and initiating structured engagement with leads to prepare for CSP assessments. Success will be demonstrated through approved delivery plans, active reporting cycles,	G5 G8	A3	Executive Medical Director	**Q2** **Moderate Delivery Confidence** **Last Update: Aug 26**

	and evidence of areas' readiness to enter the CSP process in Q3.				
4C.3	Deliver the full CSP assessment process for the first tranche of priority services, including evidence gathering (including use of key population level intelligence, assessment workshops, option development and prioritisation. This will be supported by structured engagement with leads and clinical and operational teams from the full set of professional groups to ensure clarity, collaboration and high-quality outputs. Success will be demonstrated through completed CSP assessment documentation and agreed prioritisation outcomes for all first tranche areas that demonstrates Community by Design principles, maximise pathway redesign and strengthened joint working between primary and secondary care and partners.	G2 G7	A3	Executive Medical Director	**Q3** **Moderate Delivery Confidence** **Last Update: Aug 26**
4C.4	Finalise and submit the first tranche of CSP service change proposals for formal approval by the CSP Programme Board. This will include refining proposals based on feedback, completing required documentation, and ensuring alignment with strategic, operational and financial considerations. Success will be demonstrated through Programme Board approval of all first tranche service change proposals and confirmation of readiness for wider Health Board governance approvals and implementation planning.	G2 G7	A3	Executive Medical Director	**Q4** **Moderate Delivery Confidence** **Last Update: Aug 26**
4G.9	Develop a robust benefits framework for the programme, which allows for the effective measurement of activity and resources linked to VBHC (clinical staff, administrative staff, budgets, buildings,	G6	A1 A2	Executive Director of Finance	**Q1** **(Complete)**

	energy etc) to improve patient outcomes, patient experience and resource efficiency to ensure value and patient-centred care.				
4G.12	Deliver a refreshed Value & Sustainability programme that realises the agreed recurrent savings target for 26/27, aligned with the national value and sustainability structure and associated priorities and which also ensures that savings and mitigations delivered in 2025/26 are maintained in full on a recurrent basis.	G6	A1 A2 A5	Executive Director of Finance	**Q4** **High Delivery Confidence** **Last Update: Jul 26**
4I.5	Agree the approach to developing a revised Estates Strategic Plan, in line with the Health Board's 10-year Strategy and Clinical Services Plan.	G3 G7	A3	Director of Environment & Estates	**Q4** **Moderate Delivery Confidence** **Last Update: Aug 26**
4J.7	Implement in partnership strategic workforce planning across the organisation, improving alignment with Clinical Service Plans, use of technology, Financial Plans linked to IMTP objectives. Progress will be measured through the Foundations for the Future programme board. Plans will proactively identify any workforce capacity, skills and talent gaps and set out initiatives to address these in order to meet organisational objectives.	G8	A3	Executive Director of People Services & Organisational Development	**Q4** **High Delivery Confidence** **Last Update: Sep 26**
4K.1	Maintain financial control measures from start of financial year, with a view to step them down as assurance and confidence is being gained in delivery of the financial plan. Particularly important due to FFTF structure changes mid-year that could otherwise cause some disruption in delivery of financial plan.	G1 G6	A4 A5	Executive Director of Finance	**Q2** **Low Delivery Confidence** **Last Update: Sep 26**
4K.2	Contribute to the broader performance accountability agreements to ensure		A4	Executive Director of Finance	**Q1** **(Complete)**

	that budget owners are clear on their budget for the year and their accountabilities in relation to delivery within budget.				
4K.13	Prepare and commence execution of a robust and sustainable recovery plan, as detailed within Standing Financial Instructions, following submission of an in year deficit outturn	G1 G6	A4 A5	Executive Director of Finance	**Q3** **High Delivery Confidence** **Last Update: Jul 26**

BAF Risk	Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range	Status of Actions at mapping	Strategic intent Priority	Mapped deliverable	BAF 26_03 – Failure to Improve access, outcomes and experience	BAF 26_04 Failure to deliver and create a modern, people centred heath care system that is future focused
BAF24-02: Not Delivering Strategic Development and Digital Transformation	Senior Posts for reviewing Digital architecture and EHR. Funding for Architecture and EHR Teams is temporary and has been sourced from various non-recurrent budgets. Teams likely to have to stand down from April 2025 onwards and therefore progress halted (subject to budget setting process). NB. This is a 3-to-5-year piece of work. Activity which is required by 31st March 2025 will be completed. Senior Architecture posts in place but funded non-recurrently. These are resolving clinical system integration, which will also halt on the 31/03/2026 should recurrent funding not be secured.	Overdue	4D – Digital, Data & Intelligence 4C – Clinical Services Planning	• 4D.19 Review and update Digital Roadmap • 4D.15 Decommission legacy unsupported systems • 4D.16 Strategic Outline Case for digitisation of patient records • 4C.1–4C.4 CSP methodology & alignment of digital requirements		X
BAF24-02: Not Delivering Strategic Development and Digital Transformation	Roll-out of key priority EHR transformation projects. No funding from April 2025 onwards, to progress EHR Programme and other augmentation projects to improve the current digital environment. NB. This is a 3-to-5-year piece of work. The Electronic Health Record (EHR) – Acute and Community, Outline Business Case (OBC) first draft was handed over from the external consultants in March 25, the OBC has been updated following engagement with legal, finance, procurement and DDaT. Currently, there is no funding to progress this further, and Welsh Government have asked all Health Boards to pause while they agree a national approach. The Mental Health EHR is progressing with the procurement evaluation complete. Once assurance activities have been completed the next step will be to finalise the Full Business Case (FBC) and award contract following board approval. A strategic outline case for the scanning plan is being prepared, with anticipated submission for formal approval in April 2026 via the appropriate governance board.	Progressing	4D – Digital, Data & Intelligence 3D – Mental Health & Learning Disabilities	• 4D.19 Digital Roadmap alignment to 10-year Strategy & CSP • 4D.11–4D.12 Population Health Management datasets • 3D.9 Mental Health EHR transformation	X	X
BAF24-02: Not Delivering Strategic Development and Digital Transformation	Transformation of the DDaT Operating Model. Proposals for 2025/26 onwards are being progressed for consideration. Due to significant digital inflation, plans have been put forward and are currently being considered in line with other inflationary pressures. Bids for growth are being revised to align with IMTP Planning processes Anticipated position and due date will be 30th April 2026	Delayed	4D – Digital, Data & Intelligence 4A – Foundations for the Future	• 4D.1 Demand & capacity tools for digital • 4D.19 Digital Roadmap alignment • 4A.1–4A.7 Foundations for the Future: new operating model design		X

BAF24-02: Not Delivering Strategic Development and Digital Transformation	Proposals, (repeated from previous years) for 2025/26 onwards are being progressed for consideration. Cost Pressures and Growth proposals submitted to Executive Team for consideration. Only RIGA 1 additional funding resource received which doesn't take into consideration the required cost pressures or growth initiatives. Will continue to review funding gaps and available schemes.	Overdue	4K – Finance & Commissioning 4G – Value & Sustainability	4K.1 Financial control measures • 4K.2 Accountability agreements • 4G.12 Recurrent savings realisation • 4G.3 Address clinical variation & resource efficiency		X
BAF24-02: Not Delivering Strategic Development and Digital Transformation	Expand the implementation of the Digital Training Academy enhancing the skills and understanding of clinical and non-clinical systems and O365 tools.	Progressing	4D – Digital, Data & Intelligence	• 4D.13 Digital Skills Assessment • 4D.14 Data literacy & "Making Data Count" training offer		X
BAF24-02: Not Delivering Strategic Development and Digital Transformation	Implement and ensure Executive Decision and oversight of the Digital Prioritisation of projects and programmes in line with IMTP and Funding Arrangements.	Progressing	4D – Digital, Data & Intelligence 4B – Strategy & Planning	4D.19 Roadmap integration with Strategy & CSP • 4B.1–4B.3 Strategy Discovery & Design phases		X
BAF24-02: Not Delivering Strategic Development and Digital Transformation	Develop phase 2 of the Clinical Services Plan for implementation - a blueprint for services across North Wales	Progressing	4B – Strategy and Planning 4C - Clinical Services Planning	4B1, 2, 3 & 4B5 – 11 4C1, 2, 3, 4		X
BAF24-03: Not Achieving Long Term Financial Sustainability	Decarbonisation reporting of key objectives through to Committee (PPHP) completed, articulating goals and objectives through to Health Board. Revised NHS Wales decarb plan was published in 2025 and is currently under review. Health Board then to draft plan and an action plan.	Delayed	4I – Environment & Estates	• 4I.10 Development of BCUHB Climate Adaptation Plan • 4I.11 REFIT / carbon-reduction grant funding access • 4I.12 Renewable energy implementation (e.g., PV array) 4I.7 4I.5		X
BAF24-03: Not Achieving Long Term Financial Sustainability	Ongoing development of Estates strategy to be informed by completion of a reduced facet survey (to reflect unallocated budget), a register of assets and most importantly clinical strategies (this review of estates is likely to take 12 months) and will be used to drive estate utilisation and rationalisation. At present, this is delayed pending clinical service plans.	Delayed	4I – Environment & Estates 4C – Clinical Services Planning	• 4I.5 Revised Estates Strategic Plan aligned to 10-year Strategy & CSP • 4I.7 Estate utilisation & rationalisation improvements • 4C.1–4C.4 Clinical Services Plan methodology, prioritisation & alignment		X
BAF24-04: Not Establishing a Compassionate Culture, Leadership, Engagement and workforce capacity and capability	Prioritise implementing the workforce planning framework across the Health Board, with initial prioritisation for 'challenged services'. This action is on-going as services become familiar with the templates and the governance arrangements for the framework are embedded throughout 2026/27.	Overdue	4J – Workforce 4F – Education Partnerships	• 4J.7 Strategic Workforce Planning implementation • 4J.1–4J.4 Workforce productivity, job planning & sickness absence reduction • 4F.9–4F.10 Governance alignment of education & workforce planning		X
BAF24-04: Not Establishing a Compassionate Culture, Leadership, Engagement and workforce capacity and capability	Support the implementation of measures to aid reducing agency usage and improve value and sustainability of workforce. Progress has been made in some staff groups and now a particular focus on M&D agency is needed throughout 2026/27. The action end date will need to be extended to the end of Q4 (from 31/03/2026).	Delayed	4G – Value & Sustainability 4J – Workforce	• 4G.1–4G.12 Value & Sustainability (clinical variation, workforce efficiencies) • 4J.2–4J.3 Reduce agency spend & improve workforce sustainability • 4J.7 Strategic Workforce Planning implementation		X

BAF24-04: Not Establishing a Compassionate Culture, Leadership, Engagement and workforce capacity and capability	Implementing Values and Behaviours Framework. The V&B framework has been implemented, additional actions will be agreed to further embed and enhance its adoption, these will be added to the BAF in the coming weeks.	Overdue	4A – Foundations for the Future 4J – Workforce 4C – Clinical Leadership	• 4A.1 Culture, Leadership & Engagement programme • 4J.5–4J.6 Culture, engagement & behavioural improvement actions • 4C.9–4C.10 Interprofessional team working & leadership behaviours		X
BAF24-04: Not Establishing a Compassionate Culture, Leadership, Engagement and workforce capacity and capability	Embedding Integrated Leadership Development Framework. Three of the four programmes have already been written and launched. The remaining program pilot will be developed by the end of Q2 and the expected launch will be Q426/27. The ILDF framework will be reviewed by the Executive Committee in Q1 2026/27 to ensure it remains strategically aligned to the IMPT. The end date for action will be extended to end of September 2026 (from 31/03/2026).	Delayed	4C – Clinical Services Planning & Leadership 4A – Foundations for the Future 4J – Workforce	• 4C.5–4C.8 Clinical leadership roles, training & capability • 4A.1 Leadership culture & organisational development • 4J.5 Leadership & engagement improvement programme		X
BAF24-04: Not Establishing a Compassionate Culture, Leadership, Engagement and workforce capacity and capability	Developing Anchor Institute Framework – ongoing, draft Anchor Charter developed with partners and being formally discussed at regional wellbeing and anchor charter event on 19.03.26.	Overdue	1C – Health Inequalities / Anchor Institute Partnership & Regional Collaboration	• 1C.6 Anchor principles & missions implementation (Environment, Communities, Housing, Employment, Food, Learning, Creative & Active Lifestyles) • Section 5 – Working with Partners: strengthening regional collaboration & social value frameworks		
BAF24-04: Not Establishing a Compassionate Culture, Leadership, Engagement and workforce capacity and capability	Citizen Engagement Plan being reviewed – the draft principles and framework developed – Co-production, Engagement and Consultation Toolkit developed, Principles and Framework to be discussed at Executive Group Meeting before end of April 2026.	Progressing	3B – Citizen Engagement 4A – Foundations for the Future 4B – Strategy & Planning	• 4A.12 Partner engagement in operating model • 4B.1–4B.4 Embedding engagement into IMTP & Strategy processes	X	X
BAF24-04: Not Establishing a Compassionate Culture, Leadership, Engagement and workforce capacity and capability	Communications and engagement plan November 2025 to post Senedd election 2026 addressing progress to date and areas of Board focus in the months ahead – plan in development, overseen by the Chief Executive Officer.	Progressing	3B – Citizen Engagement 4A – Foundations for the Future 4B – Strategy & Planning	• 4B.2–4B.3 Strategic design & delivery – embedding public voice 4B.4, 4B7	X	X
BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Learning Repository Development – A Project Group oversees governance, strategic alignment, and accountability for the wider rollout by 31st April 2026. (Delayed from 31/11/2025)	Delayed	4H – Quality	• 4H.13 Implementation of learning repository & embedding organisational learning		X
BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Harms review process to be approved for planned care activity.	Overdue	3B – Planned Care 4H – Quality 4C – Clinical Services Planning	• 4H.1–4H.3 Quality Management System & governance framework development	X	X

BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Diabetes Pathway Programme – completion of case for change and next steps agreed - delay in appointing Clinical Lead however this has now gone out for expressions of interest. There have been some revisions to the plan as a result and also in keeping with wider priority programmes including Primary Care. Completion of the Diabetes Pathway Programme case for change has been completed however the overall implementation of the programme has been delayed in 25.26 due to dependencies, including the appointment of a Clinical Lead. The plan has been revised to align with wider priorities, and the completion date has moved from July 2025 to December 2026.	Delayed	1B – Disease Prevention 2A Primary Care 2B Community by Design 4G – Value & Sustainability 4C – Clinical Services Plan 4D – Population Health Management	• 1B.4–1B.7 Diabetes pathway (care processes, variation reduction, best practice) 2A.5 integrated primary & Community care 2B.1 -4 Community by Design (mapping, planning, delivery) • 4G.2 High Value/High Impact Diabetes Pathway • 4C.1-4 CSP alignment with disease pathways 4D.11-12 Population health intelligence		X
BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Deliver Primary Care based approaches to improving the compliance with NICE guidance. Awaiting update and revised date from Primary Care leads.	Overdue	2A – Primary Care 2B – Community by Design 1B – Disease Prevention 4H – Quality 4C – Clinical Services Plan	Incomplete improvement in NICE compliance; requires strengthened primary-community-secondary integration and clearer pathways.		X
BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Prevention embedded in Board Major Programmes.	Overdue	1A–1D – Prevention & Inequalities 4B – Strategy & Planning 4C – Clinical Services Plan 4G – Value Based Healthcare	• 1A–1D Prevention, Health improvement, Health Inequalities, Health Protection • 4B.1–4B.3 Strategy & IMTP alignment • 4C.1 CSP methodology – embedding prevention & PHM 4G.10 Respond to key population health intelligence		X
BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Development of Clinical Services Plan and Health Board Strategy recognises prevention as component part. Development of the Clinical Services Plan and Health Board Strategy, which incorporates prevention as a key component, has been delayed due to dependencies on preceding work. The completion date has moved from March 2025 to December 2026.	Delayed	1A-D Prevention & inequalities 4C – Clinical Services Planning 4B – Strategy & Planning 4D – Population Health Management 4I – Environment & Estates	1A-D Prevention, Health improvement, Health Inequalities, Health Protection • 4C.1–4C.4 Clinical Services Plan development & prioritisation • 4B.1–4B.3 10-year Strategy Discovery/Design/Delivery 4D.11-12 Population health intelligence • 4I.5 Estates Strategy alignment to CSP		X
BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Increased pathways with Primary care. Primary Care Service Transformation Delivery group has progressed with work completed outlining system challenges to inform next steps. On track but will be ongoing.	Delayed	3D MHLD 2A – Primary Care 4C – Clinical Leadership	• 3D.3 - Agree and develop with partners • 2A.5 Integrated primary & community pathways • 4C.9–4C.10 Interprofessional working	X	X

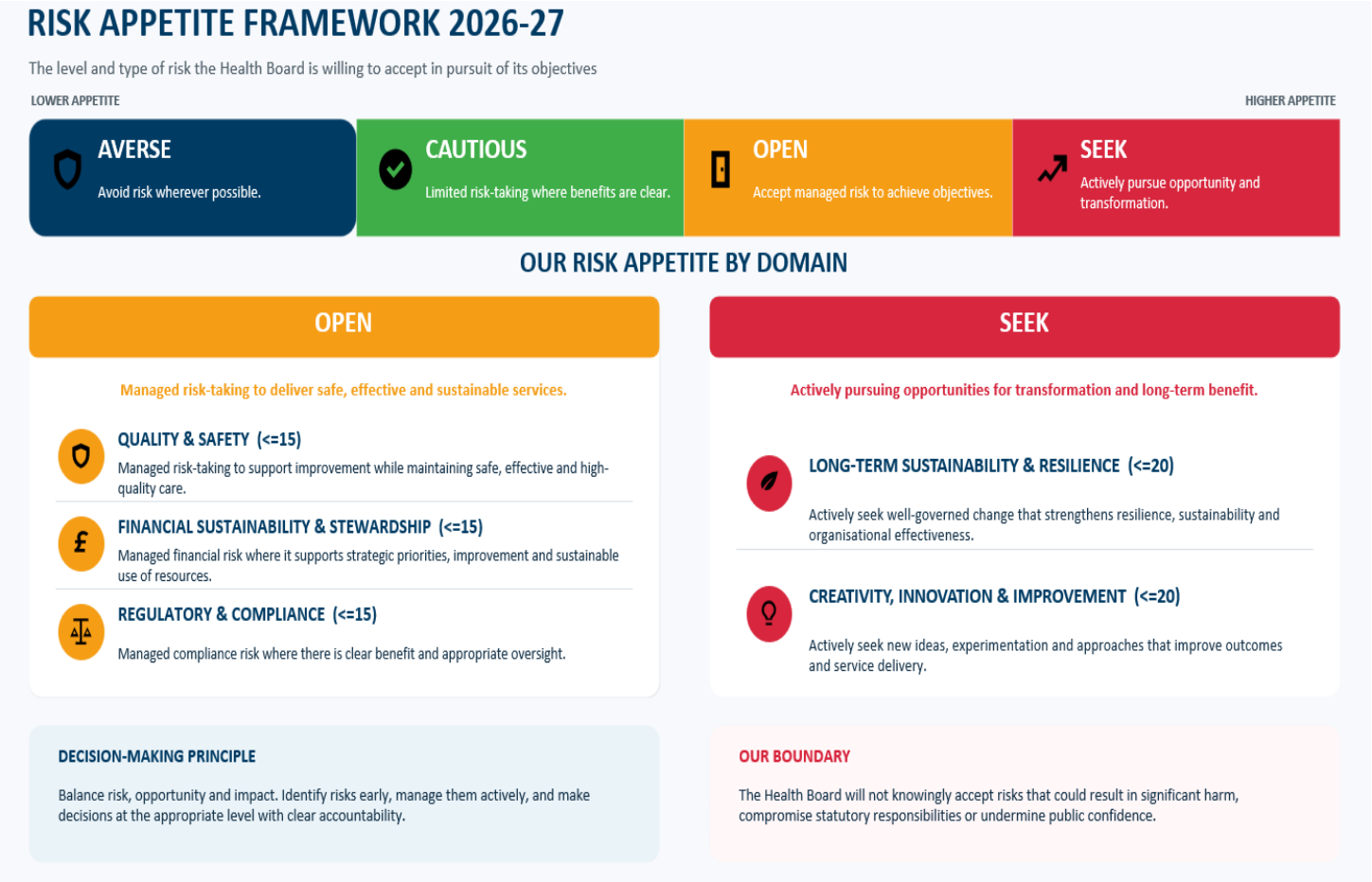
BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Electronic Health Record programme with MHLD as early adopter. Procurement concluded - assurance activity underway for award of contract. Implementation will be impacted by contract award timescales; this may impact the control completion date, but measures are being into place to mitigate this.	Overdue	4D – Digital, Data & Intelligence 3D – Mental Health & LD	• 4D.19 Digital Roadmap • 4D.6–4D.8 Coding, AI & data quality improvements • 3D.9 MHLD EHR programme rollout	X	X
BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Enhanced Savings plans. OOA/ CHC remain the well documented risks here for delivery, but plans are progressing well.	Overdue	3D MHLD 4G – Value & Sustainability 4K – Finance & Commissioning	3D.5 - Deliver a material reduction 4G.1–4G.12 Value & Sustainability Programme 4K.1–4K.3 Financial control & commissioning improvements	X	X
BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Capping OOA bed utilisation	Overdue	3D – Mental Health & LD 4G – Value & Sustainability	3D.5 Reduction in out-of-area placements • 4G.12 Financial sustainability & reducing unwarranted cost variation	X	X
BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Continued implementation of waiting list protocol to ensure patients are supported whilst waiting.	Progressing	3D MHLD	3D.3 agree & develop with partners a phrased open access MH service model	X	
BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Alignment with Learning Disabilities national programme- Improving Care Improving lives review.□ The LD transformation programme covers ECRS, Inpatient and Community Services and is fully aligned to the NHS P&I National improvement works. Improvements are project managed through service and divisional governance as well as the national programme. Progress to date includes successful roll out and uptake of Paul Ridd disability awareness training across BCU (not just LD services), introduction of the Health Equalities Framework (HEF) outcomes measure to support identifying health inequalities for people with a learning disability.	Overdue	3D – Mental Health & Learning Disabilities 4C – Clinical Services Planning & Interprofessional Leadership	3D.6–3D.7 MHLD improvement actions including health inequalities reduction, crisis response, • 4C.1–4C.4 CSP methodology & redesign of challenged services	X	X
BAF24-07: Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk	Use of data analytics to identify high-risk populations (completed) and optimise resource allocation, as a part of workstream one, needs aligning to enhanced community care Priorities agreed for primary and community transformation led by DPH, EMD and COO.	Overdue	4D – Digital, Data & Intelligence 1B – Proactive Strategies for Prevention	• 4D.1 Demand & capacity modelling tools • 4D.11–4D.12 Population Health Management intelligence • 1B.1–1B.3 Population health & prevention roadmap		X

BAF24-07: Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk	Deployment of live dashboards for real-time monitoring (complete) of performance and governance metrics. Standardise data collection and reporting processes to reduce variability in decision-making. Review of various dashboards to align input criteria and date. Data quality and alignment to data dictionary review ongoing. Dashboard designs work ongoing. Design phase to be complete by 31/07/2025. Once designed, build and deployment to take place with timescale tbc. Dashboard completed and information now used in UEC programme management, further work to continue moving forward as we develop SPoA This is on track. Due date extended to 30/09/2026 from June 2026.	Progressing	4D – Digital, Data & Intelligence	4D.13–4D.14 Digital & data skills improvement 4D.6–4D.8 Coding & data quality improvements 4D.19 Digital Roadmap alignment		X
BAF24-07: Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk	Strengthen digital capabilities to support service teams (such as e-triage, further roll out of home adaptations particularly rural areas, single patient tracking lists). Align digital plan to UEC plans. Alignment of plans consistent with revised prioritisation. Work underway to improve digital interface with UEC. WECDS has just been updated to enhance the data collection for ED's.	Overdue	4D – Digital, Data & Intelligence	4D.19 Digital Roadmap • 4D.15–4D.16 Legacy system reduction & digital records • 4D.5 RPA & automation opportunities		X
BAF24-07: Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk	Standardising care pathways across the Health Board. Current mapping exercise. Sits within clinical service strategy, community health pathways being rolled out for development in elective care. SPoA 'operational 'phase is commencing in Q1. There are clear performance metrics and expectations assigned to the developments into 2026/27	Overdue	3A – Urgent & Emergency Care 3B – Planned Care 4C – Clinical Services Planning	3A.4–3A.12 UEC care pathway redesign • 4C.1–4C.4 CSP methodology & service redesign 3B.2 Planned care 3B.5 Planned care	X	X
BAF24-07: Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk	Re-enforce specialty level planning cycle through service line demand and capacity plan across the Health Board. Reinforced with services, complete. To be evidenced in April 2026 through Plans. Demand & capacity (D&C) planning session held in April to review core demand and capacity planning across specialties within Q1 to confirm the position for 2026/27. A further session is scheduled in May with a specific focus on Cancer and Diagnostics to enable more detailed discussions on demand and capacity for 26/27. This will be supported by a 'planned care sprint' to improve booking of long waiters into core capacity and transfers of care to appropriate services	Overdue	Awaiting mapping	Awaiting mapping		
BAF24-07: Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk	Strengthened workforce planning for key areas linked to challenged services.	Overdue	4J – Workforce 4A – Foundations for the Future	• 4J.7 Strategic workforce planning • 4J.1–4J.4 Workforce productivity controls • 4A.1 Leadership, culture & engagement improvement		X

BAF24-07: Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk	Telehealth care to strengthen out of hospital care including home systems and video facilitated care forms workstream 1 or 4 for UEC.	Overdue	2A – Primary Care 1B – Prevention 4D – Digital, Data & Intelligence	2A.8 Digital innovation in primary care (NHS app, virtual care) • 1B.3 Preventive digital interventions • 4D.19 Digital Roadmap		X
BAF24-07: Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk	Continued efforts to further strengthen collaboration with local authorities and voluntary sectors for integrated care delivery models. Milestones to be reported. Operational workshop to be held in May with health & Social care partners to discuss development of a 12 month plan for implementation	Overdue	Awaiting mapping	Awaiting mapping		
BAF24-07: Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk	Incorporate public health needs analysis to service planning (such as deprivation links to access for UEC, Planned Care, CAMHS and Womens services).	Overdue	1B.1–1B.3 PHM intelligence • 4B.1–4B.3 Strategy Discovery/Design/Delivery • 3A.1–3A.3 UEC prevention & falls pathways 4C.1-4C.4	• 1B – Population Health 4B – Strategy & Planning 4C Clinical Services Plan 3A – UEC	X	X
BAF24-07: Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk	Regional improvement approach for Child and Adolescent Mental Health (CAMHS)and Childrens Neurodevelopmental Services. CAMHS Improvement Plan revised for 2026/27 to sustain delivery of the Mental Health Measure access targets which the HB achieved in 2026/27 for assessment and intervention. The Childrens ND 3-year improvement plan has been agreed with RPB to implement a needs-led Childrens ND delivery model across health, social care and education. Confirmation of WG funding allocation (£2m) 26-27 for ND assessments, received in April. Approval from Exec Committee & PFIG subsequently confirmed for the continued use and extension of the private provider contract for children's ND assessments to support delivery against WG expectations for 2026/27.	Overdue	3E – CAMHS & ND 3D – MHLD 4C – Clinical Leadership & CSP 1A - Preventative Approaches to Health & Wellbeing 4B - Strategy & Planning	3E.1–3E.6 CAMHS & ND redesign • 3D.9 EHR for MHLD • 4C.3 CSP alignment with challenged services 1A.3 Deliver approved Grant Funded Programmes of work (WSA) 4B.5 Draw on support for NHS P&I colleagues	X	X

BAF24-08: Not Implementing Evidenced Based Improvement and Innovation	Develop a model for Cancer Referrals and activity for single modality. Work is continuing with cancer services looking at breast pathways. Stage 1 demand for all tumour sites has been assessed against ringfenced capacity to incorporate into Referral to Treatment demand and capacity work, linked to workstream 6 of the Planned Care Programme. Due to operational challenges and the complexity of cancer pathways and associated data, current focus is on short term operational forecasting and we will with colleagues from NHS Performance & Improvement to develop longer term (annual and beyond) forecasting tools for the cancer pathways. Revised due date 30/06/2026 from 30/11/2025)	Delayed	3B – Planned Care, Cancer & Diagnostics 4D – Digital, Data & Intelligence	• 3B.7–3B.15 Cancer pathway optimisation & diagnostics modernisation • 4D.1 Demand & capacity modelling • 4D.10 Transition to cloud analytics	X	X
BAF24-08: Not Implementing Evidenced Based Improvement and Innovation	Strengthen collaborative research projects with university partners. Draft 'Research Strategy on a Page' developed with Bangor University for consideration by the BU & BCUHB Strategic Steering Group which is due to meet on 8th May 2026. Action delayed from 31/03/2025 to 31/05/2026	Delayed	4E – Research, Development & Innovation	• 4E.1–4E.5 Research, Development & Innovation strategic plan, joint appointments & academic partnerships		X
BAF24-08: Not Implementing Evidenced Based Improvement and Innovation	Strengthen academic career pathways with universities Academic Careers Community of Interest Working Group has been established and draft framework developed. The community of Interest is to be established during 2026/27. The development of this is to be supported by focus groups and workshops approach. A paper for the consideration of Executive Committee was considered on 4th March 2026 and agreement reached regarding support pending a further paper with a business case approach describing anticipated benefits and costs. Delayed from 31/03/2025 to 31/05/2026.	Delayed	4F – Education Partnerships & Academic Careers	• 4F.7–4F.11 Academic careers framework; governance for strategic education planning; HEI partnerships		X

BAF24-08: Not Implementing Evidenced Based Improvement and Innovation	Strengthen collaboration with Higher and Further Education partners across North Wales Memoranda of Understanding have been developed with Bangor and Wrexham Universities as well as Group Llandrillo Menai and College Cambria. Signing is complete apart from CC which is expected to take place in April/May. Strategic Steering Groups are in place with Bangor, Wrexham and GLIM with arrangements to follow with CC in April/May. The collaborative partnerships will progress and mature during the course of 2026/27.	Progressing	4F – Education Partnerships & Academic Careers	• 4F.1–4F.6 HE/FE partnerships; Medical School & Dental School collaboration; MoU implementation		X
BAF24-08: Not Implementing Evidenced Based Improvement and Innovation	Increase R&D collaboration with industry and academic institutions. MoUs have been developed as described above. Collaborations with industry have resulted in a number of joint bid applications to i4i, Contracts for Innovation and NIHR. BCU staff have presented nationally at events such as BioWales London, Cancer innovation.	Overdue	• 4E.2–4E.5 Innovation Centre development; external funding; research activity expansion	4E – Research, Development & Innovation		X
BAF24-08: Not Implementing Evidenced Based Improvement and Innovation	Secure additional funding for healthcare innovation projects. A number of grant applications are being developed or are awaiting decision from funders. To date funding has been secured from Welsh Government Innovation and from Contracts for Innovation.	Overdue	• 4E.2 Innovation Centre & funding model • 4E.4 Growth of research studies and income	4E – Research, Development & Innovation		X
BAF24-08: Not Implementing Evidenced Based Improvement and Innovation	Increase the number of joint appointments between the Health Board and academic institutions. A number of honorary appointments have been awarded, and a joint research fellow post has been appointed to. A joint research fellow post in cardiology is in progress. We are awaiting decision regarding readvertising the joint post in cancer services.	Overdue	• 4F.7–4F.11 Academic careers pathways & joint roles • 4E.3–4E.5 Embedding research into clinical roles	4F – Academic Careers 4E – Research, Development & Innovation		X



Risk Appetite

2026-2027

RISK APPETITE STATEMENTS 2026/27

1. Quality & Safety	Appetite: OPEN (≤15)
The Health Board is committed to delivering safe, effective and high-quality care. We recognise that service improvement and transformation involve some degree of risk and are prepared to accept managed risks where there is a clear benefit to patients, services or outcomes. Quality and safety risks will be identified, monitored and managed through appropriate controls and assurance arrangements. We will not knowingly accept unmanaged risks or avoidable harm arising from poor decision-making or inadequate controls.	
2. Financial Sustainability & Stewardship	**Appetite: OPEN (≤15)**
The Health Board has a statutory responsibility to achieve financial balance and ensure good stewardship of public resources. We are prepared to accept managed financial risks where they support strategic objectives, service improvement, innovation or long-term sustainability. Financial risks will be actively managed and balanced against quality, workforce and performance considerations. We will not knowingly accept unmanaged financial risks that threaten service delivery, financial resilience or statutory responsibilities.	
3. Regulatory & Compliance	**Appetite: OPEN (≤15)**
The Health Board recognises that some regulatory and compliance risk is unavoidable when delivering complex healthcare services and transformational change. We are prepared to accept managed risks where there is a clear organisational, service or patient benefit. We will seek to comply with all legal, statutory, regulatory and professional requirements and proactively manage areas of non-compliance. We will not knowingly accept risks that could result in significant harm, regulatory sanctions, governance failure or loss of public confidence.	
4. Long Term Sustainability	**Appetite: SEEK (≤20)**
The Health Board actively seeks opportunities to strengthen long-term sustainability, resilience and organisational effectiveness. We recognise that achieving sustainable services requires transformation, innovation and a willingness to challenge established ways of working. We are prepared to accept higher levels of managed risk where this supports long-term sustainability and improved outcomes for patients, staff and communities. We will not knowingly accept risks that could result in significant harm, compromise statutory responsibilities or undermine safe and effective service delivery.	
5. Creativity & Innovation	**Appetite: SEEK (≤20)**
The Health Board actively seeks opportunities for creativity, innovation and continuous improvement. We recognise that improving outcomes and transforming services requires new ideas, experimentation and responsible risk-taking. We are prepared to accept higher levels of managed risk where there is clear potential to improve services, outcomes or organisational effectiveness. We will not knowingly accept risks that could result in significant harm, compromise statutory responsibilities or undermine public confidence.	

STANDING ORDERS

Scheme of Reservation and Delegation of Powers

(Schedule 1 of the Standing Orders)

SCHEME OF RESERVATION AND DELEGATION OF POWERS

This Schedule forms part of, and shall have effect as if incorporated in the Local Health Board Standing Orders

Date approved by Health Board:

MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS

Introduction

As set out in Standing Order 2, the Board, subject to any directions that may be made by the Welsh Ministers, shall make arrangements for certain functions to be carried out on its behalf so that the day to day business of the LHB may be carried out effectively, and in a manner that secures the achievement of its aims and objectives. The Board may delegate functions to:

i) A Committee, e.g., Performance, Finance and Information Governance Committee (PFIG);

ii) A sub-Committee, e.g., a locality based Performance, Finance and Information Governance (PFIG) Committee taking forward matters within a defined area. Any such delegation would, subject to the Board's authority, usually be via a main Committee of the Board;

iii) A joint-Committee or joint sub-Committee, e.g., with other LHBs or Local Authorities established to take forward matters relating to services; and

iv) Officers of the LHB (who may, subject to the Board's authority, delegate further to other officers and, where appropriate, other third parties, e.g., shared/support services, through a formal scheme of delegation)

and in doing so, must set out clearly the terms and conditions upon which any delegation is being made. These terms and conditions must include a requirement that the Board is notified of any matters that may affect the operation and/or reputation of the LHB.

The Board's determination of those matters that it will retain, and those that will be delegated to others are set out in the following:

- Schedule of matters reserved to the Board;
- Scheme of delegation to Committees and others; and
- Scheme of delegation to officers.

all of which must be formally adopted by the Board in full session and form part of the LHB's SOs.

DECIDING WHAT TO RETAIN AND WHAT TO DELEGATE: GUIDING PRINCIPLES

The Board will take full account of the following principles when determining those matters that it reserves, and those which it will delegate to others to carry out on its behalf:

- Everything is retained by the Board unless it is specifically delegated in accordance with the requirements set out in Standing Orders or Standing Financial Instructions.

- The Board must retain that which it is required to retain (whether by statute or as determined by the Welsh Ministers) as well as that which it considers is essential to enable it to fulfil its role in setting the organisation's direction, equipping the organisation to deliver and ensuring achievement of its aims and objectives through effective performance management

- Any decision made by the Board to delegate functions must be based upon an assessment of the capacity and capability of those to whom it is delegating responsibility

- The Board must ensure that those to whom it has delegated powers (whether a Committee, partnership or individuals) remain equipped to deliver on those responsibilities through an ongoing programme of personal, professional and organisational development

- The Board must take appropriate action to assure itself that all matters delegated are effectively carried out

- The framework of delegation will be kept under active review and, where appropriate, will be revised to take account of organisational developments, review findings or other changes

- Except where explicitly set out, the Board retains the right to decide upon any matter for which it has statutory responsibility, even if that matter has been delegated to others

- The Board may delegate authority to act, but retains overall responsibility and accountability

- When delegating powers, the Board will determine whether (and the extent to which) those to whom it is delegating will, in turn, have powers to further delegate those functions to others.

HANDLING ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS: WHO DOES WHAT

The Board

The Board will formally agree, review and, where appropriate revise schedules of reservation and delegation of powers in accordance with the guiding principles set out earlier.

The Chief Executive

The Chief Executive will propose a Scheme of Delegation to Officers, setting out the functions they will perform personally and which functions will be delegated to other officers. The Board must formally agree this scheme.

In preparing the scheme of delegation to officers, the Chief Executive will take account of:

- The guiding principles set out earlier (including any specific statutory responsibilities designated to individual roles);
- Their personal responsibility and accountability to the Chief Executive, NHS Wales in relation to their role as designated Accountable Officer; and
- Associated arrangements for the delegation of financial authority to equip officers to deliver on their delegated responsibilities (and set out in Standing Financial Instructions).

The Chief Executive may re-assume any of the powers they have delegated to others at any time.

The Director of Corporate Governance

The Director of Corporate Governance will support the Board in its handling of reservations and delegations by ensuring that:

- A proposed schedule of matters reserved for decision by the Board is presented to the Board for its formal agreement;
- Effective arrangements are in place for the delegation of LHB functions within the organisation and to others, as appropriate; and
- Arrangements for reservation and delegation are kept under review and presented to the Board for revision, as appropriate.

The Audit Committee

The Audit Committee will provide assurance to the Board of the effectiveness of its arrangements for handling reservations and delegations.

Individuals to who powers have been delegated

Individuals will be personally responsible for:

- Equipping themselves to deliver on any matter delegated to them, through the conduct of appropriate training and development activity; and
- Exercising any powers delegated to them in a manner that accords with the LHB's values and standards of behaviour.

Where an individual does not feel that they are equipped to deliver on a matter delegated to them, they must notify the Chief Executive or the Director of Corporate Governance of their concern as soon as possible in so that an appropriate and timely decision may be made on the matter.

In the absence of an officer to whom powers have been delegated, those powers will be exercised by the individual to whom that officer reports, unless the Board has set out alternative arrangements.

If the Chief Executive is absent their nominated Deputy may exercise those powers delegated to the Chief Executive on their behalf. However, the guiding principles governing delegations will still apply, and so the Board may determine that it will reassume certain powers delegated to the Chief Executive or reallocate powers, e.g., to a Committee or another officer.

SCOPE OF THESE ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS

The Scheme of Delegation to officers referred to here shows only the "top level" of delegation within the LHB. The Scheme is to be used in conjunction with the system of control and other established procedures within the LHB.

SCHEDULE OF MATTERS RESERVED TO THE BOARD[1]

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
1	FULL	GENERAL	Board may determine any matter for which it has statutory or delegated authority in accordance with SOs (except for those decisions delegated to the NHS Wales Joint Commissioning Committee (the JCC)).
2	FULL	GENERAL	The Board must determine any matter that will be reserved to the whole Board. These will be set out within Schedule of Matters Reserved to the Board.
3	FULL	GENERAL	Approve the LHB's Governance Framework
4	FULL	OPERATING ARRANGEMENTS	Approve, vary and amend: ▪ Standing Orders; ▪ Standing Financial Instructions; ▪ Schedule of matters reserved to the LHB; ▪ Scheme of delegation to Committees and others; and ▪ Scheme of delegation to officers. In accordance with any directions set by the Welsh Ministers.
5	FULL	OPERATING ARRANGEMENTS	Ratify any urgent decisions taken by the Chair and the Chief Executive in accordance with Standing Order requirements
6	NO – Audit Committee	OPERATING ARRANGEMENTS	Formal consideration of report of Director of Corporate Governance on any non-compliance with Standing Orders, making proposals to the Board on any action to be taken.

[1] Any decision to reserve a matter, and the manner in which that retained responsibility is carried out will be in accordance with any regulatory and/or Welsh Government requirements.

7	FULL	OPERATING ARRANGEMENTS	Receive report and proposals regarding any non-compliance with Standing Orders, and where required ratify in public session any action required in response to failure to comply with SOs.
8	FULL	OPERATING ARRANGEMENTS	Authorise use of the LHB's official seal.
9	FULL	OPERATING ARRANGEMENTS	Approve the Standards of Business Conduct Policy.
10	NO - Chair on behalf of Joint Committee, Vice-Chair on behalf of Joint Committee if Chair is declaring interest	ORGANISATION STRUCTURE & STAFFING	Require, receive and determine action in response to the declaration of Board members' interests, in accordance with advice received, e.g. from Audit Committee or Director of Corporate Governance
11	FULL	STRATEGY & PLANNING	Determine the LHB's strategic aims, objectives and priorities
12	FULL	STRATEGY & PLANNING	Approve the LHB's key strategies and programmes related to: ▪ Population Health Needs Assessment and Commissioning Plan ▪ The development and delivery of patient and population centred health and care/clinical services ▪ Improving quality and patient safety outcomes ▪ Workforce and Organisational Development ▪ Infrastructure, including IM &T, Estates and Capital (including major capital investment and disposal plans)

13	FULL	STRATEGY & PLANNING	Approval of Joint Area Plan prepared under the direction of the Regional Partnership Board and in response to the population assessment
14	FULL	STRATEGY & PLANNING	Agreement of Well-being objectives in accordance with the requirements of the Well-being and Future Generations (Wales) Act 2015
15	FULL	STRATEGY & PLANNING	Approval of Well-being Plan prepared and agreed by the Public Service Board
16	FULL	STRATEGY & PLANNING	Approve the LHB's Integrated Medium Term Plan, including the balanced Medium-Term Financial Plan
17	FULL	STRATEGY & PLANNING	Approve the LHB's budget and financial framework (including overall distribution of the financial allocation and unbudgeted expenditure)
18	FULL	OPERATING ARRANGEMENTS	Approve the LHB's framework and strategy for performance management.
19	FULL	STRATEGY & PLANNING	Approve the LHB's framework and strategy for risk and assurance.
20	FULL	OPERATING ARRANGEMENTS	Ratify policies for dealing with raising concerns, complaints and incidents in accordance with the Putting Things Right and health and safety requirements.
21	FULL	OPERATING ARRANGEMENTS	Agree the arrangements for ensuring the adoption of standards of governance and performance (including the quality and safety of healthcare, and the patient experience) to be met by the LHB, including standards/ requirements determined by Welsh Government, regulators, professional bodies/others, e.g. National Institute of Health and Care Excellence (NICE)
22	FULL	STRATEGY & PLANNING	Approve the LHB's patient, public, staff, partnership and stakeholder engagement and co-production strategies.

23	FULL	OPERATING ARRANGEMENTS	Approve the introduction or discontinuance of any significant activity or operation. Any activity or operation shall be regarded as significant if the Board determines it so based upon its contribution/impact on the achievement of the LHB's aims, objectives and priorities
24	FULL	ORGANISATION STRUCTURE & STAFFING	Appointment of officer members of the Board (Chief Executive and Directors) in accordance with the provisions of the Regulations and in accordance with Ministerial Instructions
25	NO – Remuneration and Terms of Service Committee	ORGANISATION STRUCTURE & STAFFING	Termination of appointment and suspension officer members in accordance with the provisions of the Regulations and in accordance with Ministerial instructions
26	NO – Remuneration and Terms of Service Committee	ORGANISATION STRUCTURE & STAFFING	Consider appraisal of officer members of the Board (Chief Executive and Directors)

27	NO – Remuneration and Terms of Service Committee	ORGANISATION STRUCTURE & STAFFING	Approve the appointment, appraisal, discipline and dismissal of any other Board level appointments and other senior employees, in accordance with Ministerial Instructions e.g. the Director of Corporate Governance
28	NO – Remuneration and Terms of Service Committee	ORGANISATION STRUCTURE & STAFFING	Consider and approve redundancy and Early Release Applications, noting that where the settlement is £50,000 or above subsequent agreement of Welsh Government is required.
29	FULL	ORGANISATION STRUCTURE & STAFFING	Approve, [arrange the] review, and revise the LHB's top level organisation structure and corporate policies
30	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, [arrange the] review, revise and dismiss LHB Committees, including any joint-Committees directly accountable to the Board
31	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss the Chair and members of any Committee, joint-Committee or Group set up by the Board
32	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss individuals appointed to represent the Board on outside bodies and groups
33	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the standing orders and terms of reference and reporting arrangements of all Committees, joint-Committees and groups established by the Board

34	NO – Audit Committee	OPERATING ARRANGEMENTS	Approve arrangements relating to the discharge of the LHB's responsibility as a bailee for patients' property
35	FULL - except where Chapter 6 specifies appropriate to delegate to a committee, Chief Executive or Officers	OPERATING ARRANGEMENTS	Approve individual compensation payments in line with the provisions of Annex 4 to Chapter 6 of the Welsh Government Manual for Accounts
36	FULL - except where Chapter 6 specifies appropriate to delegate to a committee, Chief Executive or Officers	OPERATING ARRANGEMENTS	Approve individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and officers
37	FULL	OPERATING ARRANGEMENTS	Approve proposals for action on litigation on behalf of the LHB
38	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the arrangements relating to the discharge of the LHB's responsibilities as a corporate trustee of funds held on trust in accordance with the provision of Paragraph 20 of the Standing Financial Instructions.

39	FULL	STRATEGY & PLANNING	Approve new contracts for the LHB to provide, or to secure provision from providers for Personal Medical; Dental; Pharmacy; Optometry services to some or all of the LHB's population where the value exceeds the delegated limit of the Chief Executive
40	FULL	STRATEGY & PLANNING	Approve individual contracts (other than NHS contracts) above the limit delegated to the Chief Executive set out in the Standing Financial Instructions
41	FULL	PERFORMANCE & ASSURANCE	Approve the LHB's audit and assurance arrangements
42	FULL	PERFORMANCE & ASSURANCE	Receive reports from the LHB's Executive on progress and performance in the delivery of the LHB's strategic aims, objectives and priorities and approve action required, including improvement plans, as appropriate
43	FULL	PERFORMANCE & ASSURANCE	Receive reports from the LHB's Committees, groups and other internal sources on the LHB's performance and approve action required, including improvement plans, as appropriate
44	FULL	PERFORMANCE & ASSURANCE	Receive reports on the LHB's performance produced by external regulators and inspectors (including, e.g., Audit Wales, HIW, etc) that raise significant issue or concerns impacting on the LHB's ability to achieve its aims and objectives and approve action required, including improvement plans, taking account of the advice of Board Committees (as appropriate)
45	FULL	PERFORMANCE & ASSURANCE	Receive the annual opinion of the LHB's Chief Internal Auditor and approve action required, including improvement plans
46	FULL	PERFORMANCE & ASSURANCE	Receive the annual management report from the Auditor General for Wales and approve action required, including improvement plans

47	FULL	PERFORMANCE & ASSURANCE	Receive assurance regarding the LHB's performance against the Health and Care Standards for Wales and the arrangements for approving required action, including improvement plans.
48	FULL	REPORTING	Approve the LHB's Reporting Arrangements, including reports on activity and performance locally, to citizens, partners and stakeholders and nationally to the Welsh Government where required
49	FULL	REPORTING	Receive, approve and ensure the publication of LHB reports, including its Annual Report and annual financial accounts in accordance with directions and guidance issued

DELEGATION OF POWERS TO COMMITTEES AND OTHERS[2]

Standing Order 2 provides that the Board may delegate powers to Committees and others. In doing so, the Board has formally determined:

- the composition, terms of reference and reporting requirements in respect of any such Committees; and
- the governance arrangements, terms and conditions and reporting requirements in respect of any delegation to others, in accordance with any regulatory requirements and any directions set by the Welsh Ministers.

The Board has delegated a range of its powers to the following Committees and others:

- Audit Committee
- Charitable Funds Committee
- Mental Health Legislation Committee
- Quality, Safety and Experience Committee
- Partnership, People and Population Health Committee
- Performance, Finance and Information Governance Committee
- Executive Committee
- Remuneration Committee

The scope of the powers delegated, together with the requirements set by the Board in relation to the exercise of those powers are as set out in i) Committee terms of reference, and ii) Formal arrangements for the delegation of powers to others. Collectively, these documents form the LHB's Scheme of Delegation to Committees.

[2] As defined in Standing Orders

SCHEME OF DELEGATION TO EXECUTIVE DIRECTORS, OTHER DIRECTORS AND OPERATIONAL BUDGET MANAGERS

The LHB Standing Orders and Standing Financial Instructions specify certain key responsibilities of the Chief Executive, the Executive Director of Finance and other officers.

The Chief Executive's Job Description, together with their Accountable Officer Memorandum, sets out their specific responsibilities. The individual job descriptions determined for Executive Director level posts also define in detail the specific responsibilities assigned to those post holders. These documents, together with the schedule of additional delegations below and the associated financial delegations set out in the Standing Financial Instructions, form the basis of the LHB's Scheme of Delegation to Officers.

This element of the scheme of delegation only relates to matters delegated by the Board to the Chief Executive and the Executive Directors which are not covered by the Standing Financial Instructions.

Delegated Matter	Table Reference No.
MEETINGS	1
PERSONNEL	2
ENGAGEMENT OF STAFF (NOT ON THE ESTABLISHMENT)	3
REPORTING INCIDENTS TO THE POLICE	4
LEGAL PROCEEDINGS	5
INSURANCE POLICIES AND RISK MANAGEMENT	6
CLINICAL AUDIT	7
PUTTING THINGS RIGHT REGULATIONS	8
SEAL	9
GIFTS & HOSPITALITY	10
DECLARATION OF INTERESTS	11
INFORMATICS AND THE DATA PROTECTION ACT	12
AUTHORISATION OF NEW DRUGS	13
AUTHORISATION OF RESEARCH PROJECTS	14
AUTHORISATION OF CLINICAL TRIALS	15
INFECTIOUS DISEASES & NOTIFIABLE OUTBREAKS	16
REVIEW OF FIRE PRECAUTIONS	17
HEALTH & SAFETY	18
MEDICINES INSPECTORATE REGULATIONS	19
ENVIRONMENTAL REGULATIONS	20
COSTS/NOTIONAL RENT/THIRD PARTY DEVELOPER/IMPROVEMENT GRANTS	21
COMPLIANCE LEAD ROLES: CALDICOTT GUARDIAN, DPO, SIRO	22
EMERGENCY PLANNING	23
STATUTORY COMPLIANCE WITH RESPECTIVE LEGISLATION	24
APPOINTMENT OF MEDICAL & DENTAL CONSULTANT POSTS	25
HUMAN TISSUE ACT 2004	26
IONISING RADIATION (MEDICAL EXPOSURE) REGULATIONS 2017 [IR(ME)R]	27
NURSE STAFFING LEVELS (WALES) ACT 2016	28
WELSH LANGUAGE STANDARD REPORTING	29
CONTROLLED DRUGS ACCOUNTABLE OFFICER	30
UPHOLDING PROFESSIONAL STANDARDS IN WALES (UPSW)	31

Board Member Responsible (Tiers 2, 3 or 4): in line with the Standing Orders, delegated approval to the relevant Board Member, Board Committee, Executive Director or Executive Team member. Where there is more than one Executive ~~Director~~ Team member named the applicable responsibility is in relation to their individual service area.

Specific Delegation Where Applicable: The intention is to delegate to the Operational Divisions wherever possible, however some Matters are either delegated through a Director, Associate or Assistant then to the Operational Division, or they are not delegated beyond this secondary level. This column sets out the delegation flow where relevant. Where there is more than one 'Accountable Lead' named the applicable responsibility is in relation to their individual service area.

Operational Responsibility (Tier 4): – where Matters are delegated to the Operational Divisions, the generic term "Service Director" has been used to identify the Accountable Lead, for example IHC Director, Director of Mental Health, Cancer, and Support Functions. It is also recognised that these Matters are delegated within Health Board Policy and where relevant are directly supported by Finance, People Services and other Support Functions.

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
1. Meetings			
a) Calling meetings of the LHB	Chair	Director of Corporate Governance	Not Delegated
b) Chair all LHB Board meetings and associated responsibilities	Chair or Vice Chair in Chair's absence	Not Delegated	Not Delegated
2. Personnel			All Matters locally supported by CFO / FD / People
a) Nominate officers to enter into contracts of employment regarding staff, agency staff or consultancy service contracts in accordance with the "Policy for the Safe Recruitment and Selection Practices" together with accompanying guidance, particularly the need for pre-employment checks.	Executive Director People and OD	Supported by Members of the Executive Committee	Service Director
b) Approve the commencement of employment prior to all pre-employment checks being completed.	Executive Director People and OD	Associate Director People Services	Not delegated
c) Authority to fill funded post on the establishment with permanent staff.	Executive Director People and OD	Deputy Director Workforce & OD / Associate Di rector of People Services (IHC / PAN BCU / Support Services)	Service Director
d) Travel & subsistence expenses			
Authority to authorise travel & subsistence expenses	Executive Director People and OD	Direct to Operational Services	(Tier 4)
Maintenance of a list of managers authorised to sign payroll and travel expense documentation (and via e-expense systems)	Executive Director People and OD	Deputy Director of Workforce & OD	Service Director

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
e) Leave			
Approval of annual leave in accordance with LHB policy	Executive Director People and OD	Direct to Operational Services	Service Director
Carry-over of annual leave in exceptional circumstances up to a maximum of 5 days	Executive Director People and OD	Direct to Operational Services	(Tier 4)
Compassionate leave	Executive Director People and OD	Direct to Operational Services	Service Director
Special leave arrangements (to be applied in accordance with All Wales Policy)	Executive Director People and OD	Direct to Operational Services	Service Director
Leave without pay	Executive Director People and OD	Direct to Operational Services	(Tier 4)
Medical Staff Leave of Absence – paid and unpaid	Executive Director People and OD	Direct to Operational Services	Service Director
Consultants Special Leave	Executive Medical Director	Direct to Operational Services	(Tier 4)
Time off in lieu	Executive Director People and OD	Direct to Operational Services	Service Director
Maternity / Paternity Leave – paid and unpaid	Executive Director People and OD	Direct to Operational Services	(Tier 4)
f) Annualised hours/flexible working hours system- maintenance of adequate records	Executive Director People and OD	Direct to Operational Services	Service Director

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
g) Sick Leave			
Extension of sick leave on half pay up to three months	Executive Director People and OD	Direct to Operational Services in conjunction with Associate Director of People Services	Not delegated
Return to work part-time on full pay to assist recovery	Executive Director People and OD	Direct to Operational Services in conjunction with Associate Director of People Services	Service Director (Tier 4)
Extension of sick leave on full pay	Executive Director People and OD	Direct to Operational Services in conjunction with Associate Director of People Services	Not delegated
h) Study Leave			
Study leave outside the UK (non-medical staff excluding clinical staff)	Executive Director People and OD	Direct to Operational Services	Service Director
Medical staff study leave (UK)	Executive Medical Director / Executive Director People and OD	Direct to Operational Services	(Tier 4)
Consultant Medical Staff Leave (UK)	Executive Medical Director	Direct to Operational Services	Service Director
All Medical and non-Medical Clinical Staff study leave outside the UK (as per relevant professional lead)	Executive Medical Director / Executive Director of Nursing & Midwifery / Executive Director of Therapies & Health Science / Chief Operating Officer	Direct to Operational Services	(Tier 4)
All other study leave (UK)	Executive Director People and OD	Direct to Operational Services	Service Director

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
i) Removal Expenses			
Authorisation of payment of removal expenses incurred by officers taking up new appointments (providing consideration was promised at interview)	Executive Director People and OD	Direct to Operational Services → In accordance with BCUHB policy / approval from the Executive Director People and OD	Service Director
j) Respect & Resolution Procedure	Executive Director People and OD	Direct to Operational Services	(Tier 4)
k) Professional Misconduct/Competence-Medical and Dental Staff	Executive Medical Director / Executive Director People and OD	Deputy Responsible Officer / Deputy Medical Director / Deputy Director of Workforce & OD	Not Delegated
l) Suspension of Doctors employed directly by the LHB	Executive Medical Director	Deputy Responsible Officer / Deputy Medical Director / Deputy Director of Workforce & OD	Not Delegated
m) Formal actions as required under The Performers List	Chief Executive	Executive Medical Director supported Executive Director People and OD and Chief Operating Officer	Not Delegated to Operational Divisions, cover for Executive Medical Director provided through the Deputy Responsible Officer or Deputy Medical Director
n) Requests for new posts to be authorised as car users	Executive Director of Finance	Direct to Operational Services	Service Director
o) Renewal of Fixed Term Contract	Executive Director People and OD	Direct to Operational Services	(Tier 4)

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
p) Ill Health Retirement Decision to pursue retirement on the grounds of ill-health following advice from Workforce & OD Department	Executive Director People and OD	Associate Director of People Services	Service Director for local implementation: Ultimate Approval is via NHS Pensions Agency
q) Disciplinary Procedure (excluding Executive Directors)	Executive Director People and OD	Executive Directors and Members of the Executive Committee	Service Director (Tier 4)
3. Engagement of Staff Not On the Establishment			
a) Non clinical Consultancy Staff	Executive Director of Finance	Supported by Executive Team	Service Director
b) Medical Locum staff	Executive Medical Director	Direct to Operational Services	(Tier 4)
c) Booking of Agency Nursing Staff	Executive Director of Nursing & Midwifery	Direct to Operational Services	Service Director (Tier 4)
d) Booking of Bank Staff:			
Nursing	Executive Director of Nursing & Midwifery	Direct to Operational Services	Service Director (Tier 4)
Other Staffing Groups	Executive Director People and OD	Direct to Operational Services	Service Director (Tier 4)

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
4. Procedure to follow after reporting of incidents to the Police (refer to Standing Operating Process in relation to reporting requirement to Security Advisors)			
a) Where a criminal offence is suspected	Executive Director of Finance and Executive Director of People and OD	Direct to Operational Services	Service Director for implementation and compliance
b) Criminal offence of a sexual or violent nature	Ex Executive Director of People and OD Executive Director of Workforce & OD	Direct to Operational Services	Service Director for implementation and compliance
c) Arson or theft	Executive Director of Finance and Executive Director of People and OD	Direct to Operational Services	Service Director for implementation and compliance
d) Other	Chief Executive and Executive Director of Finance and Executive Director of People and OD	Direct to Operational Services → dependent upon the nature of the suspected offence	Service Director for implementation and compliance
5. Legal Proceedings			
a) Engagement of the LHB's Legal Services	Director of Corporate Governance	Deputy Director for Legal Services	List of officers authorised to instruct Legal Services will be detailed in the Legal Services Policy Out of Hours approval via Gold On-Call.

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
b) Approve and sign all documents on behalf of the LHB which will be necessary in legal proceedings	Director of Corporate Governance	Any Director of the Board or the Deputy Director for Legal Services provided such approval is in accordance with advice from a regulated legal professional – all contrary decisions are reserved for the Chief Executive	Not Delegated
c) Sign on behalf of the LHB any agreement or document not requested to be executed as a deed	Chief Executive	Any Executive Director of the Board or an officer formally nominated by the Chief Executive	Not Delegated
6. **Insurance Policies (incorporating Risk Management)**			
Insurance Policies (incorporating Risk Management)	Chief Executive	Executive Director of Finance and Director of Corporate Governance	Not Delegated except for matters relating to the Welsh Risk Pool where the Deputy Director for Legal Services may act
7. Clinical Audit			
Clinical Audit	Chief Executive	Executive Medical Director	Service Director (Tier 4)

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
8. Putting Things Right Regulations (in line with WRP Policy & Guidance)			
a) Overall responsibility for ensuring that all concerns (as defined in PTR Regulations) are dealt with effectively	Chief Executive	Executive Director of Nursing & Midwifery / Director of Corporate Governance (for redress, personal injury claims and clinical negligence claims)	Service Director Patient Safety Team, and Patient and Carer Experience/Complaints Team/Legal Services Team for implementation
b) Responsibility for ensuring complaints are investigated thoroughly, and learning is embedded.	Chief Executive	Executive Director of Nursing & Midwifery	Service Director and Patient and Carer Experience/Complaints Team for implementation
c) Medico – Legal Matters - Co-ordination of their management (including redress, personal injury claims and clinical negligence claims)	Director of Corporate Governance	Deputy Director for Legal Services	Legal Services Team
9. Seal			
a) The keeping of a register of seal and safekeeping of the seal	Chief Executive	Director of Corporate Governance	Not Delegated
b) Attestation of seal in accordance with Standing Orders	Chief Executive and Chair	Director of Corporate Governance	Not Delegated
c) Signing and sealing documents in accordance with Standing Orders	Chief Executive and Chair	Director of Corporate Governance	Not Delegated

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
10. Gifts and Hospitality			
a) Keeping of gifts and hospitality register	Chief Executive	Director of Corporate Governance	Service Director for implementation and compliance
11. Declaration of Interests			
a) Maintaining a register of interests	Chief Executive	Director of Corporate Governance	Service Director for implementation and compliance
12. Informatics and the Data Protection Act			
a) Review of LHB's compliance with the Data Protection Act	Chief Executive	Chief Digital and Information Officer	Data Protection Officer
b) Responsibility for Informatics policy and strategy	Chief Executive	Chief Digital and Information Officer	Service Director
c) Responsibility for ensuring that adequate management (audit) trails exist in Informatics systems	Chief Executive	Chief Digital and Information Officer	(Tier 4)

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
13. Authorisation of New Drugs			
Authorisation of New Drugs	Chief Executive	Executive Medical Director on the advice of the appropriate professional bodies (Clinical approval via NICE Implementation Group and Drugs and Therapy Group for onward financial approval by Executive Committee)	Not Delegated
14. Authorisation of Research Projects (individuals responsible for their own declaration of interest to UKPI and BCUHB)			
Authorisation of Research Projects (individuals responsible for their own declaration of interest to UKPI and BCUHB)	Executive Medical Director	Director of Research & Development	Service Director (Tier 4)
15. Authorisation of Clinical Trials			
Authorisation of Clinical Trials	Chief Executive	Executive Medical Director	Service Director (Tier 4)
16. Infectious Diseases & Notifiable Outbreaks – outbreak control / public health monitoring and surveillance / provision of public health advice			
	Chief Executive	Executive Director of Public Health	Not Delegated

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
17. Review of Fire Precautions			
Review of Fire Precautions	Chief Executive	Director of Environment and Estates	Not Delegated
18. Health & Safety			
Review of all statutory compliance legislation and Health and Safety requirements (including associated mandatory staff awareness training).	Chief Executive	Director of Environment and Estates	Not Delegated
19. Medicines Inspectorate Regulations			
Review Regulations Compliance	Chief Executive	Executive Medical Director supported by Chief Pharmacist	Service Director via Head of Medicines Management
20. Environmental Regulations			
Review of compliance with environmental regulations, for example those relating to clean air and waste disposal	Chief Executive	Director of Estates and Environment	Not Delegated
21. Cost/Notional Rent/Third Party Developer/Improvement Grants		All Matters locally supported by CFO / FD	
Approval of all schedules of payments	Chief Executive	Chief Operating Officer	Service Director (Tier 4)
Submission to Welsh Government for all new GP premises or major extensions in accordance with BCU Strategy	Chief Executive	Chief Operating Officer and Director of Estates and Environment	Not Delegated

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
22. Compliance Lead Roles:			
a) Caldicott Guardian b) Data Protection Officer c) Senior Information Risk Owner	Chief Executive Chief Executive Chief Executive	Executive Medical Director Data Protection Officer Chief Digital Information Officer	Deputy Medical Director Head of Information Governance Not Delegated
23. Emergency Planning & Major Incidents – Civil Contingencies Act (Category 1 Responder)			
Emergency Planning & Major Incidents – Civil Contingencies Act (Category 1 Responder)	Chief Executive	Executive Director of Public Health	Head of Emergency Preparedness Response and Resilience
24. Statutory compliance with respective Legislation			
Individual Board Members responsible for the implementation of respective legislation	Chief Executive	Director of Corporate Governance	Service Director for implementation
25. National Health Service (Appointment of Consultants) (Wales) (Amendment) Regulations 2005 (Statutory Instrument 2005: 3039) Appointment of all Medical and Dental Consultant posts. Consultant posts within Public Health that are open to both medically qualified and those qualified in other disciplines other than medicine should follow this process, even though they fall outside of the requirements of the Statutory Instrument.			
Appointment of all Medical and Dental Consultant posts	Board	Chair of ACC's and reported to the People and Culture Committee	Not Delegated

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
26. Human Tissue Act 2004			
Compliance with the Human Tissues Act	Chief Executive	Executive Medical Director	Service Director for implementation
27. Ionising Radiation (Medical Exposure) Regulations 2017			
Compliance Ionising Radiation (Medical Exposure) Regulations 2017	Chief Executive	Executive Director of Allied Health Professionals and Health Science / Executive Medical Director	Service Director for implementation
28. Nurse Staffing Levels Act (Wales) 2016			
Compliance with Nurse Staffing Levels Act (Wales) 2016	Chief Executive	Executive Director of Nursing & Midwifery	Service Director for implementation
29. Welsh Language Standard Reporting			
Compliance with the Welsh Language Standards	Chief Executive	Executive Director of Allied Health Professionals and Health Science	Service Director for implementation
30. Controlled Drugs Accountable Officer			
Controlled Drugs Accountable Officer	Chief Executive	Chief Pharmacist	Not Delegated

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
31. Upholding Professional Standards in Wales (UPSW)			
Responsible Officer	Executive Medical Director (SRO)	Deputy Medical Director (Deputy Responsible Officer)	Service Director for implementation
Appointing a Designated Board Member	Health Board Chair	Remuneration Committee	Not Delegated

SCHEME OF DELEGATION LINKED TO STANDING FINANCIAL INSTRUCTIONS

Introduction

This Schedule of additional delegations identifies those specific areas within the Standing Financial Instructions which require additional delegations from the Board, Chief Executive and the Executive Director of Finance and other Officers.

This Schedule should not be read in isolation and needs to be used alongside the full set of Standing Financial Instructions at Schedule 3 of Standing Orders.

The following principles will apply:

i. Financial limits are at the discretion of the Board;
ii. Each cost centre must have a single approved budget holder who is accountable for ensuring budgets do no overspend and that expenditure is committed within the Health Board's delegated approved levels as detailed in the budget holder signed Accountability Agreement;
iii. In an officer's absence, financial limits can be delegated in part or in total either generally or for specific items;
iv. Directors can assign delegated budget holders with approval limits up to £150k at their discretion
v. These limits apply to requisition authorisation, which is where the control lies;
vi. In exceptional circumstances, the Chair may have delegated authority on behalf of the Board, and the use of the delegated authority to the Chair must be included in the minutes of the next meeting of the Board;
vii. Each Director has the responsibility of cascading the delegation within their area and ensuring that authorised signatories are in place but will remain ultimately accountable for their budget. It may be appropriate for some areas of expenditure to be notified to the Board even if they are within the budget holder's limits;
viii. The delegations and approval levels apply to all financial activity of the Health Board, irrespective of the income source relating to the expenditure, for example, any ringfenced income and expenditure must still follow this Scheme of Delegation.

Responsibility for authorising the purchase of goods and services (including capital schemes), Service Level Agreements and Memorandum of Understandings, with non-NHS bodies are subject to the maximum delegated levels of authority and also other approval requirements and delegations as detailed in the Scheme of Delegation, as follows:

Financial Delegations

Tier	Authority Delegated to ~~Financial delegation~~	Financial delegation ~~Authority Delegated to~~	Oracle Approvers
0	Board	Above £1,000,000	Chief Executive following approval by Board and Welsh Government
1	Chief Executive	Up to £1,000,000	Chief Executive
2	Executive Director of Finance Deputy Chief Executive	Up to £500,000	Executive Director of Finance Deputy Chief Executive
3	Executive Directors	Up to £300,000	Executive Directors
4	Senior Officers *(not included in tier 3 including Finance Director: Commissioning and Financial Planning; Director of Corporate Governance; Director of Communications and Engagement; Chief Digital and Information Officer; and Director of Estates and Environment)*	Up to £250,000	Senior Officers *(not included in tier 3 including Finance Director: Commissioning and Financial Planning; Director of Corporate Governance; Director of Communications and Engagement; Chief Digital and Information Officer; and Director of Estates and Environment)*
5	Assistant / Associate / Deputy Directors or Heads of Service	Up to £150,000	Assistant / Associate / Deputy Directors or Heads of Service
6	Service Contract Manager or Head of Operations	Up to £50,000	Service Contract Manager or Head of Operations

7	Service Lead or Site / General Manager	Up to £30,000	Service Lead or Site / General Manager
8	Nominated Budget Holder for specific cost centres	Up to £25,000	Nominated Budget Holder for specific cost centres

1. General Requirements, Overriding Financial Instructions and Financial Provisions and Obligations

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
1A	Health Board's must agree Standing Financial Instructions (SFIs) for the regulation of their financial proceedings and business. They shall have the effect as if incorporated in the Standing Orders (SOs).	1.1.1	Board	Director of Corporate Governance working with the Executive Director of Finance to ensure SFIs are in place and agreed by the full Board.
1B	All financial policies ~~procedures~~ must be approved by the Executive Director of Finance and Audit Committee.	1.1.3	Executive Director of Finance Audit Committee	No further delegation
1C	Should any difficulties arise in the interpretation of any of the SFIs then advice of the Director of Corporate Governance and Executive Director of Finance should be sought before acting. The users of SFIs should also be familiar with the provisions of the health boards SOs.	1.1.4	All Board Members and Officers of the Health Board	Director of Corporate Governance is responsible for ensuring all Board members are aware of this requirement Executive Directors are responsible for ensuring that their teams are aware of this requirement.

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
1D	Full details of any non-compliance with SFIs and explanation of the reasons for non-compliance to be reported to the Executive Director of Finance and Director of Corporate Governance.	1.2.1	All Board Members and Officers of the Health Board	Director of Corporate Governance is responsible for ensuring all Board members are aware of this requirement Members of the Executive Committee are responsible for ensuring that their teams are aware of this requirement.
1E	Executive Director of Finance and Director of Corporate Governance to refer any matters of non-compliance to the Audit Committee to formally consider the matter. Audit Committee to make proposals to the Board on any action to be taken.	1.2.1	Executive Director of Finance/ Director of Corporate Governance Audit Committee	Finance Director: Commissioning and Financial Planning in the absence of the Executive Director of Finance ~~and~~ the Head of Corporate Governance in the absence of the Director of Corporate Governance.
1F	The Board as a whole and the Chief Executive in particular, in their role as the Accountable Officer must ensure that the health board meets its statutory obligation to perform its functions within the available financial resources.	1.3.1	Board Chief Executive specifically	No further delegation. Guidance on the responsibility of budget holders is set out later in this document.

2. Responsibilities and delegation

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
2A	The Board exercises financial supervision and control by: a) Formulating the Medium-Term Financial Plan (MTFP) as part of the Integrated Medium-Term Plan (IMTP); b) Requiring the submission and approval of budgets within approved allocations/overall funding c) Defining and approving essential features in respect of important financial policies, systems and controls (including the need to obtain value for money and sustainability); and d) Defining specific responsibilities placed on Board members and Health Board officers, and Health Board committees and Advisory Groups as indicated in the 'Scheme of delegation' document.	2.1.1	Board	Coordination and management of the development of the IMTP - Executive Director of Transformation, Strategic Planning & Commissioning Coordination and development of the MTFP – Executive Director of Finance
2B	Responsibility for the health board's system of internal control.	2.2.2	Chief Executive	Executive Directors are responsible for ensuring adequate systems of internal control are in place across their areas of responsibility.

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
2C	It is the duty of the Chief Executive to ensure that Board members, health board officers, and all new appointees are notified of, and put in a position to understand their responsibilities within these SFIs	2.2.3	Chief Executive	Director of Corporate Governance and Executive Director of Finance are responsible for ensuring all Board members understand their responsibilities. Executive Directors are responsible for ensuring that their teams understand their responsibilities.
2D	The Executive Director of Finance is responsible for: a) Implementing the health board's financial policies and for coordinating any corrective action necessary to further these policies; b) Maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;	2.3.1	Executive Director of Finance	Finance Director: Commissioning and Financial Planning Finance Director: Commissioning and Financial Planning

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
	c) Ensuring that sufficient records are maintained to show and explain the health board's transactions, in order to disclose, with reasonable accuracy, the financial position of the health board at any time; and d) Without prejudice to any other functions of the health board, Board members and health board officers, the duties of the Executive Director of Finance include: (i) the provision of financial advice to other Board members and health board officers, and health board committees and Advisory Groups, (ii) the design, implementation and supervision of systems of internal financial control, and (iii) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the health board may require for the purpose of carrying out its statutory duties.			Finance Director: Commissioning and Financial Planning No further delegation
2E	The Executive Director of Finance is responsible for ensuring an ongoing training and communication programme is in place to affect these SFIs.	2.3.2	Executive Director of Finance	Finance Director: Commissioning and Financial Planning

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
2F	All Board members and health board officers, and health board Committees and Advisory Groups, severally and collectively, are responsible for: a) The security of the property of the health board; b) Avoiding loss; c) Exercising economy, efficiency and sustainability in the use of resources; and d) Conforming to the requirements of SOs, SFIs, Financial Control Procedures and the Scheme of delegation.	2.4.1	All Board members, officers, Committees and Advisory Groups	No further delegation
2G	Any contractor or employee of a contractor who is empowered by the health board to commit the health board to expenditure or who is authorised to obtain income shall be covered by the SFIs. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.	2.5.1	Chief Executive	Executive Directors are responsible for ensuring this is understood by contractors working in their area.

3. Audit, Fraud and Corruption, and Security Management

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
3A	In accordance with SOs the Board shall formally establish an Audit Committee with clearly defined terms of reference.	3.1.1	Board	No further delegation. Director of Corporate Governance will support the establishment of the Committee and ensure clear terms of reference are in place.
3B	The Audit Committee will follow the guidance set out in the NHS Wales Audit Committee Handbook. *Note: if new or revised guidance is issued in addition to / replacement of the Handbook, the Committee should follow the revised guidance.*	3.1.1	Chair of Audit Committee	No further delegation. Chair of Audit Committee to be supported by Director of Corporate Governance.
3C	Ensuring there are arrangements in place to review, evaluate and report on the effectiveness of internal financial control, including the establishment of an effective Internal Audit function.	3.2.1 (a)	Chief Executive	Director of Corporate Governance
3D	Ensuring that the Internal Audit function meets the required standards and provides sufficient independent and objective assurance to the Audit Committee and the Accountable Officer.	3.2.1 (b)	Chief Executive	Chief Executive to be supported by Director of Corporate Governance Head of Internal Audit

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
3E	Deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption	3.2.1 (c)	Chief Executive	Director of Corporate Governance and Executive Director of Finance or Executive Director of People Services and Organisational Development
3F	Ensuring that an annual Internal Audit report is prepared for the consideration of the Audit Committee and the Board.	3.2.1 (d)	Chief Executive	Head of Internal Audit and Director of Corporate Governance
3G	The health board's Audit Committee must ensure that a cost-effective external audit service is delivered.	3.4.1	Audit Committee	Director of Corporate Governance and Executive Director of Finance to support the Audit Committee.
3H	The Audit Committee should consider the annual audit plan prepared by the external auditors and the associated fees. The Audit Committee should consider material changes to the annual audit plan.	3.4.3	Audit Committee	No further delegation. Director of Corporate Governance to ensure review scheduled in to the Committee's work programme
3I	The Auditor General's representative should be invited to attend every Audit Committee.	3.4.4	Director of Corporate Governance	

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
3J	The health board will provide the Auditor General and his representatives with whatever facilities are necessary to facilities audits, including accommodation and access to IT facilities.	3.4.7	Executive Director of Finance	Finance Director: Commissioning and Financial Planning
3K	The Chief Executive and Executive Director of Finance shall monitor and ensure compliance with Directions issued by the Welsh Ministers on fraud and corruption.	3.5.1	Chief Executive and Executive Director of Finance	No further delegation The Executive Director of Finance will be responsible for regular liaison with Counter Fraud Services
3L	The health board shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist.	3.5.2	Board	Executive Director of Finance to put arrangements in place. Audit Committee to review adequacy of arrangements.
3M	Local Counter Fraud Specialist to provide a written report to the Executive Director of Finance and Audit Committee at least annually, on counter fraud work within the health board	3.5.4	Local Counter Fraud Specialist	No further delegation. Director of Corporate Governance to ensure report scheduled in to the work programme of the Audit Committee.

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
3N	The health board must participate in the annual National Fraud Initiative. The Audit Committee should consider the health board's participation in additional dataset matching in order to support the detection of fraud across the whole public sector.	3.5.5	Executive Director of Finance Audit Committee	Director of Corporate Governance to ensure review scheduled in to the work programme of the Audit Committee.
3O	The Chief Executive will monitor and ensure compliance with Directions issued by the Welsh Ministers on NHS security management.	3.6.1	Chief Executive	Executive Director of Finance, with support from relevant Directors.
3P	The Chief Executive has overall responsibility for controlling and co-ordinating security.	3.6.2	Chief Executive	Executive Director of Finance, with support from relevant Directors.

4. Financial Duties

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
4A	The Executive Director of Finance of the Health Board will: a) Prior to the start of each financial year, submit to the Board for approval a report showing the total allocations received, assumed in-year adjustments and their proposed distribution, including any sums to be held in reserve; b) Ensure that any ring-fenced or non-discretionary allocations are disbursed in accordance with Welsh Ministers' requirements; c) Periodically review any assumed in-year allocations to ensure that these are reasonable and realistic; and d) Regularly update the Board on significant changes to the initial allocation and the application of such funds.	4.2.4	Executive Director of Finance	No further delegation
4B	The Chief Executive has overall executive responsibility for the health board's activities and is responsible to the Board for ensuring that it meets its financial duty to breakeven.	4.2.5	Chief Executive	Executive Directors

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
4C	The Chief Executive will compile and submit to the Board, on an annual basis, the rolling 3 year Integrated Medium Term Plan.	4.3.7	Chief Executive	Executive Director of Transformation and Strategic Planning
4D	The Board will: a) Approve the Integrated Medium-Term Plan (IMTP) prior to the beginning of the financial year of implementation. b) Approve a balanced Medium Term Financial Plan (MTFP) as part of the Integrated Medium-Term Plan, which meets all probity and value for money requirements; and c) Prepare and agree with the Welsh Government a robust and sustainable recovery plan in accordance with Welsh Ministers' guidance where the health board plan is not in place or in balance.	4.3.8	Board	Performance, Finance and Information Governance Committee and the Planning, Population and Health Partnership Committee will scrutinise the draft IMTP and MTFP and make recommendations to the Board.
4E	The Board approved Integrated Medium-Term Plan will be submitted to the Welsh Government in line with the requirements of the Integrated Planning Framework.	4.3.9	Board	Chief Executive on Board's behalf

5. Financial Management and Budgetary Control

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
5A	Prior to the start of the financial year the Executive Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval and delegation by the Board.	5.1.1	Executive Director of Finance	No further delegation
5B	Approval and Delegation of budgets	5.1.1	Board	No further delegation
5Bi	Approval of annual detailed budget for Directorates within budget approved by Board	Local	Executive and Associate Directors	No further delegation
5Bii	Delegation of budgets to budget holders including ensuring the appropriate documentation is completed and returned to the Finance Directorate	Local	Executive and Associate Directors	No further delegation
5Biii	Authorisation of expenditure above budget	Local	Chief Executive	Reported to Audit Committee See Table 5B (1) below
5C	The Chief Executive may delegate, via the Executive Director of Finance, the management of a budget to permit the performance of a defined range of activities, including pooled budget arrangements under Regulations made in accordance with Section 33 of the NHS (Wales) Act 2006 (C.42). This delegation must be in writing, in the form of a letter	5.2.1	Chief Executive	Executive Director of Finance

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
	of accountability, and be accompanied by a clear definition of: a) The amount of the budget; b) The purpose(s) of each budget heading; c) Individual or committee responsibilities; d) Arrangements during periods of absence; e) Authority to exercise virement; f) Achievement of planned levels of service; and g) The provision of regular reports.			
5D	Delegation to include the authority to exercise virement and budget transfers	5.2.1	Chief Executive	Executive Director of Finance See Table 5D (1) below
5E	The Chief Executive, Executive Director of Finance and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.	5.2.2	Chief Executive	Executive Director of Finance Budget Holders
5F	Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Executive Director of Finance.	5.2.4	Chief Executive *[advised by Executive Director of Finance]*	No further delegation
5G	All budget holders must provide information as required by the Executive Director of Finance to enable budgets to be compiled and managed appropriately.	5.2.5	Budget Holders	No further delegation
5H	All budget holders are required to sign up to their allocated budgets at the start of the financial year.	5.2.6	Budget Holders	See Table 5H (1) below

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
5l	The Executive Director of Finance has a responsibility to ensure that appropriate and timely financial information is provided to budget holders and that adequate training is delivered on an on-going basis to assist budget holders managing their budgets successfully.	5.2.7	Executive Director of Finance	Chief Finance Officers

Table 5B (1) - Authority to commit resources above expenditure baselines set within delegated budgets

Ref	Revenue Business Case Value (Total Value)	Approved by:
1	Up to £0.25m	Chief Executive (or Deputy Chief Executive) and Executive Director of Finance All approvals retrospectively reported to Executive Committee
2	Above £0.25m, up to £0.5m	Relevant Executive Director and Executive Director of Finance and then approval by Executive Committee
3	Above £0.5m, up to £1.0m	Relevant Executive Director and Executive Director of Finance and then approval by Executive Committee plus the Performance, Finance & Information Governance Committee
4	Above £1.0m	Relevant Executive Director and Executive Director of Finance and then approval by Executive Committee plus the Performance, Finance & Information Governance Committee plus approval by Board and Welsh

		Government

Table 5D (1) -Approval of variation of budgets, including authority to vire

Delegated Authority	Between budget lines	Capital to Revenue budgets & *vice versa*
Within own budget* ~~a department~~	Budget manager*	Executive Director of Finance **in liaison with Welsh Government**
Between Area Teams, Hospital Teams or Corporate Departments*	Relevant Tier 3 or 4 Officer(s)*	
Between Area Teams, Hospital Teams or Corporate Departments Above Tier 3 or 4 Officer's delegated limit and up to £0.5m	Relevant Tier 3 or 4 Officer(s) and the Finance Director – Commissioning and Financial Planning	
Between Area Teams, Hospital Teams or Corporate Departments: Above £0.5m and up to £1.0m	Relevant Tier 3 or 4 Officer(s) and the Executive Director of Finance or Chief Executive	
Between Area Teams, Hospital Teams or Corporate Departments Above £1.0m	Board	
* Virement requests for increases in STAT (WTE)	*Also require approval of Finance Director: Commissioning and Financial Planning	
Budget transfers between Reserves and delegated budgets	Finance Director: Commissioning and Financial Planning	
Notification of virement to Directorate of Finance to ensure budget updated	Individual authorising the virement	

Table 5H (1)

Delegated Matter	Delegated to:	Agreed by:
Delegation of the management of defined Revenue budgets to budget holders: i. Revenue budgets for Clinical Directorates ii. Revenue budgets for Corporate Directorates iii. Reserves	i. Budget Holders ii. Budget Holders iii. Finance Director: Commissioning and Financial Planning	i. Executive Directors ii. Executive Directors iii. Executive Director of Finance

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
5J	Monitor financial performance against budget and plans and report the current and forecast position, and financial risks, on a monthly basis and at every Board meeting. Any significant variances should be reported to the Board as soon as they come to light and the Board shall be	5.3.1	Executive Director of Finance	No further Delegation *[*Finance Director: Commissioning and Financial Planning *supports preparation]*

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
	advised on any action to be taken in respect of such variances.			
5K	Devise and maintain systems of financial management, performance reporting and budgetary control.	5.3.2	Executive Director of Finance	Finance Director: Commissioning and Financial Planning
5L	Each Budget Holder is responsible for ensuring that: a) Any likely overspending or reduction of income that cannot be met by virement is not incurred without the prior consent of the Chief Executive subject to the Board's scheme of delegation; b) The amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised, subject to the rules of virement; c) No permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and workforce establishment as approved by the Board.	5.3.4	Budget Holders	No further delegation
5M	The Chief Executive is responsible for identifying and implementing cost and efficiency improvements and income generation initiatives in accordance with the	5.3.5	Chief Executive	Executive Director of Finance with Executive and Associate Directors

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
	requirements of the Medium-Term Financial Plans.			
5N	All monitoring returns must be supported by a detailed commentary signed by the Executive Director of Finance and Chief Executive. This commentary should also highlight and quantify any significant risks with an assessment of the impact and likelihood of these risks maturing.	5.5.2	Chief Executive and Executive Director of Finance	No further delegation *[if not available these are delegated to their deputies]*
5O	All information made available to the Welsh Ministers must be made available to the Board.	5.5.3	Chief Executive and Executive Director of Finance	Director of Corporate Governance

6. Annual Accounts and Reports

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
6A	The Board must approve the health board's annual accounts prior to submission to the Welsh Ministers and the Auditor General for Wales in accordance with the annual timetable.	6.1	Board	No further delegation The Audit Committee will provide advice and make recommendations.
6B	The Chair and Chief Executive have responsibility for signing the accounts on behalf of the health board. The Chief Executive has responsibility for signing the Performance Report, Accountability Report, Statement of Financial Position and the Governance Statement.	6.2	Chair and Chief Executive Chief Executive	No further delegation No further delegation
6C	Ensuring that financial reports and returns are prepared in accordance with the accounting policies, guidance and timetable determined by the Welsh Ministers and consistent with Financial Reporting Manual and International Financial Reporting Standards.	6.3	Executive Director of Finance	Finance Director: Commissioning and Financial Planning

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
6D	The health board's audited annual accounts must be adopted by the Board at a public meeting and made available to the public.	6.4	Board	No further delegation *[Director of Corporate Governance responsible for ensuring arrangements for a public meeting are made]*
6E	The health board will publish an annual report, in accordance with guidelines on local accountability, and present it at its Annual General Meeting. The document will comply with the Welsh Government's Manual for Accounts.	6.5	Board	Director of Corporate Governance to prepare draft for Board consideration.

7. Banking arrangements

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
7A	The Executive Director of Finance is responsible for managing the Health Board's banking arrangements and for advising the Board on the provision of banking services and operation of accounts. This advice will take into account guidance/ Directions issued from time to time by the Welsh Ministers. Health boards are required to use the Government Banking Service (GBS) for its banking services.	7.1.1	Executive Director of Finance	Finance Director: Commissioning and Financial Planning
7B	Approval of banking arrangements	7.1.2	Board	Audit Committee
7C	The Executive Director of Finance is responsible for: a) Establishing bank accounts; b) Establishing additional commercial accounts (exceptionally); c) Establishing separate bank accounts for the health board's non-exchequer funds; d) Ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made; e) ensuring accounts are not overdrawn except in exceptional and planned situations; f) Reporting to the Board all arrangements made with the	7.2.1	Executive Director of Finance	Finance Director: Commissioning and Financial Planning

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
	health board's bankers for accounts to be overdrawn; g) Monitoring compliance with Welsh Ministers' guidance on the level of cleared funds.			
7D	All accounts should be held in the name of the health board. No officer other than the Executive Director of Finance shall open any account in the name of the health board or for the purposes of furthering health board activities	7.2.2	Executive Director of Finance	No further delegation
7E	The Executive Director of Finance will prepare detailed instructions on the operation of bank accounts which must include: i) The conditions under which bank accounts are to be operated; ii) Those authorised to sign cheques or other orders drawn on the health board's accounts; iii) Authorised signatories are identified with sufficient seniority, and in the case of e-banking approvers, together with an appropriate approval hierarchy.	7.3.1	Executive Director of Finance	i) Finance Director: Commissioning and Financial Planning ii) See Table 7E (1) below
7F	The Executive Director of Finance must advise the Health Board's bankers in writing of the conditions under which each account will be operated.	7.3.2	Executive Director of Finance	No further delegation

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
7G	The Executive Director of Finance shall approve security procedures for any cheques issued without a hand-written signature	7.3.3	Executive Director of Finance	Finance Director: Commissioning and Financial Planning
7H	The Executive Director of Finance will review banking arrangements of the health board at regular intervals to ensure they reflect best practice, that they are efficient and effective and represent best value for money.	7.4.1	Executive Director of Finance	Finance Director: Commissioning and Financial Planning
7I	The results of the review should be reported to the Audit Committee.	7.4.1	Executive Director of Finance	Director of Corporate Governance to ensure that such reports go to the Committee.

Table 7E (1)

Day to day operation of bank accounts: i. maintain list of approved signatories for manual payments ii. approval to authorise automated payments: • accounts payable* • payroll • primary care contractors iii. maintain list of bankline users and authorisers for internet banking transactions	i. Finance Director: Commissioning and Financial Planning ii. NHS Wales Shared Services Partnership iii. Finance Director: Commissioning and Financial Planning

***after confirmation from Head of Financial Control that sufficient funds are available in the bank account**

8. Cash, cheques, Payment Cards and other negotiable instruments

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
8A	The Executive Director of Finance is responsible for: a) Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable; b) Ordering and securely controlling any such stationery with management responsibility given to a duly designated employee; c) The provision of adequate physical facilities and systems for officers whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; d) establishing systems and procedures for handling cash and negotiable securities on behalf of the health board; e) Ensuring effective control systems are in place for the use of payment cards; f) Ensuring that there are adequate control systems in place to minimise the risk of cash/card misappropriation.	8.1.1	Executive Director of Finance	Finance Director: Commissioning and Financial Planning

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
8B	Purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Executive Director of Finance	8.2.1	Executive Director of Finance	Finance Director: Commissioning and Financial Planning

9. Income, fees and charges

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
9A	Designing and maintaining procedures to ensure compliance with systems for the proper recording, invoicing, and collection and coding of all monies due.	9.2.1	Executive Director of Finance	Finance Director: Commissioning and Financial Planning
9B	Ensuring that systems are in place for the prompt banking of all monies received.	9.2.2	Executive Director of Finance	Finance Director: Commissioning and Financial Planning
9C	Approving and regularly reviewing the level of all fees and charges, other than those determined by the Welsh Ministers or by statute (*Private patients, overseas visitors, income generation and other related services)*	9.3.1	Executive Director of Finance	Head of Healthcare Contracting - Finance
9D	All officers must inform the Executive Director of Finance promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.	9.3.2	All Officers of the Health Board	Executive Directors are responsible for ensuring that all their teams are aware of this requirement. Table 9D (1) sets out details of delegations related to fees and charges.

Table 9D (1)

Fees and Charges:	Authority Delegated to
Service Level Agreements / Contracts with other NHS bodies i. Up to £30,000 ii. Up to £50,000 iii. Up to £150,000 iv. Up to £250,000 v. Between £250,000 and £5 million vi. Between £5 million and £10 million vii. Over £10 million	~~Agreement to **provide** services with an **annual income value** up to £250,000 must be provided by the Chief Operating Officer and Executive Director of Finance.~~ Above £300~~250~~,000 must be approved by Executive Committee. SLA / Contracts to be signed in accordance: i. Specific Budget Holders as per operational Schemes of Delegation ii. Service Contract Manager iii. Director / Head of Service iv. Relevant IHC / Service Director v. Relevant Executive Director and Finance Director: Commissioning and Financial Planning vi. Executive Director of Finance or Chief Executive vii. Chief Executive (**following approval by the Executive Committee and the Board**)
Grant Funding Agreements Agreement to **receive** a grant with a **total income value**:	

i. up to £75,000 ii. up to £250,000 iii. up to £500,000 iv. up to £1 million v. over £1 million	i. Assistant Directors Associate / Deputy Directors (Tier 5) ii. Service Directors (Tier 4) iii. An Executive Director and Finance Director: Commissioning and Financial Planning (following approval by the Executive Committee) iv. Executive Director of Finance or Chief Executive (following approval by the Executive Committee) v. Chief Executive (following approval by the Board and Welsh Government)
Healthcare Agreements / Contracts with Private and 3rd Sector Organisations Authority to sign Agreement to **provide** services with a **total income value** over life of contract (following relevant governance approvals): i. up to £75,000 ii. up to £250,000 iii. up to £500,000 iv. up to £1 million v. over £1 million	i. Assistant / Associate / Deputy Directors (Tier 5) ii. Service Directors (Tier 4) **iii.** An Executive Director and Finance Director: Commissioning and Financial Planning (**following approval by the Executive Committee)** iv. Executive Director of Finance or Chief Executive (**following approval by the Executive Committee**) v. Chief Executive (**following approval by the Executive Committee and the Board**
Healthcare Agreements / Contracts with Local Authorities and Public Bodies Authority to sign Agreement to **provide** services with a **total income value** over life of contract (following relevant governance approvals):	

i. up to £75,000 ii. up to £250,000 iii. up to £1 million iv. up to £5 million v. over £5 million	i. Assistant / Associate / Deputy Directors (Tier 5) ii. Service Directors (Tier 4) **iii.** An Executive Director and Finance Director: Commissioning and Financial Planning (**following approval by the Executive Committee)** **iv.** Executive Director of Finance or Chief Executive (**following approval by the Executive Committee)** v. Chief Executive (**following approval by the Executive Committee and the Board**
Individual NHS patient treatment charges outside of Agreements / Contracts Agreement to provide treatment	Executive Director of Finance
Private Patients and overseas patients without reciprocal agreements i. pricing policy and price structure ii. payment policy, including use of deposits, income guarantees, arrangements with insurance companies	Executive Director of Finance with relevant Director
Commercial sponsorship offers (including funding contributions for staff & non staff costs) Agreement to receive commercial sponsorship or funding (in accordance with the relevant Health Board Policy)	Chief Executive or Executive Director of Finance

Commercial and non-commercial research projects and trials Agreement to receive funding: i. up to £50,000 ii. £50,000 to £100,000 iii. Over £100,000	i. Executive Medical Director and Director of Finance – Commissioning & Financial Planning ii. Executive Medical Director and Executive Director of Finance iii. Executive Director of Finance (following approval by Executive Committee)

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
9E	The Executive Director of Finance is responsible for recovering income due and for ensuring debt recovery procedures are in place.	9.4.3	Executive Director of Finance	Finance Director: Commissioning and Financial Planning
9F	Ensuring the Welsh Ministers' guidance on disputed debt arbitration is strictly adhered to.	9.4.6	Chief Executive & Executive Director of Finance	Finance Director: Commissioning and Financial Planning

10. Non-Pay expenditure

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
10A	The Chief Executive will approve the level of non-pay expenditure and operational scheme of delegation and authorisation to budget holders and managers within the parameters set out in the health board's scheme of delegation	10.1.2	Chief Executive	Executive and Service Directors See Table Below for Oracle and non-Oracle requisitions

ALL DIRECTORATES MUST HAVE A LOCAL / OPERATIONAL SCHEME OF DELEGATION LINKING ACTIVITIES TO THE MAXIMUM DELEGATED LIMITS SET OUT BELOW AT A GRANULAR LEVEL OF APPLICATION WITHIN THEIR SERVICE AREA.

All Financial Limits shown below are inclusive of VAT irrespective of recovery arrangements

ORACLE REQUISITIONS	Authority Delegated to
Up to £25,000	Nominated Budget Holder for specific cost centres
Up to £30,000	Service Lead or Site / General Manager
Up to £50,000	Service Contract Manager or Head of Operations

ORACLE REQUISITIONS	Authority Delegated to
Up to £150,000	Assistant / Associate / Deputy Directors or Heads of Service
Up to £250,000	Service Director including Finance Director: Commissioning and Financial Planning
Up to £300,000	Executive Director
Up to £500,000	Executive Director of Finance Deputy Chief Executive
Up to £1 million	Chief Executive
Above £1 million	Chief Executive following approval by the Executive Committee, Board and Welsh Government

Expenditure commitments made outside of the ORACLE requisition process		Authority Delegated to
Contracts for HealthCare Services	See Section 12	See Section 12
Non-contracted activity for Healthcare Services	i. Up to £15,000 ii. Up to £30,000	i. Senior Finance Manager – Healthcare contracts ii. Principal Finance Manager –

	iii. Up to £75,000 iv. Up to £500,000 v. Above £500,000	Healthcare contracts iii. Head of Healthcare Contracting – Finance iv. Executive Director of Finance v. Chief Executive
Staff Travel and Subsistence		Line Managers
Pension Agency Invoices (Injury Benefit/Compensation)		Executive Director of Finance
Legal costs All claims and defence costs to be supported by formal legal advice	i. Up to £0.5 million ii. Up to £1 million iii. Above £1 million	i. Deputy Director of Legal Services ii. Director of Corporate Governance iii. Chief Executive (following Board approval unless otherwise delegated)
Legal Advice Requests	Chief Executive	Director of Corporate Governance (or Deputy Director of Legal Services) List of officers authorised to instruct approved Legal Services will be detailed in the Legal Services Policy

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
10B	The Chief Executive will set out in the operational scheme of delegation and authorisation: a) The list of managers who are authorised to place requisitions for the supply of goods, services and works and for the awarding of contracts; and b) The maximum level of each requisition and the system for authorisation above that level.	10.1.3	Chief Executive	Executive and Service Directors
10C	The Executive Director of Finance will: a) Advise the Board regarding the thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds would be incorporated in SOs and SFIs; b) Preparation of instructions and guidance on non-pay expenditure; c) Ensure systems of authorisation are in place; d) Ensure Directors and officers strictly follow NHS Wales system and procedures of verification, recording and payment of all amounts payable; e) Maintain a list of Executive Directors and officers (including specimens of their signatures) authorised to certify invoices; f) Be responsible for ensuring compliance with the Public Sector Payment policy; g) Ensure that where consultancy advice is being obtained, the procurement of such advice must be in accordance with applicable procurement legislation,	10.2.1	Executive Director of Finance	See Table 10C (1) below for competition requirements for 'Goods and Non-Health Services Only' where there is no suitable procurement framework to source the required item(s)

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
	guidance issued by the Welsh Ministers and SFIs; h) Be responsible for Petty Cash system, procedures, authorisation and record keeping, and ensure purchases from petty cash are restricted in value and by type of purchase in accordance with procedures			
10D	Compliance with the requirements below: a) All contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Executive Director of Finance in advance of both any commitment being made and NWSSP Procurement Services being engaged; b) Contracts above specified thresholds are advertised and awarded, through NWSSP Procurement Services, in accordance with EU and HM Treasury rules on public procurement; c) Contracts above specified thresholds are approved by the Welsh Ministers prior to any commitment being made; d) goods have been duly received, examined and are in accordance with specification and order; e) work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct; f) No requisition/order shall be issued for any item or items to any firm which has made an offer of gifts, reward or	10.3.1	Budget Holders	Executive Director of Finance to put arrangements to ensure compliance Executive Directors to ensure all budget holders within their Directorate are aware of the requirements

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
	benefit to Board members or LHB officers, other than: (i) Isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars, (ii) Conventional hospitality, such as lunches in the course of working visits; g) No requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Executive Director of Finance on behalf of the Chief Executive; h) All goods, services, or works are ordered on official orders; i) Requisitions/orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds; j) Goods are not taken on trial or loan in circumstances that could commit the LHB to a future uncompetitive purchase.			
10E	The Chief Executive and Executive Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance issued by the Welsh Ministers. The technical audit of these contracts shall be the responsibility of the relevant Director.	10.3.2	Chief Executive Executive Director of Finance	No further delegation
10F	Prepayments should be exceptional and are only permitted where either:	10.6.1	Executive Director of Finance	Executive Directors

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
	▪ The financial advantages outweigh the disadvantages (i.e., cash flows must be discounted to Net Present Value (NPV) using the National Loans Fund (NLF) rate plus 2%); ▪ It is the industry norm e.g., courses and conferences; There is specific Welsh Ministers' approval to do so e.g., voluntary services compact.			
10G	In exceptional circumstances prepayments can be made subject to: a) The appropriate Executive Director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Health Board if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments; b) The Executive Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold);	10.6.2	Executive Director of Finance	Executive Directors
10H	The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.	10.6.2 part c)	Budget Holders	No further delegation

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
10l	Approval for all external consultancy support (total contract value for duration of service) to be approved by Executive Committee. Approvals above £0.5m to also be approved by Board and above £1.0m to be approved by Welsh Government	Local	Executive Committee	As per Table below

Consultancy (Total contract value)	Contract to be signed by
Up to £0.25 million	An Executive Director and Finance Director: Commissioning and Financial Planning (2 to sign)
Up to £0.5 million	Executive Director of Finance or Deputy Chief Executive or Chief Executive
Up to £1 million	Chief Executive (following Board approval)
Above £1 million	Chief Executive (following approval by Board and Welsh Government)

Table 10C (1) 'Goods and Non-Health Services Only'

Goods/Services/Works (Whole Life Cost Contract Value)	Minimum Competition	Lead	Waivers, or exceptions to tender rules
Below £5,000	Evidence of value for money has been achieved	Budget owners	-
£5,000 to £24,999	Evidence of 3 written quotations	Procurement Services	Executive Director of Finance and NWSSP Procurement Services
£25,000 plus to the prevailing Procurement Act 2023 threshold	Advertised open call for competition. Minimum of 4 tenders received if available	Procurement Services	Single Tender Action authorised by Executive Director of Finance and Chief Executive
Over the prevailing Procurement Act 2023 threshold	Advertised open call for competition. Minimum of 5 tenders received if available or appropriate to the procurement route	Procurement Services	Single Tender Action prohibited
Contracts above £1m	Welsh Gov approval required (approval to be obtained at the planning stage)	Procurement Services	-

***Notes**:*
Total value excluding VAT.
Subject to the existence of suitable suppliers

11. Procurement and contracting for goods and services

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
11A	The health board shall maintain detailed policies and procedures for all aspects of procurement including tendering and contracting processes.	11.2.1	Board *[Chief Executive is ultimately responsible]*	NWSSP Procurement Services
11B	The Procurement Act 2023 and associated subordinate instruments, the Health Services (Provider Selection Regime) (Wales) Regulations 2025 and associated subordinate instruments, and the Welsh Procurement Policy Notices are the key pieces of legislation which governs public sector procurement in the UK. All Directors and their staff are responsible for ensuring that all legal requirements in the area of public procurement are understood and fully complied with.	11.3.5	Executive Directors	Officers of the Health Board
11C	To help towards ensuring that the LHB is compliant with the legislation governing public sector procurement in the UK, and Welsh Ministers' guidance and policy, the LHB shall, through Procurement Services, ensure that it shall have procedures that set out: a) requirements for, and exceptions to, formal competitive tendering ('Goods and Non-Health Services Only'); b) tendering processes including post tender discussions;	11.5.1	Board *[Chief Executive is ultimately responsible]*	Executive Director of Finance

	c) requirements and exceptions to obtaining quotations ('Goods and Non-Health Services Only'); d) evaluation and scoring methodologies; and e) approval of firms for providing goods and services. All procurement procedures must comply with all relevant legislation, the Welsh Ministers' guidance and the Health Board's delegation arrangements and approval processes. *	11.5.2		
Ref	**SFI requirement**	**SFI Ref.**	**Accountability for delivery and compliance with the SFI sits with**	**Related responsibilities delegated to**
11D	The health board shall develop sustainable procurement solutions consistent with the Wellbeing of Future Generations (Wales) Act 2015 (the WBFG Act 2015). The health board is required to consider the Welsh Government Guidance on Ethical Employment Practices in Public Sector Supply Chains and the Code of Practice on ethical employment in supply chains.	11.7.1 11.7.5	Board	No further delegation Executive Director of Transformation, Strategic Planning and Commissioning – to develop on behalf of Board
11E	The health board shall benchmark its performance in sustainable procurement against the Wellbeing of Future Generations (Wales) Act 2015 (WBFG Act 2015). For all contracts over £25,000, the health board shall take into account the social, economic, environmental and cultural goals in the WBFG Act 2015 using the Sustainable Risk Assessment Template (SRA).	11.7.6	Board	Executive Director of Finance

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
11F	Minimum thresholds for quotes and competitive tendering arrangements for 'Goods and Non-Health Services' are to be complied with.	11.10.2	Executive Director of Finance	All Officers of the Health Board See Table 10(C)1
11G	In exceptional circumstances it may be necessary to secure goods/services/works from a single supplier. In these circumstances a Single Quote / Tender Application (Waiver) must be completed. The Executive Director of Finance must approve such applications up to £25,000; the Chief Executive or designated deputy, and Executive Director of Finance, are required to approve applications exceeding £25,000. This requirement for a Single Quote / Tender Application (Waiver) applies even if the award is a Single Supplier Direct Award under a 'procurement framework'.	11.13	Executive Director of Finance	No further delegation
11H	The relevant budget holder shall oversee and manage each contract on behalf of the health board so as to ensure that obligations on delivery of business and operational objectives, and achieving value for money, are met	11.16.1	Budget Holders	No further delegation

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
11I	The budget manager in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the health board. In so doing, the health board's approved catalogue shall be used. Where a required item is not included within the catalogue, advice must be sought from procurement services.	11.18.1	Budget Holders	All individuals authorised to requisition items
11J	Where a required item is not included within the catalogue or on a framework contract, the budget manager shall request procurement services to undertake quotation / tendering exercises ('Goods and Non-Health Services Only') on their behalf.	11.18.2	Budget Holders	All individuals authorised to requisition items
11K	Approval to commence with competition via procurement services (for example, going to tender) must be received in line with this Scheme of Delegation prior to commencement of the competition.	Local	Budget Holders	All individuals authorised to requisition items
11L	All orders for goods ('Goods and Non-Health Services Only') and services must be accompanied by an official order number, available from the Procurement Department. In no circumstances must a requisition number be used as an order number.	11.18.3	Budget Holders	All individuals authorised to requisition items

Current delegated limit for contracts before requiring Ministerial approval is £1m

12. Health Care Agreements and Contracts for Health Care Services

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
12A	The Chief Executive is responsible for ensuring the health board enters into suitable Health Care Agreements, or Individual Patient Commissioning Agreements, where appropriate for the provision of health care services from external providers. All agreements must be in accordance with the functions conferred on the Health Board by the Welsh Ministers.	12.1.1 12.1.3	Chief Executive	See Table 12A (1) – 12A (11) below
12A (i)	All Continuing Health Care Pre-Placement Agreements (PPA) are to be approved by the Chief Operating Officer ~~Executive~~	Local	Chief Executive	~~No further delegation~~ Chief Operating Officer
12B	The Chief Executive will need to ensure that regular reports are provided to the Board detailing performance, quality and associated financial implications of all Health Care Agreements with external providers.	12.3	Chief Executive	Executive Director of Finance Director of Corporate Governance to ensure that such reports are built in to work programmes.

	Agreements for the purchase of services	Authority delegated to

12A (1)	**Long Term Agreements / Contracts with other NHS bodies** Approval and Signing of the Long-Term Agreements (annual renewal of contracts). New agreements / contracts, or any variations to agreement / contracts, are to be approved as per section 12A (2) below	Annual contract schedule approved via annual budget approval process
12A (2)	**Service Level Agreements / Contracts with other NHS bodies** i. up to £30,000 ii. up to £50,000 iii. up to £150,000 iv. up to £250,000 v. between £250,000 and £5 million vi. between £5 million and £10 million vii. above £10 million	~~Agreement to purchase services with an **annual value up to £250,000** must be provided by the Chief Operating Officer and Executive Director of Finance~~ **Annual contract value above £300,000~~250,000~~ must be approved by the Executive Committee.** Following approval required above, the Agreement / Contract can be signed in accordance: i. Specific Budget Holders as per operational Schemes of Delegation ii. Service Contract Manager iii. Directors / Heads of Service iv. Relevant IHC / Service Director v. Relevant Executive Director and Finance Director: Commissioning and Financial Planning vi. Executive Director of Finance or Chief Executive vii. Executive Director of Finance or Chief Executive **(following approval at Executive Committee and the Board)**

		All new contracts or variations over £1 million to be retrospectively reported to Board.
	Agreements for the purchase of services	**Authority delegated to**
12A (3)	**Healthcare Agreements / Contracts with non-NHS bodies** **(Private / 3rd Sector / Grants / Primary Care / Local Authorities)** i. up to £75,000 ii. up to £150,000 iii. up to £250,000 iv. between £250,000 and £500,000 v. between £500,000 and £1 million vi. above £1 million (contract on framework) vii. above £1 million (not under any framework)	~~Agreement to purchase services with a **total contract value up to £250,000** over the life of contract must be provided approved by the Executive Director (Tier 3) and Executive Director of Finance (Tier 2)~~ **Total contract value above £300~~250~~,000 must be approved by the Executive Committee.** Following approval required above, the Agreement / Contract can be signed in accordance: i. Assistant Directors ii. Associate / Deputy Directors iii. Service Directors iv. Relevant Executive Director and Finance Director: Commissioning and Financial Planning v. Executive Director of Finance or Chief Executive vi. Chief Executive **(following approval at Executive Committee, PFIG and the Board)** vii. Chief Executive **(following approval at Executive Committee, PFIG, Board and from Welsh Government)** *Note: Welsh Government approval required in advance of contract planning*
	Agreements for the purchase of services	**Authority delegated to**

12A (4)	**Individual Continuing Health Care (CHC) Placements/Packages -** Authorisation of individual placements/packages following recommendation from the 'Local' CHC Panel. **APPROVAL REQUIREMENTS EXCLUDES 'FAST TRACK' PROCESS AS PER THE WALES NATIONAL FRAMEWORK** Agreement to purchase services with an **annual value:** ~~i. Up to £125,000~~ ~~ii.~~i. ~~Between £125,000 and £200,000~~ ~~iii.~~ii. Between £200,000 and £1 million ~~iv.~~iii. Above £1 million	For placements **above £200,000 per annum**, recommendation is required from the Complex, Value for Money and High Risk CHC Panel prior to approval by the Executive Committee ~~i. Service Director and Chief Operating Officer~~ ~~ii. Chief Operating Officer and Executive Director of Finance~~ ~~iii.~~i. Executive Director of Finance **(following approval at Executive Committee)** ~~iv.~~ii. Chief Executive **(following approval at Executive Committee and Board)**
12A (5)	**Individual Patient Commissioning Agreements (for example, Mental Health Out of Area Placements)** Agreement to purchase services with an **annual value:** i. Up to £125,000 ii. Between £125,000 and £250,000 iii. Between £250,000 and £1 million iv. Above £1 million	i. Service Director and Chief Operating Officer ii. Chief Operating Officer and Executive Director of Finance iii. Executive Director of Finance **(following approval at Executive Committee)** iv. Chief Executive **(following approval at Executive Committee and Board)**

	Agreements for the purchase of services	Authority delegated to
12A (6)	**NHS Funded Nursing Care (FNC)** i. Authorisation of individual placements/packages following recommendation from a Nurse Assessor ii. Agreement of changes to annual standard rates	 i. IHC Director/Relevant Service Director (Tier 4) ii. Board (following recommendation from Executive Committee)
12A (7)	**Individual Patient Funding Requests (IPFR) - Authorisation of individual agreements following recommendation from the IPFR Panel:** i. Up to £125,000 ii. Between £125,000 and £299,000 iii. Between £300,000 and £1 million iv. Above £1 million	 i. Chair and Vice-chair of BCUHB IPFR Panel ii. Chief Executive iii. Wales IPFR Panel iv. Welsh Government
12A (8)	**Primary Care Contracts – General Medical Services (excluding enhanced services)** i. Approval and Signing of the GMS contracts with practices ii. Variations to the Agreement iii. Payments under the contracts	 i. Authority delegated as per Table 12A (3) ii. Authority delegated as per Table 12A (3) iii. Delegated to NWSSP
12A (9)	**Primary Care Contracts – General Medical Services (Enhanced services)** i. Approval and Signing of agreements to provide Enhanced services ii. Variations to the Agreement iii. Payments under the Agreements	 i. Authority delegated as per Table 12A (3) ii. Authority delegated as per Table 12A (3) iii. Delegated to NWSSP

	Agreements for the purchase of services	Authority delegated to
12A (10)	**Primary Care Contracts – General Dental Services** i. Approval and Signing of the GDS contracts with practices ii. Amendments to the Agreement iii. Payments under the contracts	i. Authority delegated as per Table 12A (3) ii. Authority delegated as per Table 12A (3) iii. Delegated to NWSSP
12A (11)	**Primary Care Contracts – Pharmaceutical Services (including enhanced and advanced services)** i. Payments under the contracts or enhanced service agreements ii. Approval and signing of agreements to provide enhanced services	i. Delegated to NWSSP ii. Authority delegated as per Table 12A (3)
12A (12)	**Primary Care Contracts – General Ophthalmic Services** i. Payments under the contracts or enhanced service agreements ii. Approval and signing of agreements to provide enhanced services	i. Delegated to NWSSP ii. Authority delegated as per Table 12A (3)
12A (13)	**Providing services jointly with Local authorities under Section 32 and 33 of NHS (Wales) Act 2006.** i. Approval and Signing of the pooled budget arrangements ii. Amendments to the Agreement	As per Table 12A (3) above

13. Grant funding

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
13A	Maintaining detailed policies and procedures for all aspects of grant funding- i.e., awarding of grants. Where appropriate these should comply with the Welsh Government's Code of Practice to funding the third sector.	13.2.1	Board *[Chief Executive is ultimately responsible]*	Executive Director of Finance
13B	Health Boards are responsible for ensuring that appropriate procedures exist in relation to all the grants and funding for which they are accountable. They are also responsible for ensuring that any grant provided to an entity that engages in economic activity complies with the State aid rules.	13.4.3	Board *[Chief Executive is ultimately responsible]*	Executive Director of Finance
13C	Health Boards are required to undertake due diligence checks on all potential delivery organisations to determine the economic and financial viability of any organisation(s) to administer public funds, and the reliability of the organisation(s).	13.4.4	Board *[Chief Executive is ultimately responsible]*	Executive Director of Finance
Ref	**SFI requirement**	**SFI Ref.**	**Accountability for delivery and compliance with the**	**Related responsibilities delegated to**

			SFI sits with	
13D	The health board must enter into legally binding funding agreements The health board is responsible for ensuring that all third-party delivery organisations comply with and adhere to the terms and conditions of the Funding Agreement.	13.4.5 13.4.6	Board *[Chief Executive is ultimately responsible]*	Executive Director of Finance

14. Pay expenditure

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
14A	In accordance with SOs the Board shall establish a Remuneration Committee, with clearly defined terms of reference and operating arrangements that specify which posts fall within its area of responsibility.	14.1.1	Board	Director of Corporate Governance to ensure Committee in place
14B	The Remuneration Committee shall report in writing to the Board the basis for its recommendations. The Board shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of Directors and other senior employees, in accordance with the framework set by the Welsh Ministers. Minutes of the Board's meetings should record such decisions.	14.1.2	Remuneration Committee Chair Board Chair supported by Director of Corporate Governance	Director of Corporate Governance to ensure reports from the Committee go to the Board No further delegation No further delegation
14C	The Board will, after due consideration and amendment, if appropriate approve proposals presented by the Chief Executive for the setting of remuneration and terms of service for those employees and officers not covered by the Committee.	14.1.3	Board	People and Culture Committee

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
14D	The workforce plans incorporated within the approved Integrated Medium-Term Plan will form the funded establishment, i.e., the budget for all approved posts.	14.2.1	Board to approve	Executive Director of People and Organisational Development All Executive Directors to contribute
14E	The funded establishment of any department may not be varied without the approval of the Chief Executive or an officer with delegated authority.	14.2.2	Chief Executive	Executive Director of People and Organisational Development and Executive Director of Finance
14F	No Board member or health board official may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration outside the limit of their approved budget and funded establishment unless authorised to do so by the Chief Executive.	14.3.2	Chief Executive	Executive Director of People and Organisational Development and Executive Director of Finance
14F (i)	Agree acting up salaries for staff a) Staff up to Band 9, within budget. b) Staff Band 9 and above excluding Executive Directors c) Interim Executive Directors	Local	Chief Executive	a) Service Director (Tier 4) supported by Local People Services Team b) Chief Executive c) Remuneration Committee

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
14G	Procedures to be presented by the Chief Executive for Board approval for the determination of commencing pay rates, condition of service, etc. for employees in accordance with pay, terms and conditions set out in Agenda for Change and other pay review bodies.	14.4.1	Chief Executive	Executive Director of People and Organisational Development
14H	The Executive Director of People and Organisational Development has responsibility for securing an efficient, well controlled payroll service.	14.5.1	Executive Director of People and Organisational Development	No further delegation
14I	The Executive Director of People and Organisational Development is responsible for: a) The control framework and detailed procedures which are in place to: • ensure all payments comply with HMRC, Pensions Agency and other regulation in relation to the deduction and payment of tax, national insurance, pension or other payments, • reduce the risk of fraud and error within the payroll function. b) Specifying timetables for submission of properly authorised time records and other notifications;	14.5.2	Executive Director of People and Organisational Development	No further delegation

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
	c) The final determination of pay and allowances including verification that the rate of pay and relevant conditions of service are in accordance with current agreements; d) Agreeing the timing and method of payment with the payroll service; e) Authorising the release of payroll data where in accordance with the applicable Data Protection Legislation; f) Verification and documentation of data; g) The timetable for receipt and preparation of payroll data and the payment of employees and allowances; h) Maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay; i) Security and confidentiality of payroll information; j) Checks to be applied to completed payroll before and after payment; and k) A system to ensure the recovery from those leaving the employment of the Health Board of sums of money and property due by them to the Health Board.			
14J	The Chief Executive is responsible for: a) Ensuring that any shared or hosted service arrangement is supported by appropriate Service Level Agreements, terms and conditions, adequate internal controls and audit review procedures; b) Ensuring a sound system of internal control and audit review of any internally provided payroll service;	14.5.3	Chief Executive	a) Director of Corporate Governance b) Finance Director: Commissioning and Financial Planning

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
	c) Maintenance and/or the authorisation of regular and independent reconciliation of pay control accounts.			c) Finance Director: Commissioning and Financial Planning
14K	Appropriately nominated managers have delegated responsibility for: a) Submitting time records, and other notifications in accordance with agreed timetables; b) Completing time records and other notifications in accordance with the Service Level Agreements; and c) Submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Executive Director of People and Organisational Development and/or Chief Executive must be informed immediately. In circumstances where fraud is suspected, this must be reported to the Executive Director of Finance.	14.5.4	Line Managers	No further delegation

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
14L	Ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and dealing with variations to, or termination of, contracts of employment	14.6.1	Executive Director of People and Organisational Development	No further delegation

Approve departure under compromise agreement (VERs) o Up to £50k (i & ii) o Above £50k (i, ii & iii)	i. All applications to be approved by Executive Director of People and Organisation Development, Chief Executive and Executive Director of Finance. ii. All applications also need to be approved by the Remuneration Committee iii. Any VER payments over £50k also need to be approved by Welsh Government.
Approve redundancy	Chief Executive and Executive Director of Finance and Remuneration Committee (subject to any Welsh Government approval mechanisms)
Approve departure under compromise agreement (other than VERs)	Executive Director of People and Organisation Development (subject to any Welsh Government approval mechanisms), Chief Executive and Executive Director of Finance

Note: Any agreements that are deemed contentious to be referred to Remuneration Committee

15. Capital Plan, Capital Investment, Fixed Asset Registers and Security of Assets

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
15A	The Chief Executive is responsible for: (i) ensuring that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon plans; (ii) the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; (iii) ensuring that any capital investment above the Welsh Ministers' delegated limit is not undertaken without approval of the Welsh Ministers and that confirmation of capital resources has been received; (iv) ensuring that the three-year Capital Plan and detailed annual Capital Programme is approved by the Board, as part of the IMTP, prior to the commencement of the financial year; (v) ensuring the availability of resources to finance all revenue consequences of the investment, including capital charges; and (vi) ensuring that any 3rd party use of NHS estate is properly controlled, reimbursed and reported.	15.4.1	Chief Executive	(i) Executive Director of Transformation and Strategic Planning (ii) Director of Environment and Estates (iii) Executive Director of Finance (iv) Executive Director of Transformation and Strategic Planning (v) Executive Director of Finance (vi) Director of Environment and Estates

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
15B	For every capital expenditure proposal, the Chief Executive shall ensure: a) That a business case is produced in line with Welsh Ministers' guidance and where appropriate the 5-case Model; b) That the Executive Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case and involved appropriate Health Board personnel and external agencies in the process.	15.4.2	Chief Executive	Executive Director of Finance
15C	For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management in accordance with the Welsh Ministers' guidance.	15.4.3	Chief Executive	Director of Environment and Estates and Executive Director of Finance
15D	The Chief Executive shall issue to the manager responsible for any scheme: a) Specific authority to commit expenditure; b) Authority to proceed to tender; c) Approval to accept a successful tender.	15.4.5	Chief Executive	Executive Director of Finance

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
15D(i)	Professional advice on recoverable VAT is to be sought on all major Capital Expenditure Programmes. Advice to be sought for the conclusion of each project decision gateway to validate assumptions included within the Business Cases and Plans.	Local	Executive Director of Finance	Head of Capital Finance
15D(ii)	Any movement in contract retention values included in the original contract conditions and award criteria are to be approved by the Executive Committee (unless otherwise delegated)	Local	Executive Committee (unless otherwise delegated)	As delegated by Executive Committee
15E	The Chief Executive will issue a scheme of delegation for capital investment management in accordance with the Welsh Ministers' guidance and the health board's SOs.	15.4.6	Chief Executive *[with advice from Executive Director of Finance]*	See below Table 15E (1) Detailed procedures are contained in the Health Board's Capital Manual

Table 15E (1) - Capital Schemes funded by Discretionary Allocation

Discretionary Capital Programme Approvals		Gross Expenditure on Whole Project	
Approval / Sign Off by:	**Initial Annual Discretionary Programme**	**New Approvals Schemes under £500k**	**Scheme over £500K to £1m**
Strategic Planning and Service Change Group (SPSC)			Agree project mandate and priority
Tier 4	Sign Abbreviated Business Case up to £50K	Sign Abbreviated Business Case up to £50K	-
Tier 3 or 4	Sign Abbreviated Business Case over £50K	Sign Abbreviated Business Case over £50K	Sign Abbreviated Business Case and Business Justification Case
Executive Director / Senior Responsible Officer (Tier 3 or 4)	-	-	Sign Business Justification Case
Executive Director of Finance (Tier 3)	-	-	Review and agreement
Capital Investment Group (CIG)	Recommend	Recommend	Recommend
Strategic Planning and Service Change Group (SPSC)	Recommend for onward consideration for board governance	Approve	Approve Business Justification Case
Performance, Finance and Information Governance Committee (PFIG)	Recommend	-	-
Health Board	Approve	-	-

Capital Schemes funded by Welsh Government

Strategic Planning and Service Change Group (SPSC) considers overall priorities and project mandates in advance of submission to Welsh Government for consideration (Executive approval required). For all-Wales capital schemes, the nature of the business case will be determined in discussion with Welsh Government.

Scheme under £1m	Scheme over £1m
Executive Committee considers overall priorities and project mandates (unless otherwise delegated)	
↓	↓
Scoping document submitted to Welsh Government (WG) followed by a scoping meeting with WG to jointly sign off	Scoping document submitted to WG followed by a scoping meeting with WG to jointly sign off
↓	↓
Business Justification Template signed off by lead Senior Responsible Officer and Executive Director	Strategic Outline Case signed off by Strategic Planning and Service Change Group (SPSC), Performance, Finance and Information Governance (PFIG) Committee and the Board
↓	↓
Capital Investment Group Recommend	Outline Business Case signed off by Executive Committee, PFIG Committee and the Board
↓	↓
Strategic Planning and Service Change Group Approve	Full Business Case signed off by Executive Committee, PFIG Committee and the Board
↓	↓
Submission to WG for approval	Final approval required from WG at each stage of Business Case process

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
15F	The Executive Director of Transformation & Strategic Planning and Executive Director of Finance shall issue detailed procedures governing the project, financial management including variations to contract, of capital investment projects and valuation for accounting purposes.	15.4.7	Executive Director of Transformation & Strategic Planning and Executive Director of Finance	See Table 15F (1) below
15G	The Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.	15.4.7	Executive Director of Finance	Finance Director: Commissioning and Financial Planning
15H	Approval for any new capital financing arrangements with the private sector, including Private Financing Initiatives, Mutual Investment Model and Third-party Developments, without the consent of the Welsh Ministers.	15.5.1	Welsh Ministers	No further delegation

Table 15F (1)- Capital orders and payment authorisation

ALL CAPITAL SCHEMES TO BE APPROVED AS PER TABLE 15E (1)

Leases over £250,000 are to be approved by the Executive Committee and reported to Performance, Finance and Information Governance (PFIG) committee.

Delegated authority	Variations to Discretionary Schemes	Variations to Capital Schemes funded by WG (within Approved Sum) *	Financial monitoring and reporting responsibility	Enter lease arrangement (all types) total value**
Up to £75k	Head of Capital	Head of Capital	Head of Capital	Executive Director (Tier 3 or 4) and the Executive Director of Finance
Up to £250k	Director of Environment and Estates	Director of Environment and Estates	Director of Environment and Estates	Executive Director (Tier 3 or 4) and the Executive Director of Finance
Up to £500k	Executive Director of Finance	Executive Director of Finance	Executive Director of Finance	Executive Director of Finance **(following approval by the Executive Committee)**
Up to £1 million	Chief Executive	Chief Executive	Chief Executive	Chief Executive **(following approval by the Executive Committee)**
Above £1 million	Board and Welsh Government (following consideration by PFIG)	Board and Welsh Government	Board and Welsh Government	Chief Executive **(following approval by the Executive Committee, PFIG, Board and Welsh Government)**

Any variations to Capital Schemes funded by Welsh Government that exceed the approved sum require further approval from WG

*****All property leases are to be signed under Seal***

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
15I	The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Executive Director of Transformation & Strategic Planning and Executive Director of Finance, concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted periodically. The Health Board shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be in accordance with the Welsh Ministers' guidance. Additions to the fixed asset register must be clearly identified to the delegated budget holder and be validated by reference to appropriate documentation.	15.6.1 – 15.6.3	Chief Executive	Executive Director of Finance
15J	The Executive Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.	15.6.5	Executive Director of Finance	Finance Director: Commissioning and Financial Planning

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
15K	The overall control of fixed assets is the responsibility of the Chief Executive.	15.7.1	Chief Executive	Executive Director of Finance
15L	All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Executive Director of Transformation & Strategic Planning and Executive Director of Finance.	15.7.3	Executive Director of Finance, with support from relevant Directors.	Officers of health board
15M	Approval of routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.	15.7.4	Board All officers of health board	No further delegation

16. Stores and receipt of goods

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
16A	i) overall responsibility for the control of stores shall be delegated to a senior officer by the Chief Executive. (ii) The control of any pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Manager (iii) the control of any fuel, oil and coal shall be the responsibility of a designated Estates Manager.	16.2.1	Chief Executive	Executive Director of Finance Chief Pharmacist Director of Environment and Estates
16B	The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Manager. Wherever practicable, stocks should be marked as health service property.	16.2.2	Executive Director of Finance	Service Directors
16C	Stocktaking arrangements shall be agreed with the Executive Director of Finance and there shall be a physical check covering all items in store at least once a year.	16.2.4	Executive Director of Finance	Direct to Operational Services

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
16D	Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Executive Director of Finance	16.2.5	Executive Director of Finance	No further delegation
16E	For goods supplied via NHS Wales Shared Services Partnership – Procurement Services (NWSSP-PS) or any other NHS purchasing and supplies agency central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Executive Director of Finance or authorised officer who shall satisfy themselves that the goods have been received before accepting the recharge.	16.3.1	Chief Executive	Executive Director of Finance

17. Disposals and condemnations, losses and special payments

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
17A	The Executive Director of Finance must prepare detailed procedures for the disposal of assets, including condemnations, and ensure that these are notified to managers.	17.1.1	Executive Director of Finance	Finance Director: Commissioning and Financial Planning
17B	All unserviceable assets shall be condemned or otherwise disposed of by an officer authorised for that purpose by the Executive Director of Finance. The assets should be recorded on a form indicating whether they are to be converted, destroyed or otherwise disposed of. The form should be countersigned by a second officer authorised for that purpose by the Executive Director of Finance	17.1.3	Executive Director of Finance	Following advice from appropriate heads of service (e.g. IM&T, Estates, etc.) items with original value obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively may be condemned or otherwise disposed of in accordance with the delegations set out in Table 17B (1)

Table 17B (1)

Asset value:	**Approved by:**
With current/estimated purchase price below < £499	Budget Manager
with current purchase new price above ≥£500, up to <£5000	Relevant Executive Director
With current purchase new price above ≥£5,000, up to <£250,000	Executive Director of Finance following approval by the Executive Committee
With current purchase new price above ≥£250,000	Performance, Finance and Information Governance (PFIG) Committee
Disposal of property or land (all values)	Board and Welsh Government

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
17C	The Executive Director of Finance shall ensure procedural instructions on the recording of and accounting for losses and special payments are in place; and that all losses and special payments cases are properly managed in accordance with the guidance set out in the Welsh Government's Manual for Accounts.	17.2.2	Executive Director of Finance	Finance Director: Commissioning and Financial Planning

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
17D	The Executive Director of Finance shall ensure all financial aspects of losses and special payments cases are properly registered and maintained on the centralised Losses and Special Payments Register and that 'case write off' action is recorded on the system.	17.2.8	Executive Director of Finance	Finance Director: Commissioning and Financial Planning
17E	The Audit Committee shall approve the writing off of losses or the making of special payments within delegated limits determined by Welsh Ministers and as set out in Schedule 3 of the SOs.	17.2.9	17.2.9	See Table 17E (1) Below

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
17F	The Executive Director of Finance shall ensure that all losses and special payments are reported to the Audit Committee at every meeting	17.2.13	Executive Director of Finance	Finance Director: Commissioning and Financial Planning / Director of Corporate Governance

Table 17E (1)

Ratify fruitless payments (including abandoned Capital Schemes)	*Audit Committee to regularly receive Schedule of Losses and Special Payments*
Up to £250,000	Chief Executive and Executive Director of Finance
Above £250,000	Chief Executive, Executive Director of Finance and Welsh Government (following Executive Committee approval)

Ratify payment for clinical negligence and personal injury claims where legal advice has been obtained and guidance applied (negotiated settlements) *	*Audit Committee to regularly receive Schedule of Losses and Special Payments*
Up to £500,000	Deputy Director for Legal Services
Up to £1 million	Director of Corporate Governance
Above £1 million	Chief Executive (following Board approval unless otherwise delegated) and Welsh Government
Other clinical negligence and personal injury claims where legal advice has not been obtained	*Audit Committee to regularly receive Schedule of Losses and Special Payments*
Up to £50,000	Director of Corporate Governance
Above £50,000	Welsh Government
Authority to write off losses and authorise special payments for bad debts and claims abandoned - private patients, overseas visitors and others.	*Audit Committee to regularly receive Schedule of Losses and Special Payments*
Up to £50,000	Chief Executive or Executive Director of Finance

Above £50,000	Welsh Government
Authority to write off damage to buildings, fittings, furniture and equipment, loss of equipment and property in stores and in use due to culpable causes (e.g., fraud, theft, arson) or other.	*Audit Committee to regularly receive Schedule of Losses and Special Payments*
Up to £50,000	Chief Executive or Executive Director of Finance
Above £50,000	Welsh Government
Authorise compensation payments made under legal obligation (excluding Clinical Negligence and Personal Injury)	*Audit Committee to regularly receive Schedule of Losses and Special Payments*
Up to £500,000	Deputy Director for Legal Services
Up to £1 million	Director of Corporate Governance
Above £1 million	Chief Executive (following Board approval unless otherwise delegated) and Welsh Government

Authorise extra contractual payments to contractors.	*Audit Committee to regularly receive Schedule of Losses and Special Payments*
Up to £50,000	Chief Executive or Executive Director of Finance
Above £50,000	Welsh Government
Authorise ex-gratia payments to patients and staff for the loss of personal effects	*Audit Committee to regularly receive Schedule of Losses and Special Payments*
Up to £50,000	Chief Executive or Executive Director of Finance
Above £50,000	Welsh Government
Authority to write off Losses of cash due to theft, fraud, overpayment of salaries, wages, fees and allowances	*Audit Committee to regularly receive Schedule of Losses and Special Payments*
Up to £50,000	Chief Executive and Executive Director of Finance
Above £50,000	Welsh Government

**** For all clinical negligence and personal injury cases (including Court cases) the use of structured settlements should be considered involving costs to the NHS of £250,000 or more.***
All structured settlements require approval from the Welsh Government H&SSG Director of Finance

18. Digital, Data and Technology

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
18A	The health board shall publish and maintain a Freedom of Information (FOI) publication scheme, or adopt a model publication scheme approved by the Information Commissioner.	18.1.2	Board	Chief Digital and Information officer
18B	The responsible Director for Digital Data and Technology has responsibility for the accuracy, availability and security of digital systems and data.	18.2.1	Chief Digital and Information officer	No Delegation other than responsibilities for security of patient data is delegated to the Executive Medical Director in their role of Caldicott Guardian
18C	The Executive Director of Finance shall ensure that new financial data and systems, and amendments to current financial systems, are developed in a controlled manner and thoroughly tested prior to implementation.	18.3.1	Executive Director of Finance	Finance Director: Commissioning and Financial Planning

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
18D	The responsible Director for Digital Data and Technology has responsibility for ensuring that contracts for data and digital services for clinical, management and financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the i) security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage; ii) availability of the service including resilience for continuity. The contract should also ensure rights of access for audit purposes.	18.4.1	Chief Digital Information Officer	No Delegation other than responsibilities for security of patient data is delegated to the Executive Medical Director in their role of Caldicott Guardian
18E	Where another health organisation or any other agency provides a data or digital service for clinical, management and financial applications, the responsible Director for Digital Data and Technology shall periodically seek assurances that adequate controls are in operation.	18.4.2	Chief Digital Information Officer	No Delegation other than responsibilities for security of patient data is delegated to the Executive Medical Director in their role of Caldicott Guardian

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
18F	The responsible Director for Digital Data and Technology has responsibility for ensuring that the risks to the health board arising from the use of data, information and digital are effectively identified and considered and that appropriate action is taken to mitigate or control risk. This shall include the preparation and testing of appropriate resilience plans, including business continuity and disaster recovery plan.	18.5.1	Chief Digital Information Officer	No Delegation other than responsibilities for security of patient data is delegated to the Executive Medical Director in their role of Caldicott Guardian
18G	All purchases of hardware and software must be undertaken in line with agreed IT policies, Procedures and contractual arrangements.	Requirement in support of SFIs	All Officers	
18H	No purchase or installation may be made of IT software whether new or upgrades to existing systems other than via the IT department	Requirement in support of SFIs	All Officers	

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
18l	Purchases of routine desktop hardware should be procured via health board contracts. Purchasing of servers should always be via IT	Requirement in support of SFIs	All Officers	

19. Patients' property

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
19A	Ensuring patients or their guardians are informed before or at admission, that the health board will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt	19.2.1	Chief Executive Officer	Service Directors
19B	Provide detailed written instructions on the collection, custody, investment, recording, safekeeping and disposal of patients' property	19.3.1	Executive Director of Finance	Service Directors
19C	Issuing property valued above ≥£5,000 only on production of a probate letter of administration	Local	Executive Director of Finance	Finance Director: Commissioning and Financial Planning

20. Funds Held on Trust (Charitable Funds)

The Health Board's Charitable Funds are managed through the registered charity with the Charity Commission (known as Awyr Las) and through the Charitable Funds Committee and its formal Trustee status

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
20A	The Schedule of Matters Reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of funds are to be taken and by whom	20.2.2	Board	See Table 20A (1) below
20B	Fundraising Appeals – Preparation/Monitoring/Reporting progress and performance	Local	Executive Director of Finance	Head of Fundraising See Table 20A (1) below
20C	Legacies - Authority to accept the discharge of a donor's estate	Local	Executive Director of Finance	Not delegated

Table 20A (1) Charitable Funds

Item	Delegated authority
i. Approval and setting up of designated fund Advisors for new funds. ii. Approval of changes to Fund Advisors	i. Head of Fundraising with advice from relevant Director ii. Head of Fundraising with advice from relevant Director
New Fundraising Appeal: i. Up to £5,000 ii. Above £5,000, up to £25,000 iii. Above £25,000	i. Head of Fundraising with advice from relevant Director ii. Executive Director of Finance iii. Charitable Funds Committee
Expenditure requests for Charitable funds: i. Up to £5,000 (non-contentious) * ii. Above £5,000 and any contentious expenditure* iii. Above £1 million	To be submitted to Charity Team for initial review i. Fund Advisor (subject to confirmation from the Assistant Financial Accountant - Charitable Funds that sufficient funds are available and expenditure complies with Charity guidelines) ii. Charitable Funds Committee iii. Health Board and Welsh Government
Oracle approvals: i. Up to £5,000 ii. Above £5,000, up to £50,000 iii. Above £50,000, up to £250,000	Expenditure over £5,000 is only approved following prior approval by the Charitable Funds Committee i. Assistant Financial Accountant - Charitable Funds ii. Senior Financial Accountant - Charitable Funds iii. Finance Director – Commissioning and Financial

iv. Above £250,000, up to £500,000 v. Above £500,000	Planning iv. Executive Director of Finance v. Chief Executive

The term "contentious" refers to the appropriateness of the expenditure either due to its nature or its compatibility with fund objectives as detailed in 'Your Charity Procedures'.

Investment of Charitable Funds

Investments Authority	
Investment of funds i. Decision on nature and value of investment ii. Risk level of investment fund	i. Charitable Funds Committee with guidance from Executive Director of Finance ii. Charitable Funds Committee with guidance from Executive Director of Finance and appointed investment managers

The term "investment" refers to stocks, shares, bonds, property, unit funds or other instruments derived to generate a rate of return and/or valuation gains, other than interest bearing bank accounts

21. Retention of Records

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
21A	The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with Welsh Ministers' guidance, the UK General Data Protection Legislation and any relevant domestic law considerations via the Data Protection Act 2018, and the Freedom of information Act 2000 (c.36).	21.1.1	Chief Executive	Chief Digital and Information officer / Executive Medical Director
21B	Approval for the destruction of records	Local	Chief Executive	Chief Digital and Information officer / Executive Medical Director

AUDIT, RISK AND ASSURANCE COMMITTEE

Terms of Reference & Operating Arrangements

(Schedule 3.5 of the Standing Orders)

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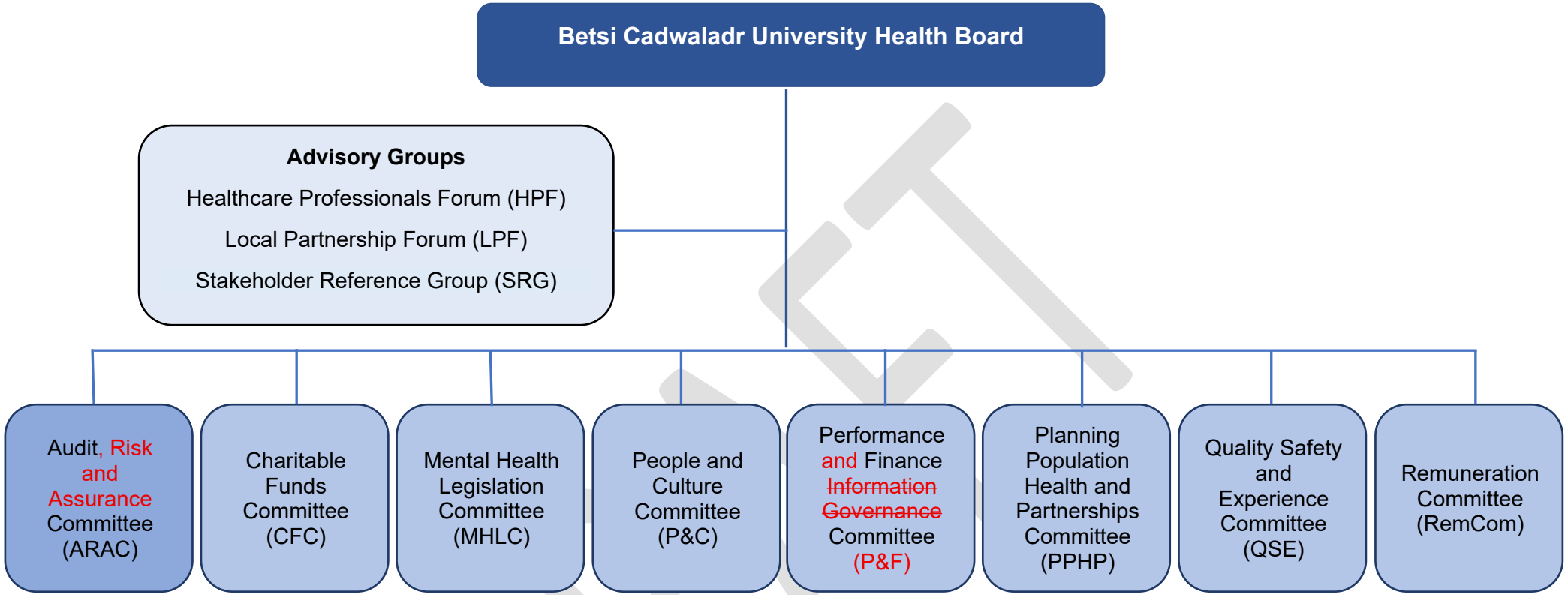
Date approved by Health Board:



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Version Control

Version	Issued to	Date	Comments
V0.1	Audit Committee	04.03.25	Endorsed for approval at the May Board
V1.0	Board	29.05.25	Approved
V1.1	Audit Committee	18.08.26	Endorsed for submission to the Board

TERMS OF REFERENCE

1 INTRODUCTION

1.1 The Betsi Cadwaladr University Health Board (BCUHB) Standing Orders provide that "The Board may and, where directed by the Welsh Government must, appoint Committees of the Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees

1.2 In accordance with Standing Orders (and the BCUHB scheme of delegation), the Board shall nominate annually a committee to be known as the Audit, Risk and Assurance Committee. The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set in this document.

2 PURPOSE

The purpose of the Committee is to act on behalf of the Board to:

2.1 Advise and assure the Board and the Accountable Officer on whether effective arrangements are in place, through the design and operation of the Health Board's system of assurance, to support them in their decision taking and in discharging their accountabilities for securing the achievement of the Health Board's objectives, in accordance with the standards of good governance determined for the NHS in Wales.

2.2 Independently monitor, review and report to the Board on the processes of governance, and where appropriate, facilitate and support, through its independence, the attainment of effective processes.

2.3 Where appropriate, advise the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further.

2.4 Review the establishment and maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities, both clinical and non-clinical.

2.5 Seek assurance that the systems for financial reporting to Board, including those of budgetary control, are effective, and that financial systems processes and controls are operating.

2.6 Work with all Committees of the Board to ensure that governance and risks are part of an embedded assurance framework that is 'fit for purpose'.

2.7 Receive assurance on delivery against relevant Planning Objectives aligned to the Committee in accordance with Board approved timescales, as set out in BCUHB's Annual Plan.

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3 DELEGATED POWERS

With regard to its role in acting on behalf of the Board, and in providing advice and assurance to the Board, the Audit, Risk and Assurance Committee will comment specifically upon:

3.1 Governance, Risk Management and Internal Control

3.1.1 The Committee shall review the adequacy of the Health Board's strategic governance and assurance arrangements and processes for the maintenance of an effective system of good governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives and designed to support the public disclosure statements that flow from the assurance processes, including the Accountability Reports.

This includes:

- the organisation's ability to achieve its objectives;
- compliance with relevant regulatory requirements, standards, quality and service delivery requirements and other directions and requirements set by the Welsh Government, the NHS Wales Executive and others;
- the reliability, integrity, safety and security of the information collected and used by the organisation;
- the efficiency, effectiveness and economic use of resources; and
- the extent to which the organisation safeguards and protects all its assets, including its people to ensure the provision of high quality, safe healthcare for its citizens.

3.1.2 In particular, the Committee will review the adequacy of:

- all risk and control related disclosure statements, together with any accompanying Head of Internal Audit documents and opinion, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board;
- the underlying assurance processes that indicate the degree of the achievement of strategic and planning objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct and accountability requirements; and
- the policies and procedures for all work related to fraud and corruption as set out in Welsh Government Directions and as required by the Counter Fraud and Security Management Service.

3.1.3 In carrying out this work, the Committee will primarily utilise the work of Internal Audit, Clinical Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.

3.1.4 This will be evidenced through the Committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report

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to it.

3.1.5 The Committee will seek assurance that effective systems are in place to manage risk, that the organisation has an effective framework of internal controls to address principal risks (those likely to directly impact on achieving strategic objectives), and that the effectiveness of that framework is regularly reviewed.

3.1.6 The Committee will monitor the assurance environment and challenge the build-up of assurance on the management of key risks across the year, and ensure that the Internal Audit plan is based on providing assurance that controls are in place and can be relied upon (particularly where there is a significant shift between the inherent and residual risk profile), and review the internal audit plan in year as the risk profile changes.

3.1.7 The Committee will also seek assurance on delivery against Integrated Medium Term Plan Objectives aligned to the Committee, considering and scrutinising the frameworks, charts/charters and action plans that are developed, supporting and endorsing these as appropriate.

3.1.8 The Committee will consider and recommend to the Board approval of any changes to the Risk Management Framework and oversee development of the Board Assurance Framework (BAF).

3.1.9 The Committee will be responsible for reviewing the Health Board's Standing Orders and Standing Financial Instructions and Scheme of Delegation annually, (including associated framework documents as appropriate), monitoring compliance, and reporting any proposed changes to the Board for consideration and approval.

3.1.10 The Committee will receive annually a full report of all offers of gifts, hospitality, sponsorship and honoraria recorded by the Health Board and report to the Board the adequacy of these arrangements.

3.1.11 It will also review and report to the Board annually the arrangements for declaring, registering, and handling interests.

3.1.12 The Committee will approve the writing-off of losses or the making of special payments within delegated limits.

3.1.13 The Committee will also receive an assurance on Post Payment Verification Audits through bi-annual reporting to the Committee.

3.1.14 The Committee will receive a report on all Single Tender Actions and extensions of contracts.

3.2 Internal Audit

3.2.1 The Committee shall ensure that there is an effective internal audit (including of the capital / PFI function) established by management that meets mandatory Internal Audit Standards for NHS Wales and provides appropriate independent assurance to the Committee, Chief Executive and Board.

3.2.2 This will be achieved by:

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- reviewing and approving the Internal Audit Strategy, Charter, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation;
- reviewing the adequacy of executive and management responses to issues identified by audit, inspection and other assurance activity, in accordance with the Charter;
- regular consideration of the major findings of internal audit work (and management's response), and ensuring co-ordination between the Internal and External Auditors to optimise audit safety;
- ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation; and
- an annual review of the effectiveness of internal audit.

3.3 External Audit

3.3.1 The Committee shall review the work and findings of the External Auditor and consider the implications of, and management's responses to, its work. This will be achieved by:

- discussion and agreement with the External Auditor, before the audit commences, on the nature and scope of the audit as set out in the Annual Plan, and ensure coordination, as appropriate, with other External Auditors and inspection bodies in the local health economy;
- discussion with the External Auditor on its local evaluation of audit risks and assessment of the Local Health Boards/NHS Trusts and associated impact on the audit fee;
- reviewing all External Audit reports, including agreement of the Annual Audit Report and Structured Assessment before submission to the Board, and any work carried outside the annual audit plan, together with the appropriateness of management responses; and
- reviewing progress against the recommendations of the annual Structured Assessment.

3.4 Other Assurance Functions

3.4.1 The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications on the governance of the organisation.

3.4.2 The Committee's programme of work will be designed to provide assurance that the work carried out by the whole range of external review bodies is brought to the attention of the Board. This will ensure that the Health Board is aware of the need to comply with related standards and recommendations of these review bodies and the risks of failing to comply. These will include, but will not be limited to, any reviews by Inspectors and other bodies (e.g. Healthcare Inspectorate Wales, Welsh Risk Pool, etc), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc).

3.4.3 The Audit, Risk and Assurance Committee and the Quality, Safety and Experience Committee both have a role in seeking and providing assurance on Clinical Audit in the organisation. The Audit, Risk and Assurance Committee will seek assurance on the overall plan, its fitness for purpose and its delivery. The Quality, Safety and Experience Committee will seek more detail on the clinical outcomes and

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improvements made as a result of clinical audit. The internal audit function will also have a role in providing assurance on the Annual Clinical Audit Plan.

3.4.4 The Audit, Risk and Assurance Committee will also seek assurances where a significant activity is shared with another organisation(s), in particular the NHS Wales Shared Services Partnership, Welsh Health Specialised Services Committee, Emergency Ambulance Services Committee and other regional committees. The Audit, Risk and Assurance Committee will expect to receive assurances from internal audit performed at these organisations that risks in the services provided to them are adequately managed and mitigated with appropriate controls.

3.5 Management

3.5.1 The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

3.5.2 The Committee may also request specific reports from individual functions within the organisation (e.g. clinical audit), as they may be appropriate to the overall arrangements.

3.5.3 The Committee may also request or commission special investigations to be undertaken by Internal Audit, directors or managers to provide specific assurance on any areas of concern that come to its attention.

3.5.4 The Committee shall review the Annual Accounts and Financial Statements before submission to the Board, focusing particularly on:

- the ISA 260 report to those charged with governance;
- changes in, and compliance with, accounting policies and practices;
- unadjusted mis-statements in the financial statements;
- major judgemental areas;
- significant adjustments resulting from the audit;
- other financial considerations include review of the Schedule of Losses and Compensation; and
- the Management Letter of Representation to the External Auditors.

3.5.5 The Audit, Risk and Assurance Committee shall prepare an Annual Report to the Board, timed to support the preparation of the Annual Governance Statement. The report should include, as a minimum, specific statements confirming that:

- the draft Annual Governance Statement is consistent with the view of the Committee on the organisation's system of internal control and that it supports the Board's approval of the Statement, subject to any reasonable limitations that the Committee wishes to draw to the attention of the Board;
- the system of risk management in the organisation is adequate in identifying risks and allowing the Board to understand the appropriate management of those risks;
- the Committee has reviewed the system of assurance, and believes that it is fit for purpose;
- there are no areas of significant duplication or omission in the systems of governance in the organisation that have come to the Committee's attention and not been adequately resolved; and

- the current self-assessment by the organisation against the relevant risk management standards is consistent with the Committee's understanding, gained through its assurance work.

3.5.6 The Committee shall also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

3.5.7 The Committee should also ensure the provision of an effective Counter Fraud service that meets the standards set for the provision of Counter Fraud in the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee.

3.5.8 The Committee should assure the Board in relation to its compliance with relevant national practice, mandatory guidance, healthcare standards and duties, including Duty of Quality, Duty of Candour, Quality Standards and Quality Management ensuring the Board is supported to make strategic decisions from a quality perspective.

4 AUTHORITY

4.1 The Committee may investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any:

- Employee - and all employees are directed to cooperate with any legitimate request made by the Committee; and
- Other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

4.2 It may also obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

5 SUB-COMMITTEES

5.1 The Committee may, subject to the approval of the Health Board, establish sub-committees or task and finish groups to perform specific aspects of Committee business.

6 MEMBERSHIP

6.1 Formal membership of the Committee shall comprise of the following:

MEMBERS
Independent Member (Chair)
2 x Independent Members (one of whom will be designated as Vice Chair) NB: At least one of the two Independent Members should be a member of the Quality, Safety & Experience Committee

6.2 The following should attend Committee meetings:

IN ATTENDANCE
Executive Director of Finance (Executive Lead)

Director of Corporate Governance
Other Attendees
Other Executive Directors as required by the Chair
Other Senior Managers as required by the Chair
Head of Internal Audit
Head / Individual responsible for Clinical Audit
Local Counter Fraud Specialist
Representative of Auditor General (External Audit)

6.3 The attendance of the Committee shall be determined by the Board, based on the recommendation of the Health Board Chair, taking into account the balance of skills and expertise necessary to deliver the Committee's remit, and subject to any specific requirements or directions made by the Welsh Government.

6.4 Other Directors/Officers will attend as required by the Committee Chair, as well as any others from within or outside the organisation whom the Committee considers should attend, taking into account the matters under consideration at each meeting.

7 COMMITTEE MEETINGS

7.1 Quorum

- A quorum shall consist of no less than two of the membership, and must include as a minimum the Chair or Vice Chair of the Committee.

7.2 Frequency of meetings

- The Committee will meet bi-monthly and an annual schedule of meetings will be determined by the corporate calendar.

- Any additional meetings will be arranged under exceptional circumstance and shall be determined by the Chair of the Committee in discussion with the Executive Lead.

7.3 Withdrawal of individuals in attendance

- The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

7.4 Meeting arrangements

- The agenda and papers will be distributed/published seven days in advance of the meeting.

- The Director of Corporate Governance is to hold an agenda setting meeting with the Chair and/or Vice Chair and the Executive Director of Finance at least six weeks before the meeting date.

- The agenda will be based on the Committee work plan, identified risks, matters arising from previous meetings, issues emerging throughout the year, and requests from Committee members.

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8 REPORTING AND ASSURANCE ARRANGEMENTS

The Committee, through its Chair and members, shall work closely with the other Committees to provide advice and assurance to the Board through joint planning and co-ordination of Board and Committee business including sharing information.

8.1 The Committee Chair, supported by the Committee Secretary, shall:

- Report formally, regularly and on a timely basis to the Board on the Committee's activities;
- Bring to the Board's specific attention any significant matter under consideration by the Committee; and
- Ensure appropriate escalation arrangements are in place to alert the Health Board's Chair, Chief Executive and/or Chairs of other relevant Committee, of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

8.2 The Committee will undertake an annual review on the effectiveness of its arrangements and responsibilities. The Director of Corporate Governance will oversee this review.

9 RELATIONSHIP WITH THE BOARD AND ITS COMMITTEES/GROUPS

Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these Terms of Reference, it retains overall responsibility and accountability for these matters.

9.1 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference.

9.2 The Committee, through its Chair and members, shall work closely with the Board's other committees, including joint (sub) committees and groups to provide advice and assurance to the Board through the:

- Joint planning and co-ordination of Board and Committee business and
- Sharing of information

In doing so, it will contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

9.3 The Committee will consider the assurance provided through the work of the Board's other committees and sub groups to meet its responsibilities for advising the Board on the adequacy of the Health Board's overall system of assurance.

9.4 The Committee shall embed the Health Board's corporate standards, priorities and requirements, e.g. equality and human rights through the conduct of its business.

10. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

10.1 The requirements for the conduct of business as set out in the Health Board's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

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• Quorum

11. REVIEW

11.1 These Terms of Reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board.

12. CHAIR'S ACTION ON URGENT MATTERS

12.1 There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Board – after first consulting with **all** Members of the Committee. The Secretariat must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

12.2 Chair's action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

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CHARITABLE FUNDS COMMITTEE

Terms of Reference & Operating Arrangements

(Schedule 3.5 of the Standing Orders)

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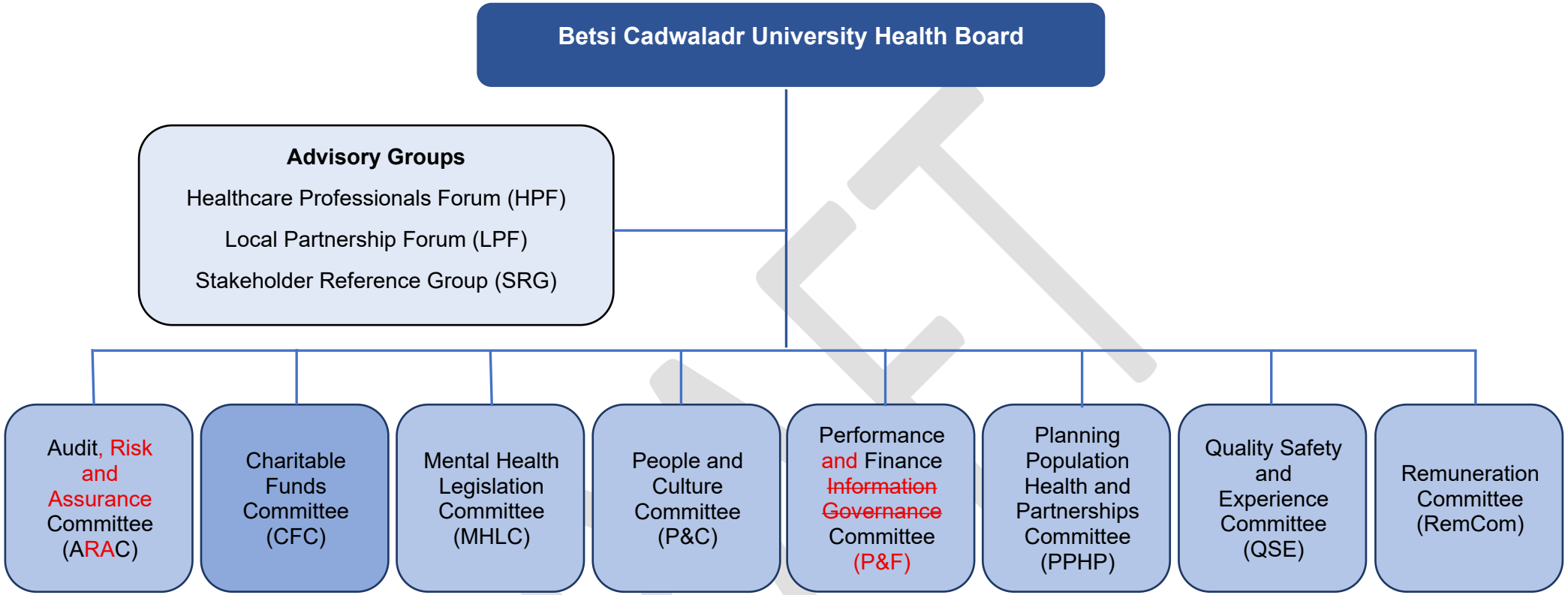
Date approved by Health Board:



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Version Control

Version	Issued to	Date	Comments
V0.1	Charitable Funds Committee	02.09.25	Endorsed for approval at the September Board
V1.0	Board	25.09.25	Approved
V1.1	Charitable Funds Committee (via email)	11.09.26	Endorsed for submission to the Board

TERMS OF REFERENCE

1 INTRODUCTION

1.1 The Betsi Cadwaladr University Health Board (BCUHB) Standing Orders provide that "The Board may and, where directed by the Welsh Government must, appoint Committees of the Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees

1.2 In accordance with Standing Orders (and the BCUHB scheme of delegation), the Board shall nominate annually a committee to be known as the Charitable Funds Committee. The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set in this document.

2 PURPOSE

The purpose of the Committee is to act on behalf of the Board to:

2.2 make and monitor arrangements for the control and management of the Health Board's Charitable Funds, within the budget, priorities and spending criteria determined by the Board and consistent with the legislative framework and that these decisions are made with the interest of the Charity in conjunction with the overarching strategy deployed by the Health Board;

2.3 provide assurance to the Board in its role as corporate trustee of the charitable funds held and administered by the Health Board. This includes an engagement and liaison role with charitable partnerships which operate with the Health Board;

2.4 receive assurance on delivery against relevant Planning Objectives aligned to the Committee, in accordance with Board approved timescales, as set out in the Health Board's Annual Plan;

2.5 agree issues to be escalated to the Board with recommendations for action;

2.6 recommend endorsement to the Trustees with regards to the annual report, annual account and strategy and to monitor this through the Charitable Funds Committee; and

2.7 ensure that, before charitable funds are applied towards service delivery, there has been a clear and open decision-making process which is independent of the Health Board's decisions concerning the use of its exchequer funds.

3 DELEGATED POWERS

With regard to its role in acting on behalf of the Board, and in providing advice and assurance to the Board, the Charitable Funds Committee will:

3.1 apply the charitable funds in accordance with its governing documents within the budget, priorities and spending criteria determined by the Health Board as corporate trustee, and

consistent with the requirements of the Charities Act 2011 (or any modification of these acts);

3.2 devise, implement and approve appropriate procedures and policies to ensure that fundraising, accounting systems and grant making are robust, donations are received and coded as instructed and that all expenditure is reasonable, clinically and ethically appropriate;

3.3 ensure that the Health Board policies and procedures for charitable funds investments are followed;

3.4 make decisions involving the sound investment of charitable funds in a way that both preserves their value and produces a proper return consistent with prudent investment and ensuring compliance with:
3.4.1 Trustee Act 2000
3 3.4.2 The Charities Act 2011
3.4.3 The Charities Act 2022
3.4.4 Terms of the fund's governing documents

3.5 receive at least twice a year reports for ratification from the Executive Director of Finance, and investment decisions and action taken through delegated powers upon the advice of the Health Board's investment adviser;

3.6 oversee and monitor the functions performed by the Executive Director of Finance as defined in the Health Board's Standing Financial Instructions;

3.7 monitor the progress of fundraising appeals where these are in place and considered to be material;

3.8 seek assurance on delivery against Planning Objectives aligned to the Committee, considering and scrutinising the programmes and processes that are developed and implemented, supporting and endorsing these as appropriate;

3.9 monitor and review the Health Board's scheme of delegation for charitable funds expenditure and to set and reflect in financial procedures the approved delegated limits for expenditure from charitable funds;

3.10 oversee the day-to-day management of the investments of the charitable funds in accordance with the investment strategy set down from time to time by the Corporate Trustees, and in accordance with the requirements of the Health Board's Standing Financial Instructions. This will include engagement, liaison and co-ordination with charitable partnerships so that the Committee is informed on relevant arrangements. The Committee is not constituted to make decisions on commercial arrangements with those charitable partnerships; and

3.11 appoint an investment manager (where appropriate) to advise it on investment matters and the delegation of day-to-day management of some or all of the investments to that investment manager. The investment manager, if appointed, must actively manage the charitable fund on behalf of the Corporate Trustee. In exercising this power, the Committee must ensure that:

- the scope of the power delegated is clearly set out in writing and communicated with the person or persons who will exercise it;

- there are in place adequate internal controls and procedures which will ensure that the power is being exercised properly and prudently;
- the performance of the person or persons exercising the delegated power is regularly reviewed;
- where an investment manager is appointed, that person is regulated under the Financial Services Act 1986; and
- acquisitions or disposal of a material nature outside the terms of agreement must always have written authority of the Committee or the Chair of the Committee in conjunction with the Executive Director of Finance.

3.12 ensure that the banking arrangements for the charitable funds should be kept entirely distinct from the Health Board's NHS funds;

3.13 ensure that arrangements are in place to maintain current account balances at minimum operational levels consistent with meeting expenditure obligations, the balance of funds being invested in interest bearing deposit accounts;

3.14 ensure the amount to be invested or redeemed from the sale of investments shall have regard to the requirements for immediate and future expenditure commitments;

3.15 ensure the operation of an investment pool when this is considered appropriate to the charity in accordance with charity law and the directions and guidance of the Charity Commission. The Committee shall propose the basis to the Health Board for applying accrued income to individual funds in line with charity law and Charity Commission guidance;

3.16 obtain appropriate professional advice to support its investment, fundraising and grant making activities;

3.17 regularly review investments to see if other opportunities or investment services offer a better return;

3.18 review alternative sources of funding to donations and legacies which could provide the Committee with additional leverage and access to additional funds;

3.19 monitor and review BCUHB's scheme of delegation for charitable funds expenditure and set and reflect in financial procedures the approved delegated limits for expenditure from charitable funds. The following thresholds are approved in the Charitable Funds Procedure: "Expenditure less than £5,000 shall only need approval by the nominated fund manager. All expenditure in excess of £5,000 will require the approval of the Charitable Funds Committee. All expenditure relating to contracts and in excess of £1,000,000 will require the approval of the Health Board in line with Welsh Government requirements";

3.20 ensure that the following expenditure types regardless of value require Charitable Funds Committee consideration and approval:

- Research & development expenditure
- Pay expenditure
- Requests of any nature resulting in ongoing charitable funds/grants commitment (such requests must report at least biennially back to the Committee to ensure the original request is still valid, and the purpose of the grant has not changed)

3.21 ensure that the following expenditure types also receive Charitable Funds Committee consideration and approval:

- Unusual or novel expenditure requests or any request which might create undue press interest under £5,000
- Overseas training requests including conferences and seminars requiring the attendance of participants outside the UK
- Higher award and academic studies over £1,500 for which significant benefit to the Health Board can be quantified through training and development objectives;

3.22 ensure that Chair's Actions are by strict exception only. The Chair's decision on which items can be approved outside the Committee will be final and all items approved outside the full Committee will be reported to the next Committee meeting for ratification;

3.23 ensure that before applying charitable funds towards service delivery there has been a clear and open decision-making process which is independent of the Health Board's decisions concerning the use of its exchequer funds;

3.24 seek assurance on the management of principal risks within the Board Assurance Framework and Corporate Risk Register allocated to the Committee and provide assurance to the Health Board that risks are being managed effectively and report any areas of significant concern e.g., where risk tolerance is exceeded, lack of timely action, etc;

3.25 recommend acceptance of risks that cannot be brought within the Health Board's risk appetite/tolerance to the Board through the Committee Update Report; and

3.26 assure the Board in relation to its compliance with relevant national practice, mandatory guidance, healthcare standards and duties, including Duty of Quality, Duty of Candour, Quality Standards and Quality Management ensuring the Board is supported to make strategic decisions from a quality perspective.

4 AUTHORITY

4.1 The Committee may investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any:

- Employee - and all employees are directed to cooperate with any legitimate request made by the Committee; and
- Other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

4.2 It may also obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

5 SUB-COMMITTEES

5.1 The Committee may, subject to the approval of the Health Board, establish sub-committees or task and finish groups to perform specific aspects of Committee business as such the Grants Decision Making Group has been created which reports into the Charitable Funds Committee.

6 MEMBERSHIP

6.1 Formal membership of the Committee shall comprise of the following:

MEMBERS
Independent Member (Chair)
2 x Independent Members (one of whom will be designated as Vice Chair)
Executive Director of Finance (Executive Lead)
2 x Executive Members

All Members of the Board (as Corporate Trustees) are welcome to attend the Committee.

6.2 The following should attend Committee meetings:

IN ATTENDANCE
Executive Director of Finance (Executive Lead)
Executive Director of Transformation and Strategic Planning
Clinical Executive Director on a rotating basis
Director of Corporate Governance
Senior Financial Accountant
Head of Charity

6.3 The membership of the Committee shall be determined by the Board, based on the recommendation of the Health Board Chair, taking into account the balance of skills and expertise necessary to deliver the Committee's remit, and subject to any specific requirements or directions made by the Welsh Government and the Charity Commission. There must be no fewer than 2 Independent Members.

6.4 Membership of the Committee will be reviewed on an annual basis.

6.5 In the event of a vote, the Chair will have the casting vote.

7 COMMITTEE MEETINGS

7.1 Quorum

- A quorum shall comprise no fewer than three of the membership, and these three must include as a minimum the Chair or Vice Chair of the Committee.

7.2 Frequency of meetings

- The Committee will meet quarterly and an annual schedule of meetings will be determined by the corporate calendar.

- Any additional meetings will be arranged under exceptional circumstance and shall be determined by the Chair of the Committee in discussion with the Executive Lead.

7.3 Withdrawal of individuals in attendance

- The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

7.4 Meeting arrangements

- The agenda and papers will be distributed/published seven days in advance of the meeting.

- The Director of Corporate Governance is to hold an agenda setting meeting with the Chair and/or Vice Chair and the Executive Director of Finance at least six weeks before the meeting date.

- The agenda will be based on the Committee work plan, identified risks, matters arising from previous meetings, issues emerging throughout the year, and requests from Committee members.

8 REPORTING AND ASSURANCE ARRANGEMENTS

The Committee, through its Chair and members, shall work closely with the other Committees to provide advice and assurance to the Board through joint planning and co-ordination of Board and Committee business including sharing information.

8.1 The Committee Chair, supported by the Committee Secretary, shall:
Report formally, regularly and on a timely basis to the Board on the Committee's activities;
- Bring to the Board's specific attention any significant matter under consideration by the Committee; and
- Ensure appropriate escalation arrangements are in place to alert the Health Board's Chair, Chief Executive and/or Chairs of other relevant Committee, of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

8.2 The Committee will undertake an annual review on the effectiveness of its arrangements and responsibilities. The Director of Corporate Governance will oversee this review.

9 RELATIONSHIP WITH THE BOARD AND ITS COMMITTEES/GROUPS

Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these Terms of Reference, it retains overall responsibility and accountability for these matters.

9.1 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference.

9.2 The Committee, through its Chair and members, shall work closely with the Board's other committees, including joint (sub) committees and groups to provide advice and assurance to the Board through the:

~ Joint planning and co-ordination of Board and Committee business and
~ Sharing of information

In doing so, it will contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

9.3 The Committee will consider the assurance provided through the work of the Board's other committees and sub groups to meet its responsibilities for advising the Board on the adequacy of the Health Board's overall system of assurance.

9.4 The Committee shall embed the Health Board's corporate standards, priorities and requirements, e.g. equality and human rights through the conduct of its business.

10 APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

10.1 The requirements for the conduct of business as set out in the Health Board's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

11 REVIEW

11.1 These Terms of Reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board.

12 CHAIR'S ACTION ON URGENT MATTERS

12.1 There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Board – after first consulting with **all** Members of the Committee. The Secretariat must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

12.2 Chair's action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

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MENTAL HEALTH LEGISLATION COMMITTEE

Terms of Reference & Operating Arrangements

(Schedule 3.5 of the Standing Orders)

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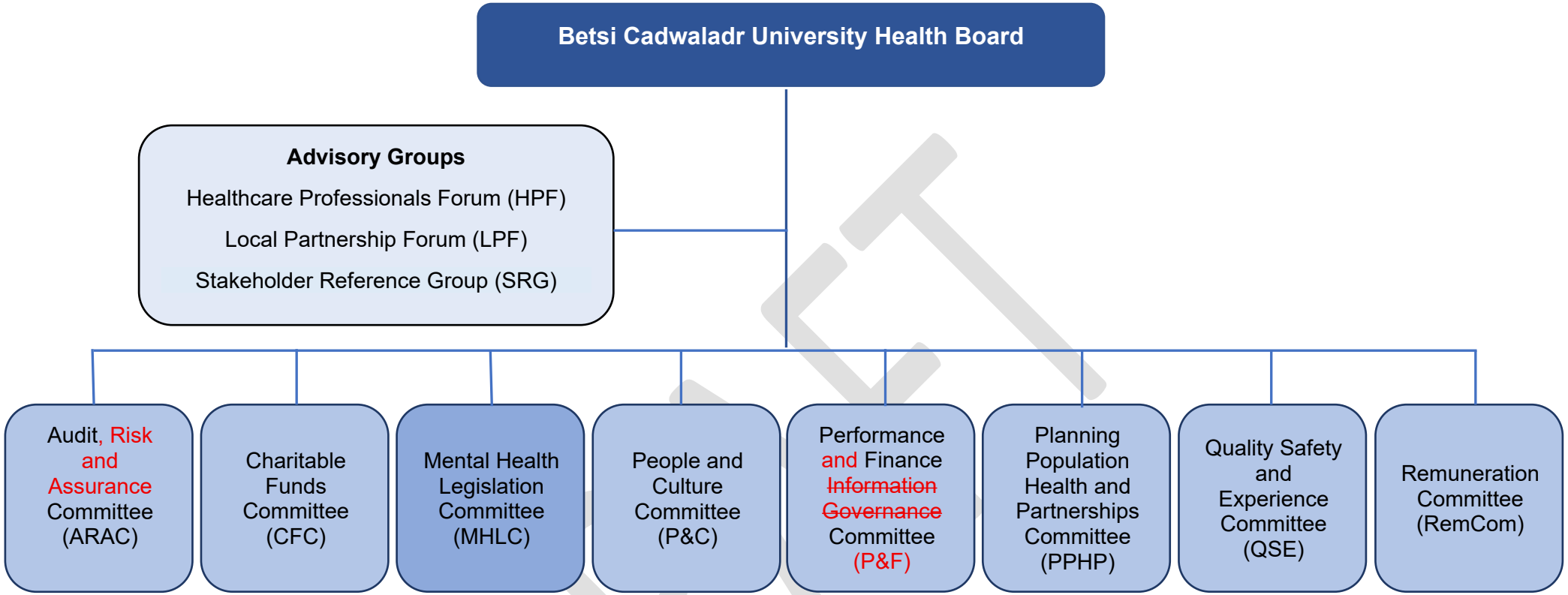
Date approved by Health Board:



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Version Control

Version	Issued to	Date	Comments
V0.1	Mental Health Legislation Committee	08.05.25	Endorsed for approval at the May Board
V1.0	Board	29.05.25	Approved
V1.1	Mental Health Legislation Committee	06.08.26	Endorsed for submission to the Board

TERMS OF REFERENCE

1 INTRODUCTION

1.1 The Betsi Cadwaladr University Health Board (BCUHB) Standing Orders provide that "The Board may and, where directed by the Welsh Government must, appoint Committees of the Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees

1.2 In accordance with Standing Orders (and the BCUHB scheme of delegation), the Board shall nominate annually a committee to be known as the Mental Health Legislation Committee. The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set in this document.

1.3 Due to the nature of the business being considered at the RC these meetings will be held in private, and papers/minutes will not be made publicly available. A summary highlight report will be received at the Public Board meeting that follows.

2 PURPOSE

The purpose of the Committee is to act on behalf of the Board to:

2.1 Provide assurance that those functions of the Mental Health Act 1983, as amended and Mental Capacity Act, 2005, as amended which have been delegated to officers and staff are being carried out correctly:

The wider operation of the two Acts in relation to the Health Board's area is appropriate and effective;

- The Health Board's responsibilities as Hospital Managers are being discharged effectively and lawfully; and
- The Health Board is compliant with Codes of Practice for the two Acts.

2.2 Identify any areas of concern in relation to compliance with mental health legislation and agree issues to be escalated to the Board with recommendations for action.

2.3 Seek assurance on the management of principal risks within the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) allocated to the Committee and provide assurance to the Board that risks are being managed effectively and report any areas of significant concern.

3 DELEGATED POWERS

With regard to its role in acting on behalf of the Board, and in providing advice and assurance to the Board, the Mental Health Legislation Committee will comment specifically upon:

3.1 The Committee shall provide advice, assurance and support to the Board in ensuring the provision of high quality, safe healthcare for its citizens of all ages, as follows:

3.2 Review reports in relation to the two Acts from Healthcare Inspectorate Wales visits, NHS Wales Executive and other external scrutiny bodies and approve the action plans for

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monitoring.

3.3 Consider issues arising from related Committees or Health Board Groups.

3.4 Receive Mental Health Legislation Assurance Reports to ensure compliance with the Codes of Practice. In respect of its provision of assurance to the Board, the Mental Health Legislation Committee will seek assurances that:

3.5 The operation of mental health legislation is exercised fairly and lawfully and that specific issues related to compliance are managed through its Committee and Group structures.

3.6 The powers provided by the Mental Health Act 1983 (notably the Board's delegated functions as Hospital Managers) are being exercised reasonably, fairly and lawfully and that specific issues related to compliance are managed through the Board's Committee and Group structure.

3.7 The powers provided by the Mental Capacity Act 2005 (notably in regard to the Deprivation of Liberty) are being exercised reasonably, fairly and lawfully and that decisions by the Court of Protection are implemented appropriately.

3.8 Identified matters of risk relating to compliance with mental health legislation are being appropriately mitigated.

3.9 Ensure that Associate Hospital Managers are being appointed, trained and appraised effectively to ensure the proper discharge of their duties and that there is appropriate access to mental health advocates; and draw on the experience of both Associate Hospital Managers and mental health advocates to receive assurance on the quality of care provided to patients.

3.10 Ensure policies and procedures are in place to facilitate compliance with the Mental Health Act 1983 and the Mental Capacity Act 2005.

3.11 Ensure that those staff who exercise the functions of mental health legislation have access to, and undertake, appropriate training to provide them with the requisite skills and competencies to discharge the Board's responsibilities.

3.12 Ensure adherence to the relevant legislation, in particular, the Human Rights Act 1998, the Equality Act 2010, and the Data Protection Act 1998.

3.13 Assure the Board in relation to its compliance with relevant national practice, mandatory guidance, healthcare standards and duties, including Duty of Quality, Duty of Candour, Quality Standards and Quality Management ensuring the Board is supported to make strategic decisions from a quality perspective.

4 AUTHORITY

4.1 The Committee may investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any:

- Employee - and all employees are directed to cooperate with any legitimate request made by the Committee; and
- Other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

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4.2 It may also obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

5 SUB-COMMITTEES

5.1 The Committee may, subject to the approval of the Health Board, establish sub-committees or task and finish groups to perform specific aspects of Committee business.

6 MEMBERSHIP

6.1 Formal membership of the Committee shall comprise of the following:

MEMBERS
Independent Member (Chair)
2 x Independent Members (one of whom will be designated as Vice Chair)

6.2 The following should attend Committee meetings:

IN ATTENDANCE
Executive Director with responsibility for Mental Health and Learning Disabilities (Executive Lead)
Executive Director of Nursing and Midwifery
Executive Medical Director
Medical Director for Mental Health and Learning Disabilities
At least one of the Medical Directors of the Integrated Health Communities
Chief Operating Officer
Deputy Director for Legal Services
Senior Manager for Mental Health Act
Senior Manager for Mental Capacity Act
At least one Director of Operations from the Integrated Health Communities
Director of Safeguarding/Head of Safeguarding
Associate Hospital Managers
CAMHS Representative
Other Attendees
The Chair can if required, invite representatives of partner agencies to attend Committees.

6.3 The attendance of the Committee shall be determined by the Board, based on the recommendation of the Health Board Chair, taking into account the balance of skills and expertise necessary to deliver the Committee's remit, and subject to any specific requirements or directions made by the Welsh Government.

6.4 Other Directors/Officers will attend as required by the Committee Chair, as well as any others from within or outside the organisation whom the Committee considers should attend, taking into account the matters under consideration at each meeting.

7 COMMITTEE MEETINGS

7.1 Quorum

- A quorum shall consist of no less than two of the membership and must include as a minimum the Chair or Vice Chair of the Committee.

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7.2 Frequency of meetings

- The Committee will meet quarterly and an annual schedule of meetings will be determined by the corporate calendar.

- Any additional meetings will be arranged under exceptional circumstance and shall be determined by the Chair of the Committee in discussion with the Executive Lead.

7.3 Withdrawal of individuals in attendance

- The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

7.4 Meeting arrangements

- The agenda and papers will be distributed/published seven days in advance of the meeting.

- The Director of Corporate Governance is to hold an agenda setting meeting with the Chair and/or Vice Chair and the Executive Director of Allied Health Professionals and health Science at least six weeks before the meeting date.

- The agenda will be based on the Committee work plan, identified risks, matters arising from previous meetings, issues emerging throughout the year, and requests from Committee members.

8 REPORTING AND ASSURANCE ARRANGEMENTS

The Committee, through its Chair and members, shall work closely with the other Committees to provide advice and assurance to the Board through joint planning and co-ordination of Board and Committee business including sharing information.

8.1 The Committee Chair, supported by the Committee Secretary, shall:

- Report formally, regularly and on a timely basis to the Board on the Committee's activities;
- Bring to the Board's specific attention any significant matter under consideration by the Committee; and
- Ensure appropriate escalation arrangements are in place to alert the Health Board's Chair, Chief Executive and/or Chairs of other relevant Committee, of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

8.2 The Committee will undertake an annual review on the effectiveness of its arrangements and responsibilities. The Director of Corporate Governance will oversee this review.

9 RELATIONSHIP WITH THE BOARD AND ITS COMMITTEES/GROUPS

Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these Terms of Reference, it retains overall responsibility and accountability for these matters.

9.1 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference.

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9.2 The Committee, through its Chair and members, shall work closely with the Board's other committees, including joint (sub) committees and groups to provide advice and assurance to the Board through the:
~ Joint planning and co-ordination of Board and Committee business and
~ Sharing of information

In doing so, it will contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

9.3 The Committee will consider the assurance provided through the work of the Board's other committees and sub groups to meet its responsibilities for advising the Board on the adequacy of the Health Board's overall system of assurance.

9.4 The Committee shall embed the Health Board's corporate standards, priorities and requirements, e.g. equality and human rights through the conduct of its business.

10 APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

10.1 The requirements for the conduct of business as set out in the Health Board's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:
• Quorum

11 REVIEW

11.1 These Terms of Reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board.

12 CHAIR'S ACTION ON URGENT MATTERS

12.1 There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Board – after first consulting with **all** Members of the Committee. The Secretariat must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

12.2 Chair's action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

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PEOPLE AND CULTURE COMMITTEE

Terms of Reference & Operating Arrangements

(Schedule 3.5 of the Standing Orders)

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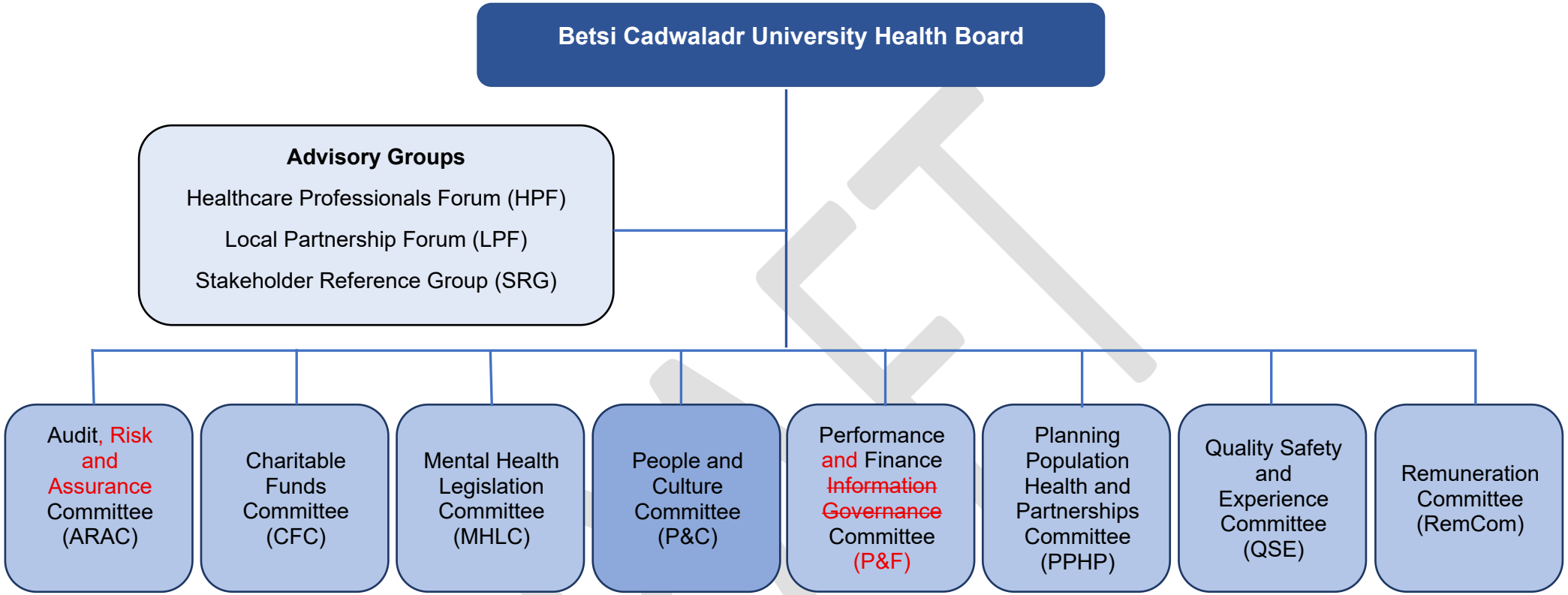
Date approved by Health Board:



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Version Control

Version	Issued to	Date	Comments
V0.1	People and Culture Committee	10.04.25	Endorsed for approval at the May Board
V1.0	Board	29.05.25	Approved
V1.1	People and Culture Committee	13.08.26	Endorsed for submission to the Board

TERMS OF REFERENCE

1 INTRODUCTION

1.1 The Betsi Cadwaladr University Health Board (BCUHB) Standing Orders provide that "The Board may and, where directed by the Welsh Government must, appoint Committees of the Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees

1.2 In accordance with Standing Orders (and the BCUHB scheme of delegation), the Board shall nominate annually a committee to be known as the People and Culture Committee. The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set in this document.

2 PURPOSE

2.1 ~~The purpose of the Committee is to act on behalf of the Board~~ The purpose of the Committee is to provide assurance to the Board regarding the effectiveness of the Health Board's workforce, organisational development and culture agenda, ensuring that the organisation has the leadership, capacity, capability and culture required to deliver its strategic objectives and provide high quality services.

The Committee will:

2.2 provide assurance to the Board on compliance with legislation, guidance and best practice to do with the People and Organisational Development (OD) agenda including:

- Foundations for the Future Programme
- Organisational Culture
- Leadership Development
- Engagement
- Workforce Planning
- Recruitment and Retention
- Wellbeing
- Welsh Language
- Employee Relations;

2.3 provide assurance to the Board on the delivery of the strategic priorities in relation to people and culture as outlined in the Integrated Medium-Term Plan (IMTP) and the all-Wales Health & Social Care Workforce Strategy, ensuring these are consistent with the Board's overall strategic direction and with any requirements and standards set for NHS bodies in Wales;

2.4 ~~provide assurance to the Board on the organisation's ability to create and manage a strong, high performance organisational culture for all its people (including~~ Provide assurance that the Health Board's people and culture agenda supports delivery of the organisation's strategic objectives, contributes to organisational performance and supports the delivery of safe, effective and sustainable services; and

~~and~~

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2.5 seek assurance on the management of principal risks within the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) allocated to the Committee and provide assurance to the Board that risks are being managed effectively and report any areas of significant concern.

2.6 approve the appointment of Consultants in accordance with the National Health Service (Appointment of Consultants) (Wales) Regulations 1996.

2.7 seek assurance on the Health Board plans to ensure the implementation of the Social Partnership and Public Procurement (Wales) Act 2023.

3 DELEGATED POWERS

With regard to its role in acting on behalf of the Board, and in providing advice and assurance to the Board, the People and Culture Committee will comment specifically upon:

3.1 provide assurance to the Board on compliance with legislation, guidance and best practice to do with the People and OD agenda, learning from work undertaken nationally and internationally, ensuring the Health Board is continually improving;

3.2 provide assurance to the Board on the delivery of the strategic priorities in relation to people and culture as outlined in the Integrated Medium term Plan (IMTP) and the all-Wales Health & Social Care Workforce Strategy, ensuring these are consistent with the Board's overall strategic direction and with any requirements and standards set for NHS bodies in Wales;

~~3.2~~3.3 provide assurance through workforce performance indicators and outcome measures that demonstrate progress against strategic workforce objectives, including workforce supply, turnover, sickness absence, recruitment, retention, staff engagement, appraisal compliance, mandatory training and workforce productivity.

3.4 pro~~vide assurance to the Board on the implementation and monitoring of the Health Board's Equality, Diversity and Inclusion arrangements~~Provide assurance on compliance with statutory equality duties, Welsh Language Standards and broader inclusion objectives, including the impact of these arrangements on workforce experience, organisational culture and leadership development.

3.5 provide assurance that the organisation is discharging its functions and meeting its responsibilities with regard to the research and innovation activity carried out within the Health Board in relation to staff development;

3.6 provide assurance that there are appropriate arrangements to ensure education and commissioning meet future workforce needs;

3.7 receive assurance on delivery against all relevant People Planning Objectives;

3.8 recommend to the Board the acceptance of risks that cannot be managed within the Health Board's agreed risk appetite or tolerance, supported by evidence that all reasonable mitigating actions have been considered.

~~recommend acceptance of risks that cannot be brought within the Health Board's risk appetite/tolerance to the Board through the Committee Update Report;~~

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3.9 receive assurance through any Committee Update Reports (that may be in existence or developed) and other management group reports that risks relating to their areas are being effectively managed across the whole of the Health Board's activities (including for hosted services and through partnerships and Joint Committees as appropriate);

3.10 assure the Board in relation to its compliance with relevant national practice, mandatory guidance, healthcare standards and duties, including Duty of Quality, Duty of Candour, Quality Standards and Quality Management ensuring the Board is supported to make strategic decisions from a quality perspective;

3.11 provide oversight, delivery and monitoring of Health and Safety strategies, planning, policies, performance and regulatory compliance; and

3.12 provide assurance regarding the effectiveness of arrangements for raising concerns, Speaking Out Safely and whistleblowing, including organisational learning, staff confidence, cultural indicators, trends and actions arising from concerns raised

~~have delegated powers to consider reports on the position in regard to whistleblowing and Speaking Out Safely.~~

3.13 Monitor compliance with issues of professional registration for all registered professionals.

3.14 Receive assurance regarding engagement with Trade Unions, professional representatives and workforce stakeholders, including compliance with the Social Partnership and Public Procurement (Wales) Act 2023 and associated partnership arrangements.

4 AUTHORITY

4.1 The Committee may investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any:

- Employee - and all employees are directed to cooperate with any legitimate request made by the Committee; and
- Other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

4.2 It may also obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

5 SUB-COMMITTEES

5.1 The Committee may, subject to the approval of the Health Board, establish sub-committees or task and finish groups to perform specific aspects of Committee business.

6 MEMBERSHIP

6.1 Formal membership of the Committee shall comprise of the following:

MEMBERS
Independent Member (Chair)
2 x Independent Members (one of whom will be designated as Vice Chair)

6.2 The following should attend Committee meetings:

IN ATTENDANCE
Executive Director of People ~~Workforce~~ and Organisational Development (Executive Lead)
Chief Executive
Director of Environment and Estates
Executive Director of Allied Health Professions & Health Science~~Executive Director (with responsibility for Welsh Language)~~

6.3 The attendance of the Committee shall be determined by the Board, based on the recommendation of the Health Board Chair, taking into account the balance of skills and expertise necessary to deliver the Committee's remit, and subject to any specific requirements or directions made by the Welsh Government.

6.4 Other Directors/Officers will attend as required by the Committee Chair, as well as any others from within or outside the organisation whom the Committee considers should attend, taking into account the matters under consideration at each meeting.

7 COMMITTEE MEETINGS

7.1 Quorum

- A quorum shall consist of no less than two of the membership, and must include as a minimum the Chair or Vice Chair of the Committee.

7.2 Frequency of meetings

- The Committee will meet bi-monthly and an annual schedule of meetings will be determined by the corporate calendar.

- Any additional meetings will be arranged under exceptional circumstance and shall be determined by the Chair of the Committee in discussion with the Executive Lead.

7.3 Withdrawal of individuals in attendance

- The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

7.4 Meeting arrangements

- The agenda and papers will be distributed/published seven days in advance of the meeting.

- The Director of Corporate Governance is to hold an agenda setting meeting with the Chair and/or Vice Chair and the Executive Director of Workforce and Organisational Development at least six weeks before the meeting date.

- The agenda will be based on the Committee work plan, identified risks, matters arising from previous meetings, issues emerging throughout the year, and requests from Committee members.

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8 REPORTING AND ASSURANCE ARRANGEMENTS

The Committee, through its Chair and members, shall work closely with the other Committees to provide advice and assurance to the Board through joint planning and co-ordination of Board and Committee business including sharing information.

8.1 The Committee Chair, supported by the Committee Secretary, shall:

- Report formally, regularly and on a timely basis to the Board on the Committee's activities;
- Bring to the Board's specific attention any significant matter under consideration by the Committee; and
- Ensure appropriate escalation arrangements are in place to alert the Health Board's Chair, Chief Executive and/or Chairs of other relevant Committee, of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

8.2 The Committee will undertake an annual review on the effectiveness of its arrangements and responsibilities. The Director of Corporate Governance will oversee this review.

9 RELATIONSHIP WITH THE BOARD AND ITS COMMITTEES/GROUPS

Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these Terms of Reference, it retains overall responsibility and accountability for these matters.

9.1 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference.

9.2 The Committee, through its Chair and members, shall work closely with the Board's other committees, including joint (sub) committees and groups to provide advice and assurance to the Board through the:
~ Joint planning and co-ordination of Board and Committee business and
~ Sharing of information

In doing so, it will contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

9.3 The Committee will consider the assurance provided through the work of the Board's other committees and sub groups to meet its responsibilities for advising the Board on the adequacy of the Health Board's overall system of assurance.

9.4 The Committee shall embed the Health Board's corporate standards, priorities and requirements, e.g. equality and human rights through the conduct of its business.

9.5 The Committee shall work collaboratively with the Remuneration Committee to provide assurance to the Board regarding leadership development, succession planning, talent management and workforce implications arising from executive and senior management arrangement

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10 APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

10.1 The requirements for the conduct of business as set out in the Health Board's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:
• Quorum

11 REVIEW

11.1 These Terms of Reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board.

12 CHAIR'S ACTION ON URGENT MATTERS

12.1 There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Board – after first consulting with **all** Members of the Committee. The Secretariat must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

12.2 Chair's action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

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PEFORMANCE AND FINANCE ~~AND INFORMATION GOVERNANCE~~ COMMITTEE

Terms of Reference & Operating Arrangements

(Schedule 3.5 of the Standing Orders)

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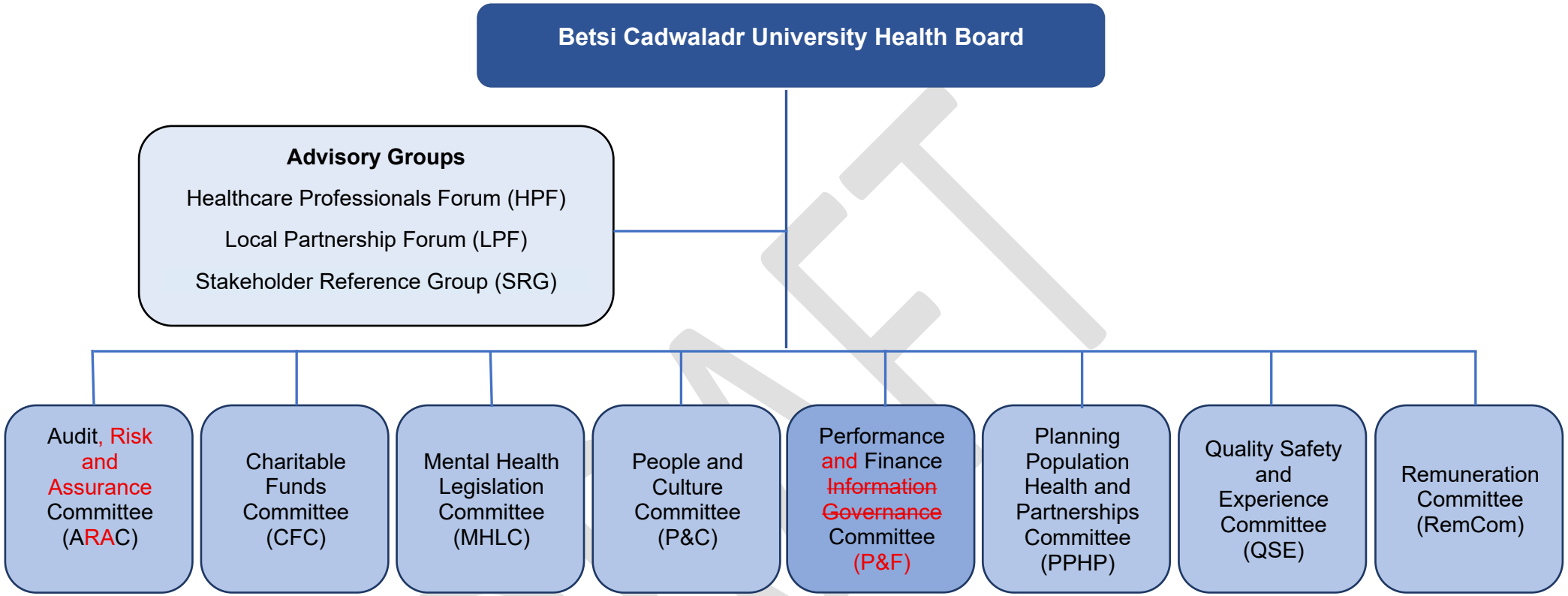
Date approved by Health Board:



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Version Control

Version	Issued to	Date	Comments
V0.1	Performance, Finance & Information Governance Committee	06.05.25	Endorsed for approval at the May Board
V1.0	Board	29.05.25	Approved
V1.1	Performance, Finance & Information Governance Committee	25.08.26	Endorsed for submission to the Board

TERMS OF REFERENCE

1 INTRODUCTION

1.1 The Betsi Cadwaladr University Health Board (BCUHB) Standing Orders provide that "The Board may and, where directed by the Welsh Government must, appoint Committees of the Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees

1.2 In accordance with Standing Orders (and the BCUHB scheme of delegation), the Board shall nominate annually a committee to be known as the Performance and Finance ~~and Information Governance~~ Committee. The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set in this document.

2 PURPOSE

The purpose of the Committee is to act on behalf of the Board to:

2.1 To advise and assure the Board in discharging its responsibilities with regard to its current and forecast financial position and performance.

2.2 Oversight, delivery and monitoring of financial strategy, planning, policies and performance including capital and external contracting.

2.3 Oversight, delivery and monitoring of performance strategies, framework, policies, WG / local targets and performance reports.

2.4 Monitoring the performance of external contracts including shared services and primary care. The Committee will provide advice on the adoption of a set of key indicators of quality of care against which the Health Board performance will be regularly assessed and reported on.

2.5 To seek assurance on the management of principle risks within the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) allocated to the Committee and provide assurance to the Board that risks are being managed effectively and report any areas of significant concern.

~~2.6 To monitor the performance and oversight of Information Governance.~~

3 DELEGATED POWERS

With regard to its role in acting on behalf of the Board, and in providing advice and assurance to the Board, the Performance and Finance ~~and Information Governance~~ Committee will comment specifically upon:

3.1 The Performance and Finance ~~and Information Governance~~ Committee is required by the Board to:

3.1.1 Provide evidence based and timely advice to the Board on the development of finance and performance related strategies and the Integrated Medium Term Plan/Annual Plan.

3.1.2 Provide evidence based and timely advice to the Board on the delivery of Strategies/aspects of strategies relating to finance and performance. ~~and information governance.~~

3.1.3 Oversee and provide evidence based and timely advice to the Board on relevant risks and mitigation.

3.1.4 Provide relevant and timely advice to the Board on developing the Integrated Medium Term Plan in relation to:

- The financial performance of the Health Board.
- The operational performance of the Health Board and associated impact on Improvement Plans.
- Evidence based assurance on the financial position, forecasting, and the capital programme.
- Evidence based assurance to the Board and Accountable Officer on whether effective arrangements are in place through the operation of the governance framework for data processing and information management.

3.1.5 Receive the results of relevant investigations and provide the Board with assurance around the implementation of accepted recommendations.

3.1.6 Seeking assurance in relation to the compliance with relevant national practice and mandatory guidance and healthcare standards and duties, including Duty of Quality, Duty of Candour, Quality Standards and Quality Management in relation to the business of the committee.

3.2 Financial Management

3.2.1 Seek assurance on the Financial Planning process.

3.2.2 Monitor financial performance and cash management against revenue budgets and statutory duties.

3.2.3 Consider submissions to be made in respect of revenue or capital in excess of £0.5m funding and the service implications of such changes, including screening and review of financial aspects of business cases as appropriate for submission to Board in line with Standing Financial Instructions.

3.2.4 Monitor turnaround and transformation programmes' progress and impact/pace of implementation of organisational savings plans.

3.2.5 Receive quarterly assurance reports arising from performance reviews, including performance and accountability reviews of individual directorates, divisions and sites.

3.2.6 Determine any new awards in respect of Primary Care contracts.

3.3 Performance Management and Accountability

3.3.1 Review and endorse revisions to the Health Board's overall Performance Management Framework (to be reviewed on a three yearly basis or sooner if required).
3.3.2 Ensure scrutiny of the performance and resources dimensions of the Quality and Performance Report (QAP)
3.3.3 Monitor performance and quality outcomes against Welsh Government targets including access times, efficiency measures and other performance improvement indicators, including local targets.
3.3.4 Review in year progress in implementing the financial and performance aspects of the Integrated Medium Term Plan (IMTP)
3.3.5 Review and monitor performance against external contracts.
3.3.6 Receive assurance reports arising from Performance and Accountability Reviews of individual teams.
3.3.7 Receive assurance reports in respect of the Shared Services Partnership.
3.3.8 Review post implementation, the extent to which benefits from business cases have been realised.

3.4 Capital Expenditure and Working Capital

3.4.1 Approve and monitor progress of the Capital Programme in excess of £0.5m.

3.5 Workforce

3.5.1 Monitor the financial aspects of workforce planning to meet service needs in line with agreed strategic plans.
3.5.2 Consider and determine any proposals from the Primary Care Board (via the Executive Team) in relation to whether the Health Board should take on responsibility for certain GP Practices.

~~3.6 Information Governance~~

~~3.6.1 Oversee the development of the Health Board's strategies and plans for maintaining the trust of patients and public through its arrangements for handling and using information, including personal information, safely and securely, consistent with the Board's overall strategic direction and any requirements and standards set for NHS bodies in Wales.~~
~~3.6.2 Oversee the direction and delivery of the Health Board's information governance strategies to drive change and transformation in line with the Health Board's integrated medium term plan that will support modernisation using information and technology.~~
~~3.6.3 Consider the information governance implications arising from the development of the Health Board's corporate strategies and plans or those of its stakeholders and partners.~~

~~3.6.4 Consider the information governance implications for the Health Board of internal and external reviews and reports.~~

~~3.6.5 Oversee the development and implementation of a culture and process for data protection by design and default (including Privacy Impact Assessments) in line with legislation (e.g. General Data Protection Regulation).~~

~~3.6.6 Oversee the direction and delivery of the Health Board's Cyber security policy (details of which will be taken in private session of the committee)~~

~~3.6.7 Oversee the direction and delivery of the Health Board's Patient records management.~~

~~3.6.8 Oversee the direction and delivery of the Health Board's National systems and programmes.~~

4 AUTHORITY

4.1 The Committee may investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any:

- Employee - and all employees are directed to cooperate with any legitimate request made by the Committee; and
- Other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

4.2 It may also obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

5 SUB-COMMITTEES

5.1 The Committee may, subject to the approval of the Health Board, establish sub-committees or task and finish groups to perform specific aspects of Committee business.

6 MEMBERSHIP

6.1 Formal membership of the Committee shall comprise of the following:

MEMBERS
Independent Member (Chair)
2 x Independent Members (one of whom will be designated as Vice Chair)

6.2 The following should attend Committee meetings:

IN ATTENDANCE
Executive Director of Finance (Executive Lead)
Chief Operating Officer
Chief Digital and Information Officer
Director of Environment and Estates

~~Director of Performance and Commissioning~~

6.3 The attendance of the Committee shall be determined by the Board, based on the recommendation of the Health Board Chair, taking into account the balance of skills and expertise necessary to deliver the Committee's remit, and subject to any specific requirements or directions made by the Welsh Government.

6.4 Other Directors/Officers will attend as required by the Committee Chair, as well as any others from within or outside the organisation whom the Committee considers should attend, taking into account the matters under consideration at each meeting.

7 COMMITTEE MEETINGS

7.1 Quorum

- A quorum shall consist of no less than two of the membership, and must include as a minimum the Chair or Vice Chair of the Committee.

7.2 Frequency of meetings

- The Committee will meet bi-monthly and an annual schedule of meetings will be determined by the corporate calendar.

- Any additional meetings will be arranged under exceptional circumstance and shall be determined by the Chair of the Committee in discussion with the Executive Lead.

7.3 Withdrawal of individuals in attendance

- The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

7.4 Meeting arrangements

- The agenda and papers will be distributed/published seven days in advance of the meeting.

- The Director of Corporate Governance is to hold an agenda setting meeting with the Chair and/or Vice Chair and the Executive Director of Finance at least six weeks before the meeting date.

- The agenda will be based on the Committee work plan, identified risks, matters arising from previous meetings, issues emerging throughout the year, and requests from Committee members.

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8 REPORTING AND ASSURANCE ARRANGEMENTS

The Committee, through its Chair and members, shall work closely with the other Committees to provide advice and assurance to the Board through joint planning and co-ordination of Board and Committee business including sharing information.

8.1 The Committee Chair, supported by the Committee Secretary, shall:

- Report formally, regularly and on a timely basis to the Board on the Committee's activities;
- Bring to the Board's specific attention any significant matter under consideration by the Committee; and
- Ensure appropriate escalation arrangements are in place to alert the Health Board's Chair, Chief Executive and/or Chairs of other relevant Committee, of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

8.2 The Committee will undertake an annual review on the effectiveness of its arrangements and responsibilities. The Director of Corporate Governance will oversee this review.

9 RELATIONSHIP WITH THE BOARD AND ITS COMMITTEES/GROUPS

Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these Terms of Reference, it retains overall responsibility and accountability for these matters.

9.1 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference.

9.2 The Committee, through its Chair and members, shall work closely with the Board's other committees, including joint (sub) committees and groups to provide advice and assurance to the Board through the:
~ Joint planning and co-ordination of Board and Committee business and
~ Sharing of information

In doing so, it will contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

9.3 The Committee will consider the assurance provided through the work of the Board's other committees and sub groups to meet its responsibilities for advising the Board on the adequacy of the Health Board's overall system of assurance.

9.4 The Committee shall embed the Health Board's corporate standards, priorities and requirements, e.g. equality and human rights through the conduct of its business.

10 APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

10.1 The requirements for the conduct of business as set out in the Health Board's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:
• Quorum

11 REVIEW

11.1 These Terms of Reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board.

12 CHAIR'S ACTION ON URGENT MATTERS

12.1 There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Board – after first consulting with **all** Members of the Committee. The Secretariat must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

12.2 Chair's action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

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DELEGATED AUTHORITY

Matter	Role	Escalation / Final Approval
Annual Discretionary Capital Programme	Recommend approval	Board
Capital Business Justification Cases > £500k	Recommend approval	Board / Welsh Government as required
Capital Schemes > £1m	Recommend approval	Board and Welsh Government [
Significant Variations to Approved Capital Schemes	Review and recommend	Board / Welsh Government as required
Asset Disposal > £250k purchase value	Approve	Delegated authority
Disposal of Land and Property (any value)	Recommend	Board and Welsh Government approval required
NHS and Non-NHS Contracts > £1m (outside framework arrangements)	Review and recommend	Board / Welsh Government as applicable
Major Contract Variations > £1m	Review and recommend	Board approval where required
Leases > £250k	Scrutiny and oversight	Executive Committee approval, reported to PFIG
Financial Elements of the IMTP	Recommend approval	Board
Major Financial Recovery Plans and Strategies	Recommend approval	Board
Information Governance Strategies and Frameworks	Recommend approval	Board where required
Special Payments, Compensation, Write-offs and Losses > £250k	Recommend in accordance with Scheme of Delegation	

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PLANNING, POPULATION HEALTH AND PARTNERSHIPS COMMITTEE

Terms of Reference & Operating Arrangements

(Schedule 3.5 of the Standing Orders)

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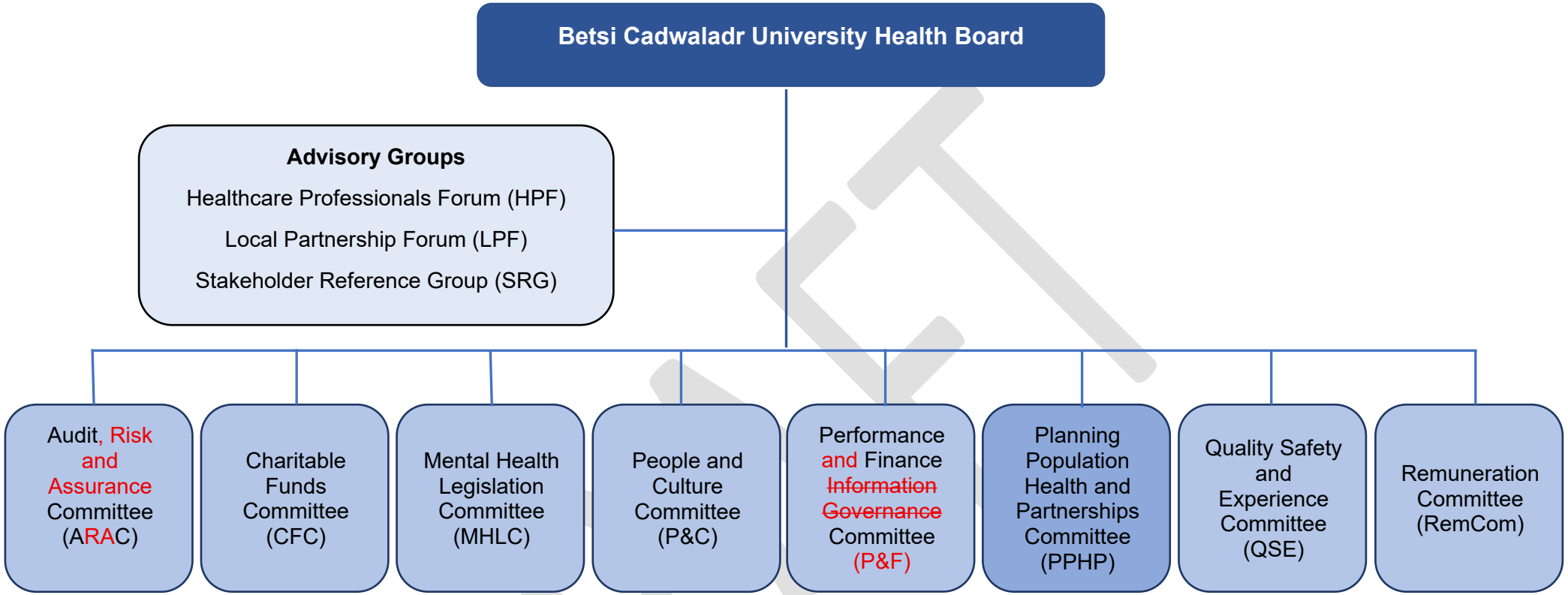
Date approved by Health Board:



Version Control

Version	Issued to	Date	Comments
V0.1	Planning, Population Health & Partnerships Committee	01.05.25	Endorsed for approval at the May Board
V1.0	Board	29.05.25	Approved
V1.1	Planning, Population Health & Partnerships Committee	03.09.26	Endorsed for submission to the Board

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TERMS OF REFERENCE

1 INTRODUCTION

1.1 The Betsi Cadwaladr University Health Board (BCUHB) Standing Orders provide that "The Board may and, where directed by the Welsh Government must, appoint Committees of the Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees

1.2 In accordance with Standing Orders (and the BCUHB scheme of delegation), the Board shall nominate annually a committee to be known as the Planning, Population health and Partnerships Committee. The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set in this document.

2 PURPOSE

The purpose of the Committee is to act on behalf of the Board to:

2.1 Provide advice and assurance to the Board with regard to the development and oversight of the Health Board's long-term planning, Integrated Medium-Term Plan and Annual Operating Plan ensuring that enabling strategies are aligned to these plans.

2.2 Ensure effective partnership arrangements are in place to improve Population Health (i.e. primary care, public health and the social determinants of health) and reduce health inequalities.

2.3 Provide oversight, delivery and monitoring (by exception) of Population Health improvement and health inequalities strategies, policies and performance informed through Population Need's Assessment.

2.4 Seek assurance on the management of principal risks within the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) allocated to the Committee and provide assurance to the Board that risks are being managed effectively and report any areas of significant concern.

3 DELEGATED POWERS

With regard to its role in acting on behalf of the Board, and in providing advice and assurance to the Board, the Planning, Population health and Partnerships Committee will comment specifically upon:

3.1 Providing advice, assurance and support to the Board on compliance with legislation, guidance and best practice relevant to the Planning, Population Health and Partnerships agenda, learning from work undertaken nationally

and internationally, ensuring the Health Board can continually improve the quality of healthcare for the population.

3.2 Providing advice and insight to the Board on the implementation of the strategies related to the Committee's remit and assurance that it is consistent with the Board's overall strategic direction and with any requirements and standards set for NHS bodies in Wales.

3.3 Providing advice, assurance and insight to the Board on the organisation's ability to create and manage strong planning, population health and partnership arrangements, including through a robust data strategy.

3.4 Providing the Board with advice and insight on the development of the Health Board's Integrated Medium Term Plan (IMTP), and long-term planning based on robust business intelligence and modelling and assuring the development of delivery plans within the scope of the Committee including their alignment to the Population Health Needs assessment. Seeking assurances on all outstanding plans in relation to the National Networks and Joint Committees including commitments agreed with partner organisations.

3.5 Receiving assurance through any update reports (that may be in existence or developed) and other management group reports that risks relating to their areas are being effectively managed across the whole of the Health Board's activities (including for hosted services and through partnerships and Joint Committees as appropriate).

3.6 Oversee the development of the Health Board's strategies and plans for maintaining the trust of patients and public through its arrangements for handling and using information, including personal information, safely and securely, consistent with the Board's overall strategic direction and any requirements and standards set for NHS bodies in Wales.

3.7 Oversee the direction and delivery of the Health Board's information governance strategies to drive change and transformation in line with the Health Board's integrated medium term plan that will support modernisation using information and technology.

3.8 Consider the information governance implications arising from the development of the Health Board's corporate strategies and plans or those of its stakeholders and partners.

3.9 Consider the information governance implications for the Health Board of internal and external reviews and reports.

3.10 Oversee the development and implementation of a culture and process for data protection by design and default (including Privacy Impact Assessments) in line with legislation (e.g. General Data Protection Regulation).

3.11 Oversee the direction and delivery of the Health Board's Cyber security policy (details of which will be taken in private session of the committee)

3.12 Oversee the direction and delivery of the Health Board's Patient records management.

3.13 Oversee the direction and delivery of the Health Board's National systems and programmes.

~~Receiving assurance on the development of plans for Digital and Information Management noting that operational assurance of Information Governance requirements is under the remit of the Health Board's Performance, Finance and Information Governance Committee.~~

3.14 Seeking insights and relevant information from Committee Advisory Groups where relevant to the remit of this agenda.

3.15 Assuring the Board in relation to its compliance with relevant national practice, mandatory guidance, healthcare standards and duties, including Duty of Quality, Duty of Candour, Quality Standards, Quality Management and the Civil Contingencies Act ensuring the Board is supported to make strategic decisions from a quality perspective.

4 AUTHORITY

4.1 The Committee may investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any:

- Employee - and all employees are directed to cooperate with any legitimate request made by the Committee; and
- Other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

4.2 It may also obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

5 SUB-COMMITTEES

5.1 The Committee may, subject to the approval of the Health Board, establish sub-committees or task and finish groups to perform specific aspects of Committee business.

6 MEMBERSHIP

6.1 Formal membership of the Committee shall comprise of the following:

MEMBERS
Independent Member (Chair)
2 x Independent Members (one of whom will be designated as Vice Chair)

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6.2 The following should attend Committee meetings:

IN ATTENDANCE
Executive Director of Transformation, Strategic Planning and Commissioning (Executive Lead)
Executive Director of Public Health
Director of Partnerships, Engagement and Communications
Chief Digital and Information Officer
Chief Operating Officer

6.3 The attendance of the Committee shall be determined by the Board, based on the recommendation of the Health Board Chair, taking into account the balance of skills and expertise necessary to deliver the Committee's remit, and subject to any specific requirements or directions made by the Welsh Government.

6.4 Other Directors/Officers will attend as required by the Committee Chair, as well as any others from within or outside the organisation whom the Committee considers should attend, taking into account the matters under consideration at each meeting.

7 COMMITTEE MEETINGS

7.1 Quorum

- A quorum shall consist of no less than two of the membership, and must include as a minimum the Chair or Vice Chair of the Committee.

7.2 Frequency of meetings

- The Committee will meet bi-monthly and an annual schedule of meetings will be determined by the corporate calendar.

- Any additional meetings will be arranged under exceptional circumstance and shall be determined by the Chair of the Committee in discussion with the Executive Lead.

7.3 Withdrawal of individuals in attendance

- The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

7.4 Meeting arrangements

- The agenda and papers will be distributed/published seven days in advance of the meeting.

- The Director of Corporate Governance is to hold an agenda setting meeting with the Chair and/or Vice Chair and the Executive Director

Transformation, Strategic Planning and Commissioning at least six weeks before the meeting date.

- The agenda will be based on the Committee work plan, identified risks, matters arising from previous meetings, issues emerging throughout the year, and requests from Committee members.

8 REPORTING AND ASSURANCE ARRANGEMENTS

The Committee, through its Chair and members, shall work closely with the other Committees to provide advice and assurance to the Board through joint planning and co-ordination of Board and Committee business including sharing information.

8.1 The Committee Chair, supported by the Committee Secretary, shall:

- Report formally, regularly and on a timely basis to the Board on the Committee's activities;
- Bring to the Board's specific attention any significant matter under consideration by the Committee; and
- Ensure appropriate escalation arrangements are in place to alert the Health Board's Chair, Chief Executive and/or Chairs of other relevant Committee, of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

8.2 The Committee will undertake an annual review on the effectiveness of its arrangements and responsibilities. The Director of Corporate Governance will oversee this review.

9 RELATIONSHIP WITH THE BOARD AND ITS COMMITTEES/GROUPS

Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these Terms of Reference, it retains overall responsibility and accountability for these matters.

9.1 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference.

9.2 The Committee, through its Chair and members, shall work closely with the Board's other committees, including joint (sub) committees and groups to provide advice and assurance to the Board through the:
~ Joint planning and co-ordination of Board and Committee business and
~ Sharing of information

In doing so, it will contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

9.3 The Committee will consider the assurance provided through the work of the Board's other committees and sub groups to meet its responsibilities for advising the Board on the adequacy of the Health Board's overall system of

assurance.

9.4 The Committee shall embed the Health Board's corporate standards, priorities and requirements, e.g. equality and human rights through the conduct of its business.

10 APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

10.1 The requirements for the conduct of business as set out in the Health Board's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:
• Quorum

11 REVIEW

11.1 These Terms of Reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board.

12 CHAIR'S ACTION ON URGENT MATTERS

12.1 There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Board – after first consulting with **all** Members of the Committee. The Secretariat must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

12.2 Chair's action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

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QUALITY, SAFETY AND EXPERIENCE COMMITTEE

Terms of Reference & Operating Arrangements

(Schedule 3.5 of the Standing Orders)

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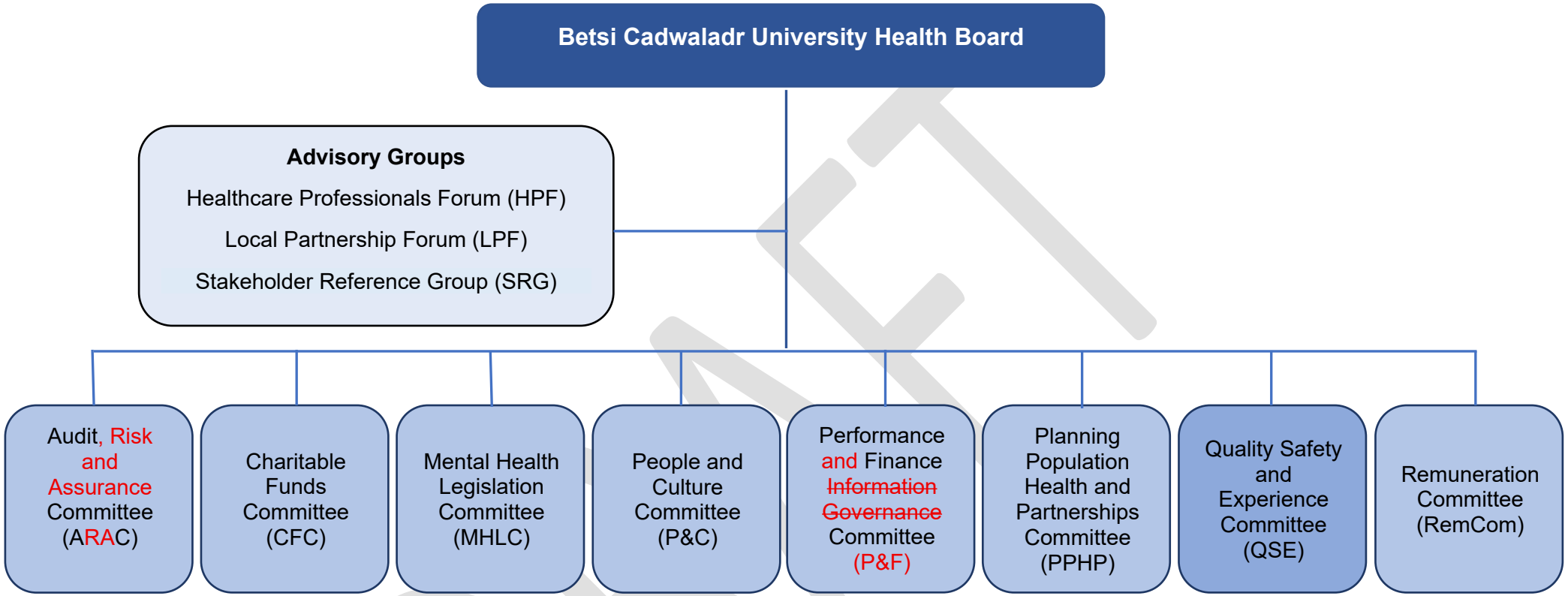
Date approved by Health Board:



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Version Control

Version	Issued to	Date	Comments
V0.1	Quality, Safety & Experience Committee	01.05.25	Endorsed for approval at the May Board
V1.0	Board	29.05.25	Approved
V1.01	Quality, Safety & Experience Committee	03.09.26	Endorsed for submission to the Board

TERMS OF REFERENCE

1 INTRODUCTION

1.1 The Betsi Cadwaladr University Health Board (BCUHB) Standing Orders provide that "The Board may and, where directed by the Welsh Government must, appoint Committees of the Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees

1.2 In accordance with Standing Orders (and the BCUHB scheme of delegation), the Board shall nominate annually a committee to be known as the Quality, Safety and Experience Committee. The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set in this document.

2 PURPOSE

The purpose of the Committee is to act on behalf of the Board to:

2.1 scrutinise, assess and seek assurance in relation to the patient experience, safety, impact, quality and health outcomes of the services provided by the Health Board;

2.2 provide evidence-based and timely advice to the Board to assist it in discharging its functions and meeting its responsibilities with regard to the quality and safety of health care provided and secured by the Health Board;

2.3 provide assurance that the Health Board has an effective strategy and delivery plan(s) for improving the quality and safety of care patients receive, commissioning quality and safety impact assessments where considered appropriate. This includes consideration of the Annual Plan/Integrated Medium Term Plan (IMTP); and

2.4 provide assurance that the organisation, at all levels, has the right governance arrangements and strategy in place to ensure that the care planned or provided is of a high standard.

3 DELEGATED POWERS

With regard to its role in acting on behalf of the Board, and in providing advice and assurance to the Board, the Quality, Safety and Experience Committee will comment specifically upon:

3.1 provide advice to the Board on the adoption of a set of key indicators of quality of care against which the Health Board's performance will be regularly assessed and reported on;

3.2 seek assurance on the management of principal risks within the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) allocated to the Committee and provide assurance to the Board that risks are being managed effectively and report any areas of significant concern;

3.3 ensure the right enablers are in place to promote a positive culture of quality improvement based on best evidence;

3.4 seek assurance on delivery against planning objectives aligned to the Committee, considering and scrutinising the processes that are developed and implemented, supporting and endorsing these as appropriate;

3.5 provide assurance that all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality and safety of care provided and, in particular, that sources of internal assurance are reliable, there is capacity and capability to deliver and lessons are learned from patient safety incidents, complaints and claims;

3.6 provide assurance to the Board in relation to improving the experience of patients, including those services provided by other organisations or in a partnership arrangement. Patient stories will feature as a key area for patient experience and lessons learnt;

3.7 provide assurance to the Board in relation to its responsibilities for the quality and safety of mental health, primary and community care, public health, health promotion, prevention and health protection activities and interventions in line with the Health Board's strategies. This includes consideration of those health and safety matters which fall under the responsibilities of this Committee;

3.8 ensure that the organisation is meeting the requirements of the NHS Concerns, Complaints and Redress Arrangements (Wales) Regulations;

3.9 approve the required action plans in respect of any concerns investigated by the Ombudsman;

3.10 agree actions, as required, to improve performance against compliance with incident reporting;

3.11 provide assurance that the Central Alert Systems process is being effectively managed with timely action where necessary;

3.12 provide assurance on the delivery of action plans arising from investigation reports and the work of external regulators;

3.13 approve the annual clinical audit plan, ensuring that internally commissioned audits are aligned with strategic priorities;

3.14 provide assurance that a review process to receive and act upon clinical outcome indicators suggesting harm or unwarranted variation is in place and is operating effectively with concerns escalated to the Board;

3.15 consider advice on clinical effectiveness and, where decisions about implementation have wider implications with regard to prioritisation and finances, prepare reports for consideration by the Executive Team which will collectively agree recommendations for consideration through relevant Committee structures;

3.16 provide assurance in relation to the organisation's arrangements for safeguarding vulnerable people, children and young people;

3.17 approve policies and plans within the scope of the Committee, having taken assurance that the quality and safety of patient care has been considered within these policies and plans;

3.18 assure the Board in relation to its compliance with relevant national practice, mandatory guidance, healthcare standards and duties, including Duty of Quality, Duty of Candour,

Quality Standards and Quality Management ensuring the Board is supported to make strategic decisions from a quality perspective;

3.19 develop a work plan which sets clear priorities for improving quality, safety and experience each year, together with intended outcomes, and monitor delivery throughout the year;

3.20 refer quality and safety matters which impact on other Board Committees and receive referrals from other Committees; and

3.21 agree issues to be escalated to the Board with recommendations for action.

4 AUTHORITY

4.1 The Committee may investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any:

- Employee - and all employees are directed to cooperate with any legitimate request made by the Committee; and
- Other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

4.2 It may also obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

5 SUB-COMMITTEES

5.1 The Committee may, subject to the approval of the Health Board, establish sub-committees or task and finish groups to perform specific aspects of Committee business.

6 MEMBERSHIP

6.1 Formal membership of the Committee shall comprise of the following:

MEMBERS
Independent Member (Chair)
2 x Independent Members (one of whom will be designated as Vice Chair)

6.2 The following should attend Committee meetings:

IN ATTENDANCE
Executive Director of Nursing and Midwifery (Executive Lead)
Executive Medical Director
Executive Director of Allied Health Professionals and Health Science
Other Executive Directors as required by the Chair including:
Chief Operating Officer
~~Director of Performance and Commissioning~~
Executive Director of People and Organisational Development
Other BCUHB Senior Managers as required by the Chair and
Chair of Healthcare Professionals Forum (Associate Board Member)
Representative of Llais

6.3 The attendance of the Committee shall be determined by the Board, based on the recommendation of the Health Board Chair, taking into account the balance of skills and expertise necessary to deliver the Committee's remit, and subject to any specific requirements or directions made by the Welsh Government.

6.4 Other Directors/Officers will attend as required by the Committee Chair, as well as any others from within or outside the organisation whom the Committee considers should attend, taking into account the matters under consideration at each meeting.

7 COMMITTEE MEETINGS

7.1 Quorum

- A quorum shall consist of no less than two of the membership, and must include as a minimum the Chair or Vice Chair of the Committee.

7.2 Frequency of meetings

- The Committee will meet bi-monthly and an annual schedule of meetings will be determined by the corporate calendar.

- Any additional meetings will be arranged under exceptional circumstance and shall be determined by the Chair of the Committee in discussion with the Executive Lead.

7.3 Withdrawal of individuals in attendance

- The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

7.4 Meeting arrangements

- The agenda and papers will be distributed/published seven days in advance of the meeting.

- The Director of Corporate Governance is to hold an agenda setting meeting with the Chair and/or Vice Chair and the Executive Director of Nursing and Midwifery at least six weeks before the meeting date.

- The agenda will be based on the Committee work plan, identified risks, matters arising from previous meetings, issues emerging throughout the year, and requests from Committee members.

8 REPORTING AND ASSURANCE ARRANGEMENTS

The Committee, through its Chair and members, shall work closely with the other Committees to provide advice and assurance to the Board through joint planning and co-ordination of Board and Committee business including sharing information.

8.1 The Committee Chair, supported by the Committee Secretary, shall:

- Report formally, regularly and on a timely basis to the Board on the Committee's activities;
- Bring to the Board's specific attention any significant matter under consideration by the Committee; and

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- Ensure appropriate escalation arrangements are in place to alert the Health Board's Chair, Chief Executive and/or Chairs of other relevant Committee, of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

8.2 The Committee will undertake an annual review on the effectiveness of its arrangements and responsibilities. The Director of Corporate Governance will oversee this review.

9 RELATIONSHIP WITH THE BOARD AND ITS COMMITTEES/GROUPS

Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these Terms of Reference, it retains overall responsibility and accountability for these matters.

9.1 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference.

9.2 The Committee, through its Chair and members, shall work closely with the Board's other committees, including joint (sub) committees and groups to provide advice and assurance to the Board through the:
~ Joint planning and co-ordination of Board and Committee business and
~ Sharing of information

In doing so, it will contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

9.3 The Committee will consider the assurance provided through the work of the Board's other committees and sub groups to meet its responsibilities for advising the Board on the adequacy of the Health Board's overall system of assurance.

9.4 The Committee shall embed the Health Board's corporate standards, priorities and requirements, e.g. equality and human rights through the conduct of its business.

10 APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

10.1 The requirements for the conduct of business as set out in the Health Board's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:
• Quorum

11 REVIEW

11.1 These Terms of Reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board.

12 CHAIR'S ACTION ON URGENT MATTERS

12.1 There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Board – after first consulting with **all** Members of

the Committee. The Secretariat must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

12.2 Chair's action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

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Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

AUDIT COMMITTEE

Annual Report 2025-26

FOREWORD

I am pleased to present the 2025-26 Annual Report of the BCUHB Audit Committee which outlines the activity for the period 1 April 2025 – 31 March 2026.

Sir Paul Lambert
Chair of the Audit Committee

Annual Report 2025 - 2026

1. Introduction

1.1 This report summarises the key areas of business activity undertaken by the Committee between 1 April 2025 and 31 March 2026 and highlights some of the key issues which the Committee intend to give further consideration to over the next 12 months.

1.2 The Committee's Annual 'Business Cycle' was a key component in ensuring that the Committee effectively carried out its role during 2025 – 26.

1.3 This report reflects the Committee's key role in the development and monitoring of the Governance and Assurance framework with respect to the (activity/function).

2. Role and Responsibilities

2.1 The primary purpose of the Committee is to act on behalf of the Board to:

2.1.1 Advise and assure the Board and the Accountable Officer on whether effective arrangements are in place, through the design and operation of the Health Board's system of assurance, to support them in their decision taking and in discharging their accountabilities for securing the achievement of the Health Board's objectives, in accordance with the standards of good governance determined for the NHS in Wales.

2.1.2 Independently monitor, review and report to the Board on the processes of governance, and where appropriate, facilitate and support, through its independence, the attainment of effective processes.

2.1.3 Where appropriate, advise the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further.

2.1.4 Review the establishment and maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities, both clinical and non-clinical.

2.1.5 Seek assurance that the systems for financial reporting to Board, including those of budgetary control, are effective, and that financial systems processes and controls are operating.

2.1.6 Work with all Committees of the Board to ensure that governance and risks are part of an embedded assurance framework that is 'fit for purpose'.

2.1.7 Receive assurance on delivery against relevant Planning Objectives aligned to the Committee in accordance with Board approved timescales, as set out in BCUHB's Annual Plan.

3. Agenda Planning Process

3.1 The Chair of the Committee, in conjunction with the Executive Lead and Meeting Secretary develops the final agenda for the Committee meetings.

3.2 The venue, location and other administrative arrangements are organised a year in advance where possible.

3.3 The secretariat for the meeting was provided by Laura Jones and latterly by Diane Davies.

3.4 The agenda and papers are disseminated to Committee members prior to the date of the meeting. Where appropriate all papers are accompanied by a cover sheet which provides an executive summary and guidance to the Committee on the action required.

4. Operating Arrangements

4.1 The Board approved the Terms of Reference, as endorsed by the Committee on 4.3.25, at the Board meeting held on 29.5.25, subsequently there were no amendments considered necessary in year in respect of the Terms of Reference and Operating arrangements for the Audit Committee.

4.2 The new Committee Cycle of Business for the Audit Committee is being presented for approval on 18 August 2026, however the agenda for each meeting is sufficiently flexible to allow the Committee to consider any emerging issues. The Committee will be renamed to Audit, Risk and Assurance Committee.

5. Membership, Frequency and Attendance

5.1 The Terms of reference of the Committee state that the Committee should consist of a minimum of three members of the Board.

5.2 During the year the Committee met on six occasions in public session, with member attendance as follows:

Name	Audit Committee Attendance
Paul Lambert (Committee Chair from October 2026)	Three out of three
Urtha Felda	Six out of six
Rhian Watcyn Jones	Five out of six
Dyfed Jones	Five out of six
Karen Balmer (Committee Chair to July 2026)	Two out of two

5.3 The Committee requires the attendance of other Health Board Officers for advice, support and information routinely at meetings. It may also co-opt additional independent ‘external’ members from outside the organisation to provide specialist skills, knowledge and expertise.

6. Committee Activity

6.1 The Committee fulfilled its work plan for 2025-2026 covering a wide range of activity. This work can be summarised under the following headings;

a) Financial Annual Accounts 2025/26
b) Annual Report 2025/26
c) Head of Internal Audit Opinion and Annual Report 2025/26

d) ISA 260 Audit of Financial Statements
e) Local Counter Fraud Annual Report and Counter Fraud Functional Standard Return 2025/26
f) Progress against Outstanding Audit Recommendations
g) Update on Internal and External Audit Recommendations
h) Health Board Policies and Written Control Documents
i) Welsh Health Circulars and Ministerial Directions
j) Declarations of Interest and Gifts and Hospitality
k) Corporate Risks and Board Assurance Framework associated with the Committee
l) Scheme of Delegation
m) Standing Orders Reservations and Delegation of Powers
n) Conformance Report
o) External Audit Progress Report
p) Internal Audit Progress Report
q) Structured Assessment
r) Local Counter Fraud Progress Report

7. Key Achievements/Benefits:

7.1 As a reader you will see from this report what a successful and varied year the Audit Committee has had during 2025-26. Although detailed more fully above and within the Committee papers, some of the key highlights were:

- Successful transition of Committee Chair with full engagement from members and supporting officers.
- Continued cycle of Executive Directors reporting on outstanding audit recommendations with improvements made to monitoring Internal and External recommendations through the Executive Team and extended to include reporting on assigned corporate risks.
- Supported the implementation of the Accountability Statement process from 2026 onward, noting that the Audit Committee would provide oversight as part of the Health Board's overall governance and accountability mechanisms.
- Received updates to the Health Board's Governance and Accountability Framework, including revisions to the Scheme of Reservation and Delegation (SORD).
- Continued improvements to the content and format of the Corporate Risk Register and Board Assurance Framework
- Monitored the implementation of a more robust policy management process and ensured risk assessment of overdue policies was undertaken and escalation process introduced.
- Strengthened the profile of Internal Audit and its function and benefits within the organisation.
- Improved processes to monitor implementation of Ministerial Directions and Welsh Health Circulars.
- Strengthened the regular Statutory Compliance report through amalgamation of various reports including audit tracking and policy compliance. As well as balancing the level of detail needed to provide confidence of effective assurance levels.
- Introduced reporting of a Corporate Governance Improvement Plan.
- Monitored the implementation of a Commissioning Assurance Framework to strengthen governance.
- Assurance was provided that improvements to processes had been implemented to ensure robust Clinical Audit plans were in place and being monitored effectively.
- Assurance was provided that a Learning Repository had been installed for lessons learned along with the introduction of thematic learning reviews across the Health Board.

- Continuous evaluation of meeting effectiveness was undertaken at each meeting including input from internal and external attendees.
- Development sessions were held to focus on Committee improvements, Risk Management and the Role of Internal Audit and Executive support.
- Covered a wide range of governance and assurance activities including:
    - Financial accounts and audit reports.
    - Risk management and control frameworks.
    - Policy and compliance oversight.
    - Fraud prevention
- Conducted a self-assessment using the Audit Committee Handbook.
- Regular 'AAA Reports' were submitted to the Board.
- Transparent publication of minutes and papers on the Health Board's website.

8. Key Challenges

8.1 A focus for the Committee in 2026 forward into 2027, will be the work which is underway to give assurance at a strategic level.

8.2 Finally, although these challenges remain, the Committee will continue to monitor activity and develop innovative ways to support new developments and opportunities.

9. Committee Effectiveness & Performance

9.1 The Committee regularly reviews its own performance by completing this report on an annual basis, reviewing the cycle of business which provides the Committee with the basis on which it will monitor its progress during the year and also provide clarity for all of those who contribute to the agenda as to the expectations of them.

9.2 A Committee effectiveness questionnaire will be issued again circa February 2027, the outcome of which will be reported to the Committee in respect of recommendations and subsequent actions in response to areas identified for improvement.

9. Reporting the Committee's Work

9.1 The Committee Chair reports the key issues discussed at each of its meetings by way of a 'AAA Report' to the Board.

9.2 These reports are supported by the relevant and more detailed Committee minutes. Committee papers, including minutes are routinely published on the Health Board's website.

10. Conclusion and way forward

10.1 The Committee is very grateful to all those involved in the work of the Committee for their support over the past 12 months, and for the constructive and positive way in which they have contributed to the activity.

10.2 The Committee will continue to ensure that it conducts its business in accordance with legislation and best practice.

10.3 It will provide the assurance that the Committee has in place the appropriate governance arrangements and resources to ensure success in achieving its objectives.

11. Further Information

Please visit the Health Board's websites for further information as outlined below:
Committees and Advisory Groups - Betsi Cadwaladr University Health Board

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

CHARITABLE FUNDS COMMITTEE

Annual Report 2025-26

FOREWORD

I am pleased to present the 2025-26 Annual Report of the Betsi Cadwaladr University Health Board Charitable Funds Committee, covering the period 1 April 2025 to 31 March 2026. This report provides an overview of the Committee's work during the year and highlights how charitable donations have continued to make a meaningful difference to patients, families, staff and services across North Wales.

The generosity of our local communities, supporters, fundraisers, volunteers and donors continues to have a positive impact across the Health Board. Through the careful stewardship of charitable funds, the Committee has ensured that donations have been used appropriately and effectively to support initiatives that enhance patient care, improve the experience of service users, support staff wellbeing and enable opportunities that could not otherwise be funded through core NHS resources.

During the year, the Committee maintained oversight of the Health Board's charitable funds, investment arrangements and grant-making activity, ensuring that robust governance, financial management and accountability arrangements remained in place. The Committee has also continued to receive valuable reports demonstrating the difference charitable funding makes in practice, helping us understand the real impact of donations on the people and communities we serve.

On behalf of the Committee, I would like to thank everyone who has contributed to this important work. This includes our donors and fundraisers, the Charitable Support Team, staff who have developed and delivered projects supported through charitable funding, and Committee members who have provided effective scrutiny, challenge and assurance throughout the year.

As we look ahead, the Committee remains committed to ensuring that charitable funds are managed responsibly, transparently and in line with donors' intentions, whilst continuing to maximise the positive impact that charitable giving can have across the Health Board.

Dyfed Jones
Chair of the Charitable Funds Committee

Annual Report 2025 - 2026

1. Introduction

1.1 This report summarises the key areas of business activity undertaken by the Committee between 1 April 2025 and 31 March 2026 and highlights some of the key issues which the Committee intend to give further consideration to over the next 12 months.

1.2 The Committee's Annual 'Business Cycle' was reviewed on 12 November 2024 and was a key component in ensuring that the Committee effectively carried out its role during 2025 – 26.

1.3 This report reflects the Committee's key role in the development and monitoring of the Governance and Assurance framework with respect to the (activity/function).

2. Role and Responsibilities

2.1 The primary purpose of the Charitable Funds Committee is to support the Board in its role as Corporate Trustee by providing oversight of the Health Board's charitable funds and ensuring that those funds are managed, invested and applied appropriately, effectively and in accordance with charity law, regulatory requirements, donors' intentions and best practice.

The Committee provides assurance to the Board that robust governance, financial stewardship and accountability arrangements are in place to safeguard charitable assets and maximise the benefit that charitable funding delivers for patients, service users, staff and local communities.

3. Agenda Planning Process

3.1 The Committee operates within an agreed annual cycle of business which is aligned to its Terms of Reference and designed to ensure that the Committee receives the information, assurance and oversight necessary to discharge its responsibilities on behalf of the Board as Corporate Trustee.

3.2 The Committee Chair, supported by the Executive Lead and Committee Secretariat, reviews and agrees each agenda to ensure that key statutory, governance, financial and strategic matters are considered at the appropriate time, alongside any emerging issues requiring scrutiny or assurance.

3.3 Agenda development is informed by the Committee's annual cycle of business, previous decisions and actions, regulatory requirements, and matters escalated for consideration by officers or the Board. This ensures that the Committee maintains effective oversight of charitable funds and associated governance arrangements throughout the year.

3.4 The Committee Secretariat, provided by Natalie Morrice-Evans and Harriet Abbott, coordinates the preparation and dissemination of agendas and supporting papers to enable members to undertake informed discussion, scrutiny and decision-making. Committee papers are accompanied by clear recommendations and guidance on the action required.

3.5 Whilst the Committee follows a planned programme of work, sufficient flexibility is maintained within agendas to enable consideration of emerging risks, opportunities or matters requiring timely review and decision.

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4. Operating Arrangements

4.1 The Committee operates in accordance with its approved Terms of Reference, Standing Orders, Standing Financial Instructions and the Scheme of Delegation adopted by the Board in its role as Corporate Trustee. The Committee reviews its operating arrangements periodically to ensure that they remain effective and aligned to statutory requirements, best practice and the needs of the organisation.

4.2 During 2025-26, the Committee reviewed its Terms of Reference and operating arrangements and was satisfied that they remained fit for purpose. Any amendments identified were minor in nature and were approved through the Health Board's governance process.

4.3 The Committee conducted its business through a programme of regular meetings supported by comprehensive reports covering financial performance, investment management, charitable expenditure, fundraising activity and governance matters. This enabled members to provide appropriate scrutiny, challenge and oversight of the Health Board's charitable funds and associated activities.

4.4 The Committee receives advice and support from Executive Directors and officers with responsibility for finance, governance and charitable funds administration. Specialist advice is also sought where required to support effective decision-making and the discharge of the Board's responsibilities as Corporate Trustee.

4.5 The Committee is committed to maintaining high standards of governance, transparency and accountability and seeks assurance that charitable funds are managed prudently, applied in accordance with donors' intentions and utilised to deliver maximum benefit for patients, staff and communities across North Wales.

5. Membership, Frequency and Attendance

5.1 The Terms of reference of the Committee state that the Committee should consist of a minimum of three members of the Board.

5.2 During the year the Committee met on five occasions with member attendance as follows:

Name	Attendance
Dyfed Jones, Committee Chair	Four out of five meetings
Chris Lothian-Field, Vice Chair	Three out of five meetings
Karen Balmer (Committee Member until 31.07.25)	One out of one meeting

Sir Paul Lambert (Committee Member since 13.10.25)	Three out of three meetings

5.3 The Committee requires the attendance of other Health Board Officers for advice, support and information routinely at meetings. It may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

6. Committee Assurance

Through its programme of work during 2025-26, the Committee received information, reports and evidence to enable it to discharge its responsibilities on behalf of the Board as Corporate Trustee and provide assurance regarding the stewardship, governance and management of the Health Board's charitable funds.

Then structure the section under assurance themes:

Financial Stewardship
The Committee received regular Finance Reports providing assurance regarding the overall financial position of the charitable funds, including income, expenditure and fund balances. The Committee was satisfied that charitable resources continued to be managed appropriately and in accordance with approved governance arrangements.

Investment Management
The Committee received regular Investment Management Reports, enabling members to monitor investment performance and seek assurance that charitable assets were being managed prudently and in accordance with the approved investment strategy.

Use of Charitable Funds
The Committee received assurance regarding the allocation and utilisation of charitable funds through reports from the Charitable Funds Grants Decision Meetings. These reports demonstrated how charitable funding supported projects and initiatives that enhanced patient care, staff wellbeing and service improvement.

Fundraising and Charitable Support Activities
The Committee received updates from the Charitable Support Team on fundraising activity, donor engagement and charitable support initiatives, providing assurance regarding the effective administration of charitable donations and fundraising activity.

Governance and Accountability
The Committee reviewed reports relating to governance, risk and external scrutiny, including the Audit Wales Plan, to ensure that appropriate controls, accountability arrangements and oversight mechanisms remained in place.

Based on the evidence presented throughout the year, the Committee was able to provide assurance to the Board that appropriate arrangements were in place for the stewardship, governance and management of the Health Board's charitable funds during 2025-26.

7. Key Achievements

During 2025-26, the Committee continued to discharge its responsibilities on behalf of the Board as Corporate Trustee, providing oversight and assurance regarding the governance, stewardship and application of the Health Board's charitable funds. Key achievements during the year included:

- Maintaining effective oversight of the Health Board's charitable funds and investment portfolio, providing assurance that charitable assets were managed prudently and in accordance with approved governance arrangements.
- Receiving regular assurance regarding the allocation and use of charitable funds, helping to ensure that donations continued to support initiatives that enhanced patient care, staff wellbeing and service improvement across North Wales.
- Strengthening transparency and accountability through scrutiny of financial, investment and governance reports, enabling the Committee to assure itself that charitable resources were being managed effectively and in line with donors' intentions.
- Receiving direct feedback on the impact of charitable funding, enabling members to better understand the difference charitable donations make to patients, families, staff and services across the Health Board.]
- Supporting the work of the Charitable Support Team and recognising the contribution of donors, volunteers, fundraisers and local communities whose generosity continues to enhance healthcare services across North Wales.
- Providing assurance to the Board that appropriate governance, financial management and oversight arrangements remained in place throughout the year in respect of charitable funds.

9. Committee Effectiveness & Performance

9.1 The Committee regularly reviews its own performance by completing this report on an annual basis, reviewing the cycle of business which provides the Committee with the basis on which it will monitor its progress during the year and also provide clarity for all of those who contribute to the agenda as to the expectations of them.

9.2 A Committee effectiveness questionnaire will be issued again circa XXXX, the outcome of which will be reported to the Committee in respect of recommendations and subsequent actions in response to areas identified for improvement.

9. Reporting the Committee's Work

9.1 The Committee Chair reports the key issues discussed at each of its meetings by way of a 'AAA Report' to the Board.

9.2 These reports are supported by the relevant and more detailed Committee minutes. Committee papers, including minutes are routinely published on the Health Board's website.

10. Conclusion and way forward

10.1 The Committee would like to thank all donors, fundraisers, volunteers, members and officers who contributed to the work of the charity during the year. Through effective stewardship, governance and oversight, the Committee has been able to provide assurance

to the Board that charitable funds continue to be managed responsibly and used to deliver meaningful benefits for patients, staff and communities across North Wales. The Committee looks forward to building on this work during 2026-27.

10.2 The Committee will continue to ensure that it conducts its business in accordance with legislation and best practice.

10.3 It will provide the assurance that the Committee has in place the appropriate governance arrangements and resources to ensure success in achieving its objectives.

11. Further Information

Please visit the Health Board's websites for further information as outlined below:
Committees and Advisory Groups - Betsi Cadwaladr University Health Board

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

MENTAL HEALTH LEGISLATION COMMITTEE

Annual Report 2025-26

FOREWORD

I am pleased to present the 2025-26 Annual Report of the Mental Health Legislation Committee. The Committee plays a vital role in supporting the Board's responsibility to ensure that the Health Board discharges its statutory duties under the Mental Health Act 1983 and the Mental Capacity Act 2005 effectively, lawfully and with due regard to the rights, dignity and wellbeing of patients. Through its work, the Committee provides assurance to the Board that robust governance arrangements are in place to oversee compliance with mental health legislation and to monitor the effective discharge of the Health Board's responsibilities as Hospital Managers.

During 2025-26, the Committee considered a range of assurance reports covering the operation of the Mental Health Act and Mental Capacity Act, the work of Associate Hospital Managers, matters arising from Healthcare Inspectorate Wales and updates from the Power of Discharge Group. Through scrutiny of these reports and the challenge provided by Committee members, the Committee sought assurance that statutory responsibilities were being discharged appropriately and that any areas of concern were identified, monitored and addressed through the Health Board's governance arrangements.

A key aspect of the Committee's work has been maintaining oversight of areas where assurance and continued vigilance are required. Mental health legislation exists to safeguard some of the most vulnerable individuals in our care, and it is therefore essential that the Health Board continues to demonstrate strong governance, effective oversight and a culture of continuous improvement in relation to statutory compliance and patient rights. The Committee has remained committed to ensuring that these important matters receive appropriate scrutiny and attention throughout the year.

Whilst the Committee was able to gain assurance in a number of areas during 2025-26, it also recognises the importance of maintaining focus during the coming year. Continued oversight of compliance, governance arrangements, external review findings and risks relating to mental health legislation will remain a priority for the Committee in 2026-27. The Committee will continue to support the Board by providing constructive challenge, seeking evidence of improvement and ensuring that assurance is proportionate, robust and focused on those matters of greatest significance.

I would like to thank Committee members, officers and colleagues across the Health Board for their commitment and contribution throughout the year. Their expertise, professionalism and dedication have supported the Committee in fulfilling its responsibilities and providing assurance to the Board on these important statutory functions.

Gareth Williams
Chair of the Mental Health Legislation Committee

Annual Report 2025 - 2026

1. Introduction

1.1 This report provides the Board with an annual summary of the assurance received by the Mental Health Legislation Committee during 2025-26. It describes how the Committee discharged its delegated responsibilities on behalf of the Board and identifies the key areas of oversight, assurance and ongoing focus for 2026-27.

1.2 The Committee's Annual 'Business Cycle' was reviewed and was a key component in ensuring that the Committee effectively carried out its role during 2025 – 26

1.3 The Committee plays an important role in the Health Board's governance and assurance framework by providing oversight of compliance with the Mental Health Act 1983 and the Mental Capacity Act 2005. Through its work, the Committee seeks assurance that statutory responsibilities are discharged effectively and lawfully, that patients' rights are protected, and that any areas of concern are appropriately identified, managed and escalated where necessary.

2. Role and Responsibilities

2.1 The primary purpose of the Committee is to act on behalf of the Board to:

2.1.1 Provide assurance that those functions of the Mental Health Act 1983, as amended and Mental Capacity Act, 2005, as amended which have been delegated to officers and staff are being carried out correctly:

- The wider operation of the two Acts in relation to the Health Board's area is appropriate and effective;
- The Health Board's responsibilities as Hospital Managers are being discharged effectively and lawfully; and.
- The Health Board is compliant with Codes of Practice for the two Acts.

2.1.2 Identify any areas of concern in relation to compliance with mental health legislation and agree issues to be escalated to the Board with recommendations for action.

2.1.3 Seek assurance on the management of principal risks within the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) allocated to the Committee and provide assurance to the Board that risks are being managed effectively and report any areas of significant concern.

3. Agenda Planning Process

3.1 The Chair of the Committee, in conjunction with the Executive Lead and Meeting Secretary develops the final agenda for the Committee meetings.

3.2 The venue, location and other administrative arrangements are organised a year in advance where possible.

3.3 The secretariat for the meeting is provided by Harriet Abbott.

3.4 The agenda and papers are disseminated to Committee members prior to the date of the meeting. Where appropriate all papers are accompanied by a cover sheet which provides an executive summary and guidance to the Committee on the action required.

4. Operating Arrangements

4.1 Only very minor amendments were considered necessary in respect of the Terms of Reference and Operating arrangements for the Mental Health Legislation Committee.

4.2 The new Committee Cycle of Business for the Mental Health Legislation Committee is being presented for approval on 6th August 2026, however the agenda for each meeting is sufficiently flexible to allow the Committee to consider any emerging issues.

5. Membership, Frequency and Attendance

5.1 The Terms of reference of the Committee state that the Committee should consist of a minimum of three members of the Board.

5.2 During the year the Committee met on four occasions with member attendance as follows:

Name	Attendance
Gareth Williams, Committee Chair	Three out of four meetings
Rhian Watcyn Jones, Committee Vice Chair	Four out of four meetings
Dyfed Jones	Three out of four meetings

5.3 The Committee requires the attendance of other Health Board Officers for advice, support and information routinely at meetings. It may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

6. Committee Assurance

6.1 Mental Health Act Assurance

The Committee received regular Mental Health Act Assurance Reports throughout 2025-26. These reports provided assurance regarding the operation of delegated statutory functions and compliance with the legislative framework. Through review of the information presented, the Committee sought assurance that statutory responsibilities were being discharged appropriately and that any identified areas of concern were subject to management action and monitoring.

6.2 Mental Capacity Act Assurance

The Committee received assurance reports relating to the Mental Capacity Act and sought assurance that appropriate governance arrangements were in place to support compliance with statutory requirements. The Committee maintained oversight of developments relevant to the legislative framework and the associated implications for the Health Board.

6.3 Healthcare Inspectorate Wales
The Committee considered reports relating to Healthcare Inspectorate Wales and sought assurance that findings, recommendations and learning relevant to mental health legislation were being considered through the appropriate governance processes. Members provided scrutiny and challenge where required to ensure appropriate oversight of improvement activity.

6.4 Associate Hospital Managers
The Committee received regular updates regarding Associate Hospital Managers and sought assurance that appropriate arrangements remained in place to support the effective discharge of the Health Board's responsibilities as Hospital Managers.

6.5 Power of Discharge Group
The Committee received reports from the Power of Discharge Group and maintained oversight of matters relating to the exercise of Hospital Managers' functions. The Committee was assured that appropriate governance arrangements were in place to support decision-making processes within its remit.

6.6 Risk and Escalation
Any matters requiring escalation were reported to the Board through established governance arrangements.

7. Key Achievements

During 2025-26, the Committee:

- Continued to provide Board assurance regarding compliance with the Mental Health Act 1983 and Mental Capacity Act 2005.
- Maintained oversight of the Health Board's responsibilities as Hospital Managers.
- Scrutinised assurance reports relating to delegated statutory functions.
- Considered Healthcare Inspectorate Wales findings and related governance matters.
- Received assurance regarding the operation of Associate Hospital Managers arrangements.
- Maintained oversight of the Power of Discharge Group.

8. Future Focus

The Committee recognises that continued focus will be required during 2026-27 to:

- Maintain effective compliance with the Mental Health Act and Mental Capacity Act.
- Continue to strengthen assurance reporting and evidence of compliance.
- Ensure that delegated statutory functions continue to be discharged effectively and lawfully.
- Maintain effective oversight of matters arising from external inspection and review.
- Ensure that risks associated with mental health legislation remain appropriately managed and monitored.
- Continue to provide effective assurance to the Board in relation to statutory compliance and governance arrangements.

9. Committee Effectiveness & Performance

9.1 The Committee regularly reviews its own performance by completing this report on an annual basis, reviewing the cycle of business which provides the Committee with the basis on which it will monitor its progress during the year and also provide clarity for all of those who contribute to the agenda as to the expectations of them.

9.2 A Committee effectiveness questionnaire will be issued again circa July 2026, the outcome of which will be reported to the Committee in respect of recommendations and subsequent actions in response to areas identified for improvement.

9. Reporting the Committee's Work

9.1 The Committee Chair reports the key issues discussed at each of its meetings by way of a 'AAA Report' to the Board.

9.2 These reports are supported by the relevant and more detailed Committee minutes. Committee papers, including minutes are routinely published on the Health Board's website.

10. Overall Assurance Opinion

10.1 During 2025-26, the Mental Health Legislation Committee discharged its responsibilities in accordance with its Terms of Reference and approved Cycle of Business.

10.2 Through the reports received, the scrutiny undertaken and the challenge provided by Committee members, the Committee was able to provide the Board with assurance that appropriate governance arrangements were in place to support compliance with the Mental Health Act 1983 and Mental Capacity Act 2005 and to discharge the Health Board's responsibilities as Hospital Managers.

10.3 The Committee identified areas requiring continued scrutiny during 2026-27, including ongoing compliance monitoring, assurance reporting and the management of risks associated with mental health legislation.

10.4 Overall, the Committee was satisfied that appropriate governance and assurance arrangements were in place during the reporting period and will continue to provide oversight on behalf of the Board.

11. Conclusion and way forward

11.1 The Committee wishes to record its thanks to members, officers and colleagues who have supported its work throughout 2025-26 and contributed to the effective scrutiny of matters within its remit.

11.2 During 2026-27, the Committee will continue to focus on providing assurance to the Board regarding compliance with mental health legislation and will seek assurance that governance arrangements remain effective in protecting patients' rights and supporting the lawful discharge of statutory responsibilities.

11.3 Particular attention will be given to compliance assurance, governance arrangements, external review findings and the management of risks associated with mental health legislation.

12. Further Information

Please visit the Health Board's websites for further information as outlined below:
Committees and Advisory Groups - Betsi Cadwaladr University Health Board

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

PEOPLE AND CULTURE COMMITTEE

Annual Report 2025-26

FOREWORD

I am pleased to present the 2025-26 Annual Report of the People and Culture Committee.

During the year, the Committee discharged its delegated responsibilities on behalf of the Board by scrutinising performance, risks, strategic programmes and statutory obligations relating to the people and culture agenda. In doing so, the Committee sought assurance that appropriate governance arrangements, controls and improvement plans were in place to support delivery of the Health Board's strategic objectives and to respond to emerging workforce and organisational challenges.

The Committee received regular reports on workforce planning, organisational culture, staff experience, leadership development, wellbeing, equality, Welsh language, health and safety and employment matters. It also maintained oversight of relevant risks within the Board Assurance Framework and Corporate Risk Register, together with the people and organisational development implications of the Foundations for the Future Programme.

Through its work, the Committee was able to provide assurance to the Board in a number of key areas whilst identifying matters that require continued scrutiny and oversight during 2026-27. These include workforce sustainability, organisational change, staff experience, organisational culture and the effective management of risks within the Committee's remit.

The remainder of this report summarises the assurance received, the challenge provided by Committee members and the key areas requiring continued attention.

Dyfed Jones
Chair of the People and Culture Committee

Annual Report 2025 - 2026

1. Introduction

1.1 This report provides the Board with an annual summary of the assurance received by the People and Culture Committee during 2025-26. It describes how the Committee discharged its delegated responsibilities on behalf of the Board and identifies the key areas of oversight, assurance and ongoing focus for 2026-27.

1.2 The Committee's work during the year was guided by its Terms of Reference and Cycle of Business, which supported the systematic consideration of key matters within its remit. The Committee considered reports and updates relating to workforce, culture, organisational development, staff experience, wellbeing, equality, Welsh language, health and safety, and the management of relevant risks.

1.3 Through its work, the Committee sought assurance that appropriate arrangements were in place to support delivery of the Health Board's strategic priorities relating to people and culture, including those set out in the Integrated Medium-Term Plan and relevant all-Wales workforce strategies.

2. Role and Responsibilities

2.1 The primary purpose of the Committee is to act on behalf of the Board to:

2.1.1 provide assurance to the Board on compliance with legislation, guidance and best practice to do with the People and Organisational Development (OD) agenda including:

- Foundations for the Future Programme
- Organisational Culture
- Leadership Development
- Engagement
- Workforce Planning
- Recruitment and Retention
- Wellbeing
- Welsh Language
- Employee Relations

2.1.2 provide assurance to the Board on the delivery of the strategic priorities in relation to people and culture as outlined in the Integrated Medium-Term Plan (IMTP) and the all-Wales Health & Social Care Workforce Strategy, ensuring these are consistent with the Board's overall strategic direction and with any requirements and standards set for NHS bodies in Wales.

2.1.3 provide assurance to the Board on the organisation's ability to create and manage a strong, high performance organisational culture for all its people (including workforce, volunteers and stakeholders).

2.1.4 seek assurance on the management of principal risks within the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) allocated to the Committee

and provide assurance to the Board that risks are being managed effectively and report any areas of significant concern.

2.1.5 approve the appointment of Consultants in accordance with the National Health Service (Appointment of Consultants) (Wales) Regulations 1996.

2.1.6 seek assurance on the Health Board plans to ensure the implementation of the Social Partnership and Public Procurement (Wales) Act 2023.

3. Agenda Planning Process

3.1 The Chair of the Committee, in conjunction with the Executive Lead and the Corporate Governance Directorate develop the final agenda for Committee meetings.

3.2 The venue, location and other administrative arrangements are organised a year in advance where possible.

3.3 The secretariat for the meeting is provided by Laura Jones.

3.4 The agenda and papers are disseminated to Committee members prior to the date of the meeting. Where appropriate all papers are accompanied by a cover sheet which provides an Executive Summary and guidance for the Committee on the action required.

4. Operating Arrangements

4.1 The Committee reviewed its Terms of Reference and operating arrangements during the year. A minor amendment was made to ensure the Committee's remit remained clear, current and aligned to the Board's assurance requirements.

4.2 The Committee also reviewed its Cycle of Business, which provided a structured framework for ensuring that key matters within the Committee's remit were scheduled for consideration during the year. The agenda remained sufficiently flexible to allow the Committee to consider emerging issues and areas requiring additional scrutiny.

5. Membership, Frequency and Attendance

5.1 The Terms of Reference state that the Committee should consist of a minimum of three members of the Board.

5.2 During the year the Committee met on six occasions with member attendance as follows:

Name	Attendance
Councillor Dyfed Jones, Committee Chair (Local Authority)	Five out of six meetings
William Nichols, Committee Vice Chair (Trade Union Representative)	Four out of six meetings
Clare Budden	Six out of six meetings
Paul Lambert (Committee Member since 13.10.25)	Two out of three meetings
Karen Balmer	One out of two meetings

(Committee Member until 31.07.25)	

5.3 The Committee requires the attendance of other Health Board Officers for advice, support and information routinely at meetings. It may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

6. Committee Activity and Assurance Received

During 2025-26, the Committee considered a wide range of reports and updates aligned to its delegated remit. The Committee's business can be summarised under the following assurance themes:

6.1 Workforce planning, recruitment and retention

The Committee received regular assurance through the People Operations Report, Strategic Workforce Planning Framework and reports relating to recruitment, retention, sickness absence, consultant job planning and on-call arrangements. The Committee recognised that workforce capacity, capability and sustainability are critical to the Health Board's ability to deliver safe, effective and sustainable services. Through scrutiny of workforce performance, workforce risks and mitigating actions, the Committee sought assurance that appropriate plans were in place to attract, retain, develop and support the workforce, whilst addressing workforce pressures and organisational challenges.

6.2 Culture, leadership and engagement

The Committee received regular assurance on organisational culture, leadership development, staff engagement and employee experience through a range of reports and performance information. The Committee recognised these areas as critical enablers of organisational effectiveness and workforce wellbeing. Through scrutiny of progress against the Three-Year Culture, Leadership and Engagement Improvement Plan, staff survey findings and employee experience measures, the Committee was able to gain assurance that action was being taken to strengthen culture, improve engagement and support effective leadership across the Health Board, whilst recognising that continued focus will be required to embed sustainable improvement and realise the desired cultural change.

6.3 Staff Wellbeing

The Committee recognised staff wellbeing as a fundamental enabler of organisational performance, patient care and cultural improvement. During 2025-26, the Committee received assurance through a range of reports relating to workforce wellbeing, employee experience and sickness absence, seeking evidence that appropriate support mechanisms, interventions and improvement programmes were in place to support the physical, mental and emotional wellbeing of staff. The Committee considered the extent to which wellbeing initiatives were contributing to attendance, engagement, retention and staff experience, recognising that a healthy, supported and engaged workforce is critical to the delivery of safe, effective and compassionate services.

6.4 Welsh Language

The Committee received regular assurance on delivery of the Health Board's Welsh Language responsibilities through consideration of the Welsh Language Annual Report and other updates. The Committee sought assurance that Welsh language considerations remained embedded within workforce planning, staff development, organisational culture and service delivery, recognising the importance of the Welsh language to the Health Board's values, identity and strategic objectives.

6.5 Equality, Diversity and Inclusion

The Committee received assurance through consideration of the Strategic Equality Annual Report, Workforce Race Equality Standard (WRES) Report and Gender, Race and Disability Pay Gap Reports. Through these reports, the Committee scrutinised progress against statutory duties and strategic objectives, seeking assurance that actions were being taken to advance equality, reduce inequalities and foster a diverse, inclusive and fair organisational culture for staff and service users.

6.6 Health and Safety

The Committee received assurance through regular reports on the management of Health and Safety across the Health Board, including consideration of the Health and Safety Annual Report and associated performance information. The Committee recognised that maintaining a safe working environment is fundamental to staff wellbeing, organisational resilience and the delivery of high-quality patient care.

6.7 Foundations for the Future (Structures)

The Committee received regular updates on the Foundations for the Future Programme and was assured that appropriate governance arrangements were in place to support programme development. The Committee welcomed the introduction of an additional pre-engagement phase, recognising the value of early dialogue with staff in informing future proposals. Given the scale and significance of the programme, and the time taken to reach this stage of development, the Committee recognised that further assurance will be required during 2026-27 as proposals progress and the impact on staff, organisational culture and organisational development becomes clearer.

6.8 Risk and Board Assurance Framework

The Committee considered the principal risks assigned to it through the Corporate Risk Register and Board Assurance Framework and was able to gain assurance that arrangements were in place to identify, monitor and manage risks within its remit. Particular attention was given to risks relating to workforce capacity and capability, organisational culture, staff wellbeing and strategic change. The Committee recognised that effective management of these risks is critical to the delivery of the Health Board's objectives and agreed areas where continued assurance and scrutiny would be required during 2026-27.

7. Committee Effectiveness & Performance

7.1 The Committee regularly reviews its own performance by completing this report on an annual basis, reviewing the cycle of business which provides the Committee with the basis on which it will monitor its progress during the year and also provide clarity for all of those who contribute to the agenda as to the expectations of them.

7.2 A Committee effectiveness questionnaire will be issued in July 2026, the outcome of which will be reported to the Committee in respect of recommendations and subsequent actions in response to areas identified for improvement.

8. Reporting the Committee's Work

8.1 The Committee Chair reports the key issues discussed at each of its meetings by way of a 'AAA Report' to the Board.

8.2 These reports are supported by the relevant and more detailed Committee minutes. Committee papers, including minutes are routinely published on the Health Board's website.

9. Overall Assurance Opinion

During 2025-26, the People and Culture Committee discharged its responsibilities in accordance with its Terms of Reference and approved Cycle of Business, providing Board oversight of key people, culture and organisational development matters. The Committee considered a broad range of reports relating to workforce planning, organisational culture, leadership development, staff engagement, wellbeing, health and safety, equality, diversity and inclusion, Welsh language, organisational change and strategic workforce risks.

Through the reports received, the scrutiny undertaken and the challenge provided by Committee members, the Committee was able to gain assurance that appropriate governance arrangements were in place across the majority of areas within its remit. In particular, the Committee received assurance regarding workforce planning and sustainability, organisational culture and leadership development, staff wellbeing, health and safety, equality, diversity and inclusion, Welsh language and the management of risks allocated through the Corporate Risk Register and Board Assurance Framework.

The Committee also maintained oversight of the Foundations for the Future Programme, receiving regular updates on its development and the associated people, culture and organisational change implications. The Committee welcomed the introduction of an additional pre-engagement phase prior to formal consultation, recognising the importance of meaningful engagement with staff and stakeholders in shaping future proposals. Whilst assurance in relation to the programme will continue to develop as proposals progress, the Committee was assured that appropriate governance and oversight arrangements were in place and identified this as a key area for continued scrutiny during 2026-27.

The Committee recognises that workforce sustainability, organisational change, staff wellbeing, organisational culture and leadership development will remain important areas of focus during 2026-27. The Committee will therefore continue to seek assurance that the Health Board is effectively managing these priorities and associated risks in support of its strategic objectives and the delivery of safe, effective and compassionate care.

10. Conclusion and way forward

10.1 The Committee is very grateful to all those involved in the work of the Committee for their support over the past 12 months, and for the constructive and positive way in which they have contributed to the activity.

10.2 The Committee will continue to ensure that it conducts its business in accordance with legislation and best practice.

10.3 It will provide the assurance that the Committee has in place the appropriate governance arrangements and resources to ensure success in achieving its objectives.

11. Further Information

Please visit the Health Board's websites for further information as outlined below:
Committees and Advisory Groups - Betsi Cadwaladr University Health Board

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

PERFORMANCE, FINANCE AND INFORMATION GOVERNANCE COMMITTEE

Annual Report 2025-26

FOREWORD

I am pleased to present the 2025-26 Annual Report of the Betsi Cadwaladr University Health Board Performance, Finance and Information Governance Committee.

During the year, the Committee discharged its delegated responsibilities on behalf of the Board by providing scrutiny, challenge and assurance in relation to the Health Board's financial position, performance against key delivery requirements, information governance arrangements, external contracting, and the management of principal risks within its remit.

The Committee received regular reports relating to finance, operational performance, delivery against Welsh Government and local targets, information governance, external contracts, risks allocated through the Board Assurance Framework and Corporate Risk Register, and matters requiring escalation to the Board through the AAA reporting process.

Through its work, the Committee was able to provide assurance to the Board in a number of key areas, while also identifying matters requiring continued scrutiny and oversight during 2026-27. These include financial sustainability, delivery of performance improvement, strengthening of strategic risk and assurance arrangements, continued oversight of external contracts, and maintenance of robust information governance arrangements.

The remainder of this report summarises the assurance received, the challenge provided by Committee members, the key areas of Committee activity, and the matters requiring continued attention.

Gareth Williams
Chair of the Performance, Finance and Information Governance Committee

Annual Report 2025 - 2026

1. Introduction

1.1 This report provides the Board with an annual summary of the assurance received by the Performance, Finance and Information Governance Committee during 2025-26. It describes how the Committee discharged its delegated responsibilities on behalf of the Board and identifies the key areas of oversight, assurance, challenge and ongoing focus for 2026-27.

1.2 The Committee's work during the year was guided by its Terms of Reference and Cycle of Business, which supported the systematic consideration of matters within its remit. These included finance, performance, external contracts, information governance, strategic and corporate risks, and matters requiring escalation to the Board.

1.3 Through its work, the Committee sought assurance that appropriate arrangements were in place to support the delivery of the Health Board's strategic priorities, with particular regard to financial sustainability, organisational performance, information governance and the management of risks allocated to the Committee.

1.4 The Committee also provided a key mechanism for supporting the Board's wider assurance framework by ensuring that matters of concern, areas requiring further action, and issues requiring Board-level awareness were reported through the Committee Chair's AAA Reports.

2. Role and Responsibilities

2.1 The primary purpose of the Committee is to act on behalf of the Board to:

2.1.1 Advise and assure the Board in discharging its responsibilities with regard to its current and forecast financial position and performance.

2.1.2 Oversee the delivery and monitoring of financial strategy, planning, policies and performance including capital and external contracting.

2.1.3 Oversee the delivery and monitoring of performance strategic, framework, policies, Welsh Government / local targets and performance reports.

2.1.4 Monitor the performance of external contracts including shared services and primary care. The Committee will provide advice on the adoption of a set of key indicators of quality of care against which the Health Board performance will be regularly assessed and reported on.

2.1.5 Seek assurance on the management of principal risks within the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) allocated to the Committee and provide assurance to the Board that risks are being managed effectively and report any areas of significant concern.

2.1.6 Monitor the performance and oversight of Information Governance.

3. Agenda Planning Process

3.1 The Chair of the Committee, in conjunction with the Executive Lead and Corporate Governance Directorate develop the final agenda for the Committee meetings.

3.2 The venue, location and other administrative arrangements are organised a year in advance where possible.

3.3 The secretariat for the meeting is provided by Harriet Abbott.

3.4 The agenda and papers are published and sent to Committee members prior to the date of the meeting. Where appropriate all papers are accompanied by a cover sheet which provides an executive summary and guidance to the Committee on the action required.

4. Operating Arrangements

4.1 The Committee reviewed its Terms of Reference and operating arrangements during the year. A minor amendment was made to ensure the Committee's remit remained clear, current and aligned to the Board's assurance requirements.

4.2 The Committee also reviewed its Cycle of Business, which provided a structured framework for ensuring that key matters within the Committee's remit were scheduled for consideration during the year. The agenda remained sufficiently flexible to allow the Committee to consider emerging issues and areas requiring additional scrutiny.

5. Membership, Frequency and Attendance

5.1 The Terms of reference of the Committee state that the Committee should consist of a minimum of three members of the Board.

5.2 During the year the Committee met on six occasions with member attendance as follows:

Name	Attendance
Gareth Williams, Committee Chair	Five out of six meetings
Rhian Watcyn Jones, Committee Vice Chair	Five out of six meetings
Prof Mike Larvin	Six out of six meetings
Chris Lothian-Field	Four out of six meetings

5.3 The Committee requires the attendance of other Health Board Officers for advice, support and information routinely at meetings. It may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

6. Committee Assurance

During 2025-26, the Committee fulfilled its work plan and considered a wide range of matters within its delegated remit. The Committee's activity can be summarised across the following key areas:

6.1 Financial governance and sustainability

The Committee received regular reports relating to the Health Board's current and forecast financial position, financial planning, financial strategy, capital, and external contracting. Through its scrutiny of these reports, the Committee sought assurance that appropriate

arrangements were in place to monitor financial performance, identify areas of risk, and support the Board in discharging its responsibilities in relation to financial governance. Members provided challenge in relation to the clarity of financial reporting, delivery of financial plans, the management of emerging financial risks, and the robustness of actions being taken to support financial sustainability.

6.2 Performance and delivery

The Committee received regular performance reports relating to Welsh Government and local targets, key performance indicators and areas requiring improvement. These reports enabled the Committee to consider the extent to which performance issues were being identified, understood and addressed through appropriate management action.
The Committee's scrutiny focused on ensuring that performance reporting was clear, risk-based and supported by appropriate analysis, including the identification of areas requiring further assurance or escalation.

6.3 External contracts and commissioned services

The Committee maintained oversight of external contracts, including shared services and primary care arrangements, in line with its delegated responsibilities. The Committee sought assurance that contract performance was being monitored effectively and that any issues affecting delivery, value or quality were being appropriately addressed.

6.4 Risk and assurance

The Committee considered risks allocated to it through the Board Assurance Framework and Corporate Risk Register. In doing so, it sought assurance that relevant principal and corporate risks were being reviewed, managed and escalated appropriately.
The Committee also considered whether the controls, assurances and actions described in risk reports were sufficient to support effective Board oversight. Where matters required Board-level attention, these were escalated through the Committee Chair's AAA Reports.

6.5 Information Governance

The Committee maintained oversight of Information Governance arrangements during the year. This included scrutiny of reports relating to compliance, performance, risks and areas requiring improvement.

The Committee sought assurance that appropriate arrangements were in place to support the effective management of information governance responsibilities and that any risks or incidents were being managed and escalated appropriately.

6.6 Reporting and escalation to the Board

The Committee Chair reported key issues discussed at each meeting to the Board through the AAA Report. This ensured that matters requiring alert, advice or assurance were clearly communicated to the Board in a timely and structured way. This aligns with the current reporting section, which states that the Committee Chair reports key issues to the Board by way of an AAA Report

7. Key Achievements/Benefits:

During 2025-26, the Committee made an important contribution to the Board's overall system of governance and assurance. Key achievements included:

- Strengthened oversight of the Health Board's financial position, financial planning and financial risks.

- Continued scrutiny of organisational performance against key national and local requirements.
- Improved alignment between performance, finance, risk and assurance reporting.
- Regular oversight of external contracts, shared services and primary care arrangements within the Committee's remit.
- Continued monitoring of information governance arrangements, including areas of risk and compliance.
- Review of the Committee's Terms of Reference and Cycle of Business to ensure continued alignment with Board assurance requirements.
- Regular reporting to the Board through AAA Reports, ensuring that key issues, risks and areas of assurance were escalated appropriately.
- Completion of annual reporting arrangements to support transparency, accountability and continuous improvement.

8. Key Challenges

8.1 During 2025-26, the Committee recognised a number of significant challenges within its remit. These included the need to maintain robust oversight of the Health Board's financial position, support improvement in organisational performance, strengthen the maturity of risk and assurance reporting, and ensure continued compliance and resilience in relation to information governance.

The Committee will maintain a particular focus during 2026-27 on:

- Financial sustainability and delivery of financial plans.
- Performance improvement against key national and local targets.
- The quality, clarity and impact of performance reporting.
- The management and escalation of risks allocated to the Committee through the Board Assurance Framework and Corporate Risk Register.
- Oversight of external contracts, shared services and primary care arrangements.
- Information governance compliance, resilience and risk management.
- Continued improvement in the quality of assurance provided to the Board.

The Committee will continue to use its Cycle of Business, agenda planning process and AAA reporting arrangements to ensure that these matters are subject to appropriate scrutiny, challenge and escalation.

9. Committee Effectiveness & Performance

9.1 The Committee regularly reviews its own performance by completing this report on an annual basis, reviewing the cycle of business which provides the Committee with the basis on which it will monitor its progress during the year and also provide clarity for all of those who contribute to the agenda as to the expectations of them.

9.2 A Committee effectiveness questionnaire will be issued again circa July 2026, the outcome of which will be reported to the Committee in respect of recommendations and subsequent actions in response to areas identified for improvement.

10. Reporting the Committee's Work

10.1 The Committee Chair reports the key issues discussed at each of its meetings by way of a 'AAA Report' to the Board.

10.2 These reports are supported by the relevant and more detailed Committee minutes. Committee papers, including minutes are routinely published on the Health Board's website.

11. Conclusion and way forward

11.1 The Committee is very grateful to all those involved in the work of the Committee for their support over the past 12 months, and for the constructive and positive way in which they have contributed to the activity.

11.2 The Committee will continue to ensure that it conducts its business in accordance with legislation and best practice.

11.3 It will provide the assurance that the Committee has in place the appropriate governance arrangements and resources to ensure success in achieving its objectives.

12. Further Information

Please visit the Health Board's websites for further information as outlined below:
Committees and Advisory Groups - Betsi Cadwaladr University Health Board

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

PLANNING, POPULATION HEALTH AND PARTNERSHIPS COMMITTEE

Annual Report 2025-26

FOREWORD

I am pleased to present the 2025-26 Annual Report of the Planning, Population Health and Partnerships Committee.

During the year, the Committee discharged its delegated responsibilities on behalf of the Board by providing oversight, scrutiny and assurance in relation to strategic planning, population health improvement, partnership working, service transformation and the delivery of the Health Board's long-term objectives.

The Committee received regular reports on the development and delivery of strategic plans, population health and health inequalities, regional and local partnership arrangements, service planning, performance against key objectives and other matters within its delegated remit.

Through its work, the Committee was able to provide assurance to the Board in a number of key areas whilst identifying matters that require continued scrutiny and oversight during 2026-27. These include delivery of the Health Board's strategic objectives, reducing health inequalities, strengthening partnership arrangements, ensuring effective planning and transformation arrangements, and maintaining a clear focus on population health outcomes.

The remainder of this report summarises the assurance received, the challenge provided by Committee members and the key areas requiring continued attention

Clare Budden
Chair of the Planning, Population Health and Partnerships Committee

Annual Report 2025 - 2026

1. Introduction

1.1 This report provides the Board with an annual summary of the assurance received by the Planning, Population Health and Partnerships Committee during 2025-26. It describes how the Committee discharged its delegated responsibilities on behalf of the Board and identifies the key areas of oversight, assurance and ongoing focus for 2026-27.

1.2 The Committee's work during the year was guided by its Terms of Reference and Cycle of Business, which supported the systematic consideration of key matters within its remit. The Committee considered reports and updates relating to strategic planning and delivery, population health improvement, prevention and health inequalities, partnership working, public engagement, digital transformation, public health programmes and the management of associated strategic risks.

1.3 Through its work, the Committee sought assurance that appropriate arrangements were in place to support delivery of the Health Board's strategic priorities relating to long-term planning, improving population health outcomes, reducing health inequalities, strengthening partnership arrangements, enhancing citizen engagement and supporting sustainable service transformation.

2. Role and Responsibilities

2.1 The primary purpose of the Committee is to act on behalf of the Board to:

2.1.1 provide advice and assurance to the Board with regard to the development and oversight of the Health Board's long term planning, Integrated Medium Term Plan and Annual Operating Plan ensuring that enabling strategies are aligned to these plans.

2.1.2 ensure effective partnership arrangements are in place to improve Population Health (i.e., primary care, public health and the social determinants of health) and reduce health inequalities.

2.1.3 provide oversight, delivery and monitoring (by exception) of Population Health improvement and health inequalities strategies, policies and performance informed through Population Need's Assessment.

2.1.4 seek assurance on the management of principal risks within the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) allocated to the Committee and provide assurance to the Board that risks are being managed effectively and report any areas of significant concern.

3. Agenda Planning Process

3.1 The Chair of the Committee, in conjunction with the Executive Lead and Corporate Governance Directorate develop the final agenda for the Committee meetings.

3.2 The venue, location and other administrative arrangements are organised a year in advance where possible.

3.3 The secretariat for the meeting is provided by Laura Jones.

3.4 The agenda and papers are disseminated to Committee members prior to the date of the meeting. Where appropriate all papers are accompanied by a cover sheet which provides an executive summary and guidance to the Committee on the action required.

4. Operating Arrangements

4.1 The Committee reviewed its Terms of Reference and operating arrangements during the year. A minor amendment was made to ensure the Committee's remit remained clear, current and aligned to the Board's assurance requirements.

4.2 The Committee also reviewed its Cycle of Business, which provided a structured framework for ensuring that key matters within the Committee's remit were scheduled for consideration during the year. The agenda remained sufficiently flexible to allow the Committee to consider emerging issues and areas requiring additional scrutiny.

5. Membership, Frequency and Attendance

5.1 The Terms of Reference state that the Committee should consist of a minimum of three members of the Board.

5.2 During the year the Committee met on six occasions with member attendance as follows:

Name	Attendance
Clare Budden, Committee Chair	Six out of six meetings
Gareth Williams, Committee Vice Chair	Four out of six meetings
Caroline Turner	Five out of six meetings
Williams Nichols, Trade Union Representative	Six out of six meetings

5.3 The Committee requires the attendance of other Health Board Officers for advice, support and information routinely at meetings. It may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

6. Committee Activity

During 2025-26, the Committee considered a wide range of reports and updates aligned to its delegated remit. The Committee's business can be summarised under the following assurance themes:

6.1 Strategic Planning and Delivery

The Committee maintained oversight of the Health Board's strategic planning framework throughout 2025-26. This included consideration of the Integrated Medium Term Plan, Annual Delivery Plan, Health Board Strategic Intentions and associated planning reports. The Committee sought assurance that planning arrangements remained aligned to Welsh Government requirements, population need and organisational priorities, and that progress against key milestones was regularly monitored and reported.

6.2 Population Health and Prevention

The Committee received regular updates regarding population health improvement, prevention and reducing health inequalities. This included scrutiny of the Outline Prevention Plan 2025-28, Diabetes Transformation Programme, Health Protection Service, substance misuse initiatives, homelessness reduction activity and wider population health programmes. Through consideration of these reports, the Committee sought assurance that programmes were supporting improved health outcomes and addressing areas of greatest need across North Wales.

6.3 Partnerships, Engagement and Citizen Experience

The Committee considered reports relating to citizen engagement, communications and partnership working. It received assurance regarding activity to strengthen engagement with citizens, communities and partners and sought evidence that collaborative approaches were informing service planning, delivery and strategic decision-making. The Committee recognised the importance of effective partnerships in supporting population health improvement and sustainable service development.

6.4 Enabling Strategies and Organisational Development

The Committee maintained oversight of a range of enabling strategies and programmes, including Digital, Data and Technology, decarbonisation, workforce wellbeing and emergency preparedness arrangements. The Committee sought assurance that these programmes were progressing appropriately and supporting delivery of the Health Board's longer-term strategic ambitions.

6.5 Public Health, Resilience and System Leadership

The Committee received the Director of Public Health Annual Report together with reports relating to winter resilience, civil contingencies and emergency preparedness. The Committee sought assurance regarding the Health Board's readiness to respond to emerging challenges and its ability to work effectively with partner organisations to support the health and wellbeing of the population it serves.

7. Key Achievements/Benefits:

During 2025-26, the Committee continued to provide oversight and assurance across a broad range of strategic planning, population health and partnership-related matters. Key areas of focus and achievement included:

- Providing oversight of the development, delivery and monitoring of the Health Board's Integrated Medium Term Plan and Annual Delivery Plan, ensuring alignment with strategic priorities and Welsh Government expectations.
- Strengthening Board visibility of population health priorities, prevention initiatives and programmes aimed at reducing health inequalities across North Wales.
- Receiving assurance regarding the effectiveness of partnership working and stakeholder engagement, including opportunities to hear directly from partner organisations and strengthen collaborative approaches to improving outcomes for the population served.
- Monitoring progress in relation to Digital, Data and Technology programmes, recognising the importance of digital transformation as an enabler of service improvement and organisational sustainability.
- Providing oversight of key public health, resilience and prevention programmes, including winter planning, health protection, substance misuse and homelessness initiatives, supporting a proactive and preventative approach to improving health and wellbeing

8. Key Challenges and Areas of Focus

8.1 During 2026-27, the Committee will continue to develop its role in providing strategic assurance to the Board across planning, population health and partnership arrangements. Particular focus will be placed on monitoring delivery of the Health Board's strategic plans, assessing the impact of prevention and population health interventions, and ensuring that partnership arrangements continue to support delivery of improved outcomes and reduced inequalities.

8.2 The Committee recognises the continuing challenges associated with improving population health outcomes, addressing health inequalities, delivering sustainable services within available resources and responding to increasing system-wide demand. The Committee will continue to provide scrutiny, challenge and assurance in these areas and support the identification of opportunities for innovation, collaboration and service transformation.

9. Committee Effectiveness & Performance

9.1 The Committee regularly reviews its own performance by completing this report on an annual basis, reviewing the cycle of business which provides the Committee with the basis on which it will monitor its progress during the year and also provide clarity for all of those who contribute to the agenda as to the expectations of them.

9.2 A Committee effectiveness questionnaire will be issued in July 2026, the outcome of which will be reported to the Committee in respect of recommendations and subsequent actions in response to areas identified for improvement.

10. Overall Assurance Opinion

10.1 During 2025-26, the Committee discharged its responsibilities in accordance with its Terms of Reference and approved Cycle of Business. Through the reports, presentations and discussions received throughout the year, the Committee was able to provide the Board with assurance that appropriate arrangements were in place in relation to strategic planning, population health improvement, partnership working and service transformation within its remit.

10.2 Whilst assurance has been received regarding the effectiveness of governance, planning and partnership arrangements, the Committee recognises that a number of areas require continued focus and oversight during 2026-27. These include delivery of the Health Board's strategic objectives, reducing health inequalities, sustaining progress in population health improvement, strengthening partnership effectiveness, and ensuring that transformation and service planning arrangements continue to deliver measurable benefits and improved outcomes for the population of North Wales.

11. Conclusion and way forward

11.1 The Committee is very grateful to all those involved in the work of the Committee for their support over the past 12 months, and for the constructive and positive way in which they have contributed to the activity.

11.2 The Committee will continue to ensure that it conducts its business in accordance with legislation and best practice.

11.3 It will provide the assurance that the Committee has in place the appropriate governance arrangements and resources to ensure success in achieving its objectives.

12. Further Information

Please visit the Health Board's websites for further information as outlined below:
Committees and Advisory Groups - Betsi Cadwaladr University Health Board

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

QUALITY, SAFETY AND EXPERIENCE COMMITTEE

Annual Report 2025-26

FOREWORD

I am pleased to present the 2025-26 Annual Report of the BCUHB Quality, Safety and Experience Committee, which outlines the Committee's activity during the period 1 April 2025 to 31 March 2026.

During the year, the Committee discharged its delegated responsibilities on behalf of the Board by scrutinising quality, safety, patient experience, clinical effectiveness, challenged services and associated strategic risks. In doing so, the Committee sought assurance that appropriate governance arrangements, controls, performance oversight and improvement plans were in place to support the delivery of safe, effective and compassionate care.

The Committee maintained oversight of quality governance arrangements, patient experience, complaints and concerns, safeguarding, challenged services, commissioned services, quality management systems and relevant risks within the Board Assurance Framework and Corporate Risk Register. Through constructive scrutiny and challenge, the Committee sought assurance that areas of concern were being actively managed and that improvement actions were progressing as intended.

Through its work, the Committee was able to provide assurance to the Board in a number of key areas whilst identifying matters requiring continued oversight during 2026-27. These include challenged services, workforce sustainability, organisational culture, patient experience, quality governance and the effective management of strategic risks.

The remainder of this report summarises the assurance received, the scrutiny undertaken by Committee members and the areas requiring ongoing attention.

Dr Caroline Turner
Chair of the Quality, Safety and Experience Committee

Annual Report 2025 - 2026

1. Introduction

1.1 This report provides the Board with an annual summary of the assurance received by the Quality, Safety and Experience Committee during 2025-26. It describes how the Committee discharged its delegated responsibilities on behalf of the Board and identifies the key areas of oversight, assurance and ongoing focus for 2026-27.

1.2 The Committee's work during the year was guided by its Terms of Reference and Cycle of Business, which supported the systematic consideration of key matters within its remit. The Committee considered reports and updates relating to quality governance, patient safety, patient experience, challenged services, complaints and concerns, safeguarding, commissioned services, workforce matters impacting quality and safety, quality management systems, strategic service developments and associated Board Assurance Framework and Corporate Risk Register risks.

1.3 Through its work, the Committee sought assurance that effective governance arrangements, quality management systems, performance oversight arrangements and improvement mechanisms were in place to support the delivery of safe, effective and compassionate healthcare services and to promote continuous improvement across the organisation.

2. Role and Responsibilities

2.1 The primary purpose of the Committee is to act on behalf of the Board to:

2.1.1 scrutinise, assess and seek assurance in relation to the patient experience, safety, impact, quality and health outcomes of the services provided by the Health Board.

2.1.2 provide evidence-based and timely advice to the Board to assist it in discharging its functions and meeting its responsibilities with regard to the quality and safety of health care provided and secured by the Health Board.

2.1.3 provide assurance that the Health Board has an effective strategy and delivery plan(s) for improving the quality and safety of care patients receive, commissioning quality and safety impact assessments where considered appropriate. This includes consideration of the Annual Plan/Integrated Medium Term Plan (IMTP).

2.1.4 provide assurance that the organisation, at all levels, has the right governance arrangements and strategy in place to ensure that the care planned or provided is of a high standard.

3. Agenda Planning Process

3.1 The Chair of the Committee, in conjunction with the Executive Lead and Meeting Secretary develops the final agenda for the Committee meetings.

3.2 The venue, location and other administrative arrangements are organised a year in advance where possible.

3.3 The secretariat for the meeting is provided by Harriet Abbott.

3.4 The agenda and papers are disseminated to Committee members prior to the date of the meeting. Where appropriate all papers are accompanied by a cover sheet which provides an executive summary and guidance to the Committee on the action required.

4. Operating Arrangements

4.1 The Committee reviewed its Terms of Reference and operating arrangements during the year. A minor amendment was made to ensure the Committee's remit remained clear, current and aligned to the Board's assurance requirements.

4.2 The Committee also reviewed its Cycle of Business, which provided a structured framework for ensuring that key matters within the Committee's remit were scheduled for consideration during the year. The agenda remained sufficiently flexible to allow the Committee to consider emerging issues and areas requiring additional scrutiny.

5. Membership, Frequency and Attendance

5.1 The Terms of reference of the Committee state that the Committee should consist of a minimum of three members of the Board.

5.2 During the year the Committee met on six occasions with member attendance as follows:

Name	Attendance
Caroline Turner, Committee Chair	Five out of six meetings
Chris Lothian-Field, Committee Vice Chair	Four out of six meetings
Prof Mike Larvin	Six out of six meetings
Urtha Felda	Five out of six meetings

5.3 The Committee requires the attendance of other Health Board Officers for advice, support and information routinely at meetings. It may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

6. Committee Activity

During 2025-26, the Committee considered a wide range of reports and updates aligned to its delegated remit. Through detailed scrutiny and challenge, the Committee sought assurance regarding the quality, safety and experience of services provided by the Health Board, the effectiveness of governance arrangements, and the management of risks within its areas of responsibility.

The Committee's activity can be summarised under the following assurance themes.

6.1 Quality Governance and Improvement

The Committee maintained oversight of the Health Board's quality governance arrangements, including the implementation and development of the Quality Management System, nurse staffing levels and the findings of annual assurance reports. The Committee sought assurance that appropriate systems and processes

were in place to support continuous improvement, learning and the delivery of safe and effective care. The Committee also monitored relevant corporate and Board Assurance Framework risks to ensure appropriate mitigation and management actions were in place.

6.2 Patient Experience and Organisational Learning

The Committee regularly received Patient Stories to ensure that the patient voice informed discussions and organisational learning. It scrutinised complaints performance, the Putting Things Right Annual Report and the Llais Annual Report, seeking assurance that feedback, concerns and complaints were being appropriately managed and that learning was being used to drive service improvement and enhance patient experience.

6.3 Safeguarding and Professional Standards

The Committee maintained oversight of safeguarding arrangements through consideration of the Safeguarding and Public Protection Annual Report and the Designated Educational Clinical Lead Officer Annual Report. Scrutiny focused on compliance with statutory responsibilities, organisational learning, workforce capability and the effectiveness of arrangements to protect vulnerable individuals receiving Health Board services.

6.4 Clinical Quality, Safety and Service Sustainability

A significant area of the Committee's work focused on challenged services and areas of clinical performance requiring enhanced oversight. The Committee received reports relating to Urology, Vascular, Dermatology, Plastics, Oncology and Ophthalmology services, together with updates on Urgent and Emergency Care, Colonoscopy Performance, Children's Services, Women's, Maternity and Gynaecology Services and Learning Disability Services. Through this scrutiny, the Committee sought assurance regarding quality, safety, service sustainability, performance improvement and the delivery of recovery plans.

6.5 Strategic Service Development and Transformation

The Committee considered the development of the Clinical Services Plan and updates relating to commissioned services and the East Integrated Health Community. It also monitored progress against improvement actions arising from the Royal College of Psychiatrists Invited Assessment. This work enabled the Committee to assess the extent to which strategic developments and service transformation initiatives were supporting the delivery of high-quality, sustainable healthcare services.

6.6 Assurance and Risk Oversight

Throughout the year, the Committee maintained oversight of risks within its remit through review of the Corporate Risk Register and Board Assurance Framework. The Committee scrutinised the adequacy of controls, mitigating actions and assurance sources, seeking assurance that key quality, safety and experience risks were appropriately identified, monitored and managed.

7. Committee Effectiveness & Performance

7.1 The Committee regularly reviews its own performance by completing this report on an annual basis, reviewing the cycle of business which provides the Committee with the basis on which it will monitor its progress during the year and also provide clarity for all of those who contribute to the agenda as to the expectations of them.

7.2 A Committee effectiveness questionnaire will be issued in July 2026, the outcome of which will be reported to the Committee in respect of recommendations and subsequent actions in response to areas identified for improvement.

8. Reporting the Committee's Work

8.1 The Committee Chair reports the key issues discussed at each of its meetings by way of a 'AAA Report' to the Board.

8.2 These reports are supported by the relevant and more detailed Committee minutes. Committee papers, including minutes are routinely published on the Health Board's website.

9. Reporting the Committee's Work

9.1 During 2025-26, the Quality, Safety and Experience Committee discharged its responsibilities in accordance with its Terms of Reference and approved Cycle of Business, providing Board oversight of matters relating to quality, safety, patient experience, clinical effectiveness, challenged services, safeguarding, quality governance and strategic risks within its remit. The Committee considered a broad range of reports and assurance information designed to support effective scrutiny, oversight and continuous improvement.

9.2 Through the reports received, the scrutiny undertaken and the challenge provided by Committee members, the Committee was able to gain **reasonable assurance** that appropriate governance arrangements, controls and improvement actions were in place across the majority of areas within its remit. The Committee also maintained oversight of areas requiring enhanced scrutiny, including challenged services, performance improvement, patient experience, workforce-related quality issues and strategic risks, seeking additional assurance where necessary.

9.3 The Committee recognises that continued focus is required in a number of areas and will therefore maintain oversight of challenged services, workforce sustainability, patient experience, quality governance and associated strategic risks during 2026-27. The Committee will continue to seek assurance that improvement actions are being effectively implemented, risks are being appropriately managed and that services continue to support the delivery of safe, effective and compassionate care.

10. Conclusion and way forward

10.1 The Committee is very grateful to all those involved in the work of the Committee for their support over the past 12 months, and for the constructive and positive way in which they have contributed to the activity.

10.2 The Committee will continue to ensure that it conducts its business in accordance with legislation and best practice.

10.3 It will provide the assurance that the Committee has in place the appropriate governance arrangements and resources to ensure success in achieving its objectives.

11. Further Information

Please visit the Health Board's websites for further information as outlined below:
Committees and Advisory Groups - Betsi Cadwaladr University Health Board

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Health Board

ALL WALES APPROVED CLINICIANS AND SECTION 12(2) DOCTORS

BOARD REPORT – SEPTEMBER 2026

Date of Meeting	24 September 2026
Publication Status	Open/Public Not Applicable
Report Author name and title	Meryl Roberts, All Wales Approvals Manager
Lead Executive Team Member name and title	Dr Clara Day, Executive Medical Director

Report Purpose	Endorse for Board Approval

Executive Summary

This report summarises recent approvals for **Approved Clinicians** and **Section 12(2) Doctors** across Wales, ensuring compliance with the Mental Health Act 1983 (amended 2007) and written approval processes. Betsi Cadwaladr University Health Board is the central approving board for all Health Boards and exercises this delegated function on behalf of Welsh Government.

Applications for approval under the Mental Health Act are checked and scrutinised by the Approvals Team then assessed by the All Wales Approval Panel who make recommendations for approval. The Approval Panel comprises of clinical Panel Members, a Vice-Chair and Chair drawn from all Health Boards and several Local Authorities. The Panel's recommendations for approval are then submitted in writing to the Executive Medical Director for approval using authority delegated at the March 2023 Board meeting. The Panel's recommendations are submitting in writing to the Executive Medical Director for approval, using authority delegated by the Board in March 2023. Approvals are then fully reported and ratified by the Board through this paper.

The approval process complies with Welsh Government delegated authority, Mental Health Act legislation, policies and written approval processes. It promotes transparency with details of recent approvals listed in Appendices 1 and 2.

Board Actions Requested:

- Note the contents of the report.
- Ratify the Approved Clinician and Section 12(2) approvals contained within Appendices 1 and 2.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Dates**	**Outcome, Evidence and Data**
Internal action letters submitted by the All Wales Approvals Manager to Deputy Executive Medical Directors (DEMDs) seeking ratification of Panel recommendations for approval, reapproval, reinstatement of approval and suspension of approval.	Period of 8th July 2026 to 4th September 2026. Details below	Please see below.
DEMD	14.07.2026	Action letter submitted via email for ratification and approval received.
DEMD	21.07.2026	As above
DEMD	28.07.2026	As above
DEMD	04.08.2026	As above
DEMD	11.08.2026	As above
DEMD	18.08.2026	As above
DEMD	25.08.2026	As above
DEMD	01.09.2026	As above
Acronyms / Glossary of Terms		
DEMD	Deputy Executive Medical Director	

All Wales Approved Clinicians and Section 12(2) Doctors – Board Assurance

1. SITUATION

1.1 This report provides Board assurance on the operation of the All Wales Approved Clinicians and Section 12(2) Doctors approval process and seeks ratification of approvals; authorised under delegated authority.

2 BACKGROUND

2.1 Betsi Cadwaladr University Health Board undertakes the All Wales approval function for all Health Boards on behalf of Welsh Government. Approvals for approved clinicians are made in accordance with the Mental Health Act 1983 (amended 2007), the Approved Clinicians (Wales) Directions 2018, the

Approval of Approved Clinicians Welsh Government Guidance Document and the All Wales Approved Clinician Procedural Arrangements Document. Approvals for Section 12(2) Doctors are made in accordance with the Mental Health Act 1983 (amended 2007) and the All Wales Section 12(2) Process and Criteria Document.

2.2 Applications for approval are scrutinised by the Approvals Team then assessed against written criteria by the All Wales Approval Panel.

3 SPECIFIC MATTERS FOR CONSIDERATION

3.1 Ratification of approvals previously authorised via action letter by the Executive Medical Director or the Deputy Executive Medical Director.

4 KEY RISKS / MATTERS FOR ESCALATION

4.1 No significant risks identified.

5 RECOMMENDATIONS

5.1 The Board is asked to:

- Ratify approvals

ASSESSMENT	
Link to Strategic Priorities	 Choose an item. Improving quality, outcomes and experience
Design Principles	Consistency with Organisational Values If more than one applies, please list below:
Corporate Risks and Board Assurance Framework	
Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales If more than one applies, please list below:

IMPACT ASSESSMENTS		
Equality *Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)*	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	A formal assessment is not required as the report relates solely to governance and assurance arrangements only and does not introduce changes to service delivery.
Socio-Economic Impact Assessment *Have you undertaken a Socio-Economic Impact Assessment*	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	A formal assessment is not required as the report relates solely to governance and assurance arrangements only and does not introduce changes to service delivery.
Quality *Have you undertaken a Quality Impact Assessment Screening?*	**Enablers of Quality** Choose an item.	**Domains of Quality** Choose an item.
	If more than one applies, please list below:	If more than one applies, please list below:
Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales	
Environmental /Sustainability Impact (5Rs)	If more than one applies, please list below:	
	Choose an item.	
	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:	A formal assessment is not required as the report relates solely to governance and assurance arrangements

		only and does not introduce changes to service delivery.
	If no, please include rationale:	
Data Protection Impact Assessment *Have you undertaken a Data Protection Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	A formal assessment is not required as the report relates solely to governance and assurance arrangements only and does not introduce changes to service delivery.
Counter Fraud Impact Assessment *Have you considered the counter fraud impacts*	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	A formal assessment is not required as the report relates solely to governance and assurance arrangements only and does not introduce changes to service delivery.
Legal	Yes (Include further detail below)	
	The approval and ratification processes described in this report are undertaken in accordance with Welsh Minister delegation to Betsi Cadwaladr University Health Board, the Mental Health Act (1983) (as amended), Welsh Government Guidance document, Approved Clinician Directions 2018 and S12(2) Process and Criteria Document (the written approval process). There are no identified legal concerns arising from the recommendations within this report.	
Reputational	Yes (Include further detail below)	
	Robust governance of Approved Clinicians and Section 12(2) Doctor approvals is essential to maintaining public protection and public confidence in mental health services in Wales.	

	The arrangements outlined in this report provide high level assurance that approvals are subject to appropriate scrutiny, transparency and Board oversight. No reputational risks have been identified.
Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.
	There is no direct financial or workforce impact arising from the matters outlined in this report. The activity described, represents continuation of existing All Wales approval arrangements within current resources.

APPENDIX 1

Update of Register of Approved Clinicians in Wales	
	Approved Clinicians
Approvals and Re-approvals	14
Approvals suspended	2
Approvals re-instated	3
Left Wales and Removed from Register)	0
Retired	0
No longer Registered or Licensed to Practise with Professional Body	1
Transferred from AC register (to S12 Register)	0
Approval Ended	1
Death in Service	0
Performance Metrics Reporting period: 8th July 2026 – 4th September 2026	
Total number of AC applications processed	16
Number awaiting completion of application by the applicant	2
Pending Approvals	1
Average days to approval time per completed application.	12.5
Number of lapsed approvals due to missed deadlines by the applicant	1

APPENDIX 1

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

Update of Register of Approved Clinicians - Wales

Ratification Period: 8th July 2026 – 4th September 2026

Approvals and Re-approvals: 14

Surname	First Name	Workplace	Date Approval Expires
Griffiths	Mark	Aneurin Bevan University Health Board, White Valley Centre, Lodge Road, Caerleon, Newport, NP18 3XQ	7th July 2031
Syal	Sunil	Priory Healthcare, Llanarth Court Independent Hospital, Llanarth Raglan, Abergavenny , Monmouthshire, NP15 2YD	15th July 2031
Duffin-Jones	Benjamin	Cardiff and Vale University Health Board, Llanfair Unit, University Hospital Llandough, Penlan Road, Llandough, Penarth, CF64 2XX	21st July 2031
Chick	Gregory	Betsi Cadwaladr University Health Board, CAMHS, Wrexham Maelor Hospital Children's Centre, Croesnewydd Road, Wrexham LL13 7TD	26th July 2031
Davies	Abigail	Hywel Dda University Health Board, Ty Myddfai, Glien Road, Johnstown, Carmarthen, SA31 3RB	3rd August 2031
Kyaw	Myo Than	Aneurin Bevan University Health Board, Ysbyty'r Tri Cwm, College Road, Ebbw Vale, NP23 6HA	6th August 2031

Surname	First Name	Workplace	Date Approval Expires
Peter	Lionel	Aneurin Bevan University Health Board, Wentwood Suite, St Cadoc's Hospital, Lodge Road, Caerleon, Newport NP18 3XQ	6th August 2031
Till	Alexander	Cygnet Healthcare, Delfryn House Independent Hospital, Argoed Hall Lane, Mold, Flintshire, CH7 6FQ.	9th August 2031
Akinlua	Justina	Betsi Cadwaladr University Health Board, Cynydd Rehabilitation Unit, Glan Clwyd Hospital, Bodelwyddan, LL18 5UJ.	12th August 2031
Swarnkar	Anvita	Aneurin Bevan University Health Board, Cwm Coch, Ysbyty Aneurin Bevan, 3 Lime Avenue, Ebbw Vale, NP23 6GL.	19th August 2031
Lewis	Julia	Aneurin Bevan University Health Board, Aneurin Bevan Specialist Drug and Alcohol Service (ABSDAS), Hiraeth, Maindiff Court Hospital, Abergavenny, NP7 8NF	20th August 2031
Rudrappa	Shiva	Swansea Bay University Health Board, Llwyneryr Unit, 151 Clasemont Road, Swansea, SA6 6AH	26th August 2031
Talabani	Alan	Elysium Healthcare, Ty Gwyn Hall Independent Hospital, Llantillio, Pertholey, Abergavenny, NP7 6NY	27th August 2031
Siddiqui	Adeel	Swansea Bay University Health Board, Ward F Neath Port Talbot Hospital, Baglan Way, Port Talbot, SA12 7BX	31st August 2031

Approval Suspended: (*CCT not yet received): 2

Surname	First Name	Workplace	Date Approval Expires
Sameem	Hafeesa	Cwm Taf Morgannwg University Health Board, Taff Ely CMHT, Dewi Sant Health Park, Albert Road, Pontypridd, CF37 1LB	31st March 2031
Nabeela	Rafiq	Aneurin Bevan University Health Board, Caerphilly Older Adults CMHT Services, Ysbyty Ystrad Fawr, Ystrad Fawr Way, Ystrad Mynach, Hengoed, CF82 7GP	23rd April 2031

Approvals Reinstated *(CCT Later Received): 3

Surname	First Name	Workplace	Date Approval Expires
Mustafa	Saima	Betsi Cadwaladr University Health Board, Heddfan Psychiatric Unit, Wrexham Maelor Hospital, Croesnewydd Road, Wrexham, LL13 7TD	19th February 2031
Sameem	Hafeesa	Cwm Taf Morgannwg University Health Board, Taff Ely CMHT, Dewi Sant Health Park, Albert Road, Pontypridd, CF37 1LB	31st March 2031
Comeau	Catrin	Cardiff and Vale University Health Board, Hafan Y Coed, University Hospital of Llandough, Penlan Road, Penarth, Cardiff, CF64 2XX	2nd March 2031

Left Wales and Removed from AC Register: 0

Surname	First Name	Workplace	Date Approval Expired/Expires

Retired: 0

Surname		First Name	Workplace	Date Approval Expired

No longer Registered or Licensed to Practice with Professional Body: 1

Surname	First Name	Workplace	Date Approval Ended
Savage	Marie	Betsi Cadwaladr University Health Board, CMHT Noddfa, Middle Lane, Denbigh, LL16 3UR.	3rd July 2026

Approval Expired or Ended: 1

Surname	First Name	Workplace	Date Approval Expired
Rhydderch	Danielle	Swansea Bay University Health Board, Community Drug and Alcohol Team, 42 St James Crescent, Uplands, Swansea, SA1 5DR	10th August 2026

Death in Service: 0

Surname	First Name	Workplace	Date Approval Expired

APPENDIX 2

Update of Register of Section 12(2) Approved Doctors - Wales	
	Section 12(2) Approved Doctors
Approvals and Re-approvals	10
Approvals suspended	0
Approvals re-instated/ transferred/returned to work in Wales	3
Removed (Left Wales)	1
Retired	0
Registered without a licence to practise and retired	0
Transferred from AC register (to S12 Register)	0
Became AC approved	5
Approval Ended or Expired	4
Death in Service	0
Performance Metrics - Reporting period: 8th July 2026 - 4th September 2026	
Total number of Section 12(2) doctor applications processed	16
Pending approvals	4
Number awaiting completion of application by the applicant	3
Average days to approval per completed application	24.8
Number of lapsed approvals due to missed deadlines by the applicant.	1

APPENDIX 2

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

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

Ratification Period: 8th July 2026 – 4th September 2026

S12 Approvals and Re-approvals: 10

Surname	First Name	Workplace	Date Approval Expires
Ebigbagha	Esther	Cygnet Healthcare, Cygnet St Teilo House Independent Hospital, Goshen Street, Rhymney,NP22 5NF	7th July 2031
Adeleke	Tayo Peter	Swansea Bay University Health Board, Older Persons Mental Health Services, Ty Garngoch Hospital, Gorseinon, Swansea, SA4 4LH	12th July 2031
Ulfin	Sheeja	Cardiff and Vale University Health Board, Cardiff and Vale 24/7, Cardiff Royal Infirmary, Glossop Terrace, Cardiff, CF24 0SZ	13th July 2031
Ng	Christopher Chen-Wei	Cardiff and Vale University Health Board, Hafan y Coed, University Hospital Llandough, Penlan Road, Llandough, Penarth, CF64 2XX	23rd July 2031
Okoye	Uchechukwu	Cardiff and Vale University Health Board, Barry Hospital, Colcot Road, Barry, CF62 8YH.	30th July 2031
Puli	Rakesh	Cardiff and Vale University Health Board, Hafan Y Coed, University Hospital Llandough, Penlan Road, Llandough, Penarth, CF64 2XX	4th August 2031
Elsaka	Omar	Elysium Healthcare, Ty Gwyn Hall Independent Hospital, Llantilio Pertholey, Abergavenny, NP7 6NY	17th August 2031

Surname	First Name	Workplace	Date Approval Expires
Gupta	Bibek	Independent Practitioner, c/o Private Address.	19th August 2031
Low	Je Ssy	Cwm Taf Morgannwg University Health Board, Dewi Sant Hospital, Albert Road, Pontypridd, CF37 1LB	23rd August 2031
Negm	Mostafa	Betsi Cadwaladr University Health Board, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, LL57 2PW	27th August 2031

S12 suspended: 0

Surname	First Name	Workplace	Date Approval Expires

S12 Approval Reinstated/Transferred/Returned to Wales: 3

Surname	First Name	Workplace	Date Approval Expires
Enendu	Celestine Izuchukwu	Swansea Bay University Health Board, Velindre NHS Trust, 4/5 Charnwood Court, Heol Billingsley Parc, Nantgarw, CF15 7QZ	18th May 2030
Kwagiri	Sharon Joel	Swansea Bay University Health Board, Ty Penfro, 67A Pembroke Road Canton, Cardiff CF5 1QQ	8th July 2031
Thompson	John	Betsi Cadwaladr University Health Board, c/o Private Address	17th October 2026

Removed (Left Wales): 1

Surname	First Name	Workplace	Date Approval Expires
Okoye	Uchechukwu	Public Service Delivery Scotland, Murray Royal Hospital, Muirhall Road, Perth PH2 7BH	30th July 2031

Retired: 0

Surname	First Name	Workplace	Date Approval Expired

Registered Without a Licence and Retired: 0

Surname	First Name	Workplace	Date Approval Ended

S12 Ended – Became an Approved Clinician: 5

Surname	First Name	Workplace	Date Approval Ended
Mustafa	Saima	Betsi Cadwaladr University Health Board, Hafod Community Mental Health Team, Beechwood Road, Rhyl, Denbighshire, LL19 3EU.	5th August 2026
Lusby	Joshua	Cardiff and Vale University Health Board, Ty Dysgu Cefn Coed, Nantgarw, CF157QQ	5th August 2026
Sameem	Hafeesa	Aneurin Bevan University Health Board, Princess of Wales Hospital, Coity Road, Bridgend, CF311RQ	6th August 2026
Comeau	Catrin	Swansea Bay University Health Board, Ysbryd Y Coed, Cefn Coed Hospital, Waunarlwydd Road, Cockett, Swansea, SA2 0GH	7th August 2026

Surname	First Name	Workplace	Date Approval Ended
Davies	Abigail	Cardiff and Vale University Health Board, Community CAMHS department, St David's Hospital, Cowbridge Road, Cardiff, CF11 9XB.	11th August 2026

S12 Approval Ended or Expired: 4

Surname	First Name	Workplace	Date Approval Expired
*Ulfin	Sheeja *(*later reapproved)*	Cardiff and Vale University Health Board, Cardiff and Vale 24/7, Cardiff Royal Infirmary, Glossop Terrace, Cardiff, CF24 0SZ	18th June 2026
Evans	Ethan	Formerly Elysium Healthcare, Ty Gwyn Hall Independnt Hospital, Llantilio Pertholey, Abergavenny, Monmouthshire, NP7 6NY.	8th August 2026
Howells	David	Independent Practitioner, Cyncoed Consulting Rooms, Dartington Drive, Pontprennau, Cardiff CF23 8SQ	9th August 2026
Emmett	Paul	Betsi Cadwaladr University Health Board, Craig y Don Medical Practice, Clarence Road, Llandudno, Conwy LL30 1TA	23rd August 2026

Death in Service: 0

Surname	First Name	Workplace	Date Approval Ended

ASSURANCE REPORT
NHS WALES SHARED SERVICES PARTNERSHIP COMMITTEE

Reporting Committee	**Shared Services Partnership Committee (SSPC)**
Chaired by	Dr Susan Barnes, Chair
Lead Executive	Neil Frow OBE, Managing Director, NWSSP
Author and Contact Details	Roxann Davies, Corporate Services Manager
Date of Meeting	16 July 2026

Summary of key matters including achievements and progress considered by the Committee and any related decisions made

Managing Director's Update Report – The Managing Director presented an update on key NWSSP developments since the previous meeting to complement the overarching report, with particular focus on two strategic programmes: Transforming Access to Medicines Service (TrAMS) and the Future Workforce Solution (FWS).

The TrAMS South East Hub Full Business Case has been completed and was progressing through the formal approval routes within individual organisations. Construction of the South East Radiopharmacy facility had been completed, with commissioning, validation and operational readiness activities continuing. Programme momentum remained positive across all hub developments, with continued oversight required in relation to commissioning timelines, workforce capacity, funding dependencies and service continuity during transition.

In relation to FWS, the Committee noted that the Managing Director had written to the NHS Business Services Authority (NHSBSA) in June raising concerns regarding programme clarity, scope, timelines and implementation expectations. Members were advised that the go-live date remained under review by NHSBSA and Infosys through the contract review process, with further formal communication anticipated and assurances received on improved communication and benefits realisation. Members discussed the implications of a revised timeline for early adopters, later implementation waves and funding arrangements, noting that year zero and year one funding had been approved under the previous administration, with further remapping required once the revised plan was agreed. Given the scale, complexity and multi-organisational impact of FWS, Members emphasised the need for appropriate programme assurance, including Internal Audit involvement at key staging and readiness points, subject to receipt of the revised plan. A further update would be brought to the September 2026 meeting.

The Committee **NOTED** and **DISCUSSED** the Managing Director's Update Report.

Deep Dive Presentation

Foundational Economy - The Committee received a detailed presentation on the Foundational Economy programme and its contribution to wider procurement priorities, including decarbonisation, value for money, supply chain resilience, waiting list support and compliance with an increasingly complex legislative framework. Procurement activity

continued to be underpinned by a focus on patient outcomes and value.

Enhanced analytical capabilities, including new Power BI and contract pipeline reporting tools, were highlighted, providing improved visibility of supplier spend, location and future procurement opportunities. Welsh-headquartered suppliers continued to account for 42.93% of NHS Wales expenditure, with spend increasing from just over £1bn in 2019/20 to more than £2.3bn in the latest year. Members noted that around £1.1bn of contracts were due for renewal during the year, presenting opportunities to further support foundational economy objectives where market conditions allowed.

Members welcomed the improved intelligence and discussed NWSSP's role in supporting delivery of the Social Partnership and Public Procurement (Wales) Act 2023 through a collaborative all-Wales approach. Discussion focused on the need to refine measures of economic impact beyond supplier headquarters location, alongside continued supplier engagement, support for SMEs and micro-businesses, and consideration of wider economic and employment benefits. The Committee recognised NWSSP's strategic procurement role and potential to further contribute to economic growth through innovative commercial approaches and partnership models.

The Committee **NOTED** the update provided in relation to Foundational Economy.

Items for Approval

Scan for Safety Wales Programme – The Committee considered the three-year extension of the Scan for Safety Programme, noting forthcoming regulatory requirements for enhanced traceability of implantable medical devices and Wales' comparatively advanced position. The programme will support compliance requirements and further development of inventory management capabilities, including exploration of artificial intelligence to optimise stock management across NHS Wales. The Committee **APPROVED** the extension of the Scan for Safety Programme and its supporting Inventory Management Contract with Omnicell by utilising the 36 months available as per the original Full Business Case and current contract terms.

Student Awards Bursary System – The Committee considered the proposed three-year contract extension for the Student Awards Bursary System, recognising the need to maintain continuity of support for students whilst Welsh Government continues to review bursary arrangements. The Committee **APPROVED** the Student Bursary Award System contract extension for three (3) years with effect from 1 April 2027 to 31 March 2030 with a total cost of £382,515.

Material Handling Equipment Lease, Hire and Maintenance – The Committee considered proposals to award a five-year contract for material handling equipment and received assurance regarding procurement, supplier due diligence and risk mitigations, including consideration of the single tender response received. The Committee **APPROVED** the award of the contract to Toyota Material Handling UK Limited, up to a maximum estimated value of £1.04m excluding VAT over the full five-year term, and **NOTED** the demand-led nature of the agreement, the associated risks and mitigations, and that progression remained subject to all required approvals and procurement requirements being completed.

NWSSP Annual Review 2025-26 – The Committee received the Annual Review 2025-26, which reflected NWSSP's 15-year anniversary on 1 April 2026 and provided an overview of organisational achievements, governance arrangements, performance and future priorities. The Committee **APPROVED** the Annual Review.

Digital Strategy – The Committee considered the refreshed Digital Strategy, designed to support organisational priorities through strengthened digital foundations, workforce capability, data maturity, cyber resilience and innovation. Discussion highlighted alignment with national digital priorities, workforce readiness and future investment requirements. The Committee **APPROVED** the refreshed Digital Strategy.

Opportunities Pipeline – The Committee received an update on the Opportunities Pipeline, setting out existing, emerging and longer-term opportunities through which NWSSP could further support NHS Wales in response to financial and service challenges. Members endorsed the strategic direction, emphasising the importance of partnership working, governance and stakeholder sponsorship. Some members of the Committee were keen to explore NWSSP's ability to take forward initiatives on a local and regional basis and not be constrained by consensus on all-Wales approaches every time. The Committee **NOTED** the update on the NWSSP Opportunities Pipeline, including initiatives already in hand for 2026/27, and **APPROVED** the proposed approach to undertaking discovery work on medium to longer-term opportunities before any final decision on development and implementation.

NHS Wales Preparedness, Resilience and Response Annual Report 2025-26 – The Committee received assurance regarding the maturity of NWSSP's emergency preparedness, resilience and response arrangements and the organisation's contribution to wider NHS Wales planning and collaboration. AR commented that NWSSP would be working with the Welsh Government in response to the recently published COVID Inquiry Module 5 report on PPE Procurement. The Committee **APPROVED** the Annual Report for submission to NHS Performance and Improvement.

Items for Noting

Welsh Risk Pool Assurance Programme – The Committee received an update on the Welsh Risk Pool Assurance Programme, including work to strengthen forecasting, financial mitigation and learning from clinical negligence claims. Members noted ongoing engagement with NHS Wales organisations and external partners to support continuous improvement and future risk reduction. The Committee **NOTED** the update.

Finance, Performance, People, Programme and Governance Updates

Finance Report – The Committee received the Finance Report as at 31 May 2026, noting a year-to-date surplus of £813k, delivery of Cost Improvement Programme savings, continued vacancy controls and no agency expenditure reported in the year to date. Key risks related to digital programme funding, Future Workforce Solution implementation, Radiopharmacy transition costs and energy price volatility. The Committee also noted capital programme progress, Welsh Risk Pool expenditure monitoring and the ongoing grip and control improvement programme.

People and Organisational Development Report – The Committee received an update on workforce performance, noting improved staff turnover, stable sickness absence and continued targeted interventions in areas of higher absence. Strong mandatory training compliance, ongoing workforce planning activity and a positive Internal Audit review of attraction and retention were highlighted. Members also noted NWSSP's achievement of silver status under the Armed Forces Employer Recognition Scheme.

Performance Information Report – The Committee received the latest performance report, noting continued delivery of professional influence benefits of £57m and generally

positive organisational performance. A small number of targets remained below target relating to procurement savings delivery and timely responses to audit recommendations, with corrective actions underway. Improvements in recruitment performance were also noted.

Outcome Measures Report – The Committee received an update on performance against NWSSP's strategic outcomes, noting positive performance across key measures including employee satisfaction, customer satisfaction, professional influence benefits, decarbonisation and foundational economy objectives.

Transformation Management Office (TMO) Update Report – The Committee received an update on the transformation portfolio, comprising 21 programmes, projects and initiatives across NHS Wales and NWSSP. Progress was reported across a number of schemes, including projects reaching completion and continued strengthening of reporting, assurance and benefits realisation arrangements.

Integrated Medium-Term Plan (IMTP) Quarter 4 Report 2025-26 – The Committee received the year-end IMTP performance report, prior to its submission to Welsh Government, noting that the majority of objectives had either been completed or remained on track. Areas of slippage and external dependency were being managed through the 2026-27 planning cycle.

NWSSP Annual Governance Statement (AGS) 2025-26 – The Committee received the final Annual Governance Statement, noting its prior consideration and approval through the Audit Committee and inclusion within the annual accounts process.

NWSSP Corporate Risk Register – The Committee received the Corporate Risk Register, noting the current risk profile, of which there were eight red and ten amber risks for action. No new risks had been escalated, although key programme risks had been refined to improve oversight. Ongoing review of risk targets and organisational risk appetite was also noted.

The Committee **DISCUSSED** and **NOTED** the above Reports.

Items for Information

The Committee received several items for information, covering items 7.1 to 7.4 of Part A and items 1.1 to 1.9 of Part A2. These comprised the Finance Monitoring Returns for Months 1 and 2 of 2026-27, the Personal Protective Equipment (PPE) Report, the NWSSP Audit Committee Assurance Report from 28 April 2026, and the SSPC Forward Plan 2026-27, together with a suite of annual reports covering Audit Committee, Local Counter Fraud Services, Concerns and Complaints, Declarations of Interest and Gifts, Hospitality and Sponsorship, Health and Safety, Welsh Language, Duty of Quality, Medical Examiners Service and Surgical Materials Testing Laboratory.

Part B – Private

Transforming Access to Medicines Service (TrAMS) South East Hub Full Business Case – The Committee considered the Full Business Case for the South East TrAMS Hub, which forms part of the national programme to modernise aseptic medicines manufacturing services across Wales. Members noted the case for change, including infrastructure, regulatory and workforce challenges, and that the proposal sought £21.7m capital investment to develop a regional hub at Imperial Park (IP5). The Committee acknowledged extensive stakeholder engagement and the strategic importance of the

programme in delivering a sustainable all-Wales service model. The Committee **APPROVED** the Full Business Case, subject to remaining organisational approvals and submission to Welsh Government.

Transforming Access to Medicines Service (TrAMS) Clean Room Design and Build Contract Change Approval – The Committee considered proposed contract changes associated with the South East TrAMS Hub development, noting that progression remained contingent upon approval of the Full Business Case, Welsh Government approval and confirmation of capital funding. Assurance was provided regarding cost validation, governance oversight, risk management and lessons learned arrangements. The Committee **APPROVED** the clean room design and build contract changes. Trust Board approval consideration to follow on 30 July 2026.

Aseptic Isolators for the South East Transforming Access to Medicines Service (TrAMS) Project – The Committee considered the procurement of 15 aseptic isolators required to support operations within the proposed South East Hub. Members noted that the purchase formed an essential component of the overall TrAMS infrastructure programme and remained subject to Full Business Case approval, Welsh Government approval and confirmation of capital funding. The Committee **APPROVED** the purchase of the isolators. Trust Board approval consideration to follow on 30 July 2026.

Matters requiring Board/Committee level consideration and/or approval	
The Board is asked to **NOTE** the work of the Shared Services Partnership Committee.	
Date of Next Meeting	Tuesday 15 September 2026, 10.00am to 12.00pm

Cyd-bwyllgor Iechyd a Gofal y Canolbarth ar gyfer Iechyd a Gofal / **Mid Wales Joint Committee for Health and Care**	
***Cadeirydd Arweiniol* / Lead Chair**	Dyfed Edwards, Chair, Betsi Cadwaladr University Health Board In the absence of Dyfed Edwards, Dr Neil Wooding, Chair of Hywel Dda University Health Board, chaired the Mid Wales Joint Committee meeting on 1 September 2026
***Prif Weithredwr Arweiniol* / Lead Chief Executive**	Prof. Phil Kloer, Chief Executive, Hywel Dda University Health Board
Cyfarwyddwr y Rhaglen* / *Programme Director	Keith Jones, Director of Operational Planning and Performance, Hywel Dda University Health Board
***Dyddiad y Cyfarfod Diwethaf* / Date of Last Meeting**	1 September 2026
***Cyfnod Adrodd* / Reporting Period**	May to September 2026

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

Strategic Review of the Mid Wales Joint Committee (MWJC)

A strategic review of the Mid Wales Joint Committee (MWJC) has been undertaken to assess its continuing role, purpose and contribution more than a decade after publication of the Mid Wales Healthcare Study and subsequent establishment of the Joint Committee. The review recognised that the MWJC has played a significant role in strengthening collaboration between partner organisations, supporting the sustainability of key services and maintaining a collective focus on the needs of rural communities across Mid Wales. However, the health and care landscape has evolved considerably during this period, with the emergence of Regional Partnership Boards and other regional partnership arrangements, increasing workforce and financial pressures, and the growth of digital models of care.

The review concluded that, whilst many of the original ambitions of the Mid Wales Healthcare Study have been achieved, there remains a strong case for continued collaboration across Mid Wales. Key challenges identified include workforce sustainability, rural health inequalities, access to services, digital exclusion, service resilience and increasing complexity within the partnership landscape. Stakeholders also highlighted the need for greater clarity regarding the distinct role, purpose and added value of the MWJC, as well as its relationship with existing regional partnership structures.

Six potential future options were considered as part of the review. Overall, the strongest support emerged for a hybrid model that brings together the key features of the Refocused Strategic Partnership and Rural Health and Wellbeing Partnership options. The associated SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis also identified this as the strongest option overall, balancing strategic ambition with deliverability and continuity. This approach would build on the strengths and relationships developed through the MWJC whilst repositioning the Committee as a more strategic, outcome-focused partnership with an enhanced role in addressing rural health and wellbeing challenges.

The emerging preferred direction would see the MWJC transition from its current operational planning focus towards a strategic leadership, influencing and partnership role. This would provide a stronger focus on areas where collective action can deliver measurable benefits for rural communities, including workforce sustainability, reducing health inequalities, digital innovation and inclusion, research and evidence, strategic advocacy, policy influence and cross-border service planning. The proposed approach would also strengthen the Joint Committee's role in championing the needs of rural communities and promoting innovation and best practice across Mid Wales.

Members of the MWJC support this direction of travel and recognise the opportunity to build on the Joint Committee's established strengths while responding to the changing health and care environment. Members have also emphasised the importance of maintaining a strong focus on the specific challenges faced by Mid Wales communities whilst contributing to wider national discussions on rural health and wellbeing. Subject to further engagement with Welsh Government, the next phase of work will focus on developing detailed proposals for future governance arrangements, operating principles and revised implementation timescales, which will inform the future role of the MWJC and its contribution to improving outcomes and reducing inequalities for rural populations.

Mid Wales Priorities and Delivery Plan 2026/27 – Up until July 2026 (Appendix A)
The Mid Wales Planning and Delivery Executive Group (MWPDEG) oversees the delivery of the Mid Wales Priorities and Delivery Plan. The plan for 2026/27 comprises 7 priorities supported by 15 workstreams. Overall progress remains positive, with the majority of workstreams progressing in line with agreed timescales. Of the 15 workstreams, 12 are rated Green (on track), two are rated Amber (mainly on track) and one is rated Blue (completed).

- The Endodontics workstream has been completed, with the new service pathway operational as from 20 July 2026. This enables Hywel Dda University Health Board (HDdUHB) patients from the 'SY' postcode area to access endodontic treatment at Llandrindod Wells Hospital, provided by Powys Teaching Health Board (PTHB).
- Two interdependent Ophthalmology workstreams are currently rated Amber (mainly on track): the PTHB Nurse-Led Wet Age-Related Macular Degeneration (AMD) Service and Networking Opportunities and Joint Pathway Development. The original target completion date of 30 June 2026 has not been achieved due to delays in PTHB staff visits to the HDdUHB North Road Clinic, Aberystwyth. These delays have resulted from a combination of factors, including honorary contract approval processes, sickness absence affecting key personnel, and a review of Intravitreal Therapy (IVT) treatment protocols. Mitigating actions have been implemented, including a meeting between PTHB and HDdUHB in August 2026, and a visit to the North Road Clinic is now scheduled for October 2026. A revised completion date of 30 November 2026 will be considered by the Mid Wales Planning and Delivery Executive Group (MWPDEG) at its meeting on 21 September 2026.

The MWPDEG has agreed to formally close the Ophthalmology Clinical Lead workstream. This is in response to advice from the Mid Wales Ophthalmology Group that the workstream is no longer required in its current form as its objectives have been overtaken by national, regional and local developments. However, to strengthen strategic leadership and accountability, MWPDEG has recommended the identification of a designated Senior Responsible Officer (SRO) for the Ophthalmology priority. A further report will be presented to MWPDEG on 21 September 2026 seeking agreement in principle to assign a named SRO to each Mid Wales priority and their associated workstream(s). This approach will strengthen organisational ownership, accountability and oversight of delivery across the programme.

Mid Wales Clinical Advisory Group (MWCAG)

The Mid Wales Clinical Advisory Group (MWCAG) has continued to refine its approach, with an increased focus on targeted, task-and-finish activities commissioned by the Mid Wales Planning and Delivery Executive Group. This approach has enabled clinical expertise to be directed towards areas of greatest need and has improved the Group's ability to deliver meaningful outcomes and recommendations that support the Mid Wales priorities.

During 2025/26, the Group established a multidisciplinary Mid Wales Stroke Service Change Group to assess the impact of actual and proposed changes to stroke services across the region. The group's work has informed partner organisations' engagement and consultation activities and reinforced the importance of regional planning arrangements, while also highlighting the value of a coherent national approach to stroke care in ensuring equitable access to services for rural communities. In June 2026, a request was received from the HDdUHB Transformation Team to engage with the Mid Wales Planning and Delivery Executive Group (MWPDEG) and the Mid Wales Clinical Advisory Group (MWCAG) on the HDdUHB Phase 2 Consultation on Stroke Services.

- On behalf of MWCAG, the Mid Wales Stroke Service Change Group was identified as the appropriate forum for engagement with the HDdUHB Transformation Team. The Mid Wales Stroke Service Change Group met on 10 July 2026 to receive a presentation on the HDdUHB Phase 2 Consultation on Stroke Services. This was followed by discussion and feedback, the outcomes of which were collated into a collective response. The response was approved by the Chair of MWCAG on behalf of the Group and subsequently submitted to HDdUHB.
- Also at its meeting on 20 July 2026, MWPDEG received a presentation on the proposed consultation options, followed by discussion and feedback. The outcomes were collated into a collective response and subsequently submitted to HDdUHB.

MWCAG has also maintained oversight of other major strategic service change programmes across the region, including PTHB's Better Together Programme and BCUHB's Tywyn Hospital Review. The Group has also received updates on the North Powys Wellbeing Programme and the Rural Health and Care Wales Virtual Rural Healthcare Project, recognising their potential contribution to workforce sustainability, service transformation and improved access to care. These discussions have supported a broader understanding of service developments and provided opportunities to consider their collective impact on the Mid Wales population.

A key theme arising from the Group's work is the importance of clearly understanding the respective roles of local organisations, regional partnerships and national programmes in service planning and delivery. This learning is helping to inform future work programmes and support more effective use of clinical time and expertise. Whilst attendance continues to be challenging given competing clinical priorities, the targeted approach to programme delivery has proved effective in securing engagement from the most relevant clinical stakeholders and supporting focused, outcome-driven discussions.

The Group also recognised the importance of ensuring that the needs of rural communities continue to be reflected in emerging national clinical planning arrangements. Members emphasised that consideration should extend beyond urgent and emergency care pathways to include rehabilitation and community-based services, which are particularly important in supporting equitable outcomes for people living in rural areas.

Rural Health and Care Wales (RHCW)

The MWPDEG and RHCW Stakeholder Group have continued to oversee delivery of the RHCW Work Programme for 2026/27. Significant achievements include:

- Completion and dissemination of the Macmillan Rural Cancer Patient Experience Research programme, which identified a range of inequalities experienced by rural cancer patients and generated recommendations to improve access, experiences and outcomes. The findings have been presented at national conferences and formally launched through a Mid Wales symposium. The research is informing ongoing discussions with partner organisations and potential funding bodies regarding actions to improve the experience of rural cancer patients and to inform the development of NHS Wales' future cancer strategy.
- Completion of the review of the community pharmacy provision across Mid Wales, alongside the production of bilingual resources to improve public awareness of available pharmacy services.
- The programme has also advanced work relating to dementia, community resilience and workforce development. The Mid Wales Dementia Friendly Communities report has been completed, supported by engagement events across Powys, Ceredigion and Gwynedd, with further case study work underway. A community resilience toolkit, based on the LiCoSS (Listen, Connect, Support and Sustain), has been developed to help communities support vulnerable residents to remain independent within their own homes and is now being piloted within Mid Wales communities.
- Successful completion of the Sustainable Communities Project in Lampeter, with additional funding secured to support the replication of this community resilience model in other rural communities across Ceredigion.
- Completion of research and engagement work examining primary care provision and transport accessibility across Mid Wales, providing valuable intelligence to inform future service planning and improvements in access to care.
- Continued support for workforce development through initiatives promoting careers in medicine and rural healthcare, alongside support for new research focused on addressing health inequalities experienced by rural populations.
- Ongoing exploration of opportunities for the Virtual Rural Healthcare model. While there continues to be strong support for the underlying principles and potential benefits of a collaborative digital approach across Mid Wales, the complexity of the programme, rapidly evolving technological landscape and differing organisational priorities have affected progress. Further work is being undertaken to refine the scope and ensure that any future model is deliverable, sustainable and aligned with emerging local, regional and national developments.
- A recurring theme across several projects has been the impact of transport and accessibility on health and wellbeing outcomes in rural areas. Research undertaken during the year has highlighted the importance of addressing transport barriers to improve access to health and care services, and further regional work is planned with partner organisations during 2027.
- Workforce and research initiatives have continued to support the sustainability of rural services. Engagement with 27 GP practices across Mid Wales has informed research into the challenges facing primary care, while collaboration with Swansea University has promoted opportunities through the Graduate Entry Medicine (GEM) programme and a new route into medicine for school leavers. In addition, Rural Health and Care Wales has supported new research programmes, including work focusing on women's health in rural communities.

Materion sydd angen eu cytuno new trafod ymhellach gan y Bwrdd / **Items to be referred to the Board for agreement or discussion**	
The Board is asked to **NOTE** the update on the work of the MWJC including the: • Strategic Review of the MWJC. • Mid Wales Priorities and Delivery Plan. • RHCW Work Programme.	
Dyddiad y Cyfarfod Nesaf / **Date of Next Meeting**	Time and date of the next meeting of the MWJC to be confirmed.
Agenda, papers and minutes of the Mid Wales Joint Committee meeting are available on its website: English - https://mwjc.nhs.wales, Welsh - https://cbbc.gig.cymru	

Acronyms / Glossary of Terms	
AMD	Age-Related Macular Degeneration
BCUHB	Betsi Cadwaladr University Health Board
GA	General Anaesthesia
GEM	Graduate Entry Medicine
HB	Health Board
HEIW	Health Education and Improvement Wales
HDdUHB	Hywel Dda University Health Board
IVT	Intravitreal Therapy
LICoSS	Listen, Connect, Support and Sustain
MDT	Multidisciplinary Team
MWCAG	Mid Wales Clinical Advisory Group
MWJC	Mid Wales Joint Committee
MWPDEG	Mid Wales Planning and Delivery Executive Group
PSA	Prostate-Specific Antigen
PTHB	Powys Teaching Health Board
RHCW	Rural Health and Care Wales
SRO	Senior Responsible Officer
SWDP	Support Worker Development Programme
SWOT	Strengths, Weaknesses, Opportunities, Threats
WAST	Welsh Ambulance Services University NHS Trust

APPENDIX A

Mid Wales Priorities 2026/27			
Priority	**Workstream**	**Aim**	**Status (as at 31/07/26)**
Ophthalmology	Powys Teaching Health Board (PTHB) nurse led wet age-related macular degeneration (AMD) service.	Progress the proposal for a PTHB nurse led wet AMD service in North Powys (Newtown) with Hywel Dda University Health Board (HDdUHB) medical oversight / District General Hospital pathway.	Mainly on track with some minor issues
	Networking opportunities and joint pathway development	Develop opportunities for PTHB staff to work at the North Road clinic in order to inform PTHB pathway development and repatriation opportunities with eyecare Multidisciplinary Team (MDT) in Powys.	Mainly on track with some minor issues
	Mid Wales Clinical Leadership	Develop a proposal for clinical leadership for Mid Wales ophthalmology services.	On track
	Primary care eye care services for the South Gwynedd area	Explore options to strengthen primary care eye care provision in the South Gwynedd area.	On track
Cancer	Radiotherapy pathway	Identify opportunities to improve access to radiotherapy across Mid Wales by minimising unnecessary travel for patients and ensuring that suitable transport and accommodation options are available when treatment closer to home is not possible.	On track
	Chemotherapy pathway	Identify opportunities to improve access to, and increase provision of, chemotherapy services across Mid Wales.	On track
Dental	Endodontic services	Develop a pathway enabling HDdUHB Ceredigion patients residing in the Mid Wales catchment area to access endodontic treatment delivered by PTHB at Llandrindod Wells Hospital.	Complete
	Paediatric General Anaesthesia (GA) service	Explore the feasibility of establishing an integrated Paediatric GA service for Mid Wales.	On track
Strategic Service Change programmes	Strategic Service Change programmes	Review pathways affected by organisational Strategic Service Change programmes and support the development of regional and cross-border solutions.	On track
Colorectal	Colorectal service development and expansion	Explore the opportunities for expanding the HDdUHB colorectal service to include patients from other areas of PTHB and Betsi Cadwaladr University Health Board (BCUHB).	On track
Dermatology	Dermatology	Review the current Dermatology service provision across Mid Wales and identify opportunities to increase capacity and improve access.	On track

APPENDIX A

Mid Wales Priorities 2026/27			
Priority	**Workstream**	**Aim**	**Status (as at 31/07/26)**
Rural Health and Care workforce	Support Worker Development Programme (SWDP)	Expand the Mid Wales SWDP beyond the initial Health Board (HB) partnership, enabling full regional integration and cross-sector participation.	On track
	Cross-Sector Population Health, Wellbeing and Prevention Capability Development	Establish a baseline position across Mid Wales of workforce capabilities in prevention, population health and community-based wellbeing support, to identify opportunities for collaboration.	On track
	Workforce Health, Wellbeing and Psychological Support	Establish a regional baseline position of workforce health, wellbeing and psychological support needs across Mid Wales Health Boards (HB), enabling improved access, reduced duplication and strengthened resilience for staff.	On track
	National Management & Leadership Competency Framework	Support early development activity related to the national Management & Leadership Competency Framework in partnership with Health Education and Improvement Wales (HEIW), ensuring that emerging proposals are aligned across Mid Wales and duplication is avoided between the three Mid Wales HBs.	On track

MID WALES JOINT COMMITTEE FOR HEALTH AND CARE

TERMS OF REFERENCE AND OPERATING FRAMEWORK

Partners:
Betsi Cadwaladr University Health Board (BCUHB)
Hywel Dda University Health Board (HDdUHB)
Powys Teaching Health Board (PTHB)
Welsh Ambulance Service NHS Trust (WAST)
Ceredigion County Council (CCC)
Powys County Council (PCC)
Gwynedd Council (GC)

1. Purpose

The purpose of the Mid Wales Joint Committee (MWJC), as a formal sub-committee of NHS Boards, is to:

1.1 Identify annual/3 year key priorities for service development for the relevant population into a Joint Committee Work Plan; articulating these as a clear and core part of organisations Integrated Medium Term Plan/Annual Plan.

1.2 Work collectively to implement agreed key service developments; ensuring clear, robust mechanisms for delivery, including performance management mechanisms, via the Joint Committee to individual Boards.

1.3 Develop and implement clear mechanisms for engagement, involvement and consultation, and communication with the relevant population, and community/stakeholder groups; ensuring that plans, priorities for service development and evaluation of services are co-produced.

1.4 Ensure mechanisms are developed that enable close working with and engagement of other key vehicles for improving health and well-being and delivering integrated services; specifically but not exclusively Regional Partnership Boards, Public Service Boards and other NHS Joint Committees/equivalents.

2. Principles

The MWJC will operate within the following principles:

- There must be an open and honest relationship with the people of Mid Wales.
- Institutional Boundaries will not prevent collaborative service planning and delivery.
- Productive and constructive relationships with Local Authorities and the Third Sector must be supported across Mid Wales.
- Viability and sustainability of service provision is not only the responsibility of the host organisation but is a collective responsibility of the Joint Committee for Mid Wales.
- Service planning and delivery in Mid Wales must be population based not solely organisationally focused.
- Promote new thinking and innovative practice.
- When required pooled funding should be available to enable collaborative service delivery for the Mid Wales population.

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- Clinical collaboration across the Mid Wales area on the planning and delivery of services must be encouraged and supported.

3. Chair and Membership

3.1 The MWJC will be chaired by a nominated Chair of a Health Board, working on behalf of other Chairs, in rotation for a period of 2 years.

3.2 The membership of the group shall comprise the following:

Members	
Lead Chair*	One nominated representative from one of the three Mid Wales Health Boards (Betsi Cadwaladr UHB, Hywel Dda UHB, Powys THB)
Chief Executive (including Lead Chief Executive*)	Betsi Cadwaladr UHB Hywel Dda UHB, Powys THB Welsh Ambulance Service NHS Trust
One elected representative and one officer representative	Ceredigion County Council Gwynedd Council Powys County Council
Lead Clinical Executive Director(Medical/Nursing/Therapies)*	Mid Wales Joint Committee
Lead Director of Planning*	Mid Wales Joint Committee
Associate Members	
Sub-group Chairs	Mid Wales Planning and Delivery Executive Group Mid Wales Clinical Advisory Group Rural Health and Care Stakeholder Group
Co-opted Members	
One representative	Llais (Citizens Voice Body)

* Lead Mid Wales Joint Committee roles nominated from one of the three Mid Wales Health Boards:
- Betsi Cadwaladr University Health Board
- Hywel Dda University Health Board
- Powys Teaching Health Board

3.3 The following will be in attendance at meetings of the MWJC as and when required:

In attendance	
Programme Director	Mid Wales Joint Committee

3.4 The MWJC may co-opt others in an advisory capacity as appropriate.

3.5 The MWJC will invite workstream / priority leads to attend meetings, as required, to provide an update on the delivery of their respective work plan.

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4. Quoracy

4.1 The quorum for meetings shall be no less than 50% of the membership and must include either the Chair or Lead Chief Executive. Deputies may be nominated to attend where advance notice of their attendance has been given. Deputies will be assumed to have the full delegated authority of the member they represent. Members need to ensure consistency and appropriateness when nominating deputies.

4.2 In the event any partners are not represented at meetings which are quorate then any decisions taken by the group will be abided by all partners.

4.3 If a quorum has not been reached, then a "non-quorate" meeting may proceed if those attending agree, but any record of the meeting should be clearly indicated as notes rather than formal minutes and decisions will need to be ratified in the next quorate meeting.

5. Frequency of Meetings

5.1 The MWJC will meet bi-annually as follows:

- Annual meeting held in April with its main purpose being a planning meeting for the Joint Committee's future workplan.
- Annual conference held in November which will provide an opportunity to showcase the work of the Joint Committee and engage with partners and members of the public on its work.

5.2 Additional meetings may be established at the discretion of the Chair.

5.3 The Chair, in discussion with Joint Committee team, shall determine the time and the place of meetings of the MWJC and procedures of such meetings. Meetings will have video- and audio-conferencing facilities available.

5.4 Meetings will be held in public (apart from in circumstances that require private session – see 5.5 below), however, these will not be public meetings.

5.5 The Chair may enact all or part of a meeting that excludes members of the public and press under Section 1(2) Public Bodies (Admission to Meetings) Act 1960.

6. Support

6.1 The secretariat support for the MWJC will be provided by the Joint Committee Programme team.

7.1 Reporting

7.1 The agenda will be based on actions of the previous meeting, standing agenda items, matters arising and requests from Executive Group members or work commissioned by the MWJC or groups reporting to the MWJC.

7.2 Standing agenda items will include:

- Minutes and Action Log of the previous meeting
- Report of the Lead Chair
- Report of the Lead Chief Executive

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- Priorities and Delivery plan update report
- Mid Wales Planning and Delivery Executive Group update report
- Mid Wales Clinical Advisory Group update report
- Rural Health and Care Wales Stakeholder Group update report
- Listening to You session

7.3 Agenda and papers for Joint Committee meetings will be distributed in good time, usually at least 7 days prior to the meeting being held and will be made publicly available.

7.4 All meetings shall be formally minuted and a record kept of all reports/documents considered. The primary record of the meeting will be held by the Joint Committee team on behalf of the Chair. The action log will be circulated within 7 days of the meeting. Members must forward amendments within the next seven days and the final version will be agreed with the Chair.

7.5 The MWJC may establish sub-groups or task and finish groups to carry out on its behalf specific aspects of its business. The sub-groups reporting to this group are:

- Mid Wales Planning and Delivery Executive Group
- Mid Wales Clinical Advisory Group
- Rural Health and Care Stakeholder Group

8. Corporate and Financial Governance

8.1 For NHS organisations the Joint Committee will report directly to their respective Board governance structures, acting as a formal sub-committee. Reporting will take place in line with the general principles of openness and transparency already in operation for NHS bodies.

8.2 For Local Authorities the Joint Committee will report on its work to the scrutiny mechanisms in place for these organisations.

8.4 The MWJC itself will not normally hold a budget, apart from an annually agreed sum to undertake the coordination work of the Joint Committee. This would not preclude the development of Section 33 pooled funds as the work of the Joint Committee progresses and pooled funds are seen as an enabler to progress.

8.5 An annual self- assessment of effectiveness of the MWJC will take place. The MWJC may wish to undertake development activities in line with its role and function. There should be a formal review of Terms of Reference and Operating Framework by Boards at least every 2 years.

8.6 The MWJC will act as for forum for making collective recommendations to the statutory organisations for decision.

8.7 Overall responsibility for the planning and delivery of care services should remain with the sovereign bodies. This includes decisions regarding service changes that require formal engagement and consultation.

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9. Engagement

9.1 Existing engagement and involvement mechanisms for Health Boards and Local Authorities will be used as the main tools for Mid Wales engagement and involvement.

9.2 The Joint Committee Programme Director and team will lead on identifying those Mid Wales specific issues which require action and response by respective Health Boards and Local Authorities.

10. Review of the Terms of Reference

10.1 The membership and terms of reference shall be subject to continuous review and any amendments will be subject to approval by the MWJC.

Version	Issued to:	Date	Comments
v1.0	Mid Wales Healthcare Collaborative members	Aug 2017	Feedback received incorporated in version 2.0.
v2.0	Mid Wales Healthcare Collaborative	05/09/17	Re-circulate to members for final feedback.
v3.0	Mid Wales Healthcare Collaborative	05/12/17	**Agreed**
v4.0	Mid Wales Joint Committee	12/03/18	**Agreed**
v5.0	Mid Wales Planning and Delivery Executive Group	13/03/23	**Agreed**
V5.1	Mid Wales Joint Committee	25/04/23	

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Corporate Governance Directorate Transfer Log (2025/26)

BOARD / COMMITTEE					COMMITTEE				AAA REPORT		
Date of Meeting	**Action Reference Number**	**Agreed Action from Board / Committee**	**Board / Committee Action Referred From**	**Board / Committee Action Referred To**	**Has this been added to the Committee Action Log**	**How is this being dealt with by the Committee**	**Date of Committee**	**Outcome of discussion at Committee**	**Has this been reported back to Board via AAA Report**	**Date of AAA Report to Board**	**Complete**
29.05.25	25/86.3	Planning, Population Health and Partnerships Committee to support a review of opportunities and areas for transformation within Community services and Primary Care and report back to the Board.	Board	PPHP Committee	No: This has been included on the PPHP forward workplan	A Committee Development Session was held on 24 September 2025 focussed on Health and Care Services. There was discussion around Primary Care being key to prevention and early intervention agreeing this is a priority area.	24.09.25 (Development Session)	Primary Care will be the focus for the next PPHP Committee Development Session taking place in 2026.	Yes	27.11.25	Complete
31.07.25	25/129.1	People and Culture Committee to discuss opportunities to support young people into the workplace and report back to the Board.	Board	P&C Committee	No: This has been included on the P&C forward workplan	This area of work will align to the Foundations for the Future programme and will therefore report to the P&C Committee later in 2026.	Proposed to be the staff story late 2026	Discussed at agenda setting meeting for the Oct meeting and agreed that this is linked to a specific National celebration day and aligned to a work programme / strategic business later in the year.			
31.07.25	25/138.1	People and Culture Committee to discuss the increase in corporate functions and costs in relation to job evaluation.	Board	P&C Committee	No: This was dealt with directly via Georgina Roberts	A corporate growth analysis has been included as an appendix to item PC25.129 People Operations Report following a request from the Board for the Committee to discuss the increase in corporate functions and costs in relation to job evaluation.	04.12.25	The Committee noted the position.	Yes	29.01.26	Complete
25.09.25	25/170.2	Planning, Population Health and Partnerships Committee to review the final version of the Winter Resilience Plan 2025/26 at its meeting in October 2025.	Board	PPHP Committee	No: This has been included on the PPHP forward workplan	The Winter Resilience Plan Paper was received by the Committee noting that there had been much better engagement and relationship building with all Local Authorities and other sectors however much of the change work is in early stages and it will be Winter 2026 before some benefits and improvements can be fully realised.	28.10.25	The Committee approved the Winter Planning Approach on behalf of the Board.	Yes	27.11.25	Complete
21.10.25	AC25/151.1	People and Culture Committee to review sickness absence in relation to whether there are areas of fraud or disciplinary activity taking place by staff	Audit Committee (Private)	P&C Committee	No: This is being dealt with via the Transfer Log	A paper on Fraud Cases will be compiled for the next meeting in October 2026.	08.10.26				

BOARD / COMMITTEE					COMMITTEE				AAA REPORT		
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		during periods of sickness absence.									
22.10.25	PF25.96	People and Culture Committee to review the Shared Services Partnership Report and to consider what more could be done to speed up the shortlisting process.	PFIG Committee	P&C Committee	No: This has been discussed during agenda setting	The Team are collating information to highlight what interventions have been implemented and what impact this has had. The information will form part of the People Operations Report to the June meeting.	11.06.26	Work is taking place to review improvement actions to reduce recruitment shortlisting delays through enhanced processes and engagement with managers.	Yes	30.07.26	Complete
27.11.25	25.208.1	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.	Board	PPHP Committee	No: This has been included on the PPHP forward workplan	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.	07.05.26	This information will form part of regular reporting to the PPHP Committee via the revised format of the Population Health Delivery Report.	Yes	28.05.26	Complete
27.11.25	25.209.1	Progress against the Healthy Travel Charter to report back to the Board in May 2026.	Board	PPHP Committee	No: This has been included on the PPHP forward workplan	The Healthy Travel Charter has been included on the forward workplan for the PPHP Committee in November 2026. Update from Stuart 10.07.26: No progress to report as future steps with costs will need approval and further work is required.	05.11.26	Stuart and Jane to confirm how this is being taken forward.			
27.11.25	25.210.1	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.	Board	P&C Committee	No: This was dealt with directly via Georgina Roberts	The Three Year Culture, Leadership and Engagement Improvement Plan was received by the P&C Committee on 12.02.26, it was agreed the need to review and reprioritise some of the actions and present this back to a future Committee meeting.	09.04.26	Progress has been made in strengthening the Culture, Leadership and Engagement Improvement Plan, including enhanced executive ownership, clearer accountability, and OD facilitated work to improve measurability and progress will be monitored by the Committee.	Yes	28.05.26	Complete
27.11.25	25.211.1	The Performance elements of Urgent and Emergency Care to report to the Performance, Finance and Information Governance Committee and the safety elements to report to	Board	PFIG and QSE Committee	No: This was dealt with via the Committee secretariat	UEC performance was discussed at the PFIG Committee on 18.12.25 and 24.02.26 as this is a standing item and is documented in the AAA Report from both meetings. The QSE Committee received a detailed update on the fragility of UEC at the	18.12.25 24.02.26 05.03.26	These discussions form part of regular reporting to PFIG and QSE.	Yes	26.03.26	Complete

BOARD / COMMITTEE					COMMITTEE				AAA REPORT		
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		the Quality, Safety and Experience Committee.				meeting on 05.03.26, with concerns escalated regarding ED pressures, delays and safety risks associated with workforce fragility and reliance on temporary staffing.					
18.12.25	PF25.125	People and Culture Committee to consider how the establishment control process can be simplified given evidence that inability to recruit to posts within establishment in a timely manner is negatively impacting performance.	PFIG Committee	P&C Committee	No: This was dealt with via the Committee secretariat	A report on the ECR Process is being developed for the October 26 meeting taking into account this action and Action PF26.71.2					
18.12.25	PF25.125	Quality, Safety and Experience Committee to look at evidence of harm as a result of delays to follow up appointments.	PFIG Committee	QSE Committee	No: This was included on the QSE forward workplan	This information will be reported to the QSE Committee via the revised Integrated Quality and Performance Report	03.09.26	The revised IQPR was presented to the QSE Committee and agreed that the 'ask' in the action will continue to be monitored through the IQPR to the QSE Committee going forward.	Yes	24.09.26	
15.01.26	QS26.5.1	QSE Committee recommended that the National Carers Report should be reviewed by PPHP Committee.	QSE Committee	PPHP Committee	No: This is being dealt with via the Transfer Log	The QSE Committee at its meeting in January 2026 referenced the work completed through the NW Regional Carers Group, focused on mapping of current support and provision available across hospitals and communities. The outcome of this exercise will be shared with QSE and PPHP Committees once received through the National Carers Report. Discussed with Harriet 16.06.26: The National Carers Report hasn't been received as yet and once received it will be shared with QSE and PPHP, Harriet will share once received.		The report has not yet been received			
17.02.26	AC26.22.1	Provide a briefing paper to the People and Culture Committee regarding the two highlighted reports of staff committing Fraud on rehire.	Audit Committee	P&C Committee	No: This is being dealt with via the Transfer Log	A paper on Fraud Cases will be compiled for the next meeting in October 2026.	08.10.26				
05.03.26	QS26.38.2	Update to be received at Audit Committee on implementation of the Learning Repository for assurance.	QSE Committee	Audit Committee	Yes: This has been included on the AC action log	This is on the draft agenda for the next meeting on 20.10.26					

BOARD / COMMITTEE					COMMITTEE				AAA REPORT		
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05.03.26	QS26.55.1	Update on Urgent & Emergency Care to be received at the next QSE Committee and Board meeting in May.	QSE Committee	Board	No: This has been included on the QSE forward workplan	Urgent & Emergency Care was presented to the QSE Committee in May 26 and will become part of regular reporting. The Urgent and Emergency Care Progress Report is included on the Board agenda for the May meeting and has been a standing item at Board since September 2025.	07.05.26 28.05.26	Urgent & Emergency Care has been included on the QSE Committee cycle of business as a regular item.	No this hasn't been reported back via the AAA Report as this is part of regular reporting.	N/A	Complete
26.03.26	26.52.1	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.	Board	QSE Committee	No: This has been included on the QSE forward workplan	An update on Cancer Services was provided through the Planned Care item at the QSE Committee in July 26.	02.07.26	The AAA Report states that 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. The Chair of the Committee will also report back to the July Board.	Yes as per the narrative included	30.07.26	Complete

Corporate Governance Directorate Transfer Log (2026/27)

BOARD / COMMITTEE					COMMITTEE				AAA REPORT		
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08.04.26	PF26.40.2	Ensure Foundations for the Future is considered at P&C Committee to ensure oversight.	PFIG Committee	P&C Committee	No: this is included on the P&C CoB	This is a regular item on the P&C Committee CoB and is included on the agenda for all meetings.	11.06.26	A high level update was provided noting that the Committee maintain active oversight of the Foundations for the Future Programme to ensure appropriate governance and scrutiny of programme delivery and workforce implications.	Yes	30.07.26	Complete
28.04.26	PF26.44.2	PPHP Committee to reconsider the current practice of staff advising journalists to source information through FOIs (relates to Information Governance KPI Report)	PFIG Committee	PPHP Committee		Consideration being given to how this can be actioned					
12.05.26	RC26.28	Request that the P&C Committee consider the effectiveness of multidisciplinary team (MDT) working, including the alignment of leadership responsibilities and associated job descriptions, and provide assurance on any actions required to support effective clinical and professional leadership arrangements.	RemCom	P&C Committee		A Talent Management and Succession Planning Report is included on the agenda for the October 2026 meeting					
23.06.26	PF26.71.2	P&C Committee to review work underway to simplify the ECR process.	PFIG Committee	P&C Committee		A report on the ECR Process is being developed for the October 26 meeting taking into account this action and Action PF25.125					
02.07.26	PP26.71.3	People and Culture Committee to review the themes raised by staff during the engagement activity undertaken in relation to the Clinical Services Plan around the perception that staff	PPHP Committee	P&C Committee		This will be discussed at the next P&C agenda setting meeting					

BOARD / COMMITTEE					COMMITTEE				AAA REPORT		
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		do not feel enabled to implement the transformation required to change clinical services.									
02.07.26	PP26.72.1	Performance, Finance and Information Governance Committee to review zero based budgeting to ensure budgets are fit for purpose moving forward and review the position routinely throughout the year.	PPHP Committee	PFIG Committee		This is being discussed at the PFIG agenda setting meeting					
06.08.26	MH26.44.1	An update on the Learning Disabilities services to be received at the Quality, Safety & Experience Committee for system oversight following a recent Healthcare Inspectorate Wales report.	MHL Committee	QSE Committee		Included on the QSE Committee forward workplan					
18.08.26	AC26.85.01	Internal Audit Progress Report: PFIG Committee to receive and scrutinise recovery plans relating to Nuclear Medicine Consolidation and Capital Governance Arrangements.	Audit Committee	PFIG Committee		This action is noted on the draft agenda for the Oct meeting					
01.09.26	AC25/32.1	Information Governance and Records Management Position: Executive Committee to take some time to consider the matter, identify best practice, clarify that the risk is logged and bring the item back to the Committee.	Audit Committee	PPHP Committee		Director of Corporate Governance advised that this action should be transferred to PPHP Committee. Justine Parry advised that this is an outstanding recommendation from an external review on Corporate Records Management. There has been no progress to date due to staffing resource issues and needs to remain open.					
01.09.26	AC26.36	Internal Audit Progress Report: Future reports to provide six and twelve-month assurance updates on the implementation and effectiveness of improvements to on-call arrangements.	Audit Committee	P&C Committee		Pam requested that this action was transferred from Audit to P&C Committee					
01.09.26	AC26.88.01	Further to discussion of CfMHS: Ensure the resulting improvement plan from the wider RD&I review is reported back through the appropriate governance route, with clear ownership, milestones, target	Audit Committee	QSE Committee		Pam / Audit Committee agreed that this action would be transferred from Audit Committee to QSE Committee. Pam / DI have requested Clara to advise on the timescales to be assigned to this action.					

BOARD / COMMITTEE					COMMITTEE				AAA REPORT		
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		dates and residual risk assessment.									

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Health, Safety and Security Annual Performance Report

Report Presented to:

Health Board

Date of Meeting: 24th September 2026

Period Report Covers: 01/04/2025 – 31/03/2026

Report Presented by:

Stuart Keen, Director of Environment and Estates

Report Prepared and Presented by:

Lynne Bushell, Head of Health,Safety and Security
With contributions from the Health, Safety and Security Team

Contact Details:
BCU.HealthAndSafetyAdvice@wales.nhs.uk
BCU.SecurityAdvisoryTeam@wales.nhs.uk
BCU.ManualHandlingQueries@wales.nhs.uk
BCU.fittestregionalcoordinators@wales.nhs.uk

Cyfarfod a dyddiad: Meeting and date:	Board						
Cyhoeddus neu Breifat: Public or Private:	Public						
Teitl yr Adroddiad Report Title:	Summary Annual Health and Safety Report 2025-2026						
Cyfarwyddwr Cyfrifol: Responsible Director:	Stuart Keen, Director of Environment and Estates						
Awdur yr Adroddiad Report Author:	Lynne Bushell, Head of Health, Safety and Security With contributions from the Health, Safety and Security Team						
Craffu blaenorol: Prior Scrutiny:	None						
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Executive Summary

This report provides the Board with an overview of the Health Board's performance in relation to health, safety and security for the period 1 April 2025 to 31 March 2026, including key risks, areas of improvement, and priorities for 2026–2027.

Overall Assurance Position

The Health Board can demonstrate partial assurance in relation to compliance with its statutory health and safety duties.

While there is clear evidence of progress in strengthening governance arrangements, audit processes, and the development of a structured Health and Safety Management Framework, significant gaps remain in the consistent implementation of risk management, alignment of training to risk, and the maturity of supporting systems.

These gaps present moderate to high organisational risk, particularly in relation to workforce safety, patient safety, and regulatory compliance and align to the corporate risk.

Key Performance Overview

- Incident reporting remains high, with persistent risk themes consistent with previous years:
  - Sharps injuries
  - Slips, trips and falls
  - Violence and aggression

- There has been improvement in the quality and accuracy of incident reporting, particularly in relation to the classification of violence and aggression.

- Reporting under RIDDOR remains a concern, with:
  - Increased scrutiny of incidents
  - Ongoing challenges in meeting statutory reporting timelines

- Violence and aggression incidents remain a significant and sustained risk to staff, with:
  - High volumes of reported incidents
  - Increasingly accurate recording of physical assaults

- Manual handling compliance continues to improve, but remains below target and is challenged by capacity pressures and workforce constraints.

Key Risks to the Organisation

The most significant health and safety risks identified during the reporting period are:

1. Violence and aggression towards staff
   - Sustained high levels of incidents
   - Risk of physical and psychological harm
2. Lack of a mature health and safety risk management system
   - Absence of a digital solution
   - Inconsistent identification, recording and escalation of risk
3. Training misalignment and gaps in competence assurance
   - No fully embedded Training Needs Analysis
   - Limited ability to demonstrate a risk-based approach
4. Manual handling capacity and compliance challenges
   - Workforce and training capacity constraints
   - Persistent DNA rates
5. Governance and assurance inconsistency
   - Variable engagement at Strategic Occupational Safety and Health Group (SOSHG)

- Gaps in local reporting and escalation

Key Areas of Progress

During 2025–2026, the Health Board has made measurable progress in several areas:

- Implementation of a formal Health and Safety Management Framework aligned to NHS standards
- Introduction of a structured self-assessment and audit programme, including validation and data triangulation
- Development of a Training Needs Analysis, providing the foundation for a more coherent and risk-based approach to competence
- Improved incident data quality, particularly in relation to violence and aggression
- Progress in addressing findings from the internal audit, with the majority of actions now complete

Key Areas Requiring Improvement

Despite this progress, a number of critical areas remain underdeveloped:

- Risk management systems and processes are not yet sufficiently embedded
- Training provision is not fully aligned to organisational risk
- RIDDOR reporting timeliness remains inconsistent
- Governance effectiveness, particularly SOSHG engagement and quoracy, requires strengthening
- Workforce capacity continues to limit service delivery in key areas, including manual handling

Strategic Priorities for 2026–2027

The Health Board will prioritise the following actions:

- Implementation of a Health and Safety Risk Management Framework, supported by an appropriate digital system
- Completion and implementation of the Training Needs Analysis
- Development of a Health and Safety Incident Investigation Framework
- Strengthening of Strategic Occupational Safety and Health (SOSHG) governance arrangements, including accountability and reporting
- Targeted action to address violence and aggression, aligned with national standards
- Review of the Health, Safety and Security service structure to ensure it is sufficient to meet organisational needs

Conclusion

The Health Board has made meaningful progress in strengthening its approach to health and safety during 2025–2026. However, the organisation remains on a journey, with important structural and system-wide improvements still required.

Without continued focus and investment, the Health Board remains exposed to ongoing risks associated with workforce safety, violence and aggression, and inconsistent risk management practices.

Recommendations to the Board

The Board is asked to:
1. Note the overall position of partial assurance
2. Endorse the strategic priorities for 2026–2027
3. Support the development of:
   - A digital risk management solution
   - A fully implemented Training Needs Analysis
4. Agree the need to strengthen governance and accountability through SOSHG
5. Consider the future resourcing requirements of the Health, Safety and Security service

1. Introduction

This summary Health and Safety Annual Report covers the period 1st April 2025 – 31st March 2026.

The report outlines key developments and the work that has been undertaken during this reporting period and is an opportunity to consider work planning and the objectives for the year ahead.

The Health and Safety at Work etc. Act 1974, and associated regulations, provide a legislative framework to promote, stimulate and encourage excellent health and safety at work standards. The purpose is to ensure the health, safety and welfare of employees and anyone who may be affected by the Health Board's work activities.

In particular, the act requires organisations to provide and maintain:

- A Health and Safety Policy.
- A system to manage and control risks in connection with the use, handling, storage and transport of articles and substances.
- A safe and secure working environment, including provision and maintenance of access to and egress from premises.
- Safe and suitable plant, work equipment and systems of work that are without risks.
- Information, instruction, training and supervision, as necessary.
- Adequate welfare facilities.

At Betsi Cadwaladr University Health Board (here in referred to as 'the Health Board') overall responsibility for health and safety sits with the Chief Executive Officer; however, nominated responsibility is assigned to the Director of Environment and Estates.

2. Service Strategy

The Management of Health and Safety at Work Regulations requires the Health Board to appoint one or more competent persons to assist in achieving compliance with the relevant health and safety statutory requirements. The Health Board fulfils its responsibility for health and safety by:

- Maintaining a team of professionals to provide advice and support in relation to health and safety matters.
- Offering and facilitating a range of health and safety training courses in addition to the mandatory eLearning modules.
- Measuring compliance with health and safety policies through Health and Safety Reviews and other monitoring mechanisms such as monthly and quarterly performance reports.
- Consulting, in various ways, with the workforce in relation to health, safety and welfare, including via the Strategic Occupational Safety and Health Group (SOSHG).

The Health and Safety Team comprises of the following services:

- Health and Safety
- Manual Handling
- Mask Fit Testing
- Security including Violence and Aggression

Collectively, the team have built on and continue to further embedded proactive systems designed to raise awareness, and as far as is reasonably practicable, prevent or reduce the risk of harm occurring. These included introducing or reviewing several policies and procedures, including:

  - HS09 Control of Noise at Work Procedure and associated supporting documents
  - HS17 DSE Procedure and associated supporting documents
  - HS23 CCTV and Body Worn Video Procedure
  - HS33 Suspect Packages and Bomb Threat Procedure
  - HS34 Lockdown Policy
  - RIDDOR Flowchart
  - Managing COSHH in Offices

3. Occupational Safety and Health Management System (OSHMS)

3.1. BCUHB Health and Safety Standards – Self-Assessment Programme

In the Health and Safety Strategic Plan and Gap Analysis aligned to the Health and Safety Executives 'Plan, Do, Check, Act' model, taken from HSG65: Managing Health and Safety, the Corporate Health, Safety and Security Team committed to implementing the NHS Employers Workplace Health and Safety Standards, which were developed with the support of the Health and Safety Executive.

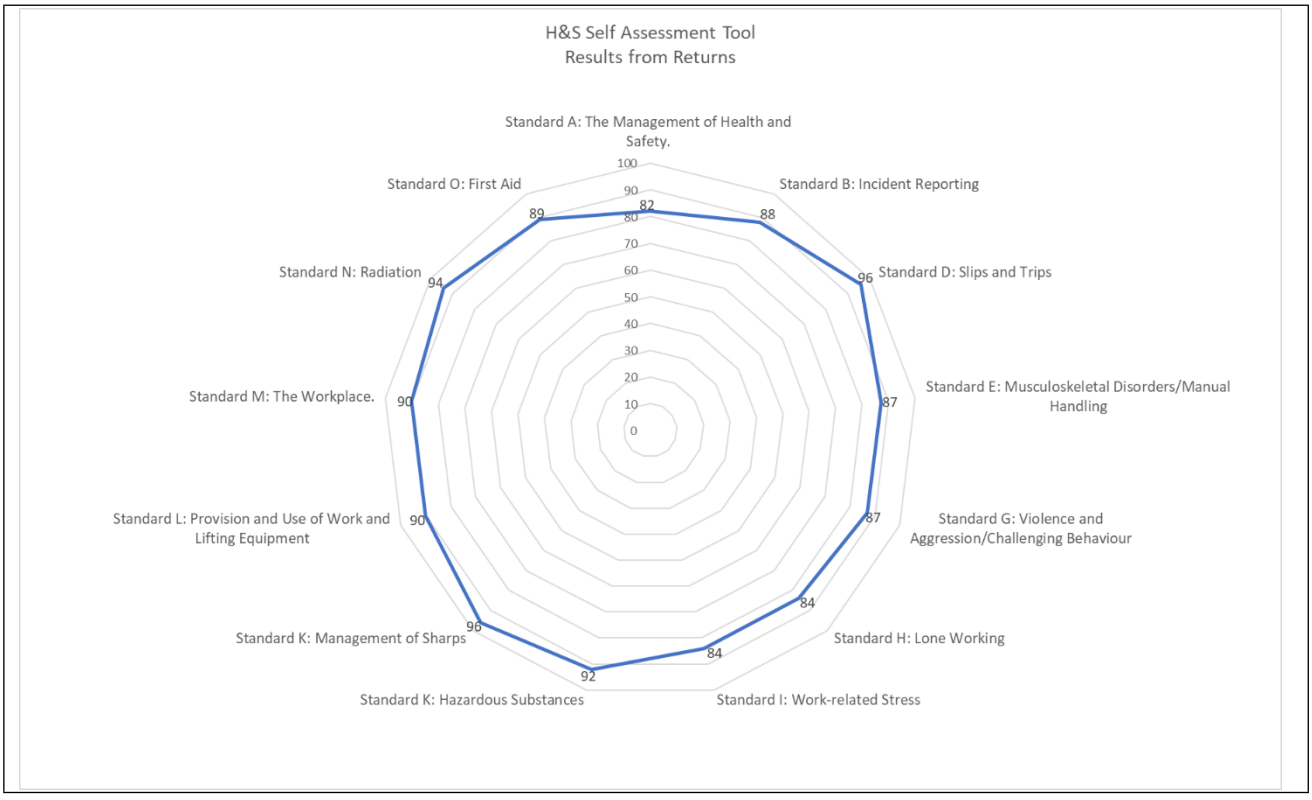
The standards are recognised as a leading indicator of health and safety performance and will be a mechanism to monitor the Health Board's Health and Safety Management Framework from Ward to Board.

In compliance with the Health Board's Health and Safety Policy, the annual Health and Safety Self-Assessment Tool was circulated for completion at ward and department level. This was the first step in the transition over to the standards

The self-assessment was rolled out as set out below.

- Cohort 1: April - East IHC, Central IHC, West IHC (DGHs only), Environment and Estates, Radiology, and MHLD.
- Cohort 2: October – Cancer Services, Womens and Maternity Services, Community Services, Pan Services, Corporate Services, and Primary Care.

Collation of the responses from this self-assessment tool have been used to identify areas of risk and this will allow mitigations to be implemented for a stronger more robust safety management system going forward. The Radar graph below shows the self-assessment results from a pan-BCUHB perspective for the full financial year 2025-2026 inclusive of both cohorts. Further analysis of these findings can be found in section 7.3 of this report: Audit, Monitor and Review.



3.2. Health and Safety Risk Assessment and Risk Management

The completion of risk assessments is a statutory requirement under the Management of Health and Safety at Work Regulations 1999. To support this compliance, the Health and Safety Team continued provide advice and guidance in the development of health and safety risk assessments.

There is one risk on the Corporate Risk Register linked to health and safety, which is risk ID 5040 (CRR 25-10). This risk has a score of 16, and is progressing. Significant progress has been made in strengthening governance, including the implementation of a Health and Safety Management Framework aligned to NHS Health and Safety Standards, enhanced Board-level oversight, and a structured programme of self-assessment. Key improvement actions remain in progress, particularly in relation to workforce capacity, digital risk management systems, and training. These actions are directly aligned to internal audit recommendations and are expected to further strengthen assurance and reduce organisational risk during 2026–27 subject to time and investment.

Other associated risks on the Risk Register are:
- Risk ID: 3893 - Manual Handling Training Compliance. This has a risk score of 16.
- Risk ID: 5041 - Security Services. This has a risk score of 12.

The management and oversight of operational health and safety risks remains a key area for improvement. This was identified as a priority workstream for 2025–2026 within the Health and Safety Strategic Plan and the gap analysis undertaken in September 2024.

Progress in this area has not yet commenced during the reporting period. Delivery requires organisational support, investment in an appropriate technology solution, and close collaboration with the Corporate Risk Management function to ensure alignment with wider risk management processes.

A structured plan has been developed to support progression, providing a clear framework to initiate and sustain improvement. This includes the temporary support of an experienced Risk Advisor to establish the approach and build momentum. In the longer term, it is hoped that this will be supported by the appointment of a permanent, full-time Risk, Health and Safety Manager to provide dedicated capacity and leadership for this workstream.

4. Communication and Consultation

4.1. Strategic Occupational Safety and Health Group (SOSHG)

The Strategic Occupational Safety and Health Group (SOSHG) continues to provide the primary forum for the oversight of health and safety across the Health Board. The Group is chaired by the Director of Environment and Estates, meets bi-monthly, and is accountable to the People and Culture Committee, with escalation to the Board where required.

SOSHG retains responsibility for monitoring the development, implementation and effectiveness of the Health Board's health and safety management arrangements. This is supported by a number of specialist sub-groups, including Asbestos, Fire, Water, Electrical and Security, designed to provide focused assurance in key risk areas.

During 2025–2026, a draft Health and Safety Meetings Governance Framework, including revised Terms of Reference and a standardised reporting structure, has been developed to strengthen governance arrangements and improve clarity of roles, responsibilities and escalation routes. However, this framework remains subject to consultation and formal approval.

Whilst SOSHG continues to discharge its core functions, progress in strengthening its effectiveness during the reporting period has been limited. Challenges have included inconsistent

attendance, with quoracy not always achieved, and variable levels of engagement from Divisions and service areas.

Addressing these issues continues to be a priority for 2026–2027. Planned actions include formal approval and implementation of the governance framework, reinforcement of accountability for attendance and reporting, and improved alignment between divisional governance structures and corporate health and safety arrangements. These actions are expected to strengthen organisational oversight, improve assurance, and support more effective management of health and safety risks across the Health Board.

4.2. Health and Safety Intranet Pages on BetsiNet

Work to update the Health and Safety Intranet Pages continues to ensure that it is a functional and informative resource available for use by all employees across the Health Board.

5. Training and Competence

The Health and Safety at Work etc. Act 1974 places a duty on employers to ensure, so far as is reasonably practicable, the health, safety and welfare of employees and others affected by its activities. This includes the provision of appropriate information, instruction, training and supervision. Managers and supervisors play a key role in meeting these duties, including ensuring staff are adequately supported to work safely and that robust arrangements are in place for monitoring and compliance.

During 2025–2026, significant progress has been made in strengthening the organisation's approach to training and competence. Central to this has been the development of a Training Needs Analysis (TNA), which is now nearing completion and will be presented to the Strategic Occupational Safety Steering Group (SOSHG) later this year. The TNA represents a key milestone in establishing a more structured, risk-based approach to health and safety training, ensuring that staff receive training appropriate to their role, responsibilities, and work environment.

The TNA has been developed in the context of Health Education and Improvement Wales (HEIW) reviewing statutory and mandatory eLearning requirements, and it will provide clarity on the level and type of training required across the organisation. This work addresses a previously identified gap, whereby critical responsibilities, such as risk assessment and incident investigation, which are not aligned to mandatory training requirements. The implementation of the TNA will therefore strengthen assurance that legal duties, including the requirement for suitable and sufficient health and safety risk assessments, are supported by appropriate competence of those assigned to their development.

During the reporting period, a range of health and safety training programmes have been delivered to support organisational capability. These have included the NEBOSH Award and NEBOSH Certificate qualifications, alongside targeted courses in risk assessment, control of substances hazardous to health (COSHH) and reporting of injuries, diseases and dangerous occurrences (RIDDOR). In addition, a new one-day course, Working Safe, Working Strong, has been developed, modelled on IOSH Managing Safely principles. This course is designed to provide a practical, accessible foundation in health and safety principles and will be launched in the 2026–2027 financial year.

Looking ahead, the training programme for 2026–2027 will focus on quality, consistency and alignment with the forthcoming TNA. As part of this, the existing risk assessment, COSHH and RIDDOR courses will be reviewed and overhauled to ensure they remain current, relevant and aligned to organisational needs and legislative requirements. During this review period, the delivery of these courses will be scaled back to enable redevelopment and quality improvement.

Work has also been undertaken to explore the development of apprenticeship pathways aligned to roles within the Health, Safety and Security portfolio. Engagement with HEIW to date has not

yet resulted in an agreed framework; however, this remains an area of strategic interest. Ongoing dialogue will continue, and contributions have been made to HEIW's broader strategy development, including attendance at national engagement events.

Overall, the organisation has made measurable progress in strengthening its approach to training and competence, moving towards a more structured and evidence-based model. The completion and implementation of the Training Needs Analysis in 2026–2027, once approved, will be a key enabler in ensuring that staff at all levels have the knowledge, skills and competence required to work safely and to meet both organisational and legal requirements.

5.1. Health and Safety Training

The table below shows compliance with statutory and mandatory Health and Safety Level 1 eLearning training broken down by service as at 31/03/2026.

eLearning Mandatory Training	DIVISION / DIRECTORATE						
	Cancer Services	Diagnostics & Clinical	IHC Central	IHC East	IHC West	MHLD	Womens and Midwifery
Health, Safety & Welfare 25-26	376 84.49%	1131 90.41%	4899 90.09%	5160 92.81%	4126 91.28%	2160 93.79%	759 88.46%
Trajectory		⇧	⇧	⇔	⇔	⇧	⇩
Health, Safety & Welfare 24-25	376 87.85%	1001 83.70%	4867 89.47%	5158 92.84%	4070 91.34%	2076 92.47%	780 91.66%

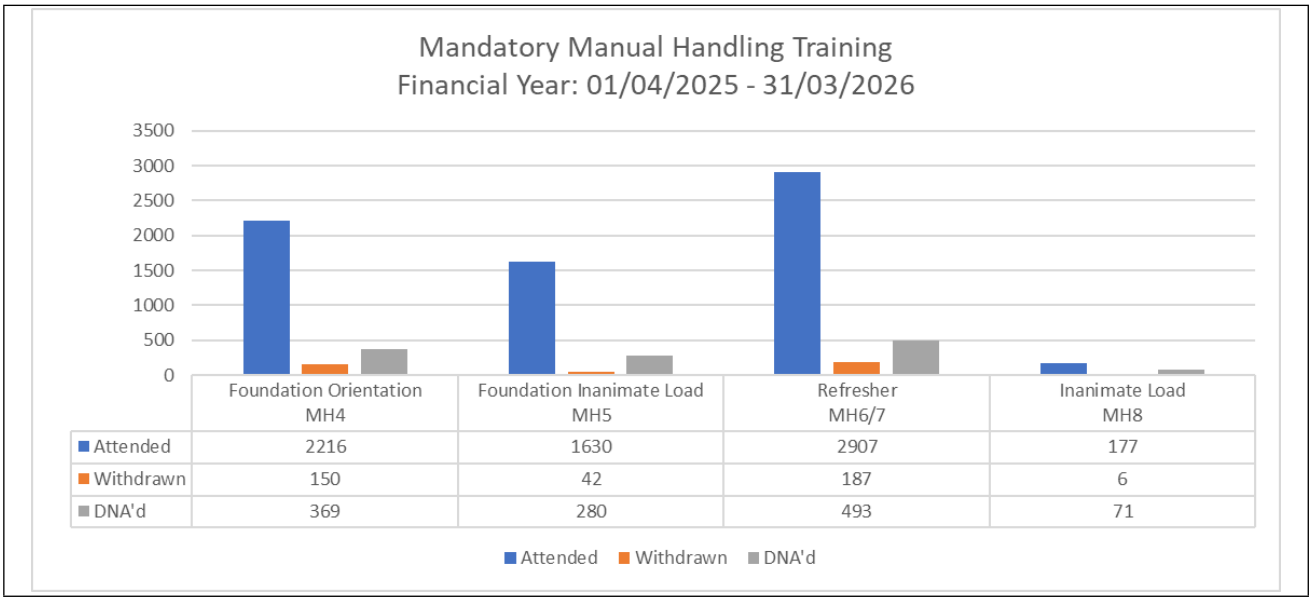
New to this year's annual report are:

eLearning Mandatory Training	DIVISION / DIRECTORATE			
	Corporate Services	Environment and Estates	ICD – Primary Care	ICD – Regional Care
Health, Safety & Welfare 25-26	10,478 87.94%	251 91.27%	237 90.46%	1507 88.86%
Trajectory	⇧	⇩	⇔	⇔
Health, Safety & Welfare 24-25	10,466 83.43%	257 93.45%	250 91.58%	1437 88.49%

The table below shows health and safety training courses run and attendance across the services for the financial year 2025/2026.

	HEALTH AND SAFETY TRAINING								
	Cancer Services	Corporate Services	DSCSS	Environment & Estates	IHC Central	IHC East	IHC West	MHLD	Midwifery and Womens
BESPOKE	0	0	0	13	6	21	29	0	1
COSHH AWARENESS	1	31	18	8	53	54	59	13	2
HS01 HEALTH AND SAFETY SELF-ASSESSMENT TOOL BOX TALK	1	41	2	11	45	12	55	5	0
ORIENTATION/MANDATORY HEALTH AND SAFETY TRAINING (CLASSROOM)	0	0	0	0	13	5	4	0	0
NEBOSH HEALTH AND SAFETY AT WORK AWARD	0	27	8	9	26	11	28	12	3
RIDDOR AWARENESS	0	45	15	16	41	32	50	15	2
RISK ASSESSMENT MADE EASY	0	34	16	13	43	51	51	20	2
TOTAL	2	137	59	48	234	191	279	212	57

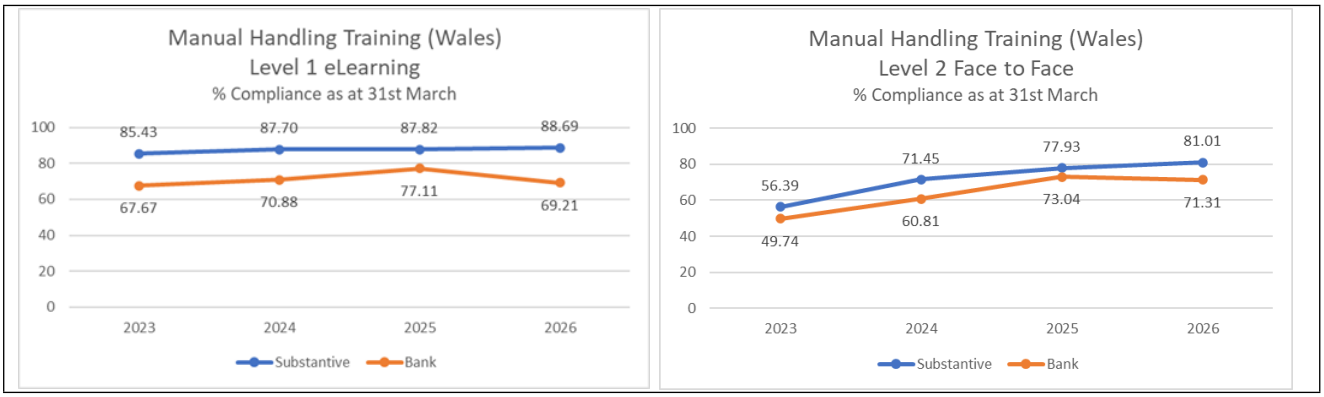
5.2. Manual Handling Training



The graph above shows the breakdown of courses by attendance etc., which demonstrates demand for all the courses remains strong but capacity pressure is evident from the number of DNAs and withdrawals recorded.

Course	No. of DNAs	%
Foundation Orientation MH4	369	16.65%
Foundation Inanimate Load MH5	280	17.18%
Refresher MH6/7	493	16.96%

DNA rates are a key issue as levels are significant across all courses, as can be seen below. However, it is important to note that the percentage is consistent and systemic. This is not course supply issue, instead indicates a 'booking -v- release -v- engagement' issue likely to be driven by organisational pressures in the clinical and non-clinical environment.



Source: Workforce BI Dashboard. All data correct as at 25/06/2025.

Manual handling training compliance for Level 2 has seen a 44% increase in compliance over the last 4-years as well as a steady increasing trend year on year. In comparison to the last financial year, Level 2 training is up by 4%. This demonstrates that the targeted intervention using ESR data is working. However, the loss of two trainers is reducing course availability and placing pressure on the manual handling service to maintain performance when coupled with the team's student training commitment.

In addition to this increase, training delivered to university students taking up placements with BCUHB, is around an additional 700 training places.

Focus is needed in reducing the number of DNAs. Attendance on all mandatory courses, but specifically those designed to provide the tools and techniques to prevent harm, sits with line manager. However, in addition to this, during this financial year, a review of 'positional numbers' commenced with the ESR Team. Positional numbers are intrinsically linked to the Job Description and Person Specification. If these are not allocated accurately at recruitment stage, it is likely to lead to complications and inconsistencies in the future. Where a positional number is shared across multiple staff members, and some require Level 2 training while others do not, the Level 2 requirement remains attached to that positional number to ensure consistency.

Based on the review undertaken at the time of writing, it is not anticipated that adjustments to positional numbers will have a significant impact on overall compliance levels and staff who are currently allocated Level 2 training but believe it is not required, will continue to be recorded as non-compliant unless they attend the training. Ways to improve compliance and reduce the need to remove Level 2 requirements from positional numbers, will continue to be explored in the new financial year.

Providing more bespoke training would ensure that staff are equipped with the appropriate skills for their specific work environment, while also enabling them to recognise and challenge poor practice where it is observed. As a consequence, in this financial year, the Manual Handling Service began exploring the upskilling of manual handling champions to support with bespoke and/or refresher training.

The loss of key trainers has impacted delivery and recruitment has been further impacted due to the vacancy freeze. Without this, the upward trends we have seen in recent years may plateau or reverse.

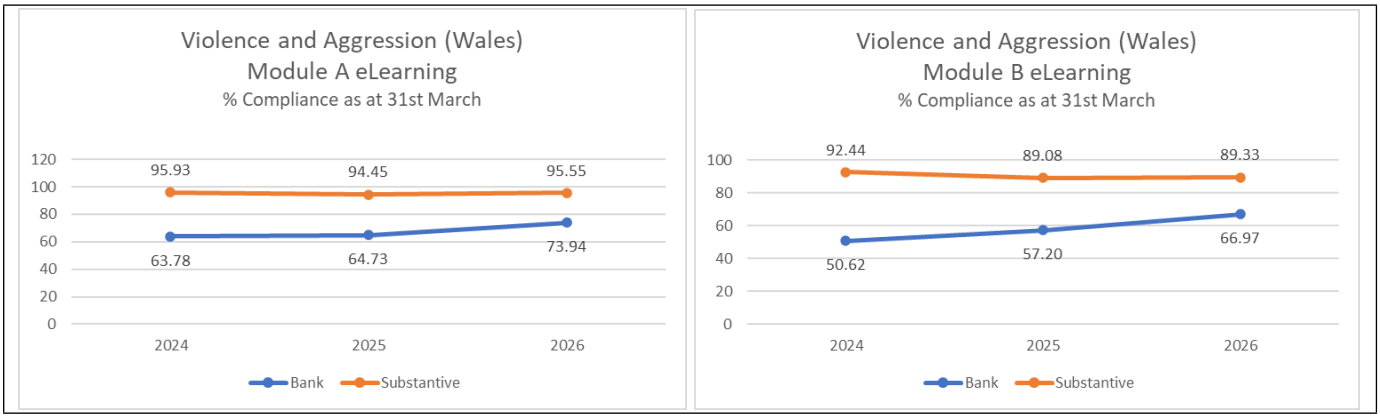
5.3. Violence and Aggression and Personal Safety Training

Training associated with violence and aggression and personal safety follows the All-Wales Violence and Aggression Passport, which is broken down into four modules:

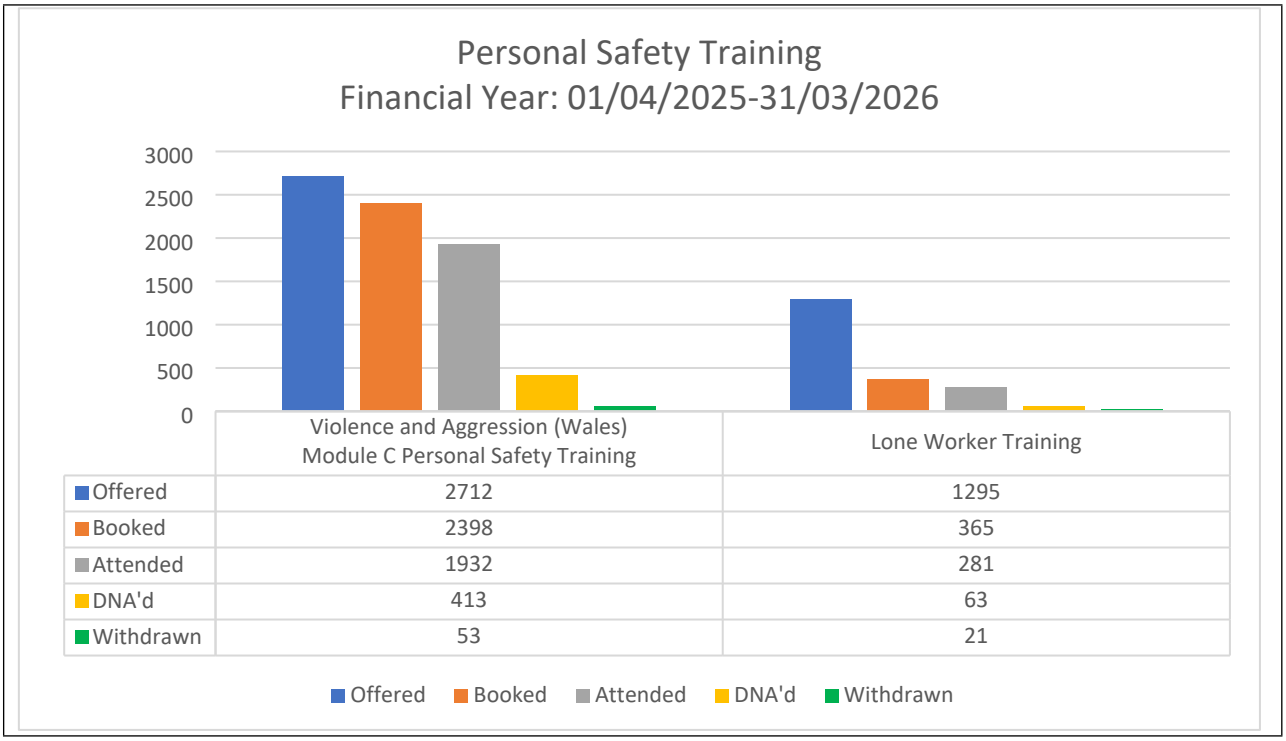
Module A – Awareness
Provides basic awareness of violence and aggression, including recognising early warning signs, personal safety, and reporting/escalation. The target audience is all staff as a foundation level for all employees.

Module B – De-escalation
Develops communication and behavioural skills to prevent and de-escalate conflict, including recognising triggers and managing challenging situations safely. The target audience is staff with regular interaction with patients, visitors, or the public, including most frontline clinical and support roles.

Compliance for these modules for substantive staff are routinely above the Health Boards target of 85%; however, further work is required for Bank and Locum colleagues, particularly those who work in higher risk areas such as Emergency Department, Assessment Units, Community Locations.



Module C – Breakaway Techniques and Lone Working
Provides practical training in safe disengagement (breakaway) techniques and managing physical aggression within legal and safety frameworks. The target audience is staff working in higher-risk environments where there is a foreseeable risk of physical aggression e.g. Emergency Departments, Security Roles, some Community Services. Neither of these courses are mandated, attendance is driven through the findings from the risk assessment developed by the various services. Currently the Security Team are unable to break down the training figures into Division, Directorate or service area, but work is underway to try to



The table above shows that Module C training is well utilised and that this course is relevant and necessary. Most staff who do book Module C also attend, which is positive; however, there is still a 20% attrition rate between booking and attendance.

As with Manual Handling Level 2 training, the number of DNAs is significant and the likely attributable factor is operational pressures or bookings are being made without release to attend being secured with the manager.

Lone worker training on the other hand shows that supply is high but demand is relatively low with only 28% of available places being booked.

The absence of service-level data and the ability to link training to risk assessments means that the organisation is currently unable to determine whether training provision is aligned to

organisational risk, or whether staff working in environments with a foreseeable risk of violence and aggression are consistently receiving appropriate training.

This lack of visibility limits the ability to:

- Provide assurance of compliance
- Demonstrate a risk-based approach to training provision
- Evidence that resources are being targeted appropriately to areas of greatest need

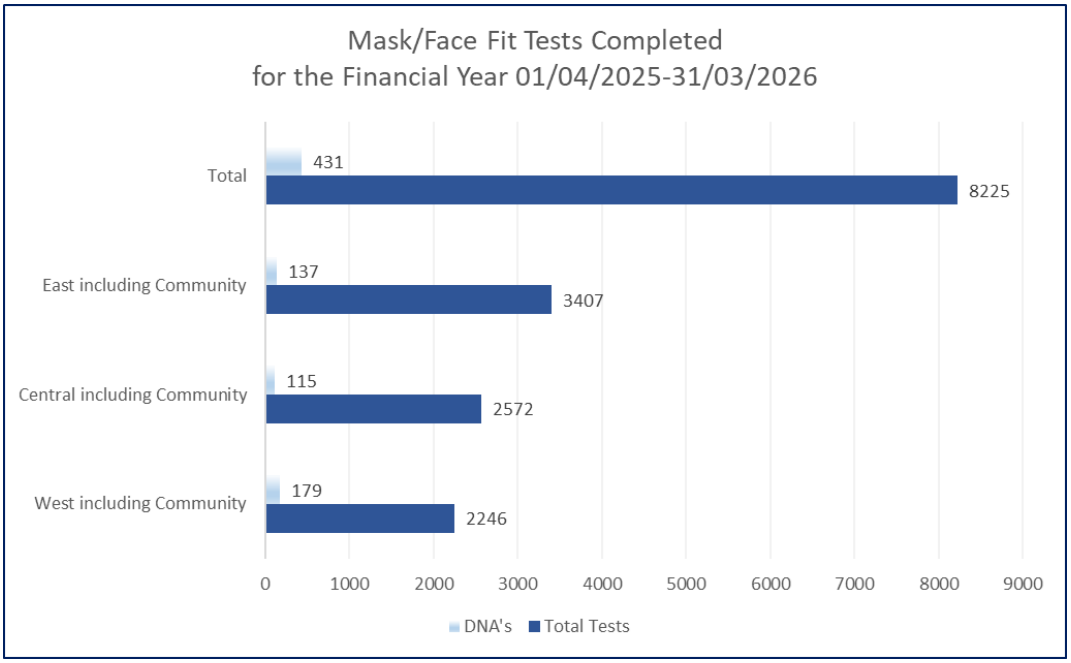
The development of ESR reporting functionality and the implementation of a electronic centralised risk assessment system will be critical in enabling a more targeted, risk-based approach to training delivery, and in providing meaningful assurance regarding compliance and workforce safety.

Module D – Advanced Restrictive Interventions
Covers specialist skills in managing high-risk violent situations, including the use of restrictive interventions in line with legal, ethical, and least-restrictive practice principles. The target audience is staff in specialist Mental Health and Learning Disability services, or other high-risk areas where restrictive interventions may be required.

Module D is not managed by the Health, Safety and Security Team. It is led and governed by Mental Health and Learning Disability services, reflecting its clinical and specialist nature.

Manual Handling Level 2 and Violence and Aggression Module C Training:
The Health Board entered into a 3-year contract with the University of Wrexham to provide statutory and mandatory training for students specific to Level 2 Manual Handling and Module C Personal Safety Training.

5.4. Mask/Face Fit Tests



Work is underway to transition from a legacy, blanket approach to face fit testing, implemented during the COVID-19 pandemic, to a risk-based model aligned to COSHH and respiratory protection requirements. A structured triage questionnaire is being developed, requiring line managers to assess their teams against defined risk criteria (including exposure to aerosol-generating procedures, airborne infections, and hazardous substances). This enables staff to be categorised into four risk tiers, ensuring that fit testing is targeted to those with a demonstrable occupational need, rather than applied universally.

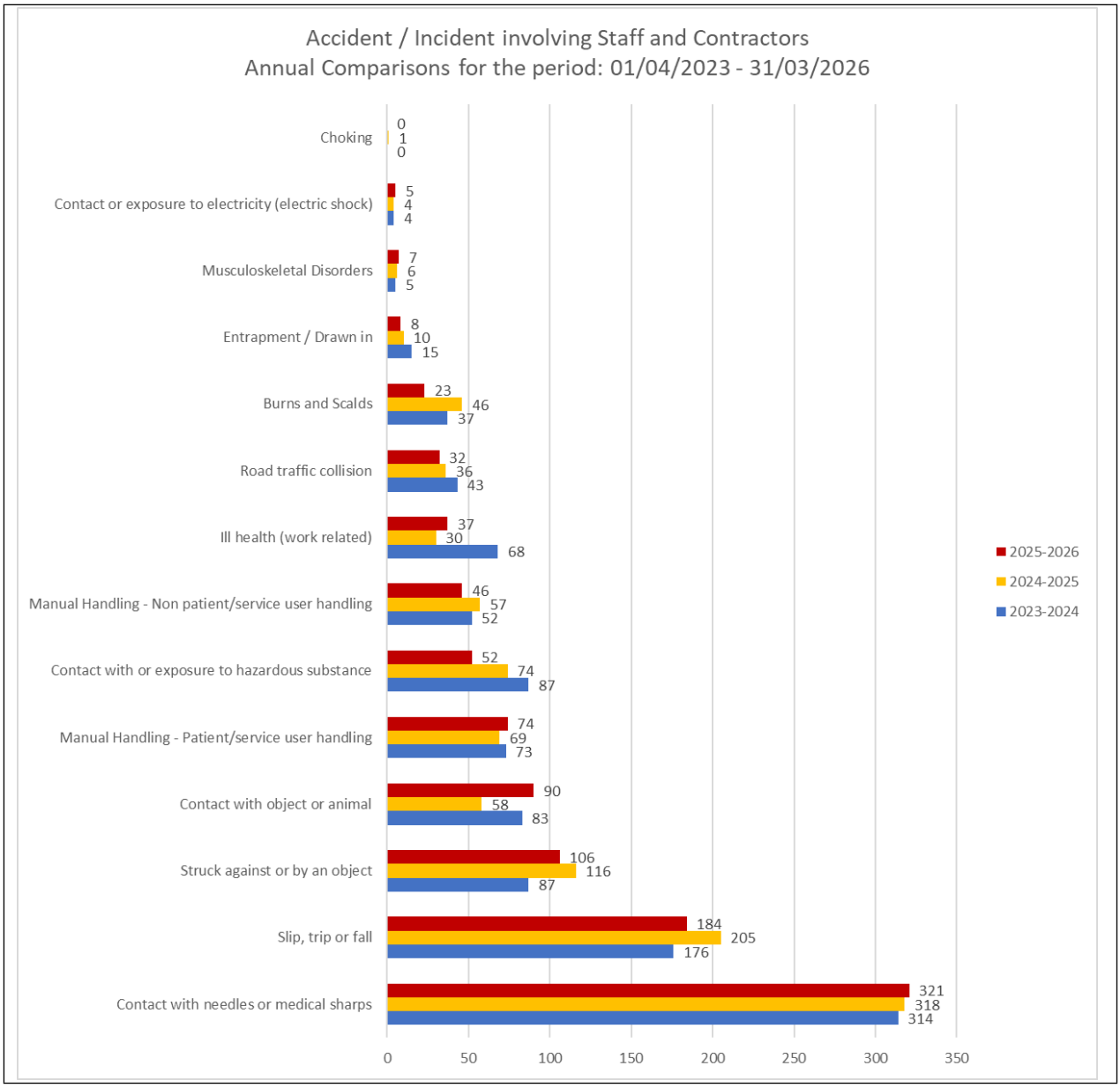
The proposed model was presented to the Strategic Occupational Health and Safety Group (SOHSG) in April 2026 and approval for the new approach is now being sought from clinical services. Once agreed, it will be implemented through a phased rollout, including manager engagement, data collection, validation, and the development of a targeted fit testing programme.

This approach is expected to improve data accuracy, strengthen managerial understanding of risk, and ensure resources are prioritised effectively.

6. Incident Reporting

6.1. Accident / Injury Incidents Reported

The tables below show the number of reported incidents for the past 3-consecutive years: 2025/2026, 2024/2025, 2023/2024 for comparison by 'Category'.

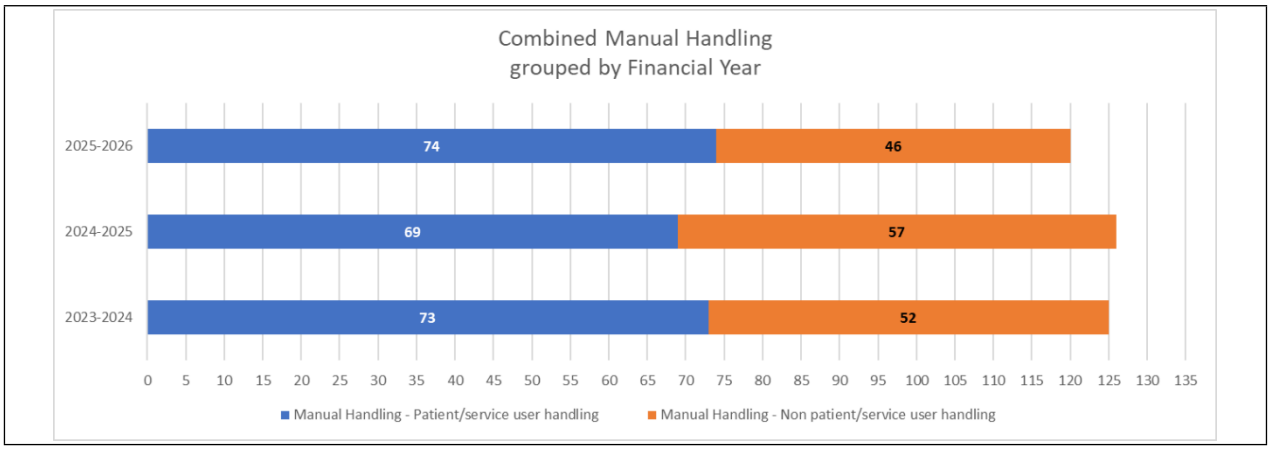


It can be seen from the graph above that the analysis of staff and contractor accident and injury data over the three-year period demonstrates a gradual reduction in total incidents, from 1,044 in 2023–2024 to 985 in 2025–2026.

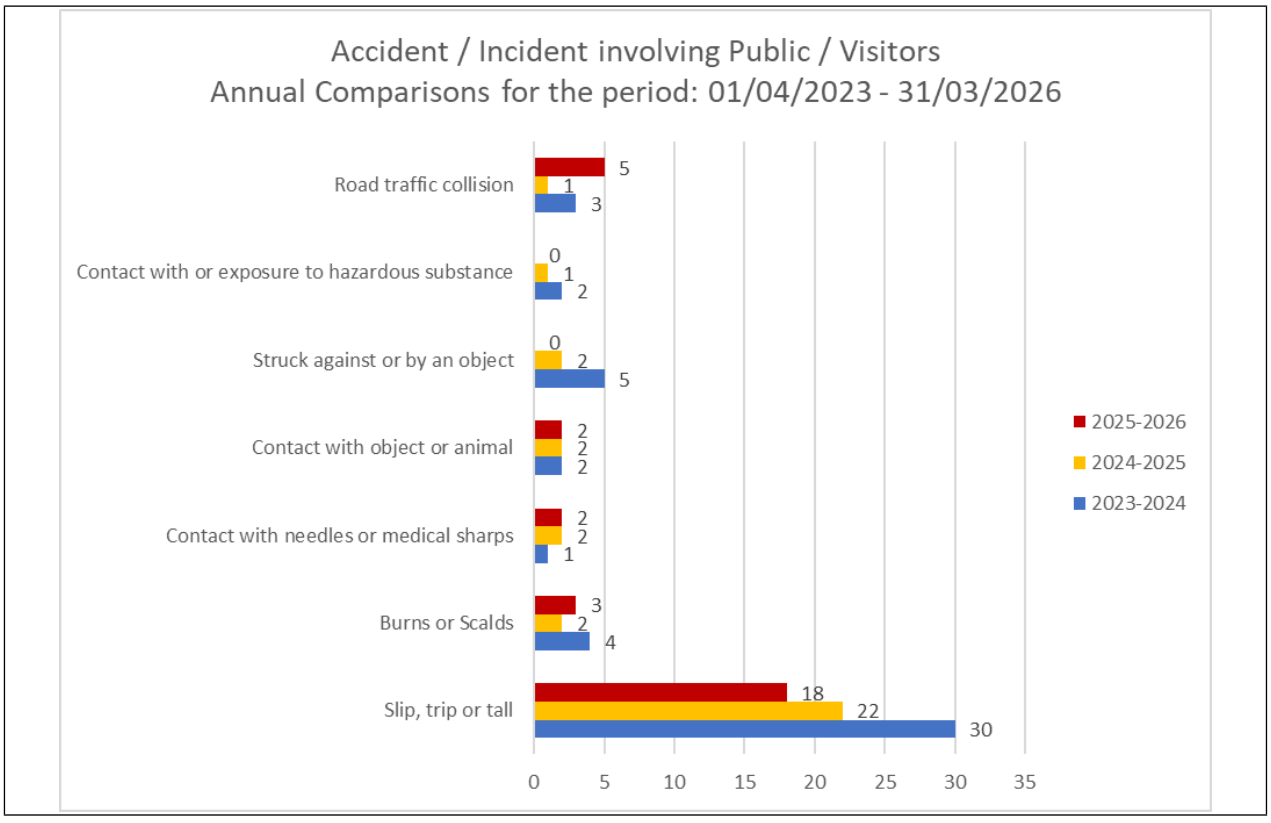
This indicates a positive overall trend and suggests that health and safety controls are having a sustained impact across a number of risk areas. However, the data also highlights that risk remains concentrated within a small number of key categories, most notably:

- Sharps injuries, which remain the single largest cause of incidents and have remained stable over the period
- Slips, trips and falls, which continue to represent a high proportion of incidents
- Struck against/by object incidents, which have increased compared to baseline levels

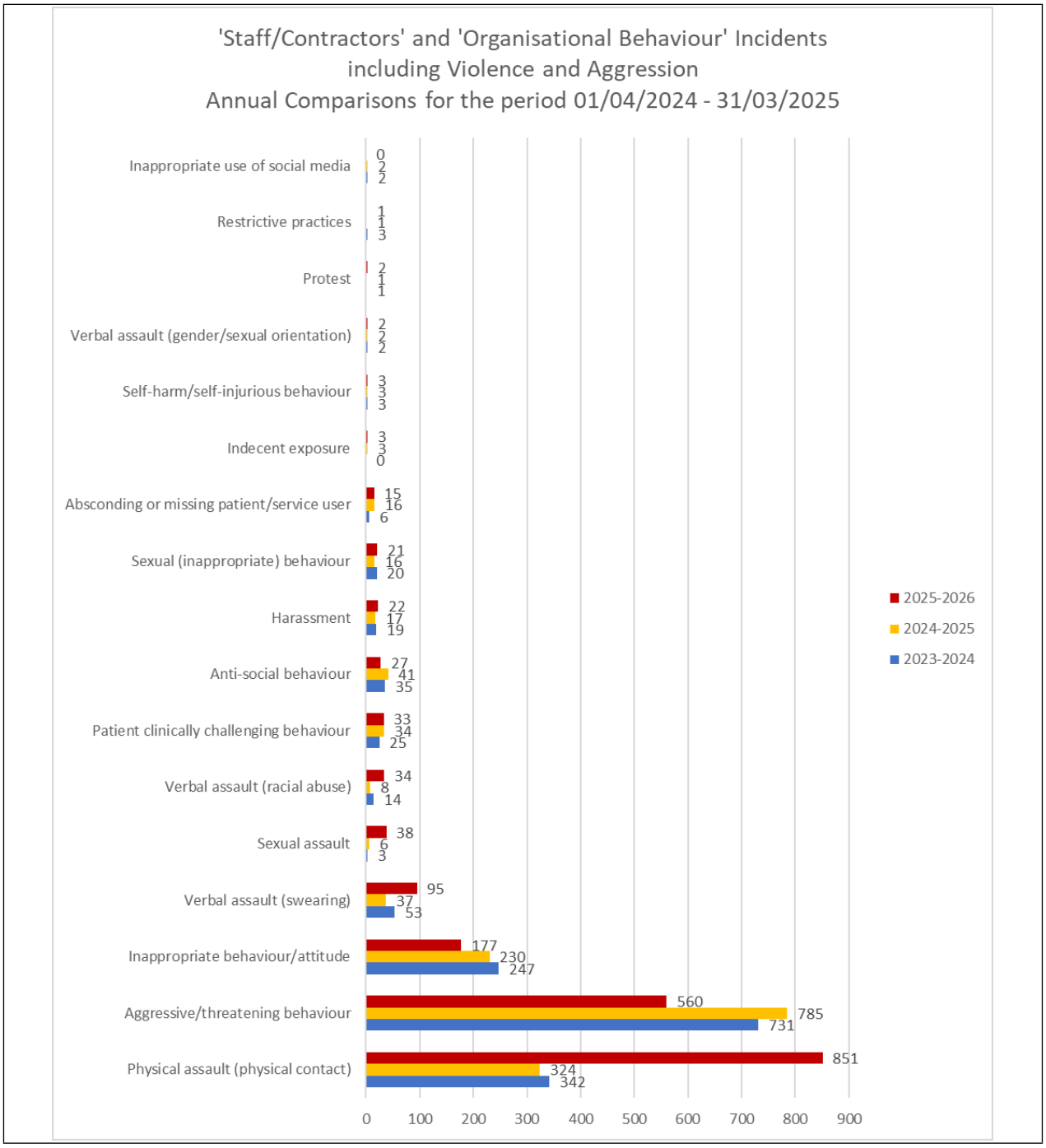
The category of manual handling incidents is split between patient and non-patient handling. If these were combined to provide an overall picture of harm associated with manual handling, this would place manual handling as the third highest cause of harm to staff.



Overall, the data indicates that while general safety performance is improving, there remain persistent and systemic risks, particularly in relation to sharps management and environmental hazards that are leading to slips and trips and staff being struck by or against objects. Notably, environmental hazards leading to slips and trips are contributing harm to the public or visitors as can be seen from the graph below.



6.2. Behaviour including Violence and Aggression



It can be seen from the graph above that the analysis of Datix incident data shows an overall increase in reported Violence and Aggression incidents in 2025–26.

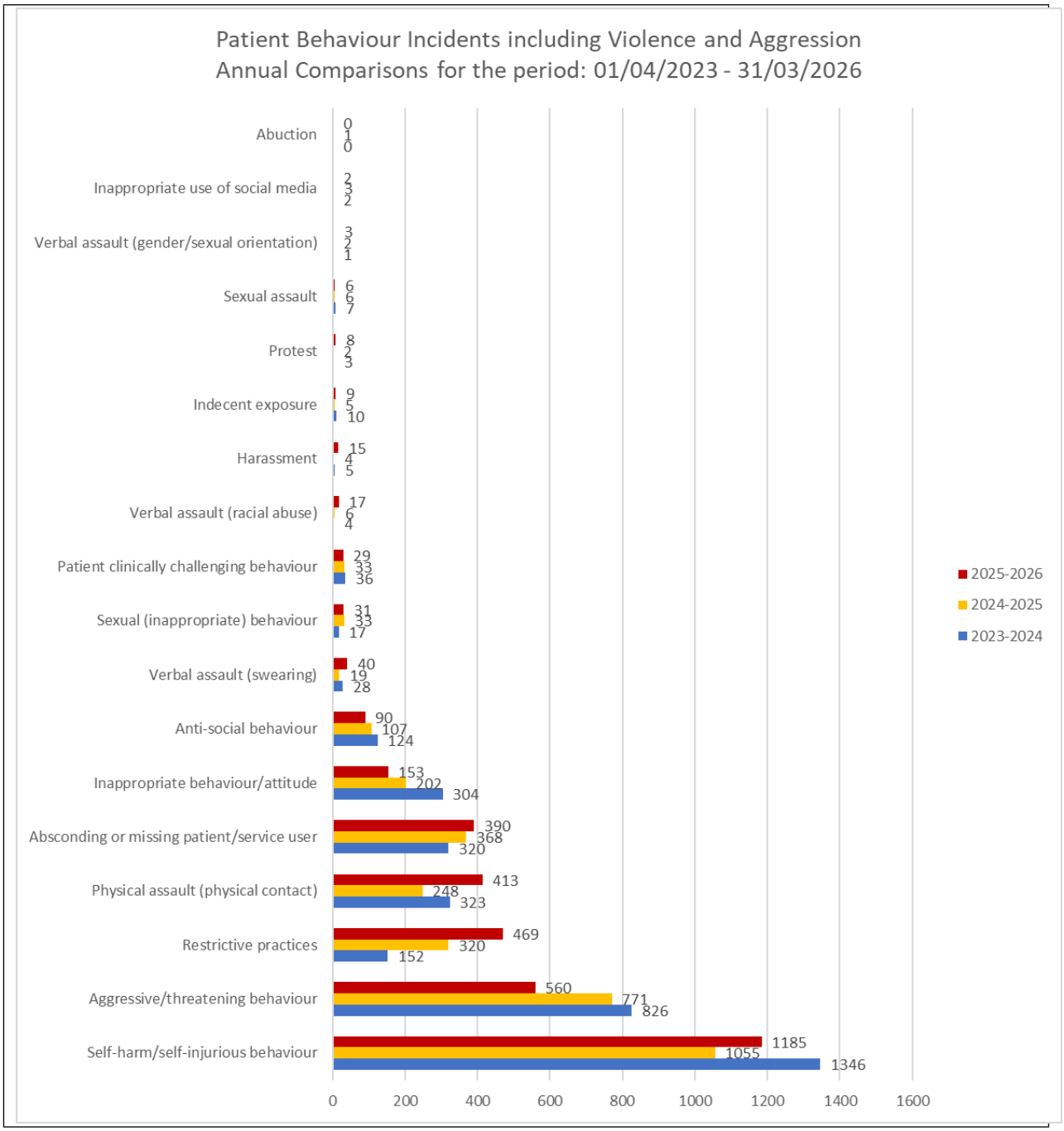
A key driver of this increase is the validation and reclassification of this type of incident, which identified that a proportion of events previously recorded as aggressive or threatening behaviour should have been categorised as physical assaults. This has resulted in:

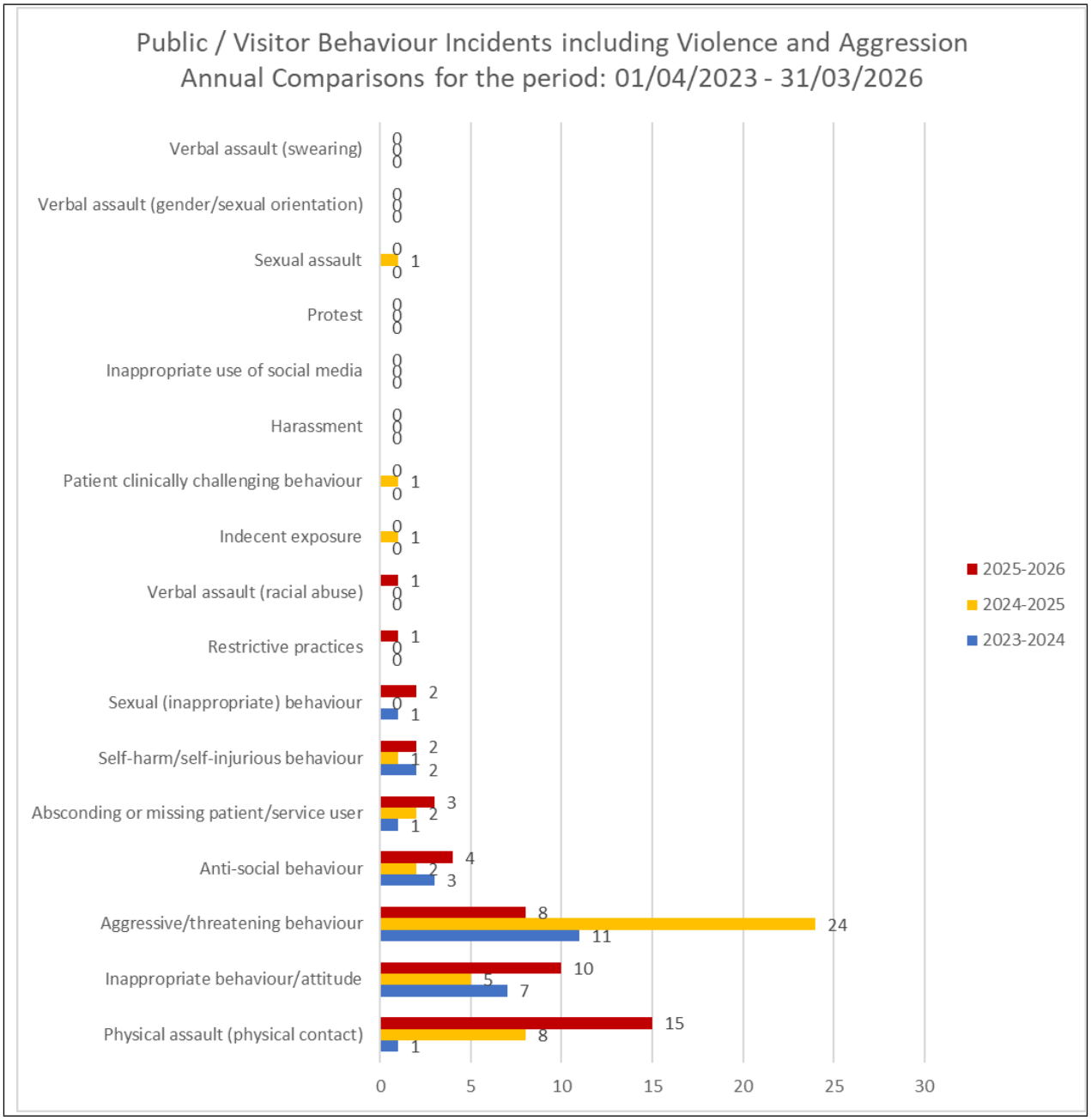
- A significant increase in recorded physical assaults
- A corresponding reduction in aggressive/threatening behaviour categories

This reflects improved accuracy in reporting rather than a direct increase in occurrence. However, even following this reclassification, aggressive and threatening behaviour remains high, representing a substantial proportion of all incidents. This indicates an ongoing and significant

demand on staff to manage challenging behaviours, with a continued risk of escalation into physical violence.

To support improved reporting and consistency at the incident submission stage, the Security Team has developed and implemented a ‘How to …. Guide’ for completing Violence and Aggression incidents, aimed at standardising categorisation and improving data quality across the organisation. In addition to this, the quality checking exercise when an incident is submitted remains in place by the Security Team.





Note: All of the above data is produced from incident data available to the Health, Safety and Security Team and may be subject to change due to permission levels within Datix.

Across the three-year period, incidents involving patient behaviour remain significantly higher in volume than those involving the public or visitors, with consistent patterns in the types of behaviours reported. The most prevalent categories for patient-related incidents are self-harm/self-injurious behaviour, aggressive/threatening behaviour, restrictive practices, and physical assault, all of which reflect the clinical complexity and acuity of the patient population.

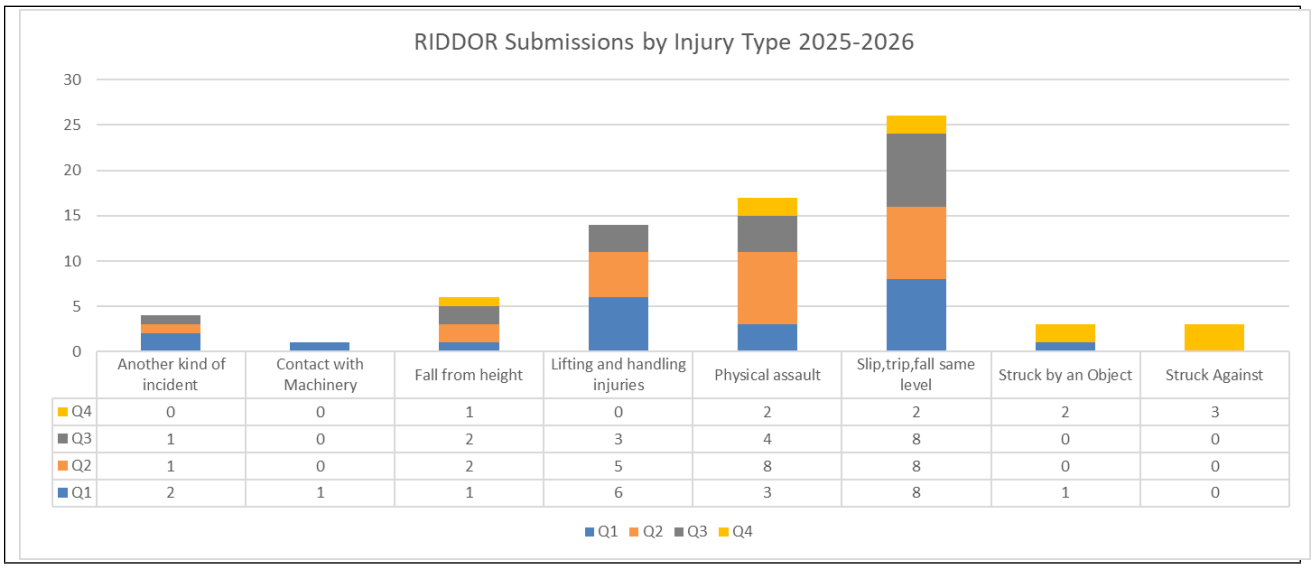
Encouragingly, several of these categories show a gradual reduction over time (notably self-harm, aggressive behaviour, and anti-social behaviour), which may indicate improvements in management strategies, staff training, or reporting practices.

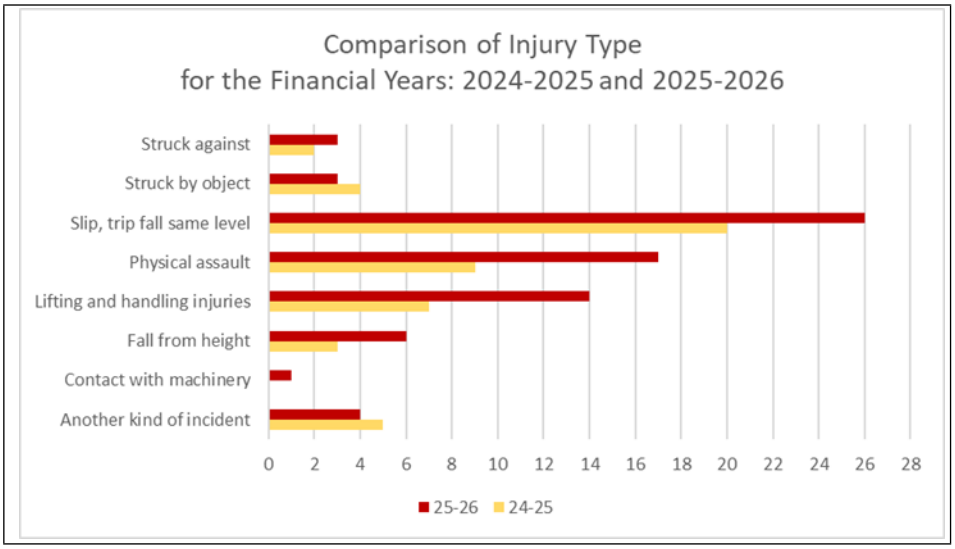
The rise in physical assaults and the continued high use of restrictive practices, suggest ongoing pressures within clinical environments and the need for continued focus on prevention, de-escalation, and safer care approaches.

6.3. **RIDDOR** (Reporting of Injuries, Diseases, and Dangerous Occurrences)

There have been 74 RIDDOR reportable incidents in the financial year 2025-2026, broken down as per the table and graphs below. This is an increase of 30% in compared to the previous year, which returned 57.

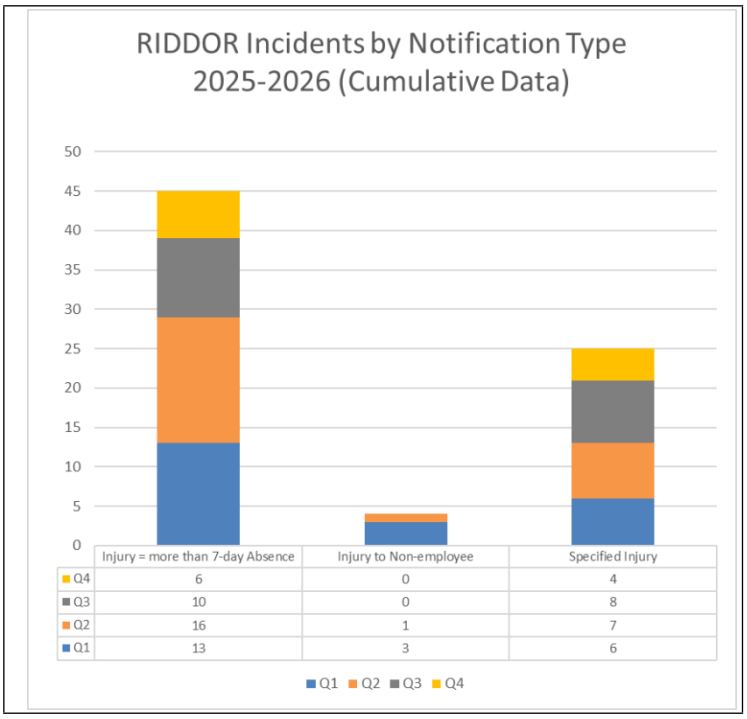
	RIDDOR INCIDENTS REPORTED THIS QUARTER								
	Cancer Services	Corporate Services	DSCSS	Environment & Estates	IHC Central	IHC East	IHC West	MHLD	Midwifery and Womens
RIDDOR INCIDENTS REPORTED THIS QTR (Staff and Public)	0	3	0	3	15	9	10	14	0
No. of Patient RIDDOR Reports incl. Suicide	1	1	0	0	10	5	1	2	0
NUMBER REPORTED OUTSIDE TIMESCALES (Staff and Public)	0	4	0	2	18	10	6	8	0
% Reported Late	**0**	**100%**	**-**	**67%**	**72%**	**71%**	**55%**	**50%**	**-**





The data indicates that slips, trips and falls continue to represent the most significant cause of injury, with a year-on-year increase observed. There have also been notable increases in physical assaults and manual handling injuries, both of which are key areas of organisational risk and contributors to staff harm.

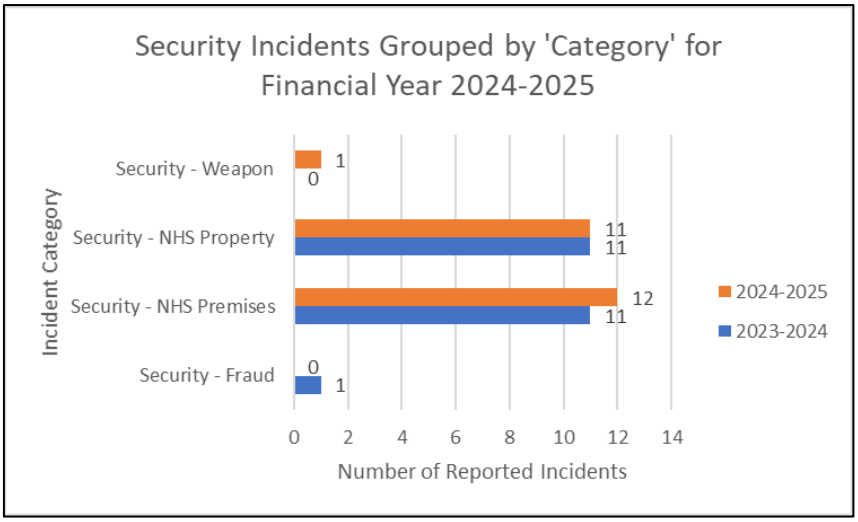
While some lower-frequency incident types remain stable, the overall trend highlights the need for continued focus on targeted risk reduction strategies, particularly in relation to workplace violence, safe systems of work for manual handling, and environmental controls to reduce slip and trip hazards.

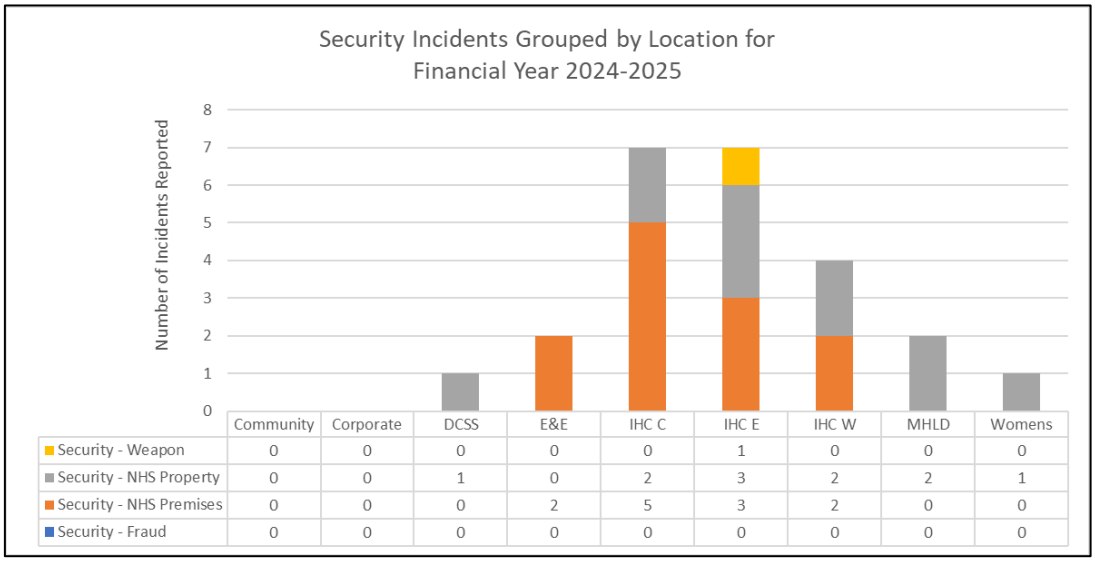


The Health and Safety Team deliver RIDDOR Awareness Training. Where incidents are notified as being RIDDOR reportable outside of the statutory timeframe set, managers will be requested to attend the training.

6.4. Security Incidents

The category NHS Property generally relates to the loss or theft of a Health Board item e.g. ID Badge whereas NHS Premises generally relates to security of premises such as intruders, lost off keys, vandalism etc.





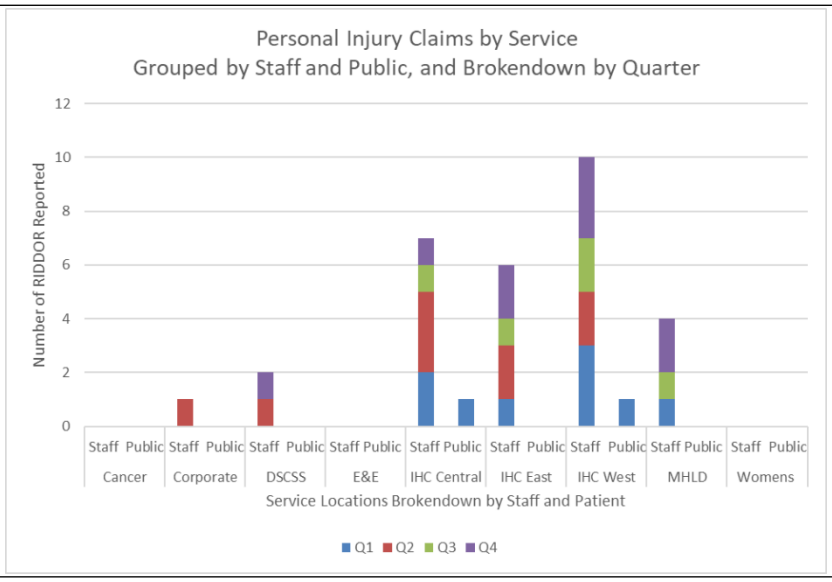
	Community	Corporate	DCSS	E&E	IHC C	IHC E	IHC W	MHLD	Womens
Security - Weapon	0	0	0	0	0	1	0	0	0
Security - NHS Property	0	0	1	0	2	3	2	2	1
Security - NHS Premises	0	0	0	2	5	3	2	0	0
Security - Fraud	0	0	0	0	0	0	0	0	0

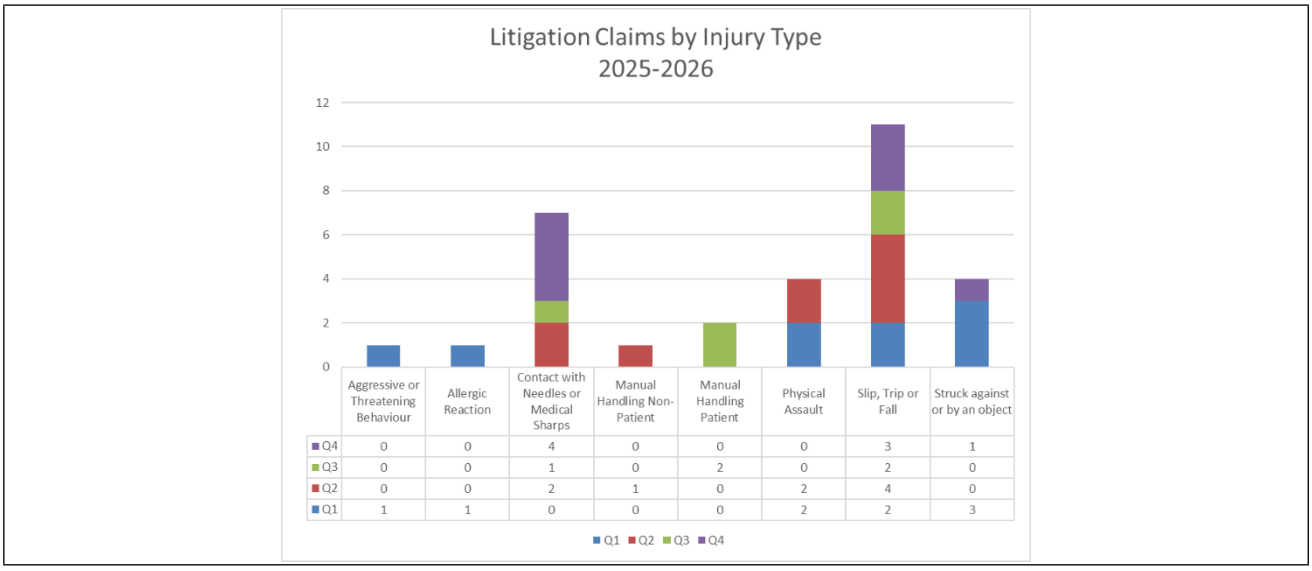
Of the incidents reported in this financial year, the highest recorded subcategory was the loss of ID Badges.

There was one incident relating to a weapon. This was reported by the Community Resources Team (CRT) following an assessment of a patient in their own home during which 2 rifles observed underneath a curtain in the lounge and the bedroom, and a hand gun in a drawer.

6.5. Personal Injury Claims

There were 32 Personal Injury Claims made during the reporting year. Broken down as follows:





Analysis of litigation data alongside incident and injury reporting demonstrates a consistent organisational risk profile, with slips, trips and falls, physical assault, and manual handling injuries representing the primary sources of harm. These themes are evident across all datasets, indicating that claims predominantly arise from known and recurring hazards within the workplace.

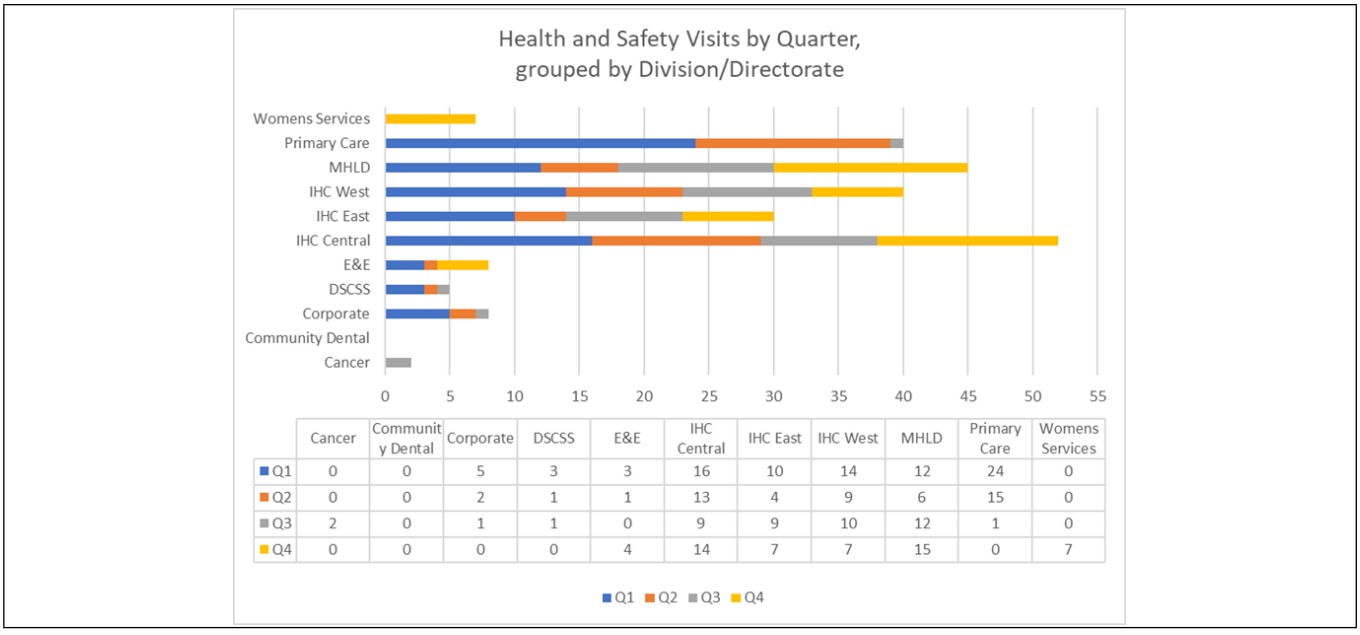
While reporting provides good visibility of these risks, the persistence of associated injury and litigation outcomes suggests that further focus is required on the effectiveness and targeting of preventative controls. In particular, work-related violence and aggression continues to present both a safety and organisational risk, with evidence of increasing harm and associated claims.

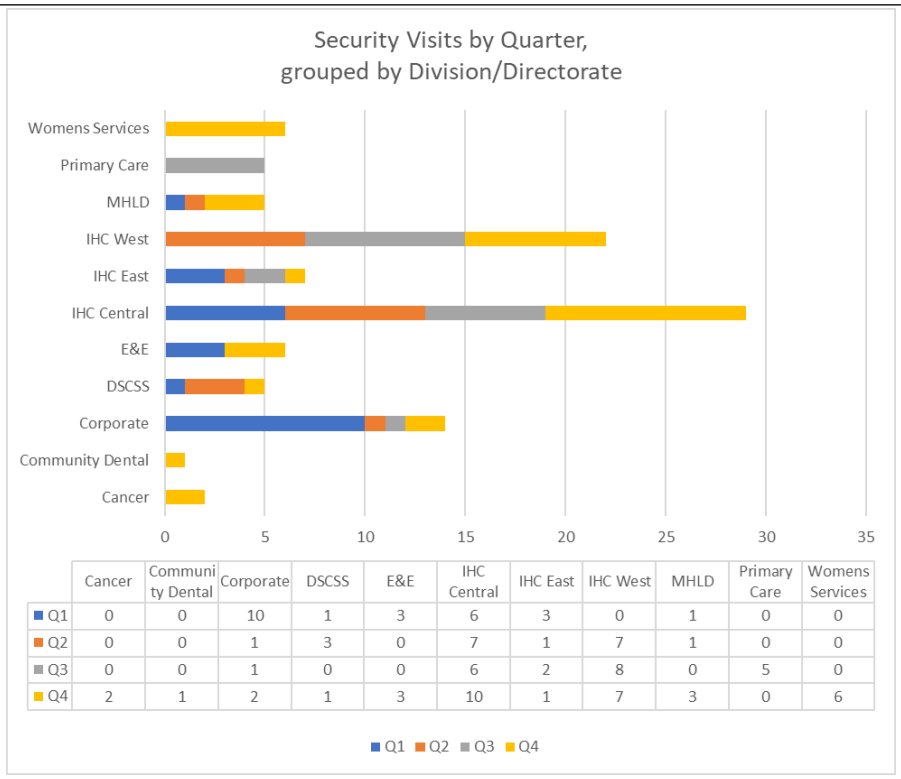
Equally, the datasets show that not all incident types lead to claims, for example, needlestick injuries are high in number but generate relatively fewer claims.

An objective for the new financial year will be to focus on the ‘big three’ risk areas, specifically looking at risk assessments, training and investment e.g. Module D RPI training for elements of the wider-workforce outside of MHLD.

7. Measuring Performance

7.1. Health, Safety and Security Reviews / Assessments / General Visits





	Cancer	Community Dental	Corporate	DSCSS	E&E	IHC Central	IHC East	IHC West	MHLD	Primary Care	Womens Services
Q1	0	0	10	1	3	6	3	0	1	0	0
Q2	0	0	1	3	0	7	1	7	1	0	0
Q3	0	0	1	0	0	6	2	8	0	5	0
Q4	2	1	2	1	3	10	1	7	3	0	6

7.2. Health, Safety and Security Performance Reports

The Health, Safety and Security Service produced quarterly reports for discussion and action as required at the Local Health, Safety and Risk Meetings. These reports look at general health, safety and security performance from a local IHC perspective.

Linked to section 4.1 of this report with reference to SOSHG, further engagement is required in the new financial year with the Chairpersons, to improve the link between the Local Health, Safety and Risk meetings and escalation to SOSHG. This continues to be an area of weakness in the governance and leadership requirements of HS01.

7.3. Audit, Monitoring and Review

During 2025–2026, the Health Board has made significant progress in establishing and implementing a structured approach to audit, monitoring and review, aligned to the “Check” and “Act” elements of the Occupational Health and Safety Management System.

Following the 2024 Internal Audit, which provided limited assurance, a comprehensive action plan was developed and is monitored via the Strategic Occupational Safety and Health Group (SOSHG). Building on this, the introduction of the NHS Health and Safety Standards self-assessment framework has enabled a more systematic approach to measuring performance across the organisation.

Importantly, this has been supported by a programme of targeted audit and validation activity, which has now been implemented in practice, with full participation from identified areas:

Targeted audits
These reviews validated self-assessment findings and, in many cases, identified material differences between perceived and actual compliance, with some areas demonstrating significant increases or decreases in validated scores.

Validation of high scores
In addition, a risk-based validation process has been applied to high-performing areas, with a sample of the top 5% of self-assessment returns subject to review/audit. This process almost consistently

identified reductions in compliance scores when tested against evidence, highlighting a tendency towards overestimation in self-reported performance.

Data triangulation

A further key development has been the introduction of data triangulation, whereby self-assessment findings are cross-referenced with incident reporting data. Targeted reviews were undertaken in areas where discrepancies were identified, specifically in relation to slips and trips and sharps management. This approach has strengthened organisational insight and demonstrated a clear gap between perceived and actual compliance.

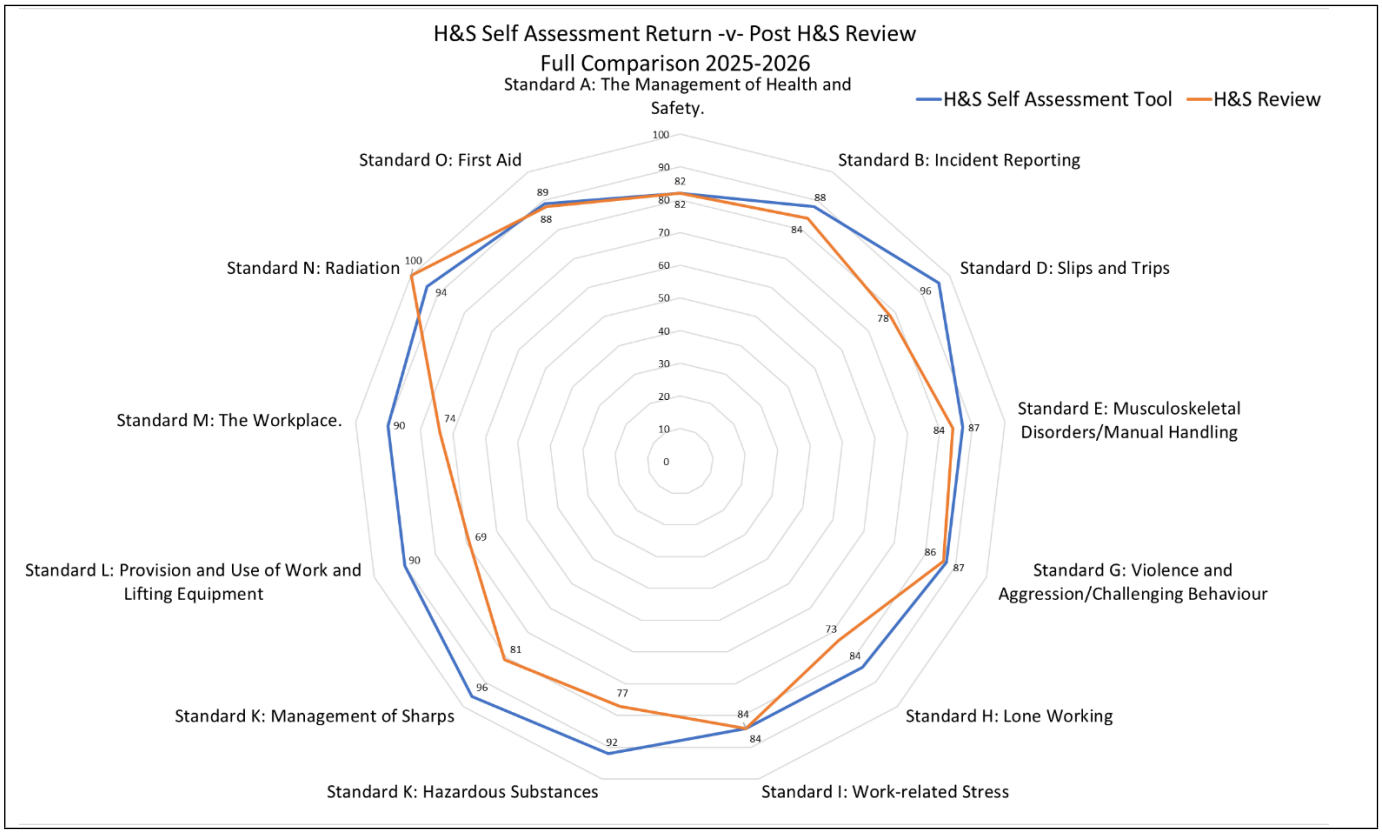
Thematic review of low-scoring standards (<80%)

The findings from audit and monitoring activity are informing thematic reviews and improvement plans, particularly in standards scoring below 80%, with ownership allocated to relevant services and progress tracked through SOSHG. This represents a shift towards a more proactive, risk-based and evidence-driven approach to assurance.

Whilst these arrangements demonstrate significant progress in strengthening audit, monitoring and review processes, variability remains in the consistency of local monitoring activity, including inspections and assurance processes at ward and departmental level. Strengthening these elements will be a key focus for further development of the health and safety management system.

Processes, training and communications were reviewed. Where ownership sat outside Corporate Health, Safety and Security, findings were escalated to the relevant service via the Strategic Occupational Safety and Health Group (SOSHG).

The radar graph below provides a pan-BCUHB picture of health and safety compliance for the standards set out, for the financial year 2025-2026. The blue line is the self-assessment returns and the orange line is the recalibrated score following the Health and Safety Review/Audit process.



The biggest gaps from the data are:

Standard	Self-Assessment (%)	H&S Review/Audit (%)	Gap
L: Work and Lifting Equipment	90	69	-21
D: Slips and Trips	96	78	-18
K: Hazardous Substances	92	77	-15
M: The Workplace	90	74	-16
H: Lone Working	84	73	-11
K: Sharps	96	81	-15

Overall, this shows the organisation is demonstrating good awareness of health and safety requirements through self-assessment; however, the health and safety review/audit findings show a consistent gap between perceived and actual compliance. This indicates that while systems and policies are in place, their implementation, consistency, and evidencing are not yet fully embedded.

The next phase will focus on closing the gap between perceived and actual compliance. This will be achieved through:

- The move from a manual labour-intensive self-assessment process to an electronic approach using Power BI and SharePoint. When ready to launch, this will introduce a formal validation step which will require evidence upload or sign off.
- Improvement Plans which will be developed for the standards with the largest variance and named accountable leads. The improvement plans will be tracked through SOSHG.
- Strengthen training gaps which are likely to be contributing to non-compliance. This will be further supported by the Health and Safety Training Needs Analysis as well as local leadership accountability.

In addition to the above, the self-assessment questions for the second-year cycle, 2026-2027, have been reviewed and updated following the first-year cycle, 2025-2026, which produced the above results. It was found that some questions were ambiguous or were not appropriately 'pitched' to test actual practice. In the new iteration of the self-assessment, questions are more direct, and operationally and evidence-based focused, which now better mirrors the health and safety review/audit approach. These changes may lead to a drop in scores, which isn't necessarily an indication of worsening performance but a more accurate picture of compliance and endeavours to ensure assurance reflects real-world practice and drives measurable risk reduction.

However, further analysis of the self-assessment and review process that demonstrates learning and growth of the safety management system, three additional 'audit, monitor and review' approaches will be added for the financial year 2025-2026. These are being worked through, but subject to approval, will focus on ensuring:

- Services with a low or no return rate are part of the review process.
- Community Hospitals have a programme in their own right.
- A percentage (to be calculated) of IHC Inpatient Wards across all 3 acute sites will have a review regardless of the self-assessment score returned.

8. HSE Contact, Enforcement, Legislation

8.1. HSE Contact

The HSE investigation in relation the inspection of Tegid Ward in the Ablett Unit, which resulted in 2x Improvement Notices in relation to ligatures and mental health procedures continued into this reporting period, and a series of 'fee for intervention' invoices have been issued by the HSE to MHLD in this regard. The outcome of the HSE investigation is outstanding.

The HSE have also requested further information in relation to a number of RIDDOR reportable incidents. These were:

Datix ID	Affected	Brief Summary	Outcome
143630	Patient	Fall resulting in fracture	No further action
153712	Patient	Fall resulting in fracture	No further correspondence
160835	Patient	Fall resulting in fracture	No further correspondence
168084	Staff	Collison with an object resulting in fracture	No further correspondence

8.2. Legislation

Staying ahead of legislation and adapting to new regulations is essential if the Health Board seeks to achieve compliance and avoid penalties. Proactively tracking legislative updates demonstrates the Health Board's commitment to safety, building trust with employees and workers.

Criminal Justice and Immigration Act (Assaults on Emergency Workers) – Wales (January 2026)

In January 2026, the introduction and strengthening of provisions under the Criminal Justice and Immigration framework further reinforced protections for NHS staff as emergency workers, particularly in relation to assaults. This legislative position supports a zero-tolerance approach to violence and aggression and aligns closely with existing organisational priorities.

During the reporting period, the Health Board has continued to strengthen incident reporting, investigation processes, alongside working with partners such as the Police to ensure appropriate escalation and enforcement. The increasing trend in physical assaults identified within incident and injury data highlights the ongoing relevance of this legislation and the need to ensure consistent application and awareness across services.

The application of CJIA is part of an Internal Audit plan to review Violence and Aggression in the financial year 2026-2027.

Terrorism (Protection of Premises) Bill ("Martyn's Law")

The proposed Terrorism (Protection of Premises) Bill, commonly referred to as Martyn's Law, introduces a framework for enhancing preparedness and protective security measures within publicly accessible locations. Although not yet fully enacted during the reporting period, the Health Board has begun to consider the implications of the legislation, particularly in relation to its estate, security infrastructure, and operational resilience. Existing arrangements, including site security measures, lock-down procedures, and emergency preparedness planning, provide a strong foundation; however, the legislation will require a more formalised approach to risk assessment, staff awareness, and preparedness for hostile threats, proportionate to the scale and nature of healthcare environments.

8.3. Enforcement

The table below shows enforcement activity in Healthcare by the Health and Safety Executive for the Financial Year 2025-2026.

Notice Number	Recipient's Name	Notice Type	Issue Date	Act or Regulation Breached	Summary
315013158	Betsi Cadwaladr University Health Board	Improvement Notice	24/04/2025	Health and Safety at Work Act 1974 / 3 / 1	Failed to implement reasonably practicable measures identified within ligature risk assessment, required to control the risks arising from an act of self-harm by patients on the Ablett Unit, Ysbyty Glan Clwyd.
315082217	South Warwickshire NHS Foundation Trust	Improvement Notice	27/05/2025	Health and Safety at Work Act 1974 / 2/ 1 Health and Safety at Work Act 1974 / 3/ 1 Health and Safety (Sharps Instruments in Healthcare) Regulations 2013 /5/	Failed to ensure the use of non-safe medical sharps in the Adult Intensive Care Unit of Warwick Hospital are avoided where reasonably practicable, where use of non-safe medical sharps are avoidable they should ensure safer sharps are used and that policies, procedures and arrangements are to be reviewed at suitable intervals to eliminate to minimise the associated risks of serious personal injury and ill health from sharps injuries and blood borne viruses so far as reasonably practicable.
315091065	Betsi Cadwaladr University Health Board	Improvement Notice	30/05/2025	Health and Safety at Work Act 1974 / 3/ 1 Management of Health & Safety at Work Regulations 1999 / 5 /	Failed to effectively manage in-patients' health and Safety risks, which arose as part of their undertaking, in relation to helping prevent self-harm acts, within Tegid Ward of the Ablett Unit, Ysbyty Glan Clwyd
315176238	The Royal Orthopaedic Hospital NHS Trust	Improvement Notice	04/07/2025	Health And Safety at Work Act 1974 / 2/ 1 Health and Safety (Sharp Instruments in Healthcare Regulations 2013 / 7 /	Failed to ensure that the line managers carry out a suitable investigation following an injury from a medical sharp's device.
315190632	Rossie Young Peoples Trust	Improvement Notice	13/07/2025	Health and Safety at Work Act 1974 /2 /1 Health and Safety at Work Act 1974 /3 /1 Control of Asbestos Regulations 2012 /4 /	Failed to prepare a written asbestos Management Plan which sets out measures to be taken to manage the risks from ACMs. They failed implement suitable measures for monitoring the condition of any Asbestos Containing Materials within their promises.
31519498	Rossie Young Peoples Trust	Improvement Notice	13/07/2025	Health and Safety at Work Act 1974 /2 /1 Health and Safety at Work Act 1974 /3 /1 Control of Asbestos Regulations 2012 /4	Failed to prepare a written asbestos Management Plan which sets out measures to be taken to manage the risks from ACMs. They also failed implement suitable measures for monitoring the condition of any Asbestos Containing Materials within their promises.

Notice Number	Recipient's Name	Notice Type	Issue Date	Act or Regulation Breached	Summary
				Control of Asbestos Regulations 2012 /4	
315251111	North Bristol NHS Trust	Improvement Notice	07/08/2025	Health and Safety at Work Act 1974 / 2 Health and Safety at Work Act 1974 / 3 Control of Substances Hazardous to Health Regs 2002 / 3 Control of Substances Hazardous to Health Regs 2002 / 9	Failed to ensure the health, safety and welfare at work of its employees and others not in their employ. Specifically, the current arrangements for the maintenance, testing, calibration or validation (as relevant) of your preventative and protective measures necessary to minimise the risk of exposure of your employees and others to hazard group 3 biological agents are inadequate.
315563694	Conan Doyle Medical Practice	Improvement Notice	08/01/2026	Health and Safety at Work Act 1974 / 2 / 1 Health and Safety at Work Act 1974 / 3 / 1 Control of Substances Hazardous to Health Regs 2002 / 7 Control of Substances Hazardous to Health Regs 2002 / 9	Failed to ensure the health, safety and welfare of all employees and failed to conduct your undertaking in such a way as to ensure that persons not in your employment, who may be affected, are not exposed to risks to their health or safety due to failure to devise and implement a written scheme to control the risk of exposure to Legionella from hot and cold-water systems.
315565108	Conan Doyle Medical Practice	Improvement Notice	08/01/2026	Health and Safety at Work Act 1974 / 2 / 1 Health and Safety at Work Act 1974 / 3 / 1 Control of Substances Hazardous to Health Regs 2002 / 12 / 4	Failed to ensure the employer's duties specific to those appointed to carry out work had not received and suitable and sufficient information, instruction and training to carry out their duties in relation to control of risks from legionella.

Notice Number	Recipient's Name	Notice Type	Issue Date	Act or Regulation Breached	Summary
315251111	Great Ormond Street Hospital for Childrens NHS TRUST	Improvement Notice	10/02/2026	Health and Safety at Work Act 1974 /2/1 Health and Safety at Work Act 1974 /3/1 Management of Health and Safety at Work Regulations 1999 / 5 / 1	Failing to ensure the health, safety, and welfare of employees and others by failing to implement appropriate arrangements for the effective planning, organisation, control, monitoring and review of your preventive and protective measures for the inactivation of Containment Level 3 waste which may contain Hazard Group 3 biological agents.
315304064	Dr N Clancy & Dr J Ewen	Improvement Notice	24/02/2026	Health and Safety at Work Act 1974 / 2 / 1 Health and Safety at Work Act 1974 /3/1 Control of Substances Hazardous to Health Regs 2002 /7/ Control of Substances Hazardous to Health Regs /9	Failed to ensure the health, safety and welfare at work of all employees and failed to conduct your undertaking in such a way as to ensure that persons not in your employment, who may be affected, are not exposed to risks to their health or safety as a result of not having and implementing a written scheme to control the risk of exposure to Legionella from hot and cold-water systems.
315658053	Dr N Clancy & Dr J Ewen	Improvement Notice	24/02/2026	Health and Safety at Work Act 1974/ 2/1 Health and Safety at Work Act 1974 /3/1 Control of Substances Hazardous to health Regs/12/4/	Failed to ensure the health, safety and welfare at work of all employees and failed to conduct your undertaking in such a way as to ensure that persons not in your employment, who may be affected, are not exposed to risks to their health or safety in that you have failed to ensure any person (whether or not his employee) who carries out work in connection with the employer's duties under these Regulations has suitable and sufficient information, instruction and training in that your appointed person has not received suitable training to carry out their duties in relation to control of risks from legionella bacteria.
315485117	Barking, Havering & Redbridge University Hospital NHS Trust	Improvement Notice	04/03/2026	Management of Health & Safety at Work Regulations 1999 / 5 / 1 Health and Safety at Work 1974/2/1	Failed to ensure the health, safety, and welfare of employees by failing to have suitable arrangements for the effective planning, organisation, control, monitoring and review of your preventive and protective measures for the provision of relevant clinical details for samples which may contain Hazard Group 3 biological agents.

Defendant's Name	Hearing Date	Result	Total Fine £	Costs awarded to HSE £	Summary
Central Scotland Healthcare (St Andrews) Ltd	Sept. 2025	Guilty	£45,000	Not specified	Resident choked on food and was pronounced dead at the scene.
HC-One Ltd	Oct. 2025	Guilty	£1,800,000	Not specified	A 96-year-old resident choked to death after being left unsupervised while eating, despite a care plan requiring close supervision. Agency staff were unfamiliar with care plans, and staffing pressures resulted in the resident being left alone for up to 20 minutes. HSE found failures in communication of care needs and safe supervision arrangements.
Chester Park Care Home	Aug. 2025	Guilty	£50,000	Not specified	A 77-year-old resident with dementia left the premises unnoticed and died outside. Staff failed to follow monitoring requirements and did not carry out a headcount after a door was found insecure. Records were falsified, and there was no effective system to manage wandering risk.
Lab 21 Healthcare Ltd	Sept. 2025	Guilty	£52,000	£26,000	Company handled high-hazard pathogens (e.g. Salmonella typhi) without notifying HSE as required under COSHH. Safety-critical equipment was poorly maintained, increasing risk of exposure to workers and the public. Failures were described as “foreseeable and avoidable”
Omega Diagnostics Ltd	May. 2025	Guilty	£35,000	Not specified	Predecessor operator of the same high-containment lab also failed to notify HSE and maintain safe containment systems. Shared systemic failings in managing biological hazards and plant integrity.
Riverside Care Ltd	Mar. 2026	Guilty	£16,000	Not specified	Resident with dysphagia died after being served food not prepared to required texture-modified diet. Failure of system controlling preparation and serving of food.

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Welsh Language Services

Annual Monitoring Report 2025-2026

Author: Eleri Hughes-Jones

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Executive Summary

This report addresses the statutory duty of Betsi Cadwaladr University Health Board (the Health Board) to provide an annual account to the Welsh Language Commissioner on compliance with the Welsh Language Standards (the Standards) over the reporting year.

The report reflects the requirements and content as stated within Standard 120 of the Standards:

- Complaints
- Workforce Planning
- Recruitment
- Language Skills
- Training to improve Welsh language skills

This report also addresses compliance with Welsh Government's Five-year plan, 'More than just words'. An overview of progress is provided, including service developments and key achievements from April 2025 to March 2026.

What has been achieved

In evaluating the current position against the objectives set during the reporting year, the Health Board has accomplished its goals.

Some of these key accomplishments include:

- improved statutory compliance through an intense and comprehensive self-assessment approach;
- roll-out of the Standard 110 clinical consultations plan to increase capacity to deliver consultations in Welsh;
- improved overall compliance in creating a bilingual corporate identity and language visibility;
- increase in the uptake of Welsh language training, in addition to achieving all training targets established as part of the 'Work Welsh' Agreement for 2024-2025 with the National Centre for Learning Welsh to ensure continuation of funding support;
- expanded university and future workforce partnerships, delivering Welsh-language awareness sessions to future healthcare professionals at Wrexham University, North Wales Medical School, and at various schools across North Wales;
- conducting successful activities and engagement events to promote the Welsh language and increase visibility;

This report will elaborate on what has been achieved and how this has been done.

The achievements delivered over the past year are not only organisational milestones—they are making a meaningful difference to the experiences of patients and families across North Wales. The following patient stories outlines how these actions are being delivered, and felt, on the ground.

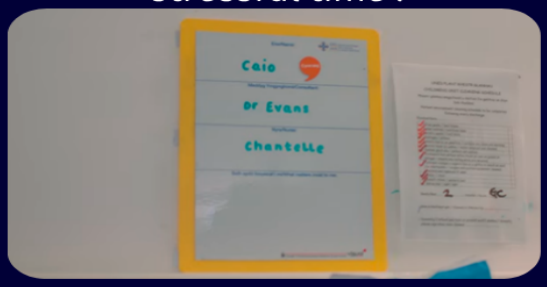
Bringing Patient Stories to Life

This year we got the chance to share two positive Welsh language patient stories, one from the Stroke Department at Deeside Community Hospital and the other from the Childrens Ward at Ysbyty Glan Clwyd.

The first patient story we shared highlighted the profound impact of hearing the Welsh language following a stroke. The gentleman was left unable to communicate and feeling increasingly frustrated. His granddaughter described the sense of relief the family felt when members of staff at Deeside hospital spoke Welsh. She explained that it not only provided comfort and reassurance to them as a family, but also had a remarkable positive effect on her grandfather. Seeing his reaction when he heard Welsh for the first time since his stroke was incredibly moving, his eyes “lit up”, demonstrating the powerful connection between language and care.

We shared how staff in Deeside support Welsh speaking patients by pairing them with Welsh speaking staff wherever possible, using Welsh words and phrases in everyday interactions, and ensuring the language is heard on the ward. Staff see first-hand how hearing Welsh provides comfort, reassurance and clarity, helping patients feel more at ease during what can be an extremely distressing time.

The other focused on Cai, a young boy whose experience of receiving a diabetes diagnosis was made easier and more reassuring through staff communicating with him and his family in Welsh on the Children’s Ward at Ysbyty Glan Clwyd. This highlighted the positive impact of care delivered in a patient's preferred language can have in reassuring the patient and family during what could have been a stressful time .



Whilst on the ward, Cai’s preferred language (Welsh) was clearly identified in his medical notes and above his bed using the orange ‘Welsh’ magnet. This made the whole experience much easier, as all ward staff were aware that Cai and his family preferred to communicate in Welsh. It removed the pressure of having to repeatedly request care in Welsh and ensured that information relating to his diabetes diagnosis could be explained in their first language, making it easier to understand and absorb during a challenging time.

The Health Board was selected by Welsh Government as the focus of two short videos showcasing the More than Just Words framework in practice. To view them click here

Background and Service Model

This report not only reflects the Health Board's progress against the requirements noted in Standard 120, it also demonstrates how the service is designed to address the needs of the population.

The Health Board's Welsh Language Team has been structured to ensure its workstreams provide the necessary support mechanisms required to mainstream language requirements into service planning. It also provides a network of support on an operational level to ensure all written correspondence is provided bilingually, and that there is a structure in place to develop the workforce to improve their language skills.

It consists of four services that support the organisation to both deliver legislative requirements and to address patients' needs.

1. Legislative Compliance
   Ensuring that the organisation is supported to deliver its obligations under the Welsh Language (Wales) Measure 2011.

2. Promotion and Engagement
   In line with the operational elements of delivering the 'More than just words' Five-year plan, services are actively supported and projects and schemes initiated to increase understanding and awareness of culture, and the impact on patient care.

3. Training Provision
   The Welsh Language Training Programme is tailored to address the requirements of various services, along with additional support provide by the 'National Centre for Learning Welsh' with the Welsh Government-funded 'Work Welsh' Agreement.

4. Translation Services
   The Translation Team ensures that the organisation is able to provide information to patients in their preferred language, and are also providing simultaneous translation to facilitate language preference in clinical and corporate settings.

Governance and Self-regulation

Structural accountability is provided through the Welsh Language Strategic Forum (the Strategic Forum), chaired at Executive Director level, with the Health Board's Chairman appointed as Board-level Welsh Language Champion. The Strategic Forum establishes internal governance arrangements. The Terms of Reference steers the strategic approach, with membership consisting of senior and active leaders who are able to drive requirements forward. There is a scrutiny route for escalating any issues of significance to the People and Culture Committee, as well as annually reporting to the Board on compliance and achievements.

Welsh Language Services Risk Register

It is essential that the Health Board recognises potential areas of risk in relation to the Welsh language and a dedicated Risk Register is in operation. Current risks include meeting the demands of the Welsh Language (Wales) Measure 2011, implementing the "Active Offer" principle in line with 'More than just words', and delivering the 'Bilingual Skills Policy and Procedure'.

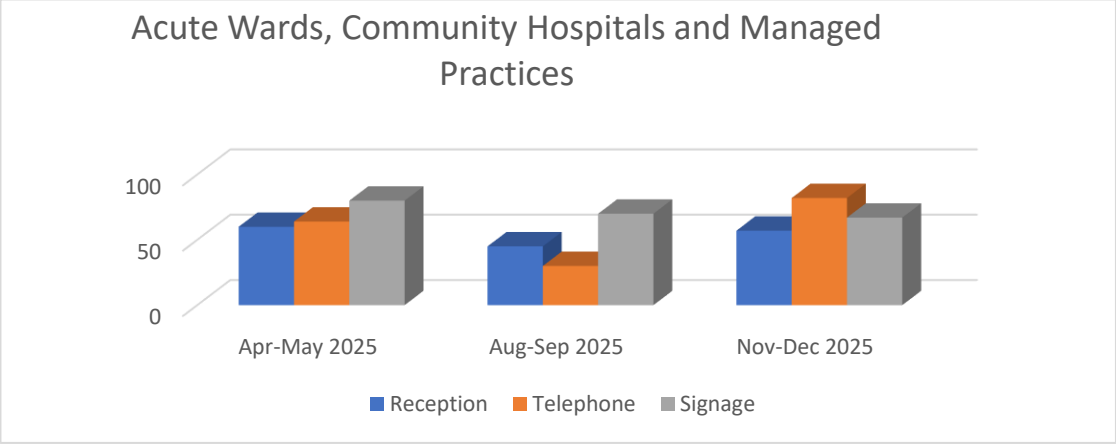
All risks have been reviewed during 2025-2026, with all three risk ratings currently at moderate or minor. In assessing current position, no risks required escalation.

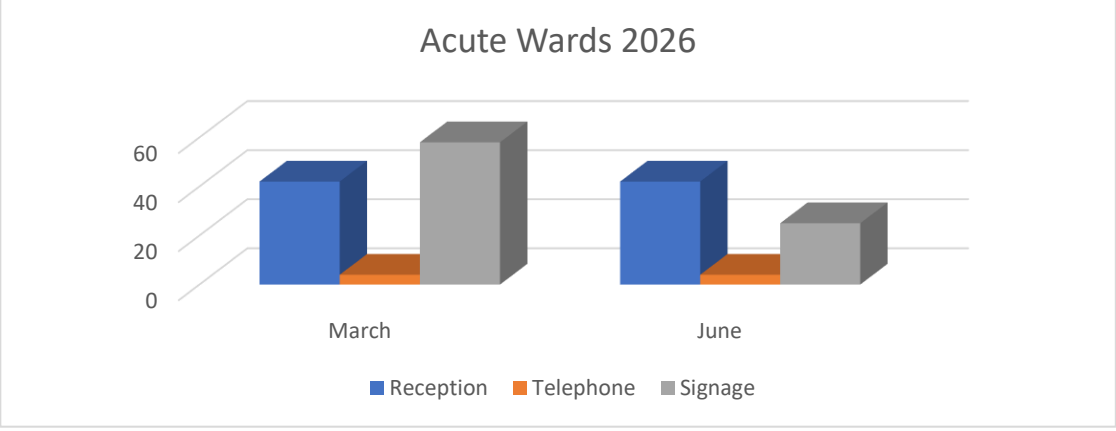
The Welsh Language Services Risk Register is monitored quarterly, and reported upon bi-annually to the Welsh Language Strategic Forum.

Internal Performance Assurance

The Health Board's self-regulation approach continued with the Mystery Shopper Monitoring Programme with the aim of providing strong assurance of the organisation's commitment to deliver high-quality Welsh-language services and maintaining compliance with the Welsh Language Standards. Monitoring results confirmed that Welsh-language signage remains a significant organisational strength, with consistently high levels of compliance across sites, demonstrating sustained commitment to a visible and accessible bilingual environment.

The programme also offered valuable insight into areas where further improvement can be targeted, specifically reception interactions, telephone contact, and the visibility of the "Active Offer".





Lower scores in acute wards must be viewed in context as it is clinical staff, rather than dedicated reception teams, often managing first-point-of-contact interactions while prioritising direct patient care. This operational reality explains some variation and highlights the unique challenges of delivering consistent bilingual communication in busy clinical settings.

Overall, the programme has strengthened the Health Board's understanding of where targeted support will have the greatest impact. The monitoring programme demonstrates that the Health Board has robust arrangements in place to assess Welsh language service delivery and identify areas for improvement. Strong performance in signage compliance provides evidence of sustained commitment to the Welsh Language Standards, while the findings from acute ward settings have offered valuable insight into the challenges faced within clinical environments. The organisation will use these findings to strengthen awareness, improve consistency of service delivery and enhance the visibility of the "Active Offer" during 2026-27, ensuring that Welsh-speaking patients continue to receive an increasingly positive experience when accessing services.

Welsh Language Standards

The Welsh Language Standards (the Standards) have been in operation since the imposition date of 30 May 2019. Significant progress has been made in progressing the implementation of the Standards, monitoring compliance and providing organisation-wide directive.

Monitoring Compliance

Monitoring activity against the Standards is progressing well across the organisation. Several Divisions have now completed a second cycle of review, enabling clear measurement of improvement from the original baseline. Notably, the East Integrated Health Community has demonstrated substantial progress since the first round, supported by the effective implementation of a wide range of remedial actions.

The example below highlights the improvements achieved within Children's Services in the East, illustrating how targeted actions are translating into meaningful and sustained change.

A Progress Summary Report was developed for Children's Services, comparing the findings of the initial monitoring work in 2024-2025 to the follow-on progress during 2025-2026. The overall position noted:

- significant improvements in compliance across all standards
- majority of standards now fully compliant or near full compliance

Compliance Level	2024-2025	2025-2026
≥90% compliant	71	107
≥70% compliant	16	2
≤50% compliant	14	1

There has been a clear shift from **mixed compliance** to **consistently high compliance,** and the key improvements were seen in these areas:

1. Telephony

- Major improvement in offering Welsh language services over the telephone
- Standard Operating Procedures introduced, with staff guidance issued and spot checks implemented
- Standard 9, relating to informing a caller that a Welsh service is available moved from non-compliant to fully compliant

2. Capturing Language Preference

- Now routinely recorded via WPAS and referral forms
- Staff reminders issued and process embedded
- Shift from inconsistent to a systematic approach

3. Meetings & Engagement

- Language preference now routinely asked for meetings
- Translation provision planned proactively
- Previously non-compliant areas now fully compliant

4. Documents & Forms

- Key documents now available in Welsh as standard
- Emergency contact forms fully translated and in use
- Transition from development stage to full implementation

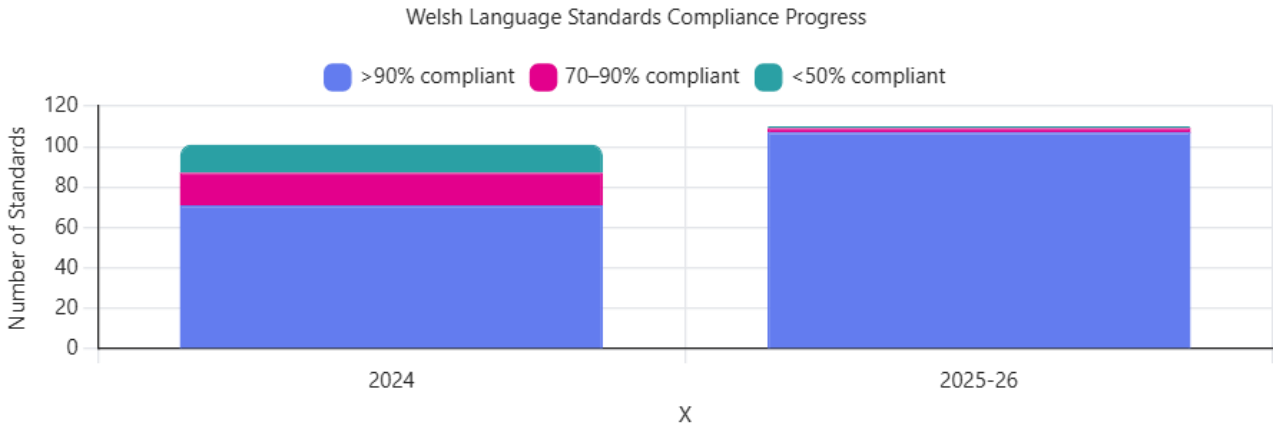
5. Reception & Public-Facing Services

- Welsh language signage and badges now in place
- Staff visibility and access to Welsh improved
- Fully compliant within these service areas

6. Promotion of Welsh Language Services

- Services clearly promoted as available in Welsh
- Information consistently bilingual across platforms

This demonstrates that significant efforts have been made across all areas which can be viewed in the compliance progress chart below:



This demonstrates that ongoing monitoring activity has driven notable improvements in compliance with the Welsh Language Standards, with several areas now demonstrating strengthened and more consistent adherence. This enhanced compliance is already having a positive, tangible

impact on patient experience, particularly through increased availability of Welsh-language communication and more responsive, culturally aligned services.

These developments highlight how systematic monitoring is not only supporting statutory compliance but also delivering meaningful benefits for patients and communities across our services.

Increasing the Health Board's capacity to deliver services in Welsh in line with Standard 110

The five-year programme to enhance compliance with Standard 110 entered its second year during the reporting period. Standard 110 requires Health Boards to publish a plan for each five-year period setting out the extent to which they are able to offer to carry out a clinical consultation in Welsh, and the proposed actions to increase the ability to do so.

This year's activity centred on developing a comprehensive "Active Offer" Toolkit designed to support wards, departments and services in consistently offering Welsh-language care to patients. The toolkit includes visual prompts such as orange magnets to place above a patient's bed, stickers and badges, alongside posters, an information leaflet and guidance on implementing a 'Buddy Scheme'.

The toolkit has already been introduced to the Stroke Team at Deeside Community Hospital, identified as the pilot site. Staff engagement has been highly positive, with the team demonstrating strong commitment to meeting patients' linguistic needs alongside their clinical requirements.

Engagement with senior clinical leaders has continued to strengthen organisational awareness of Standard 110. Presentations were delivered to both the Senior Nurses meeting and the Dietetics Senior Leadership Team, outlining the five-year plan and reinforcing expectations around compliance with the Welsh Language Standards.

Early exploratory discussions have also taken place with a Consultant in Elderly Care at Ysbyty Gwynedd regarding the feasibility of recording whether clinical consultations are actively offered in Welsh. While the concept was welcomed, practical challenges were identified, particularly given the high proportion of Welsh-speaking patients and the increasing volume of mandatory clinical documentation.

The Welsh Language Team again supported the Dementia Team at Ysbyty Gwynedd in promoting the "Active Offer". The Dementia Team continues to champion the importance of providing Welsh-language care for vulnerable patients, and information was displayed for staff and the public highlighting the critical role of language in delivering safe, person-centred care for people living with dementia.

Standard Operating Procedures

Standard Operating Procedures (SOPs) have been produced on specific Standards, providing detailed guidance for staff to ensure accurate understanding and compliance. SOP development prioritised areas of concern that were highlighted either by external concerns or through monitoring arrangements.

SOPs have been created for:

- Corresponding with the public (Standard 7)
- Answering the telephone (Standards 8, 9 and 10)

- Meetings not open to the public (Standards 21, 22, 22a and 22ch)
- Conducting Case Conferences in Welsh (Standard 25)
- Reception Services (Standards 50, 52 and 53)
- Assessing the need to offer courses in Welsh (Standard 63)
- Arrangement of Interviews (Standard 108)
- Translation Guidelines (Overall Compliance with the Standards)

All SOPs have been published on the Health Board's intranet site, 'BetsiNet'. Work will continue during the next reporting year to create further SOPs to include all Standards.

Complaints' Procedures

The Welsh Language Commissioner undertook an Enquiry Line into organisational complaints procedures in late 2025. The purpose of this exercise was to assess the effectiveness of organisations' arrangements for receiving, managing and learning from complaints relating to the Welsh language.

As bodies subject to the Welsh Language Standards, organisations are required to maintain specific processes under the supplementary standards for recording and responding to such complaints. The Enquiry Line sought to evaluate the robustness of these arrangements, identify good practice, highlight areas requiring improvement, and provide recommendations to strengthen compliance.

In response to the Commissioner's findings, the Health Board has taken steps to enhance the visibility and accessibility of information relating to Welsh-language complaints. Updated content has been published on the Health Board's website, both within the Welsh Language pages and on the People's Enquiry and Resolution Service pages. This information clearly outlines the routes available for raising concerns regarding the provision of bilingual services and compliance with the Welsh Language Standards.

To support organisational learning and continuous improvement, Welsh-language complaints have now been established as a standing agenda item at the Regulatory Assurance Group. This ensures regular scrutiny at a senior level and promotes consistent oversight of compliance, themes arising from complaints, and opportunities for service improvement.

Overall, the reporting period reflects a year of substantial progress in strengthening compliance with the Welsh Language Standards and embedding bilingual practice across the organisation. Monitoring activity has driven measurable improvements, with a marked shift from mixed compliance to consistently high performance across standard areas.

Collectively, these achievements demonstrate that the Health Board is meeting its statutory responsibilities alongside steadily increasing its capacity to deliver safe, person-centred care in Welsh, ensuring that patients experience the benefits of improved bilingual communication and culturally aligned services across North Wales.

Workforce Development Programme

The Health Board's Welsh Language Training Team has continued to make significant progress in developing a confident, bilingual workforce through the delivery of a comprehensive programme of Welsh-language learning tailored to organisational needs.

During the reporting year, more than 1,000 members of staff participated in Welsh-language training, representing a 4 per cent increase compared with 2024–25. This upward trend reflects the strong and growing commitment among staff to developing their Welsh-language skills and applying them in practice to enhance the quality, safety and cultural appropriateness of services provided to patients across North Wales.

The Team has adopted a proactive and strategic approach to aligning learning provision with legislative requirements and organisational priorities. Regular assessments of learning needs across services have enabled the development of targeted courses for frontline staff, ensuring that priority groups receive focused support to strengthen the Health Board's capacity to deliver high-quality bilingual care.

This approach has been reinforced through continued partnership working with national bodies. The Health Board renewed its twelve-month contract with the National Centre for Learning Welsh under the Welsh Government-funded *Work Welsh* scheme, ensuring continuity of provision, collaborative working and the retention of the Welsh-language Support Officer. Over the past year, 798 members of staff accessed *Work Welsh* courses, further expanding the organisation's bilingual capability.

A notable development has been the introduction of the *Building Confidence / Codi Hyder* training scheme, delivered in partnership with the National Centre for Learning Welsh. The Health Board has worked closely with the Centre to pilot a bespoke programme within the Mental Health and Learning Disabilities Division, aimed at strengthening Welsh-language skills and supporting the 'More than just words' ambition of increasing bilingual service provision. This innovative initiative is expected to increase the number of confident Welsh-speaking staff within MHLD, ensuring that patients receive an enhanced and culturally aligned bilingual service.

Collectively, these developments demonstrate the Health Board's sustained commitment to building a future bilingual workforce and ensuring that Welsh-language capability remains a core component of high-quality, person-centred care.

The Health Board's Welsh Learner of the Year Award evening was held this year, and provides an important opportunity not only to celebrate the achievements of our learners and acknowledge their dedication to developing Welsh-language skills, but also to showcase the Health Board's leadership in this area across the Welsh public sector. The event highlights how our commitment to bilingual capability is setting a strong example nationally and demonstrates the organisation's ongoing investment in building a confident, skilled and culturally aligned workforce.

The following sections provide an overview of this year's event, capturing the celebrations, the achievements recognised on the night and the wider impact of the Health Board's continued investment in Welsh-language development.

Welsh Language Training Provision Data Analysis

BCUHB renewed a 12-month contract with the National Centre of Learning Welsh.
798 members of staff had access to the 'Work Welsh' courses, including self-study, residential and confidence-building learning opportunities.

238 members of staff attended the newly launched 'Cwrs Croeso/Welcome Course', which was developed in response to the objectives set out in the Welsh Government's Mwy na Geiriau / More than Just Words five-year plan.

The internal tutor supported over 230 members of staff in learning Welsh during the year, marking a 17.5% increase from 2024–25. Encouragingly, more than 70% of participants chose to continue their Welsh language studies after completing a course.

42 members of staff attended 5-day intense courses at Nant Gwrtheyrn, with four members of staff attending a course designed specifically for staff from overseas and 12 members of staff attended the Fast Track to learning Welsh residential courses.

BCU's Welsh Learner of the Year '24 winner, Leanne Parry reached the final round of the prestigious Welsh Learner of the Year competition at the National Eisteddfod. The team arranged a Welsh Learners trip to the Eisteddfod to support Leanne.

The 'Y Gymraeg yn Betsi' Facebook group continues to showcase examples of good practice and success stories, with 593 followers at present, which is a 22% increase since April 2025.

The Health Board's Welsh Learner of the Year Competition 2026

The Health Board's Welsh Learner of the Year Competition continues to play a significant role in supporting the Health Board's commitment to developing a bilingual workforce and improving services for Welsh-speaking patients and communities across North Wales.

This year, the competition received over 50 nominations from staff across the organisation, demonstrating strong engagement with Welsh language learning and reflecting the growing importance of bilingual skills within healthcare delivery. Following a robust judging process, six finalists were shortlisted across two categories: Entry/Foundation Level and Intermediate/Higher Level.

The awards ceremony, held at the Kinmel Hotel, Abergele, successfully celebrated the achievements of learners and was widely regarded as an enhancement on previous years.

Awards were presented to Bethany Frempong Jones (Entry/Foundation Level) and Dr Caroline Jones (Intermediate/Higher Level), while Mark Butler received the Tutor's Choice Award in recognition of his exceptional commitment to learning Welsh. The event was supported by sponsorship from Cymen and Nant Gwrtheyrn.

The competition continues to deliver clear organisational benefits by recognising learner achievement, encouraging participation in Welsh language training, promoting the practical use of Welsh in the workplace, and strengthening the Health Board's culture of bilingualism. The quality of nominations and finalists highlights the innovative developments in Welsh language training provision.

Overall, the Welsh Learner of the Year Competition remains an important event for promoting and normalising the use of Welsh within the Health Board and supports the Health Board's strategic commitment to delivering high-quality bilingual healthcare services.

Translation Services

The Translation Team plays a critical strategic role in enabling the Health Board to meet its statutory obligations under the Welsh Language Standards and to strengthen the organisation's wider commitment to delivering equitable, person-centred care.

By providing high-quality written translation and interpretation services across all divisions, the team ensures that bilingual communication is embedded as a core operational requirement rather than an adjunct activity. Sustained demand for translation reflects both the increasing visibility of the Welsh language across Health Board functions and the organisation's focus on improving patient experience through accessible, culturally aligned information.

The team's robust quality-assurance processes and prioritisation of time-sensitive materials support operational resilience, mitigate compliance risk, and ensure that staff and patients receive accurate information in their preferred language, thereby reinforcing the Health Board's strategic aim of delivering safe, inclusive and legally compliant services.

The Health Board continues to generate external income through the provision of specialist Welsh-language translation services. In 2024–2025, the Welsh Language Team entered into a Service Level Agreement with Aneurin Bevan University Health Board to deliver written translation support, reflecting confidence in the team's capability and professional standards.

The success of this arrangement led to a renewed agreement in 2025–2026, and both organisations have now confirmed continuation for a third consecutive year in 2026–2027. This sustained partnership demonstrates the high quality, reliability and reputation of the team's work, while contributing valuable recurring income to the Health Board.

The team has continued to modernise its operational approach by enhancing the use of Translation Memory technology, which has been embedded in daily workflows for several years. As part of a broader efficiency programme, the team has explored opportunities to further streamline processes, reduce duplication, and accelerate turnaround times for high-volume translation requests. This work has included investment in an upgraded Translation Memory system, 'Wordfast', which offers enhanced functionality, improved consistency controls, and greater capacity to support complex translation tasks. The adoption of this updated software represents a strategic step towards strengthening productivity, supporting demand growth, and ensuring that the Health Board maintains a resilient, high-quality bilingual communication service aligned with statutory and organisational priorities.

Urgent translation requests during the reporting period have included press releases, patient correspondence, annual reports, and time-critical public-health information for social media channels. The Translation Team consistently prioritises all public- and patient-facing communications to ensure that essential information is available bilingually within 1–2 working days, and, where capacity permits, within the same working day for high-urgency items. To further safeguard timely bilingual communication, an out-of-hours service remains in place for exceptional circumstances. This provision ensures that critical information can be issued simultaneously in Welsh and English, reinforcing the Health Board's commitment to treating the Welsh language on the basis of equality and maintaining compliance with statutory requirements.

Overall, the number of words translated during the reporting year was 4,622,786.
The services with the highest translation demand were:

Service	Number of Words Translated
Workforce and Organisational Development	1,024,588
Corporate Office	234,005
Speech and Language Therapy Services	127,844
Child and Adolescent Services	127,314
Communications	122,239

The Translation Team continues to offer support in the form of simultaneous translation provided either face-to-face or on the online platforms of 'Zoom' and 'Microsoft Teams'. A total of 43 requests were received with the majority requiring interpretation for stakeholder events, meetings and conferences, and interviews for applicants who wish to have their interviews in Welsh.

Activities and Promotional Events

Activities and promotional events such as national celebration days and events, as well as wider engagement campaigns play an important strategic role in helping the Health Board promote, normalise and celebrate the Welsh language among staff, patients and the public.

By participating in high-profile cultural events and marking national occasions, the organisation demonstrates visible leadership in championing Welsh language and identity, reinforcing its commitment to delivering services that reflect the culture and linguistic needs of the communities it serves.

National Eisteddfod in Wrexham
The Health Board attended the National Eisteddfod which was held at Wrexham, and this year, the stall was delivered as a collaborative effort, with different healthcare organisations attending on different days. Over four busy and successful days, colleagues from a range of Health Board services—including the Stroke Prevention Team, Speech and Language Therapy, Physiotherapy and the Help Me Quit programme—welcomed visitors, shared information and highlighted the breadth of services available across the Health Board, with a particular emphasis on the importance of Welsh-language services and their positive impact on patients, service users and families.

Everyone's involvement throughout the week helped to showcase the diversity and reach of Health Board services and created valuable opportunities for meaningful conversations with members of the public about accessing care and support through the medium of Welsh.

The Welsh Language Team was also invited to the Careers Wales stand to provide advice, guidance and information on career opportunities within the Health Board. In addition, the Team took part in a panel discussion with Wrexham University and Jeremy Miles MS, Cabinet Secretary for Health and Social Care, exploring how the Health Board can inspire, develop and support the healthcare workforce of the future in Wales.

National Celebration Days

To mark Diwrnod Santes Dwynwen, the Health Board delivered a highly visible and engaging campaign celebrating staff pride in working for the organisation. As part of the celebration, staff across all sites were invited to share why they love working for the Health Board, highlighting the values, teamwork and sense of purpose that underpin their roles.

To celebrate St David's Day, the Health Board delivered a series of high-profile engagement activities across its three acute sites. Mudiad Meithrin and Cymraeg i Blant were welcomed onto the children's wards at Ysbyty Maelor, Ysbyty Glan Clwyd and Ysbyty Gwynedd, where children—and staff—enjoyed interactive sessions featuring well-known Welsh nursery rhymes, creating a warm and culturally rich experience for families. The Health Board also announced the staff shortlisted for the 2026 Welsh Learner of the Year awards, launched the new 'More Than Just Words' videos, and introduced a digital form to streamline resource ordering.

Information stands were held at each acute site, providing opportunities to engage directly with staff, promote upcoming Welsh-language learning opportunities, and distribute resources. Collectively, these activities strengthened the visibility of Welsh language and culture across the organisation.

To mark International Women's Day, the Health Board celebrated the vital contribution women make across the organisation and the wider NHS. Women represent a significant proportion of the Health Board's workforce and have played an integral role in shaping healthcare delivery throughout history. The Health Board highlighted and honoured the achievements of women colleagues and volunteers from across all services, with particular recognition for those who provide bilingual care to patients in North Wales. This celebration reinforced the organisation's commitment to equality, visibility and cultural inclusion, while showcasing the dedication, professionalism and impact of the women who support the Health Board's mission every day.

These activities created opportunities for direct engagement, raising awareness of the Welsh language as a valuable workplace skill, and strengthen public confidence in the Health Board's dedication to bilingual care.

An additional highlight within this year's activities and promotional events was the introduction of the first Welsh-language oncology bell in Wales. Patients on the Children's Ward at Wrexham Maelor Hospital can now celebrate the completion of their cancer treatment with a meaningful touch of Welsh pride, following the installation of a bilingual end-of-treatment bell inscribed with a Welsh-language message. This development provides children and families with the opportunity to mark a significant milestone in their first language and reflects the Health Board's commitment to the visibility of Welsh within clinical environments. The arrival of the bell was warmly received and represents a positive step in enhancing patient experience through the integration of Welsh language and identity in care settings.

Welsh Language Week

Our eighth annual Welsh Language Week took place from 20–24 October, raising awareness of the importance of bilingual healthcare and celebrating the work of staff who support Welsh-language services across the Health Board. The week also provided opportunities for the Welsh Language Team to engage directly with staff.

Highlights included:

• Sharing a patient story through the launch of a video, highlighting the importance of the Welsh language on our Childrens wards.

• Dewin visited all three Childrens wards in partnership with Mudiad Meithrin and Cymraeg i Blant who sang and read books with the children on the ward.

• 'Turbo Charge your Welsh' course were available to staff, giving them the opportunity to improve their Welsh, gain confidence in using the Welsh language and also learn more about our Welsh language training opportunities.

• Information stalls at the three acute hospitals and community hospitals in Llandudno, Denbigh and Deeside to celebrate Shwmae Sumae day. The stalls gave us the chance to chat with staff and give advice and guidance on a range of topics relating to bilingual services. In addition, we encouraged staff to use their Cymraeg/Welsh on a day-to-day basis at work.

• A 'Welsh Pledge' competition was held at the stalls to give staff the opportunity to commit to doing one thing regarding the Welsh language, e.g. I promise to start every conversation in Welsh with my patients.

At the end of the week we selected a name at random, Sarah from Deeside Hospital won a hamper for Welsh language pledge.

• Launch of the 2026 Welsh Learner of the Year Awards.

• Radio interviews on Radio Ysbyty Gwynedd and Radio Ysbyty Glan Clwyd.

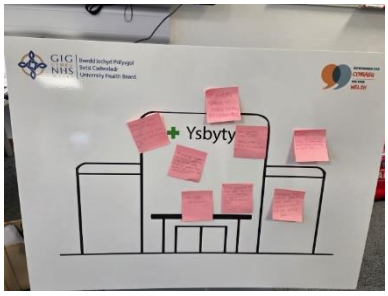
The week was a great success, celebrating the Welsh language, promoting bilingualism and encouraging staff to develop and use their Welsh-language skills.

Showcasing Welsh Language as a Professional Skill

The Health Board has strengthened its strategic partnerships with universities, schools and sector organisations to promote the Welsh language as a valuable professional skill and an essential component of a future bilingual workforce. Through this collaborative approach, the organisation is helping to embed the understanding that Welsh-language capability is integral to high-quality care and modern public-sector practice.

The Team has continued to work closely with Careers Wales on a range of engagement activities with learners across Ysgol Morgan Llwyd, Ysgol y Creuddyn, Ysgol Rhosnesni, Coleg Cambria and St Richard Gwyn Catholic High School and many more**.** These included Welsh in the Workplace sessions, carousel-style events where pupils, in small groups, had the opportunity to ask questions about the importance of the Welsh language in the workplace, as well as mock interviews for Year 10 pupils to help prepare them for their future careers. The Team also shared information and examples of good practice at careers fairs and other careers-related events.

These activities provided valuable opportunities to promote the use and importance of the Welsh language within healthcare settings and to raise awareness of the significant difference that Welsh-language services can make to patients, service users and their families. Through engagement with learners and young people, the Team highlighted the wide range of career opportunities available within healthcare and the importance of bilingual skills in delivering person-centred care.



It was encouraging to receive such positive feedback from school staff, with St Richard Gwyn Catholic High School commenting:

> *"It was great to have the Health Board's Welsh Language Team in school delivering again this year about the importance of Welsh in the workplace and in the medical sector. Having staff come in and deliver to pupils is extremely powerful in supporting the importance of being able to converse with patients in the language they are more comfortable with. This in turn supports the work of schools and student outcomes by helping to contextualise the importance of their learning and the subjects they study."*

Also, during the reporting period, the Health Board strengthened its partnership work with regional universities to support the development of a future bilingual workforce. The Welsh Language Team collaborated with Wrexham University as part of its new 20-credit 'Welsh in the Workplace 1' module for Health-Related Professions students, delivering Welsh-language and

language-awareness sessions designed to equip future clinicians with the confidence and skills to use Welsh in professional practice.

Similarly, the Health Board continued its engagement with Bangor University and the North Wales Medical School through the new Medicine Programme. The team delivered sessions outlining the organisation's strategic approach to promoting and embedding Welsh language and culture across clinical services, emphasising the importance of language choice in safe, person-centred care. One of the Health Board's Consultant in Care of the Elderly at Ysbyty Gwynedd provided a practitioner's perspective on the value of using Welsh daily in clinical interactions and the positive impact this has on patient experience.

The Health Board also took part in a question-and-answer session with Year 2 students at the North Wales Medical School to demonstrate the importance of speaking Welsh with patients, and the support offered by the Health Board once on placement.

These collaborations form an important component of the Health Board's long-term strategy to build a confident, bilingual clinical workforce and ensure that future generations of healthcare professionals are equipped to meet the linguistic needs of the population.

Key Performance Indicators

The data included below are in accordance with Standard 120 of the Welsh Language Standards under the Welsh Language (Wales) Measure 2011.

Workforce Planning

- ***Number and percentage of the organisation's employees whose Welsh language skills have been assessed across the organisation.***

Count of Employee Number	2023/24		2024/25		2025/26	
Individual Proficiency Level	Total	%	Total	%	Total	%
0 - No Skills / Dim Sgiliau	9645	46.25%	10217	48.33%	10271	49.02%
1 - Entry/ Mynediad	2781	13.34%	2739	12.96%	2828	12.93%
2 - Foundation / Sylfaen	1371	6.57%	1394	6.59%	1426	6.52%
3 - Intermediate / Canolradd	1438	6.9%	1472	6.96%	1555	7.11%
4 - Higher / Uwch	1588	7.62%	1600	7.57%	1613	7.38%
5 - Proficiency / Hyfedredd	2743	13.15%	2778	13.14%	2926	13.38%
Total	19,566	93.8%	20,200	95.54%	20,619	96.34%
Total number of staff	20,852		21,142		21,871	

2025 / 2026 Data:

96.34 per cent of the entire workforce had recorded their Welsh language skills on ESR

2024 / 2025 Data:

95.54 per cent of the entire workforce had recorded their Welsh language skills on ESR

Training to Improve Welsh Language Skills

- ***Number and percentage of the organisation's workforce that received training to improve their Welsh skills to a specific qualification level.***

2025 / 2026 Data:

Number of the organisation's workforce that have accessed training to improve their Welsh skills to a specific qualification: 1037

This total equates to 4.9 per cent of the Health Board's current workforce.

2024 / 2025 Data:

Number of the organisation's workforce that have accessed training to improve their Welsh skills to a specific qualification: 995

This total equates to 4.7 per cent of the Health Board's current workforce

Recruitment

- ***Number and percentage of new and vacant posts advertised with the requirement that:***

2025 / 2026 Data:

- **Welsh language skills are essential - 274 (6.9%)**
- **Welsh language skills are desirable - 3631 (91.1 %)**
- **Welsh language skills to be learnt - 69 (1.7%)**
- **Welsh not a required skill - 10 (0.3%)**
- **Total number of vacancies advertised - 3984**
-

2024 / 2025 Data:

- **Welsh language skills are essential - 301 (6.5 per cent)**
- **Welsh language skills are desirable - 4238 (92.2 per cent)**
- **Welsh language skills to be learnt - 49 (1.1 per cent)**
- **Welsh not a required skill - 8 (0.17 per cent)**
- **Total number of vacancies advertised - 4596**

Complaints

- ***Number of complaints received about the implementation of the Welsh Language Standards***

  The Health Board received four new complaints relating to compliance with the Welsh Language Standards during the reporting year, three through the Welsh Language Commissioner and one through the Complaints Team.

  One complaint was referred to the status of an investigation by the Welsh Language Commissioner, and concerned delays in answering a Welsh telephone line. Evidence was provided stating that there were delays on the Welsh and English lines for a period of one hour while the call centre was moving from Bangor to Caernarfon.

  The other two complaints were dealt with by the Welsh Language Commissioner in full after the initial letter, and were not escalated to the status of an investigation. One complaint related to a failure to arrange a job interview through the medium of Welsh. The second concerned English-only signage in a Children's Outpatient Department.

  The complaint sent directly to the Health Board related to a lack of Welsh language service in a Dental Centre. The dentist was reminded of the six duties that primary care services need to comply with support offered from the Welsh Language Team.

  All complaints were addressed in full in accordance with the Welsh Language (Wales) Measure 2011 complaints timetable or under the Putting Things Right Regulations.

Reflection and Forward Vision

This report has demonstrated that progress has been implemented in:

- improving the quality of care provided through the language of choice.
- increasing compliance with legal and statutory requirements.
- identifying initiatives that have been implemented and rolled out to respond to language need as an integral element of care.
- improving organisational development in terms of how the workforce is supported to deliver services through the medium of Welsh.

However, the Health Board is looking towards the initiatives and opportunities in development for the next reporting year through its three-year approach to service planning. There will be a focus on embedding Welsh language in Service Design and Delivery, enhancing the “Active Offer” across clinical settings through the implementation of the Standard 110 Five-year plan, and scaling successful initiatives across services to ensure consistent bilingual service delivery.

Setting the ambition for 2026-2027

Looking ahead, the Health Board's Integrated Medium-Term Plan 2026–2029 sets a clear vision for strengthening Welsh-language capability across services, and the coming year will focus on consolidating these foundations.

Key priorities will include:

- developing a clinical-focused plan to increase the use of Welsh in line with Standard 110;
- expanding targeted training for staff working with vulnerable groups;
- further enhancing governance arrangements to monitor compliance and progress.

Work will also continue to identify priority patient and workforce groups requiring additional support, alongside a renewed emphasis on increasing the visibility and everyday use of Welsh through staff engagement, social presence and the introduction of a Language Champions' Programme.

These actions will help embed Welsh more deeply within core functions and promote wider cultural ownership across the organisation, ensuring sustained progress and a stronger bilingual service for the people of North Wales.

Delivering the actions in the More than just words Plan 2022-27: For the period 1 April 2025 – March 2026

Organisation	**Betsi Cadwaladr University Health Board**

Completed by:	**Head of Welsh Language Services**	**Date: 28 September 2026**

KEY DATA: **When citing any statistics / data, please provide a corresponding reporting date / time period.**

Welsh Language Skills of staff

Count of Employee Number	**2023/24**		**2024/25**		**2025/26**	
Individual Proficiency Level	Total	%	Total	%	Total	%
0 - No Skills / Dim Sgiliau	9645	46.25%	10217	48.33%	10271	49.02%
1 - Entry/ Mynediad	2781	13.34%	2739	12.96%	2828	12.93%
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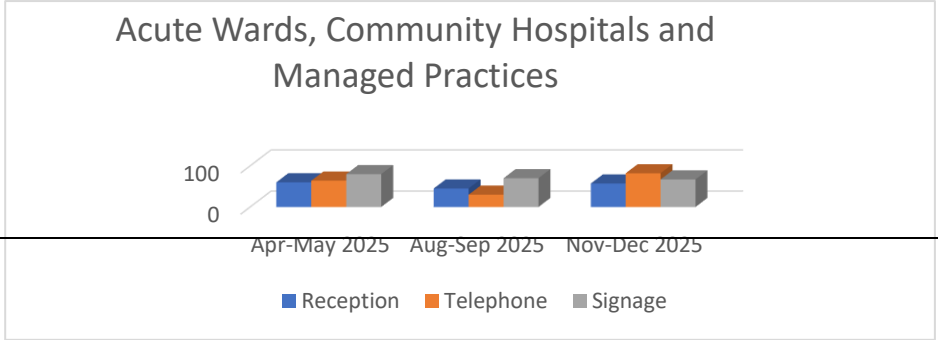
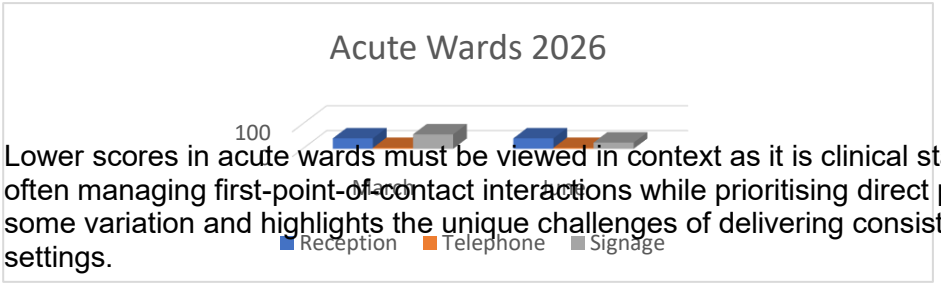
5 - Proficiency / Hyfedredd	2743	13.15%	2778	13.14%	2926	13.38%
Total	19,566	93.8%	20,200	95.54%	20,619	96.34%
Total number of staff	20,852		21,142		21,871	

	As at 31 March 2026.
Number of staff completing training	**Courtesy Course - 238** **Confidence Building Course** - 2025-2026 18 (9 of these were MHLD staff). The Health Board's agreement with the National Centre for Learning Welsh differs slightly with regard to targeted gaining confidence courses. Due to the Health Board's mature training programme already in place, and work done as part of Standard 110 foundations to identify gaps in service provision, the Health Board is in a position where it is able to target priority groups. Please also note the Health Board did not receive gaining confidence support between September and December 2025 due to issues with the provider, outside of the Health Board's control. Therefore, the total here equates to Q1 and Q4 of 2025-2026 only. **Welsh Language Awareness Course** – 85% of all staff – 18,590 members of staff **Welsh Language Training for 2025-2026 -** Number of the organisation's workforce that have accessed training to improve their Welsh skills to a specific qualification: 1,037. This total equates to 4.9 per cent of the Health Board's current workforce. **All data as at 31 March 2026.**
Patient / Service User Surveys e.g. secret shopper surveys	The Health Board's self-regulation approach continued with the Mystery Shopper Monitoring Programme with the aim of providing strong assurance of the organisation's commitment to deliver high-quality Welsh-language services and maintaining compliance with the Welsh Language Standards. Monitoring results confirmed that Welsh-language signage remains a significant organisational strength, with consistently high levels of compliance across sites, demonstrating sustained commitment to a visible and accessible bilingual environment. The programme also offered valuable insight into areas where further improvement can be targeted, specifically reception interactions, telephone contact, and the visibility of the "Active Offer". 



Lower scores in acute wards must be viewed in context as it is clinical staff, rather than dedicated reception teams, often managing first-point-of-contact interactions while prioritising direct patient care. This operational reality explains some variation and highlights the unique challenges of delivering consistent bilingual communication in busy clinical settings.

Overall, the programme has strengthened the Health Board's understanding of where targeted support will have the greatest impact. The monitoring programme demonstrates that the Health Board has robust arrangements in place to assess Welsh language service delivery and identify areas for improvement. Strong performance in signage compliance provides evidence of sustained commitment to the Welsh Language Standards, while the findings from acute ward settings have offered valuable insight into the challenges faced within clinical environments. The organisation will use these findings to strengthen awareness, improve consistency of service delivery and enhance the visibility of the "Active Offer" during 2026-27, ensuring that Welsh-speaking patients continue to receive an increasingly positive experience when accessing services.

Ref	Description of Short Term and Medium Term Action	Guidance for completing the response	Lead Accountability	Progress Report for 2025/26 (reporting period 1/4/25 – 31/3/26): What new and additional activities were delivered during 2025/26?	Examples of good practice / work done in partnership.
Culture and Leadership					
1	We'll set personal performance objectives to ensure the delivery of More than just words so that the Active Offer is embedded in annual objectives of sector leaders, cascaded throughout organisations and considered in relevant individual appraisals at all levels. This will include Chairs of NHS boards and the Directors of Social Services report (Annual Council Reporting Framework). *(Short term)*	This was a short term action. There are now requirements in place for the Chairs of NHS Boards and the Directors of Social Services to have specific objectives in relation to supporting the implementation of Mwy na geiriau and the Active Offer. Health bodies / social services do not need to provide an update for the 2025/26 report (unless there are specific developments they wish to share as good practice) as Welsh Government will	Welsh Government for 2025/26.	NA - WG Action.	Please see column to the left for all actions, which provides comprehensive evidence of any good practice and partnership working.

		review progress against objectives at the end of the year.			
2.	Over time, we expect all health and social care staff to gain an appreciation of the positive difference that learning and using Welsh can make to the care experience. In the meantime we'll bolster language awareness courses with a behavioural-science communications approach so that everything we say about Cymraeg as leaders, and as organisations and partnerships contributes to this strategy. This approach will build on the training and on the positive narrative outlined in the plan. (*Short to medium term*)	HEIW and SCW to provide a response – on the work they are taking forward to support this agenda. We request that health bodies and social services also provide information on how they are supporting this action, and good practice they want to share regarding the promotion of the Welsh language across all settings.	Welsh Government / HEIW / SCW	N/A - WG /HEIW / SCW Action.	
3	We'll expect those in leadership roles to take part in our Leading in a Bilingual Country programme. This programme works towards embedding the spirit of Cymraeg 2050 in organisational culture and policymaking. All too often, Welsh is viewed as just an issue of translation or as a 'tick box' in policy development. This values-based programme goes beyond understanding the possible impact of language on all	Where health and social care leaders have taken part in the Leading in a Bilingual Country Programme, we would like you to provide specific examples of how outputs from the Programme are continuing to make a difference to leadership roles in the organisation. We	Chairs and Chief Executives of health and social care bodies	WG approached for additional dates for the Leading in a Bilingual Country Programme.	

	aspects of our work to using what levers we have to increase its use. *(Medium term)*	would also like you to provide examples of where there have been other leadership programmes / training opportunities that have been delivered by health and social care bodies focusing specifically on leadership in a bilingual context.			
Theme 1: Welsh language planning and policies including data					
5	Identify and develop research and data that will strengthen our understanding and knowledge based on the experiences of Welsh language speakers accessing and receiving services, to support evidence-based policy and Welsh language planning in health and social care. This to include ability to provide bilingual services and to evidence how More than just words supports improved outcomes for individuals. (This action aligns with the work set out in section 4 on mapping the data and creation of the dashboard) (*Medium term*)	Welsh Government will shortly be publishing the review of Welsh Language data undertaken by Alma Economics. Health and social care bodies are asked to provide details of any research / data they may also have commissioned. For example: Health and social care bodies are asked to provide results of surveys of patient experiences of accessing and	Welsh Government / Universities, Citizen Voice Body for health and social care and think tanks	Work has been undertaken with service users to gain feedback on access and delivery of Welsh medium services. Report attached of two patient stories sharing their feedback.	

		receiving services such as Mystery Shopper etc. Llais / universities / health and social care think tank organisations to also highlight key developments that look to strengthen our understanding and knowledge of the experiences of Welsh language speakers, when accessing and receiving services.			
6	Develop tools to support mainstreaming Welsh Language considerations into planning and policies especially in the priority areas and high levels of interactions with services. This to include establishing Welsh language care pathways for vulnerable individuals in identified priority groups such as older people, children, mental health, speech therapy, learning difficulties, and stroke services. (*Long term*)	Health and social care bodies are asked to provide evidence of Welsh language care pathways for the priority groups particularly. Health and social care bodies are also asked to provide information and evidence on any tools developed to support mainstreaming Welsh	Welsh Government / Health and social care bodies	The Health Board has continued to strengthen the integration of Welsh language considerations within its Equality Impact Assessment (EQIA) processes, ensuring that the potential impact on Welsh-speaking patients, service users, staff and communities is considered as part of strategic decision-making. During 2025–	

		Language considerations into planning and policies.		2026, two substantial organisational projects were subject to full equality impact assessment, with Welsh language implications assessed alongside other protected characteristics. In addition, the Health Board undertook a separate and comprehensive Welsh Language Impact Assessment, examining the potential impact of proposals across all areas of service provision, workforce, communication, engagement and operational delivery. This enhanced approach has provided greater assurance that Welsh language considerations are embedded at the earliest stages of planning and decision-making, supporting	

				compliance with the Welsh Language Standards and the principles of *More Than Just Words*, while safeguarding opportunities for individuals to receive services through the medium of Welsh. During the reporting year, a Welsh Language Care Pathway was formed through the development of an "Active Offer" Toolkit for priority service areas to support the systematic consideration of language needs as a core component of person-centred care. The toolkit focuses particularly on groups for whom receiving care in their preferred language is critical to outcomes and experience, including people with dementia,	

				mental health conditions, learning disabilities, children and young people, and older people. It provides practical guidance to help services identify Welsh language requirements at each stage of the patient journey, strengthen the “Active Offer”, improve the recording and transfer of language preference information, support workforce planning, and mitigate risks associated with communication barriers. The introduction of the toolkit has provided a consistent framework for services to deliver equitable, safe and effective care through the medium of Welsh, while supporting compliance with Welsh Language	

				Standards and enhancing patient experience.	
7	Ensure national planning and guidance for health and social care is clear on Welsh language planning requirements, implementation and measuring delivery of outputs. This to include Integrated Medium Term Plans (IMTPs) and regional population needs assessments. *(Short term)*	Welsh Government will provide the update for this action. Welsh Language is included in the National Planning Guidance for Health Boards. Integrated Medium Term Plans (IMTPs) have been reviewed by Welsh Government and officials will continue to focus on More than just words priorities as part of NHS Governance.	Welsh Government	WG Action. BCUHB's IMTP 2026-2029 has a dedicated section for Welsh Language and Culture.	
8	An agreed national framework for the collection and collation of data on the language skills of all staff working in health and social care in Wales will be developed and implemented. This should be mandatory wherever possible and would need to align with systems and approaches	Health and social care bodies should provide an overview of how they are currently collecting and collating data on the language skills of all staff (as well as key data for the reporting period).	HEIW / SCW / DHCW / health and social care bodies including independent primary care contractors.	96.34% of the Health Board's workforce have completed their Welsh language skills on ESR. This equates to 20,619 members of staff.	

	currently in place for the collection, collation of data across the health and social care sectors including services that are provided in Welsh *(Medium term)*				
9	An annual report will be prepared by an appropriate body to bring together the data relating to the health and social care workforce. This report could be prepared and published by Statistics for Wales. The published report should be publicly available with a further level of granular detail available as appropriate to those bodies responsible for the workforce in different contexts e.g. HEIW, SCW, Health Boards. *(Short/medium term)*	. Welsh Government has commissioned Wavehill & IAITH to draft the More than just words Annual Report 2025-26. As noted above: Welsh Government has also commissioned a contractor to identify key data on Welsh Language in health and social care which will help to identify key data gaps in relation to monitoring outcomes, impact and progress. Health bodies / social services do not need to provide an update on this action for the 2024/25 report.	HEIW/SCW, health and social care bodies	NA - WG Action for 25-26.	
10	That action 30 of the 'Health and Social Care Workforce Strategy'	The HEIW Workforce Planning for the Welsh	HEIW / Social Care Wales / health and	'Bilingual Skills Policy and Procedure'	

	– to develop workforce planning guidance for Welsh language skills identification and development in the health and social care workforce – is progressed at the earliest opportunity. This guidance should consider the required number of staff with Welsh language skills and the nature of those skills in different health and social care contexts and within the priority areas of need identified. The guidance is used as part of annual workforce planning by Health Boards, Local Authorities, HEIW, Social Care Wales and other employers as appropriate. Furthermore, that the guidance inform the work of the relevant regulators and inspectorate as appropriate (*Short term*)	Language Guidance has been published. Health and social care bodies should provide examples of how this guidance has been used across different settings / policies. CIW and HIW to provide information on their inspection frameworks and how these also focus on how the HEIW guidance is being used across health and social care settings.	social care bodies / CIW / HIW	outlines recruitment and retention activities, including the advertisement of posts deemed as Welsh Essential. Four categories of front-line posts have been identified as 'Welsh Essential (ward clerks, receptionists, switchboard staff and patient appointment booking centre staff). If Welsh speakers are not recruited, there is a proviso that the successful candidate will need to learn Welsh. Please note, Learning Pathways have been developed to address this. Swyddi Cymraeg Hanfodol / Welsh Essential Posts (Please note: If details are not accessible, Word copies can be provided).	
11	The importance of the Active Offer in planning and delivering quality services to be included in	Welsh Government will update on this action. The Duty of Quality	Welsh Government	N/A - WG Action.	

	the guidance and reporting requirements for the Duty of Quality and refreshed health and care standards. The Health and Social Care (Quality and Engagement) (Wales) Act ('the Act') became law on 1 June 2020 with its full implementation to be completed by spring 2023. This includes reframing and broadening the existing duty of quality on NHS bodies. *(Short term)*	has been introduced and the importance of the Active Offer was included in the statutory guidance published in April 2023.			
12	The importance of the Welsh language in planning and delivery to be included as a cross cutting theme within the revised National Outcomes Framework and progress reports to be incorporated into the development of the More than just words accountability arrangements including the dashboard. *(Medium term)*	Welsh Government will update on this action.	Welsh Government	NA – WG Action.	
Theme 2: Supporting and developing the Welsh language skills of the current and future workforce					
13	Health and social care organisations to identify workforce skills gaps in key areas and develop plans to address them. This will be embedded in workforce and skills plans developed and delivered within individual organisations and involve close	Health and social care bodies should provide examples of how they have identified workforce skills, where the gaps exist, and whether they have plans in place to address them. Health	Health and social care bodies, HEIW and SCW	During the reporting year, a comprehensive baseline assessment of Welsh language skills across the workforce was completed to support the work of the Health	

	working with HEIW and SCW. *(Medium term)*	boards should specifically update on the baseline work they have undertaken to support the work of the Health Forum Collaboration and the delivery of Standard 110 (see also Action 18).		Forum Collaboration and the delivery of Welsh Language Standard 110. The assessment drew on workforce data, Welsh language skills information, recruitment trends and service-level reviews to identify existing Welsh language capacity and areas where skills gaps were evident. Findings were used to inform workforce planning, strengthen the alignment between service need and Welsh language provision, and support the development of targeted actions to address identified gaps through recruitment, training and succession planning. This work has provided a clearer understanding of the Board's Welsh language workforce profile and	

				established a robust evidence base to support future service and workforce development. Data can be provided.	
14	We'll expect all NHS and social care colleagues to follow a language 'awareness 'course which will explain how important Cymraeg is in service delivery and as a patient need. Following the introduction of Welsh language awareness training for all health and social care professional, we'll expect that this training is provided across all disciplines for trainees and introduced as part of the induction process for new employees in the health and social care workforce who have not already undertaken the training. *(Medium term)*	Health and social care bodies should provide key data on take up of Welsh Language Awareness Courses. This includes data on providing the course as part of the induction process.	Health and social care bodies	85% of all staff – 18,590 members of staff have completed the course. Data as at 31 March 2026. Additional language awareness sessions have been provided at numerous senior level clinical meetings, to medical and health care students at wrexham University and the North wales Medical School, and to individual GP Practices. Awareness sessions were also delivered on a cross-border level with the Mother and Baby Unit in Chester receving speicifc Welsh language awarenes and Welsh language training.	

15	The National Centre for Learning Welsh develop further their plans to offer Welsh language training to the health and social care sectors and provide an enabling environment on the use of Welsh in workplaces. This should complement informal language learning through on-line tools and apps to be made available across the sector. It could be modelled on recently announced developments for the education workforce. This should include tailored provision to support practice in health and social care and identify opportunities (along with relevant employers) to support staff confidence to make more use of their Welsh language skills (at whatever level) in the workplace. We further recommend that Welsh Government explore what resources are required to deliver adequate support for such a scheme including supporting employers to release key staff to undertake substantive Welsh language learning. (*Medium term*)	National Centre for Learning Welsh to provide an update on key actions, take up of specific courses, and outcomes. Health and social care bodies are asked to describe how they've worked strategically with National Centre for Learning Welsh to meet their own priorities.	Welsh Government / National Centre for Learning Welsh	NA – WG Action. <u>Workforce Development Programme</u> The Health Board's Welsh Language Training Team has successfully delivered a wide range of Welsh language courses tailored to organisational needs. During the reporting year, over 1,000 members of staff participated in Welsh language learning, representing a 4% increase compared to 2024–25. This demonstrates the continued commitment of BCUHB staff to learning Welsh and applying their developing language skills to improve the quality of services provided to patients across North Wales. The Welsh Language	

				Training Team has taken a proactive and strategic approach to ensuring that training provision aligns with legislative requirements and organisational priorities. Learning needs have been regularly assessed across the Health Board, enabling the development of targeted Welsh language courses for frontline staff. Priority groups have received focused support to strengthen the organisation's capacity to provide high-quality services in Welsh. <u>Working in Partnership</u> The Welsh Language Training team renewed a twelve-month contract with the 'National Centre for Learning Welsh' under the Welsh Government-funded 'Work Welsh	

				Scheme'. This ensured the continuation of opportunities and collaborative working as well as employing our Support Officer. 798 members of staff had access to the 'Work Welsh' courses over the last year <u>New training scheme gives boost to MHLD team</u> Since 2024, a full-time 'Building Confidence / Codi Hyder' Tutor has been allocated to each health board in partnership with the National Centre of Learning Welsh. The Centre has worked with BCU to pilot a programme for the MHLD department, aimed at improving Welsh language skills and supporting the *More than Just Words* goal of delivering more services bilingually. This	

				innovative initiative hopes to increase the number of confident Welsh speakers within MHLD, ensuring an enhanced bilingual service provision. TRAINING DATA: - BCUHB renewed a 12-month contract with the National Centre of Learning Welsh. 798 members of staff had access to the 'Work Welsh' courses, including self-study, residential and confidence-building learning opportunities. - 238 members of staff attended the newly launched 'Cwrs Croeso/Welcome Course', which was developed in response to the objectives set out in the Welsh Government's Mwy na Geiriau / More	

				than Just Words five-year plan. -The internal tutor supported over 230 members of staff in learning Welsh during the year, marking a 17.5% increase from 2024–25. Encouragingly, more than 70% of participants chose to continue their Welsh language studies after completing a course. - 42 members of staff attended 5-day intense courses at Nant Gwrtheyrn, with four members of staff attending a course designed specifically for staff from overseas and 12 members of staff attended the Fast Track to learning Welsh residential courses. - BCU's Welsh Learner of the Year '24 winner, Leanne Parry reached the	

				final round of the prestigious Welsh Learner of the Year competition at the National Eisteddfod. The team arranged a Welsh Learners trip to the Eisteddfod to support Leanne. - The 'Y Gymraeg yn Betsi' Facebook group continues to showcase examples of good practice and success stories, with 593 followers at present, which is a 22% increase since April 2025. <u>Welsh Learner of the Year</u> The Health Board's Welsh Learner of the Year Competition continues to play a significant role in supporting the Health Board's commitment to developing a bilingual workforce and improving	

				services for Welsh-speaking patients and communities across North Wales. This year, the competition received over 50 nominations from staff across the organisation, demonstrating strong engagement with Welsh language learning and reflecting the growing importance of bilingual skills within healthcare delivery. Following a robust judging process, six finalists were shortlisted across two categories: Entry/Foundation Level and Intermediate/Higher Level. The awards ceremony, held at the Kinmel Hotel, Abergele, successfully celebrated the achievements of learners and was widely regarded as an	

				enhancement on previous years. Awards were presented to Bethany Frempong Jones (Entry/Foundation Level) and Dr Caroline Jones (Intermediate/Higher Level), while Mark Butler received the Tutor's Choice Award in recognition of his exceptional commitment to learning Welsh. The event was supported by sponsorship from Cymen and Nant Gwrtheyrn. The competition continues to deliver clear organisational benefits by recognising learner achievement, encouraging participation in Welsh language training, promoting the practical use of Welsh in the workplace, and strengthening BCUHB's culture of bilingualism.	

				The quality of nominations and finalists highlights the positive impact of ongoing investment in Welsh language development. Overall, the Welsh Learner of the Year Competition remains an important event for promoting and normalising the use of Welsh within BCUHB and supports the Health Board's strategic commitment to delivering high-quality bilingual healthcare services. 2025 / 2026 Data: Number of the organisation's workforce that have accessed training to improve their Welsh skills to a specific qualification: 1,037 This total equates to 4.9 per cent of the Health Board's current workforce.	

16	Organisations to define the level of Welsh language skills required in all job adverts as per best practice in some health boards and local authorities *(Medium term – guidance to be developed and shared in the short term)*	All health and social care bodies to provide an update on work being taken forwards to define Welsh language skills required in all job adverts, as well as key data on whether posts are being advertised as Welsh desirable and Welsh essential.	Health and social care bodies	Already in place as part of the Bilingual Skills Policy and Procedure. Please see details below with regard to the number of posts being advertised as Welsh Essential / Welsh Desirable / Welsh to be learned: 2025 / 2026 Data: Welsh language skills are essential - 274 (6.9%) Welsh language skills are desirable - 3631 (91.1 %) Welsh language skills to be learned - 69 (1.7%) Welsh not a required skill - 10 (0.3%) Total number of vacancies advertised - 3984	
17	Gradual introduction of a minimum “courtesy” level of Welsh language skills making staff more aware	National Centre for Learning Welsh to provide data on the new courtesy course (as part of the health	National Centre for Learning Welsh Health and social care bodies	238 members of staff have completed the ‘courtesy level’ Welsh language course.	

	of positive impact that learning and using Welsh can have on individuals accessing and receiving health and social care services. By the end of the life of this plan, all staff working in health and social care should have courtesy level Welsh. *(Short term- introduction)*	and social care scheme) and take up across the organisations. Health and social care bodies to also provide information on other courtesy courses being developed (not by the National Centre for Learning Welsh) and delivered locally, and key data on take up.		Many of these have progressed to other courses. Total number of staff who accessed Welsh language training courses during 25-26 were 1037.	
18	Organisations to develop and implement a targeted Welsh language training and workforce strategy – with initial focus on addressing gaps in More than just words key priority areas and those who lack confidence (need to consider the potential for working with team leaders / managers /employers to also create the conditions for individuals to use their Welsh) *(Medium term)*	Health boards to provide an update on work to support the delivery of Standard 110, and how they are increasing the use of Welsh across clinical settings.	Health and social care bodies	An end of Year 2 Report for delivering the outcomes within the Standard 110 Five-Year Plan was presented at the Welsh Language Strategic Forum in June 2026. Report attached. End-of Year Standard 110 Implementation F	
19	Instigate a national awareness and promotion campaign to make staff more aware of the positive difference that learning and using Welsh can make to the services they provide. This to	Welsh Government launched a suite of films in October 2025 (based in different health and social care settings) and an	Welsh Government/ SCW and HEIW	See Action 15 above.	

	include recruitment campaigns articulating the importance of the Welsh language. The campaigns to involve role models and case studies on the difference use of Welsh has in improving outcomes for individuals. *(Medium term)*	overarching animation to promote the aims of Mwy na geiriau and the active offer. Health and social care bodies to provide information on promotion campaigns they are also delivering to raise awareness of the difference learning Welsh can make. This should include case studies and awards which feature the Welsh language.			
20	Careers Wales / HEIW and SCW to promote the importance and opportunities Welsh language skills can provide within careers in health and social care utilising the Tregyrfa portal resources and through roadshows and engagement sessions with young people. *(Short/medium term)*	HEIW to provide information on Tregyrfa, including data on numbers accessing the site. HEIW to also provide information on roadshows and engagement events held with educational institutions. Careers Wales to provide information on initiatives promoting the importance of Welsh language skills	Careers Wales / HEIW and SCW / health and care bodies	The Health Board has strengthened its strategic partnerships with universities, schools and sector organisations to promote the Welsh language as a valuable professional skill and an essential component of a future bilingual workforce. Through this collaborative approach, the organisation is helping to embed the	

		in health and social care careers, including data on attendee numbers for any events / roadshows / engagement sessions. Health and care bodies to provide information on roadshows and engagement with young people, including data on attendee numbers.		understanding that Welsh-language capability is integral to high-quality care and modern public-sector practice. The Team has continued to work closely with Careers Wales on a range of engagement activities with learners across Ysgol Morgan Llwyd, Ysgol y Creuddyn, Ysgol Rhosnesni, Coleg Cambria and St Richard Gwyn Catholic High School and many more**.** These included Welsh in the Workplace sessions, carousel-style events where pupils, in small groups, had the opportunity to ask questions about the importance of the Welsh language in the workplace, as well as mock interviews for Year 10 pupils to help prepare them for their future careers.	

				The Team also shared information and examples of good practice at careers fairs and other careers-related events. These activities provided valuable opportunities to promote the use and importance of the Welsh language within healthcare settings and to raise awareness of the significant difference that Welsh-language services can make to patients, service users and their families. Through engagement with learners and young people, the Team highlighted the wide range of career opportunities available within healthcare and the importance of bilingual skills in delivering person-centred care.	

				It was encouraging to receive such positive feedback from school staff, with St Richard Gwyn Catholic High School commenting: *"It was great to have the Health Board's Welsh Language Team in school delivering again this year about the importance of Welsh in the workplace and in the medical sector. Having staff come in and deliver to pupils is extremely powerful in supporting the importance of being able to converse with patients in the language they are more*	

				comfortable with. This in turn supports the work of schools and student outcomes by helping to contextualise the importance of their learning and the subjects they study." Also, during the reporting period, the Health Board strengthened its partnership work with regional universities to support the development of a future bilingual workforce. The Welsh Language Team collaborated with Wrexham University as part of its new 20-credit 'Welsh in the Workplace 1' module for Health-Related Professions students, delivering	

				Welsh-language and language-awareness sessions designed to equip future clinicians with the confidence and skills to use Welsh in professional practice. Similarly, the Health Board continued its engagement with Bangor University and the North Wales Medical School through the new Medicine Programme. The team delivered sessions outlining the organisation's strategic approach to promoting and embedding Welsh language and culture across clinical services, emphasising the importance of language choice in safe, person-centred care. One of the Health Board's Consultant in Care of the Elderly at Ysbyty Gwynedd provided a practitioner's	

				perspective on the value of using Welsh daily in clinical interactions and the positive impact this has on patient experience. The Health Board also took part in a question-and-answer session with Year 2 students at the North Wales Medical School to demonstrate the importance of speaking Welsh with patients, and the support offered by the Health Board once on placement. These collaborations form an important component of the Health Board's long-term strategy to build a confident, bilingual clinical workforce and ensure that future generations of healthcare professionals are equipped to meet the	

				linguistic needs of the population.	
21	HEIW, MEDR and SCW to monitor the numbers of bilingual students being trained as health and social care professionals each year in line with the agreed framework for measuring Welsh language skills, and publish the data annually. This could reflect or develop upon requirements that are already in place in relation to HEIW contracts, SCW monitoring and/ or HESA data. In relation to publishing the data we recommend that a specific table is included in the annual Statistics Bulletin – Welsh in Higher Education Institutions to report on this data. This data to also be incorporated in the dashboard development set out under Section 4 *(Short term)*	HEIW / MEDR / SCW to provide data on the numbers of bilingual students being trained as health and social care professionals. This data should be provided in line with the recommendations from the Data Mapping and Review Exercise undertaken by Alma Economics.	HEIW / MEDR / SCW	NA - HEIW / MEDR / SCW Action	
22	Welsh Government monitor the number of bilingual learners and apprentices undertaking Health and Social Care courses and/or apprenticeships each year in line with the agreed framework for measuring Welsh language skills and publish the data annually. This data to also be incorporated	Welsh Government will include the latest data in the Mwy na geiriau Annual Report for 2025-26.	Welsh Government	NA – WG Action.	

	into the dashboard development set out under Section 4. *(Short term)*				
23	Welsh Government / MEDR have established a benchmark for bilingual provision i.e. that one third of a course (at least) is available in Welsh. Such a benchmark allows students who are confident in Welsh to undertake part of their course through the medium of Welsh and to develop a level of confidence to work bilingually. This also reflects international best practice e.g. University of Helsinki Medical School. HEIW / SCW to work with universities in Wales and the Coleg Cymraeg Cenedlaethol to identify any courses where students cannot at present study one third of their health and social care courses bilingually and take appropriate action to ensure that bilingual provision is offered on every health and social care course in Wales. Appropriate consideration is also given to placements and support provided for students to undertake bilingual placements as part of their training. *(Short term)*	Coleg Cymraeg Cenedlaethol to update on the number of undergraduate courses in the areas of health and care. This to include information on health and social care courses where students cannot study one third of the course in Welsh. This data should be provided in line with the recommendations from the Data Mapping and Review Exercise undertaken by Alma Economics.	HEIW / SCW / Coleg Cymraeg Cenedlaethol	NA - HEIW / SCW / Coleg Cymraeg Cenedlaethol Action.	

24	Welsh Government consider what incentives (financial or otherwise) may be offered to students undertaking an element of their course through the medium of Welsh. Incentives are already offered in relation to the Education workforce. *(Short term)*	Welsh Government is collating information on incentives currently available to students including bursaries.	Welsh Government	NA – WG Action.	
25	Consideration is given to expanding the highly successful Doctoriaid Yfory scheme which supports prospective students to apply successfully to medical school, to encompass all health and social care professions where the application process for University study is competitive. More broadly Welsh Government to consider whether such a scheme may assist pupils from deprived backgrounds to apply successfully to study medicine and other subjects. *(Short term)*	The Doctoriaid Yfory Scheme has now been extended to more general health and social care career including dentistry. Welsh Government will consider opportunities for further promoting the scheme. Coleg Cymraeg Cenedlaethol to provide latest data on take up.	Welsh Government / Coleg Cymraeg Cenedlaethol	N/A - Welsh Government / Coleg Cymraeg Cenedlaethol Action.	
26	Every provider of health and social care training in Wales prepares a medium-term plan on developing Welsh language awareness and bilingual skills of their students and submits the plan within 12 months to the relevant commissioning / accrediting / regulatory body. These should include details of	HEIW and Coleg Cymraeg Cenedlaethol to provide an update on work being taken forwards to progress this action.	Welsh Government / Coleg Cymraeg Cenedlaethol / HEIW	NA - Welsh Government / Coleg Cymraeg Cenedlaethol / HEIW Action.	

	the teaching capacity required to deliver bilingual programmes as required. Welsh Government to consider the role Coleg Cymraeg Cenedlaethol could have to review and provide feedback and advice to the relevant bodies on the medium term plans. *(Short term)*				
27	Welsh Government to review the plans developed under Action 30 of the Health and Social Care Workforce Strategy and take appropriate action to support the development of bilingual teaching capacity and where appropriate, provide suitable resources to support these developments. *(Short term)*	**Action 30** of *A Healthier Wales: Our Workforce Strategy for Health and Social Care* is: Strengthen the Welsh language capability of the health and social care workforce, ensuring staff are supported to learn, use and develop their Welsh in the workplace. Health and social care bodies, SCW, Coleg Cymraeg Cenedlaethol and HEIW to provide examples of work they have taken forwards to support this agenda. For health boards, this will include work being taken forwards to support the Health Forum Collaboration.	Welsh Government / SCW / HEIW / Coleg Cymraeg Cenedlaethol / health and social care bodies.	N/A	

28	Coleg Cymraeg Cenedlaethol is tasked with undertaking a review of bilingual provision in health and social care across the FE and apprenticeship sector and making recommendations as appropriate as to further steps required to develop bilingual skills amongst level 2 and 3 learners *(Medium term)*	Coleg Cymraeg Cenedlaethol to provide information on this review and the implementation of recommendations.	Coleg Cymraeg Cenedlaethol	NA - Coleg Cymraeg Cenedlaethol Action.	
Theme 3: Sharing best practice and an enabling approach					
29	We'll collate and share examples of innovative good practice which is accessible across the sector utilising existing portals and hubs including the Research and Innovation Hubs. *(Short term)*	Health and social care bodies should provide examples of where and how they have shared good practice, including internally as well as with other organisations. Health and social care bodies to also provide information on whether they have used Hwb Iaith to share good practice. They should also provide evidence of utilising the Research and Innovation Hubs and explain why if they haven't.	Welsh Government / health and social care bodies	Good practice shared as part of the 'More than just words' newsletter. Quarterly submission from the Health Board to ensure all good practice is shared in a consistent manner.	
30	We'll use our Bilingual Technology Toolkit to ensure	DHCW and health and social care bodies	DHCW / health and social care bodies		

	that when we procure and/or develop new digital services, they will include a bilingual user interface wherever possible. For information and advice websites we'll bring translators closer to content creation, drafting in Welsh and English together, so that we communicate clearly in both languages. *(Short term)*	should provide specific examples of where and how the principles of the Bilingual Toolkit has been used.			
32	We'll ensure that Welsh language Executive Leads and Welsh Language Officers and champions meet nationally to share best practice to ensure a consistent approach on key issues and develop initiatives to celebrate success including promoting More than just words within existing awards and accolade schemes. *(Short term)*	Health and social care bodies to provide information on examples of good practice shared as part of existing networks, awards and events. Welsh Government will also provide an update on the National Stakeholder Event held in October 2025.	Welsh Government, Health and social care bodies	See 29 above.	
33	We'll undertake a survey with primary care providers to understand the impact the Welsh language duties have had in delivering the Active Offer. This will identify best practice and provide advice for Executive Directors of Primary Care to further progress and enhance	Welsh Government will provide the update on this action. Results of the survey carried out in 2024 and supporting qualitative research carried out in	Health Boards and Primary Care Clusters	Primary Care Project Update - a collaboration between Betsi Cadwaladr University Health Board and Fforwm Iaith Môn The joint GP surgeries project	

	services in Welsh, working closely with the clusters *(Medium term)*	2025 and 2026 is due to be published shortly. Health bodies / primary care clusters do not need to provide an update on this action for the 2025/26 report.		between BCUHB and Fforwm Iaith Môn has developed into an important step in trying to understand and improve the Welsh language provision in private surgeries on the island. The aim of the project is to gather feedback from patients and the public about the current situation, creating a solid baseline of the services currently available. The primary care area is not subject to Welsh Language Standards in the same way as Health Boards. However, there are 6 duties that apply to them, which include ensuring that posters and signs are translated. The contribution of the Language Forum has been key to the success of the project so far. Through the	

				circulation of questionnaires to the public, over 50 responses have already been received, and work is underway to analyse these. This work is an example of strong and meaningful collaboration between local partners, ensuring that the voice of the community is central to the process. At the same time, the project is still awaiting responses from the surgeries themselves, which will add to the full picture of the current provision. In addition, the establishment of the Welsh Provision Academy is a significant strategic step. The Academy offers a single central site where all primary care providers—including GP surgeries, dentists, opticians and	

				pharmacists—can access support and resources to strengthen their use of the Welsh language. This support, which is available free of charge from the Health Board, includes the translation of signs and letters, Welsh resource packs, guidance on answering the phone bilingually, as well as access to Welsh learning courses and language awareness sessions. The next step in the development of the project is the launch of the Academy with the participation of a single surgery on Anglesey, laying the foundation for expanding support to other providers in the future. The work to date is testament to the dedication and expertise of the	

				partners, and in particular to the valuable contribution of the Language Forum, which has ensured that the project continues to reflect the needs and ambitions of the local community.	
34	Enable the development of standard Welsh language diagnostic assessments and resources to support Welsh speakers in identified priority areas such as mental health, learning disabilities, and the visually impaired, building on work already underway to develop a nationally available set of standard assessments for Welsh speakers with dementia. *(Long term)*	Welsh Government will provide the update on this action. However – as noted for Action 6: Health and social care bodies are asked to provide evidence of Welsh language care pathways for the priority groups. Welsh Government is currently collating diagnostic assessments and resources that should be available in Welsh.	Welsh Government	N/A – WG Action.	
35	Visual markers not only enable service users to identify Welsh speaking staff but also to convey a message that Welsh is a	Health and social care bodies to update on work being taken forwards to support	Welsh Government / DHCW / health and social care	Staff are provided with the option to have the 'Cymraeg' logo on their uniforms	

	‘normal’ everyday part of service delivery and builds on ethos of belonging. We’ll extend the Iaith Gwaith project across Wales to allow workers who can offer or partially offer services in Welsh to readily identify themselves by wearing Iaith Gwaith badges or lanyards. We’ll also in our ICT systems capture, display and share information that let us know as individuals and staff who can speak Welsh and what services they will be offering in Welsh — so we can use our Welsh with them. (Consideration would need to be given to additional funding / resources to enable this to be delivered.) (*Short term*)	and promote the identification of Welsh speaking staff – including any work in relation to digital systems locally. DHCW to update on work happening at a national level to support this agenda.	bodies	(Nursing and HCSWs).	
36	We’ll continue to improve Welsh language capabilities of national health and social care digital systems and ensure apps being developed such as the NHS Wales App support the vision and actions in this plan. This will include the sharing, recording and tracking of Information between systems including language preference. We’ll also work with service users on all	DHCW to update on actions being taken forward to deliver this commitment. DHCW also to provide data on the numbers accessing / using the Welsh language options in the App, if this is possible.	Welsh Government / DHCW	N/A - Welsh Government / DHCW Action.	

	technical and content processes to make sure they're easy to use and understand in Welsh and English. *(Medium term)*				
37	We'll further develop dictionary resources, high standard terminological corpus, language memory systems and practical tools to support staff to use their Welsh skills, for example Gair i Glaf. This to include in the short-term Welsh language officers and translators working together on collation of terms and translation capacity and capability. *(Short term- joint working on developing standard terms)*	Health and social care bodies and NWSSP to update on work being taken forwards to develop and support the implementation of these resources.	Welsh Government / health and social care bodies / NWSSP	The Translation Team plays a critical strategic role in enabling the Health Board to meet its statutory obligations under the Welsh Language Standards and to strengthen the organisation's wider commitment to delivering equitable, person-centred care. By providing high-quality written translation and interpretation services across all divisions, the team ensures that bilingual communication is embedded as a core operational requirement rather than an adjunct activity. Sustained demand for translation reflects both the increasing	

				visibility of the Welsh language across Health Board functions and the organisation's focus on improving patient experience through accessible, culturally aligned information. The team's robust quality-assurance processes and prioritisation of time-sensitive materials support operational resilience, mitigate compliance risk, and ensure that staff and patients receive accurate information in their preferred language, thereby reinforcing the Health Board's strategic aim of delivering safe, inclusive and legally compliant services. The Health Board continues to generate external income through the provision of specialist	

				Welsh-language translation services. In 2024–2025, the Welsh Language Team entered into a Service Level Agreement with Aneurin Bevan University Health Board to deliver written translation support, reflecting confidence in the team's capability and professional standards. The success of this arrangement led to a renewed agreement in 2025–2026, and both organisations have now confirmed continuation for a third consecutive year in 2026–2027. This sustained partnership demonstrates the high quality, reliability and reputation of the team's work, while contributing valuable recurring income to the Health Board.	

				The team has continued to modernise its operational approach by enhancing the use of Translation Memory technology, which has been embedded in daily workflows for several years. As part of a broader efficiency programme, the team has explored opportunities to further streamline processes, reduce duplication, and accelerate turnaround times for high-volume translation requests. This work has included investment in an upgraded Translation Memory system, 'Wordfast', which offers enhanced functionality, improved consistency controls, and greater capacity to support complex translation tasks. The adoption of this updated software	

				represents a strategic step towards strengthening productivity, supporting demand growth, and ensuring that the Health Board maintains a resilient, high-quality bilingual communication service aligned with statutory and organisational priorities. Urgent translation requests during the reporting period have included press releases, patient correspondence, annual reports, and time-critical public-health information for social media channels. The Translation Team consistently prioritises all public- and patient-facing communications to ensure that essential information is available bilingually within 1–2 working	

				days, and, where capacity permits, within the same working day for high-urgency items. To further safeguard timely bilingual communication, an out-of-hours service remains in place for exceptional circumstances. This provision ensures that critical information can be issued simultaneously in Welsh and English, reinforcing the Health Board's commitment to treating the Welsh language on the basis of equality and maintaining compliance with statutory requirements. The Translation Team continues to offer support in the form of simultaneous translation provided either face-to-face or on the online platforms of 'Zoom'	

				and ‘Microsoft Teams’. Requests were received with the majority requiring interpretation for stakeholder events, meetings and conferences, and interviews for applicants who wish to have their interviews in Welsh.	
38	We’ll work with those who inspect and drive quality improvement to ensure the active offer is part of their brief. We will direct underperforming organisations to support and advice. *(Medium term)*	CIW and HIW to provide information on guidance and training for inspectors to support reporting on Welsh language and culture, and the Active Offer. CIW and HIW to also provide relevant inspection data on compliance/non-compliance with Welsh language requirements.	Regulation and Inspection Bodies (CIW and HIW)		
39	Further develop the mapping of available data provided in Annex A of the framework and identify data gaps that would help measure progress. *(Short term)*	Welsh Government will provide the update on this action. This commitment links directly to Action 5 and the work undertaken	Welsh Government		

		by Alma Economics to map and review data on the Welsh language in health and social care (due to be published shortly).			
40	Using available data where possible, develop indicators that measure progress towards the Active Offer and delivery of bilingual services and identify data gaps that would further help measure progress. *(Develop initial indicators – Short term Identify data gaps – Short term* *Fill data gaps where possible – Medium term)*	Welsh Government will provide the update for this action. This will become possible once the data mapping and review exercise has been published (see Action 5).	Welsh Government		
41	Establish a working group to develop a dashboard that brings together performance data to demonstrate progress on the Active Offer and delivery of bilingual services. This to include data from the local authority performance framework; CIW; HIW; WL Commissioner office; NHS IMTP/ performance reporting. *(Establish working group Short term* *First dashboard publication Medium Term* *Summit to share dashboard with data owners Medium term)*	This will become possible once the data mapping and review exercise has been published (see Action 5).	Welsh Government		

42	All health bodies and local authorities to appoint a person to be responsible for ensuring delivery on the actions and targets set in the plan.	All health bodies and local authorities to list the person responsible for ensuring delivery of the actions.	All health bodies and local authorities	Completed.	
43	More than just words progress monitoring: Provide a written update on progress with actions on a 12 month basis *(First Annual Report – Summer 2023)*	Welsh Government will provide the update on this action.	All accountable organisations listed in this plan	Completed.	
44	Establish an advisory board to monitor and scrutinise progress against the action plan. The advisory Board will make recommendations to the Minister where further progress could be made and any emerging concerns where ambition is not being met. A report will be prepared for Ministerial consideration and shared with health and social care leaders. The advisory board will also consider and advise on audit and evaluation requirements to provide independent assessments on progress. *(Annual advisory report 2023 Advisory report to include reflection on dashboard data from 2025)*	Welsh Government will provide the update on this action. The Advisory Board for Mwy na geiriau has been in place since August 2023.	Welsh Government		
45	Minister to hold annual progress meetings with leaders of organisations listed to deliver	Welsh Government will provide the update on this action.	Welsh Government		

	actions within the plan, including NHS and Local Authorities, to recognise achievements and where further progress is required. Statement on progress to be shared with Senedd Members annually. *(First Annual Progress Meeting – Autumn 2023 First Statement to Senedd Members – Autumn 2023* *From 2025 the progress report to include the performance data dashboard)*				

Completed form to be returned by no later than: 1 September 2026

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

Gwasanaethau'r Gymraeg

Adroddiad Monitro Blynyddol 2025-2026

Awdur: Eleri Hughes-Jones

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Crynodeb Gweithredol

Mae'r adroddiad hwn yn mynd i'r afael â dyletswydd statudol Bwrdd Iechyd Prifysgol Betsi Cadwaladr (y Bwrdd Iechyd) i ddarparu adroddiad blynyddol i Gomisiynydd y Gymraeg ar gydymffurfio â Safonau'r Gymraeg (y Safonau) yn ystod y flwyddyn adrodd.

Mae'r adroddiad yn adlewyrchu'r gofynion a'r cynnwys fel y'i nodir yn Safon 120 y Safonau:

- Cwynion
- Cynllunio'r Gweithlu
- Recriwtio
- Sgiliau Iaith
- Hyfforddiant i wella sgiliau iaith yn y Gymraeg

Mae'r adroddiad hwn hefyd yn mynd i'r afael â chydymffurfiaeth â chynllun pum mlynedd Llywodraeth Cymru, 'Mwy na geiriau'. Darperir trosolwg o'r cynnydd, gan gynnwys datblygiadau gwasanaeth a'r prif gyflawniadau yn ystod y cyfnod o fis Ebrill 2025 hyd at fis Mawrth 2026.

Yr hyn sydd wedi'i gyflawni

Wrth werthuso'r sefyllfa bresennol yn erbyn yr amcanion a osodwyd yn ystod y flwyddyn adrodd, mae'r Bwrdd Iechyd wedi cyflawni ei nodau.

Mae rhai o'r cyflawniadau allweddol hyn yn cynnwys:

- gwell cydymffurfiaeth statudol trwy ddilyn dulliau hunanasesu dwys a chynhwysfawr;
- cyflwyno cynllun ymgynghoriadau clinigol Safon 110 er mwyn gwella capasiti i gyflwyno ymgynghoriadau yn Gymraeg;
- gwell cydymffurfiaeth yn gyffredinol wrth greu hunaniaeth gorfforaethol ddwyieithog ac amlygu'r Gymraeg;
- cynnydd yn nifer y bobl sy'n mynychu hyfforddiant iaith Gymraeg, yn ogystal â bodloni'r holl dargedau hyfforddi a sefydlwyd gyda'r Ganolfan Dysgu Cymraeg Genedlaethol fel rhan o Gytundeb 'Cymraeg Gwaith' 2024-2025 er mwyn sicrhau parhad y gefnogaeth ariannol;
- wedi ehangu partneriaethau â phrifysgolion a gweithluoedd ar gyfer y dyfodol, gan gynnig sesiynau ymwybyddiaeth o'r Gymraeg i ddarpar weithwyr gofal iechyd proffesiynol ym Mhrifysgol Wrecsam, Ysgol Feddygol Gogledd Cymru, ac mewn ysgolion amrywiol ar draws Gogledd Cymru;
- cynnal gweithgareddau a digwyddiadau ymgysylltu llwyddiannus er mwyn hybu'r Gymraeg a gwella ei gweledigaeth;

Bydd yr adroddiad yn manylu ar yr hyn a gyflawnwyd a sut yr aethpwyd ati i'w gyflawni.

Nid yn unig y mae'r cyflawniadau sydd wedi'u sicrhau dros y flwyddyn ddiwethaf yn gerrig milltir sefydliadol - maent yn gwneud gwahaniaeth ystyrlon i brofiadau cleifion a theuluoedd ar draws Gogledd Cymru. Mae'r straeon cleifion a ganlyn yn amlinellu sut mae'r camau gweithredu'n cael eu cyflawni, a'u profi, ar lefel sylfaenol.

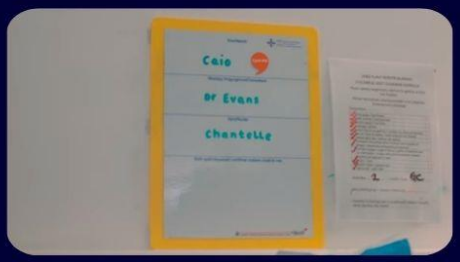
Dod â Straeon Cleifion yn Fyw

Eleni, cawsom y cyfle i rannu dwy stori bositif gan gleifion yn ymwneud â'r Gymraeg, un o'r Adran Strôc yn Ysbyty Cymuned Glannau Dyfrdwy a'r llall o Ward y Plant yn Ysbyty Glan Clwyd.

Roedd y stori gyntaf yr oeddem wedi'i rhannu'n tynnu sylw at effaith ddwys clywed y Gymraeg yn dilyn strôc. Ni allai'r gŵr dan sylw gyfathrebu yn ei sgil a arweiniodd ato'n teimlo'n fwyfwy rhwystredig. Gwnaeth ei wyres ddisgrifio'r ymdeimlad o ryddhad roedd y teulu'n ei deimlo pan wnaeth aelodau o staff yn Ysbyty Glannau Dyfrdwy siarad Cymraeg. Esboniodd ei fod, nid yn unig, wedi rhoi cysur a sicrwydd iddyn nhw fel teulu, ond ei fod hefyd wedi cael effaith bositif aruthrol ar ei daid. Roedd gweld ei ymateb pan glywodd y Gymraeg am y tro cyntaf ers ei strôc yn wefreiddiol, 'roedd ei lygaid yn disgleirio", gan ddangos y cysylltiad pwerus rhwng iaith a gofal.

Gwnaethom rannu sut mae staff yn Ysbyty Cymuned Glannau Dyfrdwy yn rhoi cymorth i gleifion sy'n medru'r Gymraeg trwy eu paru â staff Cymraeg eu hiaith lle bynnag y bo'n bosibl, gan ddefnyddio geiriau ac ymadroddion Cymraeg mewn rhyngweithiadau o ddydd i ddydd, ac yn sicrhau bod yr iaith yn cael ei chlywed ar y ward. Mae staff yn gweld o lygad y ffynnon sut mae clywed y Gymraeg yn rhoi cysur, sicrwydd ac eglurder, gan helpu cleifion i deimlo'n fwy cyfforddus yn ystod yr hyn sy'n gallu bod yn adeg hynod heriol.

Roedd y stori arall yn canolbwyntio ar Cai, sef bachgen bach y cafodd ei brofiad o dderbyn diagnosis o ddiabetes ei esmwytho a'i hwyluso wrth i staff gyfathrebu ag ef a'i deulu yn Gymraeg ar Ward y Plant yn Ysbyty Glan Clwyd. Gwnaeth hyn dynnu sylw at yr effaith bositif y gall gofal a gynigir yn newis iaith y claf ei chael o ran rhoi tawelwch meddwl i'r claf a'r teulu yn ystod yr hynny a allai fod wedi bod yn gyfnod hynod heriol.



Tra bu ar y ward, cafodd dewis iaith Cai (Cymraeg) ei nodi'n glir yn ei nodiadau meddygol ac uwchben ei wely gan ddefnyddio magnet oren 'Cymraeg'. Roedd hyn wedi gwneud y profiad cyfan yn haws o lawer, gan fod holl staff y ward yn ymwybodol ei bod yn well gan Cai a'i deulu gyfathrebu yn Gymraeg. Gwnaeth hyn chwalu'r pwysau sydd ynghlwm wrth orfod gofyn am ofal yn Gymraeg dro ar ôl tro ac roedd yn fodd o sicrhau y gellid esbonio gwybodaeth yn ymwneud â'i ddiagnosis diabetes yn eu hiaith gyntaf, gan ei gwneud yn haws ei ddeall a'i amgyffred yn ystod cyfnod heriol.

Cafodd y Bwrdd Iechyd ei ddethol gan Lywodraeth Cymru fel y ffocws ar gyfer dau arolwg byr yn arddangos y fframwaith Mwy na Geiriau yn ymarferol. I'w gweld, cliciwch yma

Cefndir a Model Gwasanaeth

Yn ogystal ag adlewyrchu cynnydd y Bwrdd Iechyd o ran gofynion Safon 120, mae'r adroddiad hwn hefyd yn dangos sut y cynlluniwyd y gwasanaeth i fynd i'r afael ag anghenion y boblogaeth.

Mae Tîm y Gymraeg yn y Bwrdd Iechyd wedi'i strwythuro i sicrhau bod ei ffrydiau gwaith yn darparu'r mecanweithiau cymorth angenrheidiol sy'n ofynnol i brif ffrydio gofynion iaith wrth gynllunio gwasanaethau. Mae hefyd yn darparu rhwydwaith o gefnogaeth ar lefel weithredol i sicrhau bod yr holl ohebiaeth ysgrifenedig yn cael ei darparu'n ddwyieithog, a bod strwythur ar waith i ddatblygu'r gweithlu i wella eu sgiliau iaith.

Mae'n cynnwys pedwar gwasanaeth sy'n cefnogi'r sefydliad i gyflawni gofynion deddfwriaethol ac i fynd i'r afael ag anghenion cleifion.

1. Cydymffurfio â Deddfwriaeth
   Sicrhau bod y sefydliad yn cael cymorth i gyflawni ei rwymedigaethau o dan Fesur y Gymraeg (Cymru) 2011.

2. Hybu ac Ymgysylltu
   Yn unol ag elfennau gweithredol cyflawni'r cynllun pum mlynedd 'Mwy na geiriau', mae gwasanaethau'n cael cymorth rhagweithiol, a chaiff prosiectau a chynlluniau eu lansio i wella dealltwriaeth ac ymwybyddiaeth o ddiwylliant, a'r effaith ar ofal cleifion.

3. Darpariaeth Hyfforddiant
   Mae Rhaglen Hyfforddiant y Gymraeg wedi'i theilwra i fynd i'r afael â gofynion gwasanaethau amrywiol, ynghyd â chefnogaeth ychwanegol a ddarperir gan y Ganolfan Dysgu Cymraeg Genedlaethol gyda'r cytundeb 'Cymraeg Gwaith' a ariennir gan Lywodraeth Cymru.

4. Gwasanaethau Cyfieithu
   Mae'r Tîm Cyfieithu'n sicrhau bod y sefydliad yn gallu darparu gwybodaeth ar gyfer cleifion yn eu dewis iaith, ac maent hefyd yn cyfieithu ar y pryd er mwyn hwyluso dewis iaith mewn lleoliadau clinigol a chorfforaethol.

Llywodraethu a Hunanreoleiddio

Ceir atebolrwydd strwythurol drwy Fforwm Strategol y Gymraeg (y Fforwm Strategol), a gadeirir gan y Cyfarwyddwr Gweithredol, ac mae Cadeirydd y Bwrdd Iechyd wedi'i benodi'n Bencampwr y Gymraeg ar lefel y Bwrdd. Y Fforwm Strategol sy'n gosod y trefniadau llywodraethu mewnol. Mae'r Cylch Gorchwyl yn llywio'r dulliau strategol, ac mae'r aelodaeth yn cynnwys uwch arweinwyr ac arweinwyr gweithredol sy'n gallu hybu'r gofynion. Mae llwybr craffu ar gyfer uwchgyfeirio unrhyw faterion o bwys i'r Pwyllgor Pobl a Diwylliant, yn ogystal ag adrodd yn flynyddol i'r Bwrdd ar gydymffurfiaeth a chyflawniadau.

Cofrestr Risg Gwasanaethau'r Gymraeg

Mae'n hanfodol bod y Bwrdd Iechyd yn cydnabod meysydd risg posibl mewn perthynas â'r Gymraeg a bod Cofrestr Risg bwrpasol ar waith. Mae'r risgiau presennol yn cynnwys bodloni gofynion Mesur y Gymraeg (Cymru) 2011, rhoi egwyddor y "Cynnig Rhagweithiol" ar waith yn unol â 'Mwy na Geiriau', a chyflawni 'Polisi a Gweithdrefn Sgiliau Dwyieithog'.

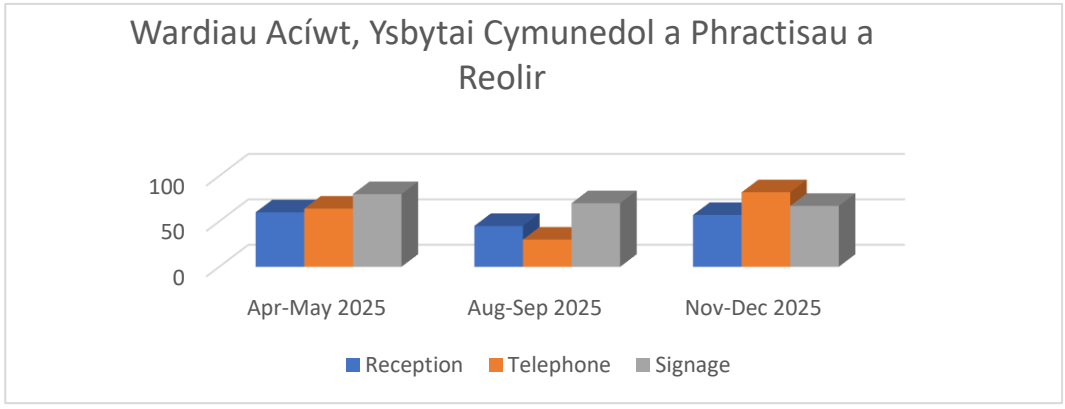
Adolygwyd yr holl risgiau yn ystod 2025-2026, a graddiwyd pob un o'r tair sgôr risg fel rhai cymedrol neu fach. Wrth asesu'r sefyllfa bresennol, nid oedd angen uwchgyfeirio unrhyw risgiau.

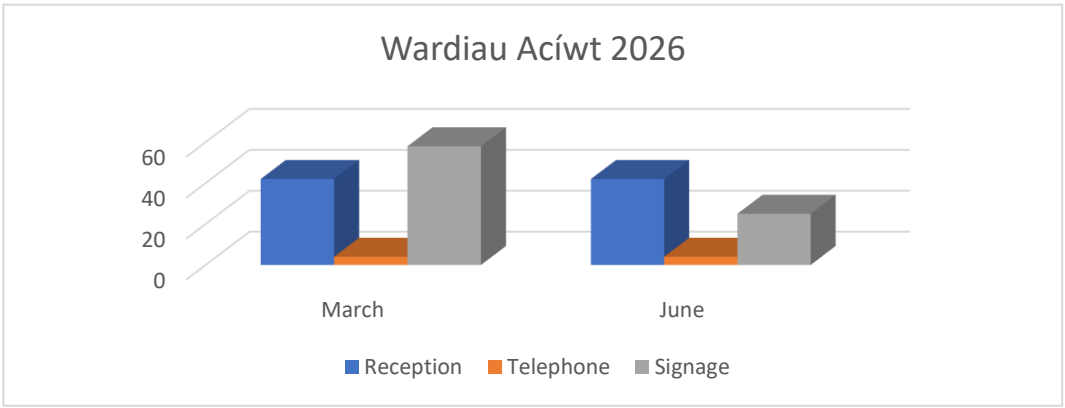
Caiff Cofrestr Risg Gwasanaethau Cymraeg ei monitro bob chwarter, ac adroddir arni ddwywaith y flwyddyn i Fforwm Strategol y Gymraeg.

Sicrwydd Perfformiad Mewnol

Gwnaeth dull hunanreoleiddio'r Bwrdd Iechyd barhau gyda Rhaglen Monitro Siopwr Cudd gyda'r nod o roi sicrwydd cryf o ymrwymiad y sefydliad i gynnig gwasanaethau Cymraeg o ansawdd uchel a chynnal cydymffurfiaeth â Safonau'r Gymraeg. Cadarnhaodd gwaith monitro safonau fod arwyddion Cymraeg yn parhau i fod yn gryfder sylweddol gan y sefydliad, yn cynnwys lefelau cydymffurfio sy'n gyson uchel ar draws safleoedd, gan ddangos ymrwymiad cyson i amgylchedd dwyieithog gweladwy a hygyrch.

Roedd y rhaglen hefyd yn cynnig mewnwelediad gwerthfawr i feysydd lle gellid targedu gwelliannau pellach, yn enwedig rhyngweithiadau wrth dderbynfeydd, cyswllt dros y ffôn, a gweledded y "Cynnig Rhagweithiol".





Mae'n rhaid ystyried sgoriau is o ran wardiau acíwt yn eu cyd-destun gan mai staff clinigol, yn hytrach na thimau derbynfa pwrpasol, sy'n delio â rhyngweithiadau pwynt cyswllt cyntaf yn aml gan flaenoriaethu gofal uniongyrchol i gleifion. Mae'r realiti gweithredol hwn yn esbonio rhywfaint o amrywiadau ac mae'n tynnu sylw at yr heriau unigryw sydd ynghlwm wrth gynnig cyfathrebiadau dwyieithog cyson mewn lleoliadau clinigol prysur.

Ar y cyfan, mae'r rhaglen wedi atgyfnerthu dealltwriaeth y Bwrdd Iechyd am ble y bydd cymorth wedi'i dargedu'n cael yr effaith fwyaf. Mae'r rhaglen monitro'n dangos bod gan y Bwrdd Iechyd drefniadau cadarn ar waith i asesu darpariaeth gwasanaeth Cymraeg a nodi meysydd ar gyfer gwella. Mae perfformiad cadarn o ran cydymffurfiaeth ag arwyddion yn darparu tystiolaeth o ymrwymiad parhaus i Safonau'r Gymraeg, er bod y canfyddiadau o leoliadau wardiau acíwt wedi cynnig mewnwelediadau gwerthfawr i'r heriau sy'n codi o fewn amgylcheddau clinigol. Bydd y sefydliad yn defnyddio'r adnoddau hyn i atgyfnerthu ymwybyddiaeth, gwella cysondeb o ran darpariaeth gwasanaeth a gwella gweledd y "Cynnig Rhagweithiol" yn ystod 2026-27, gan sicrhau bod cleifion sy'n medru'r Gymraeg yn parhau i dderbyn profiad mwyfwy cadarnhaol wrth fanteisio ar wasanaethau.

Safonau'r Gymraeg

Mae Safonau'r Gymraeg (y Safonau) ar waith ers y dyddiad gweithredu, sef 30 Mai 2019. Bu cynnydd sylweddol o ran bwrw ymlaen â gweithredu'r Safonau, monitro cydymffurfiaeth a rhoi cyfarwyddyd ar draws y sefydliad.

Monitro Cydymffurfiaeth

Mae gweithgarwch monitro o ran y Safonau yn mynd rhagddo'n dda ar draws y sefydliad. Mae nifer o Uwch Adrannau bellach wedi cwblhau ail gylch adolygu, sy'n caniatáu mesur gwelliannau'n glir o'r llinell sylfaen wreiddiol. Yn nodedig, mae Cymuned Iechyd Integredig y Dwyrain wedi dangos cynnydd sylweddol ers y rownd gyntaf, wedi'i ategu gan roi ystod eang o gamau unioni effeithiol ar waith.

Mae'r enghraifft isod yn tynnu sylw at y gwelliannau sydd wedi'u cyflawni yng Ngwasanaethau Plant yn y Dwyrain, gan ddangos sut mae camau gweithredu wedi'u targedu'n arwain at newid ystyrlon a pharhaus.

Cafodd Adroddiad Cryno o Gynnydd ei ddatblygu ar gyfer Gwasanaethau Plant, yn cymharu canfyddiadau'r gwaith monitro cychwynnol yn 2024-2025 â'r cynnydd dilynol yn ystod 2025-2026. Gwnaeth y sefyllfa gyffredinol nodi'r canlynol:

- gwelliannau sylweddol o ran cydymffurfiaeth ar draws yr holl safonau
- bod y rhan fwyaf o safonau bellach yn cydymffurfio'n llawn neu eu bod bron â bod yn cydymffurfio'n llawn

Lefel Gydymffurfiaeth	2024-2025	2025-2026
cydymffurfiaeth o ≥90%	71	107
cydymffurfiaeth o ≥70%	16	2
cydymffurfiaeth o ≥50%	14	1

Cafwyd newid amlwg o **gydymffurfiaeth gymysg** i **gydymffurfiaeth a oedd yn uchel yn gyson,** a gwelwyd y gwelliannau allweddol yn y meysydd a ganlyn:

1. **Teleffoni**
   - Gwelliant mawr o ran cynnig gwasanaethau yn y Gymraeg dros y ffôn
   - Cyflwynwyd Gweithdrefnau Gweithredu Safonol, cyhoeddwyd arweiniad i staff a rhoddwyd hapwiriadau ar waith
   - Symudodd statws Safon 9, sy'n ymwneud â rhoi gwybod i alwr bod gwasanaeth Cymraeg ar gael, o beidio â chydymffurfio i gydymffurfio'n llwyr

2. **Cofnodi Dewis Iaith**
   - Mae hyn bellach yn cael ei gofnodi fel mater o drefn trwy WPAS a ffurflenni cyfeirio
   - Dosbarthwyd nodiadau atgoffa i staff ac ymgorfforwyd proses briodol
   - Newid o ddull anghyson i ddull systematig

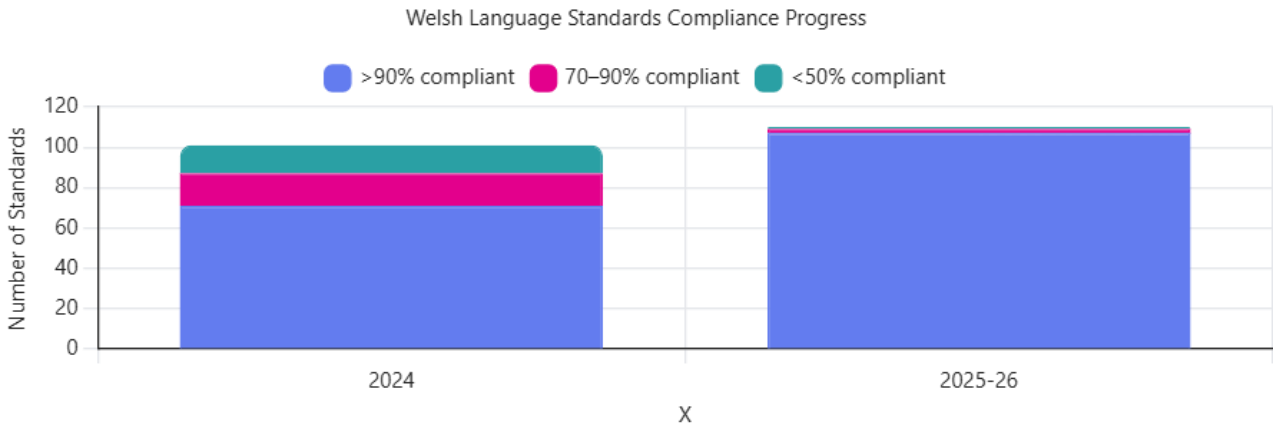
3. **Cyfarfodydd ac Ymgysylltu**
   - Gofynnir am ddewis iaith ar gyfer cyfarfodydd fel mater o drefn erbyn hyn
   - Cynllunio darpariaeth gyfieithu'n rhagweithiol
   - Mae meysydd nad oeddent yn cydymffurfio'n flaenorol yn cydymffurfio'n llwyr erbyn hyn

4. **Dogfennau a Ffurflenni**
   - Mae dogfennau allweddol bellach ar gael yn Gymraeg fel mater o drefn
   - Mae ffurflenni cyswllt brys wedi cael eu cyfieithu'n llawn ac maent yn cael eu defnyddio bellach
   - Y broses o newid rhwng y cam datblygu a gweithredu'n llawn

5. **Derbynfeydd a Gwasanaethau ar gyfer y Cyhoedd**
   - Mae arwyddion a bathodynnau Cymraeg yn eu lle erbyn hyn
   - Mae gweledegd a mynediad staff i'r Gymraeg wedi gwella
   - Yn cydymffurfio'n llwyr yn y meysydd gwasanaeth hyn

6. **Hyrwyddo Gwasanaethau Cymraeg**
   - Hyrwyddo gwasanaethau'n glir fel rhai sydd ar gael yn Gymraeg
   - Gwybodaeth sydd ar gael yn ddwyieithog yn gyson ar draws platfformau

Mae hyn yn dangos bod ymdrechion sylweddol wedi cael eu gwneud ar draws yr holl feysydd a gellir gweld hyn yn y siart cynnydd ar gydymffurfiaeth isod:



Mae hyn yn dangos bod gweithgarwch monitro parhaus wedi arwain at welliannau nodedig o ran cydymffurfiaeth â Safonau'r Gymraeg, ac mae nifer o feysydd bellach yn dangos cydymffurfiaeth gryfach a mwy cyson. Mae'r gydymffurfiaeth gynyddol hon eisoes yn cael effaith bositif a sylweddol ar brofiad cleifion, yn enwedig trwy argaeledd cynyddol o gyfathrebu yn Gymraeg a gwasanaethau sy'n fwy ymatebol ac sydd wedi'u halinio ar lefel ddiwylliannol.

Mae'r datblygiadau hyn yn amlinellu sut mae monitro systematig nid yn unig yn ategu cydymffurfiaeth statudol ond hefyd yn arwain at fuddion ystyrlon i gleifion a chymunedau ar draws ein gwasanaethau.

Cynyddu capasiti'r Bwrdd Iechyd i ddarparu gwasanaethau yn y Gymraeg yn unol â Safon 110

Yn ystod y cyfnod adrodd, dechreuodd ail flwyddyn y rhaglen pum mlynedd i wella cydymffurfiaeth â Safon 110. Mae Safon 110 yn ei gwneud yn ofynnol i Fyrddau Iechyd gyhoeddi cynllun ar gyfer pob cyfnod pum mlynedd yn amlinellu i ba raddau y maent yn gallu cynnal ymgynghoriad clinigol yn Gymraeg, a'r camau gweithredu arfaethedig er mwyn gwella'r gallu i wneud hynny.

Roedd gweithgarwch eleni'n canolbwyntio ar ddatblygu Pecyn Offer y "Cynnig Rhagweithiol" cynhwysfawr sydd â'r bwriad o gynorthwyo wardiau, adrannau a gwasanaethau i gynnig gofal yn y Gymraeg yn gyson i gleifion. Mae'r pecyn offer yn cynnwys deunydd gweledol megis magnetau oren i'w gosod uwchben gwely claf, sticeri a bathodynnau, ochr yn ochr â phosteri, taflen wybodaeth ac arweiniad ar roi 'Cynllun Cyfeillio' ar waith.

Mae'r pecyn offer eisoes wedi cael ei gyflwyno i'r Tîm Strôc yn Ysbyty Cymuned Glannau Dyfrdwy, sydd wedi'i nodi fel safle'r peilot. Mae ymgysylltu â staff wedi bod yn hynod bositif, ac mae'r tîm yn dangos ymrwymiad cryf i ddiwallu anghenion ieithyddol cleifion ochr yn ochr â'u gofynion clinigol.

Mae ymgysylltu ag uwch arweinwyr clinigol wedi parhau i atgyfnerthu ymwybyddiaeth yn y sefydliad o Safon 110. Cafodd cyflwyniadau eu rhoi i gyfarfod yr Uwch Nyrsys a'r Uwch Dîm Arwain ym maes Deieteg, yn amlinellu'r cynllun pum mlynedd ac yn atgyfnerthu disgwyliadau'n ymwneud â chydymffurfiaeth â Safonau'r Gymraeg.

Mae trafodaethau archwilio cynnar hefyd wedi cael eu cynnal gyda Meddyg Ymgynghorol ym maes Gofal yr Henoed yn Ysbyty Gwynedd ynghylch dichonoldeb cofnodi p'un a yw ymgynghoriadau clinigol yn cael eu cynnig yn rhagweithiol yn Gymraeg. Er bod y cysyniad wedi cael croeso cynnes, nodwyd heriau ymarferol, yn enwedig o ystyried y gyfran fawr o gleifion sy'n medru'r Gymraeg a'r cyfaint cynyddol o ddogfennaeth glinigol orfodol.

Unwaith eto, gwnaeth Tîm y Gymraeg roi cymorth i'r Tîm Dementia yn Ysbyty Gwynedd o ran hyrwyddo'r "Cynnig Rhagweithiol". Mae'r Tîm Dementia yn parhau i hyrwyddo pwysigrwydd cynnig gofal yn y Gymraeg i gleifion sy'n agored i niwed, a chafodd gwybodaeth ei harddangos i staff a'r cyhoedd gan dynnu sylw at rôl hollbwysig yr iaith o ran cynnig gofal sy'n ddiogel ac sy'n canolbwyntio ar yr unigolyn i bobl sy'n byw gyda dementia.

Gweithdrefnau Gweithredu Safonol

Cynhyrchwyd Gweithdrefnau Gweithredu Safonol (SOP) i gyd-fynd â Safonau penodol, gan ddarparu canllawiau manwl i staff er mwyn sicrhau dealltwriaeth a chydymffurfiaeth gywir. Gwnaeth datblygu'r Gweithdrefnau Gweithredu Safonol flaenoriaethu meysydd o bryder a amlygwyd naill ai gan bryderon allanol neu drwy drefniadau monitro.

Lluniwyd Gweithdrefnau Gweithredu Safonol ar gyfer y canlynol:

- Gohebu â'r cyhoedd (Safon 7)
- Ateb y ffôn (Safonau 8, 9 a 10)
- Cyfarfodydd nad ydynt ar agor i'r cyhoedd (Safonau 21, 22, 22a a 22ch)
- Cynnal Cynadleddau Achos yn Gymraeg (Safon 25)
- Gwasanaethau Derbynfa (Safonau 50, 52 a 53)
- Asesu'r angen i gynnig cyrsiau yn Gymraeg (Safon 63)
- Trefnu Cyfweliadau (Safon 108)
- Canllawiau Cyfieithu (Cydymffurfiaeth Gyffredinol â'r Safonau)

Cyhoeddwyd pob SOP ar 'BetsiNet', sef safle mewnrwyd y Bwrdd Iechyd. Bydd gwaith yn parhau yn ystod y flwyddyn adrodd nesaf i greu rhagor o weithdrefnau gweithredu safonol i gynnwys yr holl Safonau.

Gweithdrefnau ar gyfer Cwynion

Gwnaeth Comisiynydd y Gymraeg ymgymryd â Thrywydd Ymholi i weithdrefnau cwyno'r sefydliad ddiwedd 2025. Pwrpas yr ymarfer hwn oedd asesu effeithiolrwydd sefydliadau o ran derbyn, rheoli a dysgu gan gwynion yn ymwneud â'r Gymraeg.

Fel cyrff sy'n ddarostyngedig i Safonau'r Gymraeg, mae'n ofynnol i sefydliadau gadw at brosesau penodol o dan y safonau atodol at ddibenion cofnodi ymatebion o'r fath ac ymateb iddynt. Nod y Trywydd Ymholi oedd gwerthuso cadernid y trefniadau hyn, canfod arfer da, tynnu sylw at feysydd lle bo angen gwelliant, a chynnig argymhellion er mwyn atgyfnerthu cydymffurfiaeth.

Mewn ymateb i ganfyddiadau'r Comisiynydd, mae'r Bwrdd Iechyd wedi cymryd camau i wella gweledegd a hygyrchedd gwybodaeth sy'n ymwneud â chwynion ynghylch y Gymraeg. Mae'r cynnwys diweddaraf wedi'i gyhoeddi ar wefan y Bwrdd Iechyd, ar dudalennau tîm y Gymraeg ac ar dudalennau'r Gwasanaeth Ymholiadau a Datrysiadau Pobl. Mae'r wybodaeth hon yn amlinellu'r llwybrau sydd ar gael yn glir yn ymwneud â chodi pryderon ynghylch darparu gwasanaethau dwyieithog a chydymffurfio â Safonau'r Gymraeg.

I ategu dysgu sefydliadol a gwella parhaus, mae cwynion ynghylch y Gymraeg bellach wedi'u sefydlu fel eitem sefydlog ar yr agenda yn y Grŵp Sicrwydd Rheoleiddiol. Mae hyn yn sicrhau bod

craffu'n digwydd ar lefel uwch yn rheolaidd ac mae'n hybu arolygu cyson o ran cydymffurfiaeth, themâu sy'n deillio o gwynion, a chyfleoedd i wella gwasanaethau.

Ar y cyfan, mae'r cyfnod adrodd yn adlewyrchu blwyddyn o gynnydd sylweddol o ran atgyfnerthu cydymffurfiaeth â Safonau'r Gymraeg ac ymgorffori arfer dwyieithog ar draws y sefydliad. Mae gweithgarwch monitro wedi arwain at welliannau mesuradwy, gyda newid amlwg o gydymffurfiaeth gymysg i berfformiad sy'n uchel yn gyson ar draws meysydd safonol.

Gyda'i gilydd, mae'r cyflawniadau hyn yn dangos bod y Bwrdd Iechyd yn bodloni ei gyfrifoldebau statudol ochr yn ochr â gwella ei gapasiti'n raddol i gynnig gofal diogel sy'n canolbwyntio ar yr unigolyn yn Gymraeg, gan sicrhau bod cleifion yn profi buddion gwell cyfathrebu'n ddwyieithog a gwasanaethau sydd wedi'u halinio'n ddwyieithog ar draws Gogledd Cymru.

Rhaglen Datblygu'r Gweithlu

Mae Tîm Hyfforddiant Cymraeg y Bwrdd Iechyd wedi parhau i wneud cynnydd sylweddol o ran datblygu gweithlu hyderus a dwyieithog trwy gyflawni rhaglen gynhwysfawr ar gyfer dysgu'r Gymraeg wedi'i theilwra i anghenion y sefydliad.

Yn ystod y flwyddyn adrodd, gwnaeth mwy na 1,000 o aelodau o staff gymryd rhan mewn hyfforddiant y Gymraeg, sy'n cynrychioli cynnydd o 4 y cant o gymharu â 2024-25. Mae'r duedd ar i fyny hon yn adlewyrchu'r ymrwymiad cryf a chynyddol ymysg staff i ddatblygu eu sgiliau yn y Gymraeg ac i'w cymhwyso'n ymarferol er mwyn gwella ansawdd, diogelwch a phriodoldeb diwylliannol gwasanaethau a ddarperir ar gyfer cleifion ledled Gogledd Cymru.

Mae'r Tîm wedi mabwysiadu dull rhagweithiol a strategol er mwyn sicrhau bod darpariaeth ddysgu'n cydfynd â gofynion deddfwriaethol a blaenoriaethau'r sefydliad. Mae asesiadau rheolaidd o anghenion dysgu ar draws gwasanaethau wedi caniatáu datblygu cyrsiau wedi'u targedu ar gyfer staff y rheng flaen, gan sicrhau bod grwpiau blaenoriaethol yn derbyn cymorth penodol er mwyn atgyfnerthu capasiti'r Bwrdd Iechyd i gynnig gofal dwyieithog o ansawdd uchel.

Mae'r dull hwn wedi cael ei atgyfnerthu trwy weithio mewn partneriaeth yn barhaus â chyrff cenedlaethol. Gwnaeth y Bwrdd Iechyd adnewyddu ei gontract deuddeg mis gyda'r Ganolfan Dysgu Cymraeg Genedlaethol o dan gynllun *Cymraeg Gwaith* a ariennir gan Lywodraeth Cymru, gan sicrhau parhad darpariaeth, cydweithio a chadw Swyddog Cefnogi'r Gymraeg yn ei swydd. Dros y flwyddyn ddiwethaf, gwnaeth 798 o aelodau o staff fanteisio ar gyrsiau *Cymraeg Gwaith*, gan ehangu galluoedd dwyieithog y sefydliad ymhellach.

Un o'r prif ddatblygiadau fu cyflwyno cynllun hyfforddi *Codi Hyder / Building Confidence*, a gyflwynir mewn partneriaeth â'r Ganolfan Dysgu Cymraeg Genedlaethol. Mae'r Bwrdd Iechyd wedi gweithio'n agos gyda'r Ganolfan i gynnal cynllun peilot o raglen bwrpasol o fewn yr Uwch Adran Iechyd Meddwl ac Anableddau Dysgu (MHLD), sydd â'r nod o atgyfnerthu sgiliau yn y Gymraeg ac o ategu uchelgais 'Mwy na Geiriau' i wella darpariaeth gwasanaeth dwyieithog. Disgwylir i'r fenter arloesol hon gynyddu nifer y staff sy'n hyderus o ran siarad Cymraeg ym maes MHLD, gan sicrhau bod cleifion yn derbyn gwasanaeth dwyieithog gwell ac sy'n alinio ar lefel ddiwylliannol.

Ar y cyd, mae'r datblygiadau hyn yn dangos ymrwymiad parhaus y Bwrdd Iechyd i feithrin gweithlu dwyieithog ar gyfer y dyfodol ac i sicrhau bod galluoedd yn y Gymraeg yn parhau i fod yn elfen graidd o ofal o ansawdd uchel, sy'n canolbwyntio ar yr unigolyn.

Cynhaliwyd noson Gwobr Dysgwr y Flwyddyn yn y Bwrdd Iechyd eleni, ac mae'n gyfle pwysig, nid yn unig i ddathlu cyflawniadau ein dysgwyr ac i gydnabod eu hymroddiad i ddatblygu sgiliau yn y Gymraeg, ond hefyd i ddangos arweinyddiaeth y Bwrdd Iechyd yn y maes hwn ar draws y sector cyhoeddus yng Nghymru. Mae'r digwyddiad yn tynnu sylw at y ffordd y mae ein hymrwymiad i alluoedd dwyieithog yn gosod esiampl gadarn yn genedlaethol ac mae'n dangos buddsoddiad parhaus y sefydliad o ran meithrin gweithlu sy'n hyderus, sy'n fedrus ac sydd wedi'i alinio'n ddiwylliannol.

Mae'r adrannau canlynol yn rhoi trosolwg ar y digwyddiad eleni, yn taflu goleuni ar y dathliadau, y cyflawniadau a gydnabuwyd ar y noson ac effaith ehangach buddsoddiad parhaus y Bwrdd Iechyd o ran datblygu'r Gymraeg.

Dadansoddi Data Darpariaeth Hyfforddiant y Gymraeg

Gwnaeth BIPBC adnewyddu contract 12 mis gyda'r Ganolfan Dysgu Cymraeg Genedlaethol. Roedd 798 o aelodau o staff wedi manteisio ar gyrsiau 'Cymraeg Gwaith', gan gynnwys hunanastudio, cyfleoedd dysgu preswyl a magu hyder.

Gwnaeth 238 o aelodau o staff gymryd rhan yn y 'Cwrs Croeso/Welcome Course' newydd ei lansio, a gafodd ei ddatblygu mewn ymateb i'r amcanion a amlinellir yng nghynllun pum mlynedd Mwy na Geiriau / More than Just Words Llywodraeth Cymru.

Gwnaeth y tiwtor mewnol roi cymorth i dros 230 o aelodau o staff gyda dysgu Cymraeg yn ystod y flwyddyn, gan nodi cynnydd o 17.5% ers 2024-25. Yn galonogol, gwnaeth mwy na 70% o gyfranogwyr ddewis parhau â'u hastudiaethau Cymraeg ar ôl cwblhau cwrs.

Gwnaeth 42 o aelodau o staff ddilyn cyrsiau dwys pum niwrnod yn Nant Gwrtheyrn, a gwnaeth pedwar aelod o staff ddilyn cwrs a oedd wedi'i gynllunio'n benodol ar gyfer staff o dramor a gwnaeth 12 aelod o staff ddilyn cyrsia

Gwnaeth enillydd gwobr PBC Dysgwr y Flwyddyn '24, Leanne Parry, gyrraedd y rownd derfynol yng nghystadleuaeth fawreddog Dysgwr y Flwyddyn yn yr Eisteddfod Genedlaethol. Gwnaeth y tîm drefnu gwibdaith i'r Eisteddfod ar gyfer dysgwyr Cymraeg er mwyn cefnogi Leanne.

Mae grŵp Facebook 'Y Gymraeg yn Betsi' yn parhau i arddangos enghreifftiau o arfer da a straeon am lwyddiant, ac mae 593 o ddilynwyr ar hyn o bryd, sy'n gynnydd o 22% ers Ebrill 2025.

Cystadleuaeth Dysgwr y Flwyddyn y Bwrdd Iechyd 2026

Mae Cystadleuaeth Dysgwr y Flwyddyn y Bwrdd Iechyd yn parhau i gyflawni rôl sylweddol o ran ategu ymrwymiad y Bwrdd Iechyd i ddatblygu gweithlu dwyieithog a gwella gwasanaethau ar gyfer cleifion sy'n siarad Cymraeg a chymunedau ar draws Gogledd Cymru.

Eleni, derbyniwyd dros 50 o enwebiadau ar gyfer y gystadleuaeth gan staff ar draws y sefydliad, gan ddangos ymgysylltu cryf â dysgu Cymraeg a chan adlewyrchu pwysigrwydd cynyddol sgiliau dwyieithog o fewn darpariaeth gofal iechyd. Yn dilyn proses beirniadu cadarn, cyrhaeddodd chwech y rhestr fer ar draws dau gategori: Lefel Mynediad/Sylfaen a Lefel Canolradd/Uwch.

Gwnaeth y seremoni wobrwyo, a gynhaliwyd yng ngwesty Kinmel Hotel, Abergele, ddathlu cyflawniadau dysgwyr yn llwyddiannus ac ystyriwyd yn eang ei fod yn rhagori ar ddigwyddiadau dros y blynyddoedd blaenorol.

Cafodd gwobrau eu cyflwyno i Bethany Frempong Jones (Lefel Mynediad/Sylfaen) a Dr Caroline Jones (Lefel Canolradd/Uwch), a gwnaeth Mark Butler dderbyn Gwobr Dewis y Tiwtor er mwyn cydnabod ei ymrwymiad eithriadol i ddysgu'r Gymraeg. Cafodd y digwyddiad ei gynnal o dan nawdd gan Cymen a Nant Gwrtheyrn.

Mae'r gystadleuaeth yn parhau i gynnig buddion clir i'r sefydliad trwy gydnabod cyflawniadau dysgwyr, annog cymryd rhan mewn hyfforddiant y Gymraeg, hyrwyddo defnydd ymarferol o'r Gymraeg yn y gweithle, ac atgyfnerthu diwylliant dwyieithog y Bwrdd Iechyd. Mae ansawdd yr enwebiadau a'r rhai a gyrhaeddodd y rhestr fer yn tynnu sylw at y datblygiadau arloesol o ran darpariaeth hyfforddiant y Gymraeg.

Ar y cyfan, mae Cystadleuaeth Dysgwr y Flwyddyn yn parhau i fod yn ddigwyddiad pwysig o ran hybu'r Gymraeg a normaleiddio defnydd ohoni yn y Bwrdd Iechyd ac mae'n ategu ymrwymiad strategol y Bwrdd Iechyd i gynnig gwasanaethau gofal iechyd dwyieithog o ansawdd uchel.

Gwasanaethau Cyfieithu

Mae'r Tîm Cyfieithu'n cyflawni rôl strategol bwysig o ran galluogi'r Bwrdd Iechyd i fodloni ei rwymedigaethau statudol o dan Safonau'r Gymraeg ac i atgyfnerthu ymrwymiad ehangach y sefydliad i gynnig gofal teg, sy'n canolbwyntio ar yr unigolyn.

Trwy ddarparu gwasanaethau cyfieithu ysgrifenedig a chyfieithu ar y pryd o ansawdd uchel ar draws yr holl uwch adrannau, mae'r tîm yn sicrhau bod cyfathrebu dwyieithog yn cael ei ymgorffori fel gofyniad gweithredol craidd yn hytrach na gweithgaredd atodol. Mae galw cyson am gyfieithu'n adlewyrchu gweledegd cynyddol y Gymraeg ar draws swyddogaethau'r Bwrdd Iechyd a ffocws y sefydliad ar wella profiad cleifion trwy wybodaeth sy'n hygyrch, ac sydd wedi'i halinio'n ddiwylliannol.

Mae prosesau sicrhau ansawdd cadarn y tîm a'i ffordd o flaenoriaethu deunyddiau sy'n sensitif o ran amser yn ategu gwydnwch gweithredol, yn lliniaru risg o ran cydymffurfio, ac yn sicrhau bod staff a chleifion yn derbyn gwybodaeth fanwl-gywir yn eu dewis iaith, gan felly atgyfnerthu nod strategol y Bwrdd Iechyd o gynnig gwasanaethau sy'n ddiogel, sy'n gynhwysol ac sy'n cydymffurfio ar lefel gyfreithiol.

Mae'r Bwrdd Iechyd yn parhau i greu incwm allanol trwy ddarparu gwasanaethau cyfieithu Cymraeg arbenigol. Yn 2024-2025, gwnaeth Tîm y Gymraeg ymrwymo i Gytundeb Lefel Gwasanaeth gyda Bwrdd Iechyd Prifysgol Aneurin Bevan i ddarparu cymorth cyfieithu ysgrifenedig, gan adlewyrchu hyder yng ngalluoedd a safonau proffesiynol y tîm.

Arweiniodd llwyddiant y trefniant hwn at adnewyddu cytundeb yn 2025-2026, ac mae'r ddau sefydliad bellach wedi cadarnhau eu bod am fwrw ymlaen â'r trefniant hwn am y drydedd flwyddyn yn olynol yn 2026-2027. Mae'r bartneriaeth barhaus hon yn dangos ansawdd uchel, dibynadwyedd ac enw da gwaith y tîm, gan gyfrannu incwm rheolaidd gwerthfawr at y Bwrdd Iechyd.

Mae'r tîm wedi parhau i foderneiddio ei ddulliau gweithredol trwy wella defnydd o dechnoleg Cof Cyfieithu, sydd wedi cael ei hymgorffori i lifoedd gwaith dyddiol ers nifer o flynyddoedd. Fel rhan o raglen effeithlonrwydd ehangach, mae'r tîm wedi ystyried cyfleoedd i symleiddio prosesau ymhellach, lleihau dyblygu, a chyflymu amseroedd cwblhau ar gyfer ceisiadau cyfieithu o gyfaint mawr. Mae'r gwaith hwn wedi cynnwys buddsoddi mewn system Cof Cyfieithu uwchraddedig, sef 'Wordfast', sy'n cynnwys swyddogaethau ychwanegol, gwell rheolyddion o ran cysondeb, a mwy o gapasiti i gynorthwyo gyda thasgau cyfieithu cymhleth. Mae mabwysiadu'r feddalwedd ddiweddaredig hon yn cynrychioli cam strategol o ran gwella cynhyrchiant, cynnal galw cynyddol, a sicrhau bod y Bwrdd Iechyd yn cynnal gwasanaeth dwyieithog gwydn ac o ansawdd uchel sy'n cyd-fynd â blaenoriaethau statudol a sefydliadol.

Mae ceisiadau cyfieithu brys yn ystod y cyfnod adrodd wedi cynnwys datganiadau i'r wasg, gohebiaeth â chleifion, adroddiadau blynyddol, a gwybodaeth amserol hollbwysig am iechyd y cyhoedd ar gyfer sianeli'r cyfryngau cymdeithasol. Mae'r Tîm Cyfieithu'n blaenoriaethu'r holl ohebiaeth ar gyfer y cyhoedd a chleifion er mwyn sicrhau bod gwybodaeth hanfodol ar gael yn ddwyieithog o fewn 1-2 diwrnod gwaith, a lle bo capasiti'n caniatáu, bod y wybodaeth honno ar gael o fewn yr un diwrnod gwaith ar gyfer eitemau lle bo brys mawr. Er mwyn diogelu cyfathrebu'n ddwyieithog ymhellach, mae gwasanaeth y tu allan i oriau yn parhau i gael mewn

amgylchiadau eithriadol. Mae'r ddarpariaeth hon yn sicrhau bod modd rhannu gwybodaeth hollbwysig ar yr un pryd yn Gymraeg ac yn Saesneg, gan atgyfnerthu ymrwymiad y Bwrdd Iechyd i drin y Gymraeg ar y sail ei bod yn gyfatal a chan gynnal cydymffurfiaeth â gofynion statudol.

Ar y cyfan, cyfanswm nifer y geiriau a gyfieithwyd yn ystod y flwyddyn adrodd oedd 4,622,786. Y gwasanaethau â'r galw uchaf am gyfieithu oedd:

Gwasanaeth	Nifer y geiriau a gyfieithwyd
Gweithlu a Datblygu Sefydliadol	1,024,588
Y Swyddfa Gorfforaethol	234,005
Gwasanaethau Therapi Iaith a Lleferydd	127,844
Gwasanaethau Plant a Phobl Ifanc	127,314
Cyfathrebu	122,239

Mae'r Tîm Cyfieithu yn parhau i gynnig gwasanaeth cyfieithu ar y pryd a ddarperir naill ai wyneb yn wyneb neu ar lwyfannau ar-lein fel 'Zoom' a 'Microsoft Teams'. Derbyniwyd cyfanswm o 43 o geisiadau gyda'r mwyafrif yn gofyn am gyfieithu ar y pryd ar gyfer digwyddiadau i randdeiliaid, cyfarfodydd a chynadleddau, a chyfweliadau ag ymgeiswyr sy'n dymuno cael eu cyfweliadau yn y Gymraeg.

Gweithgareddau a Digwyddiadau Hyrwyddo

Mae gweithgareddau a digwyddiadau hyrwyddo megis diwrnodau dathlu cenedlaethol a digwyddiadau, yn ogystal ag ymgyrchoedd ymgysylltu ehangach yn cyflawni rôl strategol bwysig o ran helpu'r Bwrdd Iechyd i hyrwyddo, normaleiddio a dathlu'r Gymraeg ymysg staff, cleifion a'r cyhoedd.

Trwy gymryd rhan mewn digwyddiadau diwylliannol proffil mawr a nodi achlysuron cenedlaethol, mae'r sefydliad yn dangos arweinyddiaeth weladwy o ran hyrwyddo'r Gymraeg a hunaniaeth Gymreig, gan atgyfnerthu ei ymrwymiad i ddarparu gwasanaethau sy'n adlewyrchu anghenion diwylliannol ac ieithyddol y cymunedau y mae'n ei wasanaethu.

Yr Eisteddfod Genedlaethol yn Wrecsam
Aeth y Bwrdd Iechyd i'r Eisteddfod Genedlaethol a gynhaliwyd yn Wrecsam, ac eleni, cafodd y stondin ei gynnal fel ymdrech ar y cyd, a bu sefydliadau gofal iechyd gwahanol yn bresennol ar ddiwrnodau gwahanol. Dros bedwar diwrnod prysur a llwyddiannus, gwnaeth cydweithwyr o ystod o wasanaethau yn y Bwrdd Iechyd - gan gynnwys y Tîm Atal Strôc, Therapi Iaith a Lleferydd, Ffisiotherapi a rhaglen Helpa Fi i Stopio - groesawu ymwelwyr, rhannu gwybodaeth a thynnu sylw at hyd a lled y gwasanaethau sydd ar gael ar draws y Bwrdd Iechyd, gyda phwyslais arbennig ar bwysigrwydd gwasanaethau Cymraeg a'u heffaith bositif ar gleifion, defnyddwyr gwasanaeth a theuluoedd.

Gwnaeth cyfraniad pawb trwy gydol yr wythnos helpu i ddangos amrywiaeth a chyrhaeddiad gwasanaethau'r Bwrdd Iechyd a gwnaethant greu cyfleoedd gwerthfawr i gael sgyrsiau ystyrlon ag aelodau'r cyhoedd ynghylch manteisio ar ofal a chymorth trwy gyfrwng y Gymraeg.

Cafodd Tîm y Gymraeg ei wahodd hefyd i stondin Gyrfa Cymru er mwyn rhoi cyngor, arweiniad a gwybodaeth am gyfleoedd gyrfaol yn y Bwrdd Iechyd. Yn ogystal, gwnaeth y Tîm gymryd rhan mewn trafodaeth panel gyda Phrifysgol Wrecsam a Jeremy Miles, Aelod o'r Senedd, Ysgrifennydd y Cabinet dros Iechyd a Gofal Cymdeithasol, yn ystyried sut gall y Bwrdd Iechyd ysbrydoli, datblygu a chynorthwyo gweithlu gofal iechyd y dyfodol yng Nghymru.

Diwrnodau Dathlu Cenedlaethol
I nodi Diwrnod Santes Dwynwen, gwnaeth y Bwrdd Iechyd gyflwyno ymgyrch hynod weladwy a diddorol yn dathlu balchder staff mewn gweithio i'r sefydliad. Fel rhan o'r dathliad, cafodd staff ar draws yr holl safleoedd eu gwahodd i rannu pam maent wrth eu bodd yn gweithio i'r Bwrdd Iechyd, gan dynnu sylw at y gwerthoedd, y gwaith tîm a'r ymdeimlad o bwrpas sy'n sail i'w rolau.

I ddathlu Dydd Gŵyl Dewi, gwnaeth y Bwrdd Iechyd gyflwyno cyfres o weithgareddau ymgysylltu proffil mawr ar draws ei dri safle acíwt. Cafodd Mudiad Meithrin a Cymraeg i Blant eu gwahodd i wardiau'r plant yn Ysbyty Maelor, Ysbyty Glan Clwyd ac Ysbyty Gwynedd, lle gwnaeth plant - a staff - fwynhau sesiynau rhyngweithiol yn cynnwys rhigymau adnabyddus o Gymru, gan greu profiad cynnes a diwylliannol gyfoethog i deuluoedd. Gwnaeth y Bwrdd Iechyd gyhoeddi hefyd enwau'r staff a gyrhaeddodd y rhestr fer ar gyfer gwobrau Dysgwr y Flwyddyn 2026, gwnaeth lansio fideos newydd 'Mwy na Geiriau, a gwnaeth gyflwyno ffurflen ddigidol er mwyn symleiddio archebu adnoddau ar-lein. Cafodd stondinau gwybodaeth eu cynnal ar bob safle acíwt, gan roi cyfleoedd i ymgysylltu'n uniongyrchol â staff, hyrwyddo cyfleoedd sydd i

ddod i ddysgu'r Gymraeg, a dosbarthu adnoddau. Gyda'i gilydd, gwnaeth y gweithgareddau hyn wella gweledded y Gymraeg a'i diwylliant ar draws y sefydliad.

I nodi Diwrnod Rhyngwladol y Menywod, gwnaeth y Bwrdd Iechyd ddathlu'r cyfraniad hollbwysig y mae menywod yn ei wneud ar draws y sefydliad a'r GIG yn ehangach. Mae menywod yn cynrychioli cyfran sylweddol o weithlu'r Bwrdd Iechyd ac maent wedi cyflawni rhan annatod o ran llunio darpariaeth gofal iechyd yn hanesyddol. Gwnaeth y Bwrdd Iechyd dynnu sylw at gyflawniadau cydweithwyr a gwirfoddolwyr benywaidd ar draws yr holl wasanaethau a'u hanrhydeddu, gan gydnabod y rhai sy'n cynnig gofal dwyieithog i gleifion yng Ngogledd Cymru, yn benodol. Gwnaeth y dathliad hwn atgyfnerthu ymrwymiad y sefydliad i gydraddoldeb, gweledded a chynhwysiant diwylliannol, gan ddangos ymroddiad, proffesiynoldeb ac effaith menywod sy'n rhoi cymorth o ran cenhadaeth y Bwrdd Iechyd bob dydd.

Roedd y gweithgareddau hyn yn creu cyfleoedd i ymgysylltu'n uniongyrchol, codi ymwybyddiaeth o'r Gymraeg fel sgil gwerthfawr yn y gweithle, ac atgyfnerthu hyder y cyhoedd o ran ymroddiad y Bwrdd Iechyd i ofal dwyieithog.

Un uchafbwynt ychwanegol o fewn gweithgareddau a digwyddiadau hyrwyddo eleni oedd cyflwyno'r gloch oncoleg gyntaf yn Gymraeg yng Nghymru. Gall cleifion ar Ward y Plant yn Ysbyty Maelor Wrecsam ddathlu cwblhau eu triniaeth canser bellach gyda chwa ystyrlon o falchder Cymreig, yn dilyn gosod cloch ddwyieithog i nodi diwedd triniaeth sydd wedi'i harysgrifio â neges yn Gymraeg. Mae'r datblygiad hwn yn rhoi'r cyfle i blant a theuluoedd nodi carreg filltir arwyddocaol yn eu hiaith gyntaf ac mae'n adlewyrchu ymrwymiad y Bwrdd Iechyd i weledded y Gymraeg mewn amgylchiadau clinigol. Cafodd cyrhaeddiad y gloch groeso cynnes ac mae'n cynrychioli cam cadarnhaol o ran gwella profiad cleifion trwy integreiddio'r Gymraeg a hunaniaeth Gymreig mewn lleoliadau gofal.

Wythnos y Gymraeg

Cafodd ein hwythfed ddigwyddiad blynyddol Wythnos y Gymraeg ei gynnal rhwng 20-24 Hydref, gan godi ymwybyddiaeth o bwysigrwydd gofal iechyd dwyieithog ac yn dathlu gwaith staff sy'n rhoi cymorth gyda gwasanaethau Cymraeg ar draws y Bwrdd Iechyd. Roedd yr wythnos hefyd yn gyfle i Dîm y Gymraeg ymgysylltu'n uniongyrchol â staff.

Roedd yr uchafbwyntiau'n cynnwys:

·Rhannu stori claf trwy lansio fideo, yn tynnu sylw at bwysigrwydd y Gymraeg ar ein wardiau Plant.
·Gwnaeth Dewin ymweld â phob un o'r tair o wardiau'r Plant mewn partneriaeth â Mudiad Meithrin a Cymraeg i Blant a ganodd ac a ddarllenodd lyfrau gyda'r plant ar y ward.
·Roedd cwrs 'Gwefra dy Gymraeg' ar gael i staff, gan roi cyfle iddynt wella eu Cymraeg, magu hyder o ran defnyddio'r Gymraeg a hefyd i ddysgu mwy am ein cyfleoedd hyfforddiant Cymraeg.
·Stondinau gwybodaeth yn y tri ysbyty acíwt ac ysbytai cymunedol yn Llandudno, Dinbych a Glannau Dyfrdwy i ddathlu diwrnod 'Shw'mae, Su'mae'. Roedd y stondinau'n gyfle i ni siarad â staff ac i roi cyngor ac arweiniad ar ystod o bynciau'n ymwneud â gwasanaethau dwyieithog. Yn ogystal, gwnaethom annog staff i ddefnyddio eu Cymraeg o ddydd i ddydd yn y gwaith.
·Cynhaliwyd cystadleuaeth 'Addewid Cymraeg' wrth y stondinau er mwyn rhoi'r cyfle i staff ymrwymo i wneud un peth o ran y Gymraeg, e.e. Rwy'n addo dechrau pob sgwrs yn Gymraeg gyda fy nghleifion.
·Ar ddiwedd yr wythnos, gwnaethom ddewis enw ar hap, gwnaeth Sarah o Ysbyty Glannau Dyfrdwy ennill hamper ar gyfer addewid y Gymraeg.
·Lansio Gwobrau Dysgwr y Flwyddyn 2026.
·Cyfweliadau Radio ar Radio Ysbyty Gwynedd a Radio Ysbyty Glan Clwyd.

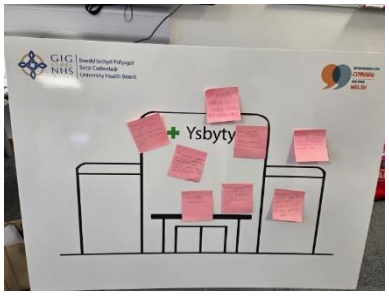
Bu'r wythnos yn llwyddiant ysgubol, yn dathlu'r Gymraeg, yn hybu dwyieithrwydd ac yn annog staff i ddatblygu a defnyddio eu sgiliau Cymraeg.

Y Gymraeg fel Sgil Proffesiynol

Mae'r Bwrdd Iechyd wedi atgyfnerthu ei bartneriaethau strategol gyda phrifysgolion, ysgolion a sefydliadau sector i hyrwyddo'r Gymraeg fel sgil proffesiynol gwerthfawr ac fel elfen hanfodol o weithlu dwyieithog yn y dyfodol. Trwy'r dull cydweithredol hwn, mae'r sefydliad yn helpu i ymgorffori'r ddealltwriaeth bod galluoedd yn y Gymraeg yn rhan annatod o ofal o ansawdd uchel ac arfer modern yn y sector cyhoeddus.

Mae'r Tîm wedi parhau i weithio'n agos gyda Gyrfa Cymru ar ystod o weithgareddau ymgysylltu gyda dysgwyr ar draws Ysgol Morgan Llwyd, Ysgol y Creuddyn, Ysgol Rhosnesni, Coleg Cambria ac Ysgol Uwchradd Gatholig Sant Richard Gwyn a llawer mwy**.** Roedd y rhain yn cynnwys sesiynau Cymraeg yn y Gweithle, digwyddiadau ar ffurf carwsél, lle cafodd grwpiau bach o ddisgyblion y cyfle i ofyn cwestiynau am bwysigrwydd y Gymraeg yn y gweithle, yn ogystal â ffug gyfweliadau i ddisgyblion Blwyddyn 10 er mwyn eu helpu i baratoi ar gyfer eu darpar yrfaoedd. Gwnaeth y Tîm hefyd rannu gwybodaeth ac enghreifftiau o arfer da mewn ffeiriau gyrfaoedd a digwyddiadau eraill sy'n gysylltiedig â gyrfaoedd.

Roedd y gweithgareddau hyn yn cynnig cyfleoedd gwerthfawr i hyrwyddo defnydd o'r Gymraeg a'i phwysigrwydd mewn lleoliadau gofal iechyd ac i godi ymwybyddiaeth o'r gwahaniaeth sylweddol y gall gwasanaethau Cymraeg ei wneud i gleifion, defnyddwyr gwasanaeth a'u teuluoedd. Trwy ymgysylltu â dysgwyr a phobl ifanc, gwnaeth y Tîm dynnu sylw at yr ystod eang o gyfleoedd gyrfaol sydd ar gael ym maes gofal iechyd a phwysigrwydd sgiliau dwyieithog wrth gynnig gofal sy'n canolbwyntio ar yr unigolyn.



Roedd yn galonogol derbyn adborth mor bositif gan staff yr ysgol, a nododd Ysgol Uwchradd Gatholig Sant Richard Gwyn y canlynol:

> *"Roedd yn wych cael Tîm y Gymraeg o'r Bwrdd Iechyd yn yr ysgol eto eleni yn rhoi cyflwyniad ar bwysigrwydd y Gymraeg yn y gweithle ac yn y sector meddygol. Mae cael staff yn dod atom i gyflwyno i ddisgyblion yn hynod bwerus o ran rhoi cymorth i hybu pwysigrwydd gallu sgwrsio â chleifion yn yr iaith maent fwyaf cyfforddus ynddi. Mae hyn yn ei dro yn ategu gwaith ysgolion a chanlyniadau i fyfyrwyr trwy helpu i roi pwysigrwydd dysgu a'r pynciau maent yn eu dysgu yn ei gyd-destun."*

Hefyd, yn ystod y cyfnod adrodd, gwnaeth y Bwrdd Iechyd atgyfnerthu ei waith mewn partneriaeth â phrifysgolion rhanbarthol i roi cymorth o ran datblygu gweithlu dwyieithog yn y dyfodol. Gwnaeth Tîm y Gymraeg gydweithio â Phrifysgol Wrecsam fel rhan o'i fodiwl 20 credyd newydd, sef 'Cymraeg yn y Gweithle 1' ar gyfer myfyrwyr Proffesiynau sy'n Gysylltiedig ag Iechyd, yn cynnig

sesiynau Cymraeg ac ymwybyddiaeth o'r iaith sydd â'r nod o roi'r hyder a'r sgiliau i ddarpar glinigwyr ddefnyddio Cymraeg yn eu harfer proffesiynol.

Yn yr un modd, gwnaeth y Bwrdd Iechyd barhau i ymgysylltu â Phrifysgol Bangor ac Ysgol Feddygol Gogledd Cymru trwy'r Rhaglen Feddygaeth newydd. Gwnaeth y tîm gyflwyno sesiynau'n amlinellu dull strategol y sefydliad ar gyfer hyrwyddo'r Gymraeg a'i diwylliant a'i hymgorffori ar draws gwasanaethau clinigol, gan bwysleisio pwysigrwydd dewis iaith o ran gofal diogel sy'n canolbwyntio ar yr unigolyn. Gwnaeth un o Feddygon Ymgynghorol Gofal yr Henoed y Bwrdd Iechyd yn Ysbyty Gwynedd roi safbwynt ymarferydd ar werth defnyddio'r Gymraeg o ddydd i ddydd mewn rhyngweithiadau clinigol a'r effaith bositif y mae hyn yn ei chael ar brofiad cleifion.

Gwnaeth y Bwrdd Iechyd hefyd gymryd rhan mewn sesiwn holi ac ateb gyda myfyrwyr Blwyddyn 2 yn Ysgol Feddygol Gogledd Cymru er mwyn dangos pwysigrwydd siarad yn Gymraeg â chleifion, a'r cymorth a gynigir gan y Bwrdd Iechyd unwaith y byddant ar leoliad.

Mae'r prosiectau cydweithio hyn yn elfen bwysig o strategaeth hirdymor y Bwrdd Iechyd i feithrin gweithlu clinigol hyderus a dwyieithog ac i sicrhau bod cenedlaethau gweithwyr gofal iechyd proffesiynol yn y dyfodol yn gallu diwallu anghenion ieithyddol y boblogaeth.

Dangosyddion Perfformiad Allweddol

Mae'r data a gynhwysir isod yn unol â Safon 120 o Safonau'r Gymraeg o dan Fesur y Gymraeg (Cymru) 2011.

Cynllunio'r Gweithlu

- ***Nifer a chanran gweithwyr y sefydliad y mae eu sgiliau Cymraeg wedi eu hasesu ar draws y sefydliad.***

Nifer y Gweithwyr	**2023/24**		**2024/25**		**2025/26**	
Lefel Hyfedredd Unigol	Cyfanswm	%	Cyfanswm	%	Cyfanswm	%
0 - No Skills / Dim Sgiliau	9645	46.25%	10217	48.33%	10271	49.02%
1 - Entry / Mynediad	2781	13.34%	2739	12.96%	2828	12.93%
2 - Foundation / Sylfaen	1371	6.57%	1394	6.59%	1426	6.52%
3 - Intermediate / Canolradd	1438	6.9%	1472	6.96%	1555	7.11%
4 - Higher / Uwch	1588	7.62%	1600	7.57%	1613	7.38%
5 - Proficiency / Hyfedredd	2743	13.15%	2778	13.14%	2926	13.38%
Cyfanswm	19,566	93.8%	20,200	95.54%	20,619	96.34%
Cyfanswm staff	20,852		21,142		21,871	

Data 2025 / 2026:

Roedd 96.34 y cant o'r gweithlu cyfan wedi cofnodi eu sgiliau Cymraeg ar ESR

Data 2024 / 2025:

Roedd 95.54 y cant o'r gweithlu cyfan wedi cofnodi eu sgiliau Cymraeg ar ESR

Hyfforddiant i Wella Sgiliau Cymraeg

- ***Nifer a chanran gweithlu'r sefydliad a gafodd hyfforddiant i wella eu sgiliau Cymraeg hyd at lefel cymhwyster penodol.***

Data 2025 / 2026:

Nifer o weithlu'r sefydliad sydd wedi cael mynediad at hyfforddiant i wella eu sgiliau Cymraeg at lefel cymhwyster penodol: 1037

Mae'r cyfanswm hwn yn cyfateb i 4.9 y cant o weithlu presennol y Bwrdd Iechyd.

Data 2024 / 2025:

Nifer o weithlu'r sefydliad sydd wedi cael mynediad at hyfforddiant i wella eu sgiliau Cymraeg at lefel cymhwyster penodol: 995

Mae'r cyfanswm hwn yn cyfateb i 4.7 y cant o weithlu presennol y Bwrdd Iechyd.

Recriwtio

- ***Nifer a chanran y swyddi newydd a gwag a hysbysebwyd gyda'r gofyniad a ganlyn:***

Data 2025 / 2026:

- **Sgiliau Cymraeg yn hanfodol - 274 (6.9%)**
- **Sgiliau Cymraeg yn ddymunol - 3631 (91.1%)**
- **Sgiliau Cymraeg i'w dysgu - 69 (1.7%)**
- **Cymraeg ddim yn sgil gofynnol - 10 (0.3%)**

- **Cyfanswm nifer y swyddi gwag a hysbysebwyd - 3984**

Data 2024 / 2025:

- **Sgiliau Cymraeg yn hanfodol - 301 (6.5 y cant)**
- **Sgiliau Cymraeg yn ddymunol - 4238 (92.2 y cant)**
- **Sgiliau Cymraeg i'w dysgu - 49 (1.1 y cant)**
- **Cymraeg ddim yn sgil gofynnol - 8 (0.17 y cant)**

- **Cyfanswm nifer y swyddi gwag a hysbysebwyd - 4596**

Cwynion

- ***Nifer y cwynion a dderbyniwyd am weithredu Safonau'r Gymraeg***

  Derbyniodd y Bwrdd Iechyd bedair cŵyn newydd yn ymwneud â chydymffurfio â Safonau'r Gymraeg yn ystod y flwyddyn adrodd - tair drwy Gomisiynydd y Gymraeg, ac un wedi'i derbyn trwy'r Tîm Cwynion.

  Cafodd un gŵyn ei chyfeirio at statws ymchwiliad gan Gomisiynydd y Gymraeg, ac roedd yn ymwneud ag oedi o ran ateb llinell ffôn Gymraeg. Rhoddwyd tystiolaeth yn datgan bod oedi ar y llinellau Cymraeg a Saesneg am gyfnod o awr tra'r oedd y ganolfan alwadau'n symud o Fangor i Gaernarfon.

  Deliwyd â'r ddwy gŵyn arall drwy Gomisiynydd y Gymraeg yn llawn ar ôl y llythyr cychwynnol, ac ni chawsant eu huwchgyfeirio at statws ymchwiliad. Roedd un gŵyn yn ymwneud â methiant i drefnu cyfweliad swydd trwy gyfrwng y Gymraeg. Roedd yr ail yn ymwneud ag arwyddion uniaith Saesneg yn un o Adrannau Cleifion Allanol y Plant.

  Roedd y gŵyn a anfonwyd yn uniongyrchol at y Bwrdd Iechyd yn ymwneud â diffyg gwasanaeth Cymraeg mewn Canolfan Ddeintyddol. Cafodd y ddeintyddfa ei hatgoffa am y chwe dyletswydd y mae'n rhaid i wasanaethau gofal sylfaenol gydymffurfio â nhw a gwnaeth Tîm y Gymraeg gynnig cymorth.

  Ymdriniwyd yn llawn â phob cŵyn yn unol ag amserlen cwynion Mesur y Gymraeg (Cymru) 2011 neu o dan Reoliadau Gweithio i Wella.

Myfyrdodau a Gweledigaeth ar gyfer y Dyfodol

Mae'r adroddiad hwn wedi dangos bod cynnydd yn y meysydd canlynol:

- gwella ansawdd y gofal a ddarperir yn y dewis iaith.
- gwella cydymffurfiaeth â gofynion cyfreithiol a statudol.
- nodi mentrau sydd wedi'u gweithredu a'u cyflwyno i ymateb i angen iaith fel elfen annatod o ofal.
- gwella datblygu sefydliadol o ran sut mae'r gweithlu'n cael ei gefnogi i ddarparu gwasanaethau drwy gyfrwng y Gymraeg.

Fodd bynnag, mae'r Bwrdd Iechyd yn edrych ar fentrau a chyfleoedd sydd ar y gweill ar gyfer y flwyddyn adrodd nesaf trwy ei ddull tair blynedd ar gyfer cynllunio gwasanaethau. Bydd ffocws ar ymgorffori'r Gymraeg o ran Cynllunio a Darparu Gwasanaethau, gwella'r "Cynnig Rhagweithiol" ar draws lleoliadau clinigol trwy roi cynllun pum mlynedd Safon 110 ar waith, ac ehangu mentrau llwyddiannus ar draws gwasanaethau er mwyn sicrhau bod darpariaeth gwasanaethau dwyieithog yn gyson.

Gosod uchelgais ar gyfer 2026-2027

Gan edrych tua'r dyfodol, mae Cynllun Tymor Canolig Integredig y Bwrdd Iechyd 2026-2029 yn gosod gweledigaeth glir ar gyfer atgyfnerthu galluoedd yn y Gymraeg ar draws gwasanaethau, a thros y flwyddyn sydd i ddod, byddwn yn canolbwyntio ar atgyfnerthu'r sylfeini hyn.

Bydd y prif flaenoriaethau'n cynnwys:

- datblygu cynllun â ffocws clinigol i gynyddu defnydd o'r Gymraeg yn unol â Safon 110;
- ehangu hyfforddiant wedi'i dargedu ar gyfer staff sy'n gweithio gyda grwpiau sy'n agored i niwed;
- gwella trefniadau llywodraethu ymhellach er mwyn monitro cydymffurfiaeth a chynnydd.

Bydd gwaith hefyd yn parhau i ganfod grwpiau blaenoriaethol o ran cleifion a'r gweithlu lle bo angen cymorth ychwanegol, ochr yn ochr â phwyslais newydd ar wella gweledd a defnydd o'r Gymraeg o ddydd i ddydd trwy ymgysylltu â staff, presenoldeb cymdeithasol a chyflwyno Rhaglen Pencampwyr y Gymraeg.

Bydd y camau gweithredu hyn yn helpu i wreiddio'r Gymraeg yn ddyfnach o fewn swyddogaethau craidd ac yn hybu perchnogaeth ddiwylliannol ehangach ar draws y sefydliad, gan sicrhau cynnydd cyson a gwasanaeth dwyieithog cryfach ar gyfer pobl Gogledd Cymru.

Cyflawni camau Cynllun Mwy na Geiriau, 2022-27: Ar gyfer y cyfnod 1 Ebrill 2025 – 31 Mawrth 2026

Sefydliad:	**Bwrdd Iechyd Prifysgol Betsi Cadwaladr**

Cwblhawyd gan:	**Bennaeth Gwasanaethau'r Gymraeg**	**Dyddiad: 28 Medi 2026**

DATA ALLWEDDOL: **Wrth ddyfynnu unrhyw ystadegau / data, rhowch ddyddiad / cyfnod adrodd cyfatebol.**

Sgiliau Cymraeg Staff

Nifer y Gweithwyr	**2023/24**		**2024/25**		**2025/26**	
Lefel Hyfedredd Unigolion	Cyfanswm	%	Cyfanswm	%	Cyfanswm	%
0 - No Skills / Dim Sgiliau	9645	46.25%	10217	48.33%	10271	49.02%
1 - Entry/ Mynediad	2781	13.34%	2739	12.96%	2828	12.93%
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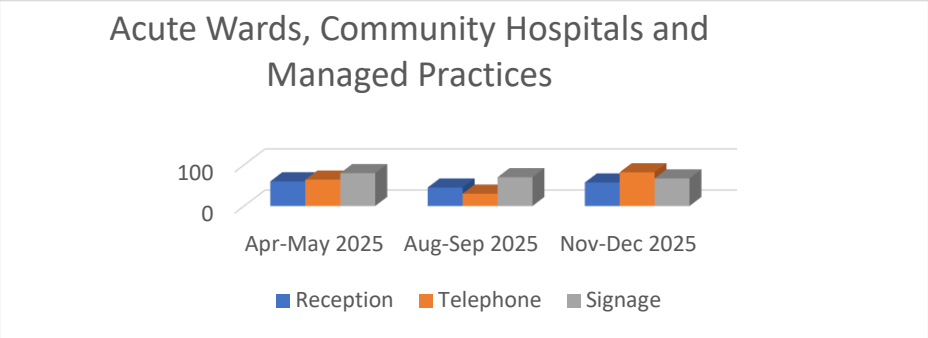
5 - Proficiency / Hyfedredd	2743	13.15%	2778	13.14%	2926	13.38%
Cyfanswm	19,566	93.8%	20,200	95.54%	20,619	96.34%
Cyfanswm y staff	20,852		21,142		21,871	

	 Ar 31 Mawrth 2026.
Nifer y staff sydd wedi cwblhau hyfforddiant	**Cwrs Cwrteisi - 238** **Cwrs Codi Hyder** - 2025-2026 18 (roedd 9 o'r rhain yn aelodau o staff yr Uwch Adran Iechyd meddwl ac Anableddau Dysgu) Mae cytundeb y Bwrdd Iechyd â'r Ganolfan Dysgu Cymraeg Genedlaethol ychydig yn wahanol o ran cyrsiau codi hyder a dargedir. Oherwydd y rhaglen hyfforddiant aeddfed y mae'r Bwrdd Iechyd eisoes wedi'i sefydlu, a'r gwaith a wnaed fel rhan o sylfeini Safon 110 i nodi bylchau yn y gwasanaethau a ddarperir, mae sefyllfa'r Bwrdd Iechyd yn ei alluogi i dargedu grwpiau blaenoriaethol. Dylid nodi hefyd na chafodd y Bwrdd Iechyd gymorth â chyrsiau magu hyder rhwng mis Medi a mis Rhagfyr 2025 oherwydd problemau â'r darparwr na allai'r Bwrdd Iechyd eu rheoli. Felly, mae'r cyfanswm yma yn ymwneud â Ch1 a Ch2 2025-26 yn unig. **Cyrsiau Ymwybyddiaeth o'r Gymraeg** – 85% o'r holl staff – 18,590 aelod o'r staff **Hyfforddiant Dysgu Cymraeg yn 2025-2026 -** Sawl aelod o weithlu'r sefydliad sydd wedi cael hyfforddiant i wella eu sgiliau yn y Gymraeg hyd at lefel cymhwyster penodol: 1,037. Mae hynny'n gyfystyr â 4.9 y cant o weithlu presennol y Bwrdd Iechyd. **Mae'r holl ddata yn ddata a oedd ar gael ar 31 Mawrth 2026.**
Arolygon Cleifion / Defnyddwyr Gwasanaeth e.e. Arolygon Siopwyr Cudd	Parhaodd dull hunanreoleiddio'r Bwrdd Iechyd trwy gynnal Rhaglen Monitro Siopwr Cudd. Nod y rhaglen honno oedd cynnig sicrwydd cryf ynghylch ymrwymiad y sefydliad i ddarparu gwasanaethau Cymraeg o ansawdd uchel a chynnal cydymffurfiaeth â Safonau'r Gymraeg. Fe wnaeth canlyniadau gwaith monitro gadarnhau bod arwyddion Cymraeg yn dal yn un o gryfderau sylweddol y sefydliad, ac roedd lefelau'r gydymffurfiaeth yn uchel yn gyson ar draws safleoedd, gan amlygu bod y Bwrdd yn parhau i ymrwymo i sicrhau amgylchedd dwyieithog gweladwy a hygyrch. Fe wnaeth y rhaglen hefyd gynnig cipolwg gwerthfawr ar feysydd lle gellir targedu rhagor o welliannau, yn benodol rhyngweithiadau mewn derbynfeydd, cyswllt dros y ffôn, ac amlygrwydd y "Cynnig Rhagweithiol".



Rhaid ystyried sgoriau is mewn wardiau acíwt yn eu cyd-destun, oherwydd staff clinigol, yn hytrach na thimau penodol derbynfeydd, sy'n aml yn rheoli rhyngweithiadau ym man y cyswllt cyntaf wrth flaenoriaethu gofal uniongyrchol i gleifion. Mae'r realiti gweithredol hwn yn egluro rhywfaint o amrywiad ac yn dwyn sylw at yr heriau unigryw o ran cyflawni cyfathrebu dwyieithog cyson mewn lleoliadau clinigol prysur.

Ar y cyfan, mae'r rhaglen wedi cryfhau dealltwriaeth y Bwrdd Iechyd o ble bydd cymorth wedi'i dargedu yn cael yr effaith fwyaf. Mae'r rhaglen fonitro yn dangos bod gan y Bwrdd Iechyd drefniadau cadarn ar waith i asesu'r gallu i ddarparu gwasanaethau yn y Gymraeg a nodi meysydd i'w gwella. Mae perfformiad cryf o ran cydymffurfio â gofynion ynghylch arwyddion yn cynnig tystiolaeth o ymrwymiad parhaus i Safonau'r Iaith Gymraeg, ac mae'r canfyddiadau o wardiau acíwt wedi cynnig cipolwg gwerthfawr ar yr heriau a wynebir mewn amgylcheddau clinigol. Bydd y sefydliad yn defnyddio'r canfyddiadau hyn i gryfhau ymwybyddiaeth, gwella cysondeb o ran y gwasanaethau a ddarperir, a gofalu y bydd y "Cynnig Rhagweithiol" yn amlycach ystod 2026-27, gan sicrhau bod cleifion sy'n siarad Cymraeg yn parhau i gael profiad cynyddol gadarnhaol wrth ddefnyddio gwasanaethau.

Cyf.	Disgrifiad o Gamau Gweithredu Tymor Byr a Thymor Canolig	Canllaw ar gyfer cwblhau'r ymateb	Prif Atebolrwydd	Adroddiad Cynnydd 2025/26 (cyfnod adrodd 1/4/25 – 31/3/26): Pa weithgareddau newydd ac ychwanegol a ddarparwyd yn ystod 2025/26?	Enghreifftiau o arfer da / gwaith sy'n cael ei wneud mewn partneriaeth
Diwylliant ac Arweinyddiaeth					
1	Byddwn yn gosod amcanion perfformiad personol i sicrhau bod cynllun Mwy na Geiriau yn cael ei roi ar waith fel bod y Cynnig Rhagweithiol yn cael ei ymwreiddio yn amcanion blynyddol arweinwyr y sector, ei raeadru drwy sefydliadau, a'i ystyried mewn arfarniadau unigol perthnasol ar bob lefel. Bydd hyn yn cynnwys adroddiad Cyfarwyddwyr Gwasanaethau Cymdeithasol (Fframwaith Adroddiad Blynyddol y Cynghorau) a Chadeiryddion byrddau'r GIG *(Tymor byr)*	Roedd hyn yn weithred tymor byr. Erbyn hyn mae gofynion ar waith i Gadeiryddion Byrddau y GIG a Chyfarwyddwyr y Gwasanaethau Cymdeithasol gael amcanion penodol mewn perthynas â chefnogi'r gwaith o weithredu Mwy na Geiriau a'r Cynnig Rhagweithiol. Nid oes angen i gyrff iechyd / gwasanaethau cymdeithasol ddarparu diweddariad ar gyfer adroddiad 2025/26	Llywodraeth Cymru ar gyfer 2025/26.	Amh. - Gweithred LlC.	I weld manylion yr holl gamau gweithredu, gweler y golofn ar y chwith, sy'n cynnig tystiolaeth gynhwysfawr ynghylch unrhyw arferion da a gwaith trwy bartneriaeth.

		(heblaw bod datblygiadau penodol y maent am eu rhannu fel arfer da) gan y bydd Llywodraeth Cymru yn adolygu cynnydd yn erbyn amcanion ar ddiwedd y flwyddyn.			
2.	Dros amser, rydym yn disgwyl i'r holl staff iechyd a gofal cymdeithasol ddod i werthfawrogi'r gwahaniaeth cadarnhaol y gall dysgu a defnyddio'r Gymraeg ei wneud i'r profiad o ofal, sy'n ddull tymor hir o weithredu. Byddwn yn ategu cyrsiau ymwybyddiaeth ieithyddol gyda dull cyfathrebu sy'n seiliedig ar wyddor ymddygiad er mwyn sicrhau bod popeth rydym ni fel arweinwyr yn ei ddweud am y Gymraeg, ac fel sefydliadau a phartneriaethau, yn cyfrannu at y strategaeth hon. Bydd y dull hwn o weithredu yn adeiladu ar yr hyfforddiant ac ar y naratif cadarnhaol a amlinellir yn y cynllun. *(Tymor byr i ganolig)*	AaGIC a GCC i ymateb – ar y gwaith y maent yn ei wneud i gefnogi'r agenda hon. Gofynnwn i gyrff iechyd a gwasanaethau cymdeithasol hefyd ddarparu gwybodaeth am sut maent yn cefnogi'r cam hwn, ac arfer da y maent am ei rannu ynglŷn â hyrwyddo'r Gymraeg ar draws pob lleoliad	Llywodraeth Cymru / Addysg a Gwella Iechyd Cymru (AaGIC) / Gofal Cymdeithasol Cymru (GCC)	Amh. - Gweithred LIC / AaGIC / GCC	
3	Byddwn yn disgwyl i'r rheini sydd mewn rolau arwain gymryd rhan yn ein rhaglen Arwain mewn Gwlad Ddwyieithog. Mae'r rhaglen hon yn gweithio tuag at ymwreiddio ysbryd Cymraeg	Pan fo arweinwyr iechyd a gofal cymdeithasol wedi cymryd rhan yn y Rhaglen Arwain mewn Gwlad Ddwyieithog,	Cadeiryddion a Phrif Weithredwyr cyrff iechyd a gofal cymdeithasol	Cysylltwyd â LIC i ofyn am ddyddiadau ychwanegol ar gyfer Rhaglen Arwain mewn Gwlad Ddwyieithog	

	2050 yn niwylliant sefydliadau a'u polisïau. Yn rhy aml o lawer, mae'r Gymraeg yn cael ei hystyried fel dim ond mater o gyfieithu neu ymarfer 'ticio'r bocs' wrth ddatblygu polisi. Mae'r rhaglen hon, sy'n seiliedig ar werthoedd, yn mynd y tu hwnt i'r gwaith hwnnw i ddeall effaith bosibl holl elfennau ein gwaith ar ein hiaith—ac i ddefnyddio'r hyn sydd gennym i ddefnyddio mwy ar yr iaith. *(Tymor canolig)*	hoffem i chi ddarparu enghreifftiau penodol o sut mae allbynnau o'r rhaglen yn parhau i wneud gwahaniaeth i rolau arweinyddiaeth yn y sefydliad. Hoffem hefyd i chi roi enghreifftiau o ble mae rhaglenni arweinyddiaeth / cyfleoedd hyfforddiant eraill wedi cael eu darparu gan gyrff iechyd a gofal cymdeithasol sy'n canolbwyntio'n benodol ar arweinyddiaeth mewn cyd-destun dwyieithog.			
Thema 1: Polisïau a chynlluniau ar gyfer y Gymraeg, gan gynnwys data					
5	Canfod a datblygu ymchwil a data a fydd yn cryfhau ein dealltwriaeth a'n gwybodaeth yn seiliedig ar brofiadau siaradwyr Cymraeg sy'n defnyddio ac yn derbyn gwasanaethau, er mwyn cefnogi polisïau sy'n seiliedig ar dystiolaeth a chynlluniau ar gyfer y Gymraeg ym maes iechyd a gofal cymdeithasol. Bydd hyn yn cynnwys y gallu i ddarparu gwasanaethau dwyieithog, ac i ddangos tystiolaeth o sut mae	Bydd Llywodraeth Cymru yn cyhoeddi adolygiad o ddata'r Gymraeg yn fuan a gynhaliwyd gan Alma Economics. Gofynnir i gyrff iechyd a gofal cymdeithasol ddarparu manylion unrhyw ymchwil / data	Llywodraeth Cymru / Prifysgolion, Corff Llais y Dinesydd ar gyfer iechyd a gofal cymdeithasol a melinau trafod	Mae gwaith wedi'i wneud gyda defnyddwyr gwasanaethau i gael adborth ynghylch cyrchu a chyflawni gwasanaethau cyfrwng Cymraeg. Atodir adroddiad ynghylch dwy stori am gleifion yn rhannu eu hadborth.	

	Mwy na Geiriau yn helpu i sicrhau gwell canlyniadau i unigolion. (Mae'r cam hwn yn cyd-fynd â'r gwaith a nodir yn adran 4 ar fapio'r data a'r broses o greu'r dangosfwrdd *(Tymor canolig)*	y gallent fod wedi'i gomisiynu hefyd. Er enghraifft: Gofynnir i gyrff iechyd a gofal cymdeithasol ddarparu canlyniadau arolygon profiadau cleifion o gael mynediad a derbyn gwasanaethau fel Siopwyr Cudd ac ati. Llais / prifysgolion / sefydliadau melinau trafod iechyd a gofal cymdeithasol hefyd i dynnu sylw at ddatblygiadau allweddol sy'n ceisio cryfhau ein dealltwriaeth a'n gwybodaeth am brofiadau'r Gymraeg y siaradwyr wrth gyrchu a derbyn gwasanaethau.			
6	Datblygu adnoddau i helpu i brif ffrydio ystyriaethau ynghylch y Gymraeg mewn cynlluniau a pholisïau, yn enwedig mewn meysydd blaenoriaeth a lefelau uchel o ryngweithio â gwasanaethau. Bydd hyn yn cynnwys sefydlu	Gofynnir i gyrff iechyd a gofal cymdeithasol ddarparu tystiolaeth o lwybrau gofal Cymraeg ar gyfer y grwpiau blaenoriaeth yn benodol.	Llywodraeth Cymru / Cyrff iechyd a gofal cymdeithasol	Mae'r Bwrdd Iechyd wedi parhau i gryfhau integreiddio ystyriaethau ynghylch y Gymraeg ym mhrosesau ei Asesiadau Effaith ar Gydraddoldeb	

	llwybrau gofal Cymraeg ar gyfer unigolion agored i niwed mewn grwpiau blaenoriaeth penodol fel pobl hŷn, plant, iechyd meddwl, therapi lleferydd, anawsterau dysgu, a gwasanaethau strôc. *(Tymor hir)*	Gofynnir i gyrff iechyd a gofal cymdeithasol hefyd ddarparu gwybodaeth a thystiolaeth am unrhyw offer a ddatblygwyd i gefnogi prif ffrydio ystyriaethau ynghylch y Gymraeg mewn cynllunio a pholisïau.		(EQIA), gan sicrhau bod yr effaith bosibl ar gleifion, defnyddwyr gwasanaethau, staff a chymunedau sy'n siarad Cymraeg yn cael ei hystyried fel rhan o brosesau i wneud penderfyniadau strategol. Yn ystod 2025–2026, ymgymerwyd â dau asesiad llawn o'r effaith ar gydraddoldeb mewn perthynas â dau o brosiectau sylweddol y sefydliad, a chafodd goblygiadau o ran y Gymraeg eu hasesu ochr yn ochr â nodweddion gwarchodedig eraill. Yn ychwanegol, fe wnaeth y Bwrdd Iechyd ymgymryd ag Asesiad o'r Effaith ar y Gymraeg cynhwysfawr ac ar wahân, gan archwilio effaith bosibl cynigion ar yr holl feysydd y darperir gwasanaethau	

				ynddynt, y gweithlu, cyfathrebu, ymgysylltu a chyflawni gweithredol. Mae'r dull cryfach hwn wedi cynnig mwy o sicrwydd bod ystyriaethau ynglŷn â'r Gymraeg yn cael eu hymgorffori yn ystod camau cynharaf cynllunio a gwneud penderfyniadau, gan gynorthwyo'r Bwrdd i gydymffurfio â Safonau'r Gymraeg ac egwyddorion Mwy na Geiriau, gan ddiogelu cyfleoedd i unigolion gael gwasanaethau trwy gyfrwng y Gymraeg. Yn ystod y flwyddyn adrodd, sefydlwyd Llwybr Gofal Iaith Gymraeg drwy ddatblygu Pecyn Cymorth y "Cynnig Rhagweithiol" ar gyfer meysydd gwasanaethau sy'n flaenoriaethau i'w cynorthwyo i fynd ati'n	

				systematig i ystyried anghenion ieithyddol fel elfen graidd o ofal sy’n canolbwyntio ar yr unigolyn. Mae'r pecyn cymorth yn canolbwyntio'n benodol ar grwpiau y mae cael gofal yn eu dewis iaith yn hanfodol o ran deilliannau a phrofiad, gan gynnwys pobl â dementia, cyflyrau iechyd meddwl ac anableddau dysgu, plant a phobl ifanc, a phobl hŷn. Mae'n cynnig canllawiau ymarferol i helpu gwasanaethau i nodi gofynion ynghylch y Gymraeg ym mhob cam o daith y claf, cryfhau'r "Cynnig Rhagweithiol", gwella prosesau cofnodi a throsglwyddo gwybodaeth am ddewis iaith, cynorthwyo â gwaith cynllunio'r gweithlu, a	

				lliniaru risgiau sy'n gysylltiedig â rhwystrau rhag cyfathrebu. Mae cyflwyno'r pecyn cymorth wedi cynnig fframwaith cyson i alluogi gwasanaethau ddarparu gofal teg, diogel ac effeithiol drwy gyfrwng y Gymraeg, gan gynorthwyo'r Bwrdd i gydymffurfio â Safonau'r Gymraeg a gwella profiad cleifion.	
7	Sicrhau bod canllawiau a chynlluniau cenedlaethol ar gyfer iechyd a gofal cymdeithasol yn eglur ynghylch gofynion cynllunio ar gyfer y Gymraeg, gweithredu a mesur y broses o gyflawni allbynnau. Bydd hyn yn cynnwys Cynlluniau Tymor Canolig Integredig ac asesiadau rhanbarthol o anghenion y boblogaeth. *(Tymor byr)*	Bydd Llywodraeth Cymru yn cynnig diweddariad ynghylch y weithred hon. Cynhwysir y Gymraeg yn y Canllawiau Cenedlaethol ar gyfer Byrddau Iechyd. Mae Cynlluniau Tymor Canolig Integredig (IMTPs) wedi cael eu hadolygu gan Lywodraeth Cymru a bydd swyddogion yn	Llywodraeth Cymru	Gweithred LlC Ceir adran benodol ynghylch y Gymraeg a Diwylliant Cymru yn IMPT BIPBC ar gyfer 2026-2029.	

		parhau i ganolbwyntio ar flaenoriaethau Mwy na Geiriau fel rhan o fframwaith Llywodraethu'r GIG.			
8	Bydd fframwaith cenedlaethol cytunedig ar gyfer casglu a chyfuno data ar sgiliau iaith yr holl staff sy'n gweithio ym maes iechyd a gofal cymdeithasol yng Nghymru yn cael ei ddatblygu a'i weithredu. Dylai'r fframwaith fod yn orfodol lle bynnag y bo modd, a byddai angen iddo gyd-fynd â'r systemau a'r dulliau sydd ar waith ar hyn o bryd i gasglu a chyfuno data ar draws y sectorau iechyd a gofal cymdeithasol, gan gynnwys gwasanaethau sy'n cael eu darparu yn Gymraeg. *(Tymor canolig)*	Dylai cyrff iechyd a gofal cymdeithasol ddarparu trosolwg o'r ffordd y maent ar hyn o bryd yn casglu ac yn coladu data ar sgiliau iaith yr holl staff (yn ogystal â data allweddol ar gyfer y cyfnod adrodd).	AaGIC/GCC/ Iechyd a Gofal Digidol Cymru / Cyrff iechyd a gofal cymdeithasol, gan gynnwys contractwyr gofal sylfaenol.	Mae 96.34% o weithlu'r Bwrdd Iechyd wedi llenwi manylion lefel eu sgiliau yn y Gymraeg ar ESR. Mae hynny'n gyfystyr â 20,619 aelod o'r staff.	
9	Bydd adroddiad blynyddol yn cael ei baratoi gan gorff priodol i ddod â data am y gweithlu iechyd a gofal cymdeithasol at ei gilydd. Byddai'r adroddiad hwn yn gallu cael ei baratoi a'i gyhoeddi gan Ystadegau Cymru. Dylai'r adroddiad fod ar gael i'r cyhoedd gyda lefel bellach o fanylder ar gael fel sy'n briodol i'r cyrff hynny sy'n gyfrifol am y gweithlu mewn gwahanol gyd-	Mae Llywodraeth Cymru wedi comisiynu Wavehill a IAITH i ddrafftio Adroddiad Blynyddol Mwy na Geiriau 2025-26. Fel y nodwyd uchod: mae Llywodraeth Cymru hefyd wedi comisiynu contractwr yn fuan i nodi data	AaGIC / GCC, cyrff iechyd a gofal cymdeithasol	Amh. - Gweithred LlC ar gyfer 25-26.	

	destunau – ee, AaGIC, GCC, Byrddau Iechyd. *(Tymor byr/canolig)*	allweddol ar y Gymraeg mewn iechyd a gofal cymdeithasol a fydd yn helpu i nodi bylchau data allweddol mewn perthynas â monitro canlyniadau, effaith a chynnydd. Nid oes angen i gyrff iechyd / gwasanaethau cymdeithasol ddarparu diweddariad ar y cam hwn ar gyfer adroddiad 2024/25.			
10	Bydd Gweithred 30 yn y 'Strategaeth Gweithlu ar gyfer Iechyd a Gofal Cymdeithasol' – datblygu canllawiau cynllunio'r gweithlu ar gyfer nodi a datblygu sgiliau iaith Gymraeg yn y gweithlu iechyd a gofal cymdeithasol – yn cael ei roi ar waith cyn gynted ag y bo modd. Dylai'r canllawiau hyn ystyried faint o staff â sgiliau Cymraeg sydd eu hangen, a natur y sgiliau hynny mewn gwahanol gyd-destunau iechyd a gofal cymdeithasol ac o fewn y meysydd angen â blaenoriaeth. Bydd y canllawiau'n cael eu defnyddio fel rhan o'r gwaith blynyddol i gynllunio'r gweithlu a wneir gan Fyrddau Iechyd,	Mae Canllawiau Cynllunio Gweithlu ar gyfer yr Iaith Gymraeg gan AaGIC wedi'u cyhoeddi. Dylai cyrff iechyd a gofal cymdeithasol ddarparu enghreifftiau o sut mae'r canllawiau hyn wedi'u defnyddio ar draws gwahanol leoliadau / polisïau. AGC ac AGIC i ddarparu gwybodaeth am eu fframweithiau arolygu a sut mae'r rhain hefyd yn canolbwyntio ar sut mae canllawiau AaGIC	AaGIC / Gofal Cymdeithasol Cymru / cyrff iechyd a gofal cymdeithasol / AGC/ AGIC	Mae 'Polisi a Gweithdrefn Sgiliau Dwyieithog' yn amlinellu gweithgareddau recriwtio a chadw staff, gan gynnwys hysbysebu swyddi yr ystyrir bod y Gymraeg yn Hanfodol ar eu cyfer. Mae pedwar categori o swyddi rheng flaen wedi'u nodi yn rhai y mae'r Gymraeg yn Hanfodol ar eu cyfer (clercod wardiau, derbynyddion, staff y switsfwrdd a staff canolfannau trefnu	

	Awdurdodau Lleol, AaGIC, Gofal Cymdeithasol Cymru a chyflogwyr eraill fel y bo'n briodol. Hefyd, bydd y canllawiau'n llywio gwaith yr arolygiaeth a'r rheoleiddwyr perthnasol fel y bo'n briodol. *(Tymor byr)*	yn cael eu defnyddio ar draws lleoliadau iechyd a gofal cymdeithasol		apwyntiadau i gleifion). Os na chaiff siaradwyr Cymraeg eu recriwtio, ceir amod y bydd angen i'r ymgeisydd llwyddiannus ddysgu Cymraeg. Dylid nodi bod Llwybrau Dysgu wedi'u datblygu i fynd i'r afael â hyn. Swyddi Cymraeg yn Hanfodol / Welsh Essential Posts (Sylwer: Os na ellir cyrchu'r manylion, gellir darparu copïau Word).	
11	Dylai pwysigrwydd y Cynnig Rhagweithiol wrth gynllunio a darparu gwasanaethau o safon gael ei gynnwys yn y canllawiau a'r gofynion adrodd ar gyfer y Ddyletswydd Ansawdd a'r safonau iechyd a gofal diwygiedig. Daeth y Ddeddf Iechyd a Gofal Cymdeithasol (Ansawdd ac Ymgysylltu) (Cymru) ('y Ddeddf') yn gyfraith ar 1 Mehefin 2020, a bydd yn cael ei gweithredu'n llawn erbyn gwanwyn 2023. Mae hyn yn cynnwys ailffurfio ac ehangu'r	Bydd Llywodraeth Cymru yn cynnig diweddariad ynghylch y weithred hon. Mae'r Ddyletswydd Ansawdd wedi'i chyflwyno a chynhwyswyd pwysigrwydd y Cynnig Rhagweithiol yn y canllawiau statudol a gyhoeddwyd ym mis Ebrill 2023.	Llywodraeth Cymru	Amh. - Gweithred LIC	

	ddyletswydd ansawdd bresennol ar gyrff y GIG. *(Tymor byr)*				
12	Bydd pwysigrwydd y Gymraeg wrth gynllunio a darparu yn cael ei gynnwys fel thema drawsbynciol yn y Fframwaith Canlyniadau Cenedlaethol diwygiedig, a bydd adroddiadau cynnydd yn cael eu cynnwys yn y broses o ddatblygu trefniadau atebolrwydd Mwy na Geiriau, gan gynnwys y dangosfwrdd. *(Tymor canolig)*	Bydd Llywodraeth Cymru yn cynnig diweddariad ynghylch y weithred hon.	Llywodraeth Cymru	Gweithred LIC	
Thema 2: Cefnogi a datblygu sgiliau iaith Gymraeg y gweithlu presennol a'r dyfodol					
13	Bydd sefydliadau iechyd a gofal cymdeithasol yn dod o hyd i fylchau yn sgiliau'r gweithlu mewn meysydd allweddol ac yn datblygu cynlluniau i fynd i'r afael â nhw. Bydd hyn yn cael ei ymwreiddio mewn cynlluniau sgiliau a gweithlu sy'n cael eu datblygu a'u cyflwyno mewn sefydliadau unigol, ac yn galw am weithio'n agos gydag AaGIC a GCC (Tymor canolig)	Dylai cyrff iechyd a gofal cymdeithasol ddarparu enghreifftiau o sut maent wedi nodi sgiliau gweithlu, lle mae'r bylchau yn bodoli, ac a oes ganddynt gynlluniau ar waith i fynd i'r afael â nhw. Dylai byrddau iechyd roi'r wybodaeth ddiweddaraf yn benodol ar y gwaith sylfaenol y maent wedi'i wneud i gefnogi gwaith Cydweithrediad y Fforwm Iechyd a chyflawni Safon 110 (gweler hefyd Cam 18).	Cyrff Iechyd a Gofal Cymdeithasol, AaGIC a GCC	Yn ystod y flwyddyn adrodd, cwblhawyd asesiad sylfaenol cynhwysfawr o sgiliau yn y Gymraeg ledled y gweithlu i gynorthwyo â Chydweithredu gan y Fforwm Iechyd a chyflawni Safon 110 yn Safonau'r Gymraeg. Wrth ymgymryd â'r asesiad, defnyddiwyd data ynghylch y gweithlu, gwybodaeth am sgiliau yn y Gymraeg, tueddiadau recriwtio ac adolygiadau ar lefel	

				gwasanaethau i nodi'r capasiti presennol yn y Gymraeg a meysydd lle'r oedd bylchau o ran sgiliau yn amlwg. Defnyddiwyd canfyddiadau i lywio gwaith cynllunio'r gweithlu, cryfhau'r gyfatebiaeth rhwng anghenion gwasanaethau a darpariaeth yn y Gymraeg, a chynorthwyo i ddatblygu camau gweithredu wedi'u targedu i fynd i'r afael â bylchau a nodwyd drwy recriwtio, hyfforddi a chynllunio olyniaeth. Mae'r gwaith hwn wedi cynnig dirnadaeth eglurach o broffil gweithlu Bwrdd sy'n gallu siarad Cymraeg ac wedi sefydlu sylfaen dystiolaeth gadarn i gynorthwyo i ddatblygu gwasanaethau a'r gweithlu yn y dyfodol.	

				Gellir darparu data.	
14	Byddwn yn disgwyl i holl gydweithwyr y GIG a gofal cymdeithasol ddilyn cwrs ymwybyddiaeth ieithyddol, a fydd yn egluro pa mor bwysig yw'r Gymraeg wrth ddarparu gwasanaethau ac fel un o anghenion cleifion. Ar ôl cyflwyno hyfforddiant ymwybyddiaeth o'r Gymraeg i bob gweithiwr proffesiynol ym maes iechyd a gofal cymdeithasol, byddwn yn disgwyl i'r hyfforddiant hwn gael ei ddarparu ym mhob disgyblaeth ar gyfer hyfforddeion, a'i gyflwyno fel rhan o'r broses gynefino i weithwyr newydd sydd heb wneud yr hyfforddiant yn barod. *(Tymor canolig)*	Dylai cyrff iechyd a gofal cymdeithasol ddarparu data allweddol ynghylch y niferoedd sy'n ymgymryd â Chyrsiau Ymwybyddiaeth o'r Gymraeg. Mae hynny'n cynnwys data ynghylch darparu'r cwrs fel rhan o'r broses sefydlu.	Cyrff Iechyd a Gofal Cymdeithasol	85% o'r staff – mae 18,590 aelod o'r staff wedi cwblhau'r cwrs. Mae'r data yn ddata a oedd ar gael ar 31 Mawrth 2026. Mae sesiynau Ymwybyddiaeth o'r Gymraeg ychwanegol wedi'u darparu mewn nifer o gyfarfodydd clinigol ar lefel uwch, i fyfyrwyr meddygaeth a gofal iechyd ym Mhrifysgol Wrecsam ac Ysgol Feddygol Gogledd Cymru, ac i Bractisau Meddygon Teulu unigol. Cynhaliwyd sesiynau ymwybyddiaeth ar y lefel drawsffiniol hefyd, a chafodd staff yn yr Uned Mamau a Babanod yng Nghaer hyfforddiant penodol ynghylch ymwybyddiaeth o'r Gymraeg a hyfforddiant dysgu Cymraeg.	

15	Bydd y Ganolfan Dysgu Cymraeg Genedlaethol yn datblygu ymhellach eu cynlluniau i gynnig hyfforddiant ar y Gymraeg i'r sectorau iechyd a gofal cymdeithasol, ac yn darparu amgylchedd sy'n galluogi pobl i ddefnyddio'r Gymraeg mewn gweithleoedd. Dylai hyn ategu'r broses anffurfiol o ddysgu iaith drwy adnoddau ac apiau ar-lein a fydd ar gael ar draws y sector. Gellid modelu hyn ar ddatblygiadau a gyhoeddwyd yn ddiweddar ar gyfer y gweithlu addysg. Dylai hyn gynnwys darpariaeth wedi'i theilwra i gefnogi ymarfer ym maes iechyd a gofal cymdeithasol, a dod o hyd i gyfleoedd (law yn llaw â chyflogwyr perthnasol) i gynyddu hyder staff i ddefnyddio mwy ar eu sgiliau Cymraeg ar ba lefel bynnag yn y gweithle. Rydym hefyd yn argymell bod Llywodraeth Cymru yn ystyried pa adnoddau sydd eu hangen i ddarparu cefnogaeth ddigonol ar gyfer cynllun o'r fath, gan gynnwys helpu cyflogwyr i ryddhau staff allweddol i fynd ati o ddifrif i ddysgu Cymraeg *(Tymor canolig)*	Y Ganolfan Dysgu Cymraeg Genedlaethol i ddarparu diweddariad ar gamau gweithredu allweddol, niferoedd sy'n ymgymryd â chyrsiau penodol, a chanlyniadau. Gofynnir i gyrff iechyd a gofal cymdeithasol ddisgrifio sut maent wedi gweithio'n strategol gyda'r Ganolfan Dysgu Cymraeg Genedlaethol i gwrdd â'u blaenoriaethau eu hunain.	Llywodraeth Cymru / y Ganolfan Dysgu Cymraeg Genedlaethol	Amh. - Gweithred LlC <u>Rhaglen Datblygu'r Gweithlu</u> Mae Tîm Hyfforddiant Dysgu Cymraeg y Bwrdd Iechyd wedi llwyddo i sefydlu ystod eang o gyrsiau dysgu Cymraeg sydd wedi'u teilwra yn unol ag anghenion y sefydliad. Yn ystod y flwyddyn adrodd, fe wnaeth dros 1,000 aelod o'r staff gyfranogi mewn cyfleoedd i ddysgu Cymraeg, ac mae hynny'n gynnydd o 4% o'i gymharu â ffigur 2024-25. Mae hyn yn dangos bod staff BIPBC yn parhau i ymrwymo i ddysgu Cymraeg a defnyddio'r sgiliau y maent yn eu datblygu yn yr iaith i wella ansawdd gwasanaethau a gaiff cleifion ledled Gogledd Cymru. Mae'r Tîm	

				Hyfforddiant Dysgu Cymraeg wedi mynd ati'n rhagweithiol ac yn strategol i sicrhau bod yr hyfforddiant a gynigir yn cyd-fynd â gofynion deddfwriaethol a blaenoriaethau'r sefydliad. Mae anghenion dysgu wedi'u hasesu'n rheolaidd ledled y Bwrdd Iechyd, gan alluogi datblygu cyrsiau dysgu Cymraeg wedi'u targedu ar gyfer staff rheng flaen. Mae grwpiau blaenoriaethol wedi cael cymorth â ffocws pendant i gryfhau gallu'r sefydliad i gynnig gwasanaethau o ansawdd uchel trwy gyfrwng y Gymraeg. <u>Gweithio trwy Bartneriaeth</u> Fe wnaeth Tîm Hyfforddiant Dysgu Cymraeg BIPBC adnewyddu contract deuddeg mis â'r	

				Ganolfan Dysgu Cymraeg Genedlaethol, dan gynllun 'Cymraeg Gwaith' sy'n cael ei ariannu gan Lywodraeth Cymru. Fe wnaeth hynny sicrhau y byddai'r cyfleoedd a'r cydweithredu yn parhau, ac y byddai'r Bwrdd yn parhau i gyflogi ein Swyddog Cefnogi Hyfforddiant Dysgu Cymraeg. Fe wnaeth 798 aelod o'r staff gyrchu'r cyrsiau 'Cymraeg Gwaith' dros y flwyddyn ddiwethaf <u>Cynllun hyfforddiant newydd yn cynnig hwb i'r tîm lechyd Meddwl ac Anableddau Dysgu</u> Ers 2024, mae Tiwtor 'Codi Hyder' amser llawn wedi'i neilltuo i bob bwrdd iechyd trwy bartneriaeth â'r Ganolfan Dysgu Cymraeg Genedlaethol. Mae'r	

				Ganolfan wedi cydweithio â BIPBC i dreialu rhaglen ar gyfer yr Uwch Adran Iechyd Meddwl ac Anableddau Dysgu, i geisio gwella sgiliau yn y Gymraeg a chynorthwyo i gyflawni nod *Mwy na Geiriau* mewn perthynas â chynnig mwy o wasanaethau'n ddwyieithog. Trwy ymgymryd â'r cynllun arloesol hwn, gobeithir y gellir cynyddu nifer y siaradwyr Cymraeg hyderus yn yr Uwch Adran Iechyd Meddwl ac Anableddau Dysgu, gan sicrhau y gellir cynnig gwasanaeth dwyieithog gwell. <u>DATA YNGHYLCH HYFFORDDIANT</u>: - Fe wnaeth BIPBC adnewyddu contract 12 mis â'r Ganolfan Dysgu Cymraeg Genedlaethol. Fe	

				wnaeth 798 aelod o'r staff gyrchu cyrsiau 'Cymraeg Gwaith', gan gynnwys cyfleoedd dysgu hunan-astudio, preswyl a chodi hyder. - Fe wnaeth 238 aelod o'r staff gyfranogi yn y 'Cwrs Croeso' newydd, a ddatblygwyd mewn ymateb i'r amcanion a nodir yng nghynllun pum mlynedd Mwy na Geiriau Llywodraeth Cymru. -Fe wnaeth y tiwtor mewnol gynorthwyo dros 230 aelod o'r staff i ddysgu Cymraeg yn ystod y flwyddyn, sef cynnydd o 17.5% ers 2024–25. Yn galonogol, fe wnaeth mwy na 70% o gyfranogwyr ddewis parhau i astudio'r Gymraeg ar ôl cwblhau cwrs. - Fe wnaeth 42 aelod o'r staff gyfranogi	

				mewn cyrsiau dwys 5 diwrnod yn Nant Gwrtheyrn, ac fe wnaeth pedwar aelod o'r staff gyfranogi mewn cwrs a gynlluniwyd yn benodol ar gyfer staff o wledydd tramor, ac fe wnaeth 12 aelod gyfranogi mewn cyrsiau preswyl Llwybr Carlam i ddysgu Cymraeg. - Fe wnaeth Leanne Parry, Dysgwr y Flwyddyn 2024 yn BIPBC, gyrraedd rownd derfynol cystadleuaeth fawreddog Dysgwr y Flwyddyn yn yr Eisteddfod Genedlaethol. Fe wnaeth y tîm drefnu gwibdaith i'r Eisteddfod ar gyfer staff sy'n dysgu Cymraeg, er mwyn gallu cefnogi Leanne. - Mae grŵp Facebook 'Y Gymraeg yn Betsi' yn parhau i	

				arddangos enghreifftiau o arferion da a hanesion llwyddiannau, ac mae gan y grŵp 593 o ddilynwyr ar hyn o bryd, sy'n gynnydd o 22% ers mis Ebrill 2025. <u>Dysgwr y Flwyddyn</u> Mae Cystadleuaeth Dysgwr y Flwyddyn y Bwrdd Iechyd yn parhau i gyfrannu'n sylweddol at gynnal ymrwymiad y Bwrdd Iechyd i ddatblygu gweithlu dwyieithog a gwella gwasanaethau i gleifion a chymunedau sy'n siarad Cymraeg ledled Gogledd Cymru. Pan gynhaliwyd y gystadleuaeth eleni, cafwyd dros 50 o enwebiadau gan staff o bob cwr o'r sefydliad, gan amlygu ymgysylltu cryf â	

				chyfleoedd i ddysgu Cymraeg ac adlewyrchu pwysigrwydd cynyddol sgiliau dwyieithog ym maes darparu gwasanaethau gofal iechyd. Wedi proses feirniadu drylwyr, fe wnaeth chwe theilyngwr gyrraedd y rhestr fer mewn dau gategori: Lefelau Mynediad/Sylfaen a Lefelau Canolradd/Uwch, Cynhaliwyd y seremoni wobrwyo yng Ngwesty'r Cinmel, Abergele, a bu'r digwyddiad hwnnw'n ddathliad llwyddiannus o orchestion y dysgwyr, ac ystyriai llawer fod hynny'n welliant sylweddol o'i gymharu â blynyddoedd blaenorol. Cyflwynwyd gwobrau i Bethany Frempong Jones (Lefelau Mynediad/Sylfaen) a Dr Caroline Jones	

				(Lefelau Canolradd/Uwch), a chafodd Mark Butler Wobr Dewis y Tiwtor i gydnabod ei ymrwymiad eithriadol i ddysgu Cymraeg. Cafwyd nawdd gan Cymen a Nant Gwrtheyrn i gynorthwyo i gynnal y digwyddiad eleni. Mae'r gystadleuaeth yn parhau i gynnig manteision pendant i'r sefydliad drwy gydnabod cyflawniad dysgwyr, annog staff i gyfranogi mewn hyfforddiant dysgu Cymraeg, hyrwyddo defnydd ymarferol o'r Gymraeg yn y gweithle, a chryfhau diwylliant dwyieithrwydd BIPBC. Mae ansawdd yr enwebiadau a'r teilyngwyr yn amlygu dylanwad cadarnhaol parhau i fuddsoddi mewn mentrau i ddatblygu'r Gymraeg. At ei gilydd, mae Cystadleuaeth	

				Dysgwr y Flwyddyn yn dal yn ddigwyddiad pwysig at ddibenion hyrwyddo a normaleiddio defnydd o'r Gymraeg yn BIPBC ac mae'n cynorthwyo ag ymrwymiad strategol y Bwrdd Iechyd i ddarparu gwasanaethau gofal iechyd dwyieithog o ansawdd uchel. Data 2025 / 2026: Sawl aelod o weithlu'r sefydliad sydd wedi cael hyfforddiant i wella eu sgiliau yn y Gymraeg hyd at lefel cymhwyster penodol: 1,037 Mae hynny'n gyfystyr â 4.9 y cant o weithlu presennol y Bwrdd Iechyd.	
16	Bydd sefydliadau yn diffinio lefel y sgiliau Cymraeg sydd eu hangen ym mhob hysbyseb swydd, yn unol â'r arferion gorau a welir mewn rhai byrddau iechyd ac awdurdodau lleol.	Yr holl gyrff iechyd a gofal cymdeithasol i ddarparu diweddariad am y gwaith sy'n cael ei wneud i ddiffinio sgiliau Cymraeg sy'n ofynnol ym mhob	Cyrff Iechyd a Gofal Cymdeithasol	Mae hyn eisoes yn ei le fel rhan o'r Polisi a'r Weithdrefn ynghylch Sgiliau Dwyieithog. Gweler y manylion isod ynghylch nifer y	

	(Tymor canolig – datblygu a rhannu canllawiau yn y tymor byr)	hysbyseb swydd, yn ogystal â data allweddol ynghylch a yw swyddi yn cael eu hysbysebu fel Cymraeg dymunol ac yn Gymraeg hanfodol.		swyddi a hysbysebwyd gan nodi bod y Gymraeg yn Hanfodol, bod y Gymraeg yn Ddymunol, neu y Dylid Dysgu Cymraeg ar eu cyfer. Data 2025 / 2026: Mae sgiliau yn y Gymraeg yn hanfodol - 274 (6.9%) Mae sgiliau yn y Gymraeg yn ddymunol - 3631 (91.1 %) Dylid dysgu sgiliau yn y Gymraeg - 69 (1.7%) Nid yw'r Gymraeg yn sgil ofynnol - 10 (0.3%) Cyfanswm y swyddi gwag a hysbysebwyd - 3984	
17	Cyflwyno'n raddol lefel "cwrteisi" sylfaenol o sgiliau Cymraeg, gan wneud staff yn fwy ymwybodol o'r effaith gadarnhaol y gall dysgu a defnyddio'r Gymraeg ei chael ar unigolion sy'n defnyddio ac yn derbyn gwasanaethau iechyd a gofal cymdeithasol. Erbyn diwedd oes y cynllun hwn,	Y Ganolfan Dysgu Cymraeg Genedlaethol i ddarparu data ar y cwrs cwrteisi newydd (fel rhan o'r cynllun iechyd a gofal cymdeithasol) a'r niferoedd ar draws y	Y Ganolfan Dysgu Cymraeg Genedlaethol Cyrff Iechyd a Gofal Cymdeithasol	Mae 238 aelod o'r staff wedi cwblhau'r cwrs dysgu Cymraeg ar 'lefel cwrteisi'. Mae llawer o'r rhain wedi camu ymlaen i gyrsiau eraill. Roedd cyfanswm y staff a gyrchodd cyrsiau	

	dylai pob aelod o staff sy'n gweithio ym maes iechyd a gofal cymdeithasol fod â lefel cwrteisi o sgiliau Cymraeg. (Tymor byr-cyflwyno)	sefydliadau sy'n ymgymryd â'r cwrs. Cyrff iechyd a gofal cymdeithasol hefyd i ddarparu gwybodaeth am gyrsiau cwrteisi eraill sy'n cael eu datblygu (nid gan y Ganolfan Dysgu Cymraeg Genedlaethol) a'u cyflwyno'n lleol, a data allweddol ar y niferoedd sy'n ymgymryd â'r cyrsiau.		hyfforddiant dysgu Cymraeg yn ystod 25-26 yn 1037.	
18	Bydd sefydliadau'n datblygu ac yn gweithredu strategaeth gweithlu a hyfforddiant y Gymraeg wedi'i thargedu - â'r pwyslais cychwynnol ar fynd i'r afael â'r bylchau ym meysydd blaenoriaeth allweddol Mwy na Geiriau a'r rhai sydd â diffyg hyder (mae angen ystyried y potensial ar gyfer gweithio gydag arweinwyr tîm / rheolwyr / cyflogwyr i greu'r amodau i unigolion ddefnyddio eu Cymraeg)	Byrddau iechyd i roi diweddariad ar y gwaith sy'n cynorthwyo cyflawni Safon 110, a sut maent yn cynyddu'r defnydd o'r Gymraeg ar draws lleoliadau clinigol.	Cyrff iechyd a gofal cymdeithasol	Ym mis Mehefin 2026, cyflwynwyd Adroddiad Diwedd Blwyddyn 2 a oedd yn manylu ar gyflawni'r canlyniadau yng Nghynllun Pum Mlynedd Safon 110, yn Fforwm Strategol y Gymraeg. Adroddiad ynghlwm. End-of Year Standard 110 Implementation F	

	(Tymor canolig)				
19	Cychwyn ymgyrch hyrwyddo ac ymwybyddiaeth genedlaethol i wneud staff yn fwy ymwybodol o'r gwahaniaeth cadarnhaol y gall dysgu a defnyddio'r Gymraeg ei wneud i'r gwasanaethau y maen nhw'n eu darparu. Bydd hyn yn cynnwys ymgyrchoedd recriwtio sy'n cyfleu pwysigrwydd y Gymraeg. Bydd yr ymgyrchoedd yn cynnwys modelau rôl ac astudiaethau achos ar y gwahaniaeth y mae defnyddio'r Gymraeg yn ei wneud i wella canlyniadau unigolion. *(Tymor canolig)*	Lansiodd Llywodraeth Cymru gyfres o ffilmiau ym mis Hydref 2025 (wedi'u lleoli mewn gwahanol leoliadau iechyd a gofal cymdeithasol) ac animeiddiad cyffredinol i hyrwyddo amcanion Mwy na Geiriau a'r Cynnig Rhagweithiol. Cyrff iechyd a gofal cymdeithasol i ddarparu gwybodaeth ar ymgyrchoedd hyrwyddo y maent hefyd yn eu cyflwyno i godi ymwybyddiaeth o'r gwahaniaeth y gall dysgu Cymraeg ei wneud. Dylai hyn gynnwys astudiaethau achos a gwobrau sy'n cynnwys y Gymraeg.	Llywodraeth Cymru / GCC ac AaGIC	Gweler Cam gweithredu 15 uchod.	

20	Bydd Gyrfa Cymru/AaGIC a GCC yn hyrwyddo pwysigrwydd sgiliau Cymraeg a'r cyfleoedd posibl a ddaw yn sgil hynny mewn gyrfaoedd ym maes iechyd a gofal cymdeithasol, gan ddefnyddio adnoddau porth Tregyrfa a thrwy sioeau teithiol a sesiynau ymgysylltu â phobl ifanc. *(Tymor byr/canolig)*	AaGIC i ddarparu gwybodaeth am Dregyrfa, gan gynnwys data am niferoedd sy'n ymweld â'r safle. AaGIC hefyd i ddarparu gwybodaeth am sioeau teithiol a digwyddiadau ymgysylltu a gynhelir gyda sefydliadau addysgol. Gyrfa Cymru i ddarparu gwybodaeth am fentrau sy'n hyrwyddo pwysigrwydd sgiliau Cymraeg mewn gyrfaoedd iechyd a gofal cymdeithasol, gan gynnwys data ar nifer y mynychwyr ar gyfer digwyddiadau / sioeau teithiol / sesiynau ymgysylltu. Cyrff iechyd a gofal i ddarparu gwybodaeth am sioeau teithiol ac ymgysylltu â phobl	Gyrfa Cymru / AaGIC a GCC /cyrff iechyd a gofal	Mae'r Bwrdd Iechyd wedi cryfhau ei bartneriaethau strategol â phrifysgolion, ysgolion a sefydliadau sector i hyrwyddo'r Gymraeg fel sgil broffesiynol werthfawr ac elfen hanfodol o weithlu dwyieithog y dyfodol. Drwy'r dull cydweithredol hwn, mae'r sefydliad yn helpu i wreiddio'r ddealltwriaeth bod y Gymraeg yn hanfodol o ran gofal o ansawdd uchel ac arferion sector cyhoeddus modern. Mae'r Tîm wedi parhau i weithio'n agos gyda Gyrfa Cymru ar ystod o weithgareddau ymgysylltu gyda dysgwyr ar draws Ysgol Morgan Llwyd, Ysgol y Creuddyn,	

		ifanc, gan gynnwys data ar nifer y mynychwyr.		Ysgol Rhosnesni, Coleg Cambria ac Ysgol Uwchradd Gatholig Sant Richard Gwyn a llawer mwy. Roedd y rhain yn cynnwys sesiynau Cymraeg yn y Gweithle, digwyddiadau arddull carwsél lle cafodd disgyblion, mewn grwpiau bach, gyfle i ofyn cwestiynau am bwysigrwydd y Gymraeg yn y gweithle, yn ogystal â chyfweliadau ffug ar gyfer disgyblion Blwyddyn 10 i'w helpu i baratoi ar gyfer eu gyrfaoedd yn y dyfodol. Rhannodd y Tîm wybodaeth ac enghreifftiau o arfer da mewn ffeiriau gyrfaoedd a digwyddiadau eraill sy'n gysylltiedig â gyrfaoedd hefyd.	

				Rhoddodd y gweithgareddau hyn gyfleoedd gwerthfawr i hyrwyddo defnydd a phwysigrwydd yr iaith Gymraeg o fewn lleoliadau gofal iechyd ac i godi ymwybyddiaeth o'r gwahaniaeth sylweddol y gall gwasanaethau Cymraeg ei wneud i gleifion, defnyddwyr gwasanaethau a'u teuluoedd. Drwy ymgysylltu â dysgwyr a phobl ifanc, tynnodd y Tîm sylw at yr ystod eang o gyfleoedd gyrfa sydd ar gael o fewn gofal iechyd a phwysigrwydd sgiliau dwyieithog wrth ddarparu gofal sy'n canolbwyntio ar yr unigolyn. Roedd yn galonogol derbyn adborth mor gadarnhaol gan staff	

				yr ysgol, gydag Ysgol Uwchradd Gatholig Sant Richard Gwyn yn nodi: *“Roedd yn wych cael Tîm y Gymraeg y Bwrdd Iechyd yn yr ysgol yn cyflwyno eto eleni am bwysigrwydd y Gymraeg yn y gweithle ac yn y sector meddygol. Mae cael staff i ddod i'r ysgol i roi cyflwyniad i ddisgyblion yn ffordd hynod bwerus o ddangos pwysigrwydd gallu sgwrsio â chleifion yn yr iaith y maent fwyaf cyfforddus ynddi. Mae hyn yn ei dro yn ategu gwaith ysgolion a chanlyniadau myfyrwyr drwy helpu i roi cyd-destun i bwysigrwydd eu dysgu a'r pynciau y maen nhw'n eu hastudio.”*	

				Hefyd, yn ystod y cyfnod adrodd, cryfhaodd y Bwrdd lechyd ei waith partneriaeth â phrifysgolion rhanbarthol i gefnogi datblygiad gweithlu dwyieithog yn y dyfodol. Cydweithiodd Tîm y Gymraeg â Phrifysgol Wrecsam fel rhan o'i modiwl newydd 20 credyd 'Cymraeg yn y Gweithle 1' ar gyfer myfyrwyr Proffesiynau sy'n Gysylltiedig ag Iechyd, gan gyflwyno sesiynau iaith ac ymwybyddiaeth iaith a gynlluniwyd i arfogi clinigwyr y dyfodol â'r hyder a'r sgiliau i ddefnyddio'r Gymraeg mewn ymarfer proffesiynol. Yn yr un modd, parhaodd y Bwrdd	

				Iechyd â'i ymgysylltiad â Phrifysgol Bangor ac Ysgol Feddygol Gogledd Cymru drwy'r Rhaglen Feddygaeth newydd. Cyflwynodd y tîm sesiynau yn amlinellu dull strategol y sefydliad o hyrwyddo ac ymgorffori'r iaith a diwylliant Cymraeg ar draws gwasanaethau clinigol, gan bwysleisio pwysigrwydd dewis iaith mewn gofal diogel, sy'n canolbwyntio ar yr unigolyn. Rhoddodd un o Feddygon Ymgynghorol Gofal yr Henoed y Bwrdd Iechyd yn Ysbyty Gwynedd safbwynt ymarferydd ar werth defnyddio'r Gymraeg bob dydd mewn rhyngweithiadau clinigol a'r effaith gadarnhaol y mae	

				hyn yn ei chael ar brofiad cleifion. Cymerodd y Bwrdd Iechyd ran hefyd mewn sesiwn holi ac ateb gyda myfyrwyr Blwyddyn 2 yn Ysgol Feddygol Gogledd Cymru i ddangos pwysigrwydd siarad Cymraeg gyda chleifion, a'r gefnogaeth a gynigir gan y Bwrdd Iechyd ar ôl iddynt gael eu lleoli. Mae'r cydweithrediadau hyn yn rhan bwysig o strategaeth hirdymor y Bwrdd Iechyd i feithrin gweithlu clinigol hyderus a dwyieithog er mwyn sicrhau bod cenedlaethau'r dyfodol o weithwyr gofal iechyd	

				proffesiynol wedi'u paratoi'n ddigonol i ddiwallu anghenion ieithyddol y boblogaeth.	
21	AaGIC, MEDR a GCC i fonitro nifer y myfyrwyr dwyieithog sy'n hyfforddi i fod yn weithwyr proffesiynol ym maes iechyd a gofal cymdeithasol bob blwyddyn, yn unol â'r fframwaith y cytunwyd arno ar gyfer mesur sgiliau Cymraeg, a chyhoeddi'r data bob blwyddyn. Gallai hyn adlewyrchu neu adeiladu ar ofynion sydd eisoes ar waith mewn perthynas â chontractau AaGIC, monitro GCC a/neu ddata HESA. O ran cyhoeddi'r data, rydym yn argymell bod tabl penodol yn cael ei gynnwys yn y Bwletin Ystadegau blynyddol – Yr iaith Gymraeg mewn sefydliadau addysg uwch i adrodd ar y data hwn. Bydd y data hwn hefyd yn cael ei gynnwys yn y broses o ddatblygu dangosfwrdd, fel sy'n cael ei amlinellu o dan Adran 4.	AaGIC / MEDR / GCC i ddarparu data ar nifer y myfyrwyr dwyieithog sy'n cael eu hyfforddi fel gweithwyr proffesiynol iechyd a gofal cymdeithasol. Dylid darparu'r data hwn yn unol â'r argymhellion o'r Ymarfer Mapio ac Adolygu Data a gynhaliwyd gan Alma Economics.	AaGIC /MEDR / GCC	Nid yw'n berthnasol - Camau gweithredu i'w cwblhau gan AaGIC/ MEDR / GCC	

	(Tymor byr)				
22	Bydd Llywodraeth Cymru yn monitro nifer y prentisiaid a'r dysgwyr dwyieithog sy'n dilyn cyrsiau a/neu brentisiaethau Iechyd a Gofal Cymdeithasol bob blwyddyn, yn unol â'r fframwaith y cytunwyd arno ar gyfer mesur sgiliau Cymraeg, ac yn cyhoeddi'r data bob blwyddyn. Bydd y data hwn hefyd yn cael ei gynnwys yn y broses o ddatblygu dangosfwrdd, fel yr amlinellir yn Adran 4. *(Tymor byr)*	Bydd Llywodraeth Cymru yn cynnwys y data diweddaraf yn Adroddiad Blynyddol Mwy na Geiriau gyfer 2025-26.	Llywodraeth Cymru	Nid yw'n berthnasol – Cam gweithredu i'w gwblhau gan Lywodraeth Cymru.	
23	Mae Llywodraeth Cymru / MEDR wedi sefydlu meincnod ar gyfer darpariaeth ddwyieithog – hynny yw, bod traean o gwrs (o leiaf) ar gael yn y Gymraeg. Mae meincnod o'r fath yn galluogi myfyrwyr sy'n hyderus yn y Gymraeg i ddilyn rhan o'u cwrs drwy gyfrwng y Gymraeg, ac i ddatblygu lefel o hyder i weithio'n ddwyieithog. Mae hyn hefyd yn adlewyrchu arferion gorau rhyngwladol – ee, Ysgol Feddygol Prifysgol Helsinki.	Y Coleg Cymraeg Cenedlaethol i ddarparu diweddariad ar y nifer o gyrsiau israddedig ym meysydd iechyd a gofal. Mae hyn i gynnwys gwybodaeth am gyrsiau iechyd a gofal cymdeithasol lle na all myfyrwyr astudio	AaGIC / GCC / Y Coleg Cymraeg Cenedlaethol	Nid yw'n berthnasol Camau gweithredu i'w cwblhau gan AaGIC / GCC / Y Coleg Cymraeg Cenedlaethol	

	Bydd AaGIC / GCC yn gweithio gyda phrifysgolion yng Nghymru a'r Coleg Cymraeg Cenedlaethol i nodi unrhyw gyrsiau lle na all y myfyrwyr ar hyn o bryd astudio traean o'u cyrsiau iechyd a gofal cymdeithasol yn ddwyieithog, ac yn cymryd camau priodol i sicrhau bod darpariaeth ddwyieithog yn cael ei chynnig ar bob cwrs iechyd a gofal cymdeithasol yng Nghymru. Bydd ystyriaeth briodol yn cael ei rhoi i leoliadau hefyd, a bydd myfyrwyr yn cael cefnogaeth i ymgymryd â lleoliadau dwyieithog fel rhan o'u hyfforddiant. *(Tymor byr)*	traean o'r cwrs drwy gyfrwng y Gymraeg. Dylid darparu'r data hwn yn unol â'r argymhellion o'r Ymarfer Mapio ac Adolygu Data a gynhaliwyd gan Alma Economics.			
24	Bydd Llywodraeth Cymru yn ystyried pa gymelliadau (ariannol neu fel arall) y gellir eu cynnig i fyfyrwyr sy'n gwneud elfen o'u cwrs drwy gyfrwng y Gymraeg. Mae cymelliadau eisoes yn cael eu cynnig mewn perthynas â'r gweithlu Addysg. *(Tymor byr)*	Mae Llywodraeth Cymru yn casglu gwybodaeth am gymhellion sydd ar gael i fyfyrwyr ar hyn o bryd, gan gynnwys bwrsarïau.	Llywodraeth Cymru	Nid yw'n berthnasol – Cam gweithredu i'w gwblhau gan Lywodraeth Cymru.	

25	Rhoddir ystyriaeth i ehangu Doctoriaid Yfory, cynllun hynod lwyddiannus sy'n helpu darpar fyfyrwyr i wneud cais llwyddiannus i ysgol feddygol, i gynnwys yr holl broffesiynau iechyd a gofal cymdeithasol lle mae'r broses ymgeisio i astudio yn y Brifysgol yn un gystadleuol. Yn fwy cyffredinol, bydd Llywodraeth Cymru yn ystyried a allai cynllun o'r fath helpu disgyblion o gefndiroedd difreintiedig i wneud cais llwyddiannus i astudio meddygaeth a phynciau eraill. *(Tymor byr)*	Mae Cynllun Doctoriaid Yfory bellach wedi'i ymestyn i yrfaoedd iechyd a gofal cymdeithasol mwy cyffredinol, gan gynnwys deintyddiaeth. Bydd Llywodraeth Cymru yn ystyried cyfleoedd i hyrwyddo'r cynllun ymhellach. Y Coleg Cymraeg Cenedlaethol i ddarparu'r data diweddaraf ar y nifer sy'n ymgymryd â'r cynllun.	Llywodraeth Cymru / Coleg Cymraeg Cenedlaethol	Nid yw'n berthnasol - Llywodraeth Cymru / Coleg Cymraeg Cenedlaethol	
26	Bydd pob darparwr hyfforddiant iechyd a gofal cymdeithasol yng Nghymru yn paratoi cynllun tymor canolig ar ddatblygu ymwybyddiaeth o'r Gymraeg a sgiliau dwyieithog eu myfyrwyr, ac yn cyflwyno'r cynllun o fewn 12 mis i'r corff comisiynu / achredu / rheoleiddio perthnasol. Dylai'r rhain gynnwys manylion y	AaGIC a'r Coleg Cymraeg Cenedlaethol i ddarparu diweddariad am y gwaith sy'n cael ei wneud i ddatblygu'r cam hwn.	Llywodraeth Cymru / Coleg Cymraeg Cenedlaethol / AaGIC	Nid yw'n berthnasol - Camau gweithredu i'w cwblhau gan Lywodraeth Cymru / Coleg Cymraeg Cenedlaethol / AaGIC	

	capasiti addysgu y mae gofyn eu cael er mwyn cyflwyno rhaglenni dwyieithog yn ôl yr angen. Bydd Llywodraeth Cymru yn ystyried y rôl y gallai'r Coleg Cymraeg Cenedlaethol ei chwarae i adolygu a darparu adborth a chyngor i'r cyrff perthnasol ar y cynlluniau tymor canolig. *(Tymor byr)*				
27	Bydd Llywodraeth Cymru yn adolygu'r cynlluniau a ddatblygwyd o dan Gam Gweithredu 30, Ein Strategaeth Gweithlu ar gyfer Iechyd a Gofal Cymdeithasol, ac yn cymryd camau priodol i helpu i ddatblygu capasiti addysgu dwyieithog a, lle bo'n briodol, yn darparu adnoddau addas i gefnogi'r datblygiadau hyn. *(Tymor byr)*	Cam Gweithredu 30 *Cymru Iachach: Ein Strategaeth Gweithlu ar gyfer Iechyd a Gofal Cymdeithasol* yw: Cryfhau capasiti'r gweithlu iechyd a gofal cymdeithasol yn y Gymraeg, gan sicrhau bod staff yn cael eu cefnogi i ddysgu, defnyddio a datblygu eu Cymraeg yn y gweithle. Cyrff iechyd a gofal cymdeithasol, GCC, Coleg Cymraeg Cenedlaethol ac AaGIC i ddarparu	Llywodraeth Cymru / GCC / AaGIC / Coleg Cymraeg Cenedlaethol / cyrff iechyd a gofal cymdeithasol.	Nid yw'n berthnasol	

		enghreifftiau o'r gwaith y maent wedi'i ddatblygu i ategu'r agenda hon. I fyrddau iechyd, bydd hyn yn cynnwys gwaith sy'n cael ei ddatblygu i gefnogi Cydweithrediad y Fforwm Iechyd.			
28	Mae'r Coleg Cymraeg Cenedlaethol yn gyfrifol am adolygu'r ddarpariaeth ddwyieithog ym maes iechyd a gofal cymdeithasol ar draws y sector Addysg Bellach a phrentisiaethau, ac am wneud argymhellion fel y bo'n briodol ynghylch y camau pellach sydd eu hangen i ddatblygu sgiliau dwyieithog ymhlith dysgwyr lefelau 2 a 3. *(Tymor canolig)*	Coleg Cymraeg Cenedlaethol i ddarparu gwybodaeth am yr adolygiad hwn a gweithredu'r argymhellion.	Y Coleg Cymraeg Cenedlaethol	Nid yw'n berthnasol Camau gweithredu i'w cwblhau gan Y Coleg Cymraeg Cenedlaethol	
Thema 3: Rhannu arferion gorau a dulliau sy'n galluogi					
29	Byddwn yn casglu ac yn rhannu enghreifftiau o arfer da arloesol sydd ar gael ar draws y sector gan ddefnyddio'r pyrth a'r hybiau	Dylai cyrff iechyd a gofal cymdeithasol ddarparu enghreifftiau o ble a sut y maent	Llywodraeth Cymru / cyrff iechyd a gofal cymdeithasol	Arfer da yn cael ei rannu fel rhan o'r cylchlythyr 'Mwy na Geiriau'. Cyflwyniad	

	presennol gan gynnwys yr Hybiau Ymchwil ac Arloesi. *(Tymor byr)*	wedi rhannu arfer da, gan gynnwys enghreifftiau mewnol yn ogystal â sefydliadau eraill. Cyrff iechyd a gofal cymdeithasol hefyd i ddarparu gwybodaeth ynghylch a ydynt wedi defnyddio Hwb Iaith i rannu arfer da. Dylent hefyd ddarparu tystiolaeth o ddefnyddio'r Hybiau Ymchwil ac Arloesi ac os nad ydynt wedi'u defnyddio, esbonio pam.		chwarterol gan y Bwrdd Iechyd i sicrhau bod yr holl arferion da yn cael eu rhannu mewn modd cyson.	
30	Byddwn yn defnyddio'n Pecyn Cymorth Technegol Dwyieithog i sicrhau bod y gwasanaethau digidol yr ydym yn eu caffael a/neu'n eu datblygu yn cynnwys rhyngwyneb defnyddiwr dwyieithog lle bo hynny'n bosibl. O ran gwefannau gwybodaeth a chyngor, byddwn yn dod a chyfieithwyr yn agosach at y broses creu cynnwys,	Dylai Iechyd a Gofal Digidol Cymru (DHCW) a chyrff iechyd a gofal cymdeithasol ddarparu enghreifftiau penodol o ble a sut y cafodd egwyddorion y Pecyn Cymorth Dwyieithog eu defnyddio.	Iechyd a Gofal Digidol Cymru/ Cyrff iechyd a gofal cymdeithasol		

	gan gyd-ddrafftio yn y Gymraeg a'r Saesneg, fel ein bod yn cyfathrebu yn gliriach yn y ddwy iaith. *(Tymor byr)*				
32	Byddwn yn sicrhau bod Arweinwyr Gweithredol, Hyrwyddwyr a Swyddogion y Gymraeg yn cwrdd yn genedlaethol i rannu arferion gorau er mwyn sicrhau dull cyson o ymdrin â materion allweddol a datblygu mentrau i ddathlu llwyddiannau, gan gynnwys hyrwyddo Mwy na Geiriau mewn cynlluniau gwobrwyo ac anrhydeddau sydd eisoes yn bodoli. *(Tymor byr)*	Cyrff iechyd a gofal cymdeithasol i ddarparu gwybodaeth am enghreifftiau o arfer da a rennir fel rhan o rwydweithiau presennol, gwobrau a digwyddiadau. Bydd Llywodraeth Cymru hefyd yn rhoi diweddariad am y Digwyddiad Rhanddeiliaid Cenedlaethol a gynhaliwyd ym mis Hydref 2025.	Llywodraeth Cymru / Cyrff iechyd a gofal cymdeithasol	Gweler 29 uchod.	
33	Byddwn yn cynnal arolwg gyda darparwyr gofal sylfaenol i ddeall effaith y dyletswyddau o ran y Gymraeg ar ddarparu'r Cynnig Rhagweithiol. Bydd yr arolwg yn	Bydd Llywodraeth Cymru yn rhoi diweddariad ar y cam hwn.	Byrddau Iechyd a Chlystyrau Gofal Sylfaenol	Diweddariad ar Brosiect Gofal Sylfaenol - cydweithrediad rhwng Bwrdd Iechyd	

	dangos yr arferion gorau ac yn rhoi cyngor i Gyfarwyddwyr Gweithredol Gofal Sylfaenol er mwyn datblygu a gwella gwasanaethau Cymraeg ymhellach, gan weithio'n agos gyda'r clystyrau. *(Tymor canolig)*	Mae disgwyl i ganlyniadau'r arolwg a gynhaliwyd yn 2024 ac ymchwil ansoddol ategol a gynhaliwyd yn 2025 a 2026 gael eu cyhoeddi'n fuan. Nid oes angen i gyrff iechyd / clystyrau gofal sylfaenol roi diweddariad am y cam hwn ar gyfer adroddiad 2025/26.		Prifysgol Betsi Cadwaladr a Fforwm Iaith Môn Mae'r prosiect meddygfeydd teulu ar y cyd rhwng BIPBC a Fforwm Iaith Môn wedi datblygu i fod yn gam pwysig wrth geisio deall a gwella'r ddarpariaeth iaith Gymraeg mewn meddygfeydd preifat ar yr ynys. Nod y prosiect yw casglu adborth gan gleifion a'r cyhoedd am y sefyllfa bresennol, gan greu llinell sylfaen gadarn o'r gwasanaethau sydd ar gael ar hyn o bryd. Nid yw'r maes gofal sylfaenol yn ddarostyngedig i Safonau'r Iaith Gymraeg yn yr un modd â Byrddau Iechyd. Serch hynny, mae 6 dyletswydd sy'n berthnasol iddynt, sy'n cynnwys	

				sicrhau bod posteri ac arwyddion yn cael eu cyfieithu. Mae cyfraniad y Fforwm Iaith wedi bod yn allweddol i lwyddiant y prosiect hyd yn hyn. Drwy ddosbarthu holiaduron i'r cyhoedd, mae dros 50 o ymatebion eisoes wedi dod i law, ac mae gwaith ar y gweill i'w dadansoddi. Mae'r gwaith hwn yn enghraifft o gydweithio cryf ac ystyrlon rhwng partneriaid lleol, gan sicrhau bod llais y gymuned yn ganolog i'r broses. Ar yr un pryd, mae'r prosiect yn dal i aros am ymatebion gan y meddygfeydd eu hunain, a fydd yn ychwanegu at y darlun llawn o'r	

				ddarpariaeth bresennol. Yn ogystal â hyn, mae sefydlu Academi Darpariaeth Cymru yn gam strategol arwyddocaol. Mae'r Academi yn cynnig un safle canolog lle gall pob darparwr gofal sylfaenol - gan gynnwys meddygfeydd teulu, deintyddion, optegwyr a fferyllwyr - gael mynediad at gymorth ac adnoddau i gryfhau eu defnydd o'r iaith Gymraeg. Mae'r gefnogaeth hon, sydd ar gael yn rhad ac am ddim gan y Bwrdd Iechyd, yn cynnwys cyfieithu arwyddion a llythyrau, pecynnau adnoddau Cymraeg, canllawiau ar ateb y ffôn yn ddwyieithog, yn ogystal â mynediad at gyrsiau dysgu	

				Cymraeg a sesiynau ymwybyddiaeth iaith. Y cam nesaf yn natblygiad y prosiect yw lansio'r Academi gyda chyfranogiad un feddygfa ar Ynys Môn, gan osod y sylfaen ar gyfer ehangu cefnogaeth i ddarparwyr eraill yn y dyfodol. Mae'r gwaith hyd yma yn dyst i ymroddiad ac arbenigedd y partneriaid, ac yn benodol i gyfraniad gwerthfawr y Fforwm Iaith, sydd wedi sicrhau bod y prosiect yn parhau i adlewyrchu anghenion ac uchelgeisiau'r gymuned leol.	
34	Hwyluso'r broses o ddatblygu adnoddau ac asesiadau diagnostig Cymraeg safonol er mwyn helpu siaradwyr Cymraeg mewn meysydd blaenoriaeth penodol fel iechyd meddwl,	Bydd Llywodraeth Cymru yn rhoi diweddariad ar y cam hwn.	Llywodraeth Cymru	Nid yw'n berthnasol – Cam gweithredu i'w gwblhau gan Lywodraeth Cymru.	

	anableddau dysgu, a phobl â nam ar eu golwg. Bydd hyn yn adeiladu ar y gwaith sydd eisoes ar y gweill i ddatblygu set genedlaethol o asesiadau safonol ar gyfer siaradwyr Cymraeg sydd â dementia. *(Tymor hir)*	Fodd bynnag – fel y nodwyd ar gyfer Cam 6: Gofynnir i gyrff iechyd a gofal cymdeithasol ddarparu tystiolaeth o lwybrau gofal Cymraeg ar gyfer y grwpiau blaenoriaeth. Ar hyn o bryd mae Llywodraeth Cymru yn casglu asesiadau diagnostig ac adnoddau a ddylai fod ar gael yn y Gymraeg.			
35	Mae arwyddion gweledol nid yn unig yn galluogi defnyddwyr gwasanaethau i wybod pa staff sy'n siarad Cymraeg, maent hefyd yn cyfleu'r neges bod y Gymraeg yn rhan 'arferol' o'r broses bob dydd o ddarparu gwasanaethau, ac yn meithrin ethos o berthyn. Byddwn yn ymestyn y prosiect Iaith Gwaith Iedled Cymru er mwyn i weithwyr sy'n gallu cynnig gwasanaethau yn y Gymraeg, neu gynnig	Cyrff iechyd a gofal cymdeithasol i roi diweddariad am yr hyn a wneir i gefnogi'r gwaith o adnabod staff sy'n siarad Cymraeg, a'i hyrwyddo – gan gynnwys unrhyw waith mewn perthynas â systemau digidol yn lleol.	Llywodraeth Cymru / Iechyd a Gofal Digidol Cymru / cyrff iechyd a gofal cymdeithasol	Mae staff yn cael dewis rhoi'r logo 'Cymraeg' ar eu gwisg waith (Staff Nyrsio a Gweithwyr Cymorth Gofal Iechyd).	

	gwasanaethau'n rhannol drwy gyfrwng y Gymraeg, ddangos hynny'n rhwydd drwy wisgo bathodyn neu laniard laith Gwaith. Bydd ein systemau TGCh hefyd yn casglu, yn dangos ac yn rhannu gwybodaeth sy'n rhoi gwybod i ni fel unigolion a staff pwy sy'n gallu siarad Cymraeg a pha wasanaethau y byddant yn eu cynnig drwy gyfrwng y Gymraeg – er mwyn i ni allu defnyddio ein Cymraeg gyda nhw. (Mae'n bosibl bydd angen cyllid/adnoddau ychwanegol er mwyn cyflawni hyn) (*Tymor byr*)	DHCW i roi diweddariad ar y gwaith sy'n digwydd ar lefel genedlaethol i gefnogi'r agenda hon.			
36	Byddwn yn parhau i wella galluoedd Cymraeg systemau digidol cenedlaethol ym maes iechyd a gofal cymdeithasol, ac yn sicrhau bod apiau sy'n cael eu datblygu - fel Ap GIG Cymru - yn cefnogi gweledigaeth a chamau gweithredu'r cynllun	DHCW i roi diweddariad ar y camau sy'n cael eu cymryd i gyflawni'r ymrwymiad hwn.	Llywodraeth Cymru / Iechyd a Gofal Digidol Cymru	Nid yw'n berthnasol - Camau gweithredu i'w cwblhau gan Lywodraeth Cymru / Iechyd a Gofal Digidol Cymru.	

	hwn. Bydd hyn yn cynnwys rhannu, cofnodi a thracio gwybodaeth rhwng systemau, gan gynnwys dewis iaith. Byddwn hefyd yn gweithio gyda defnyddwyr gwasanaethau ar yr holl brosesau technegol a chynnwys i wneud yn siŵr eu bod yn hawdd eu defnyddio a'u deall yn Gymraeg ac yn Saesneg. *(Tymor canolig)*	DHCW hefyd i ddarparu data ar y niferoedd sy'n cyrchu / defnyddio'r opsiynau Cymraeg yn yr Ap, os yw hyn yn bosibl.			
37	Byddwn yn datblygu adnoddau geiriadurol, corpws terminoleg o safon uchel, systemau cof iaith ac adnoddau ymarferol i helpu staff i ddefnyddio eu sgiliau Cymraeg, er enghraifft Gair i Glaf. Yn y tymor byr, bydd hyn yn cynnwys swyddogion y Gymraeg a chyfieithwyr yn cydweithio ar gasglu a chyfuno termau ynghyd â gallu a chapasiti cyfieithu. *(Tymor byr- cydweithio ar ddatblygu termau safonol)*	Cyrff iechyd a gofal cymdeithasol a Phartneriaeth Cydwasanaethau GIG Cymru i roi diweddariad ar y gwaith sy'n cael ei wneud i ddatblygu a chefnogi'r gwaith o gyflwyno'r adnoddau hyn.	Llywodraeth Cymru / Cyrff iechyd a gofal cymdeithasol / NWSSP	Mae'r Tîm Cyfieithu yn chwarae rhan strategol hanfodol wrth alluogi'r Bwrdd Iechyd i gyflawni ei rwymedigaethau statudol o dan Safonau'r Iaith Gymraeg ac i gryfhau ymrwymiad ehangach y sefydliad i ddarparu gofal teg, sy'n canolbwyntio ar yr unigolyn. Drwy ddarparu gwasanaethau cyfieithu o ansawdd	

				uchel ar draws pob adran, mae'r tîm yn sicrhau bod cyfathrebu dwyieithog wedi'i ymgorffori fel gofyniad gweithredol craidd yn hytrach na gweithgaredd atodol. Mae'r galw parhaus am gyfieithu yn adlewyrchu gwelededdd cynyddol yr iaith Gymraeg ar draws swyddogaethau'r Bwrdd Iechyd a ffocws y sefydliad ar wella'r profiad i gleifion trwy wybodaeth hygyrch sy'n gydnaws â diwylliant. Mae prosesau sicrhau ansawdd cadarn y tîm a blaenoriaethu deunyddiau sy'n sensitif i amser yn cefnogi gwydnwch gweithredol, yn lliniaru risg	

				cydymffurfio, ac yn sicrhau bod staff a chleifion yn derbyn gwybodaeth gywir yn eu hiaith ddewisol, a thrwy hynny'n atgyfnerthu nod strategol y Bwrdd Iechyd o ddarparu gwasanaethau diogel, cynhwysol a chydymffurfiol â'r gyfraith. Mae'r Bwrdd Iechyd yn parhau i gynhyrchu incwm allanol drwy ddarparu gwasanaethau cyfieithu arbenigol yn y Gymraeg. Yn 2024–2025, gwnaeth Tîm y Gymraeg Gytundeb Lefel Gwasanaeth gyda Bwrdd Iechyd Prifysgol Aneurin Bevan i ddarparu cymorth cyfieithu ysgrifenedig, gan adlewyrchu hyder yng	

				ngallu a safonau proffesiynol y tîm. Arweiniodd llwyddiant y trefniant hwn at gytundeb newydd yn 2025–2026, ac mae'r ddau sefydliad bellach wedi cadarnhau parhad am y drydedd flwyddyn yn olynol yn 2026–2027. Mae'r bartneriaeth barhaus hon yn dangos ansawdd uchel, dibynadwyedd ac enw da gwaith y tîm, gan gyfrannu incwm rheolaidd gwerthfawr i'r Bwrdd Iechyd. Mae'r tîm wedi parhau i foderneiddio ei ddull gweithredol drwy wella'r defnydd o dechnoleg Cof Cyfieithu, sydd wedi'i hymgorffori mewn llif gwaith dyddiol ers	

				sawl blwyddyn. Fel rhan o raglen effeithlonrwydd ehangach, mae'r tîm wedi archwilio cyfleoedd i symleiddio prosesau ymhellach, lleihau dyblygu, a chyflymu amseroedd cwblhau ar gyfer ceisiadau cyfieithu cyfaint uchel. Mae'r gwaith hwn wedi cynnwys buddsoddi mewn system Cof Cyfieithu wedi'i huwchraddio, 'Wordfast', sy'n cynnig ymarferoldeb gwell, rheolaethau cysondeb gwell, a mwy o gapasiti i gefnogi tasgau cyfieithu cymhleth. Mae mabwysiadu'r feddalwedd wedi'i diweddaru hon yn gam strategol tuag at gryfhau cynhyrchiant, cefnogi twf yn y galw, a sicrhau bod y Bwrdd Iechyd yn	

				cynnal gwasanaeth cyfathrebu dwyieithog gwydn o ansawdd uchel sy'n cyd-fynd â blaenoriaethau statudol a sefydliadol. Mae ceisiadau cyfieithu brys yn ystod y cyfnod adrodd wedi cynnwys datganiadau i'r wasg, gohebiaeth i gleifion, adroddiadau blynyddol, a gwybodaeth iechyd cyhoeddus ar gyfer sianeli cyfryngau cymdeithasol pan fo'r elfen amser yn hollbwysig. Mae'r Tîm Cyfieithu yn gyson yn blaenoriaethu'r holl gyfathrebiadau sy'n wynebu'r cyhoedd a chleifion er mwyn sicrhau bod gwybodaeth hanfodol ar gael yn ddwyieithog o fewn 1-2 ddiwrnod gwaith, a, lle mae capasiti'n	

				caniatáu, o fewn yr un diwrnod gwaith ar gyfer eitemau brys iawn. Mae gwasanaeth y tu allan i oriau gwaith ar gyfer amgylchiadau eithriadol er mwyn sicrhau cyfathrebu dwyieithog amserol. Mae'r ddarpariaeth hon yn sicrhau y gellir cyhoeddi gwybodaeth hanfodol yn y Gymraeg a'r Saesneg ar yr un pryd, gan atgyfnerthu ymrwymiad y Bwrdd Iechyd i drin y Gymraeg yn gyfartal a chynnal cydymffurfiaeth â gofynion statudol. Mae'r Tîm Cyfieithu yn parhau i gynnig gwasanaeth cyfieithu ar y pryd a ddarperir naill ai wyneb yn wyneb neu ar lwyfannau ar-lein	

				'Zoom' a 'Microsoft Teams'. Derbyniwyd ceisiadau gyda'r mwyafrif yn gofyn am gyfieithu ar gyfer digwyddiadau, cyfarfodydd a chynadleddau rhanddeiliaid, a chyfweliadau i ymgeiswyr sy'n dymuno cael eu cyfweliadau drwy gyfrwng y Gymraeg.	
38	Byddwn yn gweithio gyda'r rheini sy'n arolygu ac yn gwella ansawdd er mwyn sicrhau bod y cynnig rhagweithiol yn rhan o'u gwaith. Byddwn y cyfeirio sefydliadau sy'n tanberfformio at gefnogaeth a chyngor priodol. *(Tymor canolig)*	Arolygiaeth Gofal Cymru ac Arolygiaeth Gofal Iechyd Cymru i ddarparu gwybodaeth am arweiniad a hyfforddiant i arolygwyr i gefnogi adrodd ar yr iaith a'r diwylliant Cymraeg, a'r cynnig rhagweithiol. AGC ac AGIC hefyd i ddarparu data arolygiaeth perthnasol ar gydymffurfiaeth / diffyg	Cyrff Rheoleiddio ac Arolygu (AGC ac AGIC)		

		cydymffurfiaeth â gofynion y Gymraeg.			
39	Datblygu'r broses o fapio'r data sydd ar gael, ac a ddarperir yn Atodiad A y fframwaith, a dod o hyd i fylchau data a fydd yn helpu i fesur cynnydd. *(Tymor byr)*	Bydd Llywodraeth Cymru yn rhoi diweddariad ar y cam hwn. Mae'r ymrwymiad hwn yn cysylltu'n uniongyrchol â Cham Gweithredu 5 a'r gwaith a wnaed gan Alma Economics i fapio ac adolygu data ar y Gymraeg mewn iechyd a gofal cymdeithasol (i'w gyhoeddi'n fuan).	Llywodraeth Cymru		
40	Gan ddefnyddio'r data sydd ar gael pan fo modd, datblygu dangosyddion sy'n mesur cynnydd tuag at y Cynnig Rhagweithiol a darparu gwasanaethau dwyieithog, a dod o hyd i fylchau data a fyddai'n helpu i fesur cynnydd ymhellach. *(Datblygu dangosyddion cychwynnol – Tymor byr Dod o hyd i fylchau data – Tymor byr*	Bydd Llywodraeth Cymru yn darparu'r diweddariad am y cam hwn. Bydd hyn yn bosibl unwaith y cyhoeddir yr ymarfer mapio ac adolygu data (gweler Cam 5).	Llywodraeth Cymru		

	Llenwi bylchau data pan fydd modd – Tymor canolig)				
41	Sefydlu gweithgor i ddatblygu dangosfwrdd sy'n dod â data perfformiad ynghyd i ddangos y cynnydd a wneir o ran y Cynnig Rhagweithiol a darparu gwasanaethau dwyieithog. Bydd hyn yn cynnwys data o fframwaith perfformiad yr awdurdod lleol; AGC; AGIC; swyddfa Comisiynydd y Gymraeg; adroddiadau perfformiad / Cynllun Tymor Canolig Integredig y GIG. *(Sefydlu gweithgor – Tymor byr* *Cyhoeddiad cyntaf y dangosfwrdd – Tymor canolig* *Uwchgynhadledd i rannu'r dangosfwrdd â pherchnogion data – Tymor canolig)*	Bydd hyn yn bosibl unwaith y cyhoeddir yr ymarfer mapio ac adolygu data (gweler Cam 5).	Llywodraeth Cymru		
42	Bydd pob corff iechyd ac awdurdod lleol yn penodi unigolyn i fod yn gyfrifol am sicrhau bod camau gweithredu a thargedau'r cynllun yn cael eu cyflawni.	Holl gyrff iechyd ac awdurdodau lleol i nodi enw'r unigolyn sy'n gyfrifol am sicrhau bod y camau yn cael eu cyflawni.	Pob corff iechyd ac awdurdod lleol	Cwblhawyd	

43	Monitro cynnydd Mwy na Geiriau: Darparu diweddariad ysgrifenedig ar y cynnydd a wnaed ar y camau gweithredu ar sail 12 mis. *(Yr Adroddiad Blynyddol Cyntaf – Haf 2023)*	Bydd Llywodraeth Cymru yn darparu diweddariad ar y cam hwn.	Pob sefydliad atebol sydd wedi'i restru yn y cynllun hwn	Cwblhawyd	
44	Sefydlu bwrdd cynghori i fonitro a chraffu ar gynnydd yn erbyn y cynllun gweithredu. Bydd y Bwrdd Cynghori yn gwneud argymhellion i'r Gweinidog ynghylch ble gellir gwneud cynnydd pellach, ac unrhyw bryderon a ddaw i'r amlwg ynglŷn â chyflawni'r uchelgais. Bydd adroddiad yn cael ei baratoi i'w ystyried gan Weinidogion, a'i rannu ag arweinwyr iechyd a gofal cymdeithasol. Bydd y bwrdd cynghori hefyd yn ystyried ac yn cynghori ar ofynion archwilio a gwerthuso er mwyn darparu asesiadau annibynnol ar gynnydd. *(Adroddiad cynghori blynyddol 2023.*	Bydd Llywodraeth Cymru yn rhoi diweddariad ar y cam hwn. Mae Bwrdd Cynghori Mwy na Geiriau wedi bod ar waith ers mis Awst 2023.	Llywodraeth Cymru		

	Bydd yr adroddiad cynghori yn pwyso a mesur data'r dangosfwrdd o 2025 ymlaen)				
45	Bydd y Gweinidog yn cynnal cyfarfodydd cynnydd blynyddol ag arweinwyr y sefydliadau a restrir i gyflawni camau gweithredu'r cynllun, gan gynnwys y GIG ac Awdurdodau Lleol, i gydnabod yr hyn a gyflawnwyd ac ym mhle mae angen gwneud rhagor o gynnydd. Bydd datganiad ar gynnydd yn cael ei rannu ag Aelodau'r Senedd bob blwyddyn. *(Cyfarfod Cynnydd Blynyddol Cyntaf – Hydref 2023 Y Datganiad Cyntaf i Aelodau'r Senedd – Hydref 2023* *O 2025 ymlaen, bydd yr adroddiad cynnydd yn cynnwys y dangosfwrdd data perfformiad)*	Bydd Llywodraeth Cymru yn rhoi diweddariad ar y cam hwn.	Llywodraeth Cymru		

Ffurflen i'w chwblhau a'i dychwelyd erbyn: 1 Medi 2025 fan bellaf